

Topic Area Summaries

I. Program Questions

Comments Received:

During the public comment process, many individuals took the opportunity to ask questions related to program design and the implementation process. These questions were not specific to the Initiative or the waivers open for public comment; rather they sought clarification from the State. Individuals raised a variety of general questions around the following general themes: (1) 1915(c) HCBS waiver assessment process; (2) MCO selection, assignment and change processes and timelines; (3) implementation member outreach processes; (4) out-of-network providers policies and procedures around selecting a provider; (5) funding and authorization rules; (6) State MCO procurement process; (7) impact to eligibility; (8) clarification on the waiver public comment process; (9) provider roles and responsibilities; (10) reimbursement rates; (11) MCO operational processes; (12) case manager roles and qualifications; (13) MCO quality oversight processes; (14) level of care assessment procedures; (15) provider enrollment processes; and (16) clarification regarding FQCH & RHC reconciliation process and prospective payment system wrap payments.

§1915(b) Waiver Specific Questions:

In addition, to the above program-related questions several specific questions were raised requesting additions to the §1915(b) waiver: (1) ensure clarity regarding the 340B drug-pricing program; (2) allow all current Marketplace Assistors to provide state-supported services to Medicaid MCO beneficiaries; (3) include additional §1915(b)(3) services (e.g., telemedicine), as identified through a public input process; and (4) include a waiver measurement that addresses disparities by racial or ethnic group.

State Response:

Because the program questions did not provide specific feedback on the waivers, no modifications were made to the waivers. These general themes will be utilized by the State to continue developing communication materials and to inform the transition process. With respect to the 340B drug-pricing program, the State feels this would be best addressed through MCO contracting and will take the commenters suggestion into consideration during this process. Regarding Iowa Marketplace Assistors, the State views Assistors as valuable community partners. As such, the State will provide Assistors with information and education about the transition to managed care as part of the stakeholder engagement strategy. This information will provide the tools needed to help inform and refer Medicaid members the Assistors may have contact with to the Medicaid Enrollment Broker, Iowa Medicaid Enterprise Member Services (MAXIMUS). Finally, additionally the State will take commenters request for the provision of additional §1915(b)(3) under advisement for future waiver amendments. The state will incorporate into its final waiver submission the recommended waiver measurement.

II. Case Management

Comments Received:

Several comments were received related to case management. Generally, commenters expressed the importance of case management being provided in a conflict free manner and without incentives for MCOs to cut services; several commenters perceived that case management provided through an MCO would not be conflict free. There were concerns that MCO case managers would not advocate for members and members were not guaranteed to have continued access to their current case manager. Commenters questioned if there would be enough qualified case managers to serve beneficiaries following the transition. Additionally, two current case managers raised concerns over their future employment status. Another commenter suggested the new program would provide an opportunity to improve the system that is currently difficult to navigate.

State Response:

The Initiative will continue case management services through the MCOs. MCOs are contractually required to ensure the delivery of services in a conflict free manner consistent with Balancing Incentive Program requirements and which administratively separates the final approval of service plans and approval of funding amounts. The State will approve and monitor all MCO policies and procedures through the readiness review and ongoing quality assurance processes, and ensure compliance and swiftly implement corrective actions in this area as needed. With respect to the number of qualified case managers available to provide services following implementation, DHS anticipates that the overall number of Medicaid beneficiaries will not materially change during the transition to managed care and that the overall system will continue to have the capacity to provide case management services to all beneficiaries regardless of delivery mechanism (i.e., managed care or fee-for-service), as they do today. The implementation plan for the Initiative allows members to retain their current case manager during the first six months of transition, regardless of whether the MCO has an agreement with the member's existing case manager. Following this six-month period, MCOs must provide advance notice of planned case manager changes, and must ensure continuity of care when such changes are made. For those beneficiaries remaining in fee for service, DHS will maintain existing contracts to ensure sufficient numbers of case managers are available to meet the needs of beneficiaries.

III. Service Delivery/Access

Comments Received:

Several comments were received related to service delivery and access. Generally, commenters expressed concern that MCOs may prioritize profit over services, which will jeopardize member health and safety, and that members with disabilities and/or serious health conditions may no longer receive the attention and care they require. One commenter expressed support that MCOs would be required to contract with the current Medicaid providers. Finally, one commenter

suggested that the State extend the transition of care period (i.e., the period during which patients are allowed to keep their existing provider) from six months to a year.

