

Section 1115 Demonstration Amendment

**Iowa Family Planning Network
Project #11-W-00188/7**

**State of Iowa
Department of Human Services**

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Section I – Introduction

The Iowa Family Planning Network Demonstration (Project #11-W-00188/7), most recently extended by the Centers for Medicaid and Medicare Services on December 20, 2013, authorizes the State to provide a limited Medicaid benefit package of family planning services to individuals not otherwise enrolled in Medicaid. Services are free and confidential, and available to Iowa residents between the ages of 12 and 54, with family incomes at or below 300% of the Federal Poverty Level. Eligible participants must be U.S. citizens or qualified immigrants, and not otherwise enrolled in Medicaid. Family planning services are also available to women who are losing Medicaid pregnancy coverage at the conclusion of the sixty-day postpartum period. Iowa Medicaid currently administers the Demonstration through a fee-for-service delivery system.

The State has sought §1915(b) waiver authority to implement the High Quality Healthcare Initiative (“Initiative”) to ensure high quality, efficient, and coordinated care to Iowa’s Medicaid population. Under the Initiative, the State will contract for delivery of health care services for the majority of Iowa Medicaid beneficiaries. The proposed amendment seeks to include the family planning services for the Iowa Family Planning Network Demonstration within a managed care delivery system under concurrent §1915(b) authority. There are no other proposed changes to enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements. The requested effective date of this amendment is January 1, 2016, and is conditioned upon approval of the State’s §1915(b) waiver to implement the Initiative, beginning January 1, 2016.

Section II – Public Process

Pursuant to the Iowa Family Planning Network Demonstration (11-W-00188/7) special terms and conditions (STCs), the following provides an explanation of the public process used by the State to reach a decision regarding the requested amendment.

Per STC 13, regarding public notice, tribal consultation, and consultation with interested parties, the State must comply with the State Notice Procedures set forth in 59 Fed. Reg. 49249 (September 27, 1994), the tribal consultation requirements set out at section 1902(a)(73) of the Act as added by section 5006(e) of the American Recovery and Reinvestment Act (P.L. 111-5), and the tribal consultation requirements as outlined in the State's approved state plan, when any program changes to the demonstration are proposed. In states with federally recognized Indian tribes, Indian health programs, and/or Urban Indian organizations, the state is required to submit evidence to CMS regarding the solicitation of advice from these entities prior to submission of any demonstration proposal, amendment, and/or renewal of this demonstration. The state must also comply with the Public Notice Procedures set forth in 42 CFR §447.205 for changes in statewide methods and standards for setting payment rates.

A. Public Notice

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings to discuss the Initiative (<http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>). Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. On March 26, 2015, the DHS released an amended version of the RFP which incorporated changes based on stakeholder feedback.

The public also had the opportunity to comment on this demonstration amendment through a public notice and comment process. Public notice was provided on July 20, 2015 (see Appendix A). This notice, waiver documents, and information about the Iowa High Quality Healthcare Initiative were posted on the aforementioned website, and non-electronic copies were made available for review at DHS Field Offices. In addition, a summary notice was published in several newspapers with statewide circulation. The notice provided the option for any individual to submit written feedback to the State by email or by USPS mail. Comments were accepted electronically through a dedicated email address and a physical address was provided for written comments to be submitted by mail or in person.

In addition, the State held four public hearings to offer an opportunity for the public to provide written or verbal comments about the above-mentioned waivers. Hearings were held at on July 27, 2015 (Bettendorf, IA), July 31, 2015 (Des Moines, IA), August 3, 2015 (Cedar Rapids, IA), and August 5, 2015 (Sioux City, IA). Toll free conference call capabilities were made available for the August 3rd and 5th dates in order to accommodate interested parties who were unable to

attend a hearing in person. Hearings followed the same format, beginning with a brief presentation by State staff about the Initiative, a short question and answer session, and at least one hour of public comments. Time permitting, State staff fielded additional questions at the end of the hearing. The public comment period ended on August 24, 2015 (35-days from the date of publication), at which time comments were cataloged, summarized, and organized.

Throughout the public comment period, a total of 162 questions and comments were received (51 questions, 42 verbal comments, and 69 written comments). Very few comments were waiver specific, as the vast majority were aimed at the Initiative in general (no comments were received directly addressing the Iowa Family Planning Network Demonstration). Of these questions and comments, a broad range of topics were addressed including eligibility/included benefits, member choice, MCO standardization, quality/safety, enrollment, outreach, reimbursement, provider issues, MCO oversight/evaluation, implementation timeline, case management, home and community based services, and service delivery/access. A summary of these comments, along with DHS responses is provided below, and has been made available on the above-mentioned webpage.

i. Program Questions

Comments Received:

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

§1915(b) Waiver Specific Questions:

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

State Response:

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

ii. Case Management

Comments Received:

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

State Response:

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

the member's existing case manager. Following this six-month period, MCOs must provide advance notice of planned case manager changes, and must ensure continuity of care when such changes are made. For those beneficiaries remaining in fee for service, DHS will maintain existing contracts to ensure sufficient numbers of case managers are available to meet the needs of beneficiaries.

iii. Service Delivery/Access

Comments Received:

Several comments were received related to service delivery and access. Generally, commenters expressed concern that MCOs may prioritize profit over services, which will jeopardize member health and safety, and that members with disabilities and/or serious health conditions may no longer receive the attention and care they require. One commenter expressed support that MCOs would be required to contract with the current Medicaid providers. Finally, one commenter suggested that the State extend the transition of care period (i.e., the period during which patients are allowed to keep their existing provider) from six months to a year.

