

FEB 23 2016

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

Dear Mr. Palmer:

This letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) is approving the state of Iowa's High Quality Healthcare Initiative waiver program (Control Number IA.08). The waiver allows Iowa to mandatorily enroll Section 1931 children and adults and related populations, blind/disabled adults and children and related populations, aged and related populations, foster care children and Title XIX SCHIP beneficiaries into a Medicaid managed care organization, with some exclusions, for services authorized under the state plan or a waiver of the state plan. This section 1915(b) waiver is authorized under sections 1915(b)(1), (3), and (4) of the Social Security Act (the Act) and provides waivers of the following:

- Section 1902(a)(10)(B) Comparability of services
- Section 1902(a)(23) Freedom of choice

Concurrently, CMS is approving the state's amendments to the following section 1915(c) waivers that adds the managed care delivery system as the method of services delivery for the services authorized under the 1915(c) waivers.

- IA 0213.R05.01 – AIDS Waiver
- IA 0242.R05.01 – Intellectual Disabilities Waiver
- IA 0299.R04.01 – Brain Injury Waiver
- IA 4155.R05.02 – Elderly Waiver
- IA 0819.R01.02 – Children's Mental Health Waiver
- IA 4111.R06.02 – Health and Disabilities Waiver
- IA 0345.R03.02 – Physical Disabilities Waiver

For the 1915(c) waivers, the state has requested a waiver of section 1902(a)(10)(B) of the Act in order to waive comparability of services.

The following number of unduplicated recipients and the estimates of average per capita cost of waiver services have been approved:

AIDS Waiver – 0213

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
07/01/2015 – 06/30/2016	1	36	X	\$9,419.84	\$339,114.24
07/01/2016 – 06/30/2017	2	37	X	\$9,025.60	\$333,947.20
07/01/2017 – 06/30/2018	3	38	X	\$9,298.25	\$353,333.50
07/01/2018 – 06/30/2019	4	39	X	\$9,584.27	\$373,786.53
07/01/2019 – 06/30/2020	5	40	X	\$9,867.11	\$394,684.40

Intellectual Disabilities – 0242

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
07/01/2015 – 06/30/2016	2	14,368	X	\$34,225.50	\$491,751,984.00
07/01/2016 – 06/30/2017	3	14,535	X	\$35,159.36	\$511,041,297.60
07/01/2017 – 06/30/2018	4	14,704	X	\$36,268.90	\$533,297,905.60
07/01/2018 – 06/30/2019	5	14,875	X	\$37,348.47	\$555,558,491.25

Brain Injury – 0299

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
10/01/2015 – 09/30/2016	2	1,568	X	\$22,894.60	\$35,898,732.80
10/01/2016 – 09/30/2017	3	1,628	X	\$22,703.50	\$36,961,298.00
10/01/2017 – 09/30/2018	4	1,690	X	\$23,392.78	\$39,533,798.20
10/01/2018 – 09/30/2019	5	1,755	X	\$24,100.05	\$42,295,587.75

Elderly – 4155

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
08/01/2015 – 07/30/2016	3	13,238	X	\$7,304.38	\$96,695,382.44
08/01/2016 – 06/30/2017	4	14,198	X	\$7,498.57	\$106,464,696.86
08/01/2017 – 06/30/2018	5	15,228	X	\$7,614.44	\$115,952,692.32

Children's Mental Health – 0819

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
07/01/2015 – 06/30/2016	3	1,646	X	\$10,633.22	\$17,502,280.12
07/01/2016 – 06/30/2017	4	1,726	X	\$8,972.54	\$15,486,604.04
07/01/2017 – 06/30/2018	5	1,810	X	\$9,129.38	\$16,524,177.80

Health & Disabilities – 4111

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
11/01/2017 – 10/30/2018	4	3,177	X	\$8,653.86	\$27,493,313.22
07/01/2018 – 06/30/2019	5	3,278	X	\$8,692.75	\$28,494,834.50

Physical Disabilities – 0345

<u>Period</u>	<u>Year</u>	<u>Unduplicated Recipients</u>		<u>Factor D</u>	<u>TOTAL</u>
07/01/2017 – 06/30/2018	4	1,418	X	\$6,114.89	\$8,670,914.02
07/01/2018 – 06/30/2019	5	1,463	X	\$8,312.93	\$12,161,816.59

These approvals are subject to the agreement to serve no more individuals than those indicated above. If the state wishes to serve more individuals or make any other alterations to these waivers, an amendment must be submitted for approval.

