STATE PLAN UNDER TITLE XIX OF THE SOCIAL SECURITY ACT

State: IOWA

MEDICAL MANAGED HEALTH CARE (MHC)
MediPASS (PCCM)

Citation: Section 1932 of the Social Security Act

A. General Description of the Program

1. This program is called Medical Managed Health Care (MHC). All Medicaid beneficiaries as described in Section C are required to enroll in the MediPASS program, a primary care case management (PCCM) program. Those described in Section D 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 recipients into the MediPASS program, where the assigned medical practitioner will authorize all primary care services and all necessary specialty services. 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 recipients enrolled in the program.

5. Recipients 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 recipient'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 recipient with a choice between at least two MediPASS PMs. Recipients 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 recipients may make an informed decision. (See Section E for more details.)

6. Non-MCO contractors will act as enrollment brokers in assisting eligible recipients 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 requires recipients 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.

8. MediPASS will operate in all counties of the state except in those geographical areas without an adequate number of patient managers participating in MediPASS. Mandatory assignment will only occur if the recipient has a choice between at least two MediPASS PMs.

9. The state has in place a public process which complies with the requirements of Section 1902(a)(13)(A) of the Social Security act for changes to this state plan section. Notification will be sent to newspapers throughout the state of Iowa including the 5 with the largest daily circulation.

B. 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.

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.

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

C. Target Groups of Recipients

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

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

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

D. Mandatory Enrollment Exclusions

1. The following groups will not be enrolled in managed care:

   a. Dual Medicare – Medicaid eligibles.

   b. Recipients enrolled in the Medically Needy program.

   c. American Indians who are members of federally recognized tribes. 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 1,300 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.

   d. Children under 19 years of age who are any of the following:

      (1) Eligible for SSI under Title XIX.

      (2) Described in Section 1902(e)(3) of the Social Security Act.

      (3) In foster care or other out-of-home placement.

(4) Receiving foster care or adoption assistance.

(5) Receiving services through a family centered, community–based coordinated care system receiving grant funds under Section 501(a)(1)(D) of Title V. Recipients 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.

e. Recipients who are residing in a nursing facility or ICF/MR.

f. Recipients who have an eligibility period that is only retroactive.

g. Recipients who participate in a home and community-based waiver.

h. Recipients who are older than 65 years of age.

i. Recipients who have commercial insurance paid under the Health Insurance Payment Program.

j. Recipients placed into the "lock-in" program by the Department after consultation with the Iowa Foundation for Medical Care.

E. Enrollment and Disenrollment

1. All recipients will be given the opportunity to choose from at least two MediPASS providers. If a recipient has a prior provider relationship that they wish to maintain, the enrollment broker will assist the recipient in choosing a PM 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.

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

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

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

f. Process the recipient's choice of PM and send enrollments to the Department for inclusion on the next monthly medical card.

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

h. Review recipient'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, recipient and provider educational correspondence, and utilization review for MediPASS providers.

j. Supplies an enrollment packet to the recipient that includes informing materials and information supplied by the state.

k. Provides enrollment counseling which includes:

   (1) Inquiring about patient/provider experience and preference.

   (2) Providing information on which MediPASS PMs are available to maintain a prior patient-provider relationship.

   (3) Providing any information and education concerning the enrollment process, benefits offered, the enrollment packet, and any of the other information provided for in this section.

l. If the recipient fails to choose a MediPASS PCCM provider within a minimum of 10 calendar days after receiving enrollment materials, the Department assigns the recipient to a PCCM.

m. Iowa allows patient managers to assist in enrolling beneficiaries. There are times when 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 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 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.

3. Information in an easily understood format will be provided to beneficiaries on providers, enrollee rights and responsibilities, grievance and appeal procedures, covered items and services, benefits not covered under the managed care arrangement.

4. Any selection or assignment of a PM may be changed at the request of the recipient 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, the recipient can change from one PM to another without cause.

6. Enrollees will be provided notification 60 days before the end of a lock-in period of their opportunity to make a new choice of PM.

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

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

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

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

11. As stated in Section E.5, an enrollment period shall not exceed nine months. 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 recipient will be informed at the time of enrollment of the right to disenroll.

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

F. Process for Enrollment in an PCCM

The following process is in effect for recipient enrollment in the MHC Program:

1. The Department shall provide beneficiaries with information in an easily understood format 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 MCEs regarding benefits and cost sharing, service areas, and quality and performance (to the extent available).

