

Medicaid Modernization Request for Proposal Fact Sheet



Iowa High Quality Health Care Initiative

On February 16, 2015, the Iowa Department of Human Services (DHS) released a Request for Proposals (RFP) for Governor Branstad's Medicaid Modernization. The initiative aims to improve the coordination and quality of care while providing predictability and sustainability for taxpayers in Medicaid spending.

GENERAL QUESTIONS

1. What is Medicaid Modernization?

DHS proposes to enroll the majority of the Medicaid, Healthy and Well Kids in Iowa (*hawk-i*) and Iowa Health and Wellness Plan enrollees in comprehensive managed care organizations (MCOs). DHS will contract with MCOs to provide comprehensive health care services including physical health, behavioral health and long-term services and supports (LTSS). This initiative creates a single system of care to promote the delivery of efficient, coordinated and high quality health care and establishes accountability in health care coordination.

What are the goals of Medicaid Modernization?

The main goals of Iowa's Medicaid Modernization are:

- Improving quality and access
- Achieving greater accountability for outcomes
- Creating a more predictable and sustainable Medicaid budget

Why is Iowa making this change?

Iowa's current Medicaid model operates multiple care management approaches based on the population being served. This contributes to a fragmented model of care. Where managed care arrangements are employed, services such as behavioral health, physical health, and transportation are provided by separate entities, which promotes the lack of care coordination among providers and limits financial incentives to actively manage a patient's health care. Additionally, by excluding Medicaid enrollees when they become eligible for HCBS waivers or long-term care, there is no financial incentive to prevent institutionalization.

General Questions

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This initiative seeks to address the shortcomings of the current model by uniting health care delivery under one system, enabling all Medicaid enrolled family members to receive care from the same entity. This creates a single system of care to promote the delivery of efficient, coordinated and high quality healthcare and establishes accountability in health care coordination.

How does this impact members?

The majority of all Medicaid members will receive services through the MCOs including the following:

- *hawk-i* members
- Iowa Health and Wellness Plan
- Long Term Care
- HCBS Waivers
- Medically Needy

A few populations, however, will be excluded from coverage under the MCOs. Excluded populations are:

- PACE (member option)
- Programs where Medicaid already pays premiums: Health Insurance Premium Payment Program (HIPP), Eligible for Medicare Savings Program only
- Undocumented persons eligible for short-term emergency services only

2. Questions About Covered Services

What services are included and excluded from the MCOs and why?

Almost all of the current Medicaid covered benefits and services will be administered by the MCO.

Dental services, however, will be excluded. Given the ongoing difficulties with providing this benefit to members and the early success of the Dental Wellness Plan, DHS is opting to continue building on the success of this model. Within the Dental Wellness Plan, integration with other services is an important value.

How will health homes and integrated health homes change?

The MCOs are required to develop a network of chronic condition health homes. The MCOs are also required to fund integrated health homes.

How will care coordination and case management happen?

Care coordination means coordinating multiple types of care: physical health care, behavioral care and long term care services, **within** the specific systems and **across** the systems. This full integration of overall care is a key goal.

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Case management is a collaborative process which assesses, plans, implements, coordinates, monitors and evaluates care based on an individual's health care needs. The goal is to provide quality and cost-effective outcomes.

The MCOs will be directly responsible for providing care coordination and case management throughout the state and may do so with its own staff or contracted staff.

How will the current care management system change?

Health Care: Today for some populations we use primary care providers to coordinate health care services and, in specific counties, there are managed care providers assisting Medicaid members. Unless otherwise excluded, all populations served by these providers will receive services through the MCOs.

Behavioral Care: The MCOs are required to utilize the Integrated Health Home to leverage coordination of behavioral care and health care. The MCOs may also have their own care coordinators for behavioral care services much like Iowa's behavior health managed care company does today.

Long Term Care: Today various Medicaid providers are paid to provide case management and care coordination. In the future, the MCOs will be responsible for the case management and care coordination. In addition, the MCOs will provide care coordination for persons served in facility based settings. This is not currently done today. The MCOs may contract for or provide these services directly.

3. Impact on Current Programs

How does Modernization impact the State Innovation Model (SIM)?

