Iowa Department of Human Services

Health Care Policy Legislative Oversight Committee

Mikki Stier, Medicaid Director

November 3, 2015

Overview

- Goal/Design
- MCO Status
- Member Update
- Provider Update
- Oversight
- MCO financing
- Administrative Rules

Iowa High Quality Health Care Initiative

- Improve quality and access
- Promote accountability for outcomes
- Create a more predictable and sustainable Medicaid budget

Contract Design

- Creates an incentive for both MCO and providers to rapidly develop business agreements
- Creates a safety net by sustaining existing member provider relationships
- Provides financial stability for existing providers by establishing a reimbursement floor
- Supports member ability to change MCO based on needs

Federal Waiver Approval

The following waiver and waiver amendments were submitted to CMS in September 2015:

- **(1) - 1915(b) Iowa High Quality Healthcare Initiative Waiver** (New Waiver)
- **(9) - 1915(c) HCBS Waiver Amendments** (Intellectual Disabilities; Brain Injury; Health and Disability; Physical Disability; HIV/Aid/Elderly; and Children's Mental Health)
- **(2) - 1115 Waiver Amendments** (Iowa Wellness Plan Demonstration and Family Planning Demonstration)

Federal Waiver Approval Continued

- DHS is working with the Centers for Medicare & Medicaid Services (CMS) to obtain federal approval for the managed care transition
- DHS held four public hearings and accepted written comments that were then submitted to CMS
- Summary comments are found at the Medicaid Modernization webpage
- Based on submission date, we expect CMS to approve the IHQHCI in early December and the remaining Waivers at the end of December

MCO Contracts

Contract awards were announced August 17, 2015, to Amerigroup, AmeriHealth Caritas, UnitedHealthcare Plan of the River Valley and WellCare

- The RFP served as the basis of contract negotiation
- The contract included:
  - MCO reimbursement
  - Provider payments/rate floor, clarified aggregate HCBS waiver cap
  - Clarification on excluded populations
  - Addition of CMS requirements
  - MCO provider enrollment

Onboarding MCOs

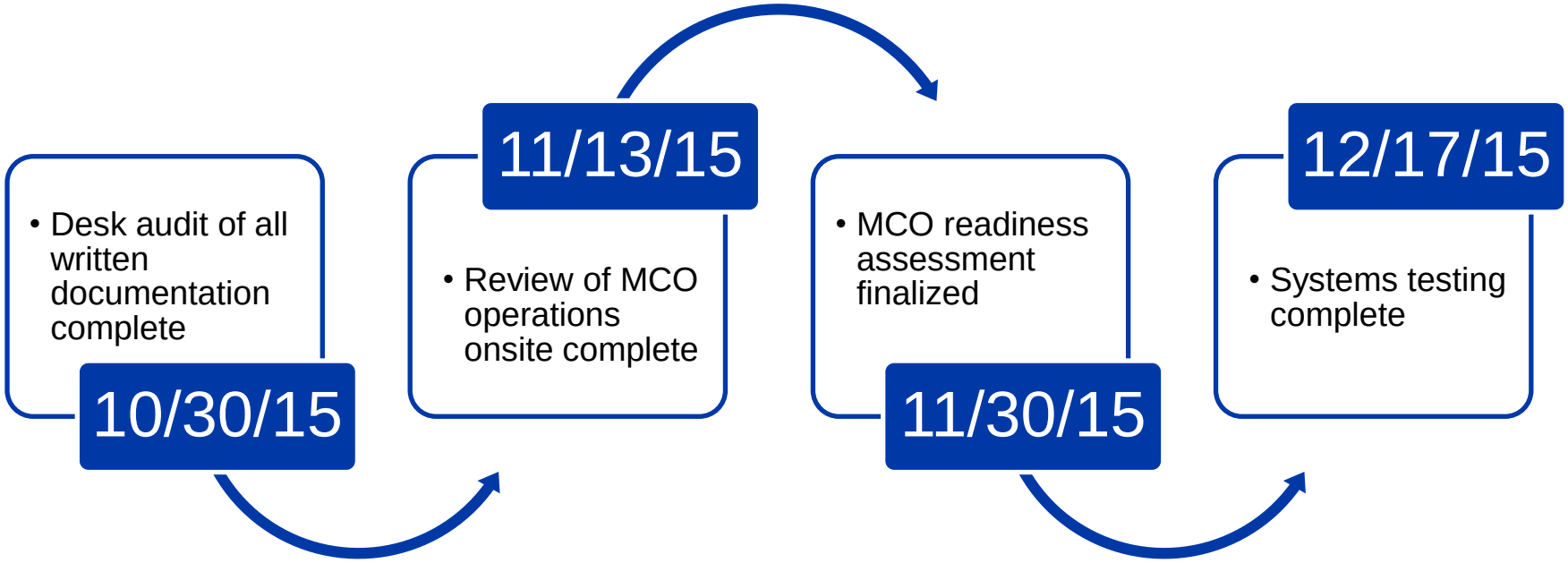
- The department has implemented a series of “onboarding” meetings with the MCOs to ensure they clearly understand Iowa’s services and providers
- Many of the meetings are focused on long term care services and supports