State Response:

The Initiative has been designed to incorporate mechanisms to ensure State funding to MCOs is spent on the delivery of services to enrollees and that quality outcomes are achieved. For example, home and community based services waiver metrics include, among other things, an assessment of whether enrollees received the all of the services outlined in their plan of care and a review of whether waiver provider enrollment applications were verified against appropriate licensing and/or certification agencies. Further, the State may require corrective action(s) and implement intermediate sanctions depending upon the nature, severity, and duration of the deficiency, and repeated nature of the non-compliance. Additionally, MCOs will have a portion of their State payments withheld; payment of the withhold amount can only be obtained by the MCO if it achieves defined quality outcomes. The State will also establish escalating targets for each quality measure in future years of the program. This means if MCOs do not achieve better results each year they will not be eligible for payment of their withheld amounts. Additionally, the State has established a medical loss ratio (MLR) to ensure State funding is spent on the delivery of services to members. An MLR caps the portion of State dollars that can be spent by the MCO on non-healthcare related services such as administration, marketing, and profits. The State will recoup funding if an MCO does not meet the required MLR. No changes have been made to the waivers as a result of these comments. With respect to extending the transition of care period, the State will be monitoring and assessing provider networks on an ongoing basis post implementation to ensure that beneficiaries' continuity of care for beneficiaries transitioning to managed care, as well as ongoing member access.

IV. Home and Community Based Services (HCBS)

Comments Received:

Multiple comments were received related to the provision of home and community based services (HCBS). Commenters expressed the importance of emphasizing HCBS over institutional services. They indicated there should be requirements and incentives for MCOs to move the State toward supporting community integration and suggested future cost savings be used to increase access to HCBS. However, it was also noted that there are access issues for community-based services that will prevent such movement. Also related to access, one commenter expressed concern that provider access would be compromised if MCOs were allowed to limit HCBS providers. Further, one commenter was concerned the Initiative would strive to move enrollees to individual apartments and out of group homes. One commenter also questioned how individuals residing in group homes would be impacted if residents were enrolled with different MCOs.

Commenters also discussed the importance of MCOs involving and partnering with family caregivers for HCBS waiver enrollees. Support for the Consumer Choices Option was expressed and individuals wanted this maintained under managed care.

Multiple comments were received related to HCBS waiver waiting lists. Specifically, commenters suggested waiver waiting lists be eliminated, or additional waiver slots added. Alternatively, it was proposed waiver enrollees be excluded from managed care until there is no waiting list. Another commenter raised the concern the MCOs would eliminate waiver slots. One commenter expressed concern with the current process for managing the waitlist and suggested individuals have a functional assessment completed upfront to prevent ineligible individuals from being placed on the waiting list. Other commenters indicated HCBS waiver enrollees should be excluded from managed care enrollment; they pointed to current strategies, which already manage waiver enrollee care, such as proposed rules for implementing budget caps.

Comments were received regarding provider types that should be eligible HCBS waiver providers. Commenters indicated Home Care Agencies should be added as an eligible provider type, which includes providers who meet the definition of an authorized provider under 641 Iowa Administrative Code 80.2(135). Another commenter indicated language regarding home care agencies should be removed, as IDPH is no longer contracting for homemaker services. Additionally, one commenter suggested the Area Agencies should not be allowed to provide services in areas where there are at least two other providers and that having the Area Agencies maintain case managers is a conflict of interest. Another commenter suggested Medicare/Medicaid certification should not be required to provide homemaker services to members. Further, comments were received related to the assessment process. One commenter indicated members already undergo extensive assessments and the results of those should be used. Another commenter expressed concern over the perception that the assessment process would no longer be uniform. Another commenter noted that the waiver and MCO request for proposals do not reference 441 Iowa Administrative Code Chapter 24, and that the amount of time a waiver enrollee is visited does not match the current regulation. Finally, one commenter expressed concern that Integrated Health Homes and BHIS were not mentioned in the waivers.

Children's Mental Health Waiver Specific Comments:

One commenter requested that the consumer choices option (CCO) be added to the waiver.

