



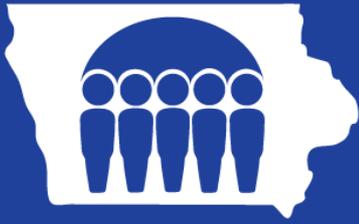
IA Health Link Kick-Off Meetings

Summary: The IA Health Link Kick-Off meetings will be held in eleven locations and will provide an overview of the IA Health Link program. Designed to appeal to a wide audience, the meetings will likely include participation from each of the four MCOs, will train community partners on the IA Health Link enrollment process and educate attendees on how to assist members through the transition and initial implementation of the program.

Target Audience: Community Partners, Advocates, Stakeholder Organizations, Enrollment Assistants, Certified Application Counselors, Family Members, General Public

Scheduled Meetings

Location	Date	Time	Venue Details
Waterloo	Monday October 5, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Hawkeye Community College – Tama Hall Room 102 (1501 East Orange Road, Waterloo, IA)
Council Bluffs	Tuesday October 6, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Iowa Western Community College – Looft Hall (2700 College Road Council Bluffs, IA)
Mason City	Wednesday October 7, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	North Iowa Area Community College – Muse Norris Conf. Ctr. (500 College Drive Mason City, IA)
Dubuque	Thursday October 8, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Northeast Iowa Community College- Rm. 106A & B (680 Main Street Dubuque, IA)
Fort Dodge	Friday October 9, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Iowa Central Community College- East Campus – Triton Rm. (2031 Quail Avenue Fort Dodge, IA)
Bettendorf	Monday October 12, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Scott Community College – Student Life Ctr. (500 Belmont Road Riverdale, IA)
Burlington	Tuesday October 13, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Pzazz Event Center (3001 Winegard Drive, Burlington, IA)
Sioux City	Wednesday October 14, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Western Iowa Tech Community College – Cargill Auditorium (4647 Stone Avenue, Sioux City, IA)
Ottumwa	Thursday October 15, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Indian Hills Community College – Bennett Building (623 Indian Hills Drive, Ottumwa, IA)
Cedar Rapids	Friday October 16, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Kirkwood Community College – Hotel Kirkwood Ballroom A & F (7725 Kirkwood Boulevard SW Cedar Rapids, IA)
Des Moines	Friday October 16, 2015	2:00 p.m. – 4:00 p.m. and 6:00 p.m. – 8:00 p.m.	Des Moines University – Olsen Center. (3200 Grand Avenue, Des Moines, IA)



IA Health Link Member/Provider Transition Update



Member Activities

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

Member Enrollment Activities

Overview of Process

Step 1: Introductory Mailing

Step 2: Tentative MCO Assignment

Step 3: MCO Contacts Member

Step 4: New Member Enrollment

Step 5: New Member HCBS Waiver

Step 6: MCO Changes for 'Good Cause'

Step 7: Enrollment Broker Role



Member Populations

Included:

Majority of Medicaid members

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

Excluded:

- PACE - can opt in to MCO
- Programs where Medicaid already pays premiums: HIPP, Medicare Savings Program only
- Medically Needy
- American Indians/Alaskan Natives (members can opt-in)
- Undocumented persons eligible for short-term emergency services only



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 are “carved out” – continue same as today



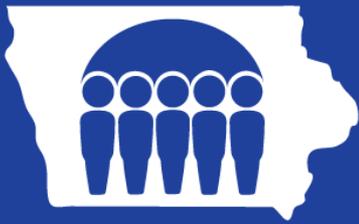
DHS Member Outreach & Education

- Tele-townhall meetings
- Events and trainings
- Newsletters
- Member educational materials
- Member mailings
- Earned media
- 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, webinars upcoming including enrollment help



