

To: Harry Rossander, Bureau of Policy Coordination, Iowa Department of Human Services

Re: Public Comment on ARC 2241C and ARC 2242C

Date: November 25, 2015

The Iowa Association of Community Providers (IACP) represents 145 organizations that provide services to children and adults with intellectual and developmental disabilities, brain injury and mental health issues. The Association's membership serves 150,000 Iowans, employs 30,000 people, and generates \$1.3 billion dollars to Iowa's economy.

IACP is supportive of the following principles outlined in the Iowa High Quality Health Care Initiative:

- Improved quality and access to health care
- Accountability for outcomes
- A predictable and sustainable Medicaid program

IACP has partnered with DHS, IME and the four MCOs to ensure that this transition is as smooth and provides as little disruption as possible to the vulnerable Iowans who utilize our members' services. The following comments and recommendations are made to ensure that this transition upholds the principles of the Iowa High Quality Health Care Initiative.

Comments on ARC 2241C:

1. **441—73.1 (249 A) Definitions:** The definition of "clean claim" on page 3 is vague, we request the following language be substituted to avoid confusion, the following is from the Michigan Department of Insurance and Financial services:
 - i. Identifies the health professional, health facility, home health care provider or durable equipment provider that provided service sufficiently to verify, if necessary, affiliation status and includes any identifying numbers.
 - ii. Sufficiently identifies the patient and health plan subscriber.
 - iii. Lists the date and place of service.
 - iv. Is a claim for covered services for an eligible individual.
 - v. If necessary, substantiates the medical necessity and appropriateness of service provided.
 - vi. If prior authorization is required for certain patient services, contains information sufficient to establish that prior authorization was obtained.

- vii. Identifies the service rendered using a generally accepted system of procedure or service coding.
 - viii. Includes additional documentation based upon services rendered as reasonably required by the health plan.
2. **441—73.1 (249 A) Definitions:** IACP supports the definition of “Emergency Services” which will allow for continued coverage and expansion of much needed mental health crisis services.
 3. **441—73.23 (3) (249 A) Claims payment by the managed care organization:** IACP objects to the payment of 90% (a 10% penalty) to non-participating providers. For this transition to be smooth it is imperative that each of the MCOs have a strong, robust network. This 10% penalty would create an unnecessary hardship on service providers statewide and could decrease network availability. We ask that a reasonable (90-120 day) transition period following January 1, 2016, be added to this rule.
 4. **441—73.4 (249 A) Disenrollment process:** IACP supports the definition of “good cause” for members to change plans, this will allow people receiving services flexibility as their needs change.
 5. **441--73.5 (2) (249 A) Covered Services:** IACP requests that the department reconsider using Chapter 90 as the definition of community based case management. The current requirements of Chapter 90 do not allow for the flexibility needed by the MCOs to achieve the stated outcomes.
 6. **441--73.9 (249 A) Incident Reporting:** The state of Iowa currently has a single standardized incident reporting system that coordinates all necessary entities from state agencies to ensure the safety and welfare of vulnerable Iowans. IACP **strongly urges** that this singular standardized system continue to be used to avoid duplication and improve service coordination for vulnerable Iowans.
 7. **441--73.14 (2) (249 A) Continuation of Benefits:** IACP requests clarification that this language allows the MCO to recoup the cost of services from the member **NOT** the provider. Please add language that specifies money will be recouped from the member and **NOT** the provider.

Comments on ARC 2242C:

1. **441--36.1 & 361.2 (3) (249 A) Assessment of Fee:** The proposed amended rule would change the collection method of the ICF/ID assessment fee from the department deducting the fee from Medicaid payments to requiring that the providers pay the fee directly to the department on a monthly basis. IACP recommends that the department bill this fee on a quarterly basis using claims paid data from the MCOs as was previously stated by the Department at the Medical Assistance Advisory Council (MAAC) Executive Council Meeting.



2. **441--77.12 (249 A) Behavioral Health Intervention:** IACP recognizes and supports the need for service providers to be accredited. This proposed amended rule requires previously unaccredited Behavioral Health Intervention Providers to become accredited to continue to provide services. Requiring accreditation from the named accreditation bodies without a reasonable time frame for transition will decrease access to services for lowans. We ask that a 12-month transition timeline be set to allow for providers who are not accredited the time necessary to complete the accreditation process.
3. **441-- 78.27 (4) & (11) (249 A) Home and Community Based Habilitation Services:** IACP is requesting clarification of this service and treatment plan approval process. Currently, service and treatment plans, along with any changes, are approved by an outside contractor (currently Magellan). Why is the approval process shifting to the IME Medical Service Unit rather than the managed care contractors? Further, why is this only being required for Habilitation Services?
4. **441-- 82.2 (4) "c" (2) (249 A) Licensing and Certification of ICF/ID Facilities:** The proposed amended rule adds language regarding interdisciplinary team meetings and the expected participants in those meetings. The new language specifies that for those clients enrolled with a managed care organization the client's case manager shall participate as appropriate and as allowed by the client. Currently, ICF/ID clients do not have outside case managers. We request clarification regarding the specific role and responsibility of the newly created case manager position as set forth in this proposed rule.

We look forward to the department's response and hope that the recommendations set forth are seriously considered to ensure that the transition to a managed care environment is as successful as possible.

Sincerely,

Shelly Chandler
Executive Director
Iowa Association of Community Providers



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Harry Rossander
Bureau of Policy Coordination
Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, IA 50319-0114

Dear Mr. Rossander:

I am the Operations Director for Caretech, Inc., an in-home provider of Home and Community Based Services (HCBS) in Iowa. Our agency has been serving Medicaid members since 1999.

I wish to enter our formal comments about Managed Care regulations Arc 2241C and 2242C. I am submitting this letter via email to policyanalysis@dhs.state.ia.

Please see the attached two pages for my comments. Feel free to contact me if you have any questions. Thank you.

Sincerely,

Jason J. Velinsky
Operations Director

Public Comments Concerning ARC 2241C and 2242C:

- 1) 441-73.23(249A) Claims payment by the managed care organization
The regulations for claims deal with "clean claim" payment deadlines. The regulations should require MCOs to allow at least 180 days for not only clean claim submissions, but any additional resubmissions, corrections or appeals. Electronic resubmissions and corrections of claims are equally, if not more, important than clean claim submissions. MCOs should also abide by the payment or denial timeline requirements in 73.23(1) for resubmissions of claims.
- 2) Furthermore, the wording states that percentages of clean claims must be paid or denied within 14 or 21 days and all claims within 90 days. However, MCOs are interpreting these regulations to mean that providers do not need to know about denials due to non-clean claims until 90 days. The wording is not correct since those providers who send non-clean claims should also receive a denial within the same time frame as clean claims. MCOs should not be allowed to wait 90 days to deny a non-clean claim. The mandate to use the new CMS 1500 form with 4 Managed Care Companies will result in many non-clean claims. Providers will need to know about all claim denials in the same period of time as "clean" claims.
- 3) MCOs should also be required in regulations to respond to providers or their clearinghouses with answers to questions within a short period of time (for example, within 24 hours from the inquiry). HCBS Providers have not been trained on CMS Form 1500, which is significantly more complicated than the current "Claim for Targeted Medical Care" claims used to bill IME. Providers will also require extensive telephone and email communication with MCOs in order answer questions and correct claim issues. These claims and billing provider protections should be mandated, not implied or left to reason.