2. All materials will be in an easily understood format (6th grade reading level or less). Materials will be translated into languages other than English if 10% of the population or 1,000 people in a service area speak a language other than English as their primary language.

3. Recipients will be able to select a PM from a list of available managed care entities in their county as well as those in contiguous counties. If the recipient wishes to remain with a patient manager with whom a patient/provider relationship is already established, the recipient is allowed to do so. Each recipient shall notify the Department by mail, telephone or in person, of his or her choice of PM. If voluntary selection is not made within the 10-calendar day period describe above, the Medicaid program shall assign a PM in accordance with the procedures outlined in E above.

4. As indicated in Section E, if the recipient does not choose a PM, the Department will assign the recipient to a PM and notify the recipient of the assignment.

5. The PCCM will be informed electronically of the recipient's enrollment.

6. The recipient will be notified of enrollment and issued an identification card.

G. Covered Services

1. Services not covered by the MHC program will be provided under the Medicaid fee-for-service program. Medicaid recipients will be informed of the services not covered under the MHC Program, the process for obtaining such services. The required coordination is specified in the state contract with PMs and is specific to the service type and service provider.

2. The PCCM shall be responsible for managing the services marked below in column (7). All Medicaid-covered services not marked in those columns will be provided by the Iowa Plan (under the requirements of that program) or Medicaid fee for service (without referral). Mental health and substance abuse treatment services are provided under the Iowa Plan for Behavioral Health under the current 1915(b) waiver in effect for those services.

Service (1)	State Plan Approved (2)	PCCM Referral/ Prior Auth. Required (7)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Day Treatment Services	X	X	
Dental	X		X
Detoxification	X		
Durable Medical Equipment	X	X	
Education Agency Services	X		X
Emergency Services	X		X
EPSDT	X		X
Family Planning Services	X		X
Federally Qualified Health Center Services	X	X	
Home Health	X	X	
Hospice	X	X	

Service (1)	State Plan Approved (2)	PCCM Referral/ Prior Auth. Required (7)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Inpatient Hospital – Psych	X		X
Inpatient Hospital – Other	X	X	
Immunizations	X		X
Lab and X-ray	X	X	
Nurse Midwife	X	X	
Nurse Practitioner	X	X	
Nursing Facility	X		X
Obstetrical Services	X	X	
Occupational Therapy	X	X	
Other Fee-for-Service Services	X	X	
Other Psych. Practitioner	X		X
Outpatient Hospital – All Other	X	X	
Outpatient Hospital – Lab & X-ray	X	X	
Partial Hospitalization	X	X	
Pharmacy	X		X
Physical Therapy	X	X	
Physician	X	X	
Prof. & Clinic and Other Lab and X-ray	X	X	
Psychologist	X		X

Service (1)	State Plan Approved (2)	PCCM Referral/ Prior Auth. Required (7)	PCCM Referral/Prior Authorization Not Required or Non-Waiver Services (9)
Rehabilitation Treatment Services	X		X
Respiratory Care	X	X	
Rural Health Clinic	X	X	
Speech Therapy	X	X	
Substance Abuse Treatment	X		X
Testing for Sexually Transmitted Diseases	X	X	
Transportation – Emergency	X	X	
Transportation - Non-emergency			
Vision Exams and Glasses	X		X

H. Mandates

1. With respect to MediPASS, the contracts Iowa enters into with PMs will contain (at a minimum) all terms required under section 1905(t)(3). Reimbursement will be made on a fee-for-service basis, with a $2.00 monthly case management fee for each MediPASS recipient assigned. The following is a list of the types of providers that qualify to be primary care providers under the MHC program: doctors of medicine or osteopathy or advanced registered nurse practitioners practicing in the following areas: family practice, general practice, pediatrics, internal medicine, or obstetrics and gynecology; FQHCs, or RHCs).

2. All participating patient managers shall be required to sign a MediPASS participation agreement in addition to the standard Medicaid provider agreement and shall be bound by its terms and conditions. Each PM shall be required to specify the number of recipients the PM is willing to serve as patient manager. Unless circumstances exist which require the Department to authorize a higher quota for a PM to ensure adequate coverage in an area, the maximum shall be 1,500 recipients per patient manager. In addition, the Department does increase the enrollment limit by 300 for MediPASS providers that have a physician assistant participating in the program. (See also Item K.11.)

