Iowa Department of Human Services

IA Health Link Update
Readiness Review and Rules

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Overview

- Readiness Review
- Rules

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Readiness Overview

- Definition and Objective
- Iowa's Readiness Review Vendor
  - Selection and Profile
- Readiness Review Process
  - Areas of focus
  - Review components
  - Review process – internal, MCO and providers
  - Long-term care requirements

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Readiness Definition & Objective

The Readiness Review ensures that:

1) Iowa DHS and 2) The MCOs are ready for the transition to managed care

The objectives are to:

- Have continuity of services for members
- Have continuity of reimbursement for providers
- Minimize negative impacts of transition

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Readiness Review Selection

- Process outlined in Medicaid Modernization Requests for Proposals MED-16-013
- Vendor selected through competitive bidding – three bidders
- Navigant awarded contract

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Readiness Review Vendor

- SFY16 $1.28 million ($640,000 general funds)
- This includes readiness reviews for each of the 4 MCOs at a total of $320,000 each review
- An additional $500,000 per year is available for ongoing technical assistance
- DHS has the ability to continue technical assistance for up to 5 years with Navigant

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Readiness Review Vendor

Navigant has:

- 19 years experience
- 5,000 staff including 16 dedicated to Iowa
- Worked recently on Readiness Reviews in the following states:

Indiana	Pennsylvania
Georgia	Mississippi
Alabama	Texas

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Readiness Review Focus

- Quality monitoring
- Service authorization and delivery
- Call center operations
- Care coordination
- Data transfer and management
- Provider network management
- Claims processing and payment

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Readiness Review Components

Key Desk Deliverables

- Navigant will be the lead on all deliverables
- State will provide Iowa specific subject matter expertise

Onsite review of critical processes/operating functions

- State staff will be present during onsite reviews to learn operations but Navigant will be lead reviewers

Systems Testing

- IME will work on systems testing with the MCOs
- Navigant will lead the Information Systems Capability Assessment for each MCO

Readiness Review Components

October 10-23

Key desk deliverables such as:

- Policies and procedures, training materials, member handbooks, educational materials, notices, incentive programs, provider agreement templates, provider manuals, financial statements, etc.

November 2-12

Critical processes and operating functions reviewed onsite such as:

- Claims processing
- Call center operations
- Service authorization validation
- Training
- Care coordination

Readiness Review Components Cont.

October 1 - November 12

IT Systems/testing

- Critical MCO systems
- Interface for eligibility, enrollment and encounter data
- Claims processing

Readiness Review Process

Organization and 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

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Readiness Review - LTC

Specific federal requirements related to long term care readiness include:

- Comprehensive LTC training
- Experience and expertise with LTC, including case management and disease management staff
- These requirements are applicable to subcontractors of the MCOs

Readiness Review Expectations

If the contractor fails to pass the readiness review at least 30 calendar day prior to scheduled member enrollment DHS may:

- Apply a $2,168 per day penalty in liquidated damages
- Delay member enrollment
- Require other remedies up to but not limited to terminating the contract
- Recover from the contractor all costs incurred because of any delay

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Rules

- Rules Overview
- Rules Chapters
- Specific Changes
- Potential Changes

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Rules Overview

- 13 chapters require rules changes
- These changes include either a member or provider impact and need to align with new initiative
- These changes will be made by:
  - Emergency after notice process
  - Public Hearings will be held week of November 17, 2015
  - The Department will be reviewing the specific changes with the MAAC Council and other key constituency groups during the next month

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Rules Cont.

- The purpose of many of the rule revisions are to account for managed care within the Iowa Medicaid program and to be consistent with the language and intent of the RFP
- The following Administrative Rule Chapters will be amended to implement the Iowa High Quality Health Care Initiative

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Rule Chapters

- Chapter 74: Iowa Health and Wellness Plan
- Chapter 75: Conditions of Eligibility
- 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

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Rule Chapters

- Chapter 82: Intermediate Care Facilities for Persons with Intellectual Disabilities
- Chapter 83: Medicaid Waiver Services
- Chapter 84: Early Periodic Screening, Diagnosis and Treatment
- Chapter 85: Services in Psychiatric Institutions
- Chapter 88: Managed Care Providers
- Chapter 90: Targeted Case Management
- Chapter 92: IowaCare

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Rules - Specific Changes

- Provide the MCO the ability to act in accordance with their contract and provide services
- Eliminate outdated rules or references (eg. MediPASS program and Iowa Plan for Behavioral Health)
- Identify the assessment tool for non-ID waiver and habilitation populations

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Rules - Potential Changes

- Modify the initial service plan requirements for waiver eligibility
- Define Level Of Care (LOC) requirements to align with use of new tools
- Modify the targeted case management service definition and corresponding targeted population

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