Iowa Medicaid: Innovations & Initiatives

Topics

- ICD-10
- ACA Expansion
- Presumptive Eligibility
- Health Information Technology
- PERM
- DHS Initiatives
- Adult Quality Measures
- SIM
- CDAC

ICD-10
ICD-10

Background
- ICD-9-CM (clinical modification) was developed by the World Health Organization (WHO) for worldwide use in 1979
- ICD-9 is over 30 years old & lacks sufficient detail
- ICD-10 was fully endorsed by WHO in 1994
- ICD-10 implementation was to be October 1, 2014

ICD-10 Delay
- On April 1, 2014, the Protecting Access to Medicare Act of 2014 (PAMA) (Pub. L. No. 113-93) was enacted
- It states that ICD-10 cannot be adopted prior to October 1, 2015
- We are awaiting an interim final rule including a new compliance date of October 1, 2015

Resources
- CMS ICD-10 resources and information: www.cms.gov/Medicare/Coding/ICD10/index.html
- Email questions to: icd-10project@dhs.state.ia.us
Affordable Care Act

ACA

Referring/Prescribing

• Practitioners ordering, prescribing, or referring (OPR) services or supplies must be enrolled
• OPR providers do not bill Medicaid
• Appropriate for practitioners who:
  o Do not plan to submit claims for services
  o Do want to be enrolled as another provider type
  o Occasionally sees a Medicaid member who needs additional services or supplies that will be covered by the Medicaid program
• Claim editing began on 1/6/14

Pre & Post Enrollment Screenings

• Federal requirement, 42 CFR 455.432
• Pre & post enrollment site visits & screening requirements began November 15, 2012
• Certain newly enrolling & re-enrolling provider types are screened according to level of risk
  o Limited
  o Moderate
  o High
  
  http://dhs.iowa.gov/ime/providers/program-integrity-provisions-for-the-aca
Provider Enrollment Application Fees

- Federal requirement, 42 CFR 455.460
- Exempt providers are:
  - Enrolled with Medicare and already paid the fee
  - Enrolled in another state’s Medicaid or CHIP program
  - Individual providers
- Application fee for Calendar Year 2014 is $542.00

Presumptive Eligibility

Rules

- 42 CFR § 435.1110 allows qualified Iowa providers to make presumptive eligibility determinations
- Presumes the applicant is eligible based on their statements
- Member is eligible for benefits until a formal eligibility determination is made or until the last day of the following month
Presumptive Eligibility

Qualified Entities

• Providers enroll to participate as a Qualified Entity
• Complete the Application to become certified
• Request access to the Medicaid Presumptive Eligibility Portal (MPEP)

Presumptive Eligibility

Categories

• Children under the age of 19
• Pregnant women (coverage of services limited to ambulatory prenatal care)
• Parents and caretaker relatives
• Individuals 19 or older and under 65
• Former foster care children under age 26
• Individuals needing treatment for breast or cervical cancer

Health Information Technology

HIT
Incentives

- Federal incentives to Medicaid providers
- To promote adoption and meaningful use of electronic health records (EHR)
- Administered by the State Medicaid Program
- Eligible providers must meet minimum patient volume thresholds for Medicaid incentives
- Up to $63,750 is available to each eligible professional over a six year period

http://dhs.iowa.gov/ime/providers/tools-trainings-and-services/EHRIncentives

Incentives

<table>
<thead>
<tr>
<th>Entity</th>
<th>Minimum Medicaid patient volume threshold</th>
<th>Or the Medicaid EP practices predominately in an FQHC or RHC – 30% needy individual patient volume threshold</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>20%</td>
<td></td>
</tr>
<tr>
<td>Dentists</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>CNMs</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>PMs when practicing at an FQHC/RHC that is led by a PA</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>NPs</td>
<td>30%</td>
<td></td>
</tr>
<tr>
<td>Acute Care Hospitals</td>
<td>10%</td>
<td></td>
</tr>
<tr>
<td>Children's Hospitals</td>
<td>No Requirement</td>
<td>N/A</td>
</tr>
</tbody>
</table>