Currently, one MCO has the following procedures for claims that are denied: *"If a claim or a portion of a claim is denied for any reason or underpaid, the provider may dispute the claim within 60 days from the date of the denial or payment. Claim disputes may be submitted in writing, along with supporting documentation, to: (MCO Physical Address)."*

This statement is unacceptable, but is allowed based on the current regulation wording. According to the above statement, if a provider miscodes or accidentally skips a field on CMS Form 1500, the MCO would be allowed to wait 90 days to issue a denial because the claim would be considered non-clean. In addition, the MCO will deny the provider the ability to correct and simply resubmit the claim electronically. By requiring resubmissions to be sent via postal mail, MCOs can delay the correction process, including the provider's ability for further denial inquiries. This is also an issue because the provider can only dispute the claim via postal mail for 60 days from the denial. Providers should have a full 180 days to electronically resubmit denied claims (including claims that are considered non-clean), and be notified of all denials within the same 14, 21, 90 timeline. If all of these areas are not addressed in regulations, MCOs will be allowed to delay and confuse the payment process to providers. If payment protections are not added to regulations, providers will be forced to bad debt legitimate services.

- 4) Are MCOs allowed to retroactively deny payments for services? In other words, if an authorization was approved for a member, but then later found to be incorrect, at no fault of the provider, are MCOs allowed to deny payments to providers or recover payments already paid recover to the providers? This should not be allowed to occur to providers and there should be a safeguard in the regulations.
- 5) 441-73.24(249A) Quality Assurances are currently required of many HCBS providers. There are over 130 DHS mandates for quality assurances that have existed since 2009. Providers have been required to develop policies and procedures to meet the multitude of Quality Assurance standards. If Managed Care Organizations are allowed to develop their own Quality Assurance programs, providers will be required to change their policies to match each of the 4 MCO requirements. This will essentially multiply Quality Assurance policies and procedures by 5 since DHS has not eliminated their Quality Assurance program. DHS must standardize Quality Assurance for both providers and the sake of DHS comparisons. Without a standardized Quality Assurance program across MCOs, DHS will essentially be comparing apples to oranges. Providers should not be required to abide by 4 different Quality Assurance standards that will not exactly compare to one another. Neither the means nor the results of 4 Quality Assurance programs will benefit the community.
- 6) 75.28(7) – a. Managed Care Organizations Capitated payment rate “means a monthly payment to the contractor on behalf of each member for the provision of health services under the contract.” Furthermore, this sections states “payment is made regardless of whether the member receives services during the month.” 73.6(2) States that managed care organizations may place appropriate limits on services on the basis of medical necessity for the purpose of utilization management.” 441-73.8(249A) states “managed care organizations shall ensure enrollees have access to services as specified in the contract...for areas of the state where provider availability is insufficient to meet these standards...the access standards shall meet the usual and customary standards for the community.” Services are not available in many areas of the State currently. This lack of service is well documented due to systemic barriers to in-home HCBS service providers. It has been stated that MCOs must have provider coverage within 30 minutes or 30 miles in urban areas and 60 minutes or 60 miles in rural areas. Why is this wording not in the regulations? Managed Care Organizations should have more responsibility to serve members and not be paid when they have the excuse “no providers are available in the area.” By paying MCOs and not requiring that they appropriately serve all members, the state is allowing MCOs to intentionally decrease service availability without repercussions.



November 24, 2015

Harry Rossander
Bureau of Policy Coordination
Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, IA 50319

Subject: Notice of Intended Action ARC 2241C

Dear Mr. Rossander,

On behalf of Iowa’s 118 community hospitals, the Iowa Hospital Association (IHA) submits the following comments on the Notice of Intended Action ARC 2241C seeking to implement the Medicaid Modernization program.

IHA continues to believe that the Department of Human Services (DHS) is extremely ill-prepared to responsibly and effectively execute this transition in a manner that would have minimal impact to Medicaid beneficiaries and providers alike and has several concerns regarding the proposed rule.

IHA’s detailed comments are as follows and focus on the issue of inconsistent definitions and terms. **IHA opposes this rule and asks that the department review these matters, provide clarification and release revised rules once these issues are resolved.**

Network Adequacy and Provider Payment Rates

The rule includes definitions for terms that are not used, while using terms that are not defined.

Of key concern are the following terms and definitions:

- Non-participating provider (used but not defined)
- Out-of-network (defined but not used)
- Non-contracted (used but not defined)

Notably, the rule does not seem to conform to the recently released provider network fact sheet released on October 28 announcing that, “providers who have not contracted with the MCO and are considered out of network. Note that the reimbursement rate for out of network providers is 90 percent of the Medicaid floor or 90 percent of the FFS rate.”

While IHA strongly believes the department does not have the authority to enact this provider payment reduction, the rule further complicates the issue by using the undefined term “non-participating provider” instead of “out-of-network”.

Section 73.23(3) states, "In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers."

These are key terms that should be clearly defined and referenced accordingly as they have a significant impact on how providers are to be reimbursed for providing health care services to Medicaid beneficiaries.

Additionally, the department should revise the rule to include a section on network adequacy standards and requirements that conform to the original policy released by the department in the Request for Proposal, the waivers submitted to the Centers for Medicare & Medicaid Services (CMS) and contained in the contracts between the MCOs and the state. The original policy (before changed in the provider network fact sheet) only reference a 90 percent payment rate in the context of an **adequate and closed provider network which requires department approval**. Therefore it is unclear what the rule means by "non-participating provider" versus "out-of-network" and does not contain a section on network adequacy requirement to provide any further clarity.

For example, a provider who has contracted with one of the four MCOs – are they considered "out-of-network" or "non-participating" with the other three and what is the impact?

This is important because according to the waiver documents, **"MCOs are required to have an open network until the MCO demonstrates that it meets the access requirements..."** and **"once the Contractor has met the network adequacy standards...the Contractor may require all of its members to seek covered services from in-network providers..."**

While the rule defines but does not use the term "out-of-network", it does not define "nonparticipating provider" and is out of sync with other terms used in previous department policy.

For the purposes of reimbursement and contract negotiations, it's imperative that these terms be defined and consistent across all policies, provider manuals, contracts and regulations.