MCO Readiness Review Requirements

- DHS must approve all aspects of the MCO operations through desk reviews, onsite audits and systems testing
- The department hired a nationally-experienced consultant, Navigant, to assist in the readiness review process

Organization & Administration	MCO Staffing	Provider Network
Financial Information	Utilization Management	Provider Relations
Management Information Systems	Quality Management	Coordination of Care
Marketing	Access and Availability	Provider Contracting
Member Services	Member Grievances	Claims Management
Enrollment & Disenrollment	Service Authorization	Scope of Services
Reporting Requirements	Performance Improvement	Continuity of Care

MCO Readiness Review Timeline



MCO Readiness Review Status

- All written policies and procedures have been submitted and desk reviews will be completed by November 10th
- Navigant and Iowa Medicaid staff will conduct a two-day onsite review of each MCO between November 2nd and November 12th
- The “go/no go” decision for each MCO will be made in mid-to-late November
- MCOs will be fined for each day they cannot demonstrate readiness beginning December 1

Status of MCO Networks

- The MCOs' websites will soon include provider network directories
  - Amerigroup: https://www.myamerigroup.com/IA
  - AmeriHealth: http://www.amerihealthcaritasia.com/
  - UHC: http://www.uhccommunityplan.com/ia/
  - WellCare: https://www.wellcare.com/Iowa
- The networks will grow daily as more providers are added
- Network information will be provided to legislators & CMS

Member/Provider Outreach

DHS developed and implemented an extensive communications strategy to ensure member, provider and stakeholder awareness. New meeting times and informational materials are available each week.

Member mailings	Tele-town hall meetings, webinars, in-person meetings	17 In-person enrollment assistance	Member educational materials
Dedicated member website & member-facing videos	Presented at over 70 meetings & conferences June - October	Media campaign & public service announcements	Member and family feedback workgroups
DHS member handbook in addition to MCO member handbook	Targeted stakeholder & advocate conference calls	22 stakeholder kick-off meetings	LTC and HCBS Member Focus Group
Public hearings 4	Medical Assistance Advisory Council (MAAC)	22 annual provider training sessions, provider materials & manuals	Provider, stakeholder & legislative toolkits

Member Informational Materials

- Detailed informational toolkits (September)
- Introductory letters about the new IA Health Link – “New choices soon available” (October)
- Enrollment packets with member handbooks, enrollment assistance details (November)
- Ongoing information will be provided via website, public meetings and webinars

Member Enrollment Support

- Iowa Medicaid Member Services offers an Independent Enrollment Broker
- Just as they already do with current Medicaid plans, the enrollment broker will provide information and conflict-free choice counseling in the selection of a new MCO
- Members can:
  - Email questions to: IMEMemberServices@dhs.state.ia.us
  - Call 1-800-338-8366, 8am-5pm, M-F and talk with a customer representative directly
  - Select their MCO through voice system option 24/7
  - Leave after-hours message for call back

Member Enrollment Timeline

September through March						
September 2015	**October 2015**	**November 2015**	**December 2015**	**January 2016**	**February 2016**	**March 2016**
Toolkits available - stakeholder meetings held throughout Iowa	Member meetings and introductory mailings	MCO Enrollment Begins Assistance Available	**December 17:** Last Day to Make MCO Choice for January 2016*	**January 1:** Begin Coverage with MCO		**March 19**: Member must have Good Cause reason to change MCOs
			December 18, 2015 - March 18, 2016: *Member can change MCO without Good Cause*			

*If no choice is made, the member is enrolled with the tentatively assigned MCO. This is to ensure coverage is in place and available January 1. Tentative assignment keeps all household members in one MCO.

Member Ongoing Rights and Supports

- DHS and the MCOs will help members with their specific issues. There will be “no wrong door” for assistance
- MCOs must have appeal and grievance processes
- Enrollees who are not satisfied with the resolution may then appeal to DHS under Chapter 7 as they do today
- Members who wish to share complaints may:
  - Contact Iowa Medicaid Member services
  - Send through the DHS Email Contact Form http://dhs.iowa.gov/contact-us
  - Contact the Long Term Care Ombudsman if receiving long term care services and supports
  - Contact the State Ombudsman

Member Rights and Supports

- Enrollees who receive long term care services may also receive support from the Long Term Care Ombudsman
- This ombudsman will:
  - Assist recipients in understanding services, coverage, access, and rights under Medicaid managed care
  - Track and report the outcomes of individual requests for assistance, the obtaining of necessary services and supports, and other aspects of services provided to eligible recipients
  - Provide advice and assistance relating to the preparation and filing of complaints, grievances, and appeals

Member Continuity of Care

Magellan:

DHS is working closely with Magellan to ensure continuity of care for behavioral health services during the transition to IA Health Link by:

- Holding information summits and meetings as necessary to monitor transition activities
- Establishing data transfer of prior authorizations and case plans
- Enrolling behavioral health providers in fee-for-service (FFS) and developing FFS claims systems for behavioral health

Member Continuity of Care (cont.)