The MCOs are required to use the Value Index Score (VIS) as a common tool for measuring population health outcomes and total cost of care. In addition, the MCOs are encouraged to use value-based purchasing and must report the percentage of total value-based contracts by 2018.

The MCOs will be given some flexibility from the SIM approach that was described in the test grant. This will enable the MCOs to manage utilization as the long term SIM goals around delivery system transformation are pursued.

How do Accountable Care Organizations (ACOs) and MCOs work together?

The RFP does not have specific requirements for MCOs regarding contracting with ACOs. It is highly likely, however, that both MCOs and ACOs will seek to establish working relationships as they are both focused on achieving outcomes measured by VIS.

How will state efforts with Balance Incentive Payment Program (BIP) be impacted?

The BIP is designed to encourage the use of HCBS waiver services as an alternative to more costly long-term care settings such as nursing facilities and intermediate care facilities

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for the intellectually disabled. The program provided Iowa with an enhanced match rate to accomplish this goal.

The RFP includes requirements to continue to focus on the BIP goals. Specifically, MCOs will be responsible for the funding of all long-term care services (community services and facility care) and are required to assure that an individual's needs are met in the least restrictive settings as possible. The MCOs will be required to assure that an individual's needs are met and that care is provided at the most efficient and appropriate level.

How will Money Follows the Person (MFP) efforts change?

MFP will continue to be administered by DHS in partnership with an administrative vendor. The MCOs are required to coordinate with the MFP program.

4. Savings

What are the projected savings?

Savings in the Governor's budget recommendation are \$51.3 million in the last 6 months of SFY16.

Are savings sustainable?

Savings will be built into the Department's budget request going forward.

5. Federal Approval Process

What is the federal approval process and timeline?

The state will work with Centers for Medicare and Medicaid Services (CMS) to obtain the authority to implement this new Medicaid model through an 1115 demonstration waiver. DHS will also work with CMS to be able to reach the January 1, 2016, timeline.

What type of demonstration waiver will Iowa be seeking?

At this time, the Department is reviewing whether to seek a new 1115 demonstration waiver or amend its current 1115 waivers and the 1915c home and community based services (HCBS) waivers. The Department is coordinating with CMS to determine the best course of action regarding this matter.

What are the conditions of approval?

CMS has different requirements for the various waiver types. The Department will work with CMS to identify and satisfy the requirements to receive approval.

Is stakeholder input required?

The Department is actively seeking input through the RFP process. Stakeholder input is required by CMS as part of the federal approval process and DHS will assure all

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requirements are met. In addition, the Department will have a formal public notice period prior to submission of the demonstration waiver in late spring/early summer 2015.

How is DHS seeking stakeholder input?

The Department plans to hold at least four statewide meetings to receive stakeholder input on the draft RFP. These meetings will be held in Cedar Rapids, Des Moines, Davenport and Council Bluffs. In addition, the Department will meet with various associations and other groups. A calendar of the meetings will be posted to the IME dedicated web page at:

<https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>

In addition, the Department has established a mailbox where public/stakeholder comments may be submitted MedicaidModernization@dhs.state.ia.us

6. Implementation Timelines

Release RFP	February 16, 2015
Series of Stakeholder Engagements	Began February 19, 2015
Stakeholder/Public Comments on RFP Due*	March 20, 2015
Amended RFP Release	March 26, 2015
RFP Responses Due	May 8, 2015
RFP Awards Published	July 31, 2015
Contracts negotiated and signed	Fall/Winter of 2015
Successful Bidders Build Networks	Prior to January 1, 2016
Medicaid Modernization Effective	January 1, 2016

**DHS intends to continue to encourage public input after this time and will have another public comment period prior to submission of the waiver.*

PROVIDER QUESTIONS

7. Provider Network and Reimbursement Rates:

Do the MCOs have to accept all Medicaid providers in their network and what are the reimbursement rates?

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Physical and Behavioral Health Care: The provider network and current rates will remain in place until June 30, 2016. Provider networks and reimbursement rates after June 30 will be negotiated by the MCOs and providers as the MCOs establish their networks.

Facility: The provider network and current rates will remain in place until December 31, 2017. Provider networks and reimbursement rates after this time period will be negotiated by the MCOs and providers as the MCOs establish their networks.