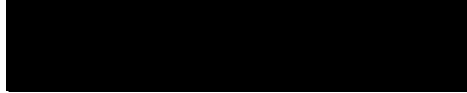
The decision to approve these section 1915(b) and 1915(c) waivers is based on evidence submitted to CMS showing that the State’s waiver program is consistent with the purposes of the Medicaid program, has met the applicable statutory and regulatory requirements for access to care and quality of services, will be a cost-effective means of providing services to Iowa enrollees, and agreement from the state on compliance with the conditions attached to this letter.

The section 1915(b) waiver is approved statewide for the five-year period from April 1, 2016 to March 31, 2021. If you wish to renew this waiver program at the end of the five-year term, a renewal application must be submitted by January 1, 2021 that includes an independent evaluation or assessment of the waiver program. If a waiver renewal is not submitted by this date, CMS will request a phase-down plan from the State for termination of the waiver program. The section 1915(c) waiver amendments will be effective April 1, 2016 with expiration dates of the following:

- IA 0213.R05.01 – AIDS Waiver – June 30, 2020
- IA 0242.R05.01 – Intellectual Disabilities Waiver – June 30, 2020
- IA 0299.R04.01 – Brain Injury Waiver – September 30, 2019
- IA 4155.R05.02 – Elderly Waiver – July 31, 2018
- IA 0819.R01.02 – Children’s Mental Health Waiver – June 30, 2018
- IA 4111.R06.02 – Health and Disabilities Waiver – October 31, 2017
- IA 0345.R03.02 – Physical Disabilities Waiver – July 31, 2017

We wish you success in the operation of this program for Medicaid beneficiaries in Iowa. If you have any questions regarding this waiver, please contact Sylvia Robinson-Tibbs, of my staff, at (410) 786- 6232, or Sandra Levels in the Kansas City Regional Office, at (816) 426-5925, regarding the section 1915(b) waiver or Deborah Read, at (816) 426-5925, regarding the section 1915(c) waivers.

Sincerely,



James I. Golden, PhD
Director
Division of Managed Care Plans



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James G. Scott -S
Date: 2016.02.23
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James G. Scott
Associate Regional Administrator
for Medicaid and Children's Health Operations

cc: Mikki Stier, IME
Jennifer Steenblock, IME

**Iowa High Quality Healthcare Initiative waiver
Terms and Conditions
Waiver Control # IA-08
April 1, 2016 through March 31, 2021**

I. Managed Long Term Services and Supports

1. The State shall ensure that beneficiaries will be allowed to keep their current case manager until at least September 30, 2016, at the member's option.
2. The State shall require that MCOs continue service plans already in existence until a new service plan is created and agreed upon by the enrollee or resolved through the appeals process. MCOs shall not reduce or modify service plans without a revised assessment. On and after April 1, 2017, the State shall require MCOs to honor a new enrollee's existing service authorization for a minimum of 30 days after the beneficiary enrolls with the MCO.
3. The State shall require MCOs to offer a contract to all currently enrolled Iowa Medicaid HCBS and Habilitation providers until March 31, 2018 and pay the minimum fee schedule (aka floor rate) determined by the State. After March 31, 2018, provider networks and reimbursement rates will be negotiated by the MCOs and providers with rates no less than a minimum fee schedule (i.e., floor rate) established by the State.
4. The State must require MCOs to prioritize service planning, and require that priority be given to those individuals whose service plans expire within the first 90 days or whose needs change and necessitate a new service plan.
5. The State shall review and approve a representative sample of LTSS plans of care that includes a reduction, suspension, or termination in services for the first year. Consistent with 42 CFR 438.420, enrollees must also have all appeal rights afforded through the MCO and state fair hearing process and the ability to continue services during the appeal.
6. The State shall participate in "ride-alongs" with MCO case management staff during the first 120 days for those individuals using LTSS to observe the service planning process for each MCO. A ride along consists of an experienced state employee who accompanies an MCO employee to observe and assist in the performance of a needs assessment and service plan development for individuals enrolled in the concurrent section 1915(c) HCBS waivers.

