Iowa Medicaid Reform

Implementation

July 1, 2005 – October 1, 2005

I. Medicaid Expansion - 5,300 enrolled

II. SED Waiver – 300 enrolled as of Oct. 1

III. Iowa Medicaid Enterprise – Operational

IV. Financial Matters – All SPAs and requests for additional information submitted

V. Rebalance Long-Term Care – SPA submitted, additional information in process, goal to complete by Oct. 1

October 1, 2005 – March 1, 2006

I. Mental Health Transformation Pilot

II. MR/DD – Physical health and Case-mix

III. Oral Health – Dental Home

IV. Iowa Medicaid Enterprise II

IME II – Well Run Managed Care Organization

- Health Prevention and Promotion
  - Smoking cessation, weight loss, IowaCare medical exams, 24-hour hotline, co-payment incentives
- Partnership with Providers
  - Care management, Electronic Medical Records, Provider Incentive Payments
- Utilization Management
  - Non-Rx prior authorization, clinical care committee
- Learning Organization
  - Best practices, provider and member education
- Price Sensitive
  - Pricing commission

October 1, 2005 – March 1, 2006

V. Research

- State of health insurance
  - barriers to access
- Role of Indigent Care
  - Amount, scope, location, extent of public tax funding

October 1, 2005 – March 1, 2006

VI. Performance Reporting

- Who is being covered? What are their characteristics?
- For what services?
- How much does it cost?
- What gaps are there?
- Impact on indigent care and uninsured?
- Impact on health status?
- How many pay premiums/hardship exemptions vs. no response?
- Level of customer satisfaction?

IowaCare Implementation Plan

Operational Plan:

1. What is the overall approach toward administering the program? Which staff person will have daily responsibility for administering, monitoring compliance, and reporting associated with IowaCare and the Special Terms and Conditions of the waiver? Key staff been assigned to address the key elements of the waiver such as contract administration, oversight of client activities, review of contractor performance, outcome/access issues, quality of care issues and monitoring of evaluations for quality assurance, and rate setting.	IowaCare is administered by the Iowa Medicaid Enterprise along with all other Medicaid programs. A separate program or unit has not been established. The IME includes 24 State FTEs and nine contracted units, including: • MMIS/Core • Provider Services • Member Services • Medical Services • Pharmacy Medical Services • Pharmacy Point of Sale • Provider Cost Audit • Revenue Collections • Surveillance and Utilization Review State technology staff support the Data Warehouse. The administration of the IowaCare Program, as a component of Medicaid, is integrated within the IME. For example, the Core Unit is performing all necessary systems changes, Provider Services and Member Services have issued informational letters and answer questions on IowaCare and Medicaid, Pharmacy Point of Sale and Medical process the IowaCare claims and prior authorizations, Revenue Collections processes the IowaCare premiums, etc. Eugene Gessow, Iowa Medicaid Director, is responsible for overall operation of all Medicaid programs including IowaCare.

	Jennifer Vermeer, Assistance Medicaid Director, will be responsible for the daily activities and key elements of IowaCare.
2. How has the State organization accommodated the operation of the traditional Medicaid program and IowaCare? Are any staff persons responsibilities different? How are they linked/coordinated?	IowaCare is operated within the current Medicaid system. Additional staff has been added as well. Proposed new staff include: • 6 eligibility determination staff for the Field Offices. • 0.5 FTE for the eligibility worker help desk phone center. • 0.5 FTE for eligibility policy. • 2.5 FTE for systems programmers. • Assistant Medicaid Director responsible for daily operational and implementation issues (already hired).
3. What problems does the State forsee in running IowaCare parallel with the HAWK-I and Medicaid programs?	Medicaid and HAWK-I staff have been involved with the implementation of IowaCare. The HAWK-I Program Manager also manages the eligibility staff for Medicaid. To date, no problems have been identified.
4. Have you established an organizational structure and delegations of authority including functional descriptions different than from the Standard Medicaid organization and IME? May we have a copy of the current organizational chart?	The organizational structure and authority for IowaCare remains the same as for Medicaid. See Attachment 2 (Organizational Chart)
5. Will the State be contracting with an MCO, PCCM, or PIHP for any portion of care or administrative? If so, how will IowaCare reimbursement to those entities be determined? Please submit the contract for any of these entities to the Regional Office for review.	N/A

6. What are the more detailed milestones to mark successful transition or completion of objectives for IowaCare outlined in the Terms and Conditions? Will Iowa please provide CMS with detailed systems implementation charts and work plans which reflect the known tasks to be accomplished to implement the waiver (i.e., task completion dates, testing of processes and outcomes, problems identifications and resolutions, etc.)?	Key milestones to implement the program include: • Completion of eligibility systems changes (complete) • Completion of MMIS programming changes (complete 8/15/05 • Completion of Pharmacy POS system changes (POS is adjudicating claims) • Enrollment of members (5,300 enrolled as of 8/5/05) • Services provided to members (IowaCare members are receiving services by the providers) • Appropriate denials of non-covered services (Some members attempted to access pharmacy and other services through non-IowaCare providers. The systems appropriately denied coverage) • Members and Providers access to information (receiving dozens of calls each week from members and providers, 2/3 of IowaCare enrollees are former State Papers recipients) • Submission of all State Plan Amendments (complete) • Other milestones are provided in workplans attached. Attachment 3 (Chart of tasks) Attachment 4 (Iowa Medicaid Reform Project Business Requirements) Attachment 5 (System Change Request)
7. Is there a legislative oversight committee? If not please explain any legislative reporting requirements for this effort.	House File 841 Division VI Section 21 (see attached bill) requires Iowa to create a Medical Assistance Projections and Assessment Council. The Council will make quarterly cost projections for Medicaid and IowaCare; Review quarterly reports on all IowaCare initiatives; Review audited financial statements for IowaCare providers; Review quarterly reports on the performance

