



STAY ENGAGED. STAY INFORMED.

2022

TUESDAY, OCTOBER 13:

**IOWA MEDICAID
MODERNIZATION**

WELCOME



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Iowa's Medicaid Program Updates and Transition

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Medicaid Today

- Medicaid in Iowa currently provides health care assistance to about 560,000 people at a cost of approximately \$4.2 billion dollars annually
- A key budgetary challenge is the increasing costs to provide services and decreasing federal funds to do so
- The cost of delivering this program has grown by 73 percent since 2003
- And, Medicaid total expenditures are projected to grow by 21% in the next three years



New Approach: Medicaid Modernization

In February 2015, DHS issued a Request for Proposal, titled the Iowa High Quality Health Care Initiative

- Moves Medicaid program towards risk-based managed care approach
- Impacts most Medicaid members and begins January 1, 2016



Iowa's Managed Care Organizations Contracting

- DHS issued a Notice of Intent to Award contracts on Monday, August 17, 2015 to the four bidders below:
 - AmeriGroup Iowa, Inc.
 - AmeriHealth Caritas Iowa, Inc.
 - UnitedHealthcare Plan of the River Valley, Inc.
 - WellCare of Iowa, Inc.



Iowa's Goals

Goal

- Improved quality and access

Goal

- Greater accountability for outcomes

Goal

- More predictable and sustainable Medicaid budget



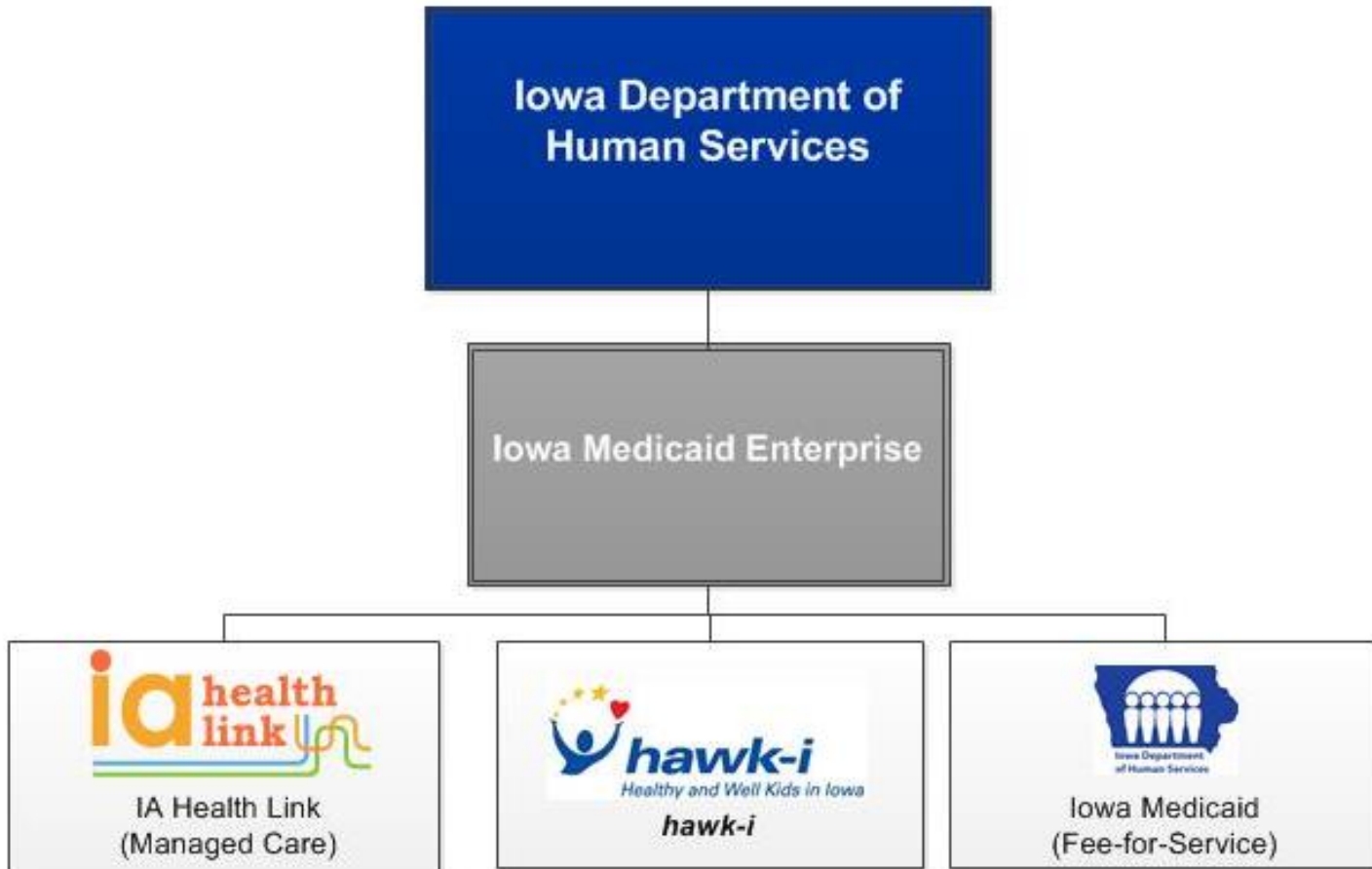
Branding and Communications

- IA Health Link is now the name for the Iowa Medicaid managed care program
- Links together physical health care, behavioral health care, and long term care under one program





Iowa Medicaid Program Overview





Iowa Medicaid External Operational Readiness: Preparing to Implement Medicaid Modernization



MCO Readiness Review

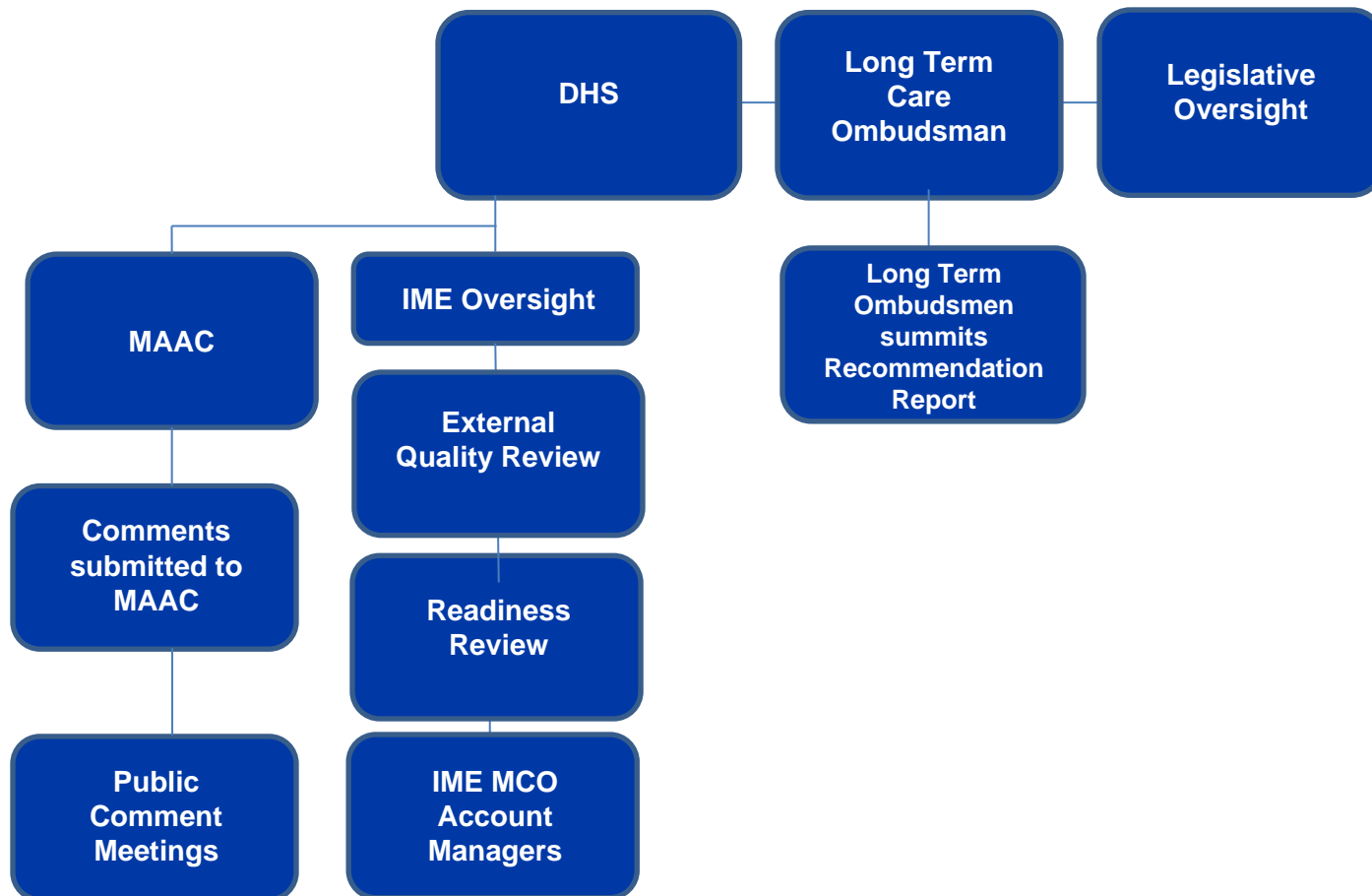
Before any MCO can begin serving Medicaid members, the MCO must demonstrate their readiness to meet the care needs of new members