Home and Community Based Services (HCBS) and Habilitation Providers: The provider network and current rates will remain in place until December 31, 2017. Provider networks and reimbursement rates after this time period will be negotiated by the MCOs and providers as the MCOs establish their networks.

Members will be allowed to keep their case manager until at least June 30, 2016, if the member chooses. All case management activities must be transitioned to the MCOs no later than December 31, 2016.

8. Provider Claims Processing

How will billing processes be different under MCOs?

Providers will send claims directly to the MCO for members who are enrolled under an MCO. If the member is not enrolled with an MCO, claims will be submitted directly to the Iowa Medicaid Enterprise (IME).

What are the payment timeframes for an MCO?

The payment standards for the MCO will be consistent with current standards. The MCO must pay or deny:

- 90 percent of clean claims within 20 calendar days of receipt;
- 99 percent of clean claims within 60 calendar days of receipt; and
- 100 percent of claims within 90 of receipt.

9. Prior Authorization

What happens with Service Authorizations?

Physical and Behavioral Health Care: Until December 31, 2016, MCOs must honor a new member's existing service authorizations for a minimum of 90 days after the member is enrolled with the MCO. On and after January 1, 2017, MCOs must honor a new member's existing service authorization for a minimum of 30 days after the member is enrolled with the MCO.

Facility: Until December 31, 2016, MCOs must honor a new member's existing service authorizations for a minimum of 90 days after the member is enrolled with the MCO. Services cannot be reduced or modified without a revised assessment. On and after January 1, 2017,

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MCOs must honor a new member's existing service authorizations for a minimum of 30 days after the member enrolls with the MCO.

Home and Community Based Services (HCBS) and Habilitation: MCOs must honor existing service authorizations for a minimum of 90 days after the member is enrolled with the MCO. Services cannot be reduced or modified without a revised assessment. On and after January 1, 2017, MCOs must honor a new member's existing service authorization for a minimum of 30 days after the member enrolls with the MCO.

10. Pharmacy Services

How will pharmacy services be impacted?

The following will remain the same:

- The Medicaid Preferred Drug List (PDL) & Prior Authorization (PA) criteria will be used by all, as well as quantity limits and clinical edits.
- The Pharmaceutical & Therapeutics (P&T) Committee will continue in its same capacity to make PDL recommendations.
- The Drug Utilization Review (DUR) Commission will continue in its same capacity including making PA criteria recommendations.

Other Utilization Management programs will be determined by the MCOs, including but not limited to:

- Lock-In
- Recipient Health Education Program (RHEP)
- Medication Therapy Management (MTM)

What may be different regarding pharmacy?

The following could vary by MCO:

- Prior Authorization (PA) process;
- Pharmacy Reimbursement: ingredient cost reimbursement and dispensing fee will be determined by the MCOs after June 30, 2016;
- Specialty Pharmacy Program: may be utilized by the MCOs to allow for a combination of payment negotiation, care coordination, and more effective clinical management; and
- Pharmacy network.

Will the MCOs be allowed to have a limited pharmacy network?

Network adequacy is addressed through various performance indicators specified in the RFP that focus on specific time and distance measures and the provider number, mix and geographic distribution, including the general access standards.

Will the state mandate a minimum pharmacy reimbursement (ingredient cost and dispensing fee)?

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The pharmacy network and current rates will remain in place until June 30, 2016. Networks and reimbursement rates after this time period will be negotiated by the MCOs and providers as the MCOs establish their networks.

11. Provider Reporting Requirements

What requirements will the MCO have for provider reporting that are different from today?

The MCOs may require their own reporting requirements. The reports may be different than what is required today.

12. Provider Requirements

Who will do the provider credentialing?

Each MCO will be responsible for provider credentialing.

13. Provider Appeal Rights

How are appeals and grievances handled under MCO?

The MCOs will have a grievance/appeal process. If providers have exhausted the MCO grievance/appeal process and are still dissatisfied with the outcome, the provider may access the DHS appeal process.

MEMBER QUESTIONS

14. Differences in Services

What are the differences between the current Medicaid program and managed care?