Provider Payment Rates

The rule also seems contrary to previously released policy on provider payment rates and the six month to two year rate floors afforded to providers regardless of in-network or out-of-network status.

According to section 6.2.2.6 of the contracts between the state and the MCOs:

During and after this two year time period, the Contractor shall reimburse in-network direct care provider types at a rate that is equal to or exceeds the Agency defined Iowa Medicaid fee-for-service floor, or as otherwise mutually agreed upon by the Contractor and the provider;

...and for all other provider types, MCOs must, "extend contract offers, at minimum, at the current Agency defined Iowa Medicaid floor. During and after this six month time

period, for in-network providers the Contractor shall reimburse these provider types at a rate that is equal to or exceeds the current Agency defined Iowa Medicaid floor, or as otherwise mutually agreed upon by the Contractor and the provider.

While the policy does include the term “in-network” as already stated, previous department policy states that the network cannot be closed until network adequacy has been met and the department approves the network be closed **which has not occurred**. Therefore, regardless of network status, providers should be afforded their six month to two year payment rates and not be subject to a 90 percent payment rate. The rules should provide clear requirements for network adequacy, timelines and provider payment rates.

IHA urges DHS to review these inconsistencies and develop revised rules that respond accordingly.

Presumptive and Retroactive Eligibility

IHA supports the concept of requiring reimbursement to providers for patients who receive care and are then enrolled in Medicaid within 90 days following the receipt of care (referred to as retroactive enrollment). The rules appear to allow for retroactive enrollment (73.3(5) Benefit reimbursement prior to enrollment), however many if not all of the state-approved MCO provider contracts strictly prohibit any claims from being paid prior to enrollment.

One provider contract states: “3.1.1.2 Excluded Populations: The Contract will not include...(ii) beneficiaries that have a Medicaid eligibility period that is retroactive.”

The rules seem to indicate that the MCOs are to reimburse providers retroactively, while the contracts clearly indicate that claims generated from retroactively enrolled Medicaid beneficiaries are not eligible for payment. **More clarity is needed on this issue.**

Similarly, IHA supports the concept of allowing providers to “presume” a patient eligible for Medicaid, provide them care and receive reimbursement (referred to as presumptive eligibility). The rule contains no reference to this, and is unclear (through this rule or other released policies) if this will be allowed.

In closing, IHA reiterates its request that the department review these unresolved concerns and release new rules once the issues have been addressed.

Sincerely,



Daniel C. Royer
Vice President, Finance Policy
Iowa Hospital Association

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December 1, 2015

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Harry Rossander
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RE: ARC 2241C – Medicaid Managed Care Administrative Rules

Dear Mr. Rossander:

On behalf of the 6,200 physician, resident, and student members of the Iowa Medical Society (IMS), thank you for this opportunity to provide comment on ARC 2241C, implementing the Iowa High Quality Healthcare Initiative, or Medicaid managed care.

The core purpose of the Iowa Medical Society is to assure the highest quality health care in Iowa through our role as physician and patient advocate. With this purpose in mind, we submit the following recommendations.

Member Choice Counseling

Section 73.3(3)(a) describes the process by which members may receive choice counseling through Medicaid’s designated enrollment broker. IMS recommends that this section be amended to prohibit any restrictions on physicians’ ability to discuss with their patients the different managed care coverage options and how they align with the patient’s unique healthcare needs.

Physicians represent the front line of healthcare access. As their patients’ most trusted source of healthcare information, often including guidance on what insurance coverage means for their care, physicians must be able to have open conversations regarding coverage options with patients without fear of contractual gag orders. Restricting the ability of physicians to discuss coverage options, including which plan may offer the best coverage for a patient’s unique medical needs, is intrusive in the crucial patient-physician relationship, could lead to greater patient confusion, and will limit patients’ ability to make the most informed choice possible about their healthcare.

Retroactive Eligibility

Section 73.4(2) references procedures for a member's disenrollment in a Managed Care Organization (MCO) by the Department of Human Services (DHS). The section indicates that an enrollee who becomes ineligible for the program and is later reinstated will be re-enrolled with the MCO under which they had previously been covered. IMS recommends that this subsection also require that the MCO retroactively cover any services provided during the member's lapse in eligibility.

Medicaid members frequently transition in and out of program eligibility as their incomes fluctuate. Particularly within the Iowa Health and Wellness Plan, there are many individuals whose incomes straddle the line of eligibility, and who frequently become ineligible for only short periods of time. These individuals are often unable to afford even basic health coverage in place of their Medicaid coverage. If the member regains program eligibility within 90 days, the MCO should be required to cover services provided during that short lapse in coverage. This period of time is consistent with current policy for Medicaid and private insurance policies purchased through the health insurance exchange. Requiring retroactive eligibility and coverage for this period of time will help maintain the continuity of that patient's care, reduce administrative burden on physician practices, and preserve the department's goal of limiting healthcare costs by effectively managing continuous patient care.

Scope of Services

Section 441-73.6(1) outlines the amount, duration, and scope of the services MCOs are required to cover. Specifically, this section establishes that MCOs may not arbitrarily deny or reduce a required service solely on the basis of diagnosis, type of illness, or condition of the enrollee. While these are vital patient protections, we know from other states that these are not the only reasons MCOs arbitrarily deny or reduce a medically necessary service.

IMS recommends the department amend this rule section to prohibit MCOs from denying a required, medically necessary service solely on the basis of cost. The department touts an aggressive cost-savings goal with the shift to the new IA Health Link program. It is imperative that these savings not be achieved at the expense of high quality patient care. Adding this requirement would offer the already-vulnerable Medicaid population a vital protection against MCO coverage determinations that put their health and safety at risk solely for these private companies' financial benefit.

Emergency Services

IMS supports the provision in draft §73.7(2)(c) which requires MCOs to pay physicians the current Medicaid fee-for-service rate floor for emergency services regardless of a physician's contract status. This measure is a vital protection to

ensure patients can access care in an emergency situation, and that the care will be covered. It also ensures physicians can offer necessary emergency services without disrupting the patient's care to determine cost responsibility.

IMS also supports the provisions in sections 73.7(2)d and 73.7(3) which compel MCOs to cover the medical screening examination and treatment of a member who presents to an emergency department with an emergency medical condition, in accordance with EMTALA standards. However, we recommend the addition of a further administrative rule protection, enumerating that MCOs must also cover the diagnostic testing and procedures used to determine if an emergency condition exists. EMTALA guidance explicitly states that medical screening examinations may involve performing diagnostic tests and procedures in addition to treatment. Holding MCOs accountable for covering those tests and procedures will ensure patients receive a comprehensive, appropriate examination in an emergency situation without facing unnecessary administrative disruptions that could jeopardize their health.

