# Appendix D: Current Program and Technical Architecture Overview

**Program Description**

The following sections provide an overview of the Iowa Medicaid Program:

D.1 Medicaid Program Administration

Multiple state and federal agencies administer the Iowa Medicaid Program. The following sections describe their roles.

D.1.1 Iowa Department of Human Services

The Iowa Department of Human Services (Agency) is the largest agency in Iowa State government, with approximately 4,233 State full-time employees. In addition to its primary Central Office location, DHS has remote office operations that serve populations in all 99 counties in Iowa. These sites house field, case management, and child-support staff. There are six institutional facilities under DHS, including mental health institutes at Cherokee and Independence; State Boys Training School at Eldora; Civil Commitment Unit for Sexual Offenders; and two resource centers at Glenwood and Woodward.

The six divisions of the Agency include:

* The Division of Fiscal Management
* The Division of Information Technology
* The Division of Field Operations
* The Division of Adult, Children, and Family Services
* The Division of Mental Health and Disability Services
* Iowa Medicaid Enterprise

An illustration of the Agency’s organization is available at: <http://dhs.iowa.gov/sites/default/files/DHS_Table_of_Org.pdf>.

The Iowa Department of Human Services is the single State entity responsible for administering the Medicaid program in Iowa. The Iowa Medicaid Program reimburses providers for delivery of services to eligible Medicaid recipients under the authority of Title XIX of the Act through enrolled providers and health plans. The Agency operates this program through its business unit, the Iowa Medicaid Enterprise (IME). The Agency is also responsible for the Children’s Health Insurance Program (CHIP – the separate CHIP program is called Healthy and Well Kids in Iowa, or Hawki).

***State of Iowa Hardware Infrastructure***

The State of Iowa, Office of the Chief Information Officer (OCIO), has a large infrastructure in place in order to support the MMIS. DHS technology supports include local area and wide area network supports to connect all DHS offices and other applications required by its users. Below are highlights of key infrastructures.

***State of Iowa Primary and Secondary Data Centers***

The primary and secondary data centers provide redundant power and cooling, networking services; fire suppression, power protected by UPS and generator; each server in every rack has capability of multiple electrical paths, authorized personnel access only and camera system monitoring, Each data center hosts storage area network connectivity and data backup solutions.

***Servers***

The State of Iowa Office of the Chief Information Officer (OCIO) and DHS server environments are based on a VMWare Virtual Machine environment, which hosts a variety of operating systems including Windows, Linux, Oracle and Solaris. Multiple virtual networks are available to support diverse host connection requirements. DHS and the OCIO have a two-way trust to support Active Directory for management of user authentication and access to server-based data. Access to enterprise storage area network devices and database solutions are available within OCIO and/or DHS to utilize in meeting IT needs.

***DHS Remote Offices***

The DHS model for server deployment has been placement of a single Microsoft Windows Domain Controller server for file-and-print services wherever there is a DHS office. This model has been modified to support the Agency reorganization to less than full time offices (LTFT). The Agency currently has 57 less than full time offices that do not have a server at their location. All data including remote Domain Controllers are backed up centrally and replicated to a secondary site.

Users in a typical remote office use Intel-based personal computers running Windows 7 desktop operating system software. Although IE11 is the default browser, current versions of Chrome are also supported. PCs, printers and the local Domain Servers are connected to an Ethernet switch, with the local server supplying network login authentication, file, and print services. In addition, users rely on WAN connectivity for access to the Internet as well as DHS Hoover-based services such as MS SQL Server databases, IIS.Net Applications, Imaging, and Central Office server-based file storage. Users in DHS' remote offices also utilize the WAN to communicate with the OCIO mainframe.

In all offices, users rely on the LAN and WAN for access to DHS' imaging solution, which centrally locates archived images on an EMC Center storage device in the OCIO Data Center. This data is also replicated to a second Center located at the IME facility.

The ICN router is attached to the Capitol Complex Ethernet network, and this link is used by the ICN to communicate with DHS and ITE's networks in Primary Data Center.

D.1.2 U.S. Department of Health and Human Services

Within the U.S. Department of Health and Human Services, three agencies administer the Medicaid program. The following paragraphs describe their roles.

The Centers for Medicare and Medicaid Services (CMS) is responsible for promulgating Title XIX (Medicaid) and Title XXI (CHIP) regulations and determining state compliance with regulations. CMS also is responsible for certifying and recertifying all state MMIS operations.

The Office of Inspector General (OIG) is responsible for identifying and investigating instances of fraud and abuse in all state Medicaid programs. The Inspector General’s office also performs audits of all state Medicaid programs.

The Social Security Administration (SSA) is responsible for supplemental security income (SSI) eligibility determination. The Social Security Administration transmits this information via a state data exchange (SDX) file to the Agency for updating the eligibility system. Information is also provided on Medicare eligibility through beneficiary data exchange and Medicare Parts A and B buy-in files. The Agency then provides Medicare eligibility information to the MMIS as part of the eligibility file update process.

D.1.3 Iowa Medicaid Enterprise

The Iowa Medicaid Enterprise (IME), led by the State Medicaid Director, administers the Iowa Medicaid and CHIP programs and coordinates the activities of its bureaus: MCO Oversight and Supports, Medical and LTSS Policy, and the IME Support and Operations team. The IME directs, coordinates, and oversees Medicaid and CHIP operations, MCO oversight, quality assurance, and cost containment activities in order to ensure effective program administration and adherence to laws, rules, regulations, and established policies.

**D.1.3.1 Iowa Medicaid Enterprise Services Overview**

Iowa Medicaid provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. The goal is for members to live healthy, stable and self-sufficient lives. Iowa Medicaid covers a comprehensive range of health care services for Iowans who meet the program’s eligibility criteria. Medicaid is also a primary funder of both long term services and supports for seniors and persons with disabilities which includes facility care and alternative choices such as community based services.

* Medical assistance State Plan Services
* Home and Community Based Services (HCBS) Waivers
* Nursing Facilities
* Intermediate Care Facilities including State Resource Centers

More information about the Medicaid programs and services offered by Iowa Medicaid can be found on the Agency’s public website: <https://dhs.iowa.gov/ime/members/medicaid-a-to-z>.

On April 1, 2016, the IME transitioned to a managed care system, known as IA Health Link.  As a result of this transition the model for service delivery and reimbursement changed from a primarily Fee-for-Service (FFS) model to a risk based Managed Care Organization (MCO) model.  The majority of services are included in this statewide managed care structure, including long-term services and supports (LTSS), behavioral health, and pharmacy. Approximately 90% of all Iowa Medicaid Members are enrolled with Iowa’s current two operational MCOs, with 10% remaining in FFS. Iowa’s Hawki population is served by the same Medicaid MCOs and included in the total MCO population. Beginning July 1, 2019 a third MCO will begin operations.

*Iowa Medicaid Coverage Groups and Corresponding Programs*

There are three Iowa Medicaid coverage groups and corresponding programs: IA Health Link, Medicaid Fee-for-Service (FFS), and Hawki. Information regarding these programs is found at this link: <http://dhs.iowa.gov/sites/default/files/Comm020.pdf>. Please note, the data presented in the link focuses on Medicaid FFS programs.

Most of the Agency’s FFS population either falls into a premium payment coverage group or into a historically exempt population. Furthermore, during the 2017 and 2018 legislative sessions it was determined that the Agency will not recognize a three month retroactive eligibility period except for pregnant women (and during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, and residents of nursing facilities licensed under Iowa Code Chapter 135C at the time of application.

The Agency is also in the initial planning stages for implementation of an MCO passive enrollment process. This process is explained in Section D.2.1.2. With the anticipated implementation of MCO passive enrollment July 1, 2019, FFS Members will decrease, as well as claims over the next few years. For example, of the 64,184 FFS Members enrolled in December 2018, only 33,318 fell within one of the premium payment coverage groups or into an historically exempt population (i.e., would not be enrolled in managed care).

**Table 1: Current Iowa Medicaid Population Structure**

|  |  |  |  |
| --- | --- | --- | --- |
| **Eligibility Group** | **December 2018 Enrollment** | **Average Monthly Claims Processed** \* | **Delivery System** |
| IA Health Link(including Hawki) | Medicaid 575,598 | 2,001,331\*\* | MCOs |
| Hawki52,075 | 54,379 \*\* |
| FFS Medicaid | 64,184 | 215,876 | Agency |
| FFS Dental | 307,955 | 31,255 | Agency |
| Dental Wellness | 325,232 | 32,003 | PAHPs |
| Hawki Dental (including dental-only) | 55,227 | 6,894 (dental claims only)  | PAHP |

\*Based on claims processed from January 2018 through December 2018, except Hawki Dental, which is from March 2018 through December 2018.

\*\*claims processed by line, which can include multiple services.

Beginning July 1, 2017, the Agency combined dental benefits for all adult enrollees into one Dental Wellness program, delivered via prepaid ambulatory health plans (PAHPs). In addition, the Agency provides children dental coverage through various packages. Medicaid kids receive comprehensive dental coverage on a FFS basis and Hawkichildren receive dental coverage through a PAHP. Hawki also has a dental-only program for children with third-party liability (TPL).