Managed care is a system for providing and paying for health care services. Managed care means that you receive your health care from a managed care organization (MCO). A MCO is an organized network of health care providers that emphasizes primary and preventive care. Hospitals, physicians and other health care providers are members of the network.

Is managed care new to Iowa?

No. We currently work with one managed care company to provide behavioral health services and another to provide all services to the Temporary Assistance for Needy Families (TANF) population and some Iowa Wellness Plan members. Additionally, the MediPASS program is available for both the TANF population and Iowa Wellness Plan members. Under Modernization, the member will have a choice of two to four MCOs. The member will receive services through the MCO's provider network.

15. Enrollment

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Are members able to choose their MCO?

Yes. The IME will inform members of their MCO choices prior to the time to enroll with MCOs. If members do not make a selection, they will be assigned to an MCO. All members will have 90 days after initially being assigned to an MCO to request a change. After that, members may change their MCO annually, or more frequently only for good cause (i.e., member moves, provider no longer with MCO).

Do members enrolled in an MCO still use a Medicaid card?

Members will receive a Medicaid card during their initial enrollment period that should be used to access services prior to the member being assigned to the MCO. As the MCO selection process may take 15 to 45 days, the member should keep the Medicaid card for use during this time. Members will also receive a card from their MCO.

Can family members have separate plans?

Yes. Family members may choose different plans and also have the option of receiving coverage through the same plan.

16. Services

Will services be different under the MCOs?

Services provided today will continue to be offered under the MCOs, including physical health care, behavioral care and long term care services. All services, except for dental, will be with the MCOs.

Will my prescription drug coverage change?

No. The MCOs will provide your prescription drug coverage and will utilize the same Preferred Drug List (PDL) and Prior Authorization (PA) criteria that Medicaid uses today. Members will not see a difference in the drugs available, but depending on which MCO members enroll, pharmacy providers may be different.

Will I still be able to get transportation like I do today?

Yes. The MCOs will be responsible for coordinating transportation services for all Medicaid populations eligible for the services.

17. My Service Providers

Can I keep my current provider(s)?

- **Physical and Behavioral Health Care:** Providers who are enrolled with Medicaid will be part of the MCO provider network until June 30, 2016. After this time period, provider networks will be negotiated by the MCOs and providers.
- **Facility:** Providers who are enrolled with Medicaid will be part of the MCO provider network until December 31, 2017. After this time period, provider networks will be negotiated by the MCOs and providers.

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- **Home and Community Based Services (HCBS) and Habilitation:** Providers who are enrolled with Medicaid will be part of the MCO provider network until December 31, 2017. After this time period, provider networks will be negotiated by the MCOs and providers.
- **Case Management:** Members will be allowed to keep their case manager until at least June 30, 2016, if the member chooses. All case management activities must be transitioned to the MCOs no later than December 31, 2016.

What do I do if my primary care provider and specialist are in different MCOs?

The member should choose the plan that best fits their needs. The MCO is expected to work with the member to ensure the best care coordination possible.

18. Appeal Rights

What are member rights under the MCO?

Under managed care, members will have the same right to make informed choices about their health care as they do under Medicaid. MCOs may require members to get their health care services from a certain network of providers, but those providers cannot take away a member's right to make their own health care decisions.

How will member appeals be handled?

Any Medicaid eligibility appeal would continue to be handled as they are today through the State Fair Hearing appeal process.

For benefit or service related issues, the member will have their first level of appeals handled internally by the MCO. If a member is dissatisfied with the MCO's decision, the member will then have access to the State Fair Hearing appeal process through the DHS.

19. How to Provide Comments or Questions

Questions and Comments may be submitted to: MedicaidModernization@dhs.state.ia.us

The Request for Proposal is available at:

http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140

Additional information is available at:

<https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>

The information provided in this document reflects the Medicaid Modernization as defined by the scope of work in the agency's request for Proposal (RFP), Iowa High Quality Healthcare Initiative, RFP# MED-16-009, issued February 16, 2015.

The Agency's written and oral responses to questions issued through this forum will not be considered part of the Iowa High Quality Healthcare Initiative RFP. If the Agency decides to change the RFP, the Agency will issue an amendment.