Member Enrollment Activities

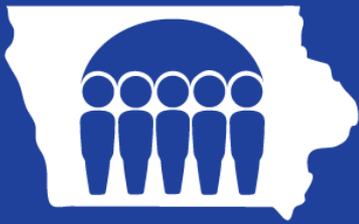
Overview of Enrollment Process

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

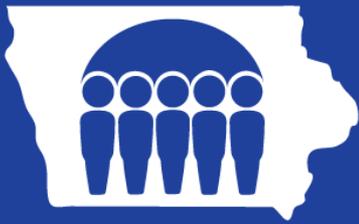
- Introductory mailings sent to members per the following schedule, and posted online:
 - Long Term Care, hawk-I, Other Medicaid groups and Current managed care versions
 - Mailing throughout September
- Mailings will include:
 - Timeline
 - FAQ
 - Links to education materials, toolkits online
 - Contacts 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 2016, with an additional 90 days after the January assignment to change MCOs for any reason
- 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: New Member Enrollment

- Starting December 8, 2015, and ongoing, the date of eligibility for new members will impact the date they are enrolled with an MCO
 - This is because there is a point in which there is a IT system cut off to review to the MCO to ensure the beginning of the month capitation
- When the member is eligible but is unable to be enrolled in the MCO in the month in which they apply - services will be paid for by the Medicaid Fee for Service program until they are enrolled with the MCO the following month
 - Both medical and behavioral services



Step 5: New Member - HCBS Waiver

- Slots will continue to be authorized through approval of waiver applications and state legislation
- DHS will continue to manage the waiting list and assignments
- Some members are not Medicaid eligible prior to being given an HCBS waiver slot. The department is in the process of determining how best to implement HCBS services in these instances
 - Timing of level of care determination
 - Financial determinations
 - Service planning critical to MCO assignment and member choice



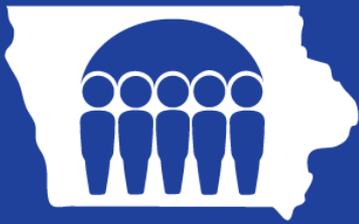
Step 6: MCO Changes for 'Good Cause'

- 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)



Good Cause Cont.

- To make a change:
 - Members call the Iowa Medicaid Enrollment Broker to request disenrollment for “good cause”
 - Members tell the Enrollment Broker which MCO they want to switch to
 - If a member has a question about whether they have a “good cause” they can call the Enrollment Broker for more information



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?



IA Health Link Provider Activities

- 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



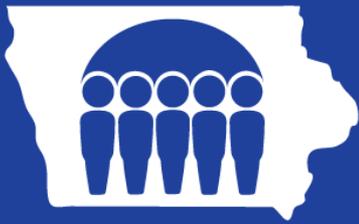
MCO Provider Network Requirements

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



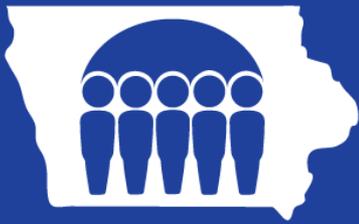
MCO Network Requirements Cont.

- 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 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
- Provider toolkits available early September 2015
- Tele-townhall meetings
- Events and trainings
- Monthly newsletters
- Provider educational materials updated continually
- Stakeholder emails
- Informational Letters 1537 and 1539 and upcoming

Annual Provider Training Schedule

Location	Date
Sioux City	Monday, September 14
Council Bluffs	Tuesday, September 15
Bettendorf	Wednesday, September 16
Burlington	Thursday, September 17
Fort Dodge	Monday, September 21
Mason City	Tuesday, September 22
Waterloo	Wednesday, September 23
Cedar Rapids	Thursday, September 24
Dubuque	Monday, September 28
Ottumwa	Tuesday, September 29
Des Moines	Wednesday, September 30



Provider Education and Training Cont.