3. Patient managers under the MHC program must:

   a. Be Medicaid-qualified providers and agree to comply with all applicable federal statutory and regulatory requirements, including those in Section 1932 of the Act, 42 CFR 434, and requirements in 42 CFR 438 and all State plan standards regarding access to care and quality of service;

   b. Sign a contract or addendum for enrollment as a patient manager which explains the patient manager's responsibilities and complies with the PM contract requirements in Section 1905(t)(3) of the Act including: making available 24-hour, 7 days per week access by telephone to a live voice (an employee of the patient manager or an answering service) or an answering machine which will immediately page an on-call medical professional for information, referral, and treatment of medical emergencies; referrals for non-emergency services; or to information about accessing services or how to handle medical problems during non-office hours;

   c. Provide comprehensive primary health care services to all eligible Medicaid beneficiaries who choose or are assigned to the primary care case manager's practice;

   d. Refer or have arrangements for sufficient numbers of appropriate health care professionals to ensure that services under the contract can be furnished to enrollees promptly and without compromise to quality of care;

   e. Have hours of operations that are reasonable and adequate. The MediPASS provider must have the same hours of operation for the MHC enrollees as they have for their other patients. The Department requires all MediPASS providers to have 24-hour access via telephone. This does allow for another provider to be on-call for the MediPASS provider during non-office hours. The MediPASS provider must respond to a referral request phone call within 30 minutes;

   f. Not refuse an assignment or disenroll an enrollee or otherwise discriminate against an enrollee solely on the basis of age, sex, race, physical or mental handicap, national origin, or health status or need for health services, except when that illness or condition can be better treated by another provider type;

   g. Take beneficiaries in the order in which they enroll with the patient manager;

   h. Not have an affiliation with person debarred, suspended, or otherwise excluded from federal procurement activities per Section 1932(d)(1) of the Act;

i. Restrict enrollment to people residing sufficiently near a service delivery site of the patient manager to be able to reach that site within a reasonable time using available and affordable modes of transportation;

4. Qualifications and requirements for PMs are noted in the provider agreements. MediPASS PMs shall meet all of the following requirements:

a. A PM shall be a Medicaid-qualified provider and agree to comply with all pertinent Medicaid regulations and state plan standards regarding access to care and quality of services.

b. The MediPASS PM shall provide comprehensive primary health care services to all eligible Medicaid recipients who choose, or are assigned to, the MediPASS Program.

c. The MediPASS PM shall refer enrollees for specialty care, hospital care, or other services when medically necessary.

d. The MediPASS PM shall make available 24-hour, 7-day-a-week access by telephone to a live voice (a representative or a representative of the MediPASS PM) or an answering machine which will immediately direct an enrollee as to how to contact an on-call medical professional, so that referrals can be made for non-emergency services and information can be given about accessing services or how to handle medical problems during non-office hours.

e. The MediPASS PM shall not refuse an assignment, disenroll a participant, or otherwise discriminate against a participant solely on the basis of age, sex, physical or mental disability, national origin, or type of illness or condition, except when that illness or condition can be better treated by another provider type.

f. The MediPASS PM shall request reassignment of the participant to another MediPASS PM only if the patient/provider relationship meets "good cause" reasons. The Department does allow PMs to request that an enrollee be disenrolled or prohibited from enrolling for good cause. All reassignments must be state-approved. Good cause is defined as enrollment harmful to the enrollee.

The Department reviews all 'good cause' reasons for transfer on a quarterly basis via the reports from the enrollment broker. The Department meets with the enrollment broker weekly to review all current issues, including any requests for disenrollment by any MediPASS provider.

g. Access to medically necessary emergency services shall not be restricted. "Emergency medical condition" means a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect the absence of immediate medical attention to result in (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, (ii) serious impairment to bodily functions, or (iii) serious dysfunction of any bodily organ or part.

h. Iowa ensures enrollee access to emergency services by requiring the PCCM to provide adequate information to all enrollees regarding emergency service access.

i. Iowa ensures enrollee access to emergency services by including in the contract requirements for coverage of the following.