**D.1.3.2 Iowa Medicaid Enterprise Professional Services**

The IME is a collaboration of third party professional and system services contractors and Agency staff. Agency staff provide program and policy guidance, oversight, and contract monitoring to ensure access, cost effectiveness, and quality. To support the IME structure, the Agency’s contractors execute the majority of the Medicaid program business functions under a performance-based structure.

The IME currently has Core MMIS, Pharmacy Point of Sale (POS) and Program Integrity (SURS) vendors who provide what CMS would consider a system or sub-system of the current Medicaid Enterprise. At the core of the IME is its MMIS, a mainframe application hosted within the State’s data center, used primarily for batch processing claims and processing various file updates. The IME’s MMIS is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains standard subsystems such as: Recipient, Provider, Claims, Reference, Management and Administrative Reporting (MAR), Managed Care and Third-Party Liability (TPL), as well as the supporting Medically Needy and Early and Periodic Screening, Diagnosis, and Treatment (EPSDT) subsystems. The Core MMIS contractor currently provides, per contractual requirements, an Electronic Data Interchange (EDI) system and support services, an NCCI-compliant claims editing solution, an imaging/scanning solution, and an HCPCS/NDC Crosswalk. The Agency will be transitioning to an Agency-wide imaging/scanning solution prior to June 30, 2020. Specific timelines for this transition are not available at this time. Once the transition is complete, the Core MMIS contractor will no longer be responsible for providing that solution.

The IME professional services contracts include responsibilities directly in support of the claims processing and data retrieval. In addition, their activities promote the State’s responsibilities for service assessment and quality indicators. A summary of professional services contracts and their primary business functions beginning July 1, 2019 is below:

**Table 2: Iowa Medicaid Primary Business Functions**

| **Contract** | **Business Functions** |
| --- | --- |
| **Member Management, Consumer Assistance, and Eligibility Help Desk Services**  | * Member Enrollment/ Enrollment Broker
* Member, DHS Contact, and Hawki Call Centers
* Member Outreach
* Managed Care Liaison
 | * Application and Renewal Assistance
* Support ELIAS Level 1 Help Desk/Ticketing
* Consumer Assistance for Program Eligibility Requirements
 |
| **Program Integrity**  | * PI System and Database
* Data Analytics and Program Analysis
* Surveillance and Utilization Review
* Encounter Data Quality
* MCO Oversight
* PERM Project
 | * Medical Necessity Reviews, Audits, and Payment Recovery
* Referrals to Department of Inspections and Appeals (DIA)
* CHIPRA and Adult Medicaid Quality Measure Reporting
* Ad Hoc Reports
 |
| **Provider Cost Audit and Rate Setting Services** | * Provider Cost Audits
* Provider, Nursing Facility, and LTC Rate Setting
 | * Provider Cost Settlements
* Drug Pricing and Pharmacy Reimbursement Methodologies
 |
| **Provider Services** | * Provider Call Center
* Provider Enrollment and Credentialing
 | * Provider Outreach, Education and Training
* Provider Publications
 |
| **Quality Improvement Organization Services**  | * Medical Support
* Utilization Management
 | * Claims Pre-Payment Review
* HCBS Quality Oversight
 |
| **Revenue Collections and Estate Recovery Services** | * Third Party Liability (TPL) Identification and Verification
* TPL Recoveries
* Premium Payment Processing
* Provider Overpayments (Credit Balance)
 | * Insurance Data Match for the Hawki Program
* Estate Recovery and Trust Operations
* Provider Withholds
 |
| **Pharmacy Point-of-Sale System** (including Pharmacy Medical Services) | * Pharmacy Claims Adjudication
* Drug-Drug Interaction Management
* Pharmacy Prior Authorization Management
 | * Retro Drug Utilization Review
* Preferred Drug List and Supplemental Rebate Program
 |

D.2 Overview of Current State Technical Architecture

The Agency currently owns and maintains multiple systems and interfaces that facilitate the processing of Medicaid Member benefits and Medicaid administrative functions. The core MMIS mainframe system continues to support the majority of Medicaid processing. However, changing legislation and technology advancements have led to the development of many smaller systems to manage rules, processes, and workflows not easily incorporated into the core MMIS. Data exchanges between systems are implemented primarily through batch-file interfaces. See Appendix F - Current MMIS System and Interface Layout for a high-level overview of the current state systems and interfaces operating to provide Medicaid services to Iowa citizens.

D.2.1 Eligibility

Medicaid eligibility is determined within one of three different systems that are managed by the Division of Information Technology (DoIT): ELIAS, FFP system, or IABC. These systems are described in Sections D.3.1-3.

**D.2.2 Current MMIS Information Technology (IT) Operations**

The legacy MMIS system is written in COBOL and controlled using Job Control Language (JCL). The Iowa MMIS is a mainframe application with primarily batch processing for fee for service claims and file updates. The Core MMIS contractor manages the system, as well as the workflow management process system known as OnBase**®**. The Agency is transitioning from OnBase to Open Text Content Suite within the next year. Once this transition is complete, the Agency will assume management of the workflow management process system. Infrastructure services are hosted by the State’s Office of the Chief Information Officer. The Division of Information Technology (DoIT) manages the separate DW/DS system, Buy-in, TXIX, IMPA, Individualized Services Information System (ISIS) and the Premium Payment System. Separate vendors manage the Pharmacy Point of Sale (POS) system that provides real-time processing for pharmacy claims and the Surveillance and Utilization Review System (SURS) that provides Medicaid Program Integrity reporting and analytics.

The Iowa MMIS, as is the case with virtually all of the systems in operation today, is built around subsystems that organize and control the data files used to process claims and provide reports. The MMIS contains the eight standard subsystems: Claims Processing, Recipient, Provider, Reference, Management and Administrative Reporting (MAR), Managed Care and Third-Party Liability (TPL), as well as the supporting Medically Needy and Early and Periodic Screening, Diagnosis and Treatment (EPSDT) subsystems.

The MMIS is Health Insurance Portability and Accountability Act (HIPAA) 5010, National Council for Prescription Drug Program (NCPDP), and International Classification of Diseases (ICD-10) complaint. In addition, the Agency strives to align with guidance in the Minimum Acceptable Risk Standards for Exchanges (MARS-E) 2.0, Medicaid Information Technology Architecture (MITA), and Medicaid Enterprise Certification Toolkit (MECT).

All hardware is located within the State of Iowa facilities. The Agency is responsible for managing the network, operating systems, and network security. The CORE MMIS vendor is responsible for installation and administering the application(s), application security, application development, and coordination of COTS vendor support as appropriate, unless another IME Unit is the designated owner.

Table 3 below provides a list of all current MMIS subsystems and related applications. An overview and description of each follows.

***Table 3: Core MMIS-related Subsystems and Applications***

| **Information System** | **Current Responsible Unit**  |
| --- | --- |
| **Iowa Medicaid Management Information System (MMIS)****D.2.2.1: Claims Processing (Fee for Service)****D.2.2.2: Recipient Subsystem (Member Management)****D.2.2.3: Provider Subsystem****D.2.2.4: Reference Subsystem****D.2.2.5: Medically Needy Subsystem****D.2.2.6: Management and Administrative Reporting System (MARS)****D.2.2.7: Surveillances and Utilization Review System (SURS)****D.2.2.8: Third Party Liability (TPL) System****D.2.2.9: Prior Authorization Function****D.2.2.10: EPSDT Subsystem****D.2.2.11: Managed Care – Assignment, Capitation and Enrollment****D.2.2.12: Managed Care – Encounter Data****D.2.2.13: Eligibility Verification Information System (ELVS)****D.2.2.14: Premium Invoicing Function****D.2.2.15: Dental Program****D.2.2.16: EDI Support Services****D.2.2.17: NCCI Claims Editing****D.2.2.18: Procedure Code/ National Drug Code Crosswalk****D.2.2.19: Workflow Process Management System** | CORE MMIS |
| **D.2.2.20: Right Fax** | Agency DoIT, CORE manages interfaces to Workflow Process Management |

**D.2.2.1 Claims Processing (Fee for Service)**

The claims processing subsystem is one of the most critical modules of the Medicaid Management Information System (MMIS). It captures, controls and processes claims data from the time of initial receipt (on hardcopy or electronic media) through the final disposition, payment and archiving of claims history files. The claims processing subsystem edits, audits and processes claims to final disposition consistent with the policies, procedures and benefit limitations of the Iowa Medicaid Program. To accomplish this, the subsystem uses the data contained in the most current recipient eligibility file, provider master file, reference files, TPL resource file and prior authorization (PA) file.

The claims processing subsystem maintains claims history including both paid and denied claims. The MARS and SURS subsystems use claims history in producing management and utilization reports, as does the claims processing subsystem in applying history-related edits and audits. Online inquiry is available for 36 months of adjudicated claims history, lifetime procedures, and any claims still in process. Service limitations for vision, dental and hearing aid are displayed in the recipient eligibility subsystem key panel.

