DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 235
Kansas City, Missouri 64106

**Division of Medicaid and Children's Health Operations**

September 9, 2009

Jennifer Vermeer, Medicaid Director
Division of Medical Services
Department of Human Services
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, Iowa 50315

Dear Ms. Vermeer:

Enclosed is the final report of the Iowa Medicaid managed care review conducted by the Centers for Medicare & Medicaid Services (CMS) during the week of June 8, 2009. The report examines operational aspects of The Iowa Plan for Behavioral Health and the Managed Health Care program and identifies noteworthy practices and recommendations for improvement of these programs. Iowa's August 11, 2009 response to the draft report has been incorporated into this final report.

I would like to express my appreciation for the cooperation of your staff throughout the planning, onsite, and analysis phases of the review. I would especially like to acknowledge Dennis Janssen for his knowledgeable input, time, and effort in assisting my staff during this review.

If you have any questions, please contact Michelle Opheim or Sharon Taggart at (816) 426-5925.

Sincerely,

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Dennis Janssen ✓

# Iowa Medicaid Managed Care
# Centers for Medicare and Medicaid Services (CMS)
# Onsite Review

**US DEPARTMENT OF HEALTH AND HUMAN SERVICES**
**Centers for Medicare and Medicaid Services**
**Kansas City Regional Office**

**Conducted**
**June 8-10, 2009**

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**REVIEWERS:**
**Michelle Opheim**
**Sharon Taggart**

## Executive Summary

The Centers for Medicare & Medicaid Services (CMS), Kansas City Regional Office (RO) conducted an onsite review of Iowa's managed care programs, Medical Managed Health Care and The Iowa Plan for Behavioral Health, during the week which began June 8, 2009. The CMS review team met with staff from the Iowa Medicaid Enterprise (IME). The review concentrated on the functional areas of Enrollment; Quality and Access to Care; Fraud and Abuse; and Encounter Data.

The RO focused particular attention on the Medical Managed Health Care Primary Care Case Management (PCCM) program, Medicaid Patient Access to Service Systems (Medipass), for two reasons. First, because the State's only Managed Care Organization (MCO) left the program effective February 1, 2009 and its enrollees were transitioned into the PCCM. Second, because the State was in the process of reprocuring its Prepaid Inpatient Health Plan (PIHP) contract for behavioral health as the current contract approached expiration.

In addition to interviews with IME staff, the Regional Office conducted desk reviews of existing data and documentation submitted by the State. The documents reviewed included the approved Medicaid State Plan Section 3.1-F; the approved 1915(b) waiver; member materials; enrollment broker operational reports; managed care plan operational reports; and State internal procedures for fraud and abuse and encounter data reporting.

This report describes both noteworthy practices and recommendations made for the continued improvement of Iowa's managed care programs. The CMS review team wishes to commend IME staff on their obvious commitment to operating a stable program that ensures quality health care services for all enrollees.

In summary, the federal review team recommendations include the following:

### Enrollment

Description of Enrollment Period

The Notice of Decision provides the enrollee a date by which they must choose a provider if they do not want the managed health care provider listed. It also indicates that the enrollee may change the managed health care provider for any reason within ninety days of the letter. After that, the enrollee will be required to stay with the same provider for a minimum of six months.

The "Your Choice" handbook under the heading "Can I Change Providers Later?" states, "From the time you receive your enrollment notification letter, you will have ninety days to choose an MHC provider. After the ninety day period, you must remain with that MHC provider for six months".

It appears the two materials are inconsistent in describing enrollment period timeframes. CMS recommends the State review the Notice of Decision and the "Your Choice" handbook to ensure consistency with the current approved State Plan and update materials as necessary to clearly communicate this to enrollees.

Provider Directory

The Notice of Decision sent to inform eligibles that they must enroll in the Medical Managed Health Care program states, "You can find out if your provider is available as a managed health care provider or request a listing of participating providers by calling the Member Services Call Center." This statement seems to indicate that the State is out of compliance with 42 CFR 438.10(f) which requires States to provide potential enrollees with a copy of the provider directory. The provision of a provider directory is an important safeguard in assisting the new enrollee to choose a Patient Manager (PM) who will meet his/her specific health care needs.