Magellan:

- Ensuring that Integrated Health Home (IHH) enrollment continues with no gaps
- Ensuring that Community Mental Health (CMH) and Habilitation authorizations and services are uninterrupted
- All Magellan authorizations will be maintained and continue to be authorized until January 1

hawk-i:

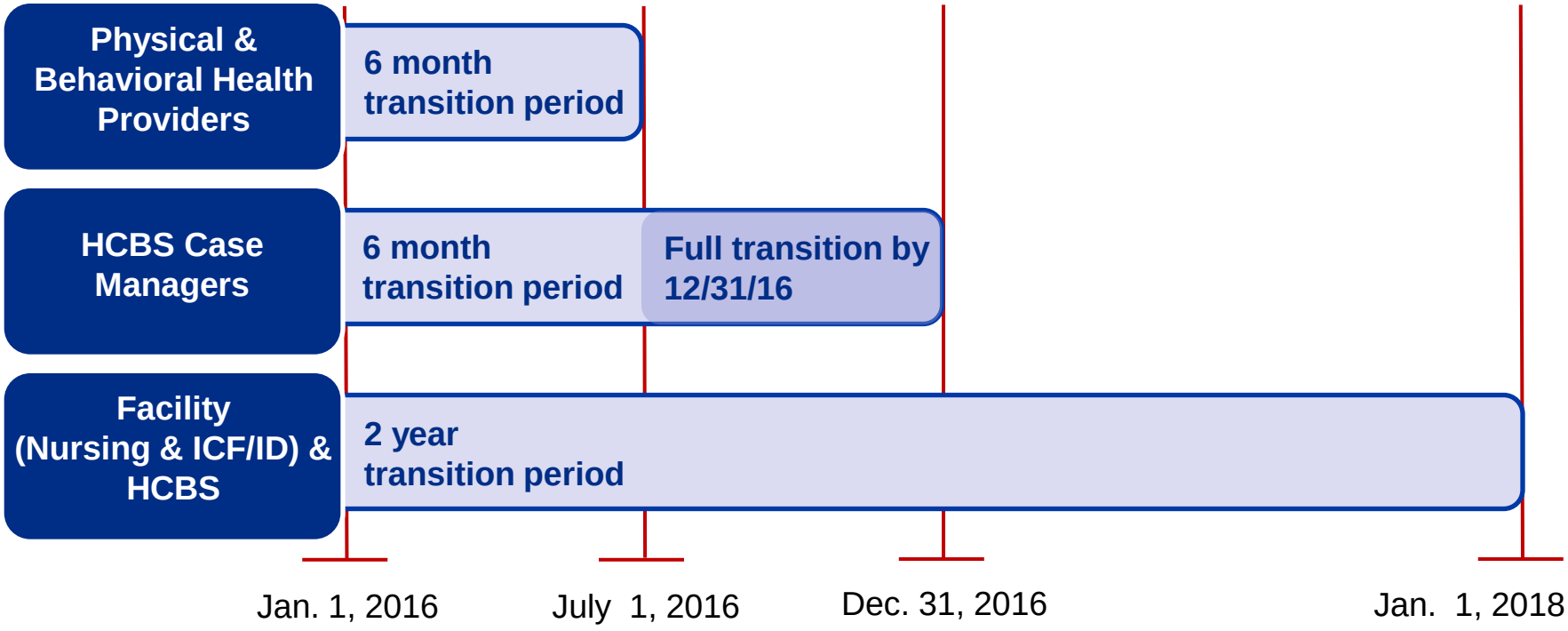
- DHS is working closely with Wellmark and United to assure effective transition by establishing data transfers of prior authorizations and case plans

Member Continuity of Care (cont.)

Primary care physicians:

DHS will transfer data files to the MCOs that identify primary care providers currently serving all members including those under MediPASS, Meridian, chronic health homes and accountable care organizations (ACOs)

