Section 1115 Demonstration: Iowa Market Place Choice Plan

Public Comments

Title	Description	Created At
Rural Health Clinics comments	On behalf of the many Medicaid patients and those not covered by insurance cared for by Iowa's 140 Rural Health Clinics (RHCs), I am writing to express great concern about our state's request to waive paragraph 1902 (a)(15) and 1902 (bb) FQHC/RHC reimbursement. Iowa Medicaid's request would completely waive RHC payment and coverage requirements. The Kaiser Commission on Medicaid and the Uninsured September 2013 Fact Sheet titled "Medicaid Expansion through Premium Assistance" appears to confirm this analysis. Iowa Medicaid has asked to enroll all Medicaid beneficiaries newly eligible (101%-133% of the federal poverty level) and current enrollees in a premium assistance program. Medicaid patients would receive money to allow them to enroll in private insurance plans and the RHCs would negotiate payment rates with the plans (no PPS). And the plans would be allowed to exclude RHCs from their networks if the plan can show "adequate" coverage. Iowa Medicaid data shows RHCs and FQHCs provide Medicaid visits at a lower cost per beneficiary ($461 at RHCs and $500 at FQHCs) than private physicians' offices ($552). The most recent Medicaid data available for Iowa providers compares a variety of cost and beneficiary information for RHCs, FQHCs, and private providers, and shows how much more dependent RHCs and FQHCs are on Medicaid as a revenue source than the average physician. So the loss of that revenue has far greater impact than in non-RHC, non-FQHC physician office settings. As with Medicaid, the Medicare cost per user is significantly lower for RHC/FQHCs than the Medicare cost per user for Evaluation and Management Services. RHCs can (and do) have a lower per capita cost but sometimes folks argue that RHCs bring patients back for more visits thus, looking at the “per user” cost would account for that. Even here, the cost per user is dramatically lower for RHCs/FQHCs than it is for physician E/M services. A final concern is that Iowa's RHCs did not have an opportunity to review and comment on this request for Medicaid waiver, which seems contrary to the transparency required in the law. Thank you for this opportunity to comment and hear RHC concerns. The safety net for Medicaid and Medicaid patients created by the Rural Health Clinic program reversed the closing of rural practices throughout the country and in Iowa. We would not want to see that occur again because insufficient opportunity is afforded to RHCs to work with Iowa Medicaid to develop a reimbursement system that works for our state.	2013-09-26 14:25
Family Planning Council of Iowa Comments on Iowa Marketplace Choice Plan	108 3rd Street, Suite 220 Des Moines, Iowa 50309 (515) 288-9028 Office (515) 288-4048 Fax fpci@fpcouncil.com www.fpcouncil.com September 26, 2013	2013-09-26 14:23

Title	Description	Created At
	Cindy Mann Deputy Administrator Centers for Medicare & Medicaid Services 7500 Security Boulevard Baltimore, MD 21244 Re: Iowa 1115 Waiver Application, Iowa Marketplace Choice Plan Dear Ms. Mann: The Family Planning Council of Iowa (FPCI) thanks you for the opportunity to submit comments on Iowa's 1115 Waiver Application, Iowa Marketplace Choice Plan ("Marketplace Choice Plan"). FPCI is a Title X grantee in the state of Iowa. We are a non-profit organization whose mission is to assure access to family planning services for all Iowans who desire such services. This mission includes assuring that family planning services are available to all Medicaid beneficiaries. As part of its 1115 Waiver Application, Iowa is requesting a waiver from §1902(a)(10)(A) "To enable Iowa not to cover all family planning providers when the Marketplace QHPs can demonstrate that Marketplace Choice Plan members will be adequately served through other providers." We are not clear about the intent of this waiver request. We are concerned that the request could, even inadvertently, eliminate the ability of Medicaid beneficiaries to receive family planning services from the provider of their choice. Section 1902(a)(23)(B) of the Social Security Act guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if the provider is outside of their Medicaid managed care network. Because of this concern, the Marketplace Choice Plan's request that CMS waive §1902(a)(10)(A) of the Social Security Act to "enable Iowa not to cover all family planning providers" should be denied. The state should be required to allow Choice Plan enrollees to access family planning services from providers outside of QHP networks regardless of the availability of the services in network, in accordance with federal law. We appreciate the opportunity to comment on the Iowa Marketplace Choice Plan Medicaid waiver application. If you require additional information about the issues raised in these comments, please contact Jodi Tomlonovic at (515) 288-9028 or jtomlonovic@fpcouncil.com. Sincerely, Jodi Tomlonovic, Executive Director Family Planning Council of Iowa	
PhRMA comments	PhRMA appreciates the opportunity to submit comments and we are submitting our comments via email.	2013-09-26 14:11
Comments from National Health Law Program	The National Health Law Program submits the below comments to Iowa's Iowa Wellness Plan and Marketplace Choice Plan. Full comments will be available on our website at www.healthlaw.org > Issues > Health Reform > NHeLP Comments. September 26, 2013 VIA ELECTRONIC SUBMISSION Centers for Medicare & Medicaid Services Department of Health and Human Services	2013-09-26 13:43