The claims processing subsystem processes, pays or disallows and reports Medicaid claims accurately, efficiently and in a timely manner. Paper claims are scanned and verified before entry into the MMIS adjudication process. Electronic claims are received through an EDI clearinghouse. Claims may also be entered manually through the online CICS screens. The claims processing subsystem includes the ability to process Medicare crossover claims.

The claims processing subsystem provides up-to-date claims status information through online inquiry and provides data to the MARS, SURS and EPSDT subsystems, and other accounting interfaces used to generate administrative reports. Claims are adjudicated during nightly batch cycles Monday-Friday. The claims engine ensures accurate and complete processing of all input to final disposition. The claims processing subsystem offers online features such as online, real-time claim credits and adjustments.

Outputs of the claims processing subsystem include detailed remittance advices for providers and member explanations of medical benefits (EOMBs). This subsystem also produces updates to the claims history files, prior authorization file, recipient eligibility file and provider file.

The MMIS processes all Iowa fee for service claim forms and a variety of electronic media claims (EMC) including transfers from claims clearinghouses and direct computer data transfer. All claims entered into the subsystem are processed similarly according to claim type, regardless of the initial format of the claim document. Pre-processing is performed to reformat the various inputs into the MMIS claim layout.

The system determines to either pay or deny a service according to criteria on the exception control file. This parameter table, which is maintained online, enables the Agency to control the disposition of edits and audits without any programming effort involved. Separate exception codes are posted for each edit and audit exception for each line item. Each exception code can be set to several dispositions depending on such factors as input media (paper or magnetic tape) and claim type. Claim type is assigned by a combination of claim invoice and other indicators within the claim.

If all exceptions on a claim have a disposition of pay, deny or pay and report, the claim is adjudicated and the payment amount is computed according to the rules and regulations of the State of Iowa. If any exception for the claim is set to suspend, then the claim is either printed on a detailed suspense correction report or listed for an online suspense correction as dictated by parameters on the exception control file. A super-suspend disposition is used for edits so severe that no resolution short of correcting the error is possible (such as invalid provider data). The pay-and-report disposition allows the Agency to test the impact of a new exception and decide how to treat the condition in the future such as pay, deny, or educate providers. Claims with special exception codes are routed according to Agency instructions. The specific unit responsible for correction of an exception is designated by the location code on the exception control file.

The MMIS allows the detail and summary resolution text to be entered on the text file of the reference subsystem. This information is then available to the resolution staff during exam entry, suspense correction, and inquiry processes, thus providing an online resolution manual.

A remittance advice is produced for every claim in the system and shows the amount paid and the reasons for claim denial or suspense. The message related to each exception code is controlled by parameters on the exception control file. A different message can be printed according to claim submission media, claim type, and whether the claim is denied or suspended. The actual text of the message is maintained online on the text file which is transferred to the IMPA system where providers are able to view their own remittance advices.

The MMIS maintains 36 months of adjudicated claims history online. The claims, as well as all claims in process, are available for online inquiry in a variety of ways. Claims can be viewed by member identification (ID), provider number, National Provider Identifier (NPI), claim transaction control number (TCN) or a combination of the above. The search criteria can be further limited by a range of service dates, payment dates, payment amounts, billed amounts, claim status, category of service, procedure codes or diagnosis codes within a claim type. Claims can be displayed either in detail, one claim per screen, in summary format, and several claims per screen. Additional inquiry capability allows the operator to browse the member, provider or reference files from the claim screen to obtain additional information related to the claim. A summary screen is also available for each provider containing month-to-date, year-to-date, and most recent payment information. The claims processing subsystem has the capability to suspend or deny claims based on TPL information carried in the MMIS files.

The MMIS supports cost containment and utilization review by editing claims against the prior authorization record to ensure that payment is made only for treatments or services, which are medically necessary, appropriate, and cost-effective. The Utilization Review (UR) criteria file provides a means of placing program limitations on service frequency and quantity as well as medical and contraindicated service limits. It provides a means for establishing prepayment criteria, including cross-referencing of procedure and diagnosis combinations.

The claims processing subsystem contains a claims processing assessment system (CPAS) module designed to provide claim sampling and reporting capability required to support the Agency in conducting CPAS reviews.

Each step in document receipt processing and disposition includes status reporting and quality control. The Iowa MMIS generates several reports useful in managing claim flow and resolution. Reports are used to track the progress of claims at each resolution location, identify potential backlogs, pinpoint specific claims that have suspended, monitor workload inventories, and ensure timely processing of all pended claims. Meanwhile, quality control staff monitors all operations for adherence to standards and processing accuracy in accordance with contractual time commitments and error rates.

The claims receipt, entry and control module function ensures that all claims and related input to the MMIS are captured at the earliest possible time in an accurate manner. This function monitors the movement and distribution of claims once they are entered into the system to ensure an accurate trail from receipt of claims through final disposition. The function includes both manual and automated processes for claim control.

**D.2.2.2 Recipient Subsystem (Member Management)**

The recipient subsystem is the source of all eligibility determination data for the MMIS, whether generated by the Agency or by the MMIS. The information contained in the MMIS eligibility file is used to support claims processing, management and administrative reporting, surveillance and utilization review reporting, managed care functionality and TPL. The recipient subsystem currently meets or exceeds all federal and state requirements for a Medicaid recipient subsystem.

The MMIS recipient subsystem is designed to provide the flexibility required to accommodate the Agency’s changing approach to the management of its public assistance programs.

The recipient subsystem currently accepts data only from the Title XIX system for eligibility and facility data. The recipient subsystem receives daily transmissions of eligibility updates from the Title XIX system, which are used for batch updates of the recipient eligibility file. In the future, an additional eligibility feed may be needed for Hawki.

The MMIS batch file update methodology is supplemented with online, real-time updates to the recipient record. The guardian effective date and ID are added or updated through the online feature of the recipient subsystem. All online updates to the recipient eligibility file are thoroughly controlled to ensure the accuracy of the updates before they are applied to the file.

Audit trails are supported through the use of the online transaction log file. The transaction log files records a before and after image of each MMIS master file record updated online. The transaction log file is then used to support daily online update activity reporting and is retained for historical purposes.

The Agency and the Contractor share the responsibility for the operation of the recipient subsystem. The Agency determines which individuals are eligible to receive benefits under the Iowa Medical Assistance program and sets limitations and eligibility periods for those individuals. The Agency is responsible for transmitting, either electronically or by other approved media, eligibility data elements required to maintain the MMIS recipient eligibility file on both a daily and monthly basis.

The Contractor is responsible for operating the MMIS recipient subsystem. The recipient subsystem will process the Agency’s daily and monthly update transmissions and submit all balancing and maintenance reports to the Agency. Any discrepancies discovered during the update process are promptly reported to the Agency.

The Contractor provides reports from the recipient subsystem files in the format specified by the Agency. These reports include the detailed recipient eligibility updates, recipient update control and update error reports. Several reports are created from monthly recipient processing, such as the recipient list reports, the possible duplicate reports, and the recipient purge report.

The purpose of the Member Management module is to accept and maintain an accurate, current, and historical source of eligibility and demographic information on individuals eligible for medical assistance in Iowa and for supporting analysis of the data contained within the Member database. The maintenance of Member data is required to support Iowa eligibility verification, claims processing and reporting functions. The Member management function maintains an accurate and current identification of Members eligible for both Medicaid and Medicare. The Member management function must also contain historical Member information that supports claims adjudication and audit requirements according to Iowa records retention rules.

**D.2.2.3 Provider Subsystem**

The provider subsystem maintains comprehensive provider related information on all providers enrolled in the Iowa Medicaid Program to support claims processing, management reporting, surveillance and utilization review. The provider subsystem processes provider applications and information changes interactively using online screens. This capability for immediate entry, verification and updating of provider information, ensures that only qualified providers complying with program rules and regulations are reimbursed for services rendered to eligible Medicaid Members. The provider subsystem currently meets or exceeds all federal and state requirements for a Medicaid provider subsystem.

The provider subsystem retains provider related data on six files: provider master file, the provider group file, provider intermediary file, Medicare-to-Medicaid cross-reference file, provider HMO plan file, and the National Association of Boards of Pharmacy (NABP)-to-Medicaid cross-reference file. These files are used to interface with the claims processing, recipient, MARS, SURS, TPL, and EPSDT subsystems to supply provider data for claims processing and provider enrollment and participation reporting. Provider enrollment is also passed into ISIS to facilitate service plans for Long Term Care service plans.

**D.2.2.4 Reference Subsystem**

The reference subsystem's function is to provide critical information to the claims processing and MAR subsystems. The data to support claims pricing and to enforce state limits on services resides in the reference subsystem. The basic design of the MMIS reference subsystem offers the Agency flexibility in meeting changing program requirements.

Real-time file updating allows for the immediate editing and correcting of update transactions to all of the reference subsystem files. Once a transaction has been applied, it is effective immediately for claims adjudication. The subsystem provides many user-maintained parameters that allow the IME to fine-tune the edits and audits of the Iowa MMIS.

While the basic design of the system stresses online file updates and inquiries, the reference subsystem also incorporates batch updating of key files. The reference subsystem accepts batch procedure, diagnosis, DRG, and APC updating.