State Response:

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

iv. Home and Community Based Services (HCBS)

Comments Received:

Multiple comments were received related to the provision of home and community based

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

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

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

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

Children’s Mental Health Waiver Specific Comments:

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

Elderly Waiver Specific Comments:

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

ID Waiver Specific Comments:

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

State Response:

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

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

Regarding the references to 441 Iowa Administrative Code Chapter 24, this particular set of rules

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

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

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

v. MCO Oversight/Evaluation

Comments Received:

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

State Response:

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

Pursuant to State legislation (Senate File 505), the Iowa Department of Human Services (DHS) will also be conducting monthly statewide public meetings, beginning March 2016, to gather input from members, stakeholders, providers, community advocates and the general public on the managed care transition and implementation. All comments will be compiled and shared with the Iowa Medical Assistance Advisory Council (MAAC), which serves as an advisory forum on the health and medical care services provided under Medicaid. The MAAC Executive

Committee will be responsible for assessing feedback received and making formal recommendations to the Iowa Department of Human Services. The Executive Committee meets monthly and consists of members from both professional and consumer organizations, as well as the general public. Current organizational representation of the Executive Committee includes the Iowa Department of Public Health, the Iowa Hospital Association, the Iowa Health Care Association/Iowa Center for Assisted Living, the Iowa Medical Society, the Iowa Association of Community Providers, the Iowa Pharmacy Association, AARP, the Coalition for Family and Children's Services in Iowa, the Iowa Association for Area Agencies on Aging, and NAMI Iowa.

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

vi. Eligibility/Included Benefits

Comments Received:

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

State Response:

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

additional data is gathered and analyzed.

vii. Provider Issues

Comments Received:

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

Some comments were received related to medical professionals versus MCOs being best suited to determine a patient's care plan and whether or not the prudent layperson standard for emergency services is met. Further, it was suggested that the State should require every patient to be assigned a primary care provider (PCP), versus the current requirement that requires a minimum of 40% of the MCO's population be in a value-based purchasing arrangement with an assigned PCP by 2018.

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

State Response:

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

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

case of long-term care services, a long-term care professional who has appropriate expertise in providing long-term care services.

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

viii. Enrollment

Comments Received:

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

State Response:

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

ix. Member Choice

Comments Received:

Several comments were received related to member choice of MCO. In general, these commenters expressed concern that the State's proposed process to facilitate MCO selection through tentative assignment would reduce member choice. One commenter indicated that institutionalized beneficiaries would be given a choice of MCO before assignment, whereas non-

institutionalized beneficiaries would not be given a choice of MCO before assignment. Another commenter suggested that in the event that two MCO options are not available, a consumer should have the opportunity to request an alternative option to receive services and that in the event a designated MCO is not providing the necessary and appropriate services, the consumer should be able to request to change MCOs.

State Response:

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

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

x. Outreach

Comments Received:

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

State Response:

The State has developed a robust communication and education plan regarding the Initiative. On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative.

This release was followed by the development of a dedicated web page, various meetings with stakeholder committees and organizations, as well as a series of public meetings to solicit feedback on key program design elements and MCO contract requirements. Stakeholders have also had the opportunity to comment on the Initiative through the public notice and hearing process, during which time stakeholders were invited to review waiver documents, provide comment, and ask questions of State staff. Finally, the State has regularly issued press releases, “Frequently Asked Questions” documents, fact sheets, and presentation documents to help inform the public and to facilitate an ongoing dialogue regarding the Initiative.

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

xi. Implementation Timeline

Comments Received:

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

State Response:

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

xii. Reimbursement

Comments Received:

Several comments were received related to MCO and provider reimbursement. With respect to MCOs, commenters suggested that the State conduct audits of payments to MCOs to ensure plan compliance and performance. One commenter suggested that the established rates were not actuarially sound and were not developed according to CMS guidelines. Concerning providers, commenters suggested that the State increase current reimbursement rates, that critical access hospitals continue to be paid on a cost-basis, that MCOs be required to make per-member/per-month payment to primary care providers, and that MCOs pay providers at a level not less than the most recent DRG base rates for inpatient services and the most recent MAPC rates for outpatient services. Two commenters also suggested the State's limitation of indirect administrative costs to 23% under 441 Iowa Administrative Code 79.1(d)(3) (i.e., methodology for determining the reasonable and proper cost for fee-for-service providers of case management) was too high. Finally, several commenters supported the State's efforts to preserve the Hospital Assessment program during implementation of managed care.

State Response:

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

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

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

request, to its members and in any marketing materials in accordance with the disclosure requirements stipulated in federal regulations.

xiii. Quality/Safety

Comments Received:

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

State Response:

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

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

Finally, the Initiative has been designed to provide high quality health care and create a level of accountability that does not exist today. The State will conduct ongoing reviews of MCO

accreditation requirements to ensure standards are maintained. Further, the State monitor MCOs on a variety of key metrics on an on-going basis (e.g., provider network and access standards).

xiv. MCO Standardization

Comments Received:

Several comments were received related to the standardization of processes across MCOs and concern that variations may be cumbersome for providers. For example, recommended areas of alignment included: (1) primary care provider assignment and algorithms; (2) quality and performance measures; (3) approach to processing, analyzing, and sharing claims and other data with providers; (3) consistent approaches to value based contracting with providers; (4) provider credentialing and application processes; (5) prior authorizations/approvals forms and processes; (6) prescription management; (7) program requirements for chronic conditions and integrated health homes; (8) utilization management processes; (9) health risk assessment tools; and (10) processes to identify 340B claims.