- Provider Toolkit was posted the week of September 8:
 - 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
- 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 providers as necessary to serve the needs of members in special situations



Iowa Department of Human Services

Provider Enrollment Timeline																		
Duration	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



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



Mikki Stier, Medicaid Director

Executive Council Committee Minutes September 17, 2015

COMMITTEE MEMBERS

Gerd Clabaugh
Sara Allen - IHA
Dan Royer
Dennis Tibben
Nancy Hale
Kirstie Oliver
Paula Connolly
Shelly Chandler
Jeff Marston
Jess Smith
Anthony Carroll
Jim Cushing

PUBLIC REPRESENTATIVES

DEPARTMENT OF HUMAN SERVICES

Mikki Stier	Liz Matney
Jennifer Steenblock	Julie Lovelady
Deb Johnson	Bob Schlueter
Lindsay Buechel	Maddisen Kies

Introductions:

Room goes through introductions as well as the phone.

Announcement:

Mikki: Magellan sent a letter to HAB providers, notifying Medicaid home based providers, new rate structure, beginning on October 15, 2015. The communication needs to be addressed. The department is immediately addressing Magellan. Help us calm down your members. We are working on additional communication to be sent out. Asked Magellan for mailing list on whom they sent this to and we are addressing to work on it in a timely manner.

Question: Letter going out today?

Mikki: It all depends on things we are working on.

Provider Rate Discussion

Mikki: We want to update you as much as possible.

Jeff: (Goes over Provider Rates Presentation) As Mikki mentioned, we want to update you as much as possible with how the rate floors are going to be defined and reimbursement rates in the future. There are some unique issues to address, out of network, and we'll talk about any

future determinations. We will look at cost based reports and submission for SFY 2016, provider considerations overall and a wrap up summary on what we've discussed.

Lindsay: We will send out a link for the presentation.

Jeff: When Iowa transitions to managed care, this number (25-30,000) members will be in FFS coverage, claims aren't going to be paid by MCOs quite yet for some members because in Tentative Assignment period. Using all state plan reimbursement rules and requirements. Permanent FFS members are HIPP, PACE, and Dual-eligible (Medicare and Medicaid). Medicaid supplies the patient the cost sharing.

Anthony: Includes permanent and transitional people (churn).

Jeff: Yes, estimated number at this point; month after month.

Jeff: As RFP states there will be a rate floor that MCOs have to follow. This sets that minimum rate that provider can be paid and MCOs cannot go below the rate floor. There are few services that won't have a rate floor. Otherwise for provider service/type- rate floors are provided. We've looked at historical claims data, and what rate structure went into that and we are staying consistent with those methodologies as much as we could so reimbursement does not go below baseline.

Dennis: PCP getting bump the last few years; that'll be their rate floor?

Jeff: At this point, yes that is what their rate floor is.

Jeff: Other considerations, current methodologies, allow MCOS flexibility to manage their networks and we didn't want to hinder relationships with providers. The rate floors will be published so providers can go and see how the rate floors are compared. The rate floors will not be adjusted unless state/federal law requires adjustment.

Question: Is rate floor specific to each provider published? Different rates for same provider type?

Jeff: Some rate floors will be provider specific. The ones that aren't, will be published by provider type and by service.

Jeff: For fee schedule providers, what Medicaid FFS was on July 1 2015, see what the fee schedule is for that date and that sets the rate floor.

Question: For BHIS, currently for Magellan, still continued for distinction; there's two rates? Group care per unit in community?

Jeff: The asterisks will have discussions about those specifically later, examples for adjustments would be hospice providers and the rates vary on geographic area of the state. This is the same for HH, nursing and therapy services. We will continue geographic rate floor through managed care transition.

Jeff: Rate floor for hospitals; we are currently in a rebasing year for inpatient hospital. We will recognize the rebasing rates in the floor. Provider tax rate add-ons will also be carried forward within the floor. Payment – graduate payment will continue in MCO as well as disproportionate hospital payments. The Medicaid uninsured provider population. As I mentioned provider tax will continue; hospitals still make payments until then.

Jeff: Nursing facilities have similar aspects to what we talked about with hospital. Rates effective July 1, 2015. Rates will be adjusted to incorporate new rates. These floors are provider specific. Need to maintain that for cost structures as well. Haven't determined how rate floors will be published yet. Provider tax program will continue under managed care. No changes to what currently happens today moving forward.

