Iowa Department of Human Services

Iowa's Medicaid Program Updates and Transition

Provider Services
Iowa Medicaid Enterprise

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.
- DHS will finalize contracts with these managed care organizations on September 11, 2015

Iowa's Goals

Goal
- Improved quality and access

Goal
- Greater accountability for outcomes

Goal
- More predictable and sustainable Medicaid budget

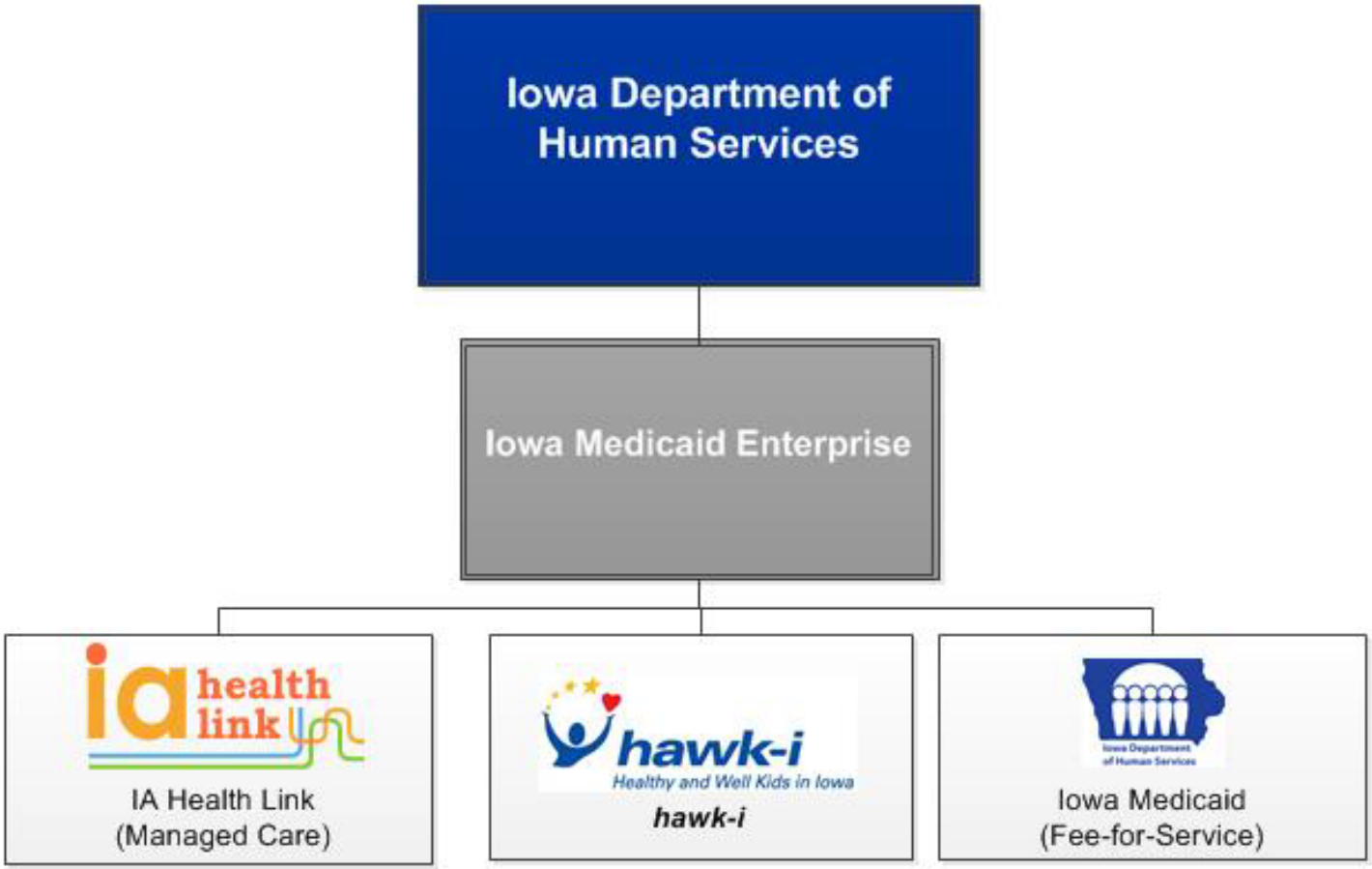
Branding and Communications

- 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

IA Health Link: Managed Care

- Previously used for the Iowa Health and Wellness Plan, but designed for larger use
  - Designed and tested directly with Medicaid members
  - Friendly and approachable design
- Will be used on managed care communications to members