State Response:

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

B. Tribal Consultation

The IME also consulted with Iowa's federally recognized Indian tribes, Indian health programs, and urban Indian health organizations prior to submission of this amendment. Consultation was conducted in accordance with the process outlined in the State's approved Medicaid State Plan, and consisted of an electronic notice directed to Indian Health Service/Tribal/Urban Indian Health (I/T/U) Tribal Leaders and Tribal Medical Directors identified by the Iowa Indian Health Services Liaison. This notice was provided July 14, 2015 and included a copy of the proposed amendment, along with a description of how and where to submit comments or questions (see Appendix B). Only one question was received asking whether I/T/U providers would be required to enroll with an MCO in order to receive reimbursement for services rendered to American Indian/Alaska Natives (AI/AN) who opt to enroll in managed care through the Initiative. The State informed this provider that he/she, whether participating in the network or not, will be paid for covered Medicaid or CHIP managed care services provided to AI/AN enrollees who are eligible to receive services either: (1) at a rate negotiated between the managed care entity and the provider; or (2) if there is no negotiated rate, at a rate not less than the level and amount of payment that would be made if the provider were not an I/T/U provider. Further, the State will operate in compliance with the provisions of the American Recovery and

Reinvestment Act and CMS guidance.

Section III – Data Analysis

Pursuant to the Iowa Family Planning Network Demonstration (11-W-00188/7) special terms and conditions (STCs), the following provides a data analysis identifying the specific impact of the proposed amendment on the current budget neutrality expenditure limit.

Pursuant to this amendment, effective January 1, 2016, current Demonstration enrollees will receive services through a managed care delivery system under concurrent §1915(b) authority. The current Demonstration budget neutrality limit assures that expenditures do not exceed the level of expenditures that would have occurred had there been no Demonstration. Inclusion of Demonstration enrollees in managed care does not impact the level of expenditures that would have occurred absent the Demonstration; therefore, this amendment does not change the current budget neutrality limit.

		CY 2014	CY 2015	CY 2016
	Trend	DY 9	DY 10	DY 11
Demonstration Enrollees	5.1%	\$35.91	\$37.75	\$39.67

Section IV – Description of Amendment

Pursuant to the Iowa Family Planning Network Demonstration (11-W-00188/7) special terms and conditions (STCs), the following provides a detailed description of the amendment, including impact on beneficiaries, with sufficient supporting documentation.

The Iowa Family Planning Network Demonstration provides a limited Medicaid benefit package of family planning services, currently through a fee-for-service delivery system, to individuals not otherwise enrolled in Medicaid. The State seeks to amend the Demonstration to establish a managed care delivery system for waiver enrollees under concurrent §1915(b) authority.

A. Delivery System

The State has recently submitted a §1915(b) waiver to establish a statewide managed care delivery system for the majority of Iowa Medicaid and waiver beneficiaries, including Demonstration participants. By requiring mandatory enrollment in managed care, the State will be positioned to improve care coordination among providers and incentivize active management of members' healthcare as a whole. Under the new delivery system, MCOs will be responsible for delivering all Demonstration covered benefits in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies, while at the same time reducing unnecessary and duplicative services. Enrollment will be mandatory, with the exception of certain populations described in the §1915(b) waiver, and Alaskan Natives and American Indians who will be enrolled voluntarily. Excepted populations will continue to receive services through the fee-for-service delivery system.

B. Readiness Review

Prior to implementing the new delivery system, the State will assess plan readiness in accordance with the requirements of 42 CFR §438. Readiness reviews will include, but not be limited to, documentation and confirmation of adequate network capacity; access to care outside of the network; access to care for enrollees with special health care needs; cultural considerations; and a process to ensure that EOBs, systems, and other notifications meet confidentiality requirements. The State will notify CMS of its intent to conduct a readiness review in advance.

C. Enrollment

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. The State will begin notifying patients and providers in fall 2015, at which time the Enrollment Broker will begin taking MCO selections and providing choice counseling to assist enrollees. To facilitate the MCO selection process, enrollees will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to: (1) distribute the population evenly among the MCOs; and (2) assign all members of a particular family to the same MCO. As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-beneficiary relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment.

becoming effective. Enrollees will be fully enrolled based on their tentative assignment in the absence of an alternative choice made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first 90 days of enrollment without cause.

D. Network Adequacy

In accordance with federal requirements, the State assures enrollee's will have the freedom of choice of DHS enrolled family planning providers and MCOs will be prohibited from requiring the use of in-network family planning providers. MCOs are also contractually required to maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. Again, while use of an in-network provider is not mandatory, various provisions are in place to assure adequate availability of in-network providers. For example, if a member enrolls with the MCO and is already established with a provider who is not a part of the network, the MCO must make every effort to arrange for the member to continue with the same provider if the member so desires. In addition, for the first six months of an MCO's contract with the State, the MCO must extend contract offers to all currently enrolled Iowa Medicaid providers in good standing, at minimum, at current Medicaid fee-for-service rates. The State will provide continuous oversight and monitoring of network adequacy through performance indicators that focus on specific time and distance measures and the provider number, mix, and geographic distribution, including general access standards. MCOs must provide the State written notice at least ninety calendar days in advance of their inability to maintain a sufficient network in any county.

E. Continuity of Care

In accordance with federal requirements, MCOs will be prohibited from implementing prior authorization requirements for family planning services. The State will ensure continuity of care for transitioning Demonstration participants. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights.

F. Quality Oversight

MCOs will also be required to develop critical incident reporting and management in accordance with State requirements, as well as convene a Stakeholder Advisory Board to engage consumers, their representatives, and providers. The State will ensure compliance with all managed care regulations set forth in 42 CFR §438, unless otherwise waived, and that capitation rates are developed and certified as actuarially sound, pursuant to 42 CFR §438.6. Finally, the State will implement a comprehensive quality management and oversight strategy including, but not limited to, monitoring and reporting on finances, member and provider helpline performance, claims payment, prior authorization, care plan development, hearings and appeals, health risk screenings, network composition, and geo-access ratios.

Section VI – Evaluation Design

Pursuant to the Iowa Family Planning Network Demonstration (11-W-00188/7) special terms and conditions (STCs), the following provides a description of how the evaluation design must be modified to incorporate the amendment provisions.

The current evaluation design, with its emphasis on global questions and hypotheses, is appropriate irrespective of delivery system. However, the State will continue to work closely with its evaluation vendor to assess the extent to which the delivery system changes might impact the evaluation design, and determine whether and how the evaluation design should be modified.

