DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop: S2-26-12
Baltimore, Maryland 21244-1850

FEB 23 2016

Mikki Stier
Medicaid Director
Iowa Department of Human Services
100 Army Post Road
Des Moines, IA 50315

Dear Ms. Stier:

Thank you for your February 23rd letter detailing the Iowa Medicaid Enterprise's (IME) response to the Centers for Medicare & Medicaid Services' (CMS) letter of December 17, 2015 regarding Iowa's transition to managed care. CMS appreciates the work Iowa has done to complete our readiness review related to Iowa's request for the section 1915(b) and 1915(c) waivers necessary to move Medicaid beneficiaries to statewide managed care. CMS and Iowa have a shared interest in providing accessible, quality care for the thousands of Medicaid beneficiaries affected by this transition.

In our December 17th letter, we said that although Iowa had made progress in areas of operational readiness, some key requirements had not yet been met. For that reason, we did not approve the waiver application with a January 1, 2016 effective date but indicated our willingness to work with you on achieving readiness with a goal of an approval of your managed care program that would be effective March 1 of this year. We identified 16 action items and asked that Iowa demonstrate progress in these areas in order for CMS to approve your 1915(b) and 1915(c) waiver applications. The information you provided to CMS in your letter and in our meetings over the past two months is consistent with the requirements in our December 17 letter.

Over the past 60 days, CMS has seen significant improvement in the extent to which MCO networks would cover expected utilization for their expected enrollment based on historical claims data, and in CMS' assessment, the MCOs' provider networks cover a meaningful percentage of historical utilization. We also acknowledge the efforts by IME and the MCOs to make it easier for out-of-network providers to be reimbursed for the provision of services by, for example, temporarily suspending prior authorization requirements for out-of-network providers. In addition, IME developed and executed a communications plan that provided more detailed information to beneficiaries and providers and substantially updated the infrastructure, staffing, and capacity of the member call center that resulted in a decrease in the call abandonment rate from 42 percent in December to less than 1.5 percent since mid-January. We appreciate Iowa's commitment to having the "Coverage Has Begun" communication campaign in place to assist

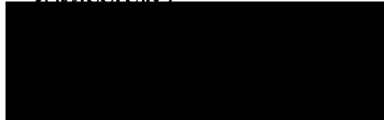
enrollees during the transition to ensure that beneficiaries understand how to access needed services.

Since December, the MCOs have significantly enhanced their provider networks for long-term services and supports (LTSS). CMS' analysis of the data shows the MCOs' networks frequently cover more than 90 percent of historical LTSS utilization. Similarly, the LTSS Ombudsman has become more prepared to assist individuals receiving LTSS in transitioning to managed care. In addition, IME's increased call center capacity will help support beneficiaries needing assistance in making the transition, and CMS is monitoring data from MCOs' member call centers to ensure that the centers are responding to beneficiary inquiries promptly and accurately. IME has also made significant strides in ensuring that LTSS case managers are available, trained, and are assigned to beneficiaries before the transition to managed care. We expect that the remaining steps to complete training for case managers will be completed on or shortly after March 1, to ensure that case managers are fully able to assist beneficiaries. We also appreciate the state's commitment to ensuring continuity of care for LTSS beneficiaries by taking the steps described in the appendix to this letter.

CMS is approving an April 1, 2016 effective date for the managed care transition, consistent with the revised waiver applications you submitted February 12, 2016. Although we understand the state's preference to move forward on March 1, the April 1 effective date provides additional time for Iowa to complete activities needed to ensure a smooth transition, such as completing contracting with providers and training case managers on each MCO's case management system. In addition, CMS established in this final 1915(b) approval specific monitoring terms and conditions. CMS will monitor Iowa's transition to managed care through these STCs, which are consistent with our June 2015 proposed managed care rule, and are summarized in the attachment to this letter.

Thank you for the work you and your team have done over the past several months. If you have questions about this letter or if we can be of further assistance, please contact James Golden at James.Golden@cms.hhs.gov.