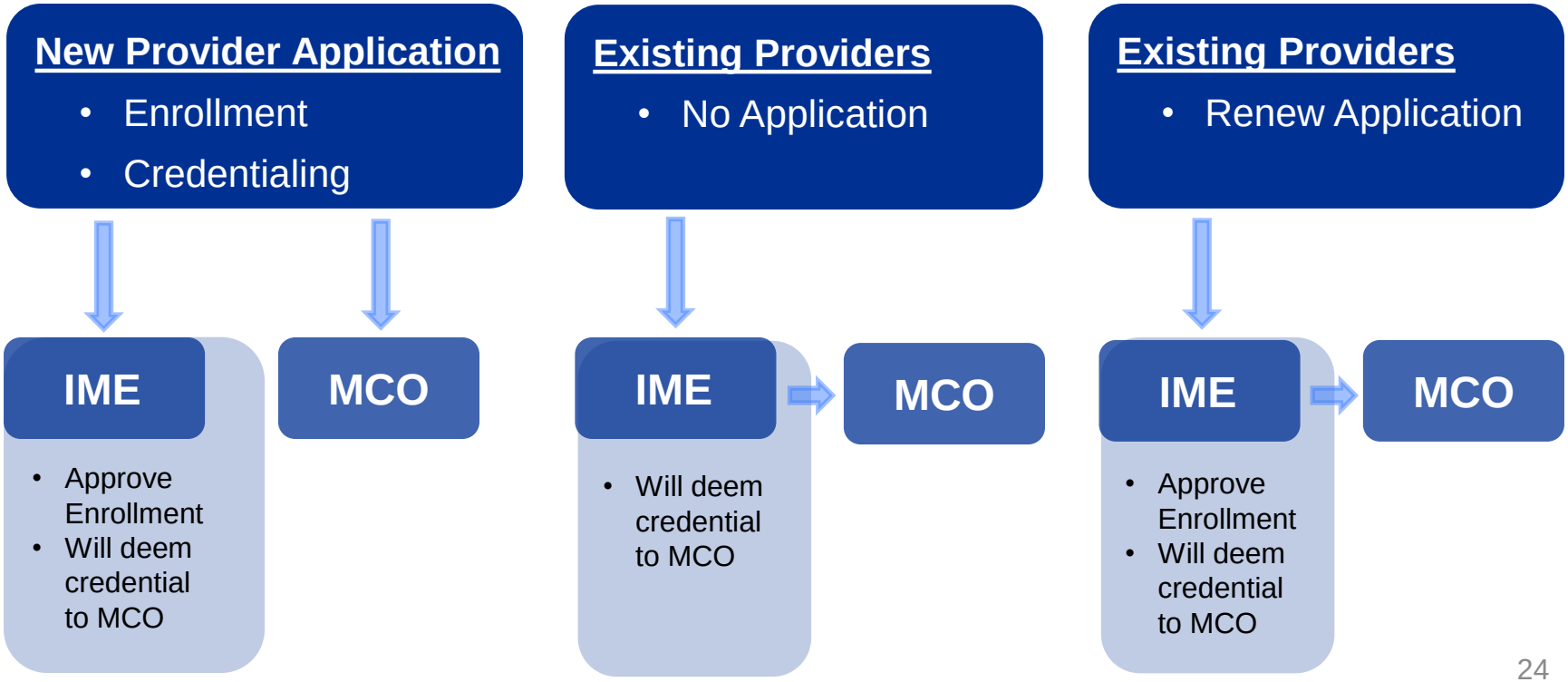
Sustaining Member/Provider Relationships



Provider Information and Materials

- Comprehensive information was distributed last month to providers through traditional communication channels to support negotiations and contracting with the MCOs
- Providers can access all the tools they need for contracting:
  - Provider agreements – DHS has approved the template agreements to be signed and executed between providers and MCOs. Providers should contact the MCO directly
  - Other important provider information accessible at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization
    - Provider manuals
    - Universal Applications
    - Baseline Rate Information – Informational Letter 1562
    - Provider Network Fact Sheet

Streamlined Provider Enrollment and Credentialing



Manage Care Oversight

Oversight will be implemented by:

- Legislative Health Policy Oversight
- Department of Human Services/ Iowa Medicaid Enterprise
- External Quality Review Organization
- Stakeholder Oversight through the MAAC