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	P.O. Box 8016 Baltimore, MD 21244-8016 Re: Iowa Wellness Plan §1115 Demonstration Application Dear Sir/Madam: The National Health Law Program (NHeLP) is a public interest law firm working to advance access to quality health care and protect the legal rights of low-income and underserved people. We appreciate the opportunity to provide comments to both of Iowa's proposed § 1115 Demonstration Applications, the Iowa Wellness Plan (IWP) and the Marketplace Choices Plan (MCP). NHeLP recommends that HHS not approve the IWP and the MCP applications for § 1115 authority exactly as requested. The applications include provisions that clearly or arguably are not authorized by any law. We urge HHS to address these problems and require Iowa to bring the proposals to a legally approvable form. We urge HHS to work with Iowa to achieve a Medicaid Expansion that will serve future Medicaid enrollees well, including those inside Iowa benefiting from these proposals and those in other states who may pursue similar proposals. We request that HHS zealously enforce its stated policies and the legal limits of Medicaid § 1115 demonstration law, to ensure progress in Iowa without opening the door to policies that ignore the fundamental nature of Medicaid as an entitlement program. Second, we ask that before HHS takes action on this request, it take steps to address its own "stewardship of federal Medicaid resources." GAO, Medicaid Demonstration Waivers: Approval Process Raises Cost Concerns and Lack of Transparency at 32 (June 2013). As the GAO recently concluded, "HHS's [budget neutrality] policy is not reflected in its actual practices and, contrary to sound management practices, is not adequately documented….[T]he policy and processes lack transparency regarding criteria." Id. A. Legal Authority for Premium Assistance In its MCP application, Iowa proposes to conduct a § 1115 demonstration program to use individual market premium assistance to implement a Medicaid Expansion. It is our understanding that Iowa proposes to conduct individual market premium assistance relying on authority at § 1905(a). However, the statute and legislative history create serious questions about the validity of this claimed authority. Section 1905(a) defines "medical assistance" and, for the most part, is a listing of services that can or must be included in this definition. By contrast, Congress has dealt with premium assistance in other, specific provisions of the Act. Congress has authorized states to conduct group or employer coverage premium assistance, which are unambiguously and carefully detailed in statute at §§ 1906 and 1906A. Notwithstanding two very recent policies from HHS (in regulatory and sub-regulatory guidance), there is no history of statutory or regulatory guidance for § 1905(a) authority. Given the uncertainty of the statutory authority and the untested regulatory framework, we believe it is incumbent upon HHS to be extremely cautious and exacting in the approval of any such authority, and even more so for related waivers. HHS should hold tightly to the principles announced in its March 2013 Question and Answer document. And under these circumstances, HHS must also be	

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	unmistakably clear as to the waiver authorities being granted and their legal limits. B. Single State Agency In addition to premium assistance authority concerns, Iowa's request, as currently written, fails to ensure that the single state Medicaid agency will remain in charge of the Medicaid program for affected populations, as the Medicaid Act requires. The application does not provide the general public or HHS with information and specifics establishing that the single state agency will continue to make administrative and policy decisions for the program. By law, the single state agency must be in control and accountable for developing and implementing Medicaid coverage. While Iowa may not formally delegate away Medicaid authority, it in effect surrenders control over the majority of benefits for an entire category of enrollees. As currently proposed, Iowa will not control many benefits package details, authorization criteria, and provider contracts and terms but will leave these to health plans. The application only envisions a "written agreement" between the state and the issuers "outlining expectations" of the state. Such an agreement does little to reduce the concern that the health plan would act as an independent entity with its own authority contrary to what Medicaid law permits. NHeLP is very supportive of HHS requiring written agreements between the involved entities to satisfy the legal requirement for a single state agency, clearly delineating roles and responsibilities, with the ultimate authority and responsibility housed in the Medicaid agency. However, the application is sparse on details and the mere presence of a written agreement "outlining expectations" does not satisfy this requirement. HHS should require more of Iowa as a condition of approval. While assuring consumer protections and enabling ongoing reporting and monitoring, this would also address some of the GAO's conclusions that find HHS processes lack the supporting evidence required to justify deviations from historical requirements. GAO, supra. at 32. C. Limits of § 1115 Waiver Authority Prior to addressing specific features of the requested waivers, we believe it is important to address one repeated misapplication of § 1115 authority within these waiver applications. § 1115 explicitly circumscribes waiver authority in Title XIX to requirements contained in § 1902. Anything outside of § 1902 is not legally waivable through the 1115 demonstration process. Despite this legal fact, Iowa repeatedly requests waiver of requirements that lie outside of § 1902. These waiver requests, sometimes explicit and other times necessitated by their objectives, include attempts to skirt requirements in § 1906, § 1916, § 1916A, § 1927, and § 1937. None of these waiver requests are permissible because the substantive requirement rests outside of 1902 and independently requires state compliance. In other words, any reference to the provision in section 1902, which could be waived, does not and cannot also waive the independent, freestanding requirements of these Medicaid Act provisions. Such waivers are also patently contrary to all of HHS' stated regulation and policy on premium assistance. In particular, Iowa also seeks to waive several requirements contained within § 1937. However, as Iowa designs a Medicaid Expansion implementing § 1937 benefits, it cannot waive § 1937 requirements which	