Sincerely,



Vikki Wachino
Director

cc: James Scott, Associate Regional Administrator, Region VII

Attachment
Overview of 1915(b) Waiver Terms and Conditions

While IME has substantially met the requirements necessary for CMS to approve the waivers necessary to transition your Medicaid program to managed care, the State will need to monitor MCOs operations and continue addressing issues related to the 16 action items to ensure that beneficiaries are fully able to access high-quality, integrated care, particularly during the transition. Consequently, CMS will be approving the 1915(b) managed care waiver with terms and conditions in the following areas:

General Monitoring
CMS' experience shows that the state is best able to identify and address potential beneficiary or provider problems quickly by diligently monitoring critical areas of the MCOs' activities and operations. Therefore to help ensure a smooth transition from fee-for-service to managed care, as well as a successful implementation of managed care, CMS will require the State to monitor each MCO's activities. We have identified the following ten MCO activities and operations for monitoring and regular reporting to CMS: 1) MCO staffing and resources; 2) Enrollee and provider communications; 3) Grievance and appeals; 4) Member services and outreach; 5) Provider network management; 6) Program integrity; 7) Case management, care coordination, and service planning; 8) Utilization management activities, including prior authorizations and service authorizations; 9) Availability and accessibility of covered services; and 10) Claims management and claim processing times.

Communications and Member Services
Transitions can be confusing times for beneficiaries. Timely and accurate communications to beneficiaries and providers are critical components of ensuring that beneficiaries understand how to access needed services. The MCOs' member services helplines must be able to provide timely accurate information to assist beneficiaries in navigating the health care system. CMS will require the State to 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. CMS will also require the State to notify CMS and place MCOs on corrective action plans for not meeting the State's requirements for MCO member services helplines. , .

To ensure that individuals receiving long-term services and supports (LTSS) are able to receive needed services, CMS will require the State to monitor the enrollee issues being identified through the Ombudsman office to ensure issues are being addressed in a timely way that minimizes disruption to the enrollee. CMS will also require the state to provide CMS with a report of the types and numbers of complaints being processed through the Ombudsman office on a monthly basis. .

Provider Networks
CMS believes that provider networks that maintain existing beneficiary-provider relationships will facilitate continuity of care through the transition period. The MCOs' provider networks cover a meaningful percentage of historical utilization. However, to ensure that the MCOs'

provider networks facilitate access to care, CMS will require the state to monitor provider networks and the availability of services. Additionally, CMS will also require the state monitor and report the extent to which each MCO's provider network covers the MCO's enrollees' historical utilization.

Case Management

Case managers and their role in helping to coordinate services are critical to ensuring that individuals receiving LTSS are able to access services. To ensure that case managers are fully able to assist beneficiaries, the state shall:

- Monitor each MCO's contracting with case management agencies and 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. .
- Monitor each MCO's training of LTSS case managers, 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, and collect evidence that all case managers assigned to beneficiaries receiving LTSS have been trained before March 15, 2016.
- Monitor each MCO's compliance with the IME's contractually established case-manager-to-beneficiary ratio for each waiver program, which the State must verify by collecting a monthly list of the case manager assigned to each beneficiary receiving LTSS from each MCO. .

Continuity of Care

The ability of beneficiaries to have continuity in their care during the transition will be important to the health and welfare of beneficiaries and the success of the transition. This continuity is particularly critical for individuals receiving LTSS. We know that IME shares this view and has taken a number of steps through your contracts with the MCOs to ensure the continuity for all beneficiaries care. As part of the waiver approval CMS will require the state to:

- Ensure that beneficiaries are allowed to keep their current case manager until at least September 30, 2016.
- 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.
- Prohibit MCOs from reducing or modifying service plans without a revised assessment.
- Require MCOs to prioritize service planning for individuals whose service plans expire within the first 90 days after implementation or whose needs change and necessitate a new service plan.
- Review and approve a representative sample of LTSS plans of care that includes a reduction, suspension, or termination in services for the first year, while providing enrollees all of their appeal rights.
- Conduct in-person reviews of MCO case management staff during the first 120 days for those individuals using LTSS in order to observe the service planning process for each MCO.

- Require MCOs, for the first year, 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.
- Require MCOs, after the first year, to honor a new enrollee's existing service authorizations for a minimum of 30 days after the beneficiary enrolls with the MCO.
- Require MCOs to take into account enrollees' existing prescriptions and ensure access to those prescriptions during the transition.