Table of Contents

State/Territory Name: Iowa

State Plan Amendment (SPA) #: 13-032

This file contains the following documents in the order listed:

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
601 East 12th Street, Suite 355
Kansas City, Missouri 64106

Division of Medicaid and Children's Health Operations

December 19, 2013

Charles M. Palmer, Director
Department of Human Services
Hoover State Office Building
1305 East Walnut, 5th Floor
Des Moines, Iowa 50319-0119

Dear Mr. Palmer:

On October 9, 2013, the Centers for Medicare & Medicaid Services (CMS) received Iowa's State Plan Amendment (SPA) transmittal #13-032. This SPA was submitted to include individuals eligible for the Wellness Plan thru Medicaid expansion under provisions of the Affordable Care Act as demonstrated in the applicable Section 1115 waiver and described under section 1902(a)(10)(A)(i)(VIII) of the Social Security Act. It should be noted that Iowa's quality management strategy should be updated by July 1, 2014, to reflect the Value Index Score utilized as described in the payment methodology.

Based upon the information received, we are now ready to approve SPA #13-032, as of December 17, 2013, with an effective date of January 1, 2014, as requested by the State. Enclosed is a copy of the CMS-179 form, as well as, the approved pages for incorporation into the Iowa State Plan. If you have any questions regarding this amendment, please contact Sharon Taggart at (816) 426-5925 or Sharon.taggart@cms.hhs.gov.

Sincerely,

//s//

James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

Enclosure

cc: Jennifer Vermeer

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

FORM APPROVED
OMB No. 0938-0193

TRANSMITTAL AND NOTICE OF APPROVAL OF STATE PLAN MATERIAL

FOR: CENTERS FOR MEDICARE & MEDICAID SERVICES

1. TRANSMITTAL NUMBER: 13-032

2. STATE: IOWA

3. PROGRAM IDENTIFICATION: TITLE XIX OF THE SOCIAL SECURITY ACT (MEDICAID)

TO: REGIONAL ADMINISTRATOR
CENTERS FOR MEDICARE & MEDICAID SERVICES
DEPARTMENT OF HEALTH AND HUMAN SERVICES

4. PROPOSED EFFECTIVE DATE: January 1, 2014

5. TYPE OF PLAN MATERIAL *(Check One)*

☐ NEW STATE PLAN ☐ AMENDMENT TO BE CONSIDERED AS NEW PLAN ☑ AMENDMENT

COMPLETE BLOCKS 6 THRU 10 IF THIS IS AN AMENDMENT *(Separate transmittal for each amendment)*

6. FEDERAL STATUTE/REGULATION CITATION

7. FEDERAL BUDGET IMPACT
a. FFY '14 $ 56,626,463
b. FFY '15 $ 97,416,112

8. PAGE NUMBER OF THE PLAN SECTION OR ATTACHMENT
Attachment 3.1-F, Page 1, 1b, 3, 7, 16

9. PAGE NUMBER OF THE SUPERSEDED PLAN SECTION OR ATTACHMENT *(If Applicable)*
Attachment 3.1-F, Page 1, 3, 7, 16

New Page: Attachment 3.1-F, Page 1b

10. SUBJECT OF AMENDMENT * Addition of the Wellness Plan population to the 1932(a) SPA.

~~Conference Committee Report for SF 446 modified reimbursement for intermittent services and private duty nursing services provided by home health agencies.~~

11. GOVERNOR'S REVIEW *(Check One)*

☒ GOVERNOR'S OFFICE REPORTED NO COMMENT
☐ COMMENTS OF GOVERNOR'S OFFICE ENCLOSED
☐ NO REPLY RECEIVED WITHIN 45 DAYS OF SUBMITTAL
☐ OTHER, AS SPECIFIED

12. SIGNATURE OF STATE AGENCY OFFICIAL

13. TYPED NAME: CHARLES M. PALMER

14. TITLE: DIRECTOR

15. DATE SUBMITTED: 10-9-13

16. RETURN TO

CHARLES M. PALMER
DIRECTOR
DEPARTMENT OF HUMAN SERVICES
1305 EAST WALNUT 5TH FLOOR
DES MOINES IA 50319-0114

FOR REGIONAL OFFICE USE ONLY

17. DATE RECEIVED: October 9, 2013

18. DATE APPROVED: December 17, 2013

PLAN APPROVED - ONE COPY ATTACHED

19. EFFECTIVE DATE OF APPROVED MATERIAL: January 1, 2014

20. SIGNATURE OF REGIONAL OFFICIAL: //s//

21. TYPED NAME: James G. Scott

22. TITLE: Associate Regional Administrator for Medicaid and Children's Health Operations

23. REMARKS

* Pen and Ink change per state e-mail dated 10.22.13.

FORM CMS-179 (07/92)

Instructions on Back

State: **IOWA**

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.

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.

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

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.