- Facilitates a smooth transition
- Minimizes negative impacts of the transition

State staff will be supported by consultants, selected through a competitive procurement process



Modernization Oversight Visual





MCO Reporting Requirements

- Developing comprehensive public reporting dashboard
 - Regular schedule for distribution of reports
- A number of reports will be required to be submitted directly to DHS by the MCOs
- Shifting staff focus to oversight and monitoring



Stakeholder Oversight

- Established through the Medical Assistance Advisory Council (MAAC) and the MAAC Executive Committee
 - Outlined in Senate File 505
 - Used as the primary stakeholder group to receive updates on implementation and make recommendations to DHS



Public Involvement in Oversight

Monthly meetings where members and the public can share comments with DHS

- Held throughout the state
- Rural and urban areas
- Comments summarized and shared with MAAC, who makes formal recommendations to DHS

Public Comment Meetings



Comments Submitted to
MAAC



MAAC Makes
Recommendations to DHS



Legislative and Other Oversight

Long Term Care Ombudsman

- New ombudsman developed to be an advocate for LTC members
- Independent of DHS

Legislative Involvement in Oversight

- Establishment of a legislative oversight committee
- Comprised of House and Senate members
- Receive reports and information on implementation



Member Transition



Member Populations

Included

- Low income families and children
- Iowa Health and Wellness Plan
- Long Term Care
- HCBS Waivers
- *hawk-i*

Excluded

- PACE (member can opt in)
- American Indians/Alaskan Natives (can opt in)
- Programs where Medicaid already pays premiums: Health Insurance Premium Payment Program (HIPPP), Medicare Savings Program only
- Medically Needy
- Undocumented persons eligible for short-term emergency services only
- Presumptively eligible



Member Eligibility

- No changes to current application or eligibility process, including waiver lists
 - Applications continue to be processed by DHS
 - Application still available online, phone, paper
- Enrollment in MCO occurs after an eligibility determination is made
 - Members will receive information and enrollment packet after eligibility notice



Member Benefits

- Physical health care in inpatient and outpatient settings, behavioral health care, transportation, etc.
- Facility-based services such as Nursing Facilities, Intermediate Care for Persons with Intellectual Disabilities, Psychiatric Medical Institution for Children, Mental Health Institutes and State Resource Centers
- Home and Community-Based Services (HCBS) waiver services
- Dental services continue as today – “carved out” of MCO



DHS Member Outreach & Education

- Tele-townhall meetings
- Events and trainings
- Newsletters
- Member educational materials
- Member mailings
- Community partnerships
- Coordination with stakeholders and providers
- Advisory and member-based focus groups
- Website content
- Webinars



Member Enrollment Activities

Overview of Enrollment Process

October 2015	October 2015	November 2015	December 2015	January 2016	February 2016	March 2016
Introductory Mailings by population	MCO Enrollment Begins	Enrollment assistance continues	December 17, 2015: Last Day to Make MCO Choice for January 2016	January 1: Begin Coverage with MCO		March 19: Member must have Good Cause to make change
			December 18, 2015- March 18, 2016: Member can change MCO without Good Cause			



Step 1: Introductory Mailings

- Introductory mailings sent to members in early October, and posted online:
 - Long Term Care and HCBS Waivers
 - *hawk-i*
 - Traditional Medicaid groups
 - Current managed care
- Mailings includes:
 - Timeline
 - FAQ
 - Contacts for questions



Step 2: Enrollment Packet and Making MCO Choice

Member enrollment packets mailed late October through November

- MCO assignment included and based on algorithm to keep families together under one MCO
- Staggered mailing by program enrollment
- Current members have until December 17 to choose their MCO for January 1, 2016
- DHS notifies MCO of selection through enrollment file