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

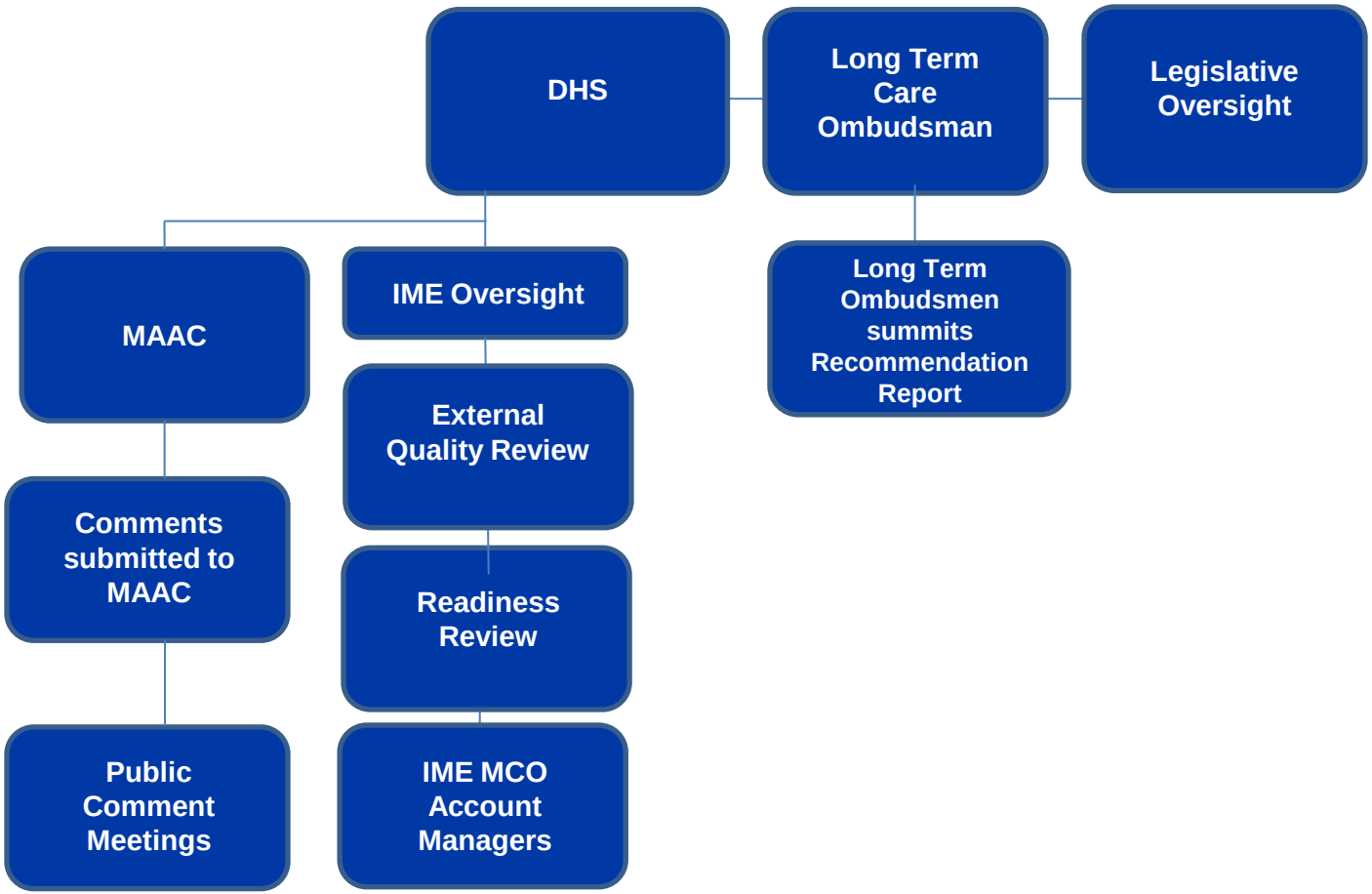
State staff will be supported by consultants, selected through a competitive procurement process