Appendix A

**NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES
PUBLIC COMMENT PERIOD FOR CHANGES TO MEDICAID WAIVERS**

Notice is hereby given that the Iowa Department of Human Services (DHS) will hold public hearings on the following waivers that will be submitted to the Centers for Medicare and Medicaid Services (CMS) to implement the Iowa High Quality Healthcare Initiative, as part of IA Health Link, the State's Medicaid Managed Care program. Through this initiative, the State will contract with private health organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)
§1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
§1915(c) HCBS Children's Mental Health Waiver (Amendment)
§1915(c) HCBS Elderly Waiver (Amendment)
§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
§1115 Family Planning Demonstration Waiver (Amendment)

Hearings offer an opportunity for the public to provide written or verbal comments about the above-mentioned waivers. All comments will be summarized and taken into consideration prior to submission to CMS. Hearings will be held at the following dates, times, and locations:

July 27, 2015

Scott Community College
Room 1501 or 2300
500 Belmont Rd.
Bettendorf, IA 52722
10:30 a.m. – 12:00 p.m.

August 3, 2015

Kirkwood Hotel
Room A
7725 Kirkwood Blvd
Cedar Rapids, IA 52404
2:30 p.m. – 4:00 p.m.

July 31, 2015

Wallace Building
Auditorium
502 E 9th St
Des Moines, IA 50319
1:30 p.m. – 3:00 p.m.

August 5, 2015

Western Iowa Tech Community College
Cargill Auditorium, Room D103
4647 Stone Ave
Sioux City, IA 51102
12:00 p.m. – 1:30 p.m.

For those wishing to attend a hearing by telephone, toll free conference call capabilities will be made available for the August 3 and 5 dates. Callers will need to dial 1-866-685-1580, and enter 515-725-1031# when prompted for a conference code.

This notice provides details about the DHS waiver submissions and serves to open the 35-day public comment period. The comment period closes Monday, August 24, 2015.

PROPOSAL & HISTORY

DHS has continually sought to improve Medicaid and the Children's Health Insurance Program (CHIP) and beneficiary choice, accountability, quality of care, and health outcomes. DHS has

also encouraged the provision of community-based services over institutional care where appropriate. The State seeks to build on its experience and improve the coordination of care, which is often available at different points throughout the Medicaid eligibility cycle and patient experience, through implementation of the Iowa High Quality Healthcare Initiative (Initiative). In recent months, this Initiative has also been referred to publicly as the Governor’s “Medicaid Modernization Initiative.”

The Initiative is intended to integrate care and gain efficiencies across the health care delivery system. In turn, the initiative intends to decrease costs through the reduction of unnecessary and duplicative services. Under the Initiative, the majority of Iowa Medicaid beneficiaries will be enrolled in a managed care organization (MCO). MCOs are private health organizations that provide and pay for health care services through an organized network of providers. MCOs use established guidelines to assure member services are appropriate and delivered at the right time, in the right way, and in the right setting. By contracting with MCOs for delivery of high quality health care services, beneficiaries’ care will be better coordinated, resulting in improved access, quality, and health outcomes.

On February 16, 2015, DHS released a preliminary Request for Proposals (RFP) for the Initiative. This release was followed by the development of a dedicated web page, and a series of public meetings. Stakeholders and members of the public were invited to attend meetings held in Cedar Rapids, Des Moines, Davenport, Iowa City, Council Bluffs, Mason City, and Sioux City. In total, close to 1,000 people attended and provided DHS with valuable comments and questions. This public engagement strategy was intended to solicit stakeholder feedback on key program design elements and MCO contract requirements. Several amendments to the RFP have been released incorporating changes based on stakeholder feedback. Additional opportunity to comment on the Initiative is provided through this notice.

GOALS & OBJECTIVES

DHS currently enrolls a portion of the Medicaid and Iowa Wellness Plan populations in managed care arrangements. Depending on a beneficiary’s geographic location and the service provided, these arrangements may include a primary care case manager, a managed care organization (MCO), a prepaid ambulatory health plan, a prepaid inpatient health plan, a separate commercial plan, or a fee-for-service model. The operation of these multiple programs and different care management approaches for each population contributes to a fragmented model of care. Where managed care arrangements are currently employed, services such as behavioral health, medical services and transportation are provided by separate entities, which limits the coordination of care among providers as well as the ability to financially incentivize active management of patients’ health care. In addition, by excluding Medicaid members from managed care when they become eligible for Home and Community-Based Services (HCBS) waivers or long-term facility care, there ceases to be a financial incentive to prevent institutionalization. Similarly, for persons enrolled in the Iowa Medicaid primary care case management option, there is no single entity responsible for overall care management, nor financial incentives to encourage integration or discourage duplication of services.

The Initiative seeks to address the shortcomings of the current model by uniting health care

delivery under one system and allowing all Medicaid enrolled family members to receive coverage from the same MCO. Specifically, the Initiative goals include:

1. Creation of a single system of care that delivers efficient, coordinated, health care and promotes accountability in health care coordination;
2. Improvement in the quality of care and health outcomes for members;
3. Integration of care across the health care delivery system;
4. Emphasis of member choice and increased access to care;
5. Increased program efficiencies and budget accountability;
6. Continued rebalancing efforts to provide community-based rather than institutional care, when appropriate;
7. Holding MCOs responsible for outcomes.

To integrate care across the delivery system, the Initiative has been designed to include a comprehensive and integrated service package. Dental benefits, school-based services, and Iowa Veterans Home services will continue to be delivered as they are today, and are not part of the MCO benefit package. Inclusion of all non-dental covered benefits will provide incentives for coordination of care, oversight of care delivery across all available settings, and reduced duplication of services. The inclusion will also promote integration and efficiency, and prevent fragmentation of services. Further, by holding MCOs accountable for all Medicaid covered benefits, there will be incentives for continuing to rebalance the system toward community-based versus institutional care when needs can be safely met in the community. This change will not prevent eligible individuals from having access to the full Early and Periodic Screening, Diagnostic and Treatment (EPSDT) benefit.