Elderly Waiver Specific Comments:

One commenter requested that the Appanoose Community Care Services be eligible to enroll as a service provider for homemaker and personal emergency response systems. Another commenter requested the addition of shared living and adult foster care as covered services under the Elderly Waiver. One commenter indicated the following language should be changed; however, the State is unable to make such a change as this is language from the Centers for Medicare and Medicaid Services (CMS) preprint application: “[t]he State assures that necessary safeguards have been taken to protect the health and welfare of persons receiving services under this waiver,” should be revised to “will be taken,” as the State does not have standards for direct caregivers.” This commenter also indicated the lifetime limit for a home modification is not realistic and MCOs should be provided additional flexibility.

ID Waiver Specific Comments:

Comments were received indicating that with the ID waiver accounting for the majority of HCBS waiver spending and new rules being promulgated to cap budgets managed care does not seem necessary.

State Response:

The State shares commenters' commitment to the emphasis on HCBS versus institutional care. This is one benefit of managed care as incentives are provided to move individuals into the community; as such, the number of individuals served under the waivers is projected to increase under the Initiative. The Initiative also strives to support and increase HCBS provider access; MCOs are held accountable for meeting contractual requirements for HCBS access standards and must authorize out-of-network care when it cannot be provided in-network. Additionally, DHS concurs with commenters' support of the Community Choices Option; as such, this is a key component of the program that MCOs must implement. While the State appreciates the concerns raised regarding inclusion of §1915(c) waiver enrollees, our belief is managed care will provide better integrated care with one single entity responsible for providing all services, including LTSS. Further, while we agree there are current management mechanisms in place for waiver enrollees, the Initiative will build upon such strategies.

With respect to eligible HCBS waiver providers, these categories are established in the Iowa Administrative Code and can only be changed through the administrative rulemaking process. The State will review and consider amendments to the list of eligible HCBS waiver providers in future rulemaking. Further, providers serving Medicaid beneficiaries, regardless of delivery system, must be enrolled with Iowa Medicaid. These certification and enrollment processes help assure qualified individuals are rendering services and provide member protections.

Regarding the references to 441 Iowa Administrative Code Chapter 24, this particular set of rules establishes case management enrollment criteria. MCOs will be required to meet the expectations in 441 Iowa Administrative Code Chapter 90, which sets forth rules for case management, including service plan requirements.

Regarding comments received on the assessment process, it appears there has been some misunderstanding regarding how the assessment process will occur under managed care. The current functional assessment tools will remain in use and MCOs cannot revise or add to the tools without express approval from the State. To the extent the State would consider proposed revisions or additions, consensus among MCOs and stakeholder engagement would be sought.

Finally, regarding the concern raised that lifetime limits should not apply to home modifications on the Elderly Waiver, as described in Appendix C of the waiver, there is a mechanism through the Exception to Policy process for requests to be reviewed when a member's need exceeds the lifetime limit. Further, no changes were made to the covered benefits under the waiver due to the implementation of managed care. However, MCOs will have the flexibility to provide enhanced services with DHS approval.

V. MCO Oversight/Evaluation

Comments Received:

Several comments were received related to MCO oversight and evaluation. Generally, commenters suggested this should be conducted by an independent entity and that results should be made publically available. One commenter suggested there should be more focused quality and pay-for-performance measures related to children's health. Commenters suggested a range of measures and factors that should be reviewed and monitored, such as network adequacy, audits of MCO claims payments, grievances and appeals, and healthcare quality outcomes. One commenter suggested the MCOs should be required to use a consistent quality measurement process.

State Response:

The State has implemented a comprehensive oversight strategy consisting of elements such as: (1) an MCO readiness review conducted by an independent entity prior to member assignment; (2) an annual external quality review; (3) an independent assessment in accordance with the §1915(b) waiver; (4) a pay-for-performance program; (5) contractual non-compliance remedies; (6) use of an Ombudsman; and (7) various quality monitoring strategies and metrics as outlined in each waiver and the MCO contracts. In addition the State is obligated to provide regular reports to CMS for §1115 Demonstration projects and §1915 HCBS waivers.