MCO Readiness Review

- Specific federal requirements related to long term care readiness
  - Comprehensive LTCSS training
  - Experience and expertise with LTCSS, including case management and disease management staff
  - Requirements applicable to subcontractors of the MCOs

Modernization Oversight

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

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 Transition Communication

- Member Populations
- Member Benefits
- DHS Member Outreach & Education
- Stakeholder Outreach & Assistance
- Member Enrollment

Member Populations

Included

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

Excluded

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

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

Stakeholder Outreach & Assistance

- Stakeholder toolkit will be available online and to all stakeholders to support accurate information in the transition to current Medicaid members
- Posted week of September 8
- Information includes:
  - IA Health Link Program Overview
  - Links to FAQs, Factsheets and DHS Website updates
  - Help in selecting an MCO Materials
  - Member Promotional Materials
  - Member Introductory Mailings

MCO Stakeholder Outreach

- MCOs have begun to reach out to stakeholders to assist in promoting an understanding of managed care benefits
- DHS must approve public facing materials such as marketing materials and member letters
- DHS has held stakeholder meetings with more to come, including upcoming webinars

Member Enrollment Activities

Overview of Enrollment Process						
September 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 per the following schedule, and posted online:
  - Week of August 31: Long Term Care
  - Week of September 8: hawk-*i*
  - Week of September 8: Other Medicaid groups
  - Week of September 21: Current managed care members
- Mailings will include:
  - Timeline
  - FAQ
  - Links to education materials, toolkits online
  - Contacts for questions

Step 2: Tentative MCO Assignment

Member enrollment packets mailed October through November

- Tentative assignment included and based on algorithm to keep families together under one MCO
- Staggered mailing by program enrollment similar to introductory mailing
- Current members have until December 17 to choose for January 1, 2016
    - Members may change MCOs for any reason through March 18, 2016
- DHS notifies MCO of selection through enrollment file

Step 3: MCO Contacts Member

MCOs will distribute enrollment materials to new members within 5 business days of receipt of member enrollment selection

- Examples of enrollment materials:
  - Provider directory
  - MCO contact information
  - Services available
  - Grievance and appeal information
  - Member protections, rights, and responsibilities
  - Information on how to contact the Enrollment Broker
  - Contact information and role of the Ombudsman

Step 4: MCO Changes for 'Good Cause'

- Members may disenroll from their MCO at any time throughout the year for reasons of "good cause"
- "Good cause" reasons can include:
  - A member's provider is not enrolled with the MCO and that provider disenrollment impacts the members' health outcomes
  - 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)

Member Services

- 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 with special focus on long term care members, schedules upcoming and 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

Member Services Cont.

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?

Provider Transition

IA Health Link Provider Communication

- MCO Provider Network Requirements
- Case Management Requirements
- Provider Education and Training, Resources
- Provider Enrollment Process Overview
- DHS Enrollment Timeline
- DHS Provider Enrollment Renewal
- MCO Provider Enrollment
- MCO Provider Enrollment Timeline
    - Questions and Answers

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

MCO Network Requirements Cont.

- MCOs must have an adequate provider network as defined in the MCO contracts with DHS

  Example Access Standards:

  - PCP – Within 30 minutes or 30 miles from all members
  - Specialists – Within 60 minutes or 60 miles for at least 75 percent of the members
  - HCBS – Within 30 minutes or 30 miles from members in urban counties and 60 minutes or 60 miles from members in rural counties
- An MCO must use non-network providers if there is a gap in coverage for a particular service
- MCOs are to extend authorization of long term care services from an out-of-network provider to ensure continuity of care

MCO Network Requirements Cont.

- MCOs are working to sign agreements with providers. For more information:
  - Amerigroup: page 1461 of proposal
  - Amerihealth: page 1278 of proposal
  - United: page 1273 of proposal
  - Wellcare: page 1103 of proposal
- DHS must approve all MCO provider contract templates
- Iowa Medicaid Informational Letter 1539 gives current Medicaid providers information on MCO contacts for MCO provider enrollment

MCO Case Management Requirements

- Members able to keep their current case management agency until at least June 30, 2016, as long as provider(s) choose to participate with the MCOs
- All case management activities must be transitioned to the MCOs no later than December 31, 2016
- MCOs will determine how to manage case assignments for community-based case management
- MCOs may provide community-based case management themselves or sub-contract with current case managers and must ensure staff maintains appropriate credentials, education, experience and orientation