While onsite, CMS confirmed that the State does, in fact, provide a hardcopy of the provider directory in the enrollment packet provided to new eligibles who are required to enroll in managed care. In light of that fact, CMS recommends that Iowa revise the Notice of Decision to reflect that a provider listing is enclosed.

**Quality and Access to Care**

Medipass Appointment Availability Survey

The State reported that it uses PM appointment availability standards of 24 hours for urgent care needs, 7 days for immunizations, and 14 days for routine care needs.

The Provider Services Unit conducts appointment surveys on a quarterly basis. The survey appropriately assesses foreign languages spoken by the PM, open/closed panel status of the PM, and appointment availability for urgent and preventive care needs. The survey does not appear to include questions to assess appointment availability for immunizations (the survey only asks whether immunizations are performed) or routine care needs.

The survey should be revised to incorporate questions to assess appointment availability for immunizations and routine care needs so that the data collected will directly correspond to the State determined appointment availability standards.

**Fraud and Abuse**

None.

**Encounter Data**

None.

Iowa's August 11, 2009 response to the CMS draft report has been incorporated into the body of this final report.

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## Introduction and Methodology

The Centers for Medicare & Medicaid Services (CMS), Kansas City Regional Office (RO) conducted an onsite review of Iowa's managed care programs, Medical Managed Health Care and The Iowa Plan for Behavioral Health, during the week which began June 8, 2009. The CMS review team met with staff from the Iowa Medicaid Enterprise (IME). The review concentrated on the functional areas of Enrollment; Quality and Access to Care; Fraud and Abuse; and Encounter Data.

The RO focused particular attention on the Medical Managed Health Care Primary Care Case Management (PCCM) program, Medicaid Patient Access to Service Systems (Medipass), for two reasons. First, because the State's only Managed Care Organization (MCO) left the program effective February 1, 2009 and its enrollees were transitioned into the PCCM. Second, because the State was in the process of reprocuring its Prepaid Inpatient Health Plan (PIHP) contract for behavioral health as the current contract approached expiration.

In addition to interviews with IME staff, the Regional Office conducted desk reviews of existing data and documentation submitted by the State. The documents reviewed included the approved Medicaid State Plan Section 3.1-F; the approved 1915(b) waiver; member materials; enrollment broker operational reports; managed care plan operational reports; and State internal procedures for fraud and abuse and encounter data reporting.

Review protocols were developed by CMS and shared with State staff in advance of the onsite review. For each protocol element, this report identifies operations considered by the federal reviewers to constitute noteworthy practices and recommendations for potential enhancements of the current programs. The recommendations are provided to serve as guidelines for State staff as they continue to refine the programs and improve managed care operations.

## Background

### Medical Managed Health Care Program

Medicaid Managed Care was introduced to Iowa in 1986 when the State contracted for the delivery of medical/surgical services in Scott County on a risk-based, capitated basis. The State contracted with John Deere Health Plan as the first Medicaid MCO. In 1990 Iowa implemented the Medipass PCCM program in seven counties.

The PCCM program enrolls the eligible with a patient manager (PM) who is responsible for providing primary care and for coordinating or authorizing other necessary care. Participating physicians are paid a monthly fee for providing case management services to assigned beneficiaries. All other services

provided through the PCCM program are reimbursed on a fee for service basis.

Today, the PCCM program operates under Section 1932(a) Medicaid State Plan authority and is offered in 93 of the State's 99 counties. The MCO program was terminated effective February 1, 2009 when the State's only remaining MCO, Coventry Health Care of Iowa, left the program. Currently, there are approximately 160,000 members enrolled in the PCCM program. This enrollment represents about 40% of the total Medicaid population.

In counties with Medicaid managed care, the PCCM program is mandatory for recipients receiving assistance through the Family Investment Program (FIP) and FIP-related programs (TANF). Enrollees are offered a choice of PMs. Enrollment is voluntary in four counties that have active PMs but do not currently meet the State-determined criteria for access. If a beneficiary residing in a mandatory county fails to choose a PM at initial enrollment, he is default assigned.