	of the Iowa Medicaid Enterprise; Assure that the IowaCare program is managed at all times within the funding limitations. Legislative members have been appointed to the Council. The first meeting is scheduled for August 31, 2005. The Council plans to meet throughout the state. In addition, the program will be overseen by the Health and Human Services Appropriations Subcommittee.
8. Have you established an advisory council for the IowaCare Program or is the MAAC committee advising the Iowa Medicaid agency on this program?	Senate File 272 amended the structure of Iowa's MAAC committee to include Medicaid members. The expanded MAAC committee will also advise on the IowaCare program.
9. How has Iowa addressed the concerns expressed by all concerned outside parties/advocacy groups? Has the State received any letters of support of complaint regarding the program? Please provide any correspondence from the involved providers (University of Iowa hospitals and clinics, government-operated acute care teaching hospitals, Broadlawns, etc.) Is there any current oppositioin to the program from either advocates or providers? Provide detail including the nature of the concerns, actions taken, and the present position of the groups expressing the concerns. Please arrange for us to meet with officials from Broadlawns, UIA and/or State Hospitals on August 11, 2005 to ask questions related to the provision of care processes as related to the IowaCare Program.	The IowaCare legislation details all aspects of the program. The legislature conducted a comprehensive public process in the passage of HF 841. This included multiple subcommittee meetings to hear the concerns of anyone who chose to participate, including provider groups, advocacy organizations, etc. The bill was amended many times to make changes to accommodate groups' concerns. By the time the bill passed, only one group was registered in opposition to the bill – the Iowa Hospital Association. Their concern was that the program would result in increased uncompensated care in hospitals furthest from the covered providers. The state argued that the provider network for IowaCare is exactly the same as the provider network under the old State Papers Program. The final legislation includes the Indigent Care Task Force, which will compile data on the cost and quantity of indigent care provided by providers throughout the state, as well as the health status of those receiving care (see HF 841, Division IV, Section

	16). This will allow the state to evaluate the amount of indigent care being provided and whether IowaCare is having an impact on other hospitals. Throughout the process, explanatory and question and answer documents were prepared by DHS and legislative staff. The documents were distributed to interested parties and posted on the website. We have included the legislative history and some of these documents as an attachment. Attachment 6 (legislative history)
10. What other proposed or actual legislative or policy initiatives in the state might or will affect the IowaCare Program?	Indigent Care Task Force (see question #9). The Mental Health/Mental Retardation Redesign Commission was established to evaluate the MH/MR system and recommend policy changes to equalize services among counties throughout the state and enhance community based care alternatives. The Commission has recommended legislative packages in the last two legislative sessions. If legislation is enacted it would enhance the state's initiatives to promote the Mental Health Transformation Pilot.
11. Does the State Legislature's agenda include a proposal to reauthorize $54.6 million and appropriated additional funding to both the Iowa State Medicaid agency as described in the Health Care Transformation Account (and in the Special Terms and Conditions)?	It is anticipated that that the Governor and State Legislature will both recommend continuing the appropriations in HF 841, including appropriations from the Health Care Transformation account.
12. How will the State Medicaid agency coordinate with other State and regulatory agencies to manage and oversee the IowaCare program? What written policies, procedures, or agreements reflect this coordination? Please provide any agreements between the Medicaid agency and the University of Iowa hospitals and clinics and Broadlawns regarding this	The amendments to the administrative rules (Chapter 92) requires IowaCare members to cooperate with the quality control unit and the Department of Inspections and Appeals Investigations Unit. Since IowaCare is part of the Medicaid Program, DIA will also investigate for fraud and abuse in the program. In addition, DHS has signed a 28E agreement with the University of Iowa Hospitals

program. How have local offices/governments been notified of the new IowaCare program and the elimination of the State Papers Program? Please submit any written notifications.	and Clinics (see attached), and is in process of finalizing a 28E agreement with Broadlawns. All local DHS offices received training on the IowaCare program (see attached). In addition, all FY 2005 State Papers recipients received a letter from DHS notifying them of the changes and inviting them to apply for IowaCare. They also received an IowaCare application. DHS also sent a letter to all county General Relief directors, who previously worked with the State Papers Program. HF 841 also requires DHS to contract with county General Relief directors (if they chose) to participate in the intake process for the IowaCare Program. To date, no counties have expressed an interest in formally contracting with DHS for this purpose. Attachment 7 – 28E agreements Attachment 8 - Training materials Attachment 9 - Letters to State Papers recipients Attachment 9 - Letters to County GR directors
13. How does the state coordinate with Indian Health Services, tribes and Native American providers regarding IowaCare?	Indian Health Services does not have an office or providers in Iowa. Iowa has a very small Native American population. The IowaCare provider network is limited to the University of Iowa, Broadlawns and the four State Mental Health Institutions.
14. How is your data or information sharing infrastructure set up between providers, services, government agencies, etc. regarding IowaCare?	The Iowa Medicaid Enterprise includes units for Provider Services and Member Services, which also support IowaCare. These units are dedicated to communicating with providers and members through call centers, provider information letters, and informational websites. The website is www.ime.state.ia.us. We also have weekly conference calls with Broadlawns and the University of Iowa to discuss problems, experience with the program, and respond to questions. All information related to the