Provider Notification of Appeal

Section 73.14 addresses the continuation of member benefits during an appeal. Specifically, §73.14(2) establishes that if the final resolution of an appeal upholds the MCO's action, the MCO may recoup any payments made for services furnished to the Medicaid member while the appeal was pending. The section does not offer any requirement of notification to the physician that their payment from an MCO may later be revoked pending the outcome of an appeal.

IMS recommends that this rule section be amended to require MCOs to notify physicians when a patient is involved in a pending appeal, and that services provided during that pending status may ultimately go unpaid. Having knowledge of a payment's tentative status will be critical to the business health of Iowa practices, particularly those small physician practices that operate with very little budgetary flexibility and already often see Medicaid patients at a financial loss.

Claims Submission

The state's recent decision to extend the required timeline for timely claim submissions from 90 to 180 days is an important step toward addressing the administrative burden practices will face under the IA Health Link. IMS commends the department for taking that important step to address concerns raised by the physician community. To ensure clarity of policy and avoid confusion with the current Medicaid timely claims submission requirements contained in 441 IAC 80.4(1), IMS recommends that the department amend draft rule §73.23 to include the new 180-day timely claims submission requirement for in-network managed care claims. In doing so, IMS recommends the new rule allow for 180 days to file a claim starting from either the date of service or the date the provider was informed of the MCO's coverage, whichever is later.

Practices do not always receive accurate coverage information at the time services are rendered; adding this flexibility to the timely claims submission deadline will protect providers from denial of payment due to incomplete information.

In addition, the 180-day claims submission filing deadline must account for instances where a claim must be adjusted or resubmitted. Practices should not be subject to shorter deadlines simply because a claim must be refiled and adjusted after initial submission. IMS recommends that the department mirror its current administrative rule 441 IAC 80.4(2), which allows practices to request an adjustment of a paid claim or a resubmission of a denied claim within the same timely filing timeframe; it also allows for these adjustments and resubmissions to be paid for a period of up to two years following the date of service for the claim. This system has worked well under the current Medicaid program and will give Iowa physician practices peace of mind as we enter the new managed care system, which is expected to result in a significant increase in the denial of legitimate claims.

The department must also acknowledge the administrative burden Iowa physician practices face as they move from a single billing system under the current Medicaid program, to potentially five separate and distinct systems. As with many components of the new IA Health Link program, IMS has significant concerns that this splintering of administrative functions will result in an unnecessary increase in the administrative workload of practices and has the potential to delay legitimate payments to practices – especially those in smaller rural communities, which operate on very narrow financial margins. Even a minor delay in payments can cause serious cash flow issues for these small businesses. We recommend the department take steps to ensure uniform billing procedures by amending the draft §73.23 to clearly articulate uniform billing procedures across all MCOs, consistent with the current Medicaid billing procedures to which physician practices are accustomed. Further, IMS recommends the department investigate models to potentially centralize the billing process and further ease the burden on physician practices.

Uniform Prior Authorization

Navigating the unique administrative processes for each of the MCOs, in addition to the remaining fee-for-service processes with the Iowa Medicaid Enterprise, is another area of concern with respect to the increased administrative burden on physician practices. Allowing separate systems for one of the central components of managed care will dramatically increase the amount of time and resources practices must spend on administration, diminishing the time and resources devoted to providing direct care to patients.

Section 73.23(2)(b) of the draft rules grants each MCO the right to require prior authorization, and the right to deny reimbursement for failure to comply with those requirements. As dedicated partners to Iowa's Medicaid program, physician

practices are making a good faith effort to adapt to the rapid changes thrust upon them by the state. The department must do all that it can to minimize the administrative burden practices face under the new managed care program. IMS recommends that the state enact clear, uniform prior authorization parameters in this rule section to ease the administrative burden on physician practices. Further, IMS recommends the state develop a mechanism for a single, centralized prior authorization procedure. Medicaid programs in states like Georgia and Vermont might serve as a model for streamlining this process here in Iowa.

Provider Transition Period

Finally, IMS reiterates our strong opposition to the policy outlined in §73.23(3), which considers non-contracted providers as out-of-network for the purposes of reimbursement during the program's initial six-month transition period. The department has consistently billed these first six months as an open-network period in which patients can continue to see their existing physician regardless of the physician's network status with individual MCOs. Undermining this intention, the policy delineated in draft rule §73.23(3) will result in an unreasonable 10% cut to the already unsustainably low Medicaid physician payment rates for no other reason than to pressure practices into contracting with MCOs as quickly as possible. The policy imposes this rate cut on physicians without giving consideration to the many delays in the managed care implementation process throughout 2015, including ongoing delays in physician practices receiving full, approved provider agreements. These delays have dramatically shortened the period of time practices have had to perform their due diligence in reviewing each MCO's policies and negotiating up to four separate provider contracts.

This rate cut policy will have disastrous consequences for vulnerable Medicaid beneficiaries. The Medicaid fee-for-services rates that existed before managed care already failed to cover the actual costs of providing services. When over a quarter of all Iowans are covered under Medicaid, Iowa physicians are often forced to make difficult decisions regarding the number of Medicaid patients they can accept while still remaining in business. Cutting physician rates so dramatically will force many practices to further limit their Medicaid patient panels, or even stop seeing Medicaid patients entirely.

IMS recommends that draft rule §73.23(3) be amended to classify all current Medicaid providers in-network for purposes of reimbursement by all four MCOs until the initial six-month transition period for physical and behavioral healthcare providers ends on June 30, 2016. IMS also recommends the department enact rules to require MCOs to retroactively adjust physician payments to in-network rates upon completion of credentialing back to the date on which a provider agreement was finalized, to ensure that any administrative delays on the part of IME or the MCOs do not further penalize those physicians who ultimately join an MCO provider network. These changes will offer both patients and physicians a true transition period, giving physicians the opportunity to negotiate with the

Harry Rossander
December 1, 2015
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MCOs in good faith and ensuring vulnerable Medicaid patients do not face disruptions in care.

IMS again thanks the department for the opportunity to submit these comments regarding the transition to Medicaid managed care. We look forward to ongoing engagement and discussion throughout this process.

Sincerely,

A handwritten signature in cursive script that reads "Clare Kelly". The signature is written in black ink and is positioned below the word "Sincerely,".

Clare M. Kelly
Executive Vice President & CEO



Iowa Behavioral Health Association

IBHA Public Comments on ARC 2241 C:

73.4 (1) (a)

"During the first 90 days following the date of the enrollee's initial enrollment with the managed care organization, the enrollee may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line."

IBHA would request that additional wording be added here to make it clear that during the first 90 days, this request for disenrollment can be made FOR ANY REASON.

73.4(1)(b)

"After the 90 days following the date of the enrollee's enrollment with the managed care organization, when an enrollee is requesting disenrollment due to good cause, the enrollee member shall first make a verbal or written filing of the issue through the managed care organization's grievance system. If the member does not experience resolution, the managed care organization shall direct the member to the enrollment broker. The enrolled member may request disenrollment in writing or by a telephone call to the enrollment broker's toll-free member telephone line and must request a good-cause change for enrollment."

