Iowa Department of Human Services

Terry E. Branstad	Kim Reynolds	Charles M. Palmer
Governor	Lt. Governor	Director

November 13, 2015

Mr. Timothy Hill
Deputy Director
Center for Medicaid & CHIP Services
Centers for Medicare & Medicaid Services
7500 Security Boulevard, Mail Stop S2-26-12
Baltimore, MD 21244-1850

Re: CMS Gate Review Process

Dear Deputy Director Hill:

Thank you for your letter dated November 6, 2015, regarding the Centers for Medicare and Medicaid Services (CMS) "Gate Review Process." We appreciate CMS's efforts to support Iowa as we implement the Iowa High Quality Healthcare Initiative. We appreciated the opportunity for Governor Branstad to discuss our plan with Secretary Burwell and we were encouraged that their conversation continued a positive dialogue and overall partnership between the State of Iowa and CMS. Following that meeting, we are encouraged that we are on-track for January 1, 2016, go-live to improve health outcomes for Iowans served by Medicaid.

We have taken unprecedented actions for an effective transition, learning from the over 25 other states who have already implemented comprehensive managed care. We have also established a thoughtful transition that phases in services, including a two-year phase-in for Iowans with long-term services and supports (LTSS). While Medicaid managed care has been in Iowa for nearly thirty years, this new Initiative will deliver physical health, behavioral health, and long term services and supports in a highly coordinated manner to improve quality outcomes for the most vulnerable Iowans, while at the same time reducing unnecessary and duplicative services, resulting in overall savings for taxpayers. We are excited to bring this innovative program, which emphasizes member choice, access, safety, independence, and responsibility, to the people of the State of Iowa.

The State has taken a number of actions to respond to CMS's concerns. As your letter noted, the State has submitted multiple documents to substantiate our complete Gate 1 readiness, many of which have been posted on the Iowa Medicaid website and are being updated regularly (https://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization). We will be submitting additional documentation for Gate 2 readiness, as well as updated reports on staffing and provider networks, as that data is constantly evolving. The State has also submitted responses to a series of requests for additional information related to its pending §1115 waiver amendment and §1915(b) waiver, and we look forward to answering any CMS questions on the remaining §1915(c) waivers. Finally, the State has conducted or attended nearly 300 public events regarding the Initiative since June 2015, twenty-two in-person

stakeholder kick-off sessions, offered in-person provider education sessions on the transition to managed care in eleven different communities throughout the State, and conducted a series of targeted, training meetings with the MCOs addressing topics such as member communications, credentialing, health homes and integrated health homes, and network adequacy.

In addition, we believe that we have addressed the major concerns outlined in your letter. As you will see, we have learned from the experience of the many states that have preceded us in transitioning to comprehensive managed care and have established a thoughtful and phased in-transition that includes special considerations for the most vulnerable Iowans served by Medicaid.

1. The managed care organizations (MCOs) are making significant and daily progress with their staffing and we have provided updated staffing reports and staff training curriculum from the MCOs to CMS. Our top priority in implementing the Initiative is to ensure and improve the health, safety and well-being of enrollees. The State has shared a comprehensive mitigation plan with CMS, should MCOs not meet certain technical functions (e.g., prior authorization systems, case management systems, etc.) at go-live or during transition. Our staged, or phased, implementation plan ensures appropriate transition time for members and providers and includes back-up plans that can be deployed on a temporary basis, if needed, to ensure full functionality for all key operational areas.

2. The State is pleased to report that all Medicaid members will have timely and adequate access to providers on January 1, 2016, as beneficiaries will be able to see any Medicaid enrolled provider until the State is confident the MCOs have adequate providers in their networks—that is, members will have access to 100% of the current Iowa Medicaid Enterprise network until an MCO demonstrates network adequacy compliance. The State has also deemed that Iowa Medicaid enrolled providers as meeting the MCO credentialing requirements, otherwise referred to as “deemed status”. In addition, for the first 3 months, all existing Medicaid authorizations will be honored by the MCOs. For the first 6 months, Medicaid patients can keep their current physical and behavioral health providers (primary care, hospitals, specialists, etc.) and case managers even if they are out-of-network. For the first 2 years, the most vulnerable Medicaid population patients can keep their current long-term services, including nursing facilities, HCBS waivers, Intermediate Care Facilities for the Intellectually Disabled services, home health services, community mental health center services, and substance use disorder treatment services even if they are out-of-network. To protect doctors and other Medicaid providers, they can sign up with as many MCOs as they wish and MCOs cannot restrict enrollment for doctors and providers. Additionally, doctors and providers who sign up with a plan are protected from reimbursement cuts and cannot be paid less than current Medicaid rates. Further, members for the first 90 days of 2016 will be permitted to change MCOs and members annually during an open enrollment period will be permitted to change MCOs to the extent their provider does not ultimately contract with their MCO.

3. We concur with CMS that beneficiaries must have access to timely information about the transition. To this end, the State has begun the process of mailing enrollment

packets to beneficiaries in order to provide information about the transition and to allow members to have adequate time to select the health plan that meets their needs. Members utilizing long terms services and supports are prioritized in this process. The State will be supplementing the mailings with member forums, call center staff, and in some cases in-person support to assist members as they make their plan selection.

4. The State's readiness review process includes a thorough assessment of key administrative functions associated with transition to ensure continuity of care for members. Though not exhaustive, examples include: (a) the State has increased staffing in the Office of the State Long-Term Care Ombudsman, through bipartisan-supported State legislation, to assist members with Medicaid-related complaints, including grievances and appeals related to the MCOs; (b) review and approval of MCO grievance and appeals policies and procedures to ensure alignment with State and Federal regulations, as well as contract terms (i.e., acceptance standards, expedited and standard processing timeframes, member communications, quality monitoring, etc.); (c) phased testing of MCO care planning and case management systems to review their ability to maintain and exchange member plans; and (d) review and approval of MCO utilization management programs. Should an MCO not be capable of meeting certain technical expectations at go-live or during transition, State systems are being maintained to provide necessary backup for care planning, case management, prior authorization, and utilization management.

In terms of Readiness Gate 2, the State continues to make strong and steady progress, and will be sending CMS regularly. Again, while we understand the Agency's concerns, we are heartened by our recent interactions with agency leaders and we are confident that our comprehensive implementation plan with a thoughtful transition will demonstrate that the State, managed care organizations, providers, and Medicaid beneficiaries are prepared for the transition. Please let me know if you have any questions.

Sincerely,

Mikki Stier, MSHA, FACHE
Medicaid Director

MS/sv

cc: Charles M. Palmer, Director
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