	program, including data for the program to date, is also posted on the website for any other interested parties to review. Attachment 10 - Provider information letters on IowaCare
15. What are the lines of communication established between providers, eligibility groups, DHS, CMS, etc. regarding changes in plans, outcomes, complaint forums, etc. for the IowaCare Program.	Any change in the Program requires a change in administrative rules. The administrative rules process includes public notices and public hearings throughout the state. All rules are reviewed by a legislative committee in public meetings. In addition, any change would include provider informational notices, letters to members, and notification to all DHS Field Staff. We have submitted required State Plan Amendments and communicate with our Iowa CMS liaison on a regular basis. Further, the Terms and Conditions #15 includes a requirement for monthly calls with CMS on IowaCare implementation. HF 841 includes includes various requirements for regular reports and program evaluation that will be provided to the Governor and General Assembly, and reviewed by the legislative Medical Assistance Projection and Assessment Council, whose meetings are also publicly noticed and include testimony from the public.
16. How is HIPAA compliance monitored for the IowaCare Program?	The IowaCare Program is administered by DHS and HIPAA compliance for IowaCare falls under the purview of HIPAA compliance for DHS as a whole.
17. In the State's move toward a more comprehensive Medicaid reform program, what is the strategic approach and step wise progression over the next five years for the state? Will the state integrate other Medicaid programs/grants in the IowaCare concept or is this considered a stand alone program?	Many of the reform initiatives in HF 841 apply to IowaCare and the Medicaid program as a whole. For example, the Electronic Medical Records initiative, smoking cessation, dietary counseling, dental home, ICF/MR case mix, nursing facility level of care, etc. These are all part of a comprehensive Medicaid reform package. Iowa would also like to incorporate some of the other aspects of HF 841 into the regular Medicaid program but are prevented by current federal regulations including differential

	co-pay or out of pocket expenditures to promote healthy activities and to provide disincentives for emergency room visits. IN addition HF 841 requires the DHS to make annual recommendations for future expansion of the IowaCare program. DHS plans to use the data from the Indigent Care Task Force and evaluation of the IowaCare program to identify opportunities for expansion and further Medicaid reform.
18. What monitoring and audit mechanisms do you have in place to detect and investigate fraud and abuse for the IowaCare Program? What operating standards are in place and how will the state exercise control?	The Fraud and Abuse system within the Medicaid program will be followed for IowaCare. SURS activities are also conducted through the IME and will also include the IowaCare program.
19. How will the state provide technical assistance when problems are detected with the IowaCare Program?	See question 14.
20. What administrative or programmatic responsibilities are contracted out for the IowaCare Program?	Responsibilities for IowaCare are contained within the IME and include the processing of IowaCare premium payments, IowaCare fiscal monitoring, reporting and utilization, provider and member communications, medical prior authorizations and SURS.
21. How will you train providers, eligibility staff and other core operating component personnel on the operating standards/procedures for the IowaCare program?	See Question 14 and 15 for communication and training that occurred prior to the program start-up.
22. What is the current status of submission and approval of State Plan Amendments as outlined in the Special Terms and Conditions?	The initial responses to State Plan amendments were submitted June 27, 2005. Revisions were submitted August 5, 2005.
23. What is the current status of the implementation plan required in Term and Condition #52?	The implementation plan is process and will be submitted as soon as possible.

System issues – Eligibility

1. Has the State made the necessary changes to its eligibility files (including MMIS)?	Yes, all system changes were completed prior to June 30, 2005 except programming to adjudicate IowaCare claims. This will be

	completed before the end of August. In the meantime, providers can submit claims. The claims are placed in the "suspense" file. Providers are being paid on a prospective basis so are not experiencing delays in payment as a result.
2. If the eligibility function has been contracted to a private entity, the effective data links are of particular importance. Assure that these links are in place and meet the program's needs.	N/A
3. How will the State identify individuals who would be eligible under Demonstration?	Letters were sent to all former FY 2005 State Papers recipients. Broadlawns and UIHC have DHS Income Maintenance workers stationed at their hospitals and Broadlawns has an established Indigent Care Program for individuals under the 200% FPL. Broadlawns is referring these individuals to the DHS Income Maintenance worker to determine eligibility for IowaCare.
4. If the State has an automated eligibility system and plans to use this method to identify individuals are the necessary screens in the system?	Yes, IowaCare eligibility is processed in the current Medicaid system. Different aid types were added to identify IowaCare applicants.
5. If eligibility workers will be applying the screens and will be entering the flags in the system, do the eligibility workers have the screens and know how to use them (i.e., are they written instructions and training materials) and the system can accept the data and assign the identifier?	Approximately 5300 applicants have been enrolled in IowaCare. Eligibility workers are using the system properly. Attachment 11 (IowaCare enrollment report)
6. To determine the amount of Medicare DSH payments to make to specific hospitals, the hospitals must be able link individual inpatient days to Medicaid eligibles. Included as Medicaid eligible are individuals who continue to receive Medicaid under the plan and demonstration participants who would remain eligible under the plan without the demonstration. CMS's preferred method for addressing this issue is for States to identify this population on the State eligibility file and have the hospitals send a tape to match against the eligibility file	The demonstration does not impact Iowa's Medicaid eligibility. A separate aid type identifies IowaCare members to assist in tracking for any reporting purposes.

with the State then providing the hospitals with a tape of matches on dates of eligibility and services. However, if the State has chosen to adopt a method whereby the health plans are going to include these flags in their identification numbers for the hospitals to identify this population upon admissions, can you assure that the State has the ability to pass on the information and the plans to use it? If ID cards have been printed and issued, check with a sample of beneficiaries to see if the identifiers are on the cards or identify another method to verify.	