**The Iowa Plan**

In 1995 the State began separate managed mental health and substance abuse programs which served most beneficiaries who were not enrolled with an MCO who were under age 65. In July of 1997, mental health and substance abuse services were carved out of the MCO responsibility and moved to the mental health and substance abuse PIHP, a statewide contract called the Iowa Plan for Behavioral Health (the Iowa Plan). This program operates under 1915(b) waiver authority.

The PIHP contractor, Magellan Behavioral Health, integrates delivery of mental health care and substance abuse treatment. Most Medicaid eligible members under the age of 65 are enrolled in the PIHP. The State plans to add the age 65 and older population to the PIHP program beginning July 1, 2010. Current enrollment is approximately 300,000 or about 80% of the total Medicaid population.

Through the use of savings realized under the 1915(b) waiver, Iowa is able to provide services to PIHP enrollees that are not covered under traditional Medicaid fee-for-service. These "additional" services are provided under Section 1915(b)(3) authority and allow for the use of a number of community-based strategies that offer a cost-efficient, less restrictive and more effective alternative to hospitalization.

**Enrollment**

CMS's focus in this functional area was on how the State modified its enrollment process to account for the departure of the MCO from the Medical Managed Health Care program. Existing MCO enrollees were given the 30 day notice

required by 42 CFR 438.10(f)(4) and were provided with a new enrollment period including choice of PM.

Iowa modified the systems logic used to default enroll Medicaid beneficiaries who reside in a mandatory county but fail to choose a PM so that it excludes the MCO. Prior to this change, the algorithm distributed assignments equally between the MCO and PCCM programs in counties in which the MCO participated. The system logic continues to make assignments based on zip code of the enrollee's residence. In addition, if the enrollee had a prior enrollment period with the PCCM program, he is reassigned to his previous PM to ensure continuity of care. If the enrollee is associated with an already active Medicaid case, the enrollee is assigned to the same PM as other household members.

The total enrollment period for the PCCM program is 9 months. As required at 42 CFR 438.56(c)(2)(i) members have the right to change their PM election during the first 90 days of the enrollment period. Sixty days prior to the end of the enrollment period members are notified of the upcoming open enrollment period and their right to change PMs at that time.

Noteworthy Practice

1. MCO Transition

Iowa is commended for its management of the MCO's transition out of the Medical Managed Health Care program. The State managed its relationship with the MCO over time in an open and cooperative manner and, as a result, was not taken offguard when the MCO decided to leave the program. The State was, therefore, in a good position to provide members with the required notifications and a smooth transition process to the PCCM program.

Recommendations

1. Description of Enrollment Period

The Notice of Decision provides the enrollee a date by which they must choose a provider if they do not want the managed health care provider listed. It also indicates that the enrollee may change the managed health care provider for any reason within ninety days of the letter. After that, the enrollee will be required to stay with the same provider for a minimum of six months.

The "Your Choice" handbook under the heading "Can I Change Providers Later?" states, "From the time you receive your enrollment notification letter, you will have ninety days to choose an MHC provider. After the ninety day period, you must remain with that MHC provider for six months".

It appears the two materials are inconsistent in describing enrollment period timeframes. CMS recommends the State review the Notice of Decision and the "Your Choice" handbook to ensure consistency with the current approved State Plan and update materials as necessary to clearly communicate this to enrollees.

**State Response:** The IME will review these two documents and make changes to assure clarity. However, we do not believe that the two statements say anything different. Both tell the member about the first 90 days from the date of the letter during which a choice must be made and both say that after that the member is required to stay with that provider except under circumstances described in the handbook. We are revising the letter to assure that the distinction is clear and that the member understands that the 6-month period begins after the 90 days expires.

**CMS Response to the State:** CMS concurs with the action proposed by the State.

2. Provider Directory

The Notice of Decision sent to inform eligibles that they must enroll in the Medical Managed Health Care program states, "You can find out if your provider is available as a managed health care provider or request a listing of participating providers by calling the Member Services Call Center." This statement seems to indicate that the State is out of compliance with 42 CFR 438.10(f) which requires States to provide potential enrollees with a copy of the provider directory. The provision of a provider directory is an important safeguard in assisting the new enrollee to choose a PM who will meet his/her specific health care needs.