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	lie outside of § 1902. Iowa attempts to avoid this problem by identifying citations in § 1902(a) to waive – but none of these change the fact there is an independent requirement at § 1937. Consequently, Iowa cannot properly waive EPSDT (protected at § 1937(a)(1)(A)(ii)), FQHC or RHC services (protected at § 1937(b)(4)), any EHB services including maternity care and pediatric dental and visions services (protected at § 1937(b)(5)), or family planning services and supplies (protected at § 1937(b)(7)). Moreover, placed outside of 1902 by Congress these provisions have been repeatedly amended to be strengthened, thus evidencing their core roles as objectives of the Medicaid Act. Finally, Iowa cannot, in this proposal, circumvent these requirements in § 1937 by requesting waiver of § 1902(k)(1). Iowa's MCP proposal (along with IWP) is predicated on receiving enhanced matching funds (100% FMAP in 2014) for its Medicaid Expansion population. However, under § 1903(i)(26), Iowa cannot receive any matching funds for the Medicaid Expansion population that are not tied to coverage of § 1937 benefits. To put it simply, HHS cannot waive elements of § 1937 and pay enhanced FFP.	
National Association of Community Health Centers (NACHC) Comments	The National Association of Community Health Centers, Inc. (NACHC) (Roger Schwartz, Associate Vice President and Executive Branch Liaison) provides the following comments on the State of Iowa's application for a 1115 demonstration to implement its proposed Marketplace Choice Plan. Please see this link to access NACHC's full comments on the demonstration: http://www.nachc.org/client/documents/NACHC%20CMTs%20on%20Iowa%20Waiver%2009262013.pdf. A summary is provided here. Under the proposed demonstration, Iowa would provide Medicaid to some members of the adult group by subsidizing their enrollment in a qualified health plan (QHP) on the Exchange. The proposed benefit package consists of "Iowa's commercial market Essential Health Benefit (EHB) benchmark package," supplemented by a commercial dental product. Iowa proposes not to otherwise supplement the EHBs to provide the remaining components of an alternative benefit plan (ABP) as described in Section 1937 of the Social Security Act. Alternative benefit plans are the required form of coverage for the chief new eligibility group created under the Affordable Care Act (ACA), referred to by CMS as the "adult group." It appears Iowa is asking for CMS to waive (among other requirements) the requirements that States provide individuals served through an ABP with access to the services that federally-qualified health centers (FQHCs) provide pursuant to federal law, and that payment for those services be made in accordance with the prospective payment system methodology. In NACHC's view, it would be both unlawful and bad policy for CMS to grant a waiver broad enough to allow Iowa not to comply with the Section 1937 requirements. We urge CMS to require Iowa to provide a wraparound benefit sufficient to ensure compliance with all requirements for alternative benefit plans, and at a minimum, to require Iowa to provide a wraparound FQHC benefit. As an initial matter, Iowa did not comply with the procedural regulations at 42 C.F.R. Part 431, Subpart G. The scope of the waiver requests in	2013-09-26 12:43

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	Iowa's August 23 application was a surprise to interested members of the public, because it was broader than the waivers included in Iowa's public notice and draft application for the Marketplace Choice Plan, published on July 15, 2013. Therefore, the public notice and draft application did not meet the requirements in the regulations to include a full list of requested waivers. Even as the final application is worded, the waiver authorities requested are not broad enough to achieve what Iowa proposes. More importantly, CMS should not approve the demonstration in its proposed form because the proposal to provide the adult group with coverage limited to the commercial EHB benefit would undermine the Medicaid program and would not serve any viable experimental objective. Coverage of the adult group under the ABP benefit, as required by the ACA, does not take effect until January 1, 2014. To permit Iowa to provide a narrower benefit package as an alternative to a not-yet-implemented mandate undermines Congress' intent. In this period of hurried preparation to implement the Medicaid expansion, other states will look to Iowa's example. A message from CMS that a Section 1115 demonstration can be used to avoid implementing the ACA-required Medicaid benefit for the adult group, and instead provide unsupplemented commercial EHB coverage to Medicaid recipients through premium assistance, would have a cascading negative effect on the implementation of the law. CMS has already agreed in the preamble to a final rule issued in July 2013 that such a broad waiver would not advance the objectives of Medicaid. NACHC urges CMS to adhere to this (correct) conclusion and require Iowa to provide the full Section 1937 benefits as a condition of approval. In addition, in NACHC's view, it by definition does not promote the purposes of the Medicaid program to deny required benefits to a categorically needy population. Congress clearly wanted for the adult group to receive the full scope of benefits under Section 1937. Congress not only amended Section 1902 of the Act to make ABPs the mandatory form of coverage for the adult group, but also, through an amendment to Section 1903 of the Act, prohibited federal financial participation in the costs of care for this population other than medical assistance provided through ABPs. More specifically, federally-qualified health center (FQHC) services and the accompanying PPS rate methodology are required for all categorically needy individuals, including the adult group. It is also imperative as a policy matter to ensure that the adult group has access to the full scope of Medicaid services provided at FQHCs. FQHCs provide comprehensive primary care, and they are a familiar source of care to many in the newly eligible group, so their services will be critical for effective and efficient coverage for this population. The failure under the proposed Marketplace Choice Plan to provide for payment for FQHC services under the cost-related PPS methodology is also highly inconsistent with the objectives of the Medicaid program. In order to approve a Section 1115 demonstration, the Secretary must make a judgment that the project has a research or a demonstration value. A demonstration motivated merely by the intention to reduce a State's administrative burdens does not meet this standard. Iowa's application does not state any viable research purpose that would be served by waiver of the coverage requirements in Section 1937. If	