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 Toolkit

- Provider Toolkit available: https://dhs.iowa.gov/sites/default/files/IAHealthLink_ProviderToolkit_FINAL.pdf
  - Intro letter and project overview
  - General provider questions/FAQ
  - Provider MCO enrollment information
  - Annual provider training schedule and information
  - Member mailing summary
  - Sample member FAQs
  - Sample member newsletter content
  - Contact information for questions (for providers and members)
  - Member introductory mailings

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

DHS Enrollment Timeline

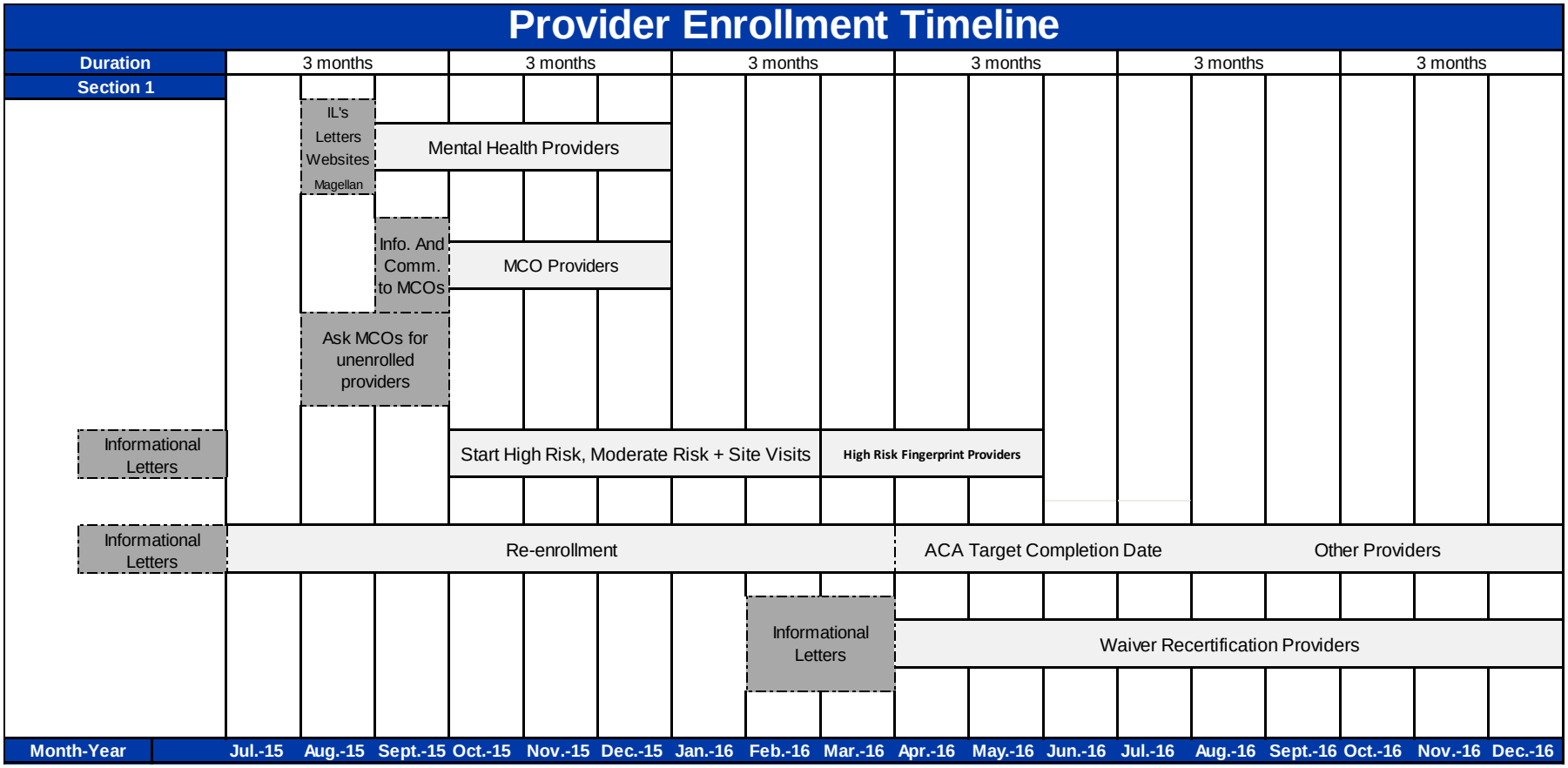
- MCO networks are effective January 1, 2016
- Over the next six months IME will:
  - Enroll behavioral care providers previously enrolled in Magellan
  - Enroll providers in the MCO networks who have not previously been enrolled in Iowa Medicaid
  - Implement a provider enrollment renewal process
    - Schedule will be announced by Informational Letter
  - Providers may scan updated paper work to the new enrollment email address
    - IMEProviderEnrollment@dhs.state.ia.us