Pursuant to State legislation (Senate File 505), the Iowa Department of Human Services (DHS) will also be conducting monthly statewide public meetings, beginning March 2016, to gather input from members, stakeholders, providers, community advocates and the general public on the managed care transition and implementation. All comments will be compiled and shared with the Iowa Medical Assistance Advisory Council (MAAC), which serves as an advisory forum on the health and medical care services provided under Medicaid. The MAAC Executive Committee will be responsible for assessing feedback received and making formal recommendations to the Iowa Department of Human Services. The Executive Committee meets monthly and consists of members from both professional and consumer organizations, as well as the general public. Current organizational representation of the Executive Committee includes the Iowa Department of Public Health, the Iowa Hospital Association, the Iowa Health Care Association/Iowa Center for Assisted Living, the Iowa Medical Society, the Iowa Association of Community Providers, the Iowa Pharmacy Association, AARP, the Coalition for Family and Children's Services in Iowa, the Iowa Association for Area Agencies on Aging, and NAMI Iowa.

No changes related to the MCO monitoring, oversight or quality assessment related portions of the waivers were made as a result of these comments.

VI. Eligibility/Included Benefits

Comments Received:

Several comments were received related to populations eligible for managed care. One commenter suggested the State exclude individuals who rely on plasma protein therapies or alternatively to allow such users to maintain access to current specialists and therapies. Another commenter expressed concern about the inclusion of individuals with mental health issues. A third commenter suggested the State change its position to require all MCOs to carve in Medicaid managed care prescriptions and other products into the 340B drug-pricing program. One commenter perceived the exclusion from managed care enrollment during a member's retroactive eligibility period as elimination of retroactive eligibility. Finally, one commenter suggested the State require MCOs to extend non-emergency transportation (NEMT) services to all patients, regardless of the individual Medicaid coverage program for which they qualify.

State Response:

The State has opted not to modify the eligibility criteria for managed care enrollment. MCOs are contractually bound to continuity of care requirements to prevent disruption for individuals reliant on plasma protein therapy. Further, the delivery of behavioral and physical health services by a single entity will promote coordinated care that addresses the full healthcare needs of members versus the current system which silos mental health and primary care. As a point of clarification for commenters, the State has not requested a waiver of retroactivity. Rather, individuals will simply not be enrolled in managed care during this time period and any costs incurred during retroactive periods will be reimbursed through fee-for-service. Finally, pursuant to an agreement with CMS, the State has conducted an analysis of Medicaid member survey responses on difficulties with transportation for beneficiaries subject to the Iowa Health and Wellness Plan (IHAWP) NEMT waivers as compared to survey responses of persons who have access to NEMT services. Findings of this analysis suggest there was not a statistically significant difference between the two populations; however, CMS requested an additional study supporting more granular analysis capability. As a result, the State was allowed to continue to waive NEMT services for members receiving coverage under the IHAWP (who are not medically exempt and who are not eligible for EPSDT services) through March of 2016, while additional data is gathered and analyzed.

VII. Provider Issues

Comments Received:

Another theme noted among comments was the impact of the Initiative on providers and in turn the importance of ensuring sufficient provider training. One commenter requested more detailed information be included in the waivers about how the MCOs will invest and continue to build and offer new payment relationships in partnership with providers.

Some comments were received related to medical professionals versus MCOs being best suited to determine a patient's care plan and whether or not the prudent layperson standard for

emergency services is met. Further, it was suggested that the State should require every patient to be assigned a primary care provider (PCP), versus the current requirement that requires a minimum of 40% of the MCO's population be in a value-based purchasing arrangement with an assigned PCP by 2018.

The concern was raised that managed care savings would come at the expense of providers. Further, one commenter noted his staff will be required to devote time to working with MCOs, a service which will not be reimbursable. Similarly, it was suggested any providers currently credentialed under Medicaid should be automatically credentialed by the MCOs. Finally, one commenter recommended the claims submission timeline be expanded.

State Response:

The State concurs that provider training will be imperative to ensure a smooth transition; plans have been developed to address provider communications, outreach and training. Further, we appreciate the request that more detailed information be provided regarding MCO strategies to develop new payment partnerships with providers; as MCO contracts have been recently awarded, these types of details can begin to be provided. The State recognizes that provider education is critical to successful implementation of the Initiative. On August 20, 2015 the State announced that it would be offering live provider education sessions on the transition to managed care in eleven different communities throughout the State during the Month of September. In an effort to meet the anticipated demand for information, the same training session will be offered twice in each community where it is presented.