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	States are not required to implement the ACA's requirements for the adult group, as enacted, in the first instance, there is no valid basis for research and experimentation under a 1115 demonstration at a later point. Similarly, the budget neutrality analysis, a core component of the Secretary's evaluation process for 1115 demonstrations, cannot be undertaken if States are not required to implement coverage for the new group under the ACA's terms. As acknowledged in the August 13, 2013 actuarial report accompanying the waiver application, projected costs without waiver "are not available or applicable" for the Marketplace Choice Plan population, because coverage for this group has not yet taken effect. Iowa's inability to document budget neutrality is particularly concerning in light of its proposed benefit cut under the Marketplace Choice Plan. If Iowa needs to avoid supplementing the commercial EHB benefit in order for premium assistance on the Exchange not to exceed the costs to the federal government of providing ABPs through Medicaid managed care plans, this suggests that the premium assistance model as proposed here does not advance the objectives of the Medicaid program. Finally, the premiums Iowa proposes to impose on enrollees under the Marketplace Choice Plan exceed the scope of the Secretary's waiver authority. NACHC urges CMS to work with Iowa to bring its proposal into compliance with federal law on this point. Thank you for considering these comments. Roger Schwartz Associate Vice President Executive Branch Liaison National Association of Community Health Centers	
CMS Should Require Iowa to Provide a Full Section 1937 Wraparound Benefit, and at Minimum, an FQHC Benefit	The National Association of Community Health Centers, Inc. (NACHC) (Roger Schwartz, Associate Vice President and Executive Branch Liaison) provides the following comments on the State of Iowa's application for a 1115 demonstration to implement its proposed Marketplace Choice Plan. Please see this link to access NACHC's full comments on the demonstration: http://www.nachc.org/client/documents/NACHC%20CMTs%20on%20Iowa%20Waiver%2009262013.pdfA summary is provided here. Under the proposed demonstration, Iowa would provide Medicaid to some members of the adult group by subsidizing their enrollment in a qualified health plan (QHP) on the Exchange. The proposed benefit package consists of "Iowa's commercial market Essential Health Benefit (EHB) benchmark package," supplemented by a commercial dental product. Iowa proposes not to otherwise supplement the EHBs to provide the remaining components of an alternative benefit plan (ABP) as described in Section 1937 of the Social Security Act. Alternative benefit plans are the required form of coverage for the chief new eligibility group created under the Affordable Care Act (ACA), referred to by CMS as the "adult group." It appears Iowa is asking for CMS to waive (among others) the requirements that States provide individuals served through an ABP with access to the services that federally-qualified health centers (FQHCs)	2013-09-26 12:36

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Magellan Health Services comments on Iowa waiver application	Magellan Health Services (Magellan) is a publicly-traded, clinically-driven specialty health care management company based in Avon, Connecticut. Magellan has operated for 35 years, providing a product portfolio that includes behavioral health (substance use disorder and mental health services), employee assistance program services, specialty pharmacy management, radiology benefits management, and Medicaid administration services to over 60 million people throughout the United States. Magellan is a leader in mental health, substance use disorder, and other specialty health care areas with a focus on care and respect; we apply clinical expertise to assist people during challenging times. Magellan values its partnership with the state of Iowa managing behavioral health (BH) benefits for the state's Medicaid beneficiaries. Magellan recently expanded this partnership to test new care delivery models - specifically behavioral health homes - to improve the delivery of primary care services and to coordinate care for individuals receiving Medicaid BH services. Magellan applauds the state's efforts to continually	2013-09-26 09:22

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	improve access to health care in the state of Iowa for its most vulnerable populations. Magellan is pleased that the two Medicaid, Section 1115 waivers pending at the Center for Medicare and Medicaid Services (CMS) aim to ensure the coordination of these services for the low- and moderate- income Iowans that have not previously had access to health care. We appreciate the open and transparent process during the waiver application process and are grateful to have the opportunity to provide the following comments on the pending waivers for your consideration: Iowa Wellness Plan Waiver (New Medicaid Eligibles under the Affordable Care Act with Incomes 0-100% of FPL) Magellan supports the proposed carve-out of BH benefits for this very low-income population. The coordination of behavioral health benefits and the behavioral health home model fits well with the overall direction of assuring the coordination of care for this expansion population. Iowa Wellness Plan and the Iowa Marketplace Choice Plan (New Medicaid Eligibles under the Affordable Care Act with Incomes 101-138% of FPL) Screening for "Medical Frailty" Both plans screen out the medically frail through a process that depends largely on beneficiary self-reporting. If identified as meeting the criteria, the plans direct them to traditional, fee–for-service (FFS) Medicaid (although they may opt for the Wellness Plan). Magellan proposes that the state enhance the screening process for populations that self identify as having BH conditions. This will help ensure that newly eligible adults receive needed services, and can be particularly beneficial for identifying individuals in need of BH/substance use disorder services. Support for Non-Emergency Medical Transportation Both plans propose to eliminate non-emergency medical transportation services (NEMT) and propose to evaluate the impact on the populations affected, with traditional Medicaid populations as the control group. Our experience in Iowa has shown us anecdotally the value of providing NEMT to the BH population to help ensure compliance with follow-up visits and prescribed medications. Because of our long experience with this population and its special needs relating to compliance, we propose that an entity with deep experience with the Medicaid BH population carry out this evaluation. Thank you for your consideration on this important matter. Please do not hesitate to contact me at jboyle@magellanhealth.com with any questions.	
CMS should not waive current FQHC reimbursement methodology	The Iowa Primary Care Association and our 14 Federally Qualified Health Centers (FQHCs) strongly object to the State's request to waive § 1902(a)(15) & 1902(bb) FQHC/RHC Reimbursement. Because the waiver of FQHC reimbursement was not included in the draft waiver application made available by the State this summer for public review and comment, we feel it is inappropriate for the State to include this in its application and infringes on required transparency by States when applying for Medicaid 1115 waivers. The rationale provided by the State for this waiver request is that it "will allow Iowa to limit its financial exposure and align reimbursement to FQHCs/RHCs for Marketplace Choice Plan members with QHPs/ contracted	2013-09-26 08:39