Information and Resources

- CMS EHR Incentive Program
- List of Certified EHR Technology
  http://oncchpl.force.com/ehrcert
- Iowa State Medicaid HIT Plan (SMHP)
  http://dhs.iowa.gov/sites/default/files/2013%20SMHP.PDF
- Iowa EHR Program FAQ
  http://dhs.iowa.gov/sites/default/files/FAQ.HIT_.pdf
**Payment Error Rate Measurement**

**PERM**

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**Background**
- Cycles every 3 years - Current cycle is Federal Fiscal Year (FFY) 2014
- In Iowa, reviews previously performed for fiscal years 2008 & 2011
- Reviews for 2014 begin in June for claims paid during FFY 2014
- CMS measures the error rate of Medicaid & CHIP payments
- Contractor for reviews is A+ Government Solutions

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**State Responsibilities**
- Reviews and validates the system provider contact information for sampled claims
- Identifies processes/contacts for the management of medical documentation
- Identifies special documentation processes or contact information for corporate contacts or multi-hospital systems
- Provides contact information for state representatives responsible for tracking provider responses
PERM

Contractor Communication
• Uses provider information from data files submitted by states
• Places initial call to the provider to verify provider’s information
  o State support needed for incorrect/non-current contact information
• Sends the initial records request via fax or mail
• Calls providers and sends reminder requests at 30-day, 45-day and 60-day intervals, as needed

PERM

Provider Responsibilities
• Send medical records for Original Requests within 75 days of request
  o Mails records or submits by esMD or fax to 1-877-619-7850
• Send additional documentation within 14 calendar days of receiving additional documentation requests
  o Provide specific detail for missing documentation verbally and in writing

DHS Initiatives
Eligibility Integrated Application Solution

- New Eligibility System to replace Iowa Automated Benefit Calculation System (IABC)
- Commercial Off the Shelf Product
  - Single streamlined application to align with the federal application
- Implementation in two phases:
  - Health care coverage application in late 2013
  - Other DHS programs forthcoming

Design

- Provide a single business process for all eligibility determinations
- Allow eligibility determinations in real-time
- Ensure automatic sharing between systems and programs
- Eliminate the need for duplicate entries
- Automate and execute verification activities in real-time
- Maximize access and allow direct client data entry
- Eliminate unnecessary paperwork and inefficiencies for clients and department staff

Adult and Children’s Quality Measures
Adult Quality Measures

Grant

- Two year grant program, *Measuring and Improving the Quality of Care in Medicaid*
- The grant has three key goals:
  - Testing and evaluating the collection and reporting of Health Care Quality Measures for Adults Enrolled in Medicaid
  - Developing staff capacity to report, analyze, and use data to improve access and quality of care in Medicaid
  - Conducting at least two Medicaid quality improvement projects (QIP)

IME Diabetes Quality Improvement Program

- Purpose is to improve rates of comprehensive diabetes care and reduce Short Term Complications (STC) admissions
  - Notifying providers of patients who have gaps in care and who are at risk for hospital admission as a result of STC of diabetes
- Goal to improve comprehensive diabetes care by:
  - Reduce the diabetes STC admission rate by 10%

IME Asthma Quality Improvement Program

- Purpose to reduce adult asthma hospital admission rate by 10%
- Goal to improve comprehensive asthma care by targeting providers with patients who:
  - Over rely on their asthma rescue medication
  - Do not refill asthma controller meds in a 90-day period
  - Have ER visits with a primary asthma diagnosis within a 90-day period
  - Asthma-related hospital inpatient admission within a 90-day period
Children’s Quality Measures

- Total of 26 measures
  - 17 are clinical care measures such as immunizations and developmental screening
  - 2 are for population health, such as HPV vaccinations and weight assessments
  - 2 are care coordination / follow-up care
  - 1 is patient safety in the hospital setting
  - 3 are efficiency and cost reduction, such as appropriate use of the emergency room
  - 1 is for completion of the Consumer Assessment of Healthcare Providers and Systems® (CAHPS) survey

State Innovation Model
SIM

Inspiring Change
- Health care delivery system is fragmented
- Reimbursement methods for providers reward volume not value
- Cost of health care is unaffordable and unsustainable for citizens and taxpayers
- Iowa’s long term care system relies heavily on institutional services
The IME Role in Delivery Reform