While onsite CMS confirmed that the State does, in fact, provide a hardcopy of the provider directory in the enrollment packet provided to new eligibles who are required to enroll in managed care. In light of that fact, CMS recommends that Iowa revise the Notice of Decision to reflect that a provider listing is enclosed.

**State Response:** In this particular instance, the commentary was meant to tell the new member that if their current provider is not on the list that they can also call us to check availability of their current practitioner. Therefore, we will change the letter to indicate that the member can check the list and, if their provider is not found, call us for assistance. There are many times when a provider does not list a contiguous county but will accept current patients from that county so this will be a place where we can improve our communication to new members.

**CMS Response to the State:** CMS concurs with the action proposed by the State.

## Quality and Access to Care

In this functional area, CMS examined provider credentialing for the PCCM and PIHP programs and monitoring of quality/access for the PCCM program.

Provider Credentialing

For the PCCM program the State does not credential providers, but does validate credentials that are required to be submitted with the signed Medicaid provider agreement. This validation includes a review and verification of current State licensure and review of any disciplinary actions from the applicable licensure board. The List of Excluded Individuals/Entities (LEIE) is reviewed along with any other federal listing that might provide information about the applicant's ability to participate in either Medicaid or Medicare. Medicaid provider agreements are renewed every four years.

For the PIHP program, the credentialing function is delegated to the PIHP contractor. The PIHP contractor's credentialing process includes site visits to those providers applying for network status that are not licensed or accredited by the State or that do not have national accreditation through the Council on Accreditation (COA), the Commission on Accreditation of Rehabilitation Facilities (CARF), or the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). The PIHP contractor conducts primary source verification of licensure, checks disciplinary and disbarment status, and requires verification of mandatory insurances. Providers are recredentialed every three years.

Monitoring of Quality/Access

The State uses Geo-access software, verification of provider appointment availability and 24 hour access, and review of referral documentation to monitor PCCM program access on a continuing basis. Quality is monitored through Healthcare Effectiveness Data and Information Set (HEDIS) and Consumer Assessment of Healthcare Providers and Systems (CAHPS) results. All HEDIS outcome measures are published.

In addition, a quarterly review is performed of all member-requested changes of PM. Any PM who has more than 20 such changes in a quarter is reviewed to determine the reasons behind these changes. Based on the results of this review, the State may implement corrective action.

Noteworthy Practices

1. Medipass Patient Utilization Report

Iowa is commended for providing feedback to PMs using the quarterly Medipass Patient Utilization Report. This report compares the average utilization of the

PM's members with specialty and statewide average utilization. The report identifies individual members with utilization more than two standard deviations from the statewide average for inpatient hospital, outpatient hospital, emergency room, home health, physician office, physician surgery, pharmacy, lab/x-ray, durable medical equipment, chiropractic, podiatry, and other practitioner visits.

Although the Medipass Patient Utilization Report specifically states that the data provided is not an indicator of PCCM performance, the effort is recognized as a significant step toward providing feedback on utilization to individual PMs.

2. Special Authorization Process

For the quarter ending 3/31/09 approximately 2,000 member-requested PM disenrollments were for the reason, "member states they have longstanding relationship with specific provider." These disenrollments accounted for about 50% of the total disenrollments for the quarter.

Iowa has developed a special authorization process to minimize the disruption in care for enrollees who fail to choose a PM at initial enrollment and are, therefore, default assigned to a PM who is other than the doctor with whom they have a longstanding relationship. The special authorization process allows the member to obtain referrals directly from IME to see his/her doctor of choice and obtain necessary medical care while the reassignment to the preferred PM is being effectuated.

The State reports that it is looking at ways to bolster the choice rate which currently stands at around 30%. As the State explores ways to improve choice, it is commended for developing the Special Authorization Process to preserve continuity of care for members who do not take action during the initial enrollment period to choose the PM they prefer.