Delivery System

1. How will FQHCs be reimbursed under IowaCare?	FQHCs are not covered in the first phase of implementation. They are included in the provider network for the comprehensive medical examination. They will be reimbursed for this service based on Medicaid reimbursement for medical examinations.

Eligibility

1. Do the Advanced Planning Documents (APD's), Requests for Proposals (RFP's), Design, Development, and Implementation Schedule, OR's knowledge of the State's MIS capabilities, and any other preparatory documents which have been developed for implementation of the waiver indicate that the State has the necessary systems hardware capacity and software capability to effectively and efficiently implement its waiver.	
2. Has the State conducted final tests of its primary and sub-systems readiness to implement its waiver on the proposed effective date? Can it provide you with listings and details of identified and corrected problems found during its final	Yes, the necessary testing was completed prior to June 30, 2005. The claims adjudication system will be completed before the end of August and testing is in process.

systems testing? Has the State conducted a full fledged "stress test" where it has run all of its primary and secondary systems at the same time to reflect the "live" conditions which will operate under the waiver? Can it provide you with listings and details of identified and corrected problems found during the "stress test"?	Testing on the Pharmacy POS system is completed and is adjudicating claims. All systems testing follows normal testing requirements of the MMIS system.
3. Please provide documentation or other evidence that demonstrates that the new or additional systems hardware requirements, created by the State's waiver provisions, can be met by the available computers and related equipment used by the State or the fiscal agent. A full stress test of the hardware with large claim or other sample test runs of the new waiver requirements should be conducted prior to approval of the systems readiness. Can the State hardware system handle all waiver related requirements at the same time it may be continuing other systems aspects of the Medicaid program?	All of the systems requirements for the waiver have been incorporated into existing hardware. Testing is either in process or is completed and the hardware system is able to accommodate all the waiver-related requirements as well as all the other system requirements in the Medicaid system.
4. Please address and provide assurances that necessary systems interfaces and required training has occurred between any other systems entities which have responsibilities related to the waiver. This may include other State agencies responsible for eligibility determinations, payment, or contracting. It may also include providers or contractors who will be submitting claims, encounter data, or other reports electronically to the State. Documentation should be provided by the State to demonstrate that it has conducted necessary training, data validation, and other tests to assure that it can effectively interact with these other data sources.	Systems changes and training has occurred, with the exception of claims adjudication. However, weekly conference calls with Broadlawns and University of Iowa Hospitals and Clinics address technical issues with claims, Pharmacy Point of Sale, and prior authorization. The processes are all the same for the regular Medicaid Program; the IowaCare program just has different aid types and provider numbers.
5. Can you provide test results which demonstrate that it can flag and or reject FFS payment claims for services in Medicaid but not in IowaCare for a recipient in IowaCare?	Attachment 12
6. What are the State's systems capabilities? Can you provide	Eligibility system changes are complete. The system is approving

test results which demonstrate that it can, when appropriate, make available through recipient identification cards or eligibility verification systems, recipient eligibility information including, restrictions in coverage, instructions to be followed in medical emergencies, etc.?	and denying applications appropriately (see enrollment report). The state has electronic and telephonic access for providers to check eligibility status. The telephone message also includes the providers covered under IowaCare. See Attachment 4 for systems change documentation.

Cost sharing/co-payments

1. Will IowaCare beneficiaries be charged any co-payments? If so, what are they?	IowaCare members (with the exception of newborns eligible pursuant to 92.2(1)"c") will be charged a co-payment according to the same rules applied to Medicaid members. The co-payment amounts are defined in IAC 441-79.1(13). Attachment 13 (co-payment amounts) In addition to the co-payments, IowaCare members shall be assessed a sliding-scale monthly premium which is based on the households' countable income as a percentage of the federal poverty level for a household of that size. The financial participation requirements of IowaCare members are provided in IAC 441-92.7, including the premium payment table. IAC 441-92.7 is included in Attachment 14.
2. What is the State's process for educating beneficiaries about cost-sharing requirements including: • Notification of the amount of cost-sharing individual beneficiaries will be required to pay. • Notification of how and where premiums and co-pays are to be paid. • Notification that cost-sharing is not allowed for certain services, e.g., well-baby care, preventive care, etc. • Notification of any rules related to cost-sharing which	• The IowaCare application includes a section that explains that a premium may be required to get IowaCare, when the premium is due and consequences of not paying the monthly premium. The application also provides instructions and a chart on how to estimate what the amount of the monthly premium may be. There is no separate notification to IowaCare Members outlining the amount of co-payments that may be required. Members are notified by the provider of the amount of co-payment at the time they receive services.