Jeff: FQHC and RHC- can get paid one of two ways; BIPA rate established by federal law (cost reports) other providers; bulk of providers – cost per encounter – look at per year and BIPA/PPS rate; we settle with the higher. Reason why that occurs; federal law requires Medicaid does the methodology. Going forward the RFP states that MCOs are required to pay at a minimum BIPA/PPS rates so the rate floor will be that. This gets updated every January. Federal law will say to be adjusted annually.

Jeff: HCBS – Provide two services: direct/indirect. For direct; hands on, in our rate system we have all the member rates- for every service that is a direct service.

Shelly: Floor will be lowest paid anywhere in the state?

Cindy: Give an example?

Jeff: Look at all rates for July 15, 2015. Within the waiver system, most members are specific. We look at all rates and take what the lowest rate is and we set the floor so lowest rate would be the floor.

Shelly: RFP says provider would be paid rate they have in effect on December 31 2015 and that is their floor. This is a significant change with what's in the RFP. Then it's for provider to negotiate with MCOs for each specific provider(s). It says providers will essentially be held harmless. This sentence in the slide states you'll cut rates significantly unless every provider/MCO negotiates, and I guarantee you not every provider will win.

Anthony: When can we see what the ranges for current rates were for July 1, 2015? Can we see that and when?

Deb: We have pulled information; hopefully will have by next week. There are some anomaly's in there so we do have a range and average in there which varies. Fee schedule in there – SCL is a hard one. Hourly is easier than daily; where you have different scenarios. We will be giving MCOs current service plans we have and what we're paying.

Shelly: They don't have to be paid what providers are currently being paid. Spread is so vast. You are giving MCOs permission to do that. Letter that Magellan sent out yesterday will be nothing.

Deb: I certainly appreciate your concern. Providers do have power. MCOs have to serve people and they want to. To cut people 500 percent from where they are doesn't make sense.

Mikki: There are network adequacy requirements that these MCOs have to maintain.

Question: Example how this works with CDAC?

Deb: Provides example: Say capitation is \$15.00 and lowest we pay is \$8.00 so that is the floor. That is the least amount that MCOs can pay.

Jeff: Other part, indirect services; home and vehicle modifications, etc. Things where cost can vary based on service. No floor for HCBS indirect service. We will make sure there is a distinction.

Question: Say \$5.00/ meal so come January 1, 2016; then what?

Jeff: No floor for that.

Question: HCBS providers aren't paid for that for two years?

Anthony: Apply to home delivery meals? Contract with MCO to have to do that?

Deb: I don't know if that will apply to them. (Will follow up)

Jeff: We will have provider specific per diem rates; also have provider tax which will continue going forward. Needs to be changed on how tax is collected in the process. We don't see a way to offset claims monthly. They submit a quarterly check to the department. How it's calculated is not changing. It's collection.

Shelly: Hospital and nursing; recognize rebasing – will MCOs be able to honor the rebasing? Such is ICFBD?

Jeff: We will check on that.

Mikki: Unless there is a change; if federal or state code we will recognize it.

Shelly: Please add to the slides so these services are recognized.

Jeff: It's going to be a customary 95 percent rate that customers have to pay. Providers should enroll with MCOs to receive higher.

Mikki: Customary rate is fee schedule.

Jeff: For cost reports and cost settlements, we have some provider types that submit for rate setting plan so no changes for cost requirements in 2016. Fee for service claims still cost settle any of those claims.

Jeff: Goes over the table. This is not the floor anymore this is the Fee For Service reimbursement.

Kirstie: No mention of PMIC?

Jeff: We will talk about that. All of them will have same structure going forward.

Kirstie: Not mentioned in these slides?

Jeff: Do they have same rate on state side?

Kirstie: They are paid on just one rate; they all have negotiated rate on Magellan side.

Jeff: We will get clarification on that.

