Department of HUMAN SERVICES

Health Policy Oversight Committee

Iowa Medicaid Program Updates

December 21, 2020
PM Presentation

Overview

- Pharmacist Immunizations
- 1915(b) Waiver Renewal (Managed Care)
- Uniform Prior Authorization
- Ground Emergency Medical Transportation (GEMT)
- Elderly, Brain Injury Waiver Monthly Budget Cap
- Health Home OIG Audit
- Electronic Visit Verification (EVV) Implementation
- Children's Dental Transition to Managed Care

Pharmacist Immunizations

Current Vaccine Billing Process

- There are currently two options under Medicaid for a Pharmacy to bill an immunization:
  1. For children – Would bill under medical claims billing using VFC vaccine but limited to flu vaccine only. Paid by fee schedule.
  2. For adults – Would bill through pharmacy point of sale for limited payable vaccines (like flu, pneumonia and shingles). Paid like other drugs at pharmacy.
- Both options require a patient specific prescription for the vaccine or a prescription under a physician-signed protocol, which would be with a specific pharmacy.

Pharmacist Immunizations

Upcoming Vaccine Billing Process

- The Iowa Board of Pharmacy, in collaboration with the Iowa Department of Public Health, developed statewide protocols for pharmacists to be able to order and administer vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP).
- In order to allow these expanded pharmacist practice protocols under Medicaid, rule changes are in process with an effective date of June 1, 2021, to allow all vaccines to be ordered by a pharmacist.
- Pharmacists are currently enrolling in Medicaid as a new provider type.
- All billing and reimbursement of vaccines, regardless of provider type, will be through the same process. Billing will be under medical billing to ensure consistency among providers as well as a coordinated Medicaid immunization record for the member.

Pharmacist Immunizations

COVID-19 Vaccine

- The PREP Act permits pharmacy/pharmacist to order and administer COVID-19 vaccines, regardless of state law limitations.
- For Medicaid the pharmacy/pharmacist must be enrolled.
- The IME is working on a process to allow this vaccine billing in advance of the pharmacist enrollment rules going into effect next June.

IA Health Link Waiver Renewal

- The Department operates the state's Medicaid managed care program under 1915(b) waiver authority, which began in April 2016.
- The Department has submitted its extension application with CMS to continue to operate the IA Health Link program for another 5 years.
- There are no modifications to the current program design being proposed.

IA Health Link Waiver Renewal

- As part of the renewal process, the state was required to conduct an independent assessment of its managed care program and submit the findings to the Centers for Medicare and Medicaid Services (CMS).
- This report was conducted by a third-party.
- Upon approval from CMS, the IA Health Link program would continue for another five years through March 31, 2026.

Uniform Prior Authorization

- House File 766 Section 63 required the Department to adopt rules to require that both Managed Care and Fee-for-Service (FFS) utilize a uniform process, to request medical prior authorization.
- Through meetings with the MCOs and providers, a set of unified forms for prior authorizations were created.
  - One PA form for outpatient services;
  - One PA form for inpatient services;
  - And, a supplemental form for additional information.
- The PA forms are universal, meaning the form can be filled out and sent to either MCO or to the IME for FFS.
- These standardized forms were available starting in July 2020, but due to COVID-19, they were not required to be used by providers until October 1, 2020.
- The only change to the current PA process is the request form. There is no change to any of the current PA requirements or approvals that are already in place.

GEMT

- The Ground Emergency Medical Transportation (GEMT) Supplemental Payment Program (SPP) is a voluntary program that allows publicly owned or operated emergency ground ambulance transportation providers supplemental payments that cover the difference between a provider's actual costs per GEMT transport and the Medicaid base payment, mileage and other sources of reimbursement.
- Includes non-state government-owned emergency medical service providers.
- Payment is made on a per claim basis for eligible transports.
- 72 providers voluntarily participated in Year One of the program (SFY20).
- Approximately $20.4 Million was paid to the GEMT providers during SFY20.
- We expect to have 72 providers voluntarily participate in SFY21.
- Providers have until January 31, 2020, to complete the required cost report and submit it to IME.

GEMT

Dry Run Issue

- A “Dry Run” occurs when an ambulance run does not result in a transport of a patient.
- Per CMS, a GEMT transport does not include dry runs therefore these claims cannot receive the supplemental payment rate.
- If dry run costs are included on the GEMT cost report the dry run must be included in the transport count in the cost per transport calculation.
- If dry run costs are excluded on the GEMT cost report the dry run does not need to be included in the transport count in the cost per transport calculation.

Waiver Monthly Budget Caps

Elderly Waiver

- Effective July 1, 2020, the Department eliminated the monthly budget maximum, or cap, for individuals eligible for the Medicaid HCBS Elderly Waiver.
- Members no longer need to request an exception to policy (ETP) to exceed the monthly cap allowed.
- The overall average cost per HCBS Elderly waiver recipient for the first quarter of SFY 21 was $1,147.31 per waiver recipient compared to $1,130.39 during the first quarter of SFY20, which is an average increase of $16.92 per waiver recipient for the first quarter of SFY21.

Brain Injury (BI) Waiver

- Similar to Elderly Waiver removal of budget cap, this was effective July 1, 2019.
- A year to date comparison shows total BI waiver expenditures increased about $1.2 Million compared to SFY19. The average annual cost per BI waiver recipient increased slightly to $20,628 per member during SFY20, which is an average increase of $416 per waiver member per year.