- The IME delivers care through the same health care system as other payers
- Payment and contracting methods are similar
- The IME is a significant payer, covers 23% of Iowans
- Primary payer of LTC Services

State Innovation Model

SIM-Step One

- State Healthcare Innovation Plan (SHIP)
- 8 month design grant awarded in February 2013
- Submitted SHIP December 2013
- Required 19 components including:
  - Vision statement for system transformation
  - Well defined “as is” for current system and “to be” for transformed state
  - Barriers and opportunities
  - Population health status measures, social/economic impacts

State Innovation Model

SIM-Step Two

- Pursue model testing grant proposal
- Round 2 released May 22
- Due July 21 - Expected award announced end of October
- SHIP is part of testing grant application
- Information available at:
  http://dhs.iowa.gov/ime/about/state-innovation-models
ACO Strategy

- Strategy 1: Implement multi-payer ACO methodology across Iowa's primary health care payers
- Strategy 2: Expand on the multi-payer ACO methodology to address integration of behavioral health services and long term care services
- Strategy 3: Population health, health promotion, member incentives

ACO

Accountable Care Organization: is a health care organization ‘characterized by a payment and delivery model that seeks to tie provider reimbursements to quality metrics and reductions in the total cost of care for an assigned population of patients…’

ACO Goals

- Care Coordination = Better outcomes
- Organized Delivery = Better Access to Care
- Patient Engagement = Improved Patient Care
- Innovation = Better Quality/Improve d Technology
- Measure quality and adapt to patient needs
- ASSIST with multiple physicians and specialists
- Ensure access to appropriate care
- Understand costs and care for better health
- Measures quality and adapt to patient needs
State Innovation Model

ACO Timeline

Step 1: Implement Health and Wellness Plan

Step 2: Expand ACO model for full Medicaid population

Step 3: Add Behavioral Health Services

Step 4: Add Long Term Care

Accountability increases as additional systems are brought into the Total Cost of Care budget

Timing of steps determined by readiness exercise between the State and ACO

Home and Community Based Services

HCBS

Settings Transition

- HCBS settings will now be defined based on the nature and quality of the member’s experiences
- New regulations ensure member choice in where they live and who provides services
- Iowa Medicaid is seeking public comment and input on the transition process
- Transition plan and more information available at: http://dhs.iowa.gov/ime/about/initiatives/HCBS
HCBS

Supports Intensity Scale (SIS)
- SIS is a core standardized assessment tool used to evaluate the support needs of a person with an Intellectual and/or Developmental Disability
- The Mental Health and Disability Redesign Workgroup recommended use of the SIS
- Senate File 446 directed DHS to contract with an independent entity to perform the SIS

Gathered information can be used to:
- Determine each member’s eligibility for long term supports and services
- Identify the individual support and service needs of each person
- Assist in developing the member’s individual service plan
- Guide the allocation of resources in a way that is equitable and consistent with the member’s needs

Implementation will begin August 1, 2014
- Begin with members new to the Intellectual Disabilities (ID) Waiver and ICF/ID services
- Randomly select one-third of the current ID Waiver and IFC/ID population
- Another one-third will be randomly selected in year two
- More information is available at: http://dhs.iowa.gov/ime/about/initiatives/BIPP/CSA
Senate File 2320

- Senate File 2320 signed into law on April 4, 2014
- Is retroactive to December 31, 2013

- Allows legal representatives to provide Consumer Directed Attendant Care (CDAC) and Consumer Choice Options (CCO) services
- Sets hour and wage limits for legal representatives
- Will transition individual CDAC providers to CCO starting July 1, 2016
- Changes agency CDAC to personal care services

When CDAC or CCO services are provided by a legal representative:
- Payment rate is fair and reasonable based on the skill level of the provider
- Cannot work more than 40 hours per week
- There must be a contingency plan for provision of services if legal representative is unable to provide care
Provider Services Outreach Staff

Offer the following services:

• On-site training
• Escalated claims issues
• Managed care education
• Email imeproviderservices@dhs.state.ia.us