Jeff: All of the providers on the table submit cost reports; CAH and RHC/FQHC have cost settlement in 2016. There's still cost report for all providers on table, CAH cost settlement and FQHA/RHC no cost settlement.

Jeff: Changed to FFS reimbursement for provider types; [Jeff refers to the table provided on slide 15.] SFY all providers in the table will have Fee schedule for SFY 2017. All providers currently submit cost report and for SFY 2016. Cost reports going forward will be Home Health and HCBS providers. All statewide rates for all providers in SFY 2017 based on cost data that we have.

Jeff: We want to still capture cost rate data going forward. Cost data can be used by the DHS to look at rates being negotiated and if they are really covering services to identify cost trends, assist in future FFS/ rate settings, establish upper payment limit demonstrations. Even though we are going to managed care, we have to do EPL and any adjustments to this have data for cost report. The encounter data is required to be collected by the state. Cost coverage statistics are rates covering costs from these providers.

Anthony: Are the cost reports coming from providers?

Jeff: Directly from providers to the IME.

Jeff: No changes to that process.

Jeff: Within RFP – [Jeff goes over the access standards.] MCOs must use non-network providers if there is a gap in coverage for a particular service. This ensures members continuity of care.

Jeff: Where MCOs are headed is a VBP to set up special programs to encourage healthy behaviors by members.

Jeff: [Goes over summary on slide 19.]

Comment: Reporting back great on Annual Provider Training; enjoyed it and we have learned a lot. Having reps from MCOs is helpful. Your presentation and slides are calming them down a bit in regards to you're giving us what you know.

Other Medicaid Modernization Updates

- **Annual Provider Training**

Mikki: We would like to express gratitude to state staff and member/provider services. We felt the need to pair them up. We did set with MCOs the expectation to be there.

Lindsay: Both morning and afternoon sessions are entirely full and some have maxed out attendance. Majority of questions have been asked about rates. So far it's been a good reception. MCOs have sent several representatives. We will give full report in October and so far so good in terms of provider training.

Bob: We are now getting out to a wider audience. The next level is coming to some of these training sessions.

Julie: In addition; there are some questions coming out of those sessions too. We are bringing back these questions and we are making sure the questions get answered.

Lindsay: Specific questions by site.

- **Stakeholder and Member Meetings**

Lindsay: Stakeholder and member meetings; will be doing two different sets of meetings; (flyer to send around) target audience for these meetings are stakeholders, member advocates, etc. This next set of trainings is geared towards people involved in the health care system. Eleven of them in all same locations that provider training was held. We are doing afternoon and evening sessions. They start in early October. MCOs will be at these specific meetings just as they are at the provider trainings.

Cindy: How are people to decide between which plans?

Lindsay: Perfect sag way to the member meetings which make people aware of how they can help members. There will be member education and enrollment events and eighteen different locations throughout the state. Start in mid-October and run through most of November. This will give members an overview of managed care. It will offer in person enrollment assistance to individuals. This is an in-person meeting session instead of just calling member services. Other piece is that many of them will be broadcasted as tele town halls via webinar. We are still tightening up the details. Information on which is available either webinar or conference call is coming very soon. This is to get dates in front of you. You are the first ones to see this. (Hands out schedule)

Question: Can you email them?

Lindsay: Yes.

- **Stakeholder and Provider Toolkits and Education**

Lindsay: Toolkits are on the website. Everything is functioning how it should be now. We will go into the toolkits next week. We will be adding member educational materials and things to be using at meetings to be coming.

Other Topics and Comments:

Jennifer: We will send out notifications that things have been updated.

Lindsay: Emails will be sent out.

Deb: Updates where?

Lindsay: Sign up on the email or the web on updates. You can subscribe both ways.

Paula: As a consumer, a disconnect that I see people being told you can't work on these things. Incentives for people to have better health outcomes, SCL things – make sure people aren't getting dinged for outcomes; for people with mild disabilities just remember this. I often hear from people that there's a real disconnect – mention in provider notes – when thinking overall and training things like that and correlating what people are providing. It's almost discrimination because there's people left behind. People don't know how to determine their health outcome or understand what that means.