could affect access or utilization of services, e.g., nonpayment of premiums results in disenrollment for a specified time, coverage does not begin for a specified period after enrollment into the program. • Inclusion of educational efforts in contracts with enrollment brokers.	Attachment 15 – application • Monthly premium invoices are generated by the Title 19 Eligibility System and mailed to IowaCare Members. A copy of premium notification letters are included in Attachment 16 (premium notification letter). • Currently there is no notification to IowaCare Members outlining the amount of co-payments that may be required and the rules governing what services may be exempt from co-payments. • The IowaCare application includes a section that explains when the premium is due and consequences of not paying the monthly premium. The premium letter includes language explaining the consequences of nonpayment of premiums. • Iowa does not contract with enrollment brokers. All enrollment is done by the Iowa Department of Human Services Income Maintenance workers. Prior to the implementation of IowaCare, training was provided to Income Maintenance workers. Monthly calls are held with Income Maintenance workers to discuss any issues related to eligibility for any of the Department's programs.
3. How is the State monitoring that the annual aggregate cost-sharing does not exceed 5% or 2% of family income, including the methods through which the families will be notified. • Shoebox method. • Health plan administrator. • Audit reconciliation. • Other.	Income eligibility is determined based upon self-declaration of income reported by applicants. The monthly premium amount shall be established for a 12-month period beginning with the first month of eligibility, based on a projected monthly income for the 12-month period. The monthly premium established for a 12-month period shall not be increased due to an increase in income or a change in household size. The premium may be reduced prospectively during the 12-month period if the member declares a reduction in projected average monthly income or an increase in

	household size or is granted a hardship exemption. No adjustment is made to the premium unless the member self-declares a reduction in monthly income.
4. How will the State assure that beneficiaries are not directly billed for premiums or other coinsurance and subsequently reimbursed if they have reached the 5% cap on cost-sharing?	See answer to question 3 directly above.
5. Is there any evidence of cost-sharing creating a barrier to access and utilization of services?	No. The Department has rules and procedures in place that allows the member to submit a statement indicating that payment of the premium would be a financial hardship and an exemption from paying the premium for that month will be made.
6. How is the State ensuring that health plans, providersw, or other entities responsible for collecting cost-sharing (e.g. premiums, co-payments, enrollment fees) are complying with all cost-sharing guidelines outlined in the Terms and Conditions and program implementation plan?	Each provider is required to complete a provider agreement with the Department of Human Services. By signing this document, providers agree to comply will all rules governing the Medicaid program.
7. How will the State assure that providers accept Medicaid's payment as payment in full, i.e., that they do not collect amounts from the beneficiaries above any approved cost-sharing amounts?	See answer to question 6 directly above. Medicaid has a contract with the Department of Inspections and Appeals to investigate fraud and abuse, which includes this area. In addition, Medicaid conducts audits and investigates complaints.

MEQC

1. In the State's new MEQC pilot (10/1/2005), how will the State address the status of quality control activities for waiver participants?	Iowa's FFY 2006 MEQC pilot has not been written or submitted to date. However, we anticipate incorporating IowaCare participants into the MEQC activities to verify, for example, income or other insurance of the IowaCare members. The plan is to select a random sample of cases, but the actual number of cases reviewed will be determined when the level of work involved for each case is known. The plan will be submitted by October 1, as required.

Reporting

1. How will the state comply with federal reporting requirements for the 1115 program?	We will collect and analyze the following data. It will be provided to CMS as required: • Approved applications • Denied applications • Number enrolled in Medicaid instead • Number enrolled in Chronic Conditions Program • Age • Gender • Recipient Income • Number of premiums paid • Number of hardship exemptions requested • Expenditures by service category • Expenditures by eligibility category • Expenditures per person • Monthly calls with CMS • Quarterly reports to CMS, to include the enrollment data above, any issues that have arisen and action plans, expenditure data in comparison to budget neutrality data (separating the Mental Health Transformation Pilot from other expenditures), and an update on the status of the implementation plan. • Annual reports to CMS containing specified information. • Annual evaluation provided by an independent auditor (funding provided in HF 841) to verify no new provider taxes, providers retain 100% of reimbursements, public hospitals and nursing facilities are paid no more than actual cost, expenditures for the Mental Health Transformation Pilot are expended for the target population only.

2. What are the legislative expectations concerning the IowaCare program? Savings achieved? Outcome measures? And how will they be reported?	The Iowa Legislature is expecting the IowaCare program to generate sufficient medical claims to generate federal matching funds for all state funds expended through a combination of Federal Financial Participation, DSH and Graduate Medical Education. They have been informed that if IowaCare is unable to generate that level of claims, that a General Fund supplemental will be required. They also expect to cover at least as many people as were covered in the prior State Papers and Broadlawns Indigent Care Programs. Further, they expect the implementation of Medicaid reform activities to generate program efficiencies, but have not assumed specific savings for those items. The outcome they expect is that more Iowans will have medical coverage and that that coverage will include incentives and results in increasing healthy activities, health awareness, and personal responsibility. The legislative Medical Assistance Projections and Assessment Council will receive quarterly reports on IowaCare, as well as numerous reporting requirements in HF 841 that are required to be sent to the General Assembly and Governor.
3. As described in the Special Terms and Conditions (Section X), provide detail as to how the benchmark reports will be constructed and what sources of information/data will be used in the reports.	See Attachment for timelines. This document is our starting point and will be refined and submitted to CMS for approval and comments. Attachment 17 (Work Plan)
4. How did you adhere to the federal public notice requirements (as per the Federal Register)? Please provide documentation of the public notice and submit copies of any comments received.	Public notice was fulfilled through the public hearings during the legislative consideration of the bill (see Attachment 6) and through the public notice and hearings for the administrative rules.