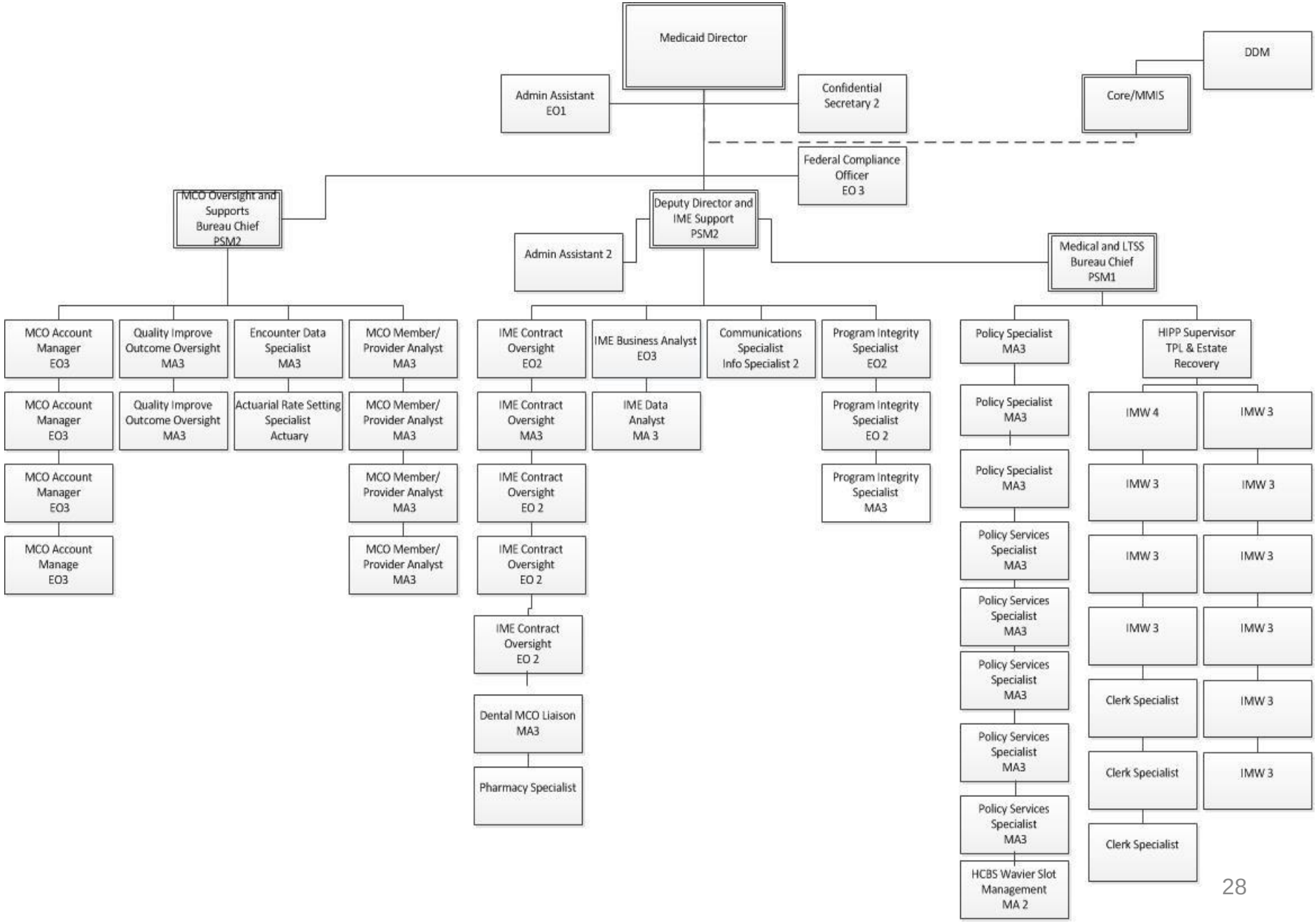
Legislative Health Policy Oversight Committee

The Health Policy Oversight Committee will:

- Receive updates
- Review data, public input and concerns
- Make recommendations for improvements, propose changes in law or rule regarding Medicaid managed care

Iowa Medicaid Oversight

- The new table of organization is designed to transition IME to serve as an effective liaison with the MCOs and focus its efforts on oversight
- All staff duties have been realigned to support managed care and smaller fee-for-service models (See Table of Organization next slide)
- Adding a Bureau of Oversight and Supports
- The MCOs are adding about 2,000 jobs and the existing professional services contracts are being resized to address reduced need


Medicaid Director
Admin Assistant EO1
Confidential Secretary 2
Core/MMIS
DDM
Federal Compliance Officer EO 3
MCO Oversight and Supports Bureau Chief PSM2
Deputy Director and IME Support PSM2
Admin Assistant 2
Medical and LTSS Bureau Chief PSM1
MCO Account Manager EO3
MCO Account Manager EO3
MCO Account Manager EO3
MCO Account Manage EO3
Quality Improve Outcome Oversight MA3
Quality Improve Outcome Oversight MA3
Encounter Data Specialist MA3
Actuarial Rate Setting Specialist Actuary
MCO Member/ Provider Analyst MA3
MCO Member/ Provider Analyst MA3
MCO Member/ Provider Analyst MA3
MCO Member/ Provider Analyst MA3
IME Contract Oversight EO2
IME Contract Oversight MA3
IME Contract Oversight EO 2
IME Contract Oversight EO 2
IME Contract Oversight EO 2
Dental MCO Liaison MA3
Pharmacy Specialist
IME Business Analyst EO3
IME Data Analyst MA 3
Communications Specialist Info Specialist 2
Program Integrity Specialist EO2
Program Integrity Specialist EO 2
Program Integrity Specialist MA3
Policy Specialist MA3
Policy Specialist MA3
Policy Specialist MA3
Policy Services Specialist MA3
Policy Services Specialist MA3
Policy Services Specialist MA3
Policy Services Specialist MA3
Policy Services Specialist MA3
HCBS Wavier Slot Management MA 2
HIPP Supervisor TPL & Estate Recovery
IMW 4
IMW 3
IMW 3
IMW 3
IMW 3
Clerk Specialist
Clerk Specialist
Clerk Specialist
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IME DHS Oversight