The system accommodates mass adjustments due to retroactive price changes. The adjusted claim is priced against the policy in effect on the date of service, even if the price is established after the date that the claim was originally processed.

**D.2.2.5 Medically Needy System**

The medically needy program provides medical assistance to individuals who meet the categorical but not the financial criteria for Medicaid eligibility. Medically needy eligible may be responsible for a portion of their medical expenses. This is referred to as "spend down.” The Agency determines the spend down obligation for these Members. Once individuals become eligible by meeting their spend down obligation, Medicaid pays the claims that were not used for spend down for the certification period.

The medically needy module serves as an “accumulator” of claims that apply toward the spend down amount. The module displays the medically needy spend down amount, the amount of claims that have accumulated towards the spend down amount, information for each certification period, the date spend down is met, and information about claims used to meet spend down. The Agency can access the medically needy screens online.

The medically needy function of the MMIS consists of processing claims for Members eligible for the medically needy program tracking medical expenses to be applied to the spend down and providing reports of spend down activity.

The Iowa medically needy subsystem’s function is to accumulate, track, and apply Medicaid claims to the spenddown for individuals who meet the categorical but not the financial criteria for Medicaid eligibility and who are described as medically needy.

Medically needy eligible individuals may be responsible for a portion of their medical expenses through the spenddown process. The Agency’s IM workers determine initial eligibility and the spenddown obligation for these Members. The Title XIX system sends a record to the MMIS unit identifying these potential medically needy eligible individuals, which allows the MMIS to accumulate claims toward their spenddown amount.

The medically needy subsystem serves as an accumulator of claims that apply toward the spenddown amount. The subsystem displays the medically needy spenddown amount, the amount of claims that have accumulated towards the spenddown amount, information for each certification period, the date that the spenddown obligation is met and information about claims used to meet the spenddown obligation. Agency staff can access these medically needy screens online.

Once individuals become eligible by meeting their spenddown obligation, Medicaid pays the claims that were not applied to the spenddown for that certification period. The medically needy function of the MMIS consists of processing claims for Members eligible for the medically needy program, tracking medical expenses to be applied to the spenddown and providing reports of the spenddown activity.

Cases that have a spenddown obligation in either the retroactive or the prospective certification period have information passed from the IABC system, to the MMIS medically needy subsystem. Medically needy cases that are approved and have zero spenddown in both the retroactive and prospective certification periods, are maintained by the IABC system and are not passed to the MMIS medically needy subsystem. Individuals with active fund codes are automatically eligible for Medicaid. The IABC system passes information to Title XIX, which then passes a Member record to the MMIS when the Member is eligible for Medicaid.

The Medicaid card is issued by a vendor under contract to the Agency.  The MMIS generates and sends a file to the contractor daily for new Members who have not previously been issued a card. Members enrolled in the medically needy program are not eligible to receive an ID card until they have met spenddown obligations and their fund codes in the MMIS system have changed to eligible fund codes. The card does not have an expiration date (e.g., there is no annual reissuance).  If a Member needs a new card, Agency staff use a system called Online Card Replacement Application (OCRA). The system generates a record that is passed daily to the MMIS and included in the daily file feed to the Medicaid card vendor. The MMIS tracks the card issuance date used to determine if a new Member has been issued a card or not.

**D.2.2.6 Management and Administrative Reporting System (MARS)**

The MARS subsystem provides the Agency management staff with a timely and meaningful reporting capability in the key areas of Medicaid program activity. MAR reports are designed to assist management and administrative personnel with the difficult task of effectively planning, directing, and controlling the Iowa Medicaid Program by providing information necessary to support the decision-making process.

The MARS subsystem presents precise information that accurately measures program activity and ensures control of program administration. The MARS subsystem also provides historical, trend and forecasting data that assists management in administering the Iowa Medicaid Program. In addition, the MAR subsystem provides necessary information to all levels of management to predict potential problems and plan solutions.

The MARS subsystem extracts key information from other subsystems for analysis and summarization. The MAR subsystem maintains this data in many different variations for use in producing its reports. This information can also be used as an extensive base of data for special or on-request reporting.

The Agency and the Contractor share responsibility for the ongoing operation of the MARS subsystem. The Agency's responsibilities are to determine the format, reporting categories, parameters, content, frequency, and medium of all routinely produced reports and special reports. The Agency is also responsible for submitting information to be incorporated with MMIS data files for reporting, including budget data, buy-in premium data and managed care encounter data. In addition, the Agency determines policy, makes administrative decisions, transmits information, and monitors contractor duties based on MAR reports.

The Contractor is responsible for operating the MARS subsystem and supporting all of the functions, files, and data elements necessary to meet the requirements of the RFP. All reports have uniform cutoff points so that consistent data is input to each MARS report covering the same time period. A complete audit trail is provided among the MAR reports and between reports generated by MARS and other subsystems for balancing within the cycle.

The Contractor produces and makes available the MARS reports and other outputs in formats, media, and time frames specified by the Agency. The Contractor produces reports at different summary levels according to the Agency specifications and verifies the accuracy of all reports.

The Contractor develops, provides and maintains both system and user documentation for the Agency personnel and its own staff. The Contractor provides knowledge transfer for the Agency personnel and contractors on an ongoing, as needed basis.

The MMIS MARS subsystem has been designed and refined to run within a batch-processing environment. The system is able to handle large amounts of input data, to manage system input and output (I and O) resources efficiently, to minimize program execution and central processing unit (CPU) time requirements and to provide reliable and effective restart and recovery capabilities.

**D.2.2.7 Surveillance and Utilization Review Subsystem (SURS)**

The SURS subsystem is designed to provide statistical information on recipients and providers enrolled in the Iowa Medicaid Program. The subsystem features effective algorithms for isolating potential mis-utilization. Also, it provides an integrated set of reports to support the investigation of that potential misuse.

**D.2.2.8 Third-Party Liability (TPL) System**

The TPL subsystem is a fully integrated part of the MMIS. A significant amount of TPL processing occurs within the recipient subsystem, claims processing subsystem and MARS subsystems.

TPL coverage is maintained by Member within the recipient subsystem. The TPL resource file within the recipient subsystem contains Member identification data, policy numbers, carrier codes, coverage types, and effective dates. An indicator on the recipient eligibility file is set for those Members having verified policy information on the TPL resource file.

The claims processing subsystem identifies claims with potential TPL coverage by examining the TPL resource file and indicators from the claim form. Claims for services with third-party coverage may be paid, paid and reported, suspended or denied based on the individual circumstances.

**D.2.2.9 Prior Authorization**

The Contractor is responsible for maintaining the prior authorization file, which contains procedures requiring prior authorization, information identifying approved authorization, certification periods, and incremental use of the authorized service. The Contractor receives file updates from the QIO contractor for selected authorization codes. These authorizations are loaded on the prior authorization file that is used by the MMIS for processing claims. The Contractor must ensure that all claims are denied for services requiring pre-procedure review by the QIO contractor if a validation number indicating approval is not present on the PA file. The Contractor is responsible for ensuring that in cases requiring preadmission review by the QIO contractor, payment is made only if an approval certification is present on the claim and that payment is made only for the approved number of days and at the specified level of care.

The Contractor will also receive file updates from the QIO contractor on authorized services. These files will cover the array of services under the QIO contractor’s responsibility.

The Contractor uses Individualized Service Information System (ISIS) as a prior authorization file to verify authorized services, Members and rates for payment of HCBS Waiver programs. ISIS is also used for prior authorization of facility, habilitation services, and targeted case management services. Approved service authorizations are sent from ISIS to the prior authorization subsystem. Approved eligibility spans are sent from ISIS through the Title XIX system to the MMIS recipient eligibility file.

All ISIS Waiver Service Authorizations are passed daily to the TXIX System for additional processing by the Prior Authorization subsystem.  Only approved service authorizations are used in a match process with all ISIS Prior Authorization Service records.  This process creates add, change and delete files that are passed daily to MMIS for ISIS service payments.

**D.2.2.10** **Early and Periodic Screening, Diagnosis and Treatment (EPSDT) Subsystem**

The EPSDT subsystem is a proactive medical services program for recipients under the age of 21. Its goal is to prevent illness, complications and the need for long-term treatment by screening and detecting health problems in the early stages. The EPSDT subsystem supports the IME in the timely initiation and delivery of services. It also supports care management; federal reporting and follow-up treatment tracking by interfacing with MMIS paid claims history and recipient eligibility.

The MMIS EPSDT subsystem satisfies the Agency’s requirements for Member notification, services tracking and reporting. The subsystem maintains EPSDT eligibility and screening information, as well as required demographic data, on the recipient eligibility file and the EPSDT master file. It generates notifications, referral notifications, and a state-defined periodicity schedule based on the information collected from the recipient eligibility file and the EPSDT master file. The EPSDT subsystem reports all screenings and referrals and tracks the treatments, which result from screening referrals. Extensive detail and summary reports are produced as well as required federal reporting and case documentation.