	Attachment 18 – (public notices for rules) Prints of website notices

Staffing/Training/Competencies

1. Which state agency is responsible for determining expansion eligibility? Monitoring compliance with the terms and conditions of the 1115? If contracted out, which state agencies and offices monitor ongoing compliance with state and federal regulations, terms and conditions of the 1115, and data collection and reports?	DHS is responsible both for determining eligibility and monitoring the terms and conditions.
2. What level of resources has the state committed to handle the increased eligibility workload brought about by the projected expansion?	See Question #2 under Operational Plan.
3. What are the training and competencies needed for eligibility staff to successfully implement the program, compliance with state and federal regulations, and toward producing desired outcomes?	Income Maintenance Workers employed by the Department of Human Services will be determining eligibility for IowaCare. See Attached job description (Attachment 19) for an Income Maintenance Worker II. See also IowaCare training materials (Operational Plan Question #12).
4. How will the state's eligibility staff collect information needed to demonstrate budget neutrality? Specifically address: • Identification of individuals who are currently eligible under the State plan, • Identification of those who would be eligible if the State were to exercise maximum flexibility under the State plan, • Identification of expansion eligibles that would not be eligible in the absence of the 1115 demonstration.	New aid types and MAS/BOE codes have been added to the eligibility system to separately identify all IowaCare members. • Individuals currently eligible under the State Plan are tracked under existing aid types and MAS/BOE codes, which are different from the new codes that were developed for IowaCare members. • Those individuals are currently identified separately in the eligibility system. • IowaCare members have new and separate codes, which allow them to be tracked separately.
5. Will a private contractor or MCO, PCCM, or PIHP be	Not applicable.

responsible for the collection of information regarding eligibility? If so, what kind of monitoring mechanisms are in place to verify the accuracy of data/information provided t the state? If the information is wrong, who is responsible for correcting and what are the consequences listed in the contract (i.e. reduce payment or other financial penalty, plan for improvement, etc.)?	
6. What actions will the state take toward contractors/employees that have been found engaging in conflicts of interest, violated HIPAA or other state/federal regulations, or impeded the access to eligibility or services by applicants or beneficiaries?	Same actions that would be taken for these violations in the Medicaid program. All are administered by DHS so all of those rules apply to Medicaid as well.
7. Does the state have a contingency plan in the event that there is a serious reduction in the number of providers/contractors participating in the IowaCare program?	Providers are statutorily required to participate, with the exception of Broadlawns. If Broadlawns indicated it did not want to participate, DHS would work with the legislature to address their issues.
8. Please provide a process flow diagram and sample application forms.	Attachment 20 – Work Flow diagram

Marketing/Outreach/Beneficiary Education

1. What are the state's marketing, outreach, and beneficiary education plans and implementation processes for IowaCare? Please submit a copy of any outreach or education materials.	The IowaCare application contains all of the pertinent information about the provider network and benefits. Marketing and outreach include letters that were sent to all State Papers recipients, staff availability and training at each county DHS office, DHS and provider staff located at the facilities that refer individuals to the program. These documents are attached in other questions in this document.
2. How successful have your initial efforts been toward meeting you expansion goals? What problems have you noted thus far?	Approximately 5,000 members have enrolled in the first month of the program. It is anticipated that the maximum unduplicated number enrolled over the 5 year period is 30,000. Members have a lot of confusion about what services are covered. These questions are being handled through the IME Member Services

	and the IowaCare providers. In the first weeks a small number of non-IowaCare providers have submitted claims that will be denied. An informational letter has been sent to all providers to clarify which providers are covered.
3. Who is responsible for enrolling individuals in IowaCare? The State? An enrollment broker? Marketing representative? Describe the coordination between entities. What standards are set by the state in the enrollment process and how are they monitored? How is each entity compensated for enrollment activities? Per enrollment? Commission?	The State DHS. The eligibility standards are set on the application, by rule, by statute, and in the eligibility system.
4. What forms of assistance are provided to beneficiaries and providers for IowaCare?	DHS field eligibility staff in each county, IME member services call center; IME provider services call center, DHS eligibility staff located at each provider, staff employed by the providers at each hospital, and the IME website. Providers and members also receive informational letters.
5. How do the providers or MCO track the numbers of enrollees who access health services in a given time period for IowaCare? (Utilization reports)? Do they also track outcomes associated with care provided? How is it reported and to whom?	Health care utilization by IowaCare members will be tracked through claims data and eligibility data to review who is receiving services, what types of conditions they have, what type of service they are receiving, and the cost of those services.
6. How does the state assure that translation services are available to all beneficiaries, regardless of language for IowaCare?	Eligibility workers have access to translation services for any applicant via the At & T Language Line.
7. Are enrollment and educational materials culturally and linguistically appropriate for IowaCare?	Yes
8. How does the state inform beneficiaries of the complaint and grievance process for resolving beneficiary issues, including issues related to authorization, coverage and payment of services for IowaCare?	
9. How are auto-assignments done (if they are done for	Not applicable.

IowaCare)? How are the beneficiaries informed and educated regarding IowaCare? How are access requirements factored into the assignment of beneficiaries to providers/network affiliates?	
10. How does the state track disenrollment and the reasons associated with each for IowaCare?	Eligibility workers utilize the current Medicaid system to disenroll individuals in IowaCare. Included in the system is a end date and reason for disenrollment. This information is stored in the MMIS and available through the DHS data warehouse.