How is "experience resolution" defined? Do people have to go through the formal appeal process and receive a resolution there before moving onto the enrollment broker?

IBHA Public Comment on ARC 2242 C:

444-77.12(249A) Behavioral health Intervention

"A provider of behavioral health intervention is eligible to participate in the medical assistance program when the provider is accredited by one of the following bodies...."

IBHA has a concern with this section because many BHIS providers were accredited and able to do BHIS services under Ch. 24. If CH. 24 is not an acceptable form of accreditation to provide BHIS services, many providers will close their programs and not be able to do the service.

Thank you for your consideration.

Kelsey Clark

Executive Director

Iowa Behavioral Health Association

515-223-6211

Kelsey@ibha.org

Rossander, Harry V

From: Bob Bartles <bob.bartles@hopehavencorp.com>
Sent: Tuesday, December 01, 2015 3:56 PM
To: Policy Analysis
Subject: Comment #6 ARC 2241C

Dear Mr. Rossander,

I am writing to comment on the draft regulations ARC 2241C and ARC 2242C. I am the Executive Director of Hope Haven, a nonprofit organization that serves over 500 persons with disabilities in southeast Iowa. My comments are as follows;

3. 441—73.23(3)(249A) Claims payment by the managed care organization:

This 10% penalty arrangement is a REALLY bad idea and is having some pretty major unintended consequences. We presently have a contract with only one Managed Care Organization (MCO). Our service recipients are getting their enrollment forms and are asking which MCOs have signed contracts with us. If their randomly assigned MCO doesn't have a contract with Hope Haven, all the recipients are changing to the one MCO that does have a contract with us. For those who don't shift over, we'll have to either serve them at a huge loss (10% cut) or force them to shift over to our contracted MCO as a condition of continuing to be served by Hope Haven. The State's agenda of MCO competition, adequate provider networks, member choice of MCOs and provider reimbursement protection all are undermined if this language stays in the Rule. Please remove it.

441-----73.5(2)(249A) Covered Services:

The language in Chapter 90 related to Casemanagement is rigid and inappropriate for the way services should be delivered at this time. Please remove the language that defines casemanagement based on Chapter 90.

441-----73.9(249A) Incident Reporting:

We already have an adequate incident reporting system. Please keep it and remove this language.

441-----73.14(2)(249A) Continuation of Benefits:

Service providers are not a funding source for MCOS. They also deserve to be paid for authorized services that are delivered, whether or not the MCO runs into trouble through its own billing practices. Please remove the language that places providers at risk for recoupment from MCOs.

Thanks for considering my comments.

Sincerely,

Bob Bartles
Executive Director
Hope Haven Area Development Center
(319) 237-1333
Fax: (319)754-0045

bob.bartles@hopehavencorp.com

Our Mission: To assist individuals with disabilities to live a life of opportunity and well-being.

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Mr. Harry Rossander
Bureau of Policy Coordination
Hoover State Office Building
1305 East Walnut Street
Des Moines, Iowa, 50319-0114

December 1st, 2015

RE: Notice of intended action ARC 2241C and 2242C

Mr. Rossander:

The Iowa Health Care Association (IHCA), The Iowa Center for Assisted Living (ICAL) and the Iowa Center for Home Care (IHC), thank you for the opportunity to provide comment on ARC 2241C and 2242C.

Following are our comments:

Comment #1

"Clean claim" definition

Strike and replace "Clean claim" definition in proposed rule 441-73.1(249)A *Definitions*. Insert:

"Clean claim" means a claim that does all of the following:

- Identifies the health provider that provided treatment or service, including a matching identifying number.
- Identifies the Medicaid member and including a matching identifying number.
- Lists the date and place of service.
- Is for covered services.
- If necessary, substantiates the medical necessity and appropriateness of the care or services provided.
- If prior authorization is required for certain patient care or services, includes any applicable authorization number, as appropriate.
- Includes additional documentation based upon services rendered as reasonably required by the managed care organization.

Comment #2

Add new subrule 441-73.3(6):

441-73.3(6)73.3(6) *Benefit reimbursement after enrollment*. After the effective date of managed care enrollment, except as provided in paragraph 73.3(5)"b', the managed care organization shall reimburse providers for covered program benefits equal to or exceeding rates pursuant to 441—Chapters 74 to 91, as applicable for eligible members.

Comment #3

Access to service

Amend proposed rule 441-73.8(2) as follows:

441-73.8(2) *Choice of providers*. An enrollee shall use the managed care organization's provider

~~network unless the managed care organization has authorized a referral to a nonparticipating provider for provision of a service or treatment plan or as specified for provision of emergency services set forth in rule 441—73.7(249A). The managed care organizations shall give all enrolled Medicaid providers meeting the conditions of participation for Medicaid the opportunity to be part of its provider network.~~ In accordance with federal funding requirements, including 42 CFR 431.51(b)(2) as amended to October 16, 2015, the managed care organization shall allow enrollees freedom of choice of providers of any department-enrolled family planning service provider including those providers who are not in the managed care organization's network.

Comment #4

Incident reporting

Amend proposed rule 441-73.9(249A) *Incident reporting*.

441—73.9(249A) *Incident reporting*. The managed care organization shall develop and implement a critical incident reporting and management system for participating providers in accordance with the department requirements for reporting incidents for Section 1915(c) HCBS Waivers, the Section 1915(i) Habilitation Program, and as required for licensure of programs through the department of inspections and appeals. The critical incident reporting and management system shall be the central reporting portal for reportable incidents with the managed care organizations then reporting reportable incidents to the appropriate regulatory or enforcement agencies. The managed care organization shall develop and implement policies and procedures, subject to department review and approval, to:

1. Address and respond to incidents;
2. Report incidents to the appropriate entities in accordance with required time frames; and
3. Track and analyze incidents.

Comment #5

Discharge

Amend proposed rule 441-73.10(249A) *Discharge planning*.

441—73.10(249A) *Discharge planning*. The managed care organization shall establish policies and procedures in compliance with 481—57.14(135C), 481—58.40(135C) and 481—69.24(231C) or other rules governing involuntary discharge or transfer, subject to approval by the department, that protect an individual from involuntary discharge that may lead to placement in an inappropriate or more restrictive setting. The managed care organization shall facilitate a seamless transition whenever a member transitions between facilities or residences.

Comment #6

Update definition for “rate determination letter”

Amend rule 441—81.1(249A) as follows:

441—81.1 (249A) *Definitions*.

“Rate determination letter” means the letter that is distributed quarterly by the Iowa Medicaid Enterprise to each nursing facility and Managed Care Organization notifying the facility of the facility's Medicaid reimbursement rate calculated in accordance with this rule and of the effective date of the reimbursement rate.