90 Day Choice Period

- Members have until December 17, 2015, to make a choice for January 1
 - If no choice is made, member is enrolled with the assigned MCO for January to ensure coverage is in place and available
- Can make a change to MCO assignment for any reason for an additional 90 days- through March 18, 2016
 - Can change for good cause reason after March 18, or during the annual choice period



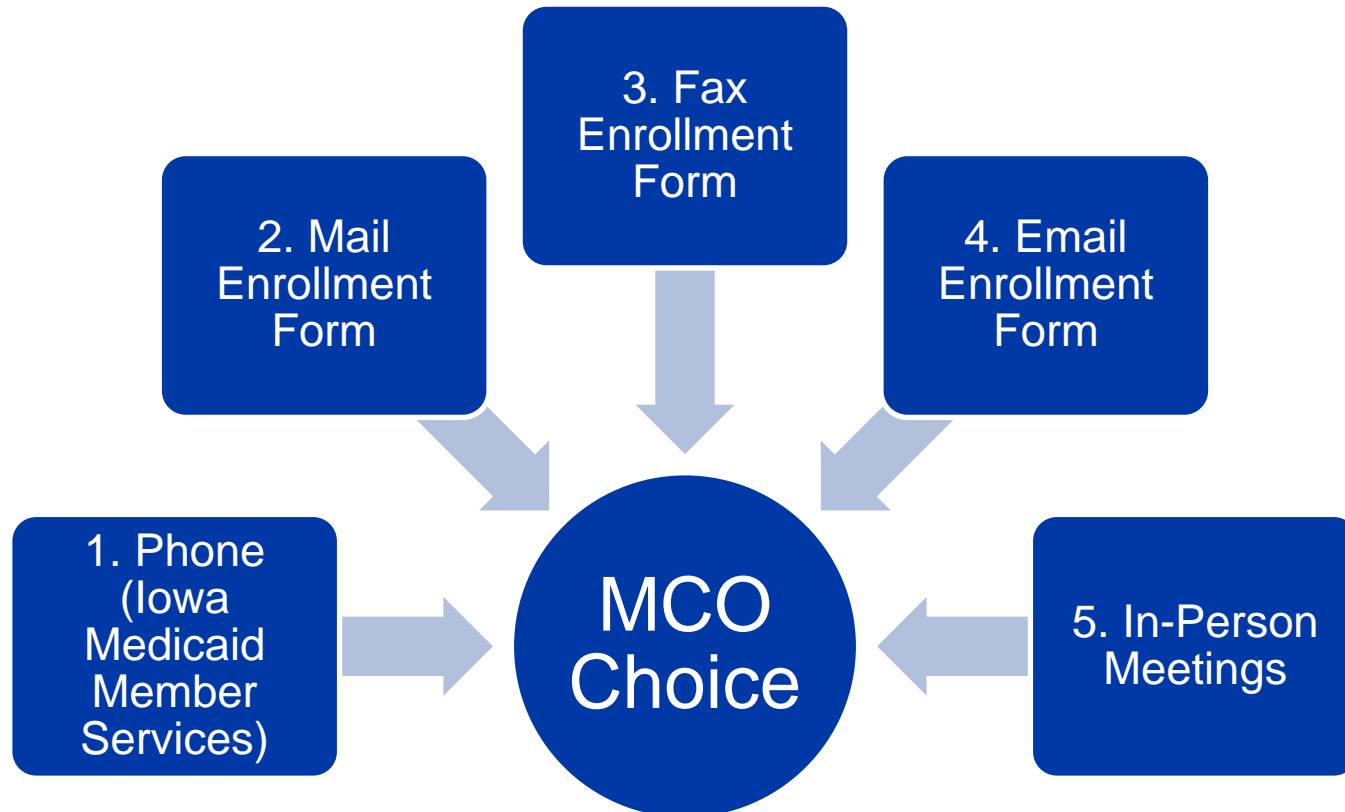
Help Making MCO Choice

- Iowa Medicaid Member Services is the independent Enrollment Broker and responsible for providing information and conflict free choice counseling for members in the selection of a MCO
- Key activities to share information and support member selection of MCO:
 - In-person meetings throughout state in October and November, schedules posted online
 - Email: IMEMemberServices@dhs.state.ia.us
 - Call Center: 1-800-338-8366, 8am-5pm, M-F

Members can select their MCO through voice system option 24/7 daily. Can leave message for call back



Step 2: Making MCO Choice





MCO Considerations for Members

Iowa Medicaid Member Services will offer health plan choice counseling to members. Choice counseling includes answering member questions about each health plan such as:

- Is my provider in the MCO network?
- Is my pharmacy in the MCO network?
- Does the MCO have specialists close to my community?
- Does the plan have value-added services that would benefit me?
- Are there special health programs that would help me?
- Does the MCO have call centers or helplines available beyond regular business hours?