**D.2.2.11 Managed Care – Assignment, Capitation and Enrollment**

The Managed Health Care system is responsible for assigning and tracking membership enrollment with a Managed Care Organization. When new Members are received from the eligibility system, Members eligible for managed health care are assigned to a default MCO. The Member receives a welcome packet and is given the option to change to or from the MCO or change their designated MCO during an open enrollment period. Members who continue in Medicaid past the first year are given open enrollment windows during which they may elect to change to a different MCO. The Managed Health Care subsystem is responsible for default MCO assignments, open enrollment period management, letter notifications to Members and providers, roster notifications, statistical reporting, Capitation Payments, and managed health care coverage rules.

Additional files are created by the MMIS for the care and coordination of a Member’s enrollment:

* Enrollment Data (834)
* LTSS and Waiver Plan
* COBA – E01 process MMIS the FFS dual eligible Members to CMS/COBC on file COBA ID 70020.
* EPSDT file to IDPH
* Prior Authorizations
* TPL
* Claims History (Institutional, Pharmacy and Professional)
* Medicaid Provider Information
* When a Member is assigned to a new MCO:
	+ CCO Detail and Summary
	+ Health Home/Integrated Health Home
	+ Case Manager
	+ Member NEMT Trips
	+ Member HCBS Waiver Service Plan
	+ Member Healthy Behaviors
	+ Exception to Policy (ETP) Documents
	+ Pharmacy Prior Authorization
	+ Provider Lien Data File

MMIS is also responsible for the determination of appropriate Capitation Payments based upon a Member’s eligibility and enrollment. Monthly Capitation Payments are generated for processing the first full week of the calendar month. The timing is intended for appropriate reporting period and also to allow additional time for latent eligibility updates. Off cycle Capitation Payments and adjusts can occur for latent eligibility, historical adjustments, maternity case payments, or recoupments,

Monthly Capitation Payments are generated in the form of ACH payments directly to the MCOs’, PAHPs’, and NEMT broker’s financial institutions. These payments will align directly with the 820 file that is created and sent to the plans and broker.

Additional files that are periodically sent to the MCOs are as follows:

* The following files are sent daily
	+ Medicaid Provider File
	+ Carrier Code File
	+ Universal Provider Application
	+ Provider Lien Data
* The following files are sent weekly
	+ Pharmacy Prior Authorization
	+ Pharmacy PDL
	+ Member Waiver Slot Status
* The following files are sent monthly
	+ Data Dictionary
	+ Provider OCD
	+ Encounter Claim Error File
	+ Healthy Behaviors File

Additional files that are periodically sent from MCOs to MMIS are as follows:

* + The following files are sent when a Member is disenrolled from the MCO
	+ TPL File
	+ Prior Authorization
	+ Case Manager File
	+ Member NEMT Trips
	+ Member HCBS Waiver Service Plan
	+ Member PCP Assignment
* The following files are sent daily
	+ HIPP Referral
	+ Death Referral
	+ Incarceration Referral
* The following files are sent weekly
	+ Terminated Pregnancy
	+ Member Healthy Behaviors
* The following files are sent monthly
	+ Maternity Case Payment Request
	+ Medicaid Provider File
	+ HH/IHH Member Months
	+ IHH/CHH File
	+ Provider Lien Data File

**D.2.2.12 Managed Care – Encounter Data**

MMIS then processes those encounter transactions and applies another set of validation edits to ensure the encounter claim meets minimum requirements. An encounter claim error reporting file is transmitted to each MCO, PAHP and the NEMT broker. If an encounter is rejected by the edits of MMIS, all reasons for rejection are sent in the reporting file. All accepted and rejected encounters are retained in MMIS.

After the encounters are processed in the MMIS, they are sent to many downstream entities, including CMS, actuarial consultants, IME Pharmacy Point of Sale vendor, IDPH, DHS Data Warehouse and the University of Iowa.

**D.2.2.13 Eligibility Verification Information System (ELVS)**

The Eligibility Verification Information System (ELVS) provides date-specific information to providers regarding Member eligibility, provider payment amounts, TPL coverage, and managed health care participation. ELVS is provided at no charge to the providers. Authorized users may request verification for a specific date with the Member SSN or State ID, and DOB. Through EDI 270/271, providers may also search by Last Name, First Name, and DOB.

The IVR unit works against the Eligibility Verification System (ELVS) database. The IVR is a telephone voice and touch-tone response system maintained by the Contractor that provides access to limited data elements from the MMIS. The IVRS operates seven days a week 24 hours a day. The information reported by IVRS is in the form of digitally recorded phrases stored on the IVR computer.

Providers may query Member eligibility or recent provider payment information by responding to prompts on their touch-tone telephones. Based on information supplied by the caller ELVS systematically retrieves data, interprets the data, and then communicates the appropriate phrases back to the caller.

**D.2.2.14 Premium Invoicing Function**

On a monthly basis, MMIS creates and sends a file to the Premium Payment System (PPS) for all months that need to be invoiced for a premium. Iowa Health and Wellness Plan and Dental Wellness Plan premiums are billed through PPS. Hawkipremiums will also be billed through PPS starting in July 2019.

A Member’s healthy behaviors are taken in to account to determine if premiums need to be billed. MMIS tracks a Member’s enrollment year to determine if and when healthy behaviors are met. Reporting is required on the healthy behaviors as well.

**D.2.2.15 Dental Program**

In June of 2017, Iowa Medicaid announced the new Dental Wellness Plan covering most adults eligible for a Medicaid dental benefit. The new plan was effective July 1, 2017, and superseded the original Dental Wellness Plan (which was limited only to those adults eligible through the Affordable Care Act’s Medicaid Expansion).

Dental Wellness Plan members have two dental carrier options to choose from, Delta Dental or MCNA Dental. All Dental Wellness Plan members will receive full dental benefits in their first year of eligibility. Members who complete their dental healthy behaviors each year will continue to receive full benefits. Members who do not complete their dental healthy behaviors may be charged a monthly premium.

Comprehensive information on the plan, including links to the dental carriers, healthy behaviors and other important information is on the Dental Wellness Plan website at: <https://dhs.iowa.gov/dental-wellness-plan>.

If a member does not pay their premiums, they are subject to having their Dental Benefits reduced to a basic set of benefits. MMIS is responsible for maintaining dental eligibility records, benefit level, claims, payments and reconciliations.

**D.2.2.16 Electronic Data Interchange (EDI)**

Iowa Medicaid currently accepts HIPAA levels 1 through 7 transactions through an Electronic Data Interchange (EDI). The current solution is operated by Electronic Data Interchange Support Services (EDISS), a subsidiary of the incumbent MMIS vendor. EDI tools provide a secure environment for the exchange of files and a test environment to onboard providers and external clearinghouses. Claims are validated prior to entry into the MMIS to ensure they meet acceptable quality standards. Claims that do not pass editing at the EDI gateway are rejected and reported back to the providers on either/or:

* Real time transactions:
* 270/271 - Health Care Eligibility Benefit Inquiry and Response
* 276/277 - Health Care Claim Status Request and Response
* 277CA - Claims Acknowledgement Report
* 999 - Functional Acknowledgement
* Batch transaction
* 820 - Premium Payment
* 834 - Benefit Enrollment and Maintenance
* 835 - Health Care Claim Payment/Advice
* 837D - Health Care Claim: Dental
* 837P - Health Care Claim: Professional
* 837I - Health Care Claim: Institutional

The EDI portal has a help desk to provide electronic data interface technical support and to assist Iowa Medicaid providers with connection and issue resolution.

**D.2.2.****17 National Correct Coding Initiative (NCCI) Claims Editing**

The CMS developed the National Correct Coding Initiative (NCCI) to promote national correct coding methodologies and to control improper coding leading to inappropriate payment in Part B claims. The CMS developed its coding policies based on coding conventions defined in the American Medical Association's CPT Manual, national and local policies and edits, coding guidelines developed by national societies, analysis of standard medical and surgical practices, and a review of current coding practices. The CMS annually updates the National Correct Coding Initiative Coding Policy Manual for Medicare Services (Coding Policy Manual). The Coding Policy Manual should be utilized by carriers and FIs as a general reference tool that explains the rationale for NCCI edits.

The current NCCI solution is provided by the incumbent contractor, through Cotiviti, Inc. Cotiviti provides NCCI and Iowa-specific CCI edits for Iowa Medicaid Claims. Claims are adjudicated in the claims engine and a batch file is sent to Cotiviti for CCI and additional cross claim edits that the existing MMIS claims engine does not perform. The cycle waits for the claims edit responses and updates the adjudication accordingly for denials and cutbacks. Cotiviti provides a portal for providers to obtain additional detail surrounding the CCI edit applied to the claim.

**D.2.2.18: Procedure Code/ National Drug Code Crosswalk**

The Social Security Act (the Act) requires States to invoice manufacturers for rebates for physician-administered drugs. To invoice for rebates, States capture drug utilization that identifies, by National Drug Code (NDC), the number of units of each drug for which the States reimbursed Medicaid providers and report the information to the manufacturers. Drugs administered by a physician are typically invoiced to the Medicaid program on a claim form using Healthcare Common Procedure Coding System (HCPCS) codes.

The current HCPCS/NDC Crosswalk file is provided by the incumbent contractor, through RJ Health Systems (RJHS). The MMIS receives the RJHS monthly Drug Pricing and Coding Database File (Standard File), and compares to an integrated drug database (First Data Bank) to update the PDL drug file and confirm NDC and procedure codes, and then applies edits to claims.