Comment #7

Strike the outdated Pay for Performance Program found in paragraph 441-81.6(16) “g”.

Comment #8

Add provider rate protection language found in DAS's Request For Proposal for the Iowa High Quality Healthcare Initiative.

Add new paragraph 441-81.6(16) “i”

441-81.6(16) “i” Effective January 1, 2016, the managed care organizations shall reimburse at a rate that is equal to or exceeds the Medicaid reimbursement rate as determined in 81.6(16) by Iowa Medicaid Enterprise, per the quarterly rate determination letter for participating network providers, or 90 percent for out-of-network providers. This applies to claims based on the

effective date, including those already processed by the managed care organization.

OR

441-81.6(16) "f". Effective January 1, 2016, the managed care organizations will reimburse providers at a rate that is equal to or exceeds the current Iowa Medicaid fee-for-service rate on all claims based on the DHS's effective rate determination letters, including reprocessing of claims paid from the effective date of the rate determinations made by DHS.

Comment #9

Include language for the Quality Assurance Assessment Fee to be paid by both DHS and the MCOs

Amend paragraph 81.6(21) "a" as follows:

IAC 441-81.6(21) "a" *Quality assurance assessment pass-through*. Effective with the implementation of the quality assurance assessment paid pursuant to 441—Chapter 36, Division II, a quality assurance assessment pass-through shall be added to the Medicaid per diem reimbursement rate by the department and the managed care organization as otherwise calculated pursuant to this rule. The quality assurance assessment pass-through shall equal the per-patient-day assessment determined pursuant to 441—subrule 36.6(2).

Comment #10

Credentialing

Amend rule 441—81.13(249A) as follows:

441—81.13(249A) *Conditions of participation for nursing facilities*. All nursing facilities shall enter into a contractual agreement with the department which sets forth the terms under which they will participate in the program. The Managed Care Organizations shall give all enrolled nursing facilities meeting the conditions of participation for Medicaid the opportunity to be part of its provider network.

Again, thank you for the opportunity to comment. Please contact me with questions bill@iowahealthcare.org.

Regards

A handwritten signature in black ink that reads "Bill Ing". The signature is written in a cursive, slightly stylized font.

Vice President, Regulatory and Government Affairs
Iowa Health Care Association



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Director Charles M. Palmer
c/o Mr. Harry Rossander
Bureau of Policy Coordination
Department of Human Services
Hoover State Office Building
Fifth Floor
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Des Moines, IA 50319-0114

December 4, 2015

via email: policyanalysis@dhs.state.ia.us
via fax: (515) 281-4980

Dear Director Palmer,

AARP opposes Rule 441-73.23(3) and urges the Iowa Department of Human Services to reconsider and withdraw this proposed rule and course of action.

"Claims payment by the managed care organization:

73.23(3) Payment to nonparticipating providers. In reimbursing nonparticipating providers, the managed care organization is obligated to pay 90 percent of the payment to participating providers."

AARP's expresses these concerns with Rule 441-73.23(3), not just on behalf of older Iowans who receive long-term Medicaid services in institutions and in their homes through the elderly waiver, but also on behalf of the many AARP Iowa members and their family members on other waiver services like DD, BI, etc. Several of these AARP Iowa members with family members on other waiver service programs have contacted AARP Iowa about their concerns of whether they will be able to see their current providers or even who a new potential Medicaid provider might be as they are faced with a pending December 17 deadline to enroll with an MCO for themselves or a family member.

In AARP's position on the MAAC Executive Council, we did not learn of this new proposed change until October. Prior to that, it was our understanding that MCOs would be required to have an open network and reimburse all credentialed Iowa Medicaid health care providers at fee-for-service rates for the first six months of 2016 whether the providers had signed a contract with individual MCOs or not.

Real Possibilities

This original positive feature of Iowa's proposed six-month transition was an important safety valve because it allows transition time so that:

1. All Iowa providers can negotiate contracts with each of the four MCOs and come to a collective understanding that best serves Iowa Medicaid participants.
2. All Iowa providers can carefully review the lengthy and complex contract proposals so they and the MCOs can best build a high-quality Medicaid system in Iowa.
3. Iowa can build a more adequate provider network for this new managed care system by giving all current and pending Medicaid providers the opportunity to continue to provide Medicaid services and be reimbursed at fee-for-service rates for the first six months while they work on points 1 & 2.
4. Iowa Medicaid members and their families have greater provider access, choice, predictability, and continuity of care for the first six months of their transition into this new system because of point 3.

Ultimately as a consumer advocate organization in Iowa, we are particularly concerned with point 4. Adopting a 90% reimbursement rate for out-of-network providers starting as early as January 1, 2016 runs contrary to point 4. If Iowa adopts Rule 441-73.23(3), by rule, Iowa's four new MCOs will be allowed to only pay 90% of fee-for-service rates to current Iowa Medicaid providers who may still be in the process of signing complex contracts. We are concerned that the consequence of this proposal will be that some Iowa Medicaid providers will be inadequately reimbursed for the services they provide and Iowa Medicaid members need.

Moreover, this proposal may cause some providers, including some high-quality providers seeking to do their due diligence before signing contracts, to simply stop seeing Iowa Medicaid members. Given the aggressive timeframe for implementation of this program, it is especially important that continuity of care for individual Medicaid members be preserved during this transition period. Withdrawing Rule 441-73.23(3) could help improve continuity of care during this first six month transition period.

We strongly urge the Department to withdraw Rule 441-73.23(3), or at a minimum, delay the effective date of this rule until July 1, 2016, to restore the original shared understanding of a six-month provider network transition period and thereby better protect continuity of care. To implement this rule would run contrary to Iowa's goal of an improved rather than diminished Iowa Medicaid program.

Thank you for your consideration. If you have any questions, please contact Anthony Carroll at acarroll@aarp.org or at 515-707-2722

Sincerely,



Kent Sovern
AARP Iowa State Director

ecc:
Director Palmer
Mikki Stier
Michael Boussetot
Anthony Carroll



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Public Hearing Comment
DSM # 9

December 3, 2015

Harry Rossander
Department of Human Services
Bureau of Policy Coordination
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319

Dear Mr. Rossander:

Thank you for this opportunity to provide comments on the new and amended rules that are being proposed to implement the Governor's Medicaid Modernization Initiative. Iowa Legal Aid appreciates the challenges and complexity inherent in administering a program of the size and scope of Iowa's Medicaid program. We hope that the following comments will assist the Department in its goal of delivering quality, patient-centered care to improve the overall health of the Medicaid population that addresses the health care needs of the whole person - physical health, behavioral health, and long-term care services and supports - in an efficient and sustainable manner.

Comment to ARC 2241C

We have a general comment with regard to MCO interactions with Medicaid members. They should be mindful of members with limited English proficiency (LEP) and should be providing information to them in a language they can understand. Because the MCOs are receiving federal money, they must meet federal LEP requirements.