ELIGIBILITY

The majority of Iowa Medicaid members will be eligible for the Initiative, including:

1. Children;
2. Iowa Health and Wellness Plan members (i.e., Iowa Wellness Plan and Iowa Marketplace Choice Plan);
3. Long term care residents; and
4. HCBS Waiver enrollees.

A few populations, however, will be excluded from coverage under the MCOs. Excluded populations are:

1. Medically needy;
2. Medicaid beneficiaries for the period of retroactive eligibility;
3. Persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage;
4. Programs where Medicaid already pays premiums (e.g., Health Insurance Premium Payment Program (HIPP), eligible for Medicare Savings Program only); and
5. Undocumented immigrants receiving time-limited coverage of certain emergency medical conditions;

American Indian and Alaskan Native (AI/AN) populations will have the option of enrolling with an MCO.

ENROLLMENT & FISCAL PROJECTIONS

The Initiative is projected to include approximately 600,000 individuals. The Initiative is expected to save \$51.3M in the first six months of State Fiscal Year 2016. Savings are attributed to the improved management of the health care needs of enrollees, and include factors such as prevention of unnecessary hospitalizations, providing preventive care and reducing duplication of services. Projected savings are not based on a reduction in medically necessary services.

BENEFITS

Under the Initiative, MCOs will be responsible for delivering all Medicaid covered benefits, with the exception of dental benefits. MCOs will deliver physical health, behavioral health, and long-term services and supports in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies, while at the same time reducing unnecessary and duplicative services. Excluded populations will continue to receive services through the fee-for-service delivery system outlined in the Medicaid State Plan.

FEDERAL AUTHORITIES

DHS is working with CMS to obtain the necessary federal authority to implement the Initiative. This will require the submission of a variety of waivers as outlined in this section. DHS is seeking a January 1, 2016, effective date for all waivers.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)

DHS is submitting for CMS approval a new, five-year, §1915(b) Waiver. This authority will permit the State to establish a statewide managed care delivery system. The State will contract with managed care organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program. Enrollees will have the choice of at least two MCOs.

MCOs will be required to maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. If a member enrolls with the MCO and is already established with a provider who is not a part of the network, the MCO must make every effort to arrange for the member to continue with the same provider if the member so desires. The MCO must also extend contract offers to all Medicaid providers during initial transition, as designated in the request for proposals. This allows for continuity of care and stability in the provider network through the transition. The State will provide continuous oversight and monitoring of network adequacy through performance indicators. The indicators will focus on specific time and distance measures and the provider number, mix, and geographic distribution, including general access standards. MCOs must provide the State written notice at least ninety calendar days in advance of their inability to maintain a sufficient network in any county in Iowa.

The State will ensure enrollee continuity of care by requiring that MCOs honor existing authorizations for covered benefits for a minimum of ninety calendar days, without regard to whether such services are being provided by contract or non-contract providers. In addition, MCOs are required to coordinate the exchange of enrollee health care information if an enrollee chooses to switch from one MCO to another. This will be done to ensure that the member's services and care coordination are seamless and without disruption.

MCOs will be required to develop Quality Management/Quality Improvement (QM/QI) programs with ongoing comprehensive quality assessment and performance improvement activities aimed at improving the delivery of health care services to members. As a key component of these QM/QI programs, MCOs will be responsible for developing incentive programs for both providers and members, with the ultimate goal of improving member health outcomes. MCOs will also be required to develop critical incident reporting and management in accordance with State requirements, as well as convene a Stakeholder Advisory Board to engage consumers, their representatives, and providers. Results of MCO QM/QI activities will be used to improve the quality of physical health, behavioral health, and long-term care service delivery with appropriate input from providers and members. Finally, the State will implement a comprehensive quality management and oversight strategy including, but not limited to:

- Monitoring and reporting on MCO finances
- Member and provider helpline performance
- Claims payment
- Prior authorization
- Care plan development
- Grievances and appeals
- Health risk screenings
- Network composition
- Geo-access ratios

§1915(c) HCBS Waivers (Amendments)

The State currently operates seven HCBS waivers. These programs provide services and supports to Medicaid beneficiaries in their home or community who would otherwise require care in an institution. Targeted groups include children with serious emotional disturbances, elderly persons, individuals with physical or intellectual disabilities, and individuals with HIV/AIDS or brain injuries. Member eligibility requirements vary based on the specific program, and services must be cost effective. Each program is subject to a program-specific, maximum number of enrollees.

To address the enrollment of individuals on HCBS waivers into managed care, DHS will be submitting for CMS approval, amendments to all seven State HCBS waiver programs. However, all of the State's current HCBS waivers, with the exception of the Intellectual Disability, Children's Mental Health, and Elderly Waivers made available pursuant to this notice, are currently under review by CMS. The four waivers currently under review are unrelated to the Initiative and were submitted for renewal and/or approval of settings transition plans in the fall

of 2014. As such, DHS is only publishing amendments to its Intellectual Disability, Children's Mental Health, and Elderly Waivers at this time. These amendments will establish a managed care delivery system for all three waivers under concurrent authority with the §1915(b) High Quality Healthcare Initiative Waiver.

When CMS finalizes its pending review of the State's other four HCBS waivers, DHS will modify them to incorporate the managed care components included in the Intellectual Disability, Children's Mental Health, and Elderly Waivers, and make all four available for public comment. The managed care descriptions, such as MCO roles and responsibilities, included in the published waivers will be the same across all of the State's HCBS waivers.