**D.2.2.19 Workflow Process Management System**

OnBase**®** from Hyland Software is the current enterprise content management (ECM) software suite that combines document imaging, electronic document management, records management, and workflow. Transform is the imagining/scanning solution currently provided by the incumbent Core MMIS contractor for all documentation, such as paper claims, thousands of forms, and correspondence that flow into the IME via the mailroom. Once documents are scanned into the system they follow the further path of classify, Optical Character Recognition (OCR), and verification before transferred to OnBase and placed in a workflow queue based on document type.

The Agency will be transitioning to an Agency-wide imaging/scanning solution prior to June 30, 2020. Specific timelines for this transition are not available at this time. Once the transition is complete, the Core MMIS contractor will no longer be responsible for providing that solution.

The IME utilizes the workflow module as the primary call log application for the call centers as well as a support application for the OnBase and MMIS help desk. The Agency owns the OnBase licenses, but the solution is currently managed by the Contractor. Other OnBase products in use include scanning computer output to laser disk (COLD), Document Import Processor (DIP) and Report Services. The scan modules are used to bring all correspondence received into the OnBase system. COLD and DIP are modules that are used to import documents from the other systems in the IME, including reports from the MMIS and claims from the imaging system. Report Services is a module used to give the users a customizable interface to standard and ad-hoc reports in the OnBase system.

The Agency anticipates transitioning to an Agency-wide workflow management process system over the next 18 months. Near the end of this transition, the Core MMIS contractor will transition from using OnBase to Open Text Content Suite. Once this transition is complete, the Agency will assume management of the workflow management process system. The Core MMIS contractor will still be responsible for interfacing with the workflow system. Specific timelines for this transition are not available at this time. OpenText Content Suite Platform, the foundation for OpenText Enterprise Information Management (EIM) offerings, is a comprehensive enterprise content management (ECM) system designed to manage the flow of information from capture through archiving and disposition. Content Suite Platform ensures agile information governance to address an increasingly complex and dynamic regulatory landscape and the rapid growth of business information. The Content Suite Platform reduces risk while allowing organizations to focus on using information to drive strategic growth and innovation.

**D.2.2.****20 RightFax**

RightFax is a fax management software product that accepts and sends faxes which uses a connector tool that allows the IME to automatically flow faxes from RightFax to the Workflow Process Management System for imaging and workflows. The software also allows IME users to send faxes from their desktops.  RightFax is supported by the DoIT. The Contractor is responsible for the interface to the document repository and workflow systems, and the administration on IME users and roles. Once the transition to OpenText Content Suite is complete, the Core MMIS contractor will no longer be responsible for administration of users and roles.

***Table 4: Other Supporting Systems and Applications***

|  |  |
| --- | --- |
| **Information Systems**  | Current Responsible Unit |
| **D.3.1: Eligibility Integrated Application Solution (ELIAS)** | Agency DoIT |
| **D.3.2: Family Planning Program (FPP) system** | Agency DoIT |
| **D.3.3: Individual Automated Benefits Calculation (IABC) system** | Agency DoIT |
| **D.3.4: Title XIX System** | Agency DoIT |
| **D.3.5: Individualized Services Information System (ISIS) and Consumer Choices Option (CCO)** | Agency DoIT |
| **D.3.6: Medicare Prescription Drug Part D Database** | Agency DoIT |
| **D.3.7: Medicaid Medicare Information Database (MMCR)** | Agency DoIT |
| **D.3.8: Medicaid for Employed People with Disabilities (MEPD)** | Agency DoIT |
| **D.3.9: Buy-In**  | Agency DoIT |
| **D.3.10: Medicaid Quality Utilization and Improvement Data System (MQUIDS)** | Agency DoIT |
| **D.3.11: Iowa Medicaid Electronic Records System (I-MERS)** | Agency DoIT |
| **D.3.12: Iowa Medicaid Portal Application (IMPA)** | Agency DoIT |
| **D.3.13: Data Warehouse and Decision Support (DW/DS) System** | Agency DoIT |
| **D.3.14: Pharmacy Point-of-Sale System** | Pharmacy Point-of-Sale Unit |
| **D.3.15: DataProbe®** | Program Integrity Unit |
| **D.3.16: HCBS Quality Assurance Provider Oversight** | QIO Unit |
| **D.3.17: Iowa EHR Medicaid Incentive Payment Administration** | PSI (MAXIMUS) |
| **D.3.18: Iowa Health Information Network (IHIN)** | Iowa Health Information Network Non-profit |
| **D.3.19: Health Insurance Premium Payment System (HIPS)** | Agency DoIT |
| **D.3.20: Premium Payment System (PPS)** | Agency DoIT |
| **D.3.21: State Payment Program** | Agency DoIT |
| **D.3.22: Iowa Medicaid Provider Search** | Agency DoIT |
| **D.3.23: Call Center Management System and IVR** | Agency DoIT/One Neck |

**D.3.1 Eligibility Integrated Application Solution (ELIAS)**

ELIAS is the Agency’s eligibility determination system for the Medicaid and CHIP programs.

The ELIAS system utilizes SOA, ESB and data and workflow triggers to maintain real-time up to date recipient information within the MMIS. ELIAS utilizes the Modified Adjusted Gross Income (MAGI) methodology to determine eligibility for Children, Adults under age 65, Parents and Caretakers, Pregnant women and for MAGI- exempt populations, for whom income is not an eligibility factor, such as foster care children. MAGI is a methodology based on federal tax rules for how income is counted and family size is determined for Medicaid and CHIP eligibility.

In addition to MAGI eligibility groups, ELIAS will determine eligibility for Medicaid programs that are not subject to the MAGI methodology (non-MAGI populations). All non-MAGI eligibility groups, with the exception of long term care and waiver populations, were transitioned to ELIAS in March of 2018. The Agency expects to move all Medicaid eligibility processing into ELIAS prior to the completion of the MEME project.

**D.3.2**  **Family Planning Program (FPP) system**

FPP is a web-based data processing system designed to allow family planning clinic workers and Agency IM workers to enter client information to determine eligibility for Iowa Family Planning Program benefits.

**D.3.3** **Individual Automated Benefits Calculation (IABC) System**

The IABC system data remains to support LTSS, SNAP and TANF programs.

**D.3.4 Title XIX System**

The Title XIX system accepts Member medical eligibility from the current IABC, FPP, and ELIAS systems. In addition, other types of eligibility are passed from the following systems:

1. ISIS system passes eligibility indicators for Targeted Case Management, PACE, and Money Follows the Person programs, and County of Legal Settlement.
2. Verified Date of Death file is received from Iowa Department of Public Health (IDPH).
3. Medicare Part A, B, and D entitlement/enrollment information is received from CMS.

The Title XIX system processes each Member record, reviews eligibility, and determines the type of coverage group that provides the most benefit coverage for the Member using hierarchical business rules. After all eligibility has been set for each Member, the Title XIX system adds the Federal Funding and Reporting codes for MARS Federal reporting. Then, the primary active eligibility coverage is analyzed and multiple coverages could be applied to provide the Member with the eligibility they are entitled or assigned to. Those coverages could include Medicare Part A, B, and D Prescription Drug Coverage, enrollment, or disenrollment in Managed Health Care, and TPL (TXIX adds indicators for other insurance from the TPL system, to the eligibility information before sending to MMIS).

The Title XIX System interfaces with a premium billing system to manage enrollment the MEPD population. TXIX passes eligibility and premium information to the billing system. MEPD premiums must be paid, or TXIX blocks eligibility from passing to the MMIS system for the MEPD Member. Medicaid eligibility is stored in the Title XIX system on a full-month basis, with 24 months of historical data included on the file. The Title XIX system checks for premium payments before passing eligibility to MMIS. The Title XIX System passes daily and monthly files to the MMIS:

1. Title XIX Member eligibility which includes Medicaid, presumptive eligibility, facility, incarceration dates, and HCBS waiver eligibility.

**D.3.5 Individualized Services Information System (ISIS)**

The purpose of ISIS is to assist workers in the facility, HCBS waiver, and targeted case management programs in both processing and tracking applications and authorizations through approval or denial. The ISIS application is used by Income Maintenance Worker (IMWs), case managers, QIO contractor staff, child health specialty clinics, transition specialists, financial management service authorization staff, Member and provider customer service representatives, and Agency policy staff.

The information for the approved Member is sent from ISIS to the Title XIX system for additional processing. The Title XIX system passes the prior authorization service record to the MMIS to allow claims to pay at the assigned rates and units.

The process starts in ISIS upon receipt of a file created by the eligibility system that contains facility and waiver program eligibility. The ISIS system prompts each participant to perform key tasks and each participant must respond by entering the appropriate information for that task before the process can move to the next task. The final approval milestone must be completed (closed) before an approved service plan can be sent to the MMIS prior authorization subsystem.

Consumer Choices Option (CCO) is used in conjunction with ISIS as an add-on for Member s to create a “savings” account for medical insurance. Veridian currently manages the Member’s accounts and are the primary users.