Regarding the authorization of services, MCO practice guidelines must be developed based on valid and reliable clinical evidence or consensus of healthcare professionals in the particular field. Further, MCOs are required to assure appropriate clinical expertise and training to interpret and apply the utilization management criteria and practice guidelines and must consult with the requesting provider when appropriate. The MCOs must document access to board certified consultants to assist in making medical necessity determinations and any decision to deny a service authorization request or to authorize a service in an amount, duration or scope that is less than requested must be made by a physical health or behavioral health care professional who has appropriate clinical expertise in treating the member's condition or disease, or in the case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

The State concurs that developing streamlined processes, such as credentialing, will be useful in some cases to minimize provider burden. However, automatic deeming of current Medicaid providers will not be implemented. To support quality, the MCOs are required to maintain national accreditation; therefore, the MCOs must maintain credentialing and re-credentialing processes that meet the standards of the accreditation entity.

VIII. Enrollment

Comments Received:

Several comments were received related to member enrollment. Generally, commenters expressed concern that they do not understand how the enrollment process will work, specifically whether they will have a choice in selecting MCOs, whether they will be allowed to change following enrollment and how the auto-assignment algorithm would operate. Comments revealed there was some misperception regarding how the implementation enrollment process would occur. The importance of sufficient member outreach and use of an unbiased Enrollment Broker during the implementation enrollment period was stressed by commenters. One commenter indicated it was important individuals eligible for both MCO and Program of All-Inclusive Care for the Elderly (PACE) enrollment be presented with the option to enroll in either program. Some commenters perceived the tentative assignment process as limiting member choice and creating the perception that assignment has already been made, as described in further detail in the Member Choice section below.

State Response:

The State will continue efforts to increase beneficiary understanding of the enrollment process. Communication efforts will be ramping up now that the MCOs have been selected. The State's goal is to ensure a seamless transition for current beneficiaries and to provide ample opportunity for informed decision-making regarding MCO selection. The tentative assignment process is intended to advise members of which MCO they will be assigned to in the absence of a choice; this will provide clarity on what will occur if contact to the State is not made regarding an alternative choice. Further, the State will utilize an independent Enrollment Broker to assure no conflict of interest in the MCO enrollment and choice counseling process. The option for PACE enrollment will also be provided.

IX. Member Choice

Comments Received:

Several comments were received related to member choice of MCO. In general, these commenters expressed concern that the State's proposed process to facilitate MCO selection through tentative assignment would reduce member choice. One commenter indicated that institutionalized beneficiaries would be given a choice of MCO before assignment, whereas non-institutionalized beneficiaries would not be given a choice of MCO before assignment. Another commenter suggested that in the event that two MCO options are not available, a consumer should have the opportunity to request an alternative option to receive services and that in the event a designated MCO is not providing the necessary and appropriate services, the consumer should be able to request to change MCOs.

State Response:

The proposed tentative assignment process is intended to facilitate a smooth transition between delivery systems and to provide numerous opportunities for members to make informed choices regarding MCO enrollment. As described in the published waivers, the State will begin accepting MCO selections from current Medicaid beneficiaries beginning in fall 2015. Members will receive a tentative, or preliminary, assignment that takes into consideration such factors as related family member assignment, and geographic considerations. Once receiving this tentative assignment, members will have an opportunity to choose another MCO prior to the assignment becoming effective, with the support of an independent Enrollment Broker. A member's MCO assignment for January 2016 will become effective on December 17, 2015 based on their tentative assignment if an alternative choice is not made. Members will also have ninety days to change MCOs without cause after the assignment or member choice is effective. Finally, all members may change their MCO annually and may disenroll for certain good cause reasons.

While the State will not be amending the proposed tentative assignment process, it will consider implementing several commenters' operational recommendations. Specifically, enrollment notices will be presented to members in a way that sets forth enrollment options first, and then describes the tentative assignment process. This is intended to assist members to understand their right to select the MCO that best meets their needs. Further, sample notices will be sent providers, including case managers, via the Individualized Services Information System (ISIS) and through Informational Letters to assist with disseminating information. Finally, the State will investigate the feasibility of conducting member interviews to assess the whether there is an enrollment manipulation.