Resources for Making MCO Choice

Iowa Medicaid Member Services

- In-Person
- Phone
- DHS Website

Enrollment Packet

- Managed Care Handbook
- MCO Informational Materials
- Samples will be posted online

Comparison Chart

- Quick MCO Comparison Guide
- Will be posted online

MCO Provider Directory

- Available Online
- Through MCOs



Member ID Cards

Member Has Two Cards

1. Medicaid Card

Member receives or continues to use Medicaid ID card for dental or fee-for-service

2. MCO Card

MCO sends member ID card for use after MCO enrollment



*Iowa Health and Wellness Plan members have three cards, using Dental Wellness Plan card for dental services and *hawk-i* members will continue to use separate dental card.



Member Enrollment in MCO

- MCO enrollment begins on the first of each month
 - Typically no mid-month MCO changes
- Member contacts MCO with questions about benefits, providers, other services
 - Each MCO will have a dedicated member phone line
 - Can contact Iowa Medicaid Member Services if there are issues or concerns with the MCO



Step 4: MCO Changes for 'Good Cause'

- Members may disenroll from their MCO at any time throughout the year for reasons of “good cause”
 - Changes requested through Iowa Medicaid Member Services
- “Good cause” reasons can include:
 - A member’s provider is not enrolled with the MCO
 - A member needs related services to be performed at the same time and not all related services are available in the MCO network

If there is a change in eligibility (for example PACE)



Provider Transition



Provider Impact

Service Authorizations

- MCOs will honor existing authorizations for at least three months

Networks

- Providers can be part of multiple MCO networks

Utilization Management

- MCOs are responsible for utilization management, approved by DHS

Claims Payment

- MCOs required to pay within similar timeframes as Medicaid does



MCO Provider Network Requirements

Physical & Behavioral

- MCOs will use all current Medicaid providers for the first six months
- MCOs network effective July 1, 2016
- Strict network adequacy

Waiver & Long Term Care

- MCOs will use all current LTC waiver providers, if they contract with the MCO, for the first two years
- MCO network effective January 1, 2018
- Strict network adequacy



DHS Provider Education and Training

- Statewide training in 11 locations across Iowa in September
- Tele-townhall meetings
- Events and trainings
- Monthly newsletters
- Provider educational materials updated continually
- Stakeholder emails
- Informational Letters 1537 and 1539 and upcoming



Provider Enrollment Process Overview

- All in-state and out-of-state providers, whether providing services under MCO or FFS, must enroll with Iowa Medicaid to ensure continuity of care for members
 - This includes referring/prescribing providers per ACA requirements
- Providers will enroll with Iowa Medicaid prior to MCO
- Provider Services will continue the IME provider enrollment process
- DHS will collaborate with MCOs to develop a provider enrollment process that is as streamlined and as efficient as possible for providers



MCO Provider Enrollment

- Each MCO will develop its provider network, enrolling all current Medicaid providers when possible
- DHS will provide Medicaid provider enrollment information to each MCO to assist in preventing a duplication of efforts for providers
- MCOs will each have their own credentialing process to meet their accreditation standards
- If an MCO recruits a new provider, it will be expected to assure that provider is also enrolled by IME
- Out-of-state and other non-contracted providers may enter into single case agreements with MCOs as necessary to serve the needs of members in special situations



Information and Questions

	Contact Information
General Information	http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization
Modernization Stakeholder Questions	Email: MedicaidModernization@dhs.state.ia.us
Modernization Member Questions	Contact Iowa Medicaid Member Services Phone: 1-800-338-8366 Email: IMEMemberServices@dhs.state.ia.us
Modernization Provider Questions	Contact Iowa Medicaid Provider Services Phone: 1-800-338-7909 Email: IMEProviderServices@dhs.state.ia.us

QUESTIONS & ANSWERS





THANKS FOR ATTENDING!

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**JOIN US TUESDAY, NOVEMBER 10:
E-PRESCRIBING OF
CONTROLLED SUBSTANCES**

Questions? Contact Laura Miller at lmiller@iarx.org or 515-270-0713