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	rates." With the federal match for the Medicaid expansion population at 100% in the first three years and gradually decreasing to no less than 90% after 2020, there is no basis for this rationale. The State loses nothing financially by ensuring FQHCs and RHCs are paid as they currently are under Medicaid. Preservation of cost-based reimbursement is critical to the financial viability of FQHCs in the near-term; however, as noted in our written comments to Iowa Medicaid Enterprise (IME) on August 15, 2013, the FQHCs are open to working in partnership with Iowa Medicaid Enterprise to cooperatively develop, evaluate, and implement alternative and contemporary payment methodologies as the health care landscape evolves. For the individuals who will be covered through the Iowa Marketplace Choice Plan, reimbursing FQHCs through the current methodology is absolutely essential. Based on our experience with IowaCare patients and the uninsured, we fully understand the resources needed to bring these individuals into a more healthful status. This includes understanding the social determinants that impact their health and having the capacity and resources to identify and address those determinants. The current payment methodology provides essential resources for FQHCs to accomplish this and, importantly, helps meet Governor Branstad's and the Legislature's goal of encouraging individuals covered through this plan to engage in healthy behaviors and take responsibility for their health. Iowa's FQHCs welcome the opportunity to have fully-informed, collaborative discussions with IME that achieves a new, fair payment methodology that does not jeopardize the financial stability of FQHCs or the State, and which allows us sufficient time to develop, test, implement, and measure the impact of a new methodology. If the State agrees to work with us over the next three years to develop a new, fair reimbursement methodology as we have outlined above, we will be able to implement a new methodology when the 100% federal match ends in 2017. As also noted in our written comments to Iowa Medicaid Enterprise, the Iowa General Assembly included the following language in legislation that created the Iowa Health and Wellness Plan: "An Iowa health and wellness plan provider shall be reimbursed for covered benefits under the Iowa health and wellness plan utilizing the same reimbursement methodology as that applicable to individuals eligible for medical assistance under section 249A.3, subsection 1." (New Code Chapter 249N.6, subsection 5a.) We were very pleased the Legislature recognized the importance of continuing to provide FQHCs cost-based reimbursement for this new Medicaid population. In mandating cost-based reimbursement through the Omnibus Budget Reconciliation Act of 1989, Congress recognized the unique role of FQHCs as a safety net provider. Before this mandate was passed, the FQHC federal grant (which comprises, on average, 19% of a health center's budget and is intended to be used for the uninsured) was subsidizing the cost of providing care to Medicaid patients. As we learned from the IowaCare 1115 waiver, reimbursing FQHCs at a rate lower than cost seriously jeopardizes the financial viability of the centers. Other Medicaid expansion programs, such as Iowa's Child Health	

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	Insurance Program (hawk-i), have acknowledged the need to reimburse FQHCs at cost for these services. Maintaining a consistent reimbursement methodology across all Medicaid programs helps ensure our financial stability and sustains the FQHC network of providers whose mission is to provide care to the underserved. Again, we welcome the opportunity to work collaboratively with the State to develop a new reimbursement methodology that does not negatively impact either the FQHCs or the State, but in the meantime, maintaining the existing reimbursement methodology is absolutely critical.	
NFPRHA Comments on Iowa Market Place Choice Plan	The National Family Planning & Reproductive Health Association (NFPRHA) is pleased to submit these comments on Iowa's 1115 Waiver Application, Iowa Choice Plan ("Choice Plan"). NFPRHA is a national membership organization representing the broad spectrum of family planning administrators and providers who serve the nation's low-income, under-insured, and uninsured women and men. NFPRHA represents approximately 550 organizational members that operate or fund a network of nearly 5,000 safety-net health centers and service sites in 49 states and the District of Columbia. NFPRHA is concerned that, as currently written, Choice Plan could exclude coverage of family planning services and providers. NFPRHA urges the Centers for Medicare & Medicaid Services (CMS) to clarify that Choice Plan and any affiliated qualified health plans (QHP) must include family planning services and supplies as required by law, and that Choice Plan cannot restrict beneficiaries' access to family planning providers. Mandatory Family Planning Services Section 1902(a)(10)(A) of the Social Security Act requires the state to provide coverage for family planning services and supplies to "all individuals" who meet eligibility requirements. Family planning services are one of the few mandatory services in the Medicaid program and, because of their importance, are reimbursed at an enhanced rate. Choice Plan requests that CMS waive § 1902(a)(10)(A) of the Social Security Act to "enable Iowa not to cover all family planning providers when the Marketplace QHPs can demonstrate that Marketplace Choice Plan members will be adequately served through other providers." Along with § 1902(a)(10)(A), other provisions of federal law also require coverage of family planning services for Medicaid beneficiaries. Section 2303(c) of the Affordable Care Act (ACA) clarifies that Medicaid benchmark and benchmark-equivalent coverage—which includes coverage for the new adult group authorized by the ACA—is required to cover family planning services and supplies. Additionally, benchmark and benchmark-equivalent coverage must include the Essential Health Benefits (EHB), which in turn includes coverage of the women's preventive health services benefit. This benefit includes the full range of FDA-approved contraceptive methods, family planning counseling, and well-woman visits. CMS has stated that under 1115 demonstrations to provide premium assistance for the purchase of qualified health plans (QHPs), "beneficiaries remain Medicaid beneficiaries and continue to be entitled to all benefits and cost-sharing protections." This would and should include coverage of family planning services and supplies, as mandated by federal law.	2013-09-25 14:53