Contracts for Services

1. What kinds of linkage agreements has the State entered into with emergency services providers for IowaCare? After hours care? Urgent care centers?	The IowaCare Provider Network is limited to Broadlawns Medical Center, University of Iowa Hospitals and Clinics and the State Mental Health Centers. All of the urgent care is coordinated through these providers.
2. Does the state contract out with a Pharmacy Benefits Management firm for IowaCare? If so, what are the limitations and how is the member notified or educated about the limitations? How is DUR done with the contractor?	No, pharmacy is a benefit to the extent that take home drugs associated with an inpatient stay or outpatient care are provided by the Network provider. DUR follows the same criteria as the Medicaid DUR.
3. Does the state employ a transportation service contractor/broker to provide transport to and from medical clinics for IowaCare? How is this monitored and reimbursed?	No, transportation is a benefit to the extent that it is offered by the network provider. The network provider submits claim information and is reimbursed as a part of the Prospective Interim Payment. (PIP)
4. What case management services are offered and how are they linked (contract arrangements, referral and continuum of care process) to the IowaCare network?	Case Management services is a benefit to the extent that the network provider offers it.
5. For Information Technology, has the state contracted with a private contractor for the integration of care providers into a clinical and financial network for IowaCare? How will this system ensure the accuracy of claims, clinical information and confidentiality of the patient?	The integration of care providers into clinical and financial network will be performed by the Iowa Medicaid Enterprise contractors. All claims processing and clinical evaluations are preformed by the Iowa Medicaid Enterprise Contractors. The Iowa Medicaid Enterprise contractors are subject to outcome

	based performance standards, have business agreements for confidentiality rules and HIPAA compliance.
6. How does the state ensure that subcontractors hired comply with the contractual terms and conditions of the main state contractor for IowaCare?	IowaCare is not being operated as a managed care program. It is operated by the DHS as a Fee For Service program. As noted above, Iowa Medicaid utilizes contractors to administer the Medicaid program, and are also providing the same services for IowaCare, but there is no main state contractor specific to IowaCare.
7. What is the scope of the state's authority to enforce contracts/standards compliance for IowaCare?	See Question #6. The scope of enforcement applies to the Iowa Medicaid Enterprise contracts. The contracts are posted on the IME website at www.ime.state.ia.us.
8. What are the penalties/sanctions for non-compliance for IowaCare?	Same as above.
9. Does the State/plan use an approved consent form indicating that all of the following requirements are met for each sterilization claim? Age 21 at time of consent, mental competency, voluntary consent, waiting period, all elements of informed consent were orally presented, recipient's signature, interpreter's signature (if one used), signature of person obtaining consent, signature of physician who performed the sterilization procedure?	Services provided under the IowaCare program will follow the same requirements as for Medicaid, including prior authorization and signed consent forms in advance for all sterilization procedures.
10. Does the State/plan have an adequate system for controlling sterilization claims? Has the State given providers adequate instructions to enable them to comply with sterilization requirements?	Sterilization requires a prior authorization, which must be done to receive payment. Providers follow the same process as in Medicaid.
11. Does the State's methodologies and procedures for insuring that health plans provide appropriate and adequate obstetrical services, including risk assessments, case management, implementation of patient noncompliance policies, referrals for specialty care, and coordination of care with drug rehabilitation, AIDS, and pertinent social welfare agencies?	IowaCare does not include any contracts with health plans.

Access to Care

1. How are the providers distributed in relation to the beneficiary population in areas such as cities and rural areas?	The provider network is limited to the University of Iowa Hospitals and Clinics, Broadlawns, and the four state Mental Health Institutions, pursuant to HF 841. This limited provider network is approved as part of the waiver.
2. What are the State's geographic accessibility requirements for IowaCare?	IowaCare members in Polk County have access to both Broadlawns and UIHC for medical care. Members outside Polk County have access to UIHC. The DHS will reimburse for transportation if provided by the provider. This is as specified in Iowa law and as approved as part of the waiver.
3. What are the State's provider capacity requirements for IowaCare? How does the state ensure that there are a sufficient number of providers in IowaCare are accepting new patients? What are the acceptable provider/beneficiary ratios?	IowaCare is a unique demonstration with a limited provider network. The typical geographical access requirements are waived under the 1115. The usage of the providers and the program will be carefully managed to stay within the budget. The enrollment targets are based on the numbers of indigent care patients being served in the past, that will now be covered by IowaCare.
4. What are the State's accessibility standards for IowaCare? How does the state monitor provider appointment waiting times, access to after hours care, emergency care, etc.?	The IowaCare program has a limited service package and provider network. Accessibility is not guaranteed under Iowa law or the 1115 waiver approved by CMS. If IowaCare members access a non-IowaCare provider for emergency room or any other medical service, the IowaCare member will be required to pay for the cost of care.