X. Outreach

Comments Received:

Several comments were received related to member outreach. In general, these commenters felt the State should solicit greater stakeholder input in developing the Initiative and that members were unaware of the implications of the transition to managed care. One commenter suggested the State monitor the effectiveness of the oversight committee and public meetings, and make modifications to the Initiative as needed. Another commenter suggested that the state establish an open enrollment period.

State Response:

The State has developed a robust communication and education plan regarding the Initiative. On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, various meetings with stakeholder committees and organizations, as well as a series of public meetings to solicit feedback on key program design elements and MCO contract requirements. Stakeholders have also had the opportunity to comment on the Initiative through the public notice and hearing process, during which time stakeholders were invited to review waiver documents, provide comment, and ask questions of State staff. Finally, the State has regularly issued press releases,

“Frequently Asked Questions” documents, fact sheets, and presentation documents to help inform the public and to facilitate an ongoing dialogue regarding the Initiative.

While the State will not be amending the proposed waivers, it will be adopting several commenters’ recommendations. Specifically, the State will continue to work with member advocacy organizations to communicate the transition to members and to ensure they understand its impact. In addition, the State will begin facilitating training sessions for providers over the coming months to ensure continuity of care and reimbursement under the Initiative. Finally, during the enrollment process, the State will review and work to update its HCBS enrollee database to facilitate effective transmission of information.

XI. Implementation Timeline

Comments Received:

Several comments were received related to the implementation timeline for the Initiative. In general, these commenters felt the implementation date of January 1, 2016 may be aggressive, could jeopardize member health and safety, could cause claims processing issues, and may not allow time for MCOs to establish provider networks. Recommendations have been made to postpone implementation to at least July 1, 2016, and/or to proceed with a “phased” approach ending with HCBS Waiver enrollees.

State Response:

The State has implemented multiple strategies to assure beneficiary continuity of care will be achieved as part of the implementation and is committed to maintaining the existing timeline for implementation. To begin with, a comprehensive readiness review process will be established to ensure that all MCOs are prepared to initiate operations prior to January 1, 2016. This process will assess the MCOs’ capability to provide services in accordance with their contract in areas such as, maintaining provider networks, processing service authorizations, and paying claims within contractually required timeframes. No MCO will be permitted to enroll members without meeting the State’s expectations for readiness. Finally, the State has selected MCOs with demonstrated experience serving Medicaid enrollees, and that are well positioned to help the State achieve its goals under the Initiative.

XII. Reimbursement

Comments Received:

Several comments were received related to MCO and provider reimbursement. With respect to MCOs, commenters suggested that the State conduct audits of payments to MCOS to ensure plan compliance and performance. One commenter suggested that the established rates were not actuarially sound and were not developed according to CMS guidelines. Concerning providers, commenters suggested that the State increase current reimbursement rates, that critical access hospitals continue to be paid on a cost-basis, that MCOs be required to make per-member/per-month payment to primary care providers, and that MCOs pay providers at a level not less than

the most recent DRG base rates for inpatient services and the most recent MAPC rates for outpatient services. Two commenters also suggested the State's limitation of indirect administrative costs to 23% under 441 Iowa Administrative Code 79.1(d)(3) (i.e., methodology for determining the reasonable and proper cost for fee-for-service providers of case management) was too high. Finally, several commenters supported the State's efforts to preserve the Hospital Assessment program during implementation of managed care.

State Response:

Rates established for the Initiative meet the rate-setting criteria established by the CMS, have been certified as being actuarially sound, and will be provided to CMS for review and approval. Further, the proposed medical loss ratio requires that MCOs spend at least 88% of premium dollars on medical care (i.e., at least \$0.88 of every premium dollar must be spent on medical care, while the remaining \$0.12 can go toward administration and profits). This not only consistent with the majority of states implementing managed care, it also meets the standard set forth in the recently proposed CMS rule regarding Medicaid managed care (CMS-2390-P).

