Citation

1932(a)(1)(A) A. Section 1932(a)(1)(A) of the Social Security Act.

The State of Iowa enrolls Medicaid beneficiaries on a mandatory basis into managed care entities (managed care organization (MCOs) and/or primary care case managers (PCCMs)) in the absence of section 1115 or section 1915(b) waiver authority. This authority is granted under section 1932(a)(1)(A) of the Social Security Act (the Act). Under this authority, a state can amend its Medicaid state plan to require certain categories of Medicaid beneficiaries to enroll in managed care entities without being out of compliance with provisions of section 1902 of the Act on statewideness (42 CFR 431.50), freedom of choice (42 CFR 431.51) or comparability (42 CFR 440.230). This authority may ***not*** be used to mandate enrollment in Prepaid Inpatient Health Plans (PIHPs), Prepaid Ambulatory Health Plans (PAHPs), nor can it be used to mandate the enrollment of Medicaid beneficiaries who are Medicare eligible, who are Indians (unless they would be enrolled in certain plans—see D.2.ii. below), or who meet certain categories of "special needs" beneficiaries (see D.2.iii. - vii. below)

B. General Description of the Program and Public Process.

For B.1 and B.2, place a check mark on any or all that apply.

1932(a)(1)(B)(i)
1932(a)(1)(B)(ii)
42 CFR 438.50(b)(1)

1. The State will contract with an

____ i. MCO
____ ii. PCCM (including capitated PCCMs that qualify as PAHPs)
__X__ iii. Both

42 CFR 438.50(b)(2)
42 CFR 438.50(b)(3)

2. The payment method to the contracting entity will be:

__X__ i. fee for service;
__X__ ii. capitation;
_____ iii. a case management fee;
__X__ iv. a bonus/incentive payment;
_____ v. a supplemental payment, or
__X__ vi. other. (Please provide a description below).

PCCM providers will receive a monthly payment for members enrolled with them which will be an administration fee for the performance of coordination and consolidation of care. Payments for state plan services will be made under the regular Medicaid payment structure.

MCOs will be paid a capitation payment which will be payment in full for all services contracted and intended to be provided by the MCO.

Citation

Condition or Requirement

PCCM providers who elect to serve Wellness Plan enrollees as noted in Section D shall be eligible to receive a bonus incentive payment if they meet standards for quality and access as determined by the state. This payment shall be no greater than $10 annually for the performance of an annual physical examination and no greater than $4 per member per month upon the determination, at the discretion of the state, that the quality standards have been met.

- The Value Index Score, a composite score of key domains, takes into account patient conditions, processes of care, and outcomes of care. Each domain includes well-researched measures that can be influenced by changes in provider behavior.
- The Value Index Score examines the overall value of care provided to a provider's patient population. It offers a road map for areas where attention and interventions may be necessary. It is one resource that can be used by all parties engaged in strengthening healthcare value and in establishing new approaches to care delivery and payments, for Medical Homes and ACOs.
- The Value Index Domains are: Member Experience, Primary and Secondary Prevention, Tertiary Prevention, Population Health Status, Continuity of Care, Chronic and Follow-up Care, Efficiency.

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A. General Description of the Program

1. This program is called Medical Managed Health Care (MHC). All Medicaid members as described in Section D are required to enroll in either a managed care organization (MCO), also known as a health maintenance organization (HMO), or into the MediPASS program, a primary care case management (PCCM) program. Those described in Section E are not subject to mandatory enrollment.

2. The objectives of this program are to reduce costs, reduce inappropriate utilization, and ensure adequate access to care for Medicaid recipients.

3. This program is intended to enroll Medicaid members in MCOs, which will provide or authorize all primary care services and all necessary specialty services, or into the MediPASS program, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. The MCO or the MediPASS assigned practitioner will act as the patient manager (PM). The PM is responsible for monitoring the care and utilization of non-emergency services. Neither emergency nor family planning services are restricted under this program.

4. The PM will assist the participant in gaining access to the health care system and will monitor the participant's condition, health care needs, and service delivery on an ongoing basis. The PM will be responsible for locating, coordinating, and monitoring all primary care and other covered medical and rehabilitation services on behalf of members enrolled in the program.

5. Members enrolled under this program will be restricted to receive covered services from the PM or upon referral and authorization of the PM. The Patient Manager will manage the member's health care delivery. The MHC program is intended to enhance existing provider-patient relationships and to establish a relationship where there has been none. It will enhance continuity of care and efficient and effective service delivery. This is accomplished by providing the member with a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program. Members will have a minimum of 10 days to make the selection but may change the initial selection at any time within the first 90 days of enrollment and at least every 12 months thereafter (without cause). The enrollment broker facilitates this through enrollment counseling and information distribution so members may make an informed decision. (See Section H for more details.)

6. Non-MCO contractors will act as enrollment brokers in assisting eligible members in choosing among competing health plans in order to provide recipients with more information about the range of health care options open to them.

7. The state will share cost savings with members resulting from the use of more cost-effective medical care with recipients by eliminating co-payments for those who enroll into an MCO program. Co-payments will apply for those services provided under the MediPASS program.

Citation

8. The state requires members in MediPASS to obtain services only from Medicaid-participating providers who provide such services. Providers must meet reimbursement, quality, and utilization standards that are consistent with access, quality, and efficient and economic provisions of covered care and services. Members enrolled in MCO plans may be referred to any MCO-credentialed provider. The plan may also choose to allow non-emergency care to be provided by other practitioners on a case-by-case basis if it benefits the enrollee.

9. MediPASS will operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in MediPASS. The MCO program will operate in counties where MCOs have contracted with the state. Mandatory assignment will only occur if the member has a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program.

1905(t)
incentive
42 CFR 440.168
42 CFR 438.6(c)(5)(iii)(iv)

3. For states that pay a PCCM on a fee-for-service basis, payments are permitted as an enhancement to the PCCM's case management fee, if certain conditions are met.

If applicable to this state plan, place a check mark to affirm the state has met ***all*** of the following conditions (which are identical to the risk incentive rules for managed care contracts published in 42 CFR 438.6(c)(5)(iv)).

__X__ i. Incentive payments to the PCCM will not exceed 5% of the total FFS payments for those services provided or authorized by the PCCM for the period covered.

__X__ ii. Incentives will be based upon specific activities and targets.

____ iii. Incentives will be based upon a fixed period of time.

____ iv. Incentives will not be renewed automatically.

____ v. Incentives will be made available to both public and private PCCMs.

__X__ vi. Incentives will not be conditioned on intergovernmental transfer agreements.

_____ vii. Not applicable to this 1932 state plan amendment.

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Citation	Condition or Requirement
CFR 438.50(b)(4)	4. Describe the public process utilized for both the design of the program and its initial implementation. In addition, describe what methods the state will use to ensure ongoing public involvement once the state plan program has been implemented. *(Example: public meeting, advisory groups.)*

This program, generally referred to as Medical Managed Health Care (MHC) was developed and implemented in July of 1990 under a 1915(b) waiver. At that time the MHC program included the PCCM component called Medicaid Patient Access to Services System (MediPASS). At that time the MHC program also included HMOs that had contracted with the Department of Human Services to provide medical managed care services of a traditional nature. In 2001 the Department applied for and was granted approval of an application to operate its MHC program under a 1932(a) state plan amendment. This meant the exclusion of enrollment of some specific members previously enrolled. These included Native American Indians, Alaska Natives and children receiving comprehensive services from the Title V agency. The Department moved to disenroll these members from the process. In January of 2009 Iowa saw the departure of the final HMO doing business with the Iowa Medicaid population. Consequent to that, Iowa was asked by federal authorities to remove referenced to HMOs in the state plan. This was done. The purpose of this submission is simply to add those references back into the state plan so as to allow an HMO to operate within the state in selected counties.

Considering the above, the question regarding design and initial implementation of the program is moot. However, the Department understands the need for input in changes such as this and has reached out to several entities. A letter was sent to all tribal entities in the region explaining the re-implementation of HMO activity in Iowa and asking for any input deemed necessary from the tribal perspective. No responses were received from that request. The Department also asked all of its Medical Assistance Advisory Committee (MAAC) members for any input they would like to provide with regard to the addition of HMO activity. The MAAC is comprised of provider organization leaders and Medicaid members and is chaired by the Director of the Department of Public Health. The MAAC contact resulted in three comments. One was a message with regard to assurances that the mental health services provided by the HMO would be appropriate. However, MH services are not included in the HMO coverage contract. The second was seeking an assurance that family planning could continue to be obtained from any appropriate source under coverage by the HMO. This is part of the contract with the HMO. The third asked if dental services would be provided by the HMO. Dental will continue to be provided under the fee-for-service system in Medicaid. In addition, the Clinical Advisory Committee filling the role of the managed health care advisory committee (MHCAC) was presented with the intended action. This committee of physicians and other providers had no objection.

The history of MHC in Iowa and the efforts to retrieve input from providers and members is sufficient cause to believe that the desired effect of public input is met.

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Citation	Condition or Requirement

1932(a)(1)(A)

5. The state plan program will __X__ / will not ____ implement mandatory enrollment into managed care on a statewide basis. If not statewide, mandatory____ / voluntary____ enrollment will be implemented in the following county/area(s):

i. county/counties (mandatory) _____

ii. county/counties (voluntary)_____

iii. area/areas (mandatory)_____

iv. area/areas (voluntary)_____

The MHC program will be implemented and will require mandatory enrollment on a state-wide basis. However, the MediPASS program must have a sufficient panel of primary care practitioners to meet the needs of the prospective enrollment. MediPASS will operate in all counties of the state except in those geographical areas without an adequate number of primary care case managers participating in MediPASS. The MCO program will operate in counties where MCOs have contracted with the state. Mandatory assignment will only occur if the member has a choice between at least two MediPASS PMs or a combination of one MCO and the MediPASS program

C. State Assurances and Compliance with the Statute and Regulations.

If applicable to the state plan, place a check mark to affirm that compliance with the following statutes and regulations will be met.

1932(a)(1)(A)(i)(I)
1903(m)
42 CFR 438.50(c)(1)

1. __X__ The state assures that all of the applicable requirements of section 1903(m) of the Act, for MCOs and MCO contracts will be met.

1932(a)(1)(A)(i)(I)
1905(t)
42 CFR 438.50(c)(2)
1902(a)(23)(A)

2. __X__ The state assures that all the applicable requirements of section 1905(t) of the Act for PCCMs and PCCM contracts will be met.

1932(a)(1)(A)
42 CFR 438.50(c)(3)

3. __X__ The state assures that all the applicable requirements of section 1932 (including subpart (a)(1)(A)) of the Act, for the state's option to limit freedom of choice by requiring recipients to receive their benefits through managed care entities will be met.

1932(a)(1)(A
42 CFR 431.51
1905(a)(4)(C)

4. __X__ The state assures that all the applicable requirements of 42 CFR 431.51 regarding freedom of choice for family planning services and supplies as defined in section 1905(a)(4)(C) will be met.

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Citation		Condition or Requirement
1932(a)(1)(A) 42 CFR 438 42 CFR 438.50(c)(4) 1903(m)	5.	__X__ The state assures that all applicable managed care requirements of 42 CFR Part 438 for MCOs and PCCMs will be met.
1932(a)(1)(A) 42 CFR 438.6(c) 42 CFR 438.50(c)(6)	6.	__X__ The state assures that all applicable requirements of 42 CFR 438.6(c) for payments under any risk contracts will be met.
1932(a)(1)(A) 42 CFR 447.362 42 CFR 438.50(c)(6)	7.	____ The state assures that all applicable requirements of 42 CFR 447.362 for payments under any nonrisk contracts will be met.
45 CFR 74.40	8.	____ The state assures that all applicable requirements of 45 CFR 92.36 for procurement of contracts will be met.

Assurances and Compliance

1. Consistent with this description, the state assures that all the requirements of Sections 1932, 1903(m), and 1905(t) of the Social Security Act will be met.

2. The MHC program is available in selected counties in Iowa. Mandatory enrollment provisions will not be implemented unless a choice of at least two MediPASS PMs or a combination of MCO and the MediPASS program is available.

3. Iowa has safeguards in effect to guard against conflict of interest on the part of employees of the state and its agents.

4. Iowa will monitor and oversee the operation of the mandatory managed care program, ensuring compliance with all federal program requirements, federal and state laws and regulations, and the requirements of the contracts agreed upon by Medicaid and its contractors.

5. Iowa will evaluate compliance by review and analysis of reports prepared and sent to the Iowa Medicaid agency by the contractors. Deficiencies in one or more areas will result in the contractor being required to prepare a corrective action plan, which will be monitored by the Iowa Medicaid agency.

6. Reports from the grievance and complaint process will be analyzed and used for evaluation purposes.

7. Iowa staff will provide technical assistance as necessary to ensure that contractors have adequate information and resources to comply with all requirements of law and their contracts.

Citation
Condition or Requirement

8. Iowa staff will evaluate each contractor for financial viability/solvency, access and quality assurance.

D. Eligible groups

1932(a)(1)(A)(i) 1. List all eligible groups that will be enrolled on a mandatory basis.

The MHC program is limited to the following target groups of members:

1. Families, children, and pregnant women eligible for Medicaid under Section 1931 of the Social Security Act or related coverage groups.

2. Members eligible for Medicaid through the Medicaid expansion under the State Child Health Insurance Program (SCHIP). (Recipients in the Iowa's separate SCHIP program are not enrolled in managed health care.)

3. Members eligible for the Wellness Plan through Medicaid expansion under the Affordable Care Act as demonstrated in the applicable 1115 waiver and described under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act.

2. Mandatory exempt groups identified in 1932(a)(1)(A)(i) and 42 CFR 438.50.

Use a check mark to affirm if there is voluntary enrollment any of the following mandatory exempt groups.

1932(a)(2)(B)
42 CFR 438(d)(1) i.____Recipients who are also eligible for Medicare.

If enrollment is voluntary, describe the circumstances of enrollment. *(Example: Recipients who become Medicare eligible during mid-enrollment, remain eligible for managed care and are not disenrolled into fee-for-service.)*

1932(a)(2)(C) ii.____Indians who are members of Federally recognized Tribes except when 42 CFR 438(d)(2) the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

1932(a)(2)(A)(i)
42 CFR 438.50(d)(3)(i) iii.____ Children under the age of 19 years, who are eligible for Supplemental Security Income (SSI) under title XVI.

1932(a)(2)(A)(iii) iv.____ Children under the age of 19 years who are eligible under

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42 CFR 438.50(d)(3)(ii)	1902(e)(3) of the Act.
1932(a)(2)(A)(v) 42 CFR 438.50(3)(iii)	v. ____Children under the age of 19 years who are in foster care or other out-of-the-home placement.
1932(a)(2)(A)(iv) 42 CFR 438.50(3)(iv)	vi. ____Children under the age of 19 years who are receiving foster care or adoption assistance under title IV-E.
1932(a)(2)(A)(ii) 42 CFR 438.50(3)(v)	vii. ____Children under the age of 19 years who are receiving services through a family-centered, community based, coordinated care system that receives grant funds under section 501(a)(1)(D) of title V, and is defined by the state in terms of either program participation or special health care needs.

E. Identification of Mandatory Exempt Groups

1932(a)(2)
42 CFR 438.50(d)

1. Describe how the state defines children who receive services that are funded under section 501(a)(1)(D) of title V. *(Examples: children receiving services at a specific clinic or enrolled in a particular program.)*

Children under age 19 receiving services through a family centered, community–based coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V. Members that are not excluded from enrollment under this subsection are defined as children with special health-care needs that are receiving direct financial assistance from the State's Maternal and Child Health Care program.

After consultation with the State's Maternal and Child Health agency, an agreement was made that these recipients will be identified using appropriate medical status codes from the Medicaid Management Information System and through a data file transfer undertaken monthly between the Title V Agency and the Department of Human Services. Any additional recipients that would be affected by this subsection will be requested to identify themselves in the enrollment process.

If Iowa's Maternal and Child Health Care program identifies any child for whom they are providing comprehensive services in that program who is enrolled in MHC, arrangements will be made to immediately disenroll the child from MHC with the appropriate exclusion code. Services provided to such children will not require authorization. Providers will be given emergency authorizations for claims processing until the child can be disenrolled.

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Citation	Condition or Requirement
1932(a)(2) 42 CFR 438.50(d)	2. Place a check mark to affirm if the state's definition of title V children is determined by: __X__ i. program participation, ____ ii. special health care needs, or ____ iii. both
1932(a)(2) 42 CFR 438.50(d)	3. Place a check mark to affirm if the scope of these title V services is received through a family-centered, community-based, coordinated care system. __X__ i. yes ____ ii. no
1932(a)(2) 42 CFR 438.50 (d)	4. Describe how the state identifies the following groups of children who are exempt from mandatory enrollment: *(Examples: eligibility database, self- identification)* i. Children under 19 years of age who are eligible for SSI under title XVI; These members are assigned a specific aid type within the Iowa Automated Benefits Calculation system from the SSNI (Title XIX) database. Any members specified as falling into this identified coverage group are not allowed enrollment through the Managed Care SubSystem of the MMIS. ii. Children under 19 years of age who are eligible under section 1902 (e)(3) of the Act; These members are assigned a specific aid type within the Iowa Automated Benefits Calculation system from the SSNI (Title XIX) database. Any members specified as falling into this identified coverage group are not allowed enrollment through the Managed Care SubSystem of the MMIS. iii. Children under 19 years of age who are in foster care or other out-of-home placement; These members are assigned a specific FBU (family base unit) number within the Iowa Automated Benefits Calculation system from the SSNI

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(Title XIX) database. Any members specified as falling into this identified coverage group are not allowed enrollment through the Managed Care SubSystem of the MMIS.

iv. Children under 19 years of age who are receiving foster care or adoption assistance.

These members are assigned a specific aid type within the Iowa Automated Benefits Calculation system from the SSNI (Title XIX) database. Any members specified as falling into this identified coverage group are not allowed enrollment through the Managed Care SubSystem of the MMIS.

1932(a)(2)
42 CFR 438.50(d)

5. Describe the state's process for allowing children to request an exemption from mandatory enrollment based on the special needs criteria as defined in the state plan if they are not initially identified as exempt. *(Example: self-identification)*

The Department does not wish to interrupt any existing provider/patient relationship that has resulted in the mutually beneficial actions leading to appropriate care management. For this reason, any member or guardian may request an exception to the policy of mandatory enrollment. The Director will consider all aspects of the request before making a decision to act upon the request.

1932(a)(2)
42 CFR 438.50(d)

6. Describe how the state identifies the following groups who are exempt from mandatory enrollment into managed care: *(Examples: usage of aid codes in the eligibility system, self- identification)*

i. Recipients who are also eligible for Medicare.

Medicare eligible members are assigned a specific aid type within the Iowa Automated Benefits Calculation system. Any member who is so designated will be excluded from the enrollment assignment process.

ii. Indians who are members of Federally recognized Tribes except when the MCO or PCCM is operated by the Indian Health Service or an Indian Health program operating under a contract, grant or cooperative agreement with the Indian Health Service pursuant to the Indian Self Determination Act; or an Urban Indian program operating under a

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contract or grant with the Indian Health Service pursuant to title V of the Indian Health Care Improvement Act.

Iowa's eligibility system (the Automated Benefit Calculation system) contains a field for ethnicity which caseworkers use to document whether a person applying for benefits is a member of a federally recognized tribe. This already existing indicator will be used to exempt American Indians from the mandatory enrollment process in Medicaid managed care.

Currently, the Mesquaki Tribe is the only Federally recognized American Indian Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi. The Iowa Tribe has fewer than 1,500 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, have resulted in a significant growth trend and a 200% birth rate increase since 1992. The Automated Benefit Calculation system will identify any Mesquaki members (as well as members of other tribes) who participate in Medicaid.

42 CFR 438.50

F. List other eligible groups (not previously mentioned) who will be exempt from mandatory enrollment

Members enrolled in the Medically Needy program

42 CFR 438.50

G. List all other eligible groups who will be permitted to enroll on a voluntary basis

None

H. Enrollment process.

1932(a)(4)
42 CFR 438.50

1. Definitions

i. An existing provider-recipient relationship is one in which the provider was the main source of Medicaid services for the recipient during the previous year. This may be established through state records of previous managed care enrollment or fee-for-service experience, or through contact with the recipient.

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	ii. A provider is considered to have "traditionally served" Medicaid recipients if it has experience in serving the Medicaid population.
1932(a)(4) 42 CFR 438.50	2. State process for enrollment by default. Describe how the state's default enrollment process will preserve: i. the existing provider-recipient relationship (as defined in H.1.i). The default selection for a member with a history of enrollment in the managed health care program will be to put the member with the last selection made by the member for either the MediPASS PM or the HMO, where applicable. The default enrollment algorithm for any member new to the system will cause a default enrollment to a practitioner in the same zip code as the member residence or as near as possible to the residence of the member. The default enrollment may be changed by the member. Iowa allows MCOs/PHPs or primary care case managers to assist in enrolling beneficiaries. There are times when the MCO or the MediPASS provider's office might be the initial point of contact with the MHC recipient. In order to process the recipient's enrollment choice efficiently, the Department does allow for the enrollment choice to be communicated to the enrollment broker from the MCO or the MediPASS provider's office. However, there are some safeguards in place to ensure that the correct enrollment is processed and that the choice is truly from the recipient. The MCOs' and MediPASS providers' offices are able to have a supply of MHC enrollment forms at their location. The enrollment form does require the signature of the case name (Medicaid applicant) in order to be accepted and processed by the enrollment broker. Telephone calls from either place will require that the person listed as the case name be on the phone making the enrollment choice. ii. the relationship with providers that have traditionally served Medicaid recipients (as defined in H.2.ii). The MediPASS program requires that the PM be enrolled and participating with the Iowa Medicaid program. This does not carry any specific volume or timelines for such Medicaid program participation but does seek to give providers with a history of participation a degree of familiarity with the Medicaid program.

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iii. the equitable distribution of Medicaid recipients among qualified MCOs and PCCMs available to enroll them, (excluding those that are subject to intermediate sanction described in 42 CFR 438.702(a)(4)); and disenrollment for cause in accordance with 42 CFR 438.56 (d)(2). *(Example: No auto-assignments will be made if MCO meets a certain percentage of capacity.)*

The enrollment algorithm for default enrollments first looks at the history of participation by the member in the managed health care program. When such a history is noted, the default enrollment will be to the last provider with whom the member was enrolled if that provider is still available to the member. A MediPASS PM may specify the area to be served which could include the county in which the practice is located and all contiguous counties. In those counties where an HMO is an option, the algorithm will split default enrollments equitably between the HMO and the available MediPASS PMs after the default first looks for a history within managed health care.

1932(a)(4)
42 CFR 438.50

3. As part of the state's discussion on the default enrollment process, include the following information:

i. The state will use a lock-in for managed care managed care.

ii. The time frame for recipients to choose a health plan before being auto-assigned will be a minimum of 10 calendar days.

iii. Describe the state's process for notifying Medicaid recipients of their auto-assignment. *(Example: state generated correspondence.)*

iv. Describe the state's process for notifying the Medicaid recipients who are auto-assigned of their right to disenroll without cause during the first 90 days of their enrollment. *(Examples: state generated correspondence, HMO enrollment packets etc.)*

v. Describe the default assignment algorithm used for auto-assignment. *(Examples: ratio of plans in a geographic service area to potential enrollees, usage of quality indicators.)*

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vi. Describe how the state will monitor any changes in the rate of default assignment. *(Example: usage of the Medical Management Information System (MMIS), monthly reports generated by the enrollment broker)*

Enrollment and Disenrollment

1. All members will be given the opportunity to choose from at least two MHC providers including enrollment into an MCO where this option is available. If a member has a prior provider relationship that they wish to maintain, the enrollment broker will assist that member in choosing a managed care entity that will maintain this relationship. Iowa contracts with an independent contractor to conduct the enrollment process and related activities. The enrollment broker performs services and supplies information as follows to facilitate the enrollment process:

   a. Under direction and oversight by the Department, recruit MediPASS patient managers for the PCCM model of the program.

   b. Review provider access for each county quarterly to assure appropriate primary care access for the enrollees. This allows the Department to determine if the default enrollment algorithm is operating properly and make adjustments as needed. Other reports generated both monthly and quarterly monitor the volume of active enrollees by county and demonstrates the number who accepted the default versus making an active selection.

   c. Answer MHC-related questions from members and providers.

   d. Prepare enrollment materials for MHC program, for Department approval, and store all MHC materials (MCO, MediPASS and MHC in general).

   e. Process new enrollment packets for those MHC eligibles identified by the Department.

   f. Process the member's choice of MHC option.

   g. Log all grievances and requests for special authorization from MediPASS enrollees.

   h. Review member's request for enrollment change during EPP for good cause.

   i. Perform various quality assurance activities for the MHC program. This includes but is not limited to; paid claim audits, 24-hour access audit, appointment system survey, encounter data validation, review and approval of special authorization for MediPASS enrollees, member and provider educational correspondence, and utilization review for MediPASS providers.

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j. Supplies an enrollment packet to the member that includes individual MCOs' informing materials and information supplied by the state. This will include a letter indicating the default selection made by the Department.

k. Provides enrollment counseling which includes:
   (1) Inquiring about patient/provider experience and preference.
   (2) Providing information on which MCOs or MediPASS PMs are available to maintain a prior patient-provider relationship.
   (3) Facilitating direct contact with individual MCOs, as necessary.
   (4) Providing any information and education concerning the enrollment process, individual MCOs', benefits offered, the enrollment packet, and any of the other information provided for in this section.

l. If the member fails to choose an MCO or MediPASS PCCM provider within a minimum of 10 calendar days after receiving enrollment materials, the Department assigns the member to a PCCM or MCO. A letter is sent to the member after the last day to make a change for the coming month indicating their MediPASS PCCM provider for the coming month.

m. Iowa allows MCOs/PHPs or primary care case managers to assist in enrolling beneficiaries. There are times when the MCO or the MediPASS provider's office might be the initial point of contact with the MHC member. In order to process the member's enrollment choice efficiently, the Department does allow for the enrollment choice to be communicated to the enrollment broker from the MCO or the MediPASS provider's office. However, there are some safeguards in place to ensure that the correct enrollment is processed and that the choice is truly from the member. The MCOs' and MediPASS providers' offices are able to have a supply of MHC enrollment forms at their location. The enrollment form does require the signature of the case name (Medicaid applicant) in order to be accepted and processed by the enrollment broker. Telephone calls from either place will require that the person listed as the case name be on the phone making the enrollment choice.

2. Default enrollment will be based upon maintaining prior provider-patient relationships or, where this is not possible, on maintaining an equitable distribution among managed care entities. The default algorithm will cause an equal split between HMO and MediPASS in those counties where both options are available. However, any member previously enrolled with either option will be kept with that option if it is still available.

3. Information in an easily understood format will be provided to members on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement, and comparative information among managed care entities regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

Citation

4. Any selection or assignment of an MCO or PCCM may be changed at the request of the member for the following "good cause" reasons: poor quality of care, lack of access to special services or other reasons satisfactory to the Department. Some examples of these reasons would be if a new MHC option becomes available in the enrollees' county, or if a provider within a network were to leave and that provider's patients/enrollees wish to change options to continue the same doctor/patient relationship. Whenever an enrollee is receiving prenatal care, there is a 'good cause' reason for allowing the enrollee to change options to maintain the existing doctor/patient relationship. Recipients may disenroll at any time for good cause.

5. During the first 90 days of the initial enrollment and the first 90 days of enrollment each nine months after the date of the initial enrollment or twelve months in the case of Wellness Plan enrollees, the recipient can change from one MCO or PCCM to another without cause. After 90 days, the member may not change the enrollment choice without good cause. This time is known as the extended participation program or EPP. Members are sent a letter after the default selection or the member's selection becomes valid in which the member is advised that a change may be made within the first 90 days of the enrollment.

6. Enrollees will be provided notification 60 days before the end of a lock-in period (EPP) of their opportunity to make a new choice of MCO or PCCM.

7. Enrollees will be given an opportunity to change MCOs or PCCMs and will be sent a notice to that effect.

8. MCOs and PCCMs will not discriminate against individuals eligible to be covered under the contract on the basis of health status or need of services.

9. The MCO and PCCMs will not terminate enrollment because of an adverse change in the recipient's health.

10. An enrollee who is terminated from an MCO or PCCM solely because the enrollee has lost Medicaid eligibility for a period of two months or less will automatically be re-enrolled into the same MCO or PCCM upon regaining eligibility.

11. As stated in #5 above, an enrollment period shall not exceed nine months or twelve months in the case of Wellness Plan enrollees. An enrollee may disenroll following the initial 90 days of any period of enrollment if all of the following circumstances occur:
    a. The enrollee submits a request for disenrollment to the Department citing good cause for disenrollment.
    b. The request cites the reason or reasons why the recipient wishes to disenroll.
    c. The Department determines good cause for disenrollment exists.

12. The member will be informed at the time of enrollment of the right to disenroll.

Revised Submission 3.7.12

Citation	Condition or Requirement

13. An enrollee will be allowed to choose his or her health professional in the MCO to the extent possible and appropriate and will be allowed to change his or her health professional as often as requested per the policy of the MCO. Changes made for good cause are not considered as a request for change if the MCO sets a number of changes allowed yearly.

14. Enrollees will have access to specialists to the extent possible and appropriate and female enrollees will have direct access to women's health services.

1932(a)(4)
42 CFR 438.50

I. State assurances on the enrollment process

Place a check mark to affirm the state has met all of the applicable requirements of choice, enrollment, and re-enrollment.

1. __X__ The state assures it has an enrollment system that allows recipients who are already enrolled to be given priority to continue that enrollment if the MCO or PCCM does not have capacity to accept all who are seeking enrollment under the program.

2. __X__ The state assures that, per the choice requirements in 42 CFR 438.52, Medicaid recipients enrolled in either an MCO or PCCM model will have a choice of at least two entities unless the area is considered rural as defined in 42 CFR 438.52(b)(3).

3. ____ The state plan program applies the rural exception to choice requirements of 42 CFR 438.52(a) for MCOs and PCCMs.

   __X__ This provision is not applicable to this 1932 State Plan Amendment.

4. ____ The state limits enrollment into a single Health Insuring Organization (HIO), if and only if the HIO is one of the entities described in section 1932(a)(3)(C) of the Act; and the recipient has a choice of at least two primary care providers within the entity. (California only.)

   __X__ This provision is not applicable to this 1932 State Plan Amendment.

5. __X__ The state applies the automatic reenrollment provision in accordance with 42 CFR 438.56(g) if the recipient is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less.

   ____ This provision is not applicable to this 1932 State Plan Amendment.

1932(a)(4)

J. Disenrollment

Revised Submission 3.9.12

State: IOWA

Citation	Condition or Requirement
42 CFR 438.50	1. The state will use lock-in for managed care.

Revised Submission 3.9.12

Citation	Condition or Requirement

2. The lock-in will apply for 9 months (up to 12 months).

3. Place a check mark to affirm state compliance.

X The state assures that beneficiary requests for disenrollment (with and without cause) will be permitted in accordance with 42 CFR 438.56(c).

4. Describe any additional circumstances of "cause" for disenrollment (if any).

K. Information requirements for beneficiaries

Place a check mark to affirm state compliance.

1932(a)(5)
42 CFR 438.50
42 CFR 438.10

X The state assures that its state plan program is in compliance with 42 CFR 438.10(i) for information requirements specific to MCOs and PCCM programs operated under section 1932(a)(1)(A)(i) state plan amendments. (Place a check mark to affirm state compliance.)

1932(a)(5)(D)
1905(t)

L. List all services that are excluded for each model (MCO & PCCM)

The following are excluded for both the MCO and PCCM:

Services delivered for the purpose of treating a mental health or substance abuse disorder.

Dental Services
Prescription Drugs
ICF/MR
Nursing Facility
HCBS Waiver Services
Educational Services
Residential Care Facility
PACE
Transportation (non-emergency)

1932 (a)(1)(A)(ii)

M. Selective contracting under a 1932 state plan option

To respond to items #1 and #2, place a check mark. The third item requires a brief narrative.

1. The state will_____/will not_X____ intentionally limit the number of entities it contracts under a 1932 state plan option.

Revised Submission 3.9.12

Citation	Condition or Requirement

2. __X__ The state assures that if it limits the number of contracting entities, this limitation will not substantially impair beneficiary access to services.

3. Describe the criteria the state uses to limit the number of entities it contracts under a 1932 state plan option. *(Example: a limited number of providers and/or enrollees.)* Not Applicable

4. __X__ The selective contracting provision in not applicable to this state plan.