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	Freedom of Choice Federal law protects the ability of Medicaid beneficiaries to receive family planning services from the provider of their choice. Section 1902(a)(23)(B) of the Social Security Act guarantees that Medicaid beneficiaries can receive family planning services from any qualified Medicaid provider, even if the provider is outside of their Medicaid managed care network. Therefore, Choice Plan's request that CMS waive § 1902(a)(10)(A) of the Social Security Act to "enable Iowa not to cover all family planning providers" should be denied. The state should be required to allow Choice Plan enrollees to access family planning services from providers outside of QHP networks regardless of the availability of the services in network, in accordance with federal law. We appreciate the opportunity to comment on the Iowa Choice Plan Medicaid waiver application. If you require additional information about the issues raised in these comments, please contact Robin Summers at 202-286-6877. Sincerely, Clare Coleman President & CEO National Family Planning & Reproductive Health Association	
Olmstead issues to consider	The Iowa Olmstead Consumer Taskforce applauds the Governor and the Legislature for coming to agreement on the Iowa Health and Wellness Plan, but has significant concerns. (1) The importance of non-emergency medical transportation to accessing health care is well known, with ample research demonstrating that lack of transportation reduces use of preventive and primary care; on the other hand, research shows that access to transportation results in decreased use of emergency room services. The request for a waiver of NEMT transportation requirements thus undermines Iowa's stated goals realted to wellness and prevention. (2) The Taskforce strongly recommends that Medicaid eligbility be retroactive to three months, which would be consistent with the stated goal of minimizing out-of-pocket expenses for Iowans with limited income. (3) We understand that the purpose of the proposed premiums is to incentivize participation in wellness and prevention activities, but individuals below 138% of federal porverty level are at risk of all the disadvantages of poverty, from lack of transportation and child care to constraints in work schedules. We urge disapproval of any exception to Iowa regarding the charging of premiums.	2013-09-24 11:36
Child and Family Policy Center's Comments on the Iowa Market Place Choice Plan	In reviewing the Iowa Marketplace Choice Plan (IMCP) waiver, there are four elements, in particular, that CFPC recommends be changed prior to submission: 1. Non-emergency transportation: Federal law requires Medicaid to cover non-emergency transportation. Providing non-emergency transportation services makes it possible for individuals to participate in services that improve or stabilize health, including preventive and health maintenance services. The waiver application does not offer any hypotheses for why eliminating non-emergency transportation will improve health. Section 1115 demonstrations are designed to test new strategies that improve health, not receive waivers from current requirements that have demonstrated effectiveness in improving health.	2013-09-19 11:43

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	2. Co-payments for non-emergency room use of emergency room care: Iowa currently requires a $3 co-payment for non-emergent use of the emergency department. The IMPC proposal calls for a $10 copayment for non-emergency use of the emergency department, which exceeds the federal maximum copayment of $8. While the actual difference between an $8 and $10 co-payment is likely to be trivial, there is no justification provided for seeking a waiver in this area – particularly as CMS has indicated it has no discretion in granting it. 3. EPSDT services for 19 to 21 year-olds: Again, federal law requires that there be EPSDT services for 19 to 21 year-olds. Failing to provide EPSDT services for this age group could delay the diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). While such EPSDT services are not part of the essential benefits for the Marketplace plans, these services should be provided to those who are 19 to 21 who require them, even if this requires some kind of wrap-around coverage for the provision of that service, similar to what is being provided for dental care. 4. Retroactive eligibility for services: While in the future, with the Marketplace, there should be far fewer individuals who become enrolled in Iowa Marketplace Choice Plan at the time of a specific medical event (often hospitalization or emergency room use), there still will be some individuals who will come to the attention of the system and can be enrolled at that time. Provisions are needed to ensure that, in these instances, individuals are covered at least as a bridge by the existing Medicaid program or the Iowa Marketplace Choice Plan. CFPC has concerns regarding the logistics of imposing premiums or monthly contributions. Even among individuals with substantial means, the use of incentives or sanctions through health insurance coverage can only do so much to support behavior changes and adoption of more healthy regimens. These are most likely to be successful for relatively simple and straightforward actions, such as obtaining a flu shot or having an annual physical examination. There are few specifics in the posted 1115 demonstrations regarding the waivable premiums. CFPC recommends the following additional provisions be added to the proposal: 1. Set very simple standards for demonstrating the individual has engaged in health improvement practices, based initially upon a review of claims data. 2. Establish an alternative means for meeting the requirement through individual reporting of activities or behavior changes. 3. Notify individuals who have not yet met the requirement on a regular basis of their need to do so, starting at least six months before their renewal period, so they can schedule activities or take action to do so. 4. Provide extensions for individuals who have scheduled qualifying activities (such as a physical examination appointment) within the initial twelve month period, even if the appointment has not yet occurred. 5. Simplify the premium structure to a $10 monthly contribution for those below 100 percent of poverty and a $20 month contribution (as it is in the posting) for those between 100 and 138 percent of poverty.	

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	6. Before initiating monthly contributions, review the claims records to determine if any individuals may qualify under the "medically frail" category and make changes to their status, as appropriate. 7. Include in the research and evaluation activities related to the 1115 demonstration specific follow-up reviews and studies of those individuals who do not meet the above requirements and become subject to monthly contributions. On issues of transparency, informed choice, and due process, there will be need to be substantially more outreach and explanation of options to those enrolling than currently exists under the standard Medicaid program. In particular, individuals will have to be fully informed of what constitutes being "medically frail" and what the difference in coverage is for those who qualify as "medically frail" if they accept either of the two new plans. In addition, particularly since the "medically frail" will include individuals who have frailties but generally do not use medical services except in times of emergency, reviewing claims data should not be used as a primary means of determining their "frailty" but should only be employed in identifying individuals for whom additional assessments may be warranted. There will need to be additional detail provided regarding the appeals and review processes related to all populations covered under the demonstration projects, with particular attention to ensuring that those who are designated (or might be designated) as "medically frail" have full information about, access to, and support to ensure their rights. The two 1115 demonstrations Iowa is submitting to cover adults under 138 percent of poverty would essentially create two additional public programs (the Iowa Wellness Plan and the Iowa Marketplace Choice Plan) in addition to the two existing Medicaid programs (the standard Medicaid program and the Health Insurance Premium Payment (HIPP) program for eligible individuals with employer-sponsored insurance). Operating these four programs and monitoring eligibility status that is dependent upon income, health status, and availability of employer-sponsored insurance will be a significant and complex administrative challenge. This process is extremely complex and will require significant and continuous outreach, education, and procedural safeguards to ensure that eligible individuals obtain the coverage and services to which they are entitled and that the federal Medicaid program requires that they receive. Adopting a continuous eligibility process (with the beneficiary's right to request a change) is one, simple change that could be made, not only to help individuals obtain and maintain coverage, but also to increase efficiency and reduce administrative burden. While the federal match rate for provision of care is 100% for the first three years of Medicaid expansion (and at least 90% thereafter), the federal match rate for administrative expenses is only 50-74%. It is in the state's fiscal interest to make administering this program as simple and efficient as possible. With respect to implementation of this new system, there should be research and hypothesis testing regarding the efficiency and effectiveness of this more complex system in relation to a simple expansion of the standard Medicaid program. This testing should include weighing the additional administrative costs and burden, as well as implications to enrollment and use of services and the costs thereof.	