Evaluation Design – Quality/Performance Improvement

1. The evaluation design is to be submitted by November 1, 2005. Based on the Special Terms and Conditions (Section XI) minimum components, what are your expected hypothses being tested with these demonstration populations and what are your expected outcomes? How will these outcomes be	Outcome 1: <u>Access</u> To improve the health of Iowans by providing more uninsured Iowans with access to medical care. • Measured by enrollment data in the program. The benchmark is enrollment by 14,000 unduplicated members in the first

measured? 2. What kind of database program has been designed and constructed to support measuring program effectiveness and outcomes? 3. What is the State Medicaid Agency's strategy for measuring, assessing and improving the quality of the program? 4. What are the main elements of the performance improvement plan for IowaCare? 5. Who collects the data, how is it reported and to which agencies?	year. • Measured by enrollment distributed in all counties of the State. Also measured by a comparison to enrollment in each county versus the number of State Papers quota each county had in the past. Benchmark is proportional enrollment based on population for each county in the state. • Measured by the data obtained on the quantity and cost of indigent care provided by providers throughout the state. Benchmark is to see a decrease in the number of uninsured compared to FY 2005. Outcome 2: Health Status To improve the health care status of IowaCare and Medicaid members through increased knowledge and personal responsibility for utilizing preventive health care and healthy lifestyles. • Measured by the recommendations of the Clinicians Advisory Panel and by use of Disease Management. • Measured by the use of the health improvement plans/risk assessments and comprehensive medical examinations. Benchmark is 100% compliance with the requirement and the outcome of the member survey questions about the plans. • Measured by an annual survey of members' customer satisfaction with the benefits, providers, and care provided through the program and their assessment of how their health care status has changed through specific questions about whether their health activities/decisions have changed since enrolling in IowaCare. Benchmark is 50% response rate to the survey, and at least 80% of people indicating improvements in health status, satisfaction with the services and providers, and that they've made changes to implement

	the improvement plan. • Measured by an increase in utilization of preventive dental services by children less than 12. Benchmark is that all Medicaid children less than 12 receive at least one dental service annually. • Measured by incidence of smoking among IowaCare and Medicaid members in comparison to the statutory goals. Benchmark is reaching the statutory goals by year 5 of the Program. Outcome 3: Efficiency To make Iowa Medicaid a nimble, analytical organization that manages the care of its members in the most efficient manner possible. • Measured by the annual evaluation of the Iowa Medicaid Enterprise by an independent contractor. Benchmark is that contractors are all meeting performance measures in their contracts. Data Reports Data collected includes: • Approved applications – monthly and year to date. • Enrollment by county and aid category. • Number of IowaCare patients who were in the former State Papers Program. • Denials – number that were denied because Medicaid eligible. • Denials – number over income, but eligible for chronic care coverage through the Disproportionate Share Program. • Denials – for any other reason. • Age, sex, ethnicity, income, marital status. • Number paying premiums, number at each level of the sliding fee scale for premiums, number requesting hardship

	exemptions. • IowaCare members who are parents of Medicaid children. • Claims data, including total expenditures by month and year to date. • Expenditures by provider, by service category, and by aid type. • Diagnosis codes, expenditures per person. • Reports on reviews of the post verification of income. • Data from the Indigent Care Task Force including the cost and quantity of indigent care provided by providers throughout the state.

Managed Care Administration (if applicable)

Not applicable	Not applicable

Finance/Accounting Processes

1. Can the State's payment system generate reports providing payment statistics by various categories (e.g. groups, rates, etc.) for IowaCare?	Yes. The MMIS system and the Data Warehouse can produce reports showing total expenditures, expenditures by service category, expenditures by eligibility category, by cost per service for each eligibility category. Any kind of statistical information as recorded in the MMIS, such as procedure codes, diagnosis codes, etc. can be captured in reports.
2. How do you collect cost share information for IowaCare?	Iowa developed an IowaCare premium payment system called the MIPS system. All premium information including summary screens is recorded in this system. In addition, the Data Warehouse will collect all information on applicable co-payments.
3. What financial reviews has the State Medicaid Agency conducted in preparation for the IowaCare implementation?	The state reviewed the Medicare cost reports for all of the IowaCare providers to determine the value of indigent care that

How will the state monitor the ongoing financial performance of IowaCare capitated providers?	was being provided in the past. IowaCare providers are fee-for-service, not capitated. All providers are required to submit audited financial statements. Their claims, expenditure and enrollment information will be reviewed continually by DHS as well as quarterly by the Medical Assistance Projection and Assessment Council.
4. What systems will the state use to track and ensure that the Federal share of expenditures does not exceed pre-defined limits on the costs incurred over the life of the demonstration? Does the methodology follow the budget neutrality guidelines?	The state will use the MMIS system to track all claims data. All expenditures for IowaCare are tracked separately from the regular Medicaid program. In addition, expenditures for regular Medicaid eligibles at the Mental Health Institutions and IowaCare recipients at the MHIs so that the budget neutrality for the MHI expenditures can be tracked separately. No Federal Financial Participation will be drawn unless there is a covered claim to document the payment. Yes, the DHS will follow all budget neutrality guidelines.

Mental Health Transformation Pilot

1. Under whose authority will this pilot program operate?	DHS
2. When will a plan be forthcoming?	A plan is in development and will accompany the IowaCare implementation plan.
3. Are there immediate implementation plans for the SED population?	Yes. Implementation date is October 1, 2005. As approved in the Waiver, the program will cover 300 children.
4. What IowaCare network components will the program utilize?	We don't understand what this question means.
5. Will both populations (IMD, SED) utilize the 1915(b) managed care provider?	The SED population will be enrolled in the 1915(b) managed care provider. The IMD population will not be enrolled in the 1915(b) provider.
6. How will you track expenditures through the five-year life cycle of the Mental Health Transformation Pilot (from program ramp up to 1115 expenditure phase out)?	Expenditures will be tracked through claims data from the MMIS/Data Warehouse.

Additional Attachments:	Attachment 21 – HF 841
	Attachment 22 – Terms and Conditions
	Attachment 23 – IowaCare administrative rules