DHS Provider Enrollment Renewal

- Per ACA requirements, IME is required to conduct increased licensure verification and database checks than it has in the past
- The volume of Iowa Plan providers and MCO providers that are newly enrolling impacts the scheduled re-enrollment capacity
- Due to the number of providers that will be impacted, IME is beginning a staged rollout process
- Informational letters and training will be available to relevant providers at the time of the staged rollout
- The goal is to re-enroll all current health care providers over the next year while also beginning the HCBS waiver provider recertification process

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


Provider Enrollment Timeline
Duration
3 months
3 months
3 months
3 months
3 months
3 months
Section 1
IL's
Letters
Websites
Magellan
Mental Health Providers
Info. And Comm. to MCOs
MCO Providers
Ask MCOs for unenrolled providers
Informational Letters
Start High Risk, Moderate Risk + Site Visits
High Risk Fingerprint Providers
Informational Letters
Re-enrollment
ACA Target Completion Date
Other Providers
Informational Letters
Waiver Recertification Providers
Month-Year
Jul.-15
Aug.-15
Sept.-15
Oct.-15
Nov.-15
Dec.-15
Jan.-16
Feb.-16
Mar.-16
Apr.-16
May.-16
Jun.-16
Jul.-16
Aug.-16
Sept.-16
Oct.-16
Nov.-16
Dec.-16

Provider Information Resources

- IME Website

  http://dhs.iowa.gov/ime

  Modernization specific information:
  http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

- Iowa Medicaid Provider Services Call Center

  1-800-338-7909 (7:30 a.m. – 4:30 p.m.)

  IMEProviderServices@dhs.state.ia.us

- Email

  Updates through IMEProviderCommunications@dhs.state.ia.us

Questions & Answers

Member Questions

Question	Answer
What if I missed the cutoff to change my MCO?	Please call the Member Services Unit at 1-800-338-8366
What if my provider isn't in my selected network?	You may use the 90-day period to select an MCO in which your provider is accessible to you
What if I don't like my MCO and want to change?	After January 1, 2016, you have 90 days to choose a different MCO, then you will stay with your MCO unless for good cause
Will my family be part of my MCO?	Families can choose to be in the same MCO, tentative assignment are made to do just that

Member Questions Cont.

Question	Answer
Will members still pay premiums if they do so today?	Yes, per existing requirements
Will there be appeal rights?	Yes, with the MCO and then the state
Will my benefits change? If my level of care changes, who do I contact for review?	Benefits stay the same unless level of care needs change or eligibility changes. Members can contact Member Services for more information about benefits
Who authorizes services?	MCOs do. Based on state policy and administrative rule, the state reviews if level of care changes

Provider Questions

Question	Answer
How will service authorizations work?	MCOs will honor existing service authorizations for at least 3 months
How does claims payment work?	MCOs are required to pay within similar timeframes that Medicaid currently pays
How many networks can providers be a part of?	Providers can be part of all of the networks, or just one. Networks, however, must be statewide
What about utilization management?	MCOs are responsible for utilization management, and their policies must be approved through DHS

Provider Questions Cont.

Question	Answer
When can I start working with MCOs?	Providers may begin working with the MCOs immediately
How do I get in contact with them?	See Informational Letter 1539 for contacts for each MCO
Will the enrollment paperwork across MCOs be the same?	Iowa Medicaid's enrollment application will be the same, but the MCOs may have additional requirements

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 Member Services Phone: 1-800-338-8366 Email: IMEMemberServices@dhs.state.ia.us
Modernization Provider Questions	Contact Provider Services Phone: 1-800-338-7909 Email: IMEProviderServices@dhs.state.ia.us