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	For further information, contact: Charles Bruner (cbruner@cfpciowa.org) or Mary Nelle Trefz (mnt@cfpciowa.org).	
Iowa Coalition of Health Advocates: Group Comments on the Iowa Marketplace Choice Plan	We would like to commend the efforts of all involved in working toward the development and successful implementation of an Iowa Health and Wellness Plan that provides high-quality healthcare services to Iowa's low-income population and assures cost-effective coverage opportunities for all Iowans. We would like to take this opportunity to recommend changes to several specific provisions within the "Iowa Marketplace Choice Plan". These changes should be made to meet the requirements of a demonstration project and to achieve the health goals for the population that is to be served by the program. We would also like to voice the importance of transparency and open discussion in articulating and developing the numerous programmatic details and definitions that must be occur prior to the implementation of the program. The four areas of concern are as follows: 1. The coverage of transportation expenses for non-emergency transportation. Federal law requires Medicaid to cover non-emergency transportation. Evidence and experience demonstrate that providing non-emergency transportation allows individuals to participate in non-emergency medical visits (including preventive and health maintenance services) and ensures the use of services that improve or stabilize health. Section 1115 demonstrations are designed to test strategies to expand coverage, expand eligibility, or test innovative delivery systems that improve care, increase efficiency, and reduce costs. No hypotheses are offered as to how eliminating these services would meet any of these demonstration strategies. 2. The provision of EPSDT services for 19-21 year-olds. Federal law requires that EPSDT services must be available for 19-21 year-olds. Failing to provide EPSDT services for this age group could delay the diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). 3. The provision for retroactive eligibility for coverage. The section 1115 applications propose ending the current Medicaid provision of retroactive eligibility. Under current Medicaid provisions, individuals are eligible for coverage at the time of their application and Medicaid can even be billed for some services the individual received prior to enrollment. While the development of the Iowa Marketplace and the expansion of the Medicaid program should reduce the number of individuals who become enrolled at the time of a specific medical event, there will still be instances where individuals may need to become enrolled at the time of a specific medical event (often a hospitalization). Ending retroactive eligibility would mean that, in these instances, the hospitals, emergency rooms, or individuals would bear these immediate costs. 4. The provision for maximum emergency room cost-sharing for non-emergent care. The maximum required copayment for non-emergency use of the emergency room, as set by federal law, is $8. The Iowa demonstration proposal, however, calls for a $10 copayment. While the actual difference between an $8 and a $10 dollar copayment is small, there is no justification provided for seeking a waiver in this	2013-09-18 07:19

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	area. CMS has indicated that it does not have the authority to waive any cost-sharing limitations with a section 1115 waiver. Implementing the Iowa Marketplace Choice Plan will require a great deal of detailed planning work and complex implementation strategies. There are several areas which are not specifically addressed in the demonstrations that should be areas for future discussions: 1. Provisions for education and outreach of those who may be eligible so they can make informed choices 2. Provisions for appeal and due process in all aspects of the process of securing and maintaining coverage. 3. Provisions for determining what constitutes a "medically frail" individual. 4. Provisions for determining when monthly premiums are waived. 5. Assurances that family planning services are covered and that federal qualified health centers are provided full and fair reimbursement. 6. How the different provisions for which a waiver is required will be subject to evaluation and, in particular, to looking for any negative consequences to individuals. We are confident that there are ways to revise the waiver, as it currently is drafted, to meet all these concerns. We are also confident that with continued open discussion, cooperation, coordination, and a lot of hard work, the technical and logistical challenges of implementation can also be overcome. Brain Injury Alliance of Iowa Easter Seals of Iowa Epilepsy Foundation of North Central Illinois, Iowa, and Nebraska Family Planning Council of Iowa Iow Mental Health Planning Council Iowa Association of Area Agencies on Aging Iowa Community Action Association Iowa Developmental Disabilities Council Iowa Federation of Labor, AFL-CIO Iowa Primary Care Association Iowa Psychological Association League of Women Voters of Iowa Leukemia, Lympompa Societ, Iowa Chapter National Alliance on Mental Illness of Greater Des Moines National Association of Social Workers, Iowa Chapter Planned Parenthood of the Heartland Polk County Health Services	
Federal budget neutrality cannot be met.	7. The requirement of federal budget neutrality cannot be met. The Iowa proposal which involves premium assistance will cost more for the federal government than just expanding Medicaid. Administratively and for overall cost, 3 programs cost more than 1 program to serve the same population – it will include the administrative cost of handling the movement of persons among 5 programs and the tracking of health and	2013-09-16 10:50