- IME will receive data to monitor individual MCOs and to support comparative analysis
- There are significant performance expectations. Data will be reported monthly, semi annually and annually. Key areas of focus include:
  - Administrative (e.g. claims processing)
  - Member Support-Appeals
  - Provider Support
  - Quality Improvement
  - Quality Health Care results & outcomes
  - Program Integrity
  - Provider Network Adequacy
  - Authorization Denial

IME Oversight

IME will develop and publish a comprehensive public reporting dashboard. This is an example of a dashboard.

2015 Member's Guide to Choosing a Medicaid Health Plan

KEY: ★★★★★ Excellent ★★★★ Above Average ★★★ Average ★★ Below Average ★ Much Below Average

PREVENTIVE CARE							
Health Plan	Childhood Immunizations	Well-Child Visits in the First 15 Months of Life	Well-Child Visits Ages 3 to 6	Adolescent Immunizations	Adolescent Well-Child Visits	Cervical Screening	Prenatal Care
Anthem BCBS Medicaid	New Plan, No Rating	New Plan, No Rating	New Plan, No Rating	New Plan, No Rating	★	★	★
Aetna Better Health of Kentucky*	★★★★	★★	★	★★★★★	★★★	★	★★★★
Humana - CareSource	★	★★	★★	★★★	★	★	★
Passport Health Plan	★★★★★	★★★★	★★★★	★★★★★	★★★★	★	★★★★
WellCare of Kentucky	★★	★★	★	★★★★	★★★	★	★★★★

ACCESS TO CARE				
Health Plan	Child Doctor Availability	21 and Under Dental Visits	Adult Doctor Visits	Adult Doctor Availability
Anthem BCBS Medicaid	★★★	New Plan, No Rating	New Plan, No Rating	★★★★★
Aetna Better Health of Kentucky*	★★★★	★★★★	★★★★	★★★
Humana - CareSource	★★★	★★★	★★★	★★★★★
Passport Health Plan	★★★	★★★★★	★★★★★	★★★
WellCare of Kentucky	★★	★★★★	★★★★	★★★

GETTING HELP WHEN NEEDED						
Health Plan	Getting Child Care Quickly	Child Customer Service	Parent Overall Satisfaction with Child's Health Plan	Getting Adult Care Quickly	Adult Customer Service	Adult Overall Satisfaction with Health Plan
Anthem BCBS Medicaid	★★★	★★	★	★★★★	★★★★	★★★
Aetna Better Health of Kentucky*	★★★★★	★★	★	★★	★★★★	★
Humana - CareSource	★★	★★★★★	★★	★★★	★★★★★	★★★★
Passport Health Plan	★★★	★★★★	★★★★★	★★	★★★★	★★★★★
WellCare of Kentucky	★★	★	★★★	★★★	★★★★★	★★★★

IME Oversight Example

Elderly and Special Needs Sample Reporting

- Demographics
- Effectiveness of care coordination
- Where members are served
- Fall-risk management
- Depression screening
- Preventive dental services
- Critical incidents
- Integration in the community

External Quality Review Organization

- The Department is contracting with an EQRO that will:
  - Validate MCO data performance
  - Validate reported performance measure calculations
  - Review and validate performance improvement projects
  - Sample and review encounter data for quality
  - Review operational processes and public-facing materials to ensure compliance

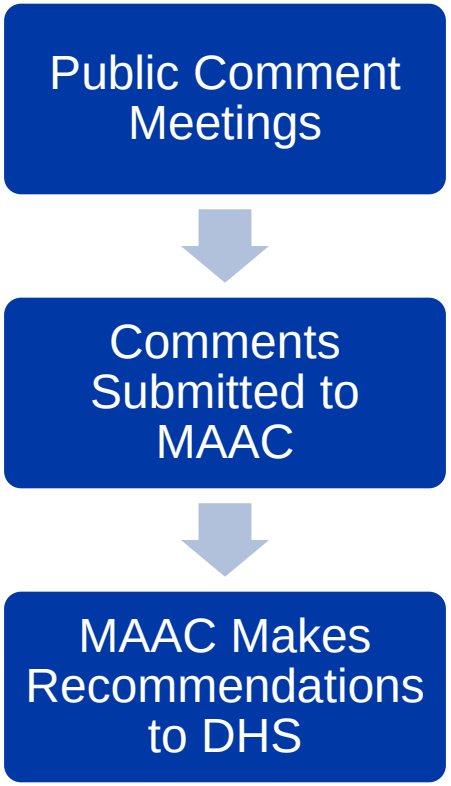
Stakeholder Oversight via the MAAC Council

Senate File 505 establishes the Medical Assistance Advisory Council (MAAC) Executive Committee as the primary stakeholder group to receive updates on implementation and make recommendations to DHS

Public Involvement in Oversight

Monthly meetings for members and the public will be held to share comments with DHS

- Held throughout the state
- Rural and urban areas
- Comments summarized and shared with MAAC, who makes formal recommendations to DHS



Administrative Code Revisions

There will be 2 rule packages to implement managed care.