(1) The screening or evaluation and all medically necessary emergency services, when an enrollee is referred by the PM to the emergency room, regardless of whether the prudent layperson definition was met,

(2) The screening or evaluation, when an absence of clinical emergency is determined, but the enrollee's presenting symptoms met the prudent layperson definition,

(3) Both the screening or evaluation and stabilization services, when a clinical emergency is determined,

(4) Continued emergency services until the enrollee can be safely discharged or transferred,

(5) Post-stabilization services that are pre-authorized by the patient manager, or were not pre-authorized, but the patient manager failed to respond to request for pre-authorization within one hour, or could not be contacted. Post-stabilization services remain covered until the patient manager contacts the emergency room and takes responsibility for the enrollee.

I. Additional Requirements

1. Any marketing materials available for distribution under the Act and state statutes shall be provided to the Department for its review and approval.

2. The PCCM shall utilize the state fair hearing process for grievances and appeals.

J. FQHC and RHC Services

If the enrollee elects not to select a managed care choice that gives access to FQHC services, no FQHC services are required to be furnished to the enrollee while the enrollee is enrolled with the PCCM selected. In any event, since reasonable access to FQHC services will be available under the MHC program, FQHC services outside the program will not be available.

All of the FQHCs in the state are participating in the MediPASS program. This allows any recipient to be able to select the FQHC as the patient manager. FQHC reimbursement will follow all applicable federal requirements.

K. Access to Care

Iowa assures that recipients will have a choice between at least two MediPASS PMs. When fewer than two choices are available in the geographic area, the managed care program is voluntary. In addition to this process, the MHC program is not likely to substantially impair access because of the following:

1. Recipients may choose any of the participating MediPASS PMs in the service areas.

2. The same range and amount of services that are available under the Medicaid fee-for-service program are available for enrollees covered under the MHC Program.

3. Access standards for distances and travel miles to obtain services for recipients under the MHC program have been established. Specifically, the MHC program must have a primary care provider within 30 miles or 30 minutes.

   The Department utilizes the 30-mile/30-minute guideline for all MHC providers. The Department requires the enrollment broker to review each county for PM access on a quarterly basis in the MediPASS program. This report is submitted to the Department for review.

   The Department realizes that there are rural portions of the state that simply do not have certain specialists within a 30-mile/30-minute radius.

   The MediPASS option allows the PM to give a referral to any Iowa Medicaid provider, thus the panel of specialists would be the entire Iowa Medicaid provider network. This allows any MediPASS enrollee to see any specialist that accepts Iowa Medicaid. Therefore, this network is no less than the network available to a person not in the MHC program.

The Department realizes that there are some counties in the state that do not have a hospital. While the normal guideline is to have at least one hospital in the county being served, consideration is given to those counties without a hospital.

Additionally, if a county has multiple hospitals, the Department expects to see a fair representation on the provider network.

4. The number of providers to participate under the MHC program is expected to increase.

5. Primary care and health education are provided to enrollees by a chosen or assigned MediPASS PM. This fosters continuity of care and improved provider/patient relationships.

6. Pre-authorization is precluded for emergency care and family planning services under the MHC Program.

7. Recipients have the right to change PMs at any time if good cause is shown.

8. MediPASS PMs are required to provide or arrange for coverage 24 hours a day, 7 days a week.

9. Recipients have available a formal appeals process under 42 CFR Part 431, Subpart E. The same appeals hearing system in effect under the Medicaid fee-for-service program is in effect under the MHC program.

10. Iowa assures that state-determined access standards are maintained by quarterly analysis of provider panels.

11. Iowa has a limit (1,500) on the number of recipients that can be managed by a provider in the MHC program in effect under the MHC program. The limit guarantees access to appointments within acceptable time parameters for urgent and illness-related conditions as well as non-symptomatic preventive care. The number of Medicaid recipients also allows for the PM to serve a sufficient number of private-pay and commercially insured patients to create a mixture of patients reflective of the insurance status of the community may be required.

    The Department has designated a maximum limit for a MediPASS providers of 1,500 per provider. The Department allows an additional 300 enrollment for MediPASS providers with a physician assistant participating in the program.

There has been one exception to this limit in regards to the FQHC in Polk County. As Polk County has over 15,000 Iowa Medicaid recipients eligible for the MHC program, this county has the largest concentration of enrollees in the state. The FQHC has satellite clinics that serve a large portion of the county. For these reasons, the Department has allowed the FQHC in Polk County to have a maximum enrollment limit of 2,500 enrollees.