**D.3.6 Medicare Prescription Drug Part D Database**

The Medicare Part D database is an eligibility component of the Title XIX System. The Part D file from CMS provides prescription drug eligibility for Dual eligible Members on Medicaid-Medicare. The Medicare Part D database processes daily and monthly, sending and receiving files to and from CMS. Using Title XIX Member data, records are created to indicate current, prospective, retroactive, or changed eligibility information in relation to dual eligibility. In an attempt to increase the match rate with CMS, the Title XIX System uses data in the Medicaid Medicare Information (MMCR) database to overlay the demographic data passed from IABC to both the Social Security Buy-in (SSBI) database and the Medicare Part D database. The Part D response records contain the Part D claw-back information and data for each Member.

NOTE: Medicare Part D database processing is not a part of the SSBI, Iowa’s part A and B Buy-in system.

**D.3.7 Medicaid Medicare Information Database (MMCR)**

The MMCR database was created by the Title XIX system and contains both Medicare and Medicaid data for each Member. In 2006, Medicare Part D Drug Coverage was enacted, and all Iowa dual eligibles were auto-assigned to Medicare Part D drug coverage, which replaced the Iowa Medicaid drug coverage for dual eligible Members. This made Medicare Part D an eligibility component of the Title XIX System.

The MMCR database provides the State with historical data passed originally from IABC and also CMS Medicare Parts A, B & D.

This database was created to store history information for Iowa Medicaid Members entitled to Part A and/or Part B Medicare. The MMCR database identifies the Medicare status of Members that appear to be eligible for Medicare Part D. This database is not only valuable as a research tool; it is also used to pass Medicare data to the MMIS and GHS, the Pharmacy POS contractor, for coordination of coverage for dual eligible Members. Also, Part D information is passed to the MMIS for the generation of the Part D informational letter.

Another purpose of the MMCR database is sending a file of dual eligible Members to the Coordination of Benefits Contractor (COBC), GHI, who is a CMS contractor. This file is used to identify Iowa’s dual eligible Members for Medicare crossover claims processing. This file is sent to the COBC bi-weekly. It contains new eligibility and updates for eligibility for all dual eligible Members.

The MMCR database provides the State with historical data passed originally from the IABC System and also CMS Medicare Parts A, B and D. The Title XIX (Medicaid) portion of the MMCR database is created by using the demographic data in the Title XIX eligibility record. Each time a TXIX record is updated by IABC, if there are demographic changes, this information is stored in the MMCR database.

The federal information (Medicare) portion of the MMCR database is created by using the data from the CMS Enrollment Database (EDB) and Part D eligibility files. This portion contains demographic data as well as Medicare A, B and D entitlement and enrollment data. When information is received from CMS, all data is checked within the MMCR database, and if changes have been made, this record is identified by source, and stored within the database.

**D.3.8 Medicaid for Employed People with Disabilities (MEPD)**

MEPD is a Medicaid coverage group implemented to allow persons with disabilities to work and continue to have access to medical assistance. The MEPD subsystem is integrated within the Title XIX system. The MEPD system applies business rules for Member Medicaid eligibility, which includes applying premium payments and creating billing statements. The process and rules for this premium program are dependent upon timely premium payment.

**D.3.9 Buy-In (BI)**

This is a Medicaid program in which recipients qualify to have the State pay a portion of their medical insurance. It has an interface with IABC, TXIX and CMS. The Buy-In system is comprised of a Custom Information Control System (CICS) and VSAM mainframe component that supports Medicare Parts A and B entitlement, enrollment, and premium activity. The BI system creates the Iowa interface with CMS for Medicare Part A and B entitlement and enrollment for Medicaid eligible Members.

The Title XIX system provides Member eligibility to the BI system. The BI system processes Member eligibility along with previous Medicare buy-in eligibility, if any, and this information is then transmitted by Iowa to CMS once a month. CMS responds to the Iowa data in the second week of the following month. The CMS response file is processed by the BI system and provides Iowa the necessary Iowa Medicare premium totals and a record for each Iowa Member denoting the Medicare eligibility and premium status. The Iowa Member records are stored in the BI system.

**D.3.10 Medicaid Quality Utilization and Improvement Data System (MQUIDS)**

The Medicaid Quality Utilization and Improvement Data System (MQUIDS) is a data entry and retrieval application designed to facilitate the QIO contractor’s job functions used by QIO. It provides common graphical user interfaces that mask the complexities of business rules associated with data entry and display of information for user analysis. The content is guided by the business and policy requirements of medical review. The QIO reviews frequently involve the documentation of health information on individual Members that must be protected. MQUIDS is hosted by DoIT.

**D.3.11 Iowa Medicaid Electronic Records System (I-MERS)**

I-MERS is a web-based tool designed to help inform medical decisions by giving providers access to information about services Iowa Medicaid has paid for specific Members. I-MERS is available to the following types of providers and administrative staff enrolled in Iowa Medicaid: physician, advanced registered nurse practitioners (ARNP), hospital, federally qualified health center (FQHC), rural health clinic (RHC), community mental health center (CMHC), psychiatric medical institution for children (PMIC), home health agency, and pharmacy.

**D.3.12 Iowa Medicaid Portal Application (IMPA)**

The Iowa Medicaid Portal Application was initially created to support provider critical incident reporting. It has been expanded to include the following features. Provider Incident Reporting – This is a real-time web application that enables IMPA users and or providers who are legally responsible to report incidents.  The application has rules-based workflow that integrates the provider reporting with DHS/IME policy and program staff.

Informational Letters (IL’s) – All IL’s are issued and made available through either secure login or anonymous access to the IME’s list server. Users sign up for IL’s under a variety of different categories (e.g., by Provider Type, by Claim Type, etc.) or a user can sign-up for e-mail notification for all IL’s issued.  The IL’s are maintained within the portal for easy access and searching.

Remittance Advice – All providers now use IMPA to access image of their remittance advice(s).

Uploading Documents – There are several reports required for various Medicaid services and programs. Within IMPA, a user can upload a document (e.g. services report) and it is then loaded within the IME’s document management system.

Provider Re-Enrollment– The entire process is accomplished via a web-based application within IMPA. This includes validation of existing provider information (e.g. Business Entity Management), current NPI’s enrolled within Medicaid (Rendering NPI Roster, Pay-To NPI Roster), and the ability to upload any and all documents required as part of the enrollment (e.g., copy of a required license). Shortly after the initiation of the re-enrollment process, all new provider enrollments will be accomplished using these modules in a web-based process.

Managed Care Organizations use IMPA extensively for looking up a Member using the Member lookup tool. This tool retrieves different pieces of information on a Member from several systems with DHS. Data from MMIS, IABC, documents from the DHS imaging system, ISIS and the Data Warehouse are all retrieved in a single location that allows external users access the data in a secured location.

**D.3.13 D****ata Warehouse and Decision Support (DW/DS) System**

The Agency maintains and operates a Data Warehouse and Decision Support (DW/DS) system. This system provides access to data for data analysis and decision-making capabilities The DW/DS system maintains the most recent 10 years of claims data from the MMIS. The DW/DS system’s relational database includes the full claim record for adjudicated claims and other Member, provider, reference and prior authorization data from the MMIS. IME staff from the Agency and contractors use the DW/DS system. The Agency’s Division of Information Technology (DoIT) provides technical support for ETL, datamart creation, and assistance in developing queries and reports to fulfill the analytical needs for the IME.

**D.3.14 Pharmacy Point-of-Sale (POS) System**

The Pharmacy Point-of-Sale (POS) system supports two primary functions: pharmacy claims processing and drug rebate. The Pharmacy POS contract also includes a prior authorization system that interfaces with the POS to receive pharmacy prior authorizations.

The Pharmacy POS system operates on a State-owned hardware platform, which is housed with the current POS contractor. The pharmacy POS contractor is responsible for developing and maintaining interfaces and achieving technical integration with all other modules that use pharmacy data.

The Pharmacy POS system provides for on-line, real time adjudication of pharmacy claims with edits, including application of prior authorization requirements and audits that support the Agency’s policies and objectives. The system includes the following functions:

1. Claims processing for pharmacy claims.
2. Reference (formulary file).
3. Prospective drug utilization review (ProDUR).
4. Drug rebates.
5. Verification of provider and client eligibility.
6. Cost avoidance edits for third-party liability including private insurance and Medicare.
7. Price determination utilizing all pricing sources required.
8. Copayment calculation and tracking in accordance with state regulations.
9. Dispensing fees requirements.
10. Standard ProDUR and customized ProDUR interventions.
11. Customized messaging.
12. Acceptance of prior authorization data from multiple sources.
13. Preferred drug list (PDL) and recommend drug list enforcement through claims processing.
14. Support for additional programs such as Medicare Part B and Medicare Transitional Assistance when they are initiated.
15. Customized override functionality.
16. Ability to implement smart PA edits using patient profiles and therapeutic classes.
17. Administration of all aspects of federal and supplemental rebates excluding supplemental rebate negotiation and contracting.
18. Patient restrictions or lock-ins.
19. Physician exemptions from certain edits.