Package 1: Managed Care Specific

- There will be a new Chapter 73 “Managed Care”
- There will be 2 Divisions deleted from Chapter 88 “Specialized Managed Care “

Package 2: Technical “clean –up language” more substantive changes due to implementation of managed care. There are 135 items.

Impacts the following chapters:

Chapter 77	• Conditions of Participation for Providers of Medical and Remedial Care
Chapter 78	• Amount Duration and Scope of Medical and Remedial Services
Chapter 79	• Other policies relating to providers of medical and Remedial Care
Chapter 81	• Nursing Facilities
Chapter 82	• Intermediate Care Facility for Persons with an Intellectual Disability
Chapter 83	• Medical Waiver Services
Chapter 85	• Services in Psychiatric Institutions
Chapter 90	• Targeted Case Management

Administrative Rules Timeline

Timeline	
October 21, 2015	Rules submitted to the Legislative Services Agency
November 10, 2015	Review of Notice of Intended Action by Council on Human Services
November 11, 2015	Rules published in the Iowa Administrative Bulletin
December 2 – 4, 2015	Oral Presentations
December 8, 2015	Review of Notice of Intended Action by ARRC
December 16, 2015	Council on Human Services to hold a special telephonic meeting to adopt the proposed rules.
January 1, 2015	Rules adopted Emergency After Notice to become effective

MCO Capitation Rates

How are MCO capitation rates developed?

- Fee-for-service historical base data
- Managed care encounter experience (Meridian and Magellan)
- Thorough review of all experience to identify opportunities for increased efficiency and additional savings
- Assumptions and adjustments including: trends, policy and program changes (e.g., cost containment, legislated rate increases), managed care adjustments, and administrative cost allowance

MCO Capitation Rates

- Plans will be paid a monthly capitation rate for each member enrolled in the plan
- 56 rate cells, determined in consideration of:
  - Age and gender
  - Eligibility group
  - Health status/condition (e.g., LTSS)
- Must be actuarially sound in accordance with 42 CFR 438.6(c)

MCO Capitation Rates & Savings

The capitation rates are for an initial 18-month rate period

- Distributes savings evenly over 18-month period
- Savings is smaller in the early periods of managed care
- Savings inherent in capitation rates
- Legislative impacts will impact capitation rates

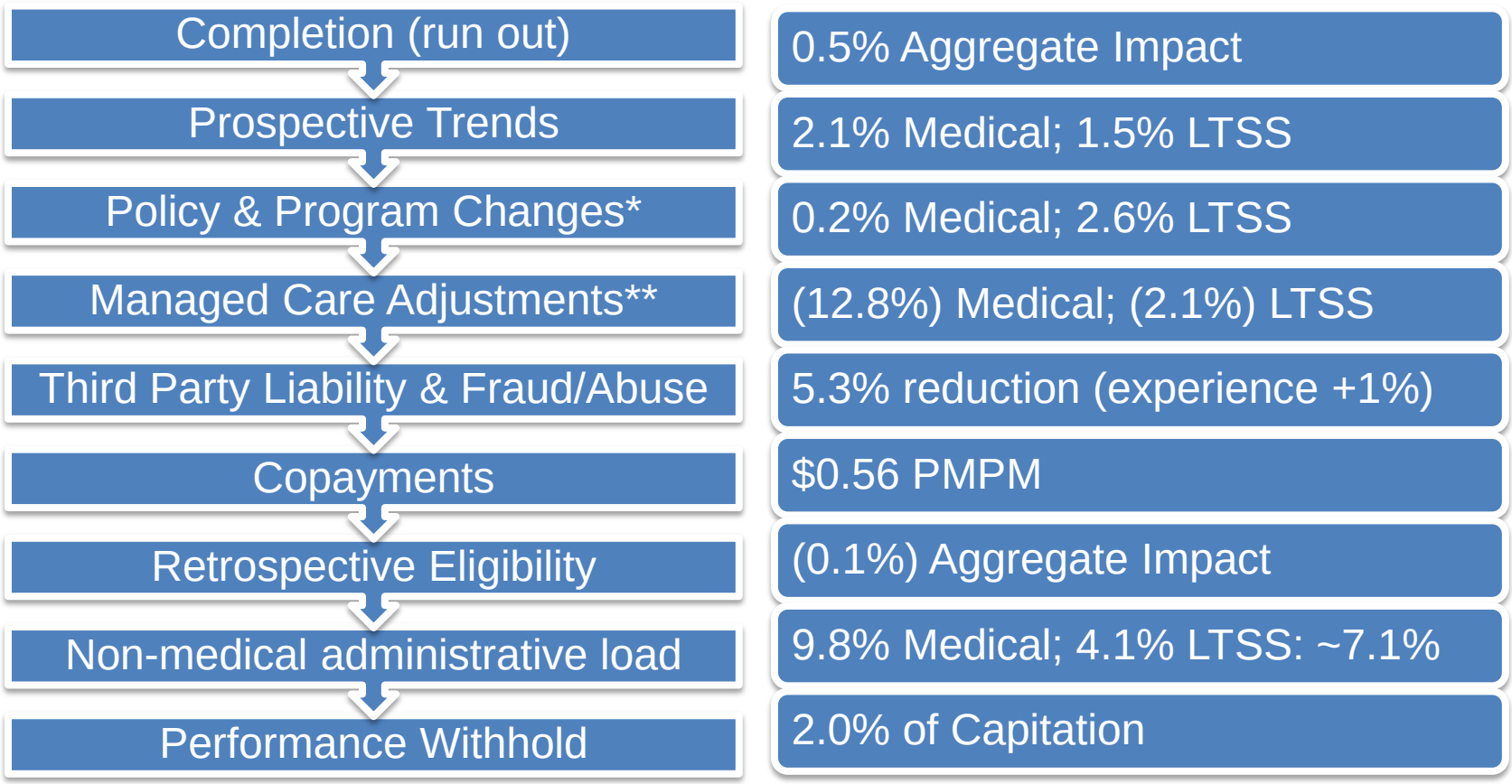
The capitation rates must be approved by CMS