§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)

DHS is submitting for CMS approval, an amendment to the §1115 Iowa Wellness Plan Demonstration Waiver that seeks to:

1. Modify eligibility to include those persons at or below 133% FPL that were previously eligible for the §1115 Marketplace Choice Demonstration; and
2. Establish a managed care delivery system for §1115 Iowa Wellness Plan Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver.

Regarding modified eligibility, the §1115 Iowa Marketplace Choice Demonstration Waiver covers monthly premium costs for adults age 19 to 64, with incomes from 101-133% of the Federal Poverty Level. Historically, members could elect to receive coverage through one of two qualified health plans—CoOpportunity Health and Coventry Health Care of Iowa. CoOpportunity withdrew from the Demonstration in November 2014. The State was also informed earlier this year that Coventry will not be accepting any new members in 2015 and does not intend to continue providing Marketplace coverage to Medicaid members after Iowa moves to a managed care delivery system. By modifying the §1115 Iowa Wellness Plan Demonstration Waiver eligibility, the State will ensure that this population continues to receive services. The §1115 Iowa Marketplace Choice Demonstration Waiver will not be amended or terminated as a result of this proposed amendment to the §1115 Iowa Wellness Plan Demonstration Waiver. However, individuals eligible for the §1115 Iowa Marketplace Choice Demonstration Waiver will now be able to access services through the §1115 Iowa Wellness Plan Demonstration Waiver.

Regarding delivery system, the §1115 Iowa Wellness Plan Demonstration Waiver currently provides health care coverage through use of primary care provider (PCP) coordination, Accountable Care Organizations (ACOs), and managed care models. Models vary by geographic region and are dependent on ACO and/or managed care delivery system availability. However, the majority of Demonstration participants have access to a PCP that provides referrals and care coordination, and focuses on quality outcomes. The proposed amendment will establish a managed care delivery system for the §1115 Iowa Wellness Plan Demonstration Waiver under concurrent authority with the §1915(b) High Quality Healthcare Initiative Waiver.

There are no proposed changes to the §1115 Iowa Wellness Plan Demonstration Waiver enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

§1115 Family Planning Demonstration Waiver (Amendment)

The §1115 Iowa Family Planning Network Demonstration Waiver is a limited-benefit Medicaid program that provides high-quality and confidential family planning services to both men and women age 12 to 54, with incomes at or below 300% of FPL. Currently, these waiver services are provided through a fee-for-service delivery system. This Waiver will be amended to establish a managed care delivery system for §1115 Family Planning Network Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver. There are no proposed changes to the §1115 Iowa Family Planning Network Demonstration enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

IMPLEMENTATION

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. The State will begin accepting MCO selections from current Medicaid members beginning in fall 2015. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights. To facilitate the MCO selection process, members will receive enrollment notices that include a tentative MCO assignment based on an algorithm designed to:

1. Distribute the population evenly among the MCOs; and
2. Assign all members of a particular family to the same MCO.

As all MCOs are required to extend contract offers to all current Iowa Medicaid enrolled providers, existing provider-member relationships should be available as the program is implemented. The notice will also include information regarding all available MCO options and will provide the opportunity for enrollees to make an alternative selection prior to the tentative assignment becoming effective. The timeline for sending these notices will be staggered based on Medicaid eligibility groups. To allow additional time and assistance for members receiving long-term services and supports, these notices will first be sent to individuals in an institution, individuals enrolled in a §1915(c) waiver, and individuals receiving §1915(i) habilitation services under the Iowa Medicaid State Plan. The Enrollment Broker will take MCO selections and provide choice counseling to assist members in selecting an MCO. Members will be fully enrolled based on their tentative assignment if alternative choice is not made by the required response date listed in the notice. Once fully enrolled, members will have the opportunity to change MCOs in the first ninety days of enrollment without cause.

WAIVER & EXPENDITURE AUTHORITIES

While existing waiver and expenditure authorities will not be modified, the following will be

added pursuant to the new §1915(b) High Quality Healthcare Initiative Waiver.

1902(a)(10)(B) Comparability of Services – This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.

1902(a)(23) Freedom of Choice – This Section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State.

REVIEW OF DOCUMENTS & SUBMISSION OF COMMENTS

This notice, waiver documents, and information about the Iowa High Quality Healthcare Initiative are available at: <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>. To reach all stakeholders, non-electronic copies of all of the aforementioned items will be made available for review at a DHS Field Office. A complete listing of DHS Filed Offices is provided as an Attachment to this notice. Written comments may be addressed to Rick Riley, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent via electronic mail to the attention of: DHS, High Quality Healthcare Initiative at ModernizationWaiverComment@dhs.state.ia.us. All comments must be received by Monday, August 24, 2015. After the comment period has ended, a summary of comments received will be made available at: <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>.

Submitted by:
Mikki Stier, Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services