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	wellness activities to justify no premium cost – a burdensome process for providers and for Medicaid personnel. In reviewing previous financial documents based on Milliman reports, total federal funds needed for the Exchange premium subsidy for only the 101% - 138% population was $442,768,339 in FY 2015. Why is this version only indicating $200 to $230 million? The total federal cost if straight Medicaid expansion was chosen for all up to 138% was $576,700,000 in FY 2015	
The public comments represented more people than indicated in waiver application.	3. Did HHS/CMS receive copies of the actual public comments? To the reader of the waiver applications, it appears there were few comments made – 13 is the maximum number in the narrative. Actually the comments submitted were on behalf of multiple organizations – in some cases, up to 30 organizations – which represent thousands of people. • AARP • Health Advocates • NAMI Iowa • NAMI Greater Des Moines • AMOS (A Mid Iowa Organizing Strategy) • Iowa Mental Health Planning Council • Access for Special Kids (ASK) Resource Center • Brain Injury Alliance of Iowa • Easter Seals of Iowa • Child and Family Policy center • Epilepsy Foundation of North Central Illinois, Iowa, Nebraska • Family Planning Council of Iowa • Iowa Alliance for Retired Americans • Iowa Association of Area Agencies on Aging • Iowa Citizen Action Network • Iowa Community Action Association • Iowa Developmental Disabilities Council • Iowa Nurses Association • Iowa Olmstead Task Force • Iowa Primary Care Association • Iowa Psychological Association • Iowa Statewide Independent Living Council • League of Women Voters of Iowa • Leukemia and Lymphoma Society, Iowa Chapter • National Association of Social Workers, Iowa Chapter • National Multiple Sclerosis Society, Upper Midwest Chapter • Planned Parenthood of the Heartland • Polk County Health Services • Visiting Nurse Services of Iowa • • And others	2013-09-16 10:46
Since Medicaid dollars are being used to finance the Marketplace Choice Plan, the Medicaid rules and benefits should follow along with the $	1. Medicaid expansion dollars are being used to pay for the Iowa Health and Wellness Plan and for the premiums in the Marketplace Choice plan – shouldn't the Medicaid rules follow along with the Medicaid dollars- aren't they one and the same?	2013-09-16 10:44

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Persons in community corrections should be eligible.	4. There is no reference to the eligibility of persons in community corrections. Persons in community corrections are often in health care limbo - the Dept. of Corrections does not pay for health care since they are technically ex-offenders – eligibility for Medicaid not possible because the interpretation is that they are still in the corrections system, and the county often does not have the funds available to pay either. People in community corrections need health care to help reduce recidivism and to lower corrections costs. Including persons in a version of Medicaid expansion will improve health outcomes.	2013-09-16 10:40
EPSDT services must be available for 19-21 year olds.	Failing to provide EPSDT services for this age group could delay the diagnosis and treatment of mental illness, as many mental illnesses manifest when individuals are in this age range (19-21 years old). To deny EPSDT services does not improve health outcomes.	2013-09-16 10:38
Do not approve the use of monthly premiums	1. Monthly premiums (contributions) are not allowable according to ACA and Medicaid expansion rules for persons with incomes less than 150% of FPL. In the waiver population, 138% of federal poverty level translates to an hourly wage of $7.62 – barely above the federal minimum wage rate of $7.25 – hardly a flush financial circumstance where premiums can be afforded. In addition to being prohibited by current Medicaid regulations, previous experience in the state of Iowa has demonstrated several negative consequences of imposing premiums on this population. During its first year of implementation, Iowa Care imposed premiums on individuals with incomes below 100% of poverty. The imposition of premiums on this population produced significant hardship and disenrollment, leading Iowa to eliminate this requirement after only its first year of practice. Why would we hit our heads against a brick wall again and expect different results? Iowa Care covers people up to 200% of FPL and there was significant hardship and disenrollment to premiums. The Iowa Wellness Plan covers people up to 100% of FPL. The Market Place Choice Plan covers people at 101% to 138% of FPL. In a review of research, even among individuals with substantial means, the use of incentives or sanctions through health insurance coverage can only do so much to support behavior changes and adoption of more healthy regimens. These are most likely to be successful for relatively simple and straightforward actions, such as obtaining a flu shot or having an annual physical examination. There is no definition of what preventative services will include. For individuals terminated from the Iowa Wellness Plan for nonpayment of required contributions – they must then reapply for the Iowa Wellness Plan and go through the eligibility process again to receive coverage. Will terminated persons also have to pay past premiums current in order to be re-enrolled? How far will the hardship waiver reach? Once again, health outcomes will improve – but not because of monthly premiums or because monthly premiums are forgiven – it will be because health insurance will finally be available to the expansion population.	2013-09-16 10:35

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Allow retroactive eligibility - 3. Retroactive eligibility should be mandatory for all programs. Current Medicaid Iowa policy is to allow b	Non-emergency medical transportation should be included as a benefit	2013-09-16 09:57
Allow Retroactive Enrollment	The Iowa Hospital Association strongly opposes the request to waive retroactive eligibility and enrollment. There are many times when an uninsured/non-enrolled patient needs access to health care services and receives care on the presumption that the individual qualifies for Medicaid. Currently, the Iowa Medicaid program allows providers to retroactively bill for care received 90 days prior to Medicaid enrollment being approved. IHA recommends this apply to both the Iowa Wellness Plan and the Iowa Marketplace Choice Plan to avoid gaps in coverage and increased out-of-pocket costs to patients.	2013-09-10 09:47
Allow Retroactive Enrollment	The Iowa Hospital Association strongly opposes the request to waive retroactive eligibility. There are many times when an uninsured/non-enrolled patient needs access to health care services and receives care on the presumption that the individual qualifies for Medicaid. Currently, the Iowa Medicaid program allows providers to retroactively bill for care received 90 days prior to Medicaid enrollment being approved. IHA recommends this apply to both the Iowa Wellness Plan and the Iowa Marketplace Choice Plan to avoid gaps in coverage and increased out-of-pocket costs to patients.	2013-09-10 09:44