With regard to proposed rule 441 - 73.1 and the definition of "Level of Care," the definition mentions an individual's need for the level of care "within the near future (one month or less)." This definition seems to be taken from 42 CFR §441.302(c)(1), which deals with Medicaid Home and Community Based Services (HCBS) waiver services that are not for individuals age 65 or older. There is a separate section regarding HCBS waiver services for individuals age 65 and older, 42 CFR §441.352(c). That section has different language with regard to the period of time: "when there is a reasonable indication that individuals age 65 or older might need those services in the near future, but for the availability of home and community-based services." This provision does not limit the phrase "near future" to one month or less. The distinction is important because it recognizes that home and community-based services can preserve the ability of many individuals age 65 and older to live independently in their home and community. HCBS waiver services are not only an alternative to nursing facility services but also

a cost-effective way of preventing or delaying the need for nursing facility services for individuals age 65 or older. Because the standard is different in federal law, Iowa should adopt different standards for these different populations as well.

With regard to proposed rule 441 - 73.3(3)(c)(1), "a member shall have a minimum of ten days from the date of the tentative assignment letter to request enrollment with a different managed care organization...." This does not appear to be enough time for people to make a decision about which MCO is the best choice for them. Although it is listed here as a minimum, it may well become the default time. In order to be able to thoughtfully consider the alternatives, a member should have at least 30 days to request enrollment with an MCO.

With regard to proposed rule 441 - 73.4(4), the proposed regulation does not provide for what happens to the member after the member is disenrolled from an MCO. Are they automatically enrolled with a different MCO? Is there a time limit for choosing a new MCO? If the member is disenrolled by the MCO because of the exception in 73.4(3), how is the member notified of the disenrollment? Is there a process for the member to appeal or dispute the MCO's request to disenroll the member? Once a member is disenrolled, is the member then served by IME rather than an MCO? DHS must arrange for Medicaid services to be provided without delay to any Medicaid enrollee of an MCO whose contract is terminated and for any Medicaid enrollee who is disenrolled from an MCO for any reason other than ineligibility for Medicaid. 42 CFR 438.62.

With regard to proposed rule 441 - 73.6(2), what are the medical necessity criteria the MCOs may use to place "appropriate limits" on services? Will those criteria be published? Will they go through any sort of public comment process? Without the opportunity for public comment on the criteria, the criteria may negatively impact persons eligible for Medicaid and inappropriately restrict access to necessary care. Furthermore, federal regulations at 42 CFR 438.236 establish standards for practice guidelines adopted by MCOs and require the dissemination of those practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. DHS needs to ensure that any practice guidelines adopted by the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members, and the general public as required by federal regulation.

With regard to proposed rule 441 - 73.10, how will these discharge policies and procedures developed by the MCOs work with the general federal requirements regarding nursing home discharge? The time frames and criteria in the federal law are not the same as those set out here.

With regard to proposed rule 441 - 73.11, who will have access to the level of care and needs-based eligibility assessments and reassessments? Will those assessment tools and criteria be published and subject to rulemaking? Currently this information is made available to providers and, upon request, to Medicaid members and the general public. Federal regulations at 42 CFR 438.236 establish standards for practice guidelines adopted by MCOs and require the dissemination of those practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. DHS needs to ensure that any practice guidelines adopted by

the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members, and the general public as required by federal regulation.

With regard to proposed rule 441 - 73.12, it is not clear that MCOs will be required to provide a notice to the member of a denial or other appealable action. It is also not clear that MCOs will be required to provide notice to members of their appeal rights and the MCO appeal process. In addition, there is no indication of how much time members have after notice of an appealable action to appeal to the MCO. Notice of the appealable action, the appeal rights, and the timeframe and process to appeal are fundamental elements of due process. These are required by the federal regulations at 42 CFR 438.402. This section should make clear that MCOs must provide written notice to members of any appealable action consistent with 42 CFR 438.404. This section should also establish a reasonable timeframe of no less than 20 days and no more than 90 days within which the member may appeal, consistent with 42 CFR 438.402(b)(2).

With regard to proposed rule 441 - 73.12(1)(f), the wording does not match that of the federal regulations at 42 CFR 438.400(b)(6). For clarity and consistency, the word "contractor" should be replaced with "MCO."

With regard to proposed rule 441 - 73.14(1)(b), it is not clear what this language means. It says that if benefits are continued or reinstated while the appeal is pending the benefits must be continued until...: "(b) ten days have passed from the date the MCO mailed the notice of an adverse decision, unless a state fair hearing has resolved the matter." This section does not comport with the requirements of 42 CFR 438.420(c)(2), which states that benefits must be continued until...: "Ten days pass after the MCO or PIHP mails the notice, providing the resolution of the appeal against the enrollee, unless the enrollee, within the 10-day timeframe, has requested a State fair hearing with continuation of benefits until a State fair hearing decision is reached." Members are entitled to the continuation of benefits until a State fair hearing decision is reached if they request the fair hearing within ten days of the MCO's notice of adverse decision. This section should be clarified to comply with 42 CFR 438.420(c)(2).

Comment to ARC 2242C

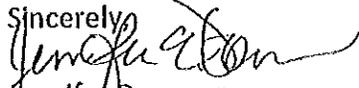
With regard to Item 19, amendment of rule 441 – 77.10 to require all dealers in medical equipment and appliances, prosthetic devices and medical supplies in Iowa or other states be certified to participate in Medicare: this will be a problem in areas where Medicare uses competitive bidding as limited numbers of providers will be certified. In addition, Medicaid pays for items that Medicare does not pay for. There will be providers that are not certified under Medicare because they offer items that Medicare does not pay for. That is going to make specialty items that Medicaid covers but Medicare does not even harder to acquire for Medicaid recipients in Iowa.

With regard to Item 31, amendment of rule 441 – 77.37(23)(d)(6) who will have access to the Supports Intensity Scale (SIS) assessment? Currently Form 470-3073 is available to the medical providers, Medicaid members, and the general public. Federal regulations at 42 CFR 438.236

establish standards for practice guidelines adopted by MCOs and require the dissemination of those practice guidelines to all affected providers and, upon request, to enrollees and potential enrollees. DHS needs to ensure that any practice guidelines adopted by the MCOs and used to make decisions regarding eligibility or coverage are made available to providers, members, and the general public as required by federal regulation.