Health Home OIG Audit

Health Home Background

- Iowa has two Health Home programs:
  - Chronic Condition Health Homes
  - Integrated Health Homes

Health Home OIG Audit

- In April 2020 The Office of Inspector General (OIG) filed its final report of the Health Home Audit.
- The audit reviewed 130 payments from calendar year (CY) 2013 to CY 2016 to Chronic Condition Health Homes (CCHH) and Integrated Health Homes (IHHs) in Iowa and concluded that 62 of the 130 payments did not comply with federal and State requirements. Most requirements that were not met were specifically related to documentation of services. The report recommends DHS take the following actions:
  - Refund $37.1 million to the federal government.
  - Improve the DHS's monitoring of the health home program to ensure that health home providers comply with federal and State requirements for maintaining documentation to support the services for which the providers billed and received per member per month (PMPM) payments.
  - Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive the higher IHH PMPM payments for intense IHH services, and educate providers on these requirements.
  - Revise the State plan to define the documentation requirements that health home providers must follow to bill and receive IHH PMPM payments for outreach services, and educate providers on these requirements.

Health Home OIG Audit

- In response to the OIG audit findings and SF2418 directed review of the program, the following has been implemented:
  - The State Plan Amendments (SPAs) were aligned to reduce administrative burden and improve the ability of the State to gather the data needed to illustrate SPA compliance. These were approved by CMS on December 9, 2020.
  - Revised the IHH and CCHH billing guides on July 1, 2020, to include informational only codes which reflect one of the six core services provided during the month.
  - Revised the IHH and CCHH provider agreements.
  - Added annual data analysis as an oversight to provide an understanding of value and utilization, as well as allow for data driven program improvements.

Health Home OIG Audit

- Improved communication between the MCOs, Health Home providers and Medicaid through the requirement of MCO/IME open office hours, weekly MCO logistics meetings, and monthly individual MCO calls with MCOs.
- The MCOs have developed tools and guidance documents to assist providers un understanding Health Home expectations.
- An annual workgroup meeting was implemented in 2020 to provide Health Homes, the MCOs and provider associations with data to elicit feedback in data driven improvements.
- Provider self-assessment that aligns with the updated SPA once the SPA has been approved by CMS (in development).
- Chart audit process including a chart review workbook to ensure Health Home services are appropriately documented.
- Full learning collaborative model that provides monthly webinars, bi-annual face-to-face training, and individual technical assistance based on individual Health Home needs.

Electronic Visit Verification (EVV)

- EVV is a federal requirement for states to implement as part of the 21st Century Cures Act that was passed in December 2016.
- EVV uses technology to electronically record when attendants begin and end providing services to Medicaid members.
- January 1, 2021, is the EVV implementation date for Iowa.
  - Required for Managed Care only; FFS continues to bill as they currently do.

Electronic Visit Verification (EVV)

- The Department is using a Managed Care implementation model for EVV.
- Both MCOs will be using the same EVV vendor: CareBridge.
- EVV will be required for:
  - Attendant care services.
  - Homemaker services.
  - Personal care services.
- Home health services and waiver providers, including Consumer Directed Attendant Care (CDAC) and Consumer Choices Option (CCO), will be required to use EVV.

Electronic Visit Verification (EVV)

- The deadline for Assisted Living Facilities (ALFs) to use the EVV solution has been delayed to July 1, 2021.
- The CareBridge mobile app is the recommended option for conducting EVV.
  - There's also a call-in option available.
- In-depth training started in October for providers and has been offered on many different days and times, and in a variety of methods.
- Once a provider has successfully completed training then they can begin using EVV.
- The Department is monitoring implementation closely to help ensure that providers will be ready by January 1, 2021, and will not have any claims denied.

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Children's Dental Transition

December 21, 2020
PM Presentation

Children's Dental Transition

- IME plans to transition the administration of children's dental benefits from FFS Medicaid to Managed Care.
  - Pre-Ambulatory Health Plans (PAHPs): Delta Dental of Iowa and Managed Care of North America (MCNA).
- Target implementation date is July 1, 2021.
- Impacts children ages 0 to 19.
- No impact to Hawki program.

Children's Dental Transition

Support for Transition

- Members will have a choice in benefit administrator.
- Families can now be enrolled with the same administrator to eliminate confusion.
- PAHPs will have more provider influence and stronger networks for better access to care for members.
- PAHPs will have the ability to adjust reimbursement rates and offer value added services.
- PAHPs (in collaboration with IDPH) will be able to complete outreach and education to members and help alleviate any barriers to care.
- Allows for a more predictable budget for the state to manage.

Children's Dental Transition

Plan Design

- Benefit package will remain the same.
  - Early Periodic Screening Diagnosis and Treatment (EPSDT) requirements must be met.
- Tentative Program Name:

  Dental Wellness Plan (DWP) Kids
  - No annual benefit maximum.
  - No Healthy Behaviors.

Children's Dental Transition

Capacity Plan

- 285,000 children enrolled in Medicaid.
- Delta Dental of Iowa and MCNA (current PAHPs) will administer benefits.
  - Open contract may mean additional administrators at some point.
  - Distribution based on readiness review.
  - Algorithm will keep families together.
- Maintain the interagency agreement with IDPH and the I-Smile program.

Children's Dental Transition

TENTATIVE Transition Timeline

- ❑ 11/20/20 Informational Letter
- ❑ 12/14/20 Tribal Notice
- ❑ 1/11/21 Public Notice
- ❑ 1/20/21 Public Hearing
- ❑ 1/21/21 Public Notice
- ❑ 3/1/21 CMS Waiver and Contract Submission
- ❑ 4/1/21 Readiness Review
- ❑ 6/1/21 Communication and Education
- ❑ 7/1/21 Implementation