Anthony: Compliment on stakeholder toolkit; which is good. Initial contact letter is going out?

Lindsay: We have shifted our timeline; more likely later in September.

Anthony: Page after timeline; enrollment broker will ask, etc. It's excellent. Here's the challenge; is my provider in the MCO network? It will be are my providers in the network and will they be seven months from now? For instance my case manager, I know you can't answer that and MCOs can't answer that...If you're truly trying to help. Just a suggestion.

Mikki: Okay.

Anthony: Dual eligible; to what degree?

Lindsay: We are doing training tomorrow morning - shift wide.

Shelly: Providers know who to bill?

Julie: Member will have a card and the ELVS or through web portal.

Lindsay: Step by step one pager ELVS can be provided.

Meeting adjourned: 12:30PM



Member Education and Enrollment Events

Summary: Iowa Medicaid will host a mix of in-person meetings and webinars branded as “tele-townhall meetings” in the top 17 populated cities in Iowa. These meetings will provide the public with an opportunity to receive information about the transition, ask questions directly to DHS staff, and receive in-person enrollment assistance.

The tele-townhalls will feature a short presentation for those with Internet access and also will be available via conference call. Iowa Medicaid will work with local venues such as public libraries to offer the in-person meetings and tele-townhalls free to the public, in order for a larger audience to view the presentation. These presentations will be designed to provide the public with the ability to participate in the process and address any questions the members have. Iowa Medicaid will track the questions that are asked, and use these meetings to prepare for further communications materials and planned responses.

Target Audience: Medicaid Members Transitioning to the IA Health Link Program, Family Members, Member Representatives

Scheduled Meetings

Location	Date	Time	Venue Details
Davenport	Wednesday October 14, 2015	5:00 PM – 7:00 PM	Davenport Public Library, Meeting Room B (321 N. Main Street, Davenport, IA)
Dubuque	Thursday October 15, 2015	3:00 PM – 5:00 PM	Carnegie-Stout Public Library: Aglur Aud. (360 W 11th Street, Dubuque, IA)
Burlington	Monday October 19, 2015	4:00 PM – 6:00 PM	Burlington Public Library, Meeting Rm A (210 Court Street, Burlington, IA)
Fort Madison	Wednesday October 21, 2015	5:00 PM – 7:00 PM	Fort Madison Public Library: (1920 Avenue East, Fort Madison, IA)
Council Bluffs	Monday, October 26, 2015	3:00 PM – 5:00 PM	Council Bluffs Public Library: (400 Willow Avenue, Council Bluffs, IA)
Sioux City	Wednesday October 28, 2015	5:30 PM – 7:30 PM	Wilbur Aalfs Library, Gleason Rm. (529 Pierce Street, Sioux City, IA)
Mason City	Friday October 30, 2015	5:00 PM – 7:00 PM	North Iowa Area Community College, Rm MH 104G (500 College Drive, Mason City, IA)
Storm Lake	Monday November 2, 2015	4:00 PM – 6:00 PM	Storm Lake Public Library: (609 Cayuga Street, Storm Lake, IA)