**D.3.15 DataProbe System®**

The DataProbe System® solution is a surveillance and utilization review system (SURS) developed and hosted by the current Program Integrity contractor. The solution includes an analytic data warehouse platform and toolset to identify fraud, waste and abuse in Iowa’s Medicaid Program, and produce SURS reporting. This solution is expected to be CMS-certified for Iowa by December 2019.

**D.3.16 HCBS Quality Assurance Provider Oversight**

The HCBS QA system provides support for quality reviews, complaint and incident management, slot management, and quality reporting for the HCBS program. The system is hosted by DoIT.

**D.3.17 Iowa EHR Medicaid Incentive Payment Administration**

The Iowa EHR Medicaid Provider Incentive Payment Portal (PIPP) is hosted and supported by Policy Studies Incorporated, now owned by Maximus. The PIPP system accepts the attestation of eligible hospitals and eligible providers for the adoption, implementation, upgrade, or meaningful use of certified EHR technology. CORE MMIS interfaces with the PIPP system by sharing provider data, receiving payment requests, and returning payment results. All interfaces are currently operated in batch mode using Secure File Transfer Protocol.

**D.3.18 Iowa Health Information Network (IHIN)**

The Health Information Technology for Economic and Clinical Health (HITECH) Act, enacted as part of the American Recovery and Reinvestment Act of 2009, was signed into law on February 17, 2009, to promote the adoption and meaningful use of health information technology. Originally, Iowa House File 2539 established eleven advisory councils charged with making recommendations for health reform in Iowa. One of these councils was the Electronic Health Information Executive Committee administered by the Iowa Department of Public Health (IDPH), e-Health Advisory Council which was formed and first met in 2009. The Iowa Health Information Network (IHIN) was developed as a federated hybrid model. In 2015 House File 381 was passed and enabled the IHIN to be used for treatment, payment, and operations (TPO), and also included language to enable Iowa Department of Public Health (IDPH) to utilize a competitive process to select a designated entity to administer and govern IHIN.

Following a bidding process by IDPH, the Hielix/Koble Group (HKG) application was selected to take over stewardship of the non-profit IHIN. On March 31, 2017, the transition to the non-profit designated entity was completed. The IHIN operates under a new nonprofit organization structure, developed with guidance from HKG, and will continue to operate and begin to enhance functionality and offerings to modernize and improve services to support Medicaid providers’ abilities to reach MU measures. The IHIN state designated HIE provides a one-to-many connection, with multiple services which would benefit many.

It is the goal of Iowa Medicaid to incorporate the capabilities of the Health Information Network to simplify administration of the program for both Medicaid and the provider organizations. IME is also committed to ensuring the IHIN is a cornerstone in facilitating information exchange for care coordination, and encouraging patient engagement and healthy behaviors through access to personal health records.

**D.3.19 Health Insurance Premium Payment System (HIPS)**

The HIPS system is utilized by Agency HIPP staff to record applications; collect the minimum data needed to evaluate the application (insurer, covered individuals, type of insurance, cost); determine if the application would be cost effective; approve or deny the application and produce notices of the action to be sent to the applicant; create a case from an approved application; establish a payment schedule and provide warrants to request the actual payments from another program; maintain all of the information on cases such as payment schedules and premium changes; maintain information about the individuals covered, employers and insurance companies; track and record the activity internally with ticklers and narratives; and inform the applicant of the status of their application with Notice of Actions.

**D.3.20 Premium Payment System (PPS)**

This system manages Iowa Health and Wellness Plan and Dental Plan Members’ premiums; amounts due; dollars paid; and generates statements and statistical program reporting. MMIS creates a monthly invoice file that is consumed by PPS in order to create the Statements that are sent to Members. PPS will be updated to begin receiving an invoice file from MMIS for Hawkipremiums in the near future.

D.3.21: State Payment Program

This system provides central office staff and county CPC offices with information about the assignment of State Payment Program cases. This system has a file transfer interface for counties to submit monthly expenditure data for State Payment Program cases that they manage. The submitted expenditures are used by central office staff to make payments to the counties.

D.3.22: Iowa Medicaid Provider Search

The Iowa Medicaid Provider Search provides users the ability to search for Medicaid providers in specific geographical locations based on specialty or Medicaid enrolled provider type.

**D.3.23 Call Center Management System**

The current call center system is with Cisco® Unified Contact Center Express 7.0. Cisco Unified Contact Center Express provides easy-to-deploy, easy-to-use, secure, virtual, highly available and sophisticated customer interaction management for up to 300 agents. Its fully integrated self-service applications improve customer response with sophisticated and distributed automatic call distributor (ACD), interactive voice response (IVR), computer telephony integration (CTI) and agent and desktop services in a single-server contact-center-in-a-box deployment, while offering the flexibility to scale to larger more demanding environments. It also supports business rules for inbound and outbound voice, email, web, and chat. Customer interaction management helps ensure that each contact is delivered to the right agent the first time. The following links provide information highlighting the Cisco system:

<http://www.cisco.com/en/US/docs/voice_ip_comm/cust_contact/contact_center/crs/express_7_0/configuration/guide/uccx70ag.pdf>

***D.4 MMIS Enhancements Currently Underway***

Active projects related to the MMIS that may be assumed by the successful bidder include the following:

**D.4.1 HawkiEnrollment and Reporting**

The Agency’s eligibility system (ELIAS) determines eligibility for Hawki. Enrollment currently occurs in a contracted third-party administrator (TPA) system. The Agency is in the process of integrating the TPA system Hawkienrollment, capitation, and reporting functions into the current MMIS, with a target completion date of June 30, 2019.

D.4.2 MCO Passive Enrollment

Currently new Members are fee for service prior to the actual MCO assignment. The Agency is in the initial planning stages for implementation of an MCO passive enrollment process. Passive enrollment means the State assigns and enrolls Members into a managed care plan without offering an “up front” plan selection period. This is often referred to as an “auto-assignment process.” Once assigned, the Member will have opportunities to change plans. This will then remove the FFS period prior to the Members being enrolled in managed care. This work is projected to begin in April 2019, with a target completion date for the project of June 30, 2019.

Below are the populations that are exempt from MCO assignment:

* State Family Planning Program
* Three month retroactive eligibility period for pregnant women (and during the 60-day period beginning on the last day of the pregnancy), infants under one year of age, and residents of nursing facilities licensed under Iowa Code Chapter 135C at the time of application.
* Alaskan Indian/ Alaskan Native
* Limited benefits for undocumented persons
* QMB/SLMB
* Medically Needy
* Presumptive eligibility
* HIPP eligible
* PACE
* Individuals residing at the campus of the Iowa Veteran’s Home in Marshalltown
* Incarcerated members
* MEPD (MEPD members below 150% FPL as assigned to MCOs; MEPD members above 150% FPL are assigned a monthly premium, and those that have not paid their premium are excluded from MCO assignment until the premium is paid.)

D.4.3 Electronic Visit Verification (EVV)

The Agency is in the initial planning stages for implementation of an EVV solution for personal care services and home health care services. Any MMIS enhancements needed to consume EVV files from an external system and tie to authorization of claims would not begin earlier than July 1, 2019. To allow for sufficient provider testing, the target completion dates are:

* Phase 1 (personal care services) is TBD
* Phase 2 (home health care services) is November 1, 2022

D.5 Provider Reimbursement

The Iowa Medicaid Program pays deductibles and coinsurance for services covered by Title XVIII (Medicare) of the Social Security Act. In certain situations, Iowa Medicaid also pays the monthly premium for supplemental medical insurance (Medicare Part B) for most Members age 65 or older and for certain blind or disabled people receiving medical assistance. Additionally, the Medicare Part A premium will be covered for Members who qualify under the Qualified Medicare Beneficiary (QMB) Program.

Iowa Admin. Code r. 441-79.1 governs Medicaid Provider reimbursement. These rules describe the types of reimbursement; basis of reimbursement of specific provider categories; and reimbursement rules and limitations or restrictions specifically for:

|  |  |
| --- | --- |
| * Ambulatory surgical centers
* Community Mental Health Centers (CMHCs) and providers of mental health services to county residents pursuant to a waiver approved under Iowa Code section 225C.7(3)
* Community-based neurobehavioral rehabilitation residential services and community-based neurobehavioral rehabilitation intermittent services
* Dentists
* Drugs
* Durable medical equipment
* EPSDT private duty nursing and personal cares program
 | * HCBS habilitation services
* HCBS home and vehicle modification and equipment Hospitals
* Home health services
* Hospice services
* Independent laboratories
* Medical supply dealers
* Outpatient reimbursement for hospitals
* Physicians
* Pharmaceutical case management services
* Prosthetic devices
* Rehabilitation agencies
* Translation and interpretation services
 |

These rules also govern:

|  |  |
| --- | --- |
| * Copayments by Members
* HCBS consumer choices financial management
* HCBS retrospectively limited prospective rates
* Medicare crossover claims
 | * Prohibition against reassignment of claims
* Prohibition against factoring
* Reasonable charges for services, supplies, and equipment
 |

Medicaid provider fee schedules can be found at this link: <http://dhs.iowa.gov/ime/providers/csrp/fee-schedule>.