ICD-10 Implementation

October 1, ~~2013~~
~~2014~~
2015

ICD-10

- Compliance date October 1, 2015
  - No more delays
- ICD-10 will be used by all providers in every health care setting
- No impact on Current Procedural Terminology (CPT) and Healthcare Common Procedure Coding System (HCPCS) codes

ICD-10 Basics

- ICD-10 codes must be used on all HIPAA transactions including outpatient and professional claims
- Institutional claims with a date of discharge on or after October 1, 2015
- Professional claims with a date of service on or after October 1, 2015
- Legal reference 45 CFR 162.1002

ICD-10 Code Basics

- ICD-10 consists of two parts:
  - **ICD-10-CM**: The clinical modification (CM) diagnosis classification system for use in all U.S. health care treatment settings
  - **ICD-10-PCS**: The procedure classification system (PCS) was developed for use in the U.S. for inpatient hospital settings only
- ICD-10 does not affect CPT coding for outpatient services

Diagnosis Code Mapping

ICD-9

- 821.11 Open Fracture of Shaft of Femur
- All Codes for femur fracture= 16

ICD-10

- S72.351C
- Displaced comminuted fracture of shaft of right femur, initial encounter for open fracture type
- All Codes for femur fracture= 1530

ICD-10 Reminders

1. A code using only the first three digits is to be used only if it is not further subdivided
2. A code is invalid if it has not been coded using the full number of characters required
3. A dummy placeholder “X” is used with certain codes to allow for expansion and/or to fill out empty characters
4. When using an ICD-10 dx code, use an ICD-10 qualifier

Claim Testing

- ICD-10 testing started in February
- The IME encourages all providers to test ICD-10 claims
- Last day to sign up for testing is October 5, 2015
  - Last date to test is October 7, 2015
- Email ICD-10Project@dhs.state.ia.us to sign up
  - Include your name, NPI, contact information

Testing Options

- The IME is conducting end-to-end and business-to-business testing
- Direct Claims Submittal
  - Returns 277 CA, 999, and 835
  - Done through Providers EDISS Connect Account
- Collaborative Testing Tool (CollabT)
  - Returns 277 CA, 999, 835, and revenue comparison reports

Common Rejection Reasons

- ICD-10 Codes with ICD-9 Qualifiers
- Diagnosis Code is not valid
- Principal diagnosis does not allow E Codes

ICD-10 Prep

1. Making sure your software is updated to bill ICD-10 codes
2. Identifying issues with claims
   - Your software
   - Your coding
   - Our software
   - Our claims processing system
3. Resolving identified issues

ICD-10 Coding Reminders

- Providers should be billing a true diagnosis
- The IME cannot offer coding advice
- Refer to coding books for coding information

ICD-10 Claim Editing

EOB Code	Description
130	DIAGNOSIS CODE IS NOT COVERED AS BILLED
068	INVALID DATES WERE BILLED AS "FROM/THROUGH" DATES OF SERVICE
099	INVALID ICD-10 PRINCIPAL DIAGNOSIS CODE
880	THE DIAGNOSIS CODE IS NOT COVERED BY IOWA MEDICAID/OR MEDICAL NECESSITY NOT ESTABLISHED WITH THE DIAGNOSIS BILLED

Electronic HCBS Waiver Claim

- Informational Letter 1513
- V00.01 (ICD-9) will be replace by Z76.89 (ICD-10)
- Any other diagnosis codes billed refer to coding books
- Form 470-2486, Claim for Targeted Medical Care, requires no diagnosis code if submitted

Contingency Plan

- Providers may download free software, PC-ACE Pro32 available through DHS
- PC-Ace Pro32 Help Documents available at: http://dhs.iowa.gov/ime/providers/forms#PAPHD
- Providers may submit claims on paper
  - Must still have accurate ICD-10 coding
- Testing will continue through October 7, 2015

ICD-10 Resources

- IME ICD-10 news: http://dhs.iowa.gov/ime/providers/tools-trainings-and-services/medicaid-initiatives/ICD-10
- CMS ICD-10 resources and information: www.cms.gov/Medicare/Coding/ICD10/index.html
- CMS Road to 10: www.roadto10.org/
- Email questions to: icd-10project@dhs.state.ia.us
- Call EDISS at 1-800-967-7902
- Call Provider Services at 1-800-338-7909

Provider Services Outreach Staff

Offer the following services:

- On-site training
- Escalated claims issues
- email imeproviderservices@dhs.state.ia.us