Recommendation

1. Medipass Appointment Availability Survey

The State reported that it uses PM appointment availability standards of 24 hours for urgent care needs, 7 days for immunizations, and 14 days for routine care needs.

The Provider Services Unit conducts appointment surveys on a quarterly basis. The survey appropriately assesses foreign languages spoken by the PM, open/closed panel status of the PM, and appointment availability for urgent and preventive care needs. The survey does not appear to include questions to assess appointment availability for immunizations (the survey only asks whether immunizations are performed) or routine care needs.

The survey should be revised to incorporate questions to assess appointment availability for immunizations and routine care needs so that the data collected will directly correspond to the State-determined appointment availability standards.

**State Response:** We have revised the interview form to capture the actual time frames that are reported to us and to add immunizations and routine care. We will continue to incorporate these findings into the MHC monthly reports that are delivered to us for review, comment and potential action. The time frames outlined by staff at the review are those which we have used for quite some time. We have an active Clinical Advisory Committee whose members are medical practitioners. We have placed this specific item on the agenda for the September meeting. While the new interview questions will not change, we may change our monitoring and reporting of the results based on the recommendation of this committee.

**CMS Response to the State:** CMS concurs with the action proposed by the State.

## Fraud and Abuse

CMS examined fraud and abuse with regard to the PIHP contractor. The PIHP contractor reports fraud and abuse to the State in a variety of ways: informal e-mail and verbal communications, formal reports within 10 days of detection, and quarterly and annual operational reports.

Fraud and abuse is a standing agenda item at all Quality Improvement Committee and Department meetings. In compliance with 42 CFR 455.17, a formal report of fraud must include the name and ID number, source of complaint, type of provider, nature of complaint, approximate dollars involved, and legal/administrative disposition of the case.

The State Medicaid Agency reports all instances of PIHP contractor identified fraud and abuse to the State's Medicaid Fraud Control Unit (MFCU). The PIHP contractor's Special Investigation Unit (SIU) also works directly with the MFCU as appropriate.

### Noteworthy Practices

1. Coordination with MFCU

The PIHP contractor's internal fraud and abuse guidelines appropriately incorporate requirements to report suspected cases of fraud and abuse to the State. The State is commended for assuring that the appropriate "linkages" exist to communicate this information to the MFCU.

Recommendations

None

## Encounter Data

The purpose of this portion of the report is to document how the State currently uses, and does not use, encounter data. No conclusions are drawn concerning noteworthy practices or recommendations.

The PIHP contractor reports encounter data in accordance with the encounter data layout file developed by the State. The State requires the PIHP contractor to certify encounter data upon submission as required at 42 CFR 438.604 and 438.60. CMS was provided with an example of such a certification.

When the State receives an encounter data submission, a completeness review is performed. The submission cannot have more than a 1% error rate in order to be accepted. When the 1% error rate is exceeded the entire encounter data file is rejected and must be recomposed by the PIHP contractor. The current PIHP contractor has never exceeded the 1% error rate.

The State does not currently perform review of medical records to validate that the services reimbursed by the PIHP were actually performed. The State reported that many mental health and substance abuse providers are reimbursed on a cost basis, so efficiency in reporting of care is not paramount. The State's primary concern is that enrollees receive care. If appropriate care is not received, the State is more likely to learn of it through other means, such as the grievance and appeals process, than through audit of medical records in conjunction with review of encounter data.

The State's primary use for encounter data is to analyze historical trends in utilization. The State's actuary takes these utilization trends into consideration when developing actuarially sound upper and lower bound rate cells for PIHP capitation rates. There is no other use of encounter data in the rate-setting process and payment by the PIHP contractor to individual providers is not considered.

## Follow-up From 2007 Review

CMS' 2007 managed care review identified only one practice in which State operations were out of compliance with federal managed care regulations. The Medipass provider listing did not include non-English languages spoken by providers in accordance with 42 CFR 438.10(e)(2)(ii)(D).

In conjunction with the 2009 review, CMS has confirmed that the State updated the Medipass provider listing to incorporate designation of non-English languages spoken by providers. This finding is now resolved.