Once again, thank you for the opportunity to provide comments on these proposed rules. If you have any questions regarding these comments, please do not hesitate to contact me at 515-243-1198, ext. 1681 or jdonovan@iowalaw.org

Sincerely,



Jennifer Donovan
Staff Attorney

OPPOSITION TO MANAGED CARE – PRIVATE INSURANCE COMPANIES SERVICING MEDICAID

My name is Judith Benson and I have been an attorney in private practice for more than 35 years. I am a partner in the law firm of Correll, Sheerer, Benson, Engels, Galles and Demro, P.L.C. located at 411 Main Street, Cedar Falls, IA. The emphasis of my practice is probate, estate planning and elderlaw. For the same 35 years I have practiced law, I have volunteered for organizations that serve the disabled and the elderly: Exceptional Persons, Permanent Planning, Northstar f/k/a Adults, Inc, Alzheimer's Association, Western Home Foundation. Both my professional career and my volunteer work have involved me in working with Medicaid and related government programs for the disabled and for seniors.

I am opposed to the managed care plan for one simple reason. It makes no sense to establish a new infrastructure to service Medicaid recipients with their benefits when the experienced staff of Department of Human Services is functioning well to deliver these services. The Medicaid rules are very complicated – they are the result of a broken health care system that imposes such illogical requirements as an income cap on facility care of \$2199/mo in 2015 and 2016 when the average cost of nursing home care in the state of Iowa is more than \$5000/mo. NOBODY could intuitively figure out the Miller trust solution to the problem. Not only are the Medicaid rules complex, but since this is a means-tested program, applying the rules requires extensive knowledge of the nature of financial assets and the income they generate. The challenges of providing service are more daunting because the recipients are disabled, many of them intellectually, so for them to formulate questions or respond to inquiries is often impossible. It takes experience and real skill to collect information from the disabled person, or their helpers – experience that only the Department of Human Services veteran staff members have.

On the next page I have copied a paragraph from my input to the Guardianship and Conservatorship Reform Task Force commissioned by the Iowa Supreme Court earlier this year. Basically what I was saying was: stop trying to "reform" guardianships and conservatorship laws in the Probate Code. They're just fine. The problem is that NOBODY (lay people and professionals alike) understand how the Medicaid laws work. So, as I recount on the next page, I found myself in court as attorney for a 39-year old disabled woman, where the apparent issue before the Court was whether her grandmother, who was her guardian, was abusing her. But the case had nothing to do with abuse - it was just that the intellectually disabled woman had lost her ID Wavier and would soon lose her Medicaid benefits because nobody understood how the programs worked. And that was not because anybody was stupid or evil, but because the program rules and their application to specific facts were so complex and misunderstood by non-DHS professionals and the disabled people themselves.

In September 2010 the Department of Human Services reorganized the processing of Medicaid facility care applications for seniors (applications to pay Medicaid benefits for nursing home care) by centralizing the project at a new facility in Council Bluffs. By the spring of 2011, the entire system had broken down as the "newbies" in Council Bluffs couldn't manage the daunting task of understanding

the Title 19 rules and mastering the financial acumen needed to process the applications. The problem was addressed by "importing" veteran staff from the field. Over time the Council Bluffs office has gained experience so that the staff is now more competent. One can only imagine the disaster which will follow if ALL the Medicaid servicing is turned over to clerical staff employed by the private insurance companies.

The fact is that working with disabled people will never be cheap. It requires highly individualized reviews and input. The most important characteristic of the servicers is that they be experienced and dedicated. You've already got that cadre at the Department of Human Services. It is absolutely foolish – and costly – to try to reinvent the wheel.

Excerpt from considerations I presented to the Guardianship and Conservatorship Reform Task Force:

The most serious problem in establishing and administering guardianships and conservatorships is not going to be resolved by the Probate Code. It is the lack of understanding on the part of family members and professionals alike about the various assistance programs: upon which wards inevitably rely: SSI and SSDI, Medicare, Medicaid/Title 19, the Waiver programs, MEPD, food stamps, housing assistance. The biggest one is Medicaid. The rules are extremely technical, there is an enormous gap in public understanding (of both Medicare and Medicaid), and there is stigma associated with using the latter – as well as food stamps, housing assistance etc. The problem cannot be addressed by general publications. The interrelated programs are just too complicated for other than individualized advice applying law and rules to facts of particular case.

I was in court for a hearing two weeks ago as a GAL (pro bono, of course) where the issue was whether an old grandma was stealing her disabled granddaughter's social security check, and otherwise taking advantage of the intellectually disabled 39 year old. First, it WAS ridiculous that the grandma – who was 87 and had bone cancer – was trying to serve as guardian and conservator, as she had done for many years. But it was also ridiculous that absolutely nobody involved had properly analyzed the situation, including the attorney for the grandma, the woman who ran a private day care attended by the disabled woman who petitioned the court to have the guardianship and conservatorship "dismissed" i.e. terminated, the non-profit financial management company that was trying to manage the woman's now-reduced social security, the extremely apt and well-meaning mother-in-law of the disabled woman who had recently married the mother-in-law's disabled son. Everybody was mad about a credit card the 39-year-old had signed up for and charged on – nobody had thought to notify the company that there was a conservatorship and therefore neither the card nor the charges were valid. There were huge arguments about the appropriateness of the marriage - but nobody had figured out that BY GETTING MARRIED the woman was now thrown off both SSI and Medicaid, because hers AND her husband's income exceeded the income guideline for 2 people. (Didn't affect disabled husband, because he is minimally employed as a dishwasher, and therefore qualified for MEPD – nice mother-in-law i.e. husband's mom didn't understand WHY – or even the fact that her son was on the ID Waiver, but not his disabled wife --- who had been thrown off the ID waiver program sometime back, when the old grandma didn't understand how to fill out the paperwork - or

may also have rejected program because of stigma . Of course lawyer didn't know either – or even that it was important; the same thing happened to two EPI clients of mine a year or so ago – nobody thought about the EPI clients throwing away the waiver paperwork because they didn't think it was important. Unfortunately, if you go off the ID Waiver (which provides many services including a job coach which might enable the woman to be employed in some limited capacity), there's a waiting list which means it will be at least two years before the 39-year-old disabled woman can get back on. (Waiting lists plague all the waiver programs except Elderly Waiver.).

The lady who ran the private day care had petitioned the court to have the guardianship and conservatorship dismissed. Actually she "ghosted" a letter for the disabled woman insisting that she was perfectly capable of making decisions for herself and taking care of herself. The disabled woman's measured IQ is 67. Everybody was prepared to do battle on whether the guardianship and conservatorship should be dismissed with the court finding that the woman was not disabled – without anybody thinking about whether this might cause a review and even DISQUALIFY her from being considered disabled by the Social Security Administration.

In summary all the matters presented to the court were non-issues although there were REAL issues nobody was addressing. The apparent "abuse" was simply a matter of NOBODY understanding the requirements of the assistance programs upon which the disabled 39 year old depended. The judge came closest to seeing the "forest": she correctly observed: "there just isn't enough money here." She was right - in important part, because the financial assistance programs weren't in place.

JUDITH R. BENSON
ATTORNEY AT LAW

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