Attachment: DHS Field Office Locations

County	Building Name	Building Address	City	Zip
Benton	Benton County DHS	114 E 4th Street	Vinton	52349
Black Hawk	Black Hawk County DHS	1407 Independence Ave.	Waterloo	50704
Buchanan	Buchanan County DHS	1415 1st Street West	Independence	50644
Buena Vista	Buena Vista County DHS	311 E. 5th Street	Storm Lake	50588
Butler	Butler County DHS	713 Elm Street	Allison	50602
Carroll	Carroll County DHS	608 N Court Street, Ste. C	Carroll	51401
Cass	Cass County DHS	601 Walnut Street	Atlantic	50022
Cerro Gordo	Cerro Gordo County DHS	Mohawk Square, 22 N Georgia Ave, Ste. 1	Mason City	50401
Clarke	Clarke County DHS	109 S Main	Osceola	50213
Clay	Clay County DHS	1900 North Grand Ave. Ste. E-8	Spencer	51301
Clinton	Clinton County DHS	121 Sixth Ave S.	Clinton	52733
Dallas	Dallas County DHS	210 N 10th Street	Adel	50003
Des Moines	Des Moines County DHS	560 Division Street, Suite 200	Burlington	52601
Dickinson	Dickinson County DHS	Dickinson County Courthouse 1802 Hill Ave, Suite 2401	Spirit Lake	51360
Dubuque	Dubuque County DHS	410 Nesler Center, 799 Main Street	Dubuque	52004
Emmet	Emmet County DHS	220 S 1st Street	Estherville	51334
Fayette	Fayette County DHS	129 A North Vine	West Union	52175
Floyd	Floyd County DHS	1206 S Main Street	Charles City	50616
Hamilton	Hamilton County DHS	2300 Superior Street	Webster City	50595
Harrison	Harrison County DHS	204 E 6th St	Logan	51546
Henry	Henry County DHS	205 W Madison Street	Mt. Pleasant	52641
Jasper	Jasper County DHS	115 N 2nd Ave E. Suite H	Newton	50208
Jefferson	Jefferson County DHS	304 South Maple	Fairfield	52556
Johnson	Johnson County DHS	855 S. Dubuque Street	Iowa City	52240
Lee	Lee County DHS	933 Avenue H	Ft. Madison	52627
Lee	Lee County DHS	307 Bank Street	Keokuk	52632
Linn	Linn County DHS	411 3rd Street SE, Suite 600	Cedar Rapids	52401
Linn	Linn County DHS, Harambee House	404 17th Street Southeast	Cedar Rapids	52403
Mahaska	Mahaska County DHS	410 S 11th Street	Oskaloosa	52577

Marshall	Marshall County DHS	206 W State Street	Marshalltown	50158
Montgomery	Montgomery County DHS	1109 Highland Ave	Red Oak	51566
Muscatine	Muscatine County DHS	3210 Harmony Lane	Muscatine	52653
O'Brien	O'Brien County DHS	160 Second Street Se	Primghar	51245
Polk	Polk County DHS	Polk County River Place, 2309 Euclid Ave	Des Moines	50310
Polk	Polk County DHS- Carpenter Office	1900-1914 Carpenter	Des Moines	50314
Polk	Centralized Service Intake Unit	401 SW 7th St, Suite G	Des Moines	50309
Pottawattamie	Pottawattamie County DHS	417 E Kanesville Blvd.	Council Bluffs	51503
Pottawattamie	Income Maintenance Customer Call Center	300 W Broadway, Suite 110	Council Bluffs	51503
Scott	Scott County DHS	600 W. 4th St. 2nd & 3rd Floors	Davenport	52801
Sioux	Sioux County DHS	215 Central Ave. Se	Orange City	50141
Story	Story County DHS	126 S Kellogg Ave, Suite 101	Ames	50010
Union	Union County DHS (SVC)	304 N Pine St	Creston	50801
Union	Union County DHS	300 N Pine St	Creston	50801
Wapello	Wapello County DHS	120 E Main St	Ottumwa	52501
Warren	Warren County DHS	1005 South Jefferson Way	Indianola	50125
Webster	Webster County DHS	330 1st Ave. N	Fort Dodge	50501
Winneshiek	Winneshiek County DHS	2307 US Highway 52 South	Decorah	52101
Woodbury	Woodbury County DHS	Trosper-Hoyt Co Svc Bld., 822 Douglas St	Sioux City	51101

Appendix B

**NOTICE OF IOWA DEPARTMENT OF HUMAN SERVICES
NOTICE OF TRIBAL COMMENT PERIOD FOR CHANGES TO MEDICAID
WAIVERS**

Notice is hereby given to all federally recognized tribes, Indian Health Programs and Urban Indian Organizations within the State of Iowa that the Iowa Department of Human Services (DHS) will be submitting the following waivers to the Centers for Medicare and Medicaid Services (CMS) to implement the Iowa High Quality Healthcare Initiative (Initiative). Through this Initiative, the State will contract with private health organizations for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)
§1915(c) HCBS Intellectual Disabilities Waiver (Amendment)
§1915(c) HCBS Children’s Mental Health Waiver (Amendment)
§1915(c) HCBS Elderly Waiver (Amendment)
§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)
§1115 Family Planning Demonstration Waiver (Amendment)

This notice provides a comprehensive summary of the purpose of the waiver/waiver amendments and describes the method for providing comments and questions.

PROPOSAL

DHS currently enrolls a portion of the Medicaid and Iowa Wellness Plan populations in various managed care arrangements, depending on a beneficiary’s geographic location and the service provided. This often contributes to a fragmented model of care. The Initiative seeks to address the shortcomings of the current model by uniting health care delivery under one system and allowing all Medicaid enrolled family members to receive coverage from the same managed care organization (MCO). The Initiative goals include:

1. Creation of a single system of care that delivers efficient, coordinated, health care and promotes accountability in health care coordination;
2. Improvement in the quality of care and health outcomes for members;
3. Integration of care across the health care delivery system;
4. Emphasis of member choice and increased access to care;
5. Increased program efficiencies and budget accountability;
6. Continued rebalancing efforts to provide community-based rather than institutional care, when appropriate;
7. Holding MCOs responsible for outcomes.

Under the Initiative, MCOs will be responsible for delivering all Medicaid covered benefits, with the exception of dental benefits. MCOs will deliver physical health, behavioral health, and long-term services and supports in a highly coordinated manner. The system is intended to integrate care and improve quality outcomes and efficiencies. This initiative will also reduce unnecessary and duplicative services. Excluded populations will continue to receive services through the fee-

for-service delivery system outlined in the Medicaid State Plan.

FEDERAL AUTHORITIES

DHS is working with CMS to obtain the necessary federal authority to implement the Initiative. This will require the submission of a variety of waivers as outlined in this section. DHS is seeking a January 1, 2016, effective date for all waivers.