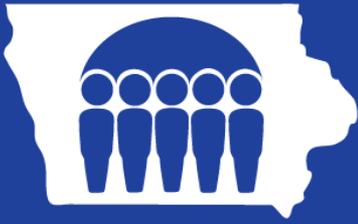
Location	Date	Time	Venue Details
Waterloo	Wednesday November 11, 2015	4:00 PM – 7:00 PM	Hawkeye Community College, Tama Hall (1501 E. Orange Road, Waterloo, IA)
Fort Dodge	Friday November 13, 2015	3:15 PM – 5:15 PM	Fort Dodge Public Library: (424 Central Ave. Fort Dodge, IA)
Cedar Rapids	Monday November 16, 2015	5:00 PM – 7:00 PM	Cedar Rapids Public Library, Ladd Library (3750 Williams Blvd., Cedar Rapids, IA)
Iowa City	Wednesday November 18, 2015	5:30 PM – 7:30 PM	Coralville Public Library: Rms. A & B (1405 5th St. Coralville, IA)
Carroll	Thursday November 19, 2015	5:00 PM – 7:00 PM	Carrollton Inn, (Hwy. 71 North, Carroll, IA)
Marshalltown	Friday November 20, 2015	3:45 PM – 5:45 PM	Marshalltown Public Library, Community Rms. A & B (105 W. Boone Street, Marshalltown, IA)
Ames	Saturday November 21, 2015	9:00 AM – 11:00 AM	Ames Public Library, FT Brown Aud. (515 Douglas Ave, Ames, IA)
Des Moines	Tuesday November 24, 2015	5:00 PM – 7:00 PM	Waukee Public Library: (950 Warrior Ln., Waukee, IA)



IA Health Link Provider Rates

September 17, 2015

Presented by Mikki Stier, Iowa
Medicaid Director



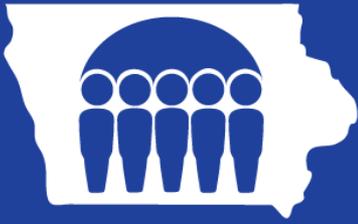
Rates Overview

- Populations Served
- MCO Rate Floor for Providers
- Rate Floor for FFS Providers
 - Hospitals
 - Nursing Facilities
 - FQHC and RHC
 - HCBS
 - ICF/ID
- Out of Network
- Future Determinations
- Cost-based Reports and Settlements
- Provider Considerations
- Summary



Rates and Populations Served

- MCOs: Providers will be paid the negotiated MCO rate for most of Iowa Medicaid's 550,000 members
- Fee-for-Service: About 25,000 to 30,000 members will be in fee-for-service (FFS) coverage at a given time and the provider will be paid directly by IME, same as today
- Permanent FFS members include:
 - HIPP
 - PACE (member option)
 - Dual-eligible (Medicare and Medicaid)



MCO Rate Floor for Providers

- The Department establishes a rate floor for the MCOs to use in determining provider payment rates
- The floor becomes the minimum payment to providers
- MCOs can pay above the defined floor, but not below
- DHS's payments to MCOs are based on historical claims data to establish a baseline
- This provides stability for members and providers that reimbursement will not go below the baseline



Establishing MCO Rate Floor

In creating a rate floor, DHS considered:

- The current reimbursement methodologies and how they work
- The relationship to a managed care system in a way that allows MCOs flexibility to manage networks
- Rate floors will be published and providers can look at how their rates compare
- Rate floors will not be adjusted except as required by federal or state law



Rate Floor for Fee Schedule Providers

- The rate floor proposed for fee schedule providers is the rate effective July 1, 2015
- **Fee Schedule Providers include:** Ambulance, Ambulatory Surgical, Audiologist, BHIS, Birthing Center, Certified Nurse Mid-Wife, Certified Registered Nurse Anesthesiologist, Chiropractor, Clinic, Community Mental Health Center*, Durable Medical Equipment, Family Planning Clinic, Habilitation Service, Hearing Aid Dealer, Lead Investigation, Maternal Health, Nurse Practitioner, Optician, Optometrist, Orthopedic Shoe, Podiatrist, Psychologist, Rehab Agency and Ind. Therapists, Screening Center, HCBS*
- Per geographic area: Intermittent Nursing, Therapy and Home Health, Hospice, cont.