II. Managed Care General

7. The State shall monitor each MCO activities to ensure a smooth transition from fee-for-service to managed care, as well as a successful implementation of managed care. The State shall monitor the following MCO activities and operations:
 - a. MCO staffing and resources;
 - b. Enrollee and provider communications;
 - c. Grievance and appeals;
 - d. Member services and outreach;
 - e. Provider network management;
 - f. Program integrity;
 - g. Case management, care coordination, and service planning;
 - h. Utilization management activities, including prior authorizations and service authorizations;
 - i. Availability and accessibility of covered services; and
 - j. Claims management and claim processing times

The State shall provide CMS a report on these activities and operations on a monthly basis through September 30, 2016 and then quarterly thereafter through September 30, 2017.

8. Prior to April 1, 2017, the State shall require MCOs to honor existing service authorizations for acute care and specialty services for a minimum of 90 days after the beneficiary is enrolled with the MCO and ensure continuity of providers and services for those specialty services. On and after April 1, 2017, the State shall require MCOs to honor a new enrollee's existing service authorizations for a minimum of 30 days after the beneficiary enrolls with the MCO. The MCO will also take into account enrollees with existing prescriptions and how to ensure access to those prescriptions during the transition.
9. The State must implement contractual non-compliance remedies and place MCOs on a corrective action plan for:
 - a. Failure to train all case managers assigned to beneficiaries prior to March 15, 2016;

- b. Failure to maintain case-manager-to-beneficiary ratios consistent with the MCO's contractual requirements at any point during the term of this waiver; and
- c. Failure to meet the State's established requirements for a member services helpline.

The State may impose other legal sanctions, including, but not limited to sanctions described in 42 CFR Part 438, Subpart I. All sanctions and corrective action plans must be reported to CMS within five business days of being issued.

III. Special Monitoring Requirements

- 10. The State shall monitor each MCO's contracting with case management agencies. The State shall provide CMS with a weekly report showing each MCO's progress toward contracting with all case management agencies enrolled in the fee-for-service program. The State shall provide this report beginning February 26, 2016 and continuing through July 1, 2016, or until all MCOs have contracted with all case management agencies enrolled in the fee-for-service program, whichever comes first.
- 11. The State shall monitor each MCO's training of LTSS case managers. To the extent possible, the State shall participate in the MCOs' case manager training activities to verify that the trainings are adequate to permit case managers to fully perform their duties within each MCO. The State shall collect evidence that all case managers assigned to beneficiaries receiving LTSS have been trained. The State shall provide CMS a weekly report to the number of case managers assigned to beneficiaries that have been trained by MCO and the evidence that the State used to determine that number. The State shall provide this report beginning February 26, 2016 and continuing through May 1, 2016, or until all MCOs have trained all case manager assigned to beneficiaries receiving LTSS, whichever comes first.
- 12. The State shall monitor each MCO's compliance with the State's contractually established case-manager-to-beneficiary ratio for each waiver program. The State shall collect a monthly list of the case manager assigned to each beneficiary receiving LTSS from each MCO to verify the ratios. The State shall provide CMS a monthly report showing for each MCO and each LTSS waiver program the MCO's case-manager-to-beneficiary ratio. The report shall also describe actions taken by the State to address any ratios that do not meet the State's contractually established case-manager-to-beneficiary ratio. The State shall provide this report to CMS beginning February 26, 2016 and continuing through January 1, 2017.

13. The State shall monitor each MCO's member call center to ensure that the call center is responding to enrollee inquires promptly and accurately, consistent with the requirements of the Member Services Helpline portion of the MCOs' contracts. The State shall provide CMS with a weekly report that describes the State's efforts to monitor call center activities, issues and problems identified, and actions taken to mitigate problems. The State shall provide CMS a weekly report beginning February 26, 2016 and continuing through July 1, 2016.
14. The State shall monitor the extent to which each MCO's provider network covers the MCO's enrollees' previous six months of utilization of covered services. The State shall provide CMS the same type and detail of data used for network adequacy report #3 in February, 2016. The State shall also collaborate with CMS in the analysis of the network adequacy data. The State will supply the data weekly to CMS beginning February 26, 2016 and continuing through June 1, 2016.
15. The State shall monitor the enrollee issues being identified through the Ombudsman office to ensure issues are being addressed in a timely manner that minimizes disruption to the enrollee. The State shall provide CMS with a report of the types and numbers of complaints being processed through the Ombudsman office on a monthly basis. The State will supply the report to CMS beginning on April 15, 2016 through September 15, 2016.