§1915(b) High Quality Healthcare Initiative Waiver (New Waiver)

DHS is submitting for CMS approval a new, five-year, §1915(b) Waiver. This authority will allow the State to establish a statewide managed care delivery system. The State will contract with MCOs for delivery of high quality health care services for the majority of current populations and services in the Iowa Medicaid program. Enrollees will have the choice of at least two MCOs.

§1915(c) HCBS Waivers (Amendments)

The State currently operates seven Home and Community Based Services (HCBS) waivers. These programs provide services and supports to Medicaid beneficiaries in their home or community who would otherwise require care in an institution.

To address the enrollment of individuals on HCBS waivers into managed care, DHS will be submitting for CMS approval, amendments to all seven State HCBS waiver programs. However, all of the State's current HCBS waivers, with the exception of the Intellectual Disability, Children's Mental Health, and Elderly Waivers made available pursuant to this notice, are currently under review by CMS. The four waivers currently under review are unrelated to the Initiative and were submitted for renewal and/or approval of settings transition plans in the fall of 2014. As such, DHS is only publishing amendments to its Intellectual Disability, Children's Mental Health, and Elderly Waivers at this time. These amendments will establish a managed care delivery system for all three waivers under concurrent authority with the §1915(b) High Quality Healthcare Initiative Waiver.

When CMS finalizes its pending review of the State's other four HCBS waivers, DHS will modify them to incorporate the managed care components included in the Intellectual Disability, Children's Mental Health, and Elderly Waivers, and make all four available for public comment. The managed care descriptions, such as MCO roles and responsibilities, included in the published waivers will be the same across all of the State's HCBS waivers.

§1115 Iowa Wellness Plan Demonstration Waiver (Amendment)

DHS is submitting for CMS approval, an amendment to the §1115 Iowa Wellness Plan Demonstration Waiver that seeks to:

1. Modify eligibility to include those persons at or below 133% FPL that were previously eligible for the §1115 Marketplace Choice Demonstration; and

2. Establish a managed care delivery system for §1115 Iowa Wellness Plan Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver.

There are no proposed changes to the §1115 Iowa Wellness Plan Demonstration Waiver enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

§1115 Family Planning Demonstration Waiver (Amendment)

The §1115 Iowa Family Planning Network Demonstration Waiver is a limited-benefit Medicaid program that provides high-quality and confidential family planning services to both men and women age 12 to 54, with incomes at or below 300% of FPL. Currently, these waiver services are provided through a fee-for-service delivery system. This Waiver will be amended to establish a managed care delivery system for §1115 Family Planning Network Demonstration Waiver under concurrent authority with the 1915(b) High Quality Healthcare Initiative Waiver. There are no proposed changes to the §1115 Iowa Family Planning Network Demonstration enrollment, benefits, enrollee rights, cost sharing, evaluation design, sources of nonfederal share of funding, budget neutrality, or other comparable program elements.

IMPLEMENTATION

Statewide MCO enrollment in the Initiative will be effective January 1, 2016. The State will begin accepting MCO selections from current Medicaid members beginning in fall 2015. Participants and providers will be notified in advance of the transition through letters and general public announcements. Information provided will include relevant changes in service delivery, MCO assignment and contact information, procedures for electing a different MCO, and member rights.

WAIVER & EXPENDITURE AUTHORITIES

While existing waiver and expenditure authorities will not be modified, the following will be added pursuant to the new §1915(b) High Quality Healthcare Initiative Waiver.

1902(a)(10)(B) Comparability of Services – This section of the Act requires all services for categorically needy individuals to be equal in amount, duration, and scope.

1902(a)(23) Freedom of Choice – This section of the Act requires Medicaid State plans to permit all individuals eligible for Medicaid to obtain medical assistance from any qualified provider in the State.

TRIBAL IMPACT

The majority of Iowa Medicaid members will be eligible for the Initiative, including children, Iowa Health and Wellness Plan members (i.e., Iowa Wellness Plan and Iowa Marketplace Choice Plan), long term care residents and HCBS Waiver enrollees. A few populations, however, will be excluded from coverage under the MCOs, specifically:

- Medically needy,
- Medicaid beneficiaries for the period of retroactive eligibility,
- Persons eligible for the Program of All-Inclusive Care for the Elderly (PACE) who voluntarily elect PACE coverage,
- Programs where Medicaid already pays premiums (e.g., Health Insurance Premium Payment Program (HIPP) and individuals eligible for Medicare Savings Program only),
- Undocumented immigrants receiving time-limited coverage of certain emergency medical conditions.

American Indian and Alaskan Native (AI/AN) populations located in the State of Iowa who are eligible for the Initiative may voluntarily enroll with an MCO. AI/AN members will be enrolled in the Medicaid fee-for-service program, and will have the option to opt-in to MCO enrollment. To address AI/AN members and providers who voluntarily elect to participate in the Initiative, DHS contracts with participating MCOs will include protections for Indian health care providers participating in Medicaid as required pursuant to Section 5006(d) of the American Recovery and Reinvestment Act of 2009 (AARA). Specifically, MCOs will be required to comply with Section 6.3.13 of the Iowa Medicaid Modernization Request for Proposals, which can be accessed at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140.

SUBMISSION OF COMMENTS

A full notice, waiver documents, and information about the Iowa High Quality Healthcare Initiative, including dates and times for public hearings, will be available the week of July 20, 2015 at: <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>. Written comments may be addressed to Rick Riley, Department of Human Services, Iowa Medicaid Enterprise, 100 Army Post Road, Des Moines, IA 50315. Comments may also be sent via electronic mail to the attention of: DHS, High Quality Healthcare Initiative at ModernizationWaiverComment@dhs.state.ia.us. Additionally, DHS would be happy to schedule a phone or in-person consultation to discuss the Initiative in further detail. All comments must be received by Monday, August 24, 2015. After the comment period has ended, a summary of comments received will be made available at: <http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization>.

Submitted by:
Mikki Stier, Medicaid Director
Iowa Medicaid Enterprise
Iowa Department of Human Services