* Later slide



Rate Floor for Hospitals

- Hospital rate floors will include rebasing effective October 1, 2015
- MCOs will recognize the rebasing
- Rebasing includes the provider tax
- Hospitals will continue to receive Graduate Medical Education (GME) and Disproportionate Share Hospital (DSH) as pass-through
- Provider tax continues



Rate Floor for Nursing Facilities

- Rate floors will be the provider-specific per diem rates that are effective July 1, 2015
- Rebase will be included in nursing facility rate floors
- Provider tax pass-through payment and add-on amount are included



Rate Floor for FQHC and RHC

- Current FFS reimbursement is cost settlement at greater of:
 - 1) cost per encounter or
 - 2) Benefits and Improvement Protection Act (BIPA) Prospective Payment System (PPS) rate
- The rate floor is established at the annual BIPA PPS rate



Rate floors for HCBS Services

HCBS Direct Services

Providers will never be paid less than the lowest rate that has been paid for that specific direct HCBS waiver service as of July 1, 2015

HCBS Indirect Services

There is no floor for “indirect” services such as Home Delivered Meals, Home & Vehicle Modification, Devices, Financial Management Services and Chores



Rate Floor for ICF/ID

- Rate floors will be the provider-specific per diem rates that are effective July 1, 2015
- Provider tax amount included
- Due to decreasing FFS claim volume there will be changes to the tax collection process
- Tax collected by provider check submitted on a quarterly basis



MCO Out of Network Providers

- Providers not contracted with MCOs will receive 95 percent customary rate
- Providers should enroll with MCOs to receive higher rate
- MCOs will use single care agreements as necessary



SFY16 Cost Report/Cost Settlement

- FFS cost report submission requirements for SFY16 will remain the same
- Cost settlement occurs for FFS claims provided during SFY16
- DHS will continue cost report collection after SFY16 for some provider types



Cost Report/Cost Settlement

Cost reporting continues for the following providers:

Provider Type	SFY16 Cost Report	SFY16 Cost Settlement	SFY17 Cost Report	SFY17 Cost Settlement	SFY17 FFS Changes
Hospital-PPS	Yes	N/A	Yes	N/A	N/A
Hospital-CAH	Yes	Yes	Yes	Yes	N/A
NF	Yes	N/A	Yes	N/A	N/A
ICF-ID	Yes	N/A	Yes	N/A	N/A
FQHC/RHC	Yes	Yes	Yes	No	PPS rates



Cost Report/Cost Settlement

DHS also is proposing a statewide fee schedule for the following providers:

Provider Type	SFY16 Cost Report	SFY16 Cost Settlement	SFY17 Cost Report	SFY17 Cost Settlement	SFY17 FFS Changes
HHA-EPSDT	Yes	Yes	Yes	No	Fee Schedule
PMIC-State	Yes	Yes	No	No	Fee Schedule
CMHC	Yes	Yes	No	No	Fee Schedule
HCBS-SCL	Yes	Yes	Yes	No	Fee Schedule
Case Management/ TCM	Yes	Yes	No	No	Fee Schedule



Cost Reports/Cost Settlement

Collecting cost data allows
DHS to:

- Evaluate adequacy of MCO reimbursement
- Review actual provider costs, verify utilization data, and identify cost trends
- Assist in future FFS rebase and rate setting
- Establish upper payment limit demonstrations, provider tax, etc.
- Capture detailed encounter data
- Gather data on cost coverage statistics



Provider Considerations when Negotiating with MCOs

- MCOs must meet network adequacy standards such as
 - PCP within 30 minutes and 30 miles
 - Specialists within 60 minutes and 60 miles for $\frac{3}{4}$ of population
 - HCBS urban and rural standards up to 60 minutes and 60 miles
- MCOs must:
 - Use non-network providers if there is a gap in coverage for a particular service
 - Extend authorization of LTC services from out-of-network provider to ensure continuity of care



Provider Considerations Cont.

- MCOs will:
 - Move to value-based purchasing (VBP)
 - Offer provider incentives to reward population health outcomes
 - Provide special programs and services that encourage members' healthy behaviors



Summary

- DHS has established a rate floor to provide stability
- MCOs need providers to meet network adequacy requirements across geographical and service types
- Providers need to negotiate with MCOs for rates that support their service delivery
- The state continues to work with providers and MCOs on establishing a system that rewards positive outcomes and supports members' needs