Capitation Rate Data Book See http://bidopportunities.iowa.gov/?pgname=download&type=R&doc_id=15549

Managed Care Strategies

- Reduction of costly, unnecessary hospital use by promoting access to primary care physicians and preventive care.
  - Reduce inappropriate use of hospital inpatient admissions and re-admissions
  - Reduce inappropriate use of Hospital Emergency Room & Outpatient Services
- Reduction in duplication of ancillary services (e.g., radiology and pathology services)
- Reduction in pharmacy dispensing fees and drug costs through prior authorization, polypharmacy management and leveraging multi-state and national contracts
- Providing alternatives to long term care when appropriate and desired by members

Capitation Rates & Current Savings Projection



* e.g., cost containment and legislated rate increases
** aka, degree of health management

Savings inherent in current rates = $43.1M
Additional pharmacy savings = $3 to 4M
Iowa Plan contract reserves = approx. $4M
Net fiscal impact = $50 to 51.1 Million

Medical Loss Ratio

The Medical Loss Ratio (MLR) is the portion of each dollar paid to the MCOs that is used for claims expenses – i.e. health care services

- The capitation rates assume 92.9% medical costs
- The MCOs are required to have a MLR requirement of 88% This requirement will:
  - Protect the state, providers and members from inappropriate denial of care to reduce medical expenditures
  - Protect the state if capitation rates are significantly above actual managed care experience (state recoups)

Administrative Loss Ratio

Administrative Loss Ratio (ALR) is the portion of each dollar paid to the MCOs that is used for administrative expenses

- ALR is 7.1% on average across rate cells and includes 0.5% profit (underwriting ratio)
- MCO administrative expenses in rank order of average spending are as follows:

1. Human capital
2. Taxes & fees
3. Outsourcing
4. Operating expenses
5. Other miscellaneous
6. Bricks & mortar

MCO Administrative Expenses

- Provider network development and provider services, community relations, member services
- Care management, medical services, utilization management,
- Quality management, compliance and program integrity
- Claims processing
- Information technology and data analytics
- State and local insurance taxes, state premium taxes, regulatory authority licenses and fees, other
- Auditing, actuarial, and other consulting; Outsourced services
- Commissions, legal fees and expenses, certifications and accreditation fees, travel, marketing and advertising
- Miscellaneous (do not fit in other categories) and one-time expenses
- Rent, occupancy, depreciation, amortization, real estate expenses and taxes

See http://us.milliman.com/insight/2015/Medicaid-risk-based-managed-care-Analysis-of-administrative-costs-for-2014/

Comparison to National Results

- Iowa provider reimbursement is high relative to average
  - Iowa MLR is higher than average
  - Iowa ALR is lower than average

Milliman 2014 Medicaid risk-based managed care financial results

- 182 plans, 37 states, $110 billion total revenue
- Composite mean medical loss ratio (MLR) 86 %
- Composite mean administrative loss ratio (ALR) 11.9 %
- Composite mean underwriting ratio 2.1 %

See http://us.milliman.com/uploadedFiles/insight/2015/medicaid-risk-bases-managed-care.pdf

More information

Please find Q&As, fact sheets, presentations, waiver information, member and provider resources and more at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization