NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES
PUBLIC COMMENT PERIOD FOR STATE PLAN AMENDMENT

Notice is hereby given, in accordance with 42 CFR 447.205 and 447.57, Section 1902(a)(13)(A) of the Social Security Act, and 42 CFR 440.386 that the Iowa Department of Human Services (DHS) has posted for public comment the following Medicaid State Plan Amendments (SPA) related to the Iowa High Quality Healthcare Initiative (Initiative), as part of IA Health Link, the State's Medicaid Managed Care program. Through this Initiative, the State will contract with private health care organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program.

This notice provides a summary of the purpose of the SPAs and also serves to open the 30-day public comment period. All comments on these SPAs must be received by December 30, 2015.

DHS is working with the Centers for Medicare and Medicaid Services (CMS) to obtain the necessary federal authority to implement the Initiative. In addition to the multiple waivers already submitted, amendments to the State Plan are also required as outlined below. Such amendments are necessary in order to obtain federal authority to operate the Initiative and to align the State Plan with the new program requirements.

Alternative Benefit Plan

This SPA revises the service delivery systems the State will use for the Iowa Wellness Plan Alternative Benefit Plan. Specifically, effective January 1, 2016, Iowa Wellness Plan members will enroll with a managed care organization (MCO) as described in the State's High Quality Healthcare Initiative §1915(b) waiver, unless specifically excluded as described in the waiver. Dental services will continue to be provided as they are today through Delta Dental, a Prepaid Ambulatory Health Plan. Those members excluded from the Iowa High Quality Healthcare Initiative waiver will receive services through a fee-for-service delivery system.

There are no changes to the Iowa Wellness Plan covered benefits. Early and Periodic Screening, Diagnostic and Treatment (EPSDT) services will continue to be provided to those individuals who are under age 21. The State will ensure MCO compliance with 42 CFR §440.345 related to EPSDT by inspecting medical and peer review records, as well as regular reports of health screenings and examination related activities. The State will assure compliance with the provisions of section 5006(e) of the American Recovery and Reinvestment Act of 2009 by continuing to engage in tribal consultations, in accordance with federal law and the Iowa Medicaid State Plan. Tribal notice has been provided for this SPA.

In addition, this SPA revises the eligibility group description to modify eligibility to include those persons at or below 133% FPL that were previously eligible for the Marketplace Choice Plan. To the extent a qualified health plan were to become available, the State may enroll individuals with income between 101% and 133% of the poverty level in the Marketplace Choice plan.

DHS is seeking a January 1, 2016, effective date for this SPA.

Cost Sharing

The proposed SPA outlines MCO responsibilities relative to member cost-sharing. MCOs are not required to impose cost-sharing on enrollees. However, any cost-sharing imposed must be in compliance with the terms of the State Plan. Current cost sharing amounts and consequences for non-payment remain unchanged from current policy and are outlined below. Cost sharing for Iowa Wellness Plan and hawk-i enrollees is not impacted by this SPA.

- $1 Copayment: Generic & preferred brand name drugs, chiropractor services, physical therapy, podiatrist services, Medicare Part B crossover claims
- $2 Copayment: Non-preferred brand-named drugs for which the cost to the state is $25.01 to $50.00, ambulance services, audiologist services, hearing aid dealer services, medical equipment and appliances, optician services, optometrist services, orthopedic shoes, prosthetic devices and sickroom supplies, psychologist services, rehabilitation agency services
- $3 Copayment: Non-preferred brand-name drugs for which the cost to the state is $50.01 or more, dental treatment, hearing aids, services rendered in a physician (MD/DO) office visit
- Nonpreferred drug cost sharing is limited to the amount imposed for a preferred drug, if the individual's prescribing provider determines a preferred drug for treatment of the same condition either will be less effective, will have adverse effects, or both.

The following populations are exempt from cost sharing:

- Individuals under 50% of the federal poverty level
- Children under age 21
- Individuals living in an institution whose medical assistance for services furnished in an institution is reduced by amounts reflecting available income other than required for personal needs.
- Individuals receiving hospice care
- Pregnant women, during pregnancy and 60-day post-partum period for pregnancy-related services
- American Indians and Alaska Natives who have ever received a service from the Indian Health Service, tribal health programs, or under contract health services referral
- Women who are enrolled in Medicaid under the Breast and Cervical Cancer Treatment Program
- Emergency services
- Family planning services and supplies
- Preventive services
- Provider-preventable services

MCOs are required to adhere to the following requirements:

1. Make co-payment information available to providers and members

2. Develop mechanisms to track cost sharing to ensure members' total cost sharing does not exceed 5% of quarterly household income, and ensure that if the 5% limit is reached, cost sharing is no longer collected until the beginning of a new quarter and the provider's

reimbursement is adjusted accordingly so that co-payment amounts are no longer deducted from claims reimbursement.

3. Account for cost-sharing of all members of the household in determining if the 5% aggregate household limit is reached, and reimburse beneficiaries and adjust claims to providers in the event a family is identified as paying over the aggregate limit.

4. Make information on cumulative cost-sharing maximums available to providers and members.

5. Operate a grievance and appeal process for enrollees who believe they have incurred cost sharing over the 5% aggregate limit. Members must have opportunity to appeal to their MCO and, if dissatisfied with the outcome of the appeal process, file an appeal with the State through the State Fair Hearing process.

DHS is seeking a January 1, 2016, effective date for this SPA.

In addition to the MCO-related components of this current SPA, 2011 Iowa Acts, House File 649, Sections 10 and 28, granted DHS the authority to implement a series of coverage and reimbursement methodologies, one of which was implementation of a $3.00 copayment for non-emergency use of hospital emergency rooms. DHS has been working with CMS to obtain SPA approval to implement this change, originally submitted under SPA IA-11-021. Over the intervening period, federal regulations under 42 CFR §447.54 have expanded requirements related to cost-sharing for services furnished in a hospital emergency department. The following modifies the original SPA submission (i.e., under IA-11-021) to be compliant with these new federal regulations, to be implemented effective for services rendered on or after, September 1, 2011.

1. Implement a $3 copayment from the Medicaid member for treatment of a nonemergency medical condition in a hospital emergency room. Copayment will not be charged if the member is admitted to the hospital for inpatient care.

2. Modify the reimbursement methodology to either reduce or eliminate payment for nonemergency services rendered in a hospital emergency room. Status Indicator V, clinic or emergency department visit, if covered by Iowa Medicaid, is paid under OPPS APC with separate APC payment, subject to limits on nonemergency services provided in an emergency room as described below:

    a. Payment to a hospital for assessment of any Medicaid member in an emergency room shall be made pursuant to fee schedule. Payment for treatment of a Medicaid member in an emergency room shall be made as follows.

        i. If the emergency room visit results in an inpatient hospital admission, the treatment provided in the emergency room is paid for as part of the payment for the inpatient services provided.

ii. If the emergency room visit does not result in an inpatient hospital admission but involved emergency services as defined under 441 Iowa Administrative Code 79.1(13)"k," payment for treatment provided in the emergency room shall be made at the full APC payment for the treatment provided.

iii. If the emergency room visit does not result in an inpatient hospital admission and did not involve emergency services as defined under 441 Iowa Administrative Code 79.1(13)"k," payment for treatment provided in the emergency room depends on whether the member had a referral to the emergency room from the member's primary care provider (PCP).

1. For members who were referred to the emergency room by their primary care physician or other appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 75 percent of the APC payment for the treatment provided.

2. For members who were not referred to the emergency room by their primary care physician or appropriate medical personnel, payment for treatment provided in the emergency room shall be made at 50 percent of the APC payment for the treatment provided.

Adoption of the changes related to nonemergency use of the emergency room proposed above were originally estimated to reduce annual aggregate expenditures by approximately $3.5 million (total state and federal dollars) for the original period September 1, 2011 through June 30, 2012. The fiscal impact of the MCO components of this SPA and the ABP changes are encompassed in the Iowa High Quality Healthcare Initiative §1915(b) waiver submission.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

This notice, SPA, and information about the Iowa High Quality Healthcare Initiative are available at: https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization/federal-documents. To reach all stakeholders, non-electronic copies of all of the aforementioned items will be made available for review at the DHS Field Offices. Written comments may be addressed to Alisa Horn, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent via electronic mail to the attention of: DHS, High Quality Healthcare Initiative – ABP and Health Homes SPAs at ModernizationWaiverComment@dhs.state.ia.us. All comments on these SPAs must be received by December 30, 2015.

Submitted by:
Mikki Stier, MSHA, FACHE
Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services