MCOs are required to reimburse all in-network provider types at rates that are equal to or exceed the Agency designated floor for current Iowa Medicaid fee-for-service rates. These rates are established pursuant to 441 Iowa Administrative Code 79.1. Generally, institutional providers are reimbursed on a prospective or retrospective cost-related basis, and practitioners are reimbursed according to a fee schedule. The latter are determined with advice and consultation from appropriate professional groups and are increased on an annual basis by an economic index reflecting overall inflation as well as inflation in office practice expenses of the particular provider category involved. Fee schedules in effect for the providers covered by fee schedules can be obtained at: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>. Payment levels for fee schedule providers of service may be altered upon direction of the Iowa Legislature through Medicaid appropriations. All provider rates are part of Iowa Administrative Code and are subject to public notice and comment any time there is change.

Finally, MCOs must establish performance-based incentive systems for their contracted providers, subject to State approval prior to implementation and before making any changes to an approved incentive. Incentive programs will be structured to encourage positive member engagement and health outcomes that are tailored to health issues prevalent among enrolled membership. The MCOs must provide information concerning its physician incentive plan, upon request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in federal regulations.

XIII. Quality/Safety

Comments Received:

Several comments were received related to the quality of services provided to beneficiaries following the transition to managed care. Generally, commenters felt that the current delivery system was capable of providing higher quality services to beneficiaries.

State Response:

Increasing the quality of care and improving health outcomes for all beneficiaries is the primary goal of the Initiative. As such, MCOs are contractually obligated to, and will be held accountable for, improving quality outcomes and developing Quality Management/Quality Improvement (QM/QI) programs with objectives that are measurable, realistic and supported by consensus among the MCO's medical and quality improvement staff. Through the QM/QI program, MCOs must have ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of healthcare services to its members. Quality information must be made available to members based on their preferred method of communication. As a key component of its QM/QI program, MCOs must develop incentive programs for both providers and members, with the ultimate goal of improving health outcomes. All QM/QI programs are subject to state approval. Further, all MCOs will be assessed according to standards established by the State and are required to provide all information and reporting necessary to complete this assessment. In accordance with federal law, the State will regularly monitor and evaluate MCO compliance with the standards established by the State and the MCOs QM/QI program. Finally, MCOs will be required to attain and maintain accreditation through the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). In the event an MCO fails to attain and maintain accreditation in the required timeframe, the MCO must submit a formal corrective action plan for State review and approval.

Separate from the above considerations, Iowa was one of eleven states awarded a State Innovation Model (SIM) grant to test whether quality and value oriented healthcare reforms could produce superior results when implemented in the context of a state-sponsored Plan. The \$43 million grant was announced in December of 2014, and was incorporated into Iowa's managed care approach via specific requirements for Value Based Purchasing (VBP) and a common quality measurement tool, called the Value Index Score (VIS) that is used across delivery systems. Because the VIS measures quality at a population health level, it ensures MCO savings is linked to whole-system improvement supporting all members, not just managing isolated pockets of opportunity within the Medicaid population. This initiative is a multi-payor strategy that aligns Medicaid with Wellmark Blue Cross and Blue Shield (specifically) and Medicare (more generally) bringing the scale necessary to influence real delivery system reform across the state.

Finally, the Initiative has been designed to provide high quality health care and create a level of accountability that does not exist today. The State will conduct ongoing reviews of MCO accreditation requirements to ensure standards are maintained. Further, the State monitor MCOs on a variety of key metrics on an on-going basis (e.g., provider network and access standards).

XIV. MCO Standardization

Comments Received:

Several comments were received related to the standardization of processes across MCOs and concern that variations may be cumbersome for providers. For example, recommended areas of alignment included: (1) primary care provider assignment and algorithms; (2) quality and performance measures; (3) approach to processing, analyzing, and sharing claims and other data

with providers; (3) consistent approaches to value based contracting with providers; (4) provider credentialing and application processes; (5) prior authorizations/approvals forms and processes; (6) prescription management; (7) program requirements for chronic conditions and integrated health homes; (8) utilization management processes; (9) health risk assessment tools; and (10) processes to identify 340B claims.

State Response:

The commercial market does have variation across health plans for different operational processes so some variation is to be expected. The MCOs are required to provide training to providers on key procedures and the State will monitor key processes after the Initiative is implemented and consider adjustments if necessary. The state will also collaborate with the MCOs to ensure that processes are developed as consistently and efficiently across MCOs as possible. In addition, common approaches may be leveraged to support overarching goals, such as the required use of VIS across all MCO's as a standard to measure delivery system quality within value based purchasing.