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

DEC 17 2015

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

Dear Ms. Stier:

Thank you for the work you and your staff have done with CMS to facilitate our review of Iowa's request for the section 1915(b) and 1915(c) waivers necessary to move Medicaid beneficiaries to statewide managed care beginning January 1, 2016. We appreciate the information you have provided in response to our November 6th letter that asked the state to demonstrate the readiness of the state, MCOs, providers, and beneficiary support systems, as well as the information you provided to my staff during their site visit to the state last week.

Iowa and CMS share an interest in achieving accessible, quality care for the 560,000 beneficiaries affected by this transition, including many individuals with intellectual and developmental disabilities, physical disabilities, and frail elders. Based on our review last week of Iowa's progress, as well as the information you have provided, CMS expects that we will ultimately be able to approve Iowa's managed care waivers. However, we do not believe that Iowa is ready to make this transition on January 1. CMS previously outlined the requirements to provide high quality, accessible care to Medicaid beneficiaries, and Iowa has not yet met those requirements, meaning that a transition on January 1 would risk serious disruptions in care for Iowa Medicaid beneficiaries. While you have made progress in some areas of readiness, our review also identified significant gaps that need to be addressed before CMS can authorize your waiver requests. For that reason, CMS will work with you toward approval of your request effective March 1, 2016, provided that the state demonstrates progress toward readiness consistent with the actions in the attachment to this letter.

Background

As you know, for more than two decades CMS has worked with 39 states and the District of Columbia to transition some or all of their Medicaid beneficiaries into managed care. As a result, over three fifths of the Medicaid population nationally is enrolled in managed care. Managed care can increase access to quality care for Medicaid beneficiaries, reduce costs, and improve the health of communities. As CMS has overseen the rapid growth in Medicaid managed care, we have developed proven transition practices to avoid disruption to beneficiaries, caregivers, and providers. Moving beneficiaries too quickly into risk-based managed care organizations (MCOs) can disrupt long-standing patient-provider relationships, compromise patient care, discourage provider participation, diminish quality and access, and create program

integrity vulnerabilities. CMS has over time developed readiness requirements to ensure that Medicaid managed care delivery systems are capable of providing timely access to high-quality, well-coordinated care that meets the needs of beneficiaries and to ensure that states and managed care organizations can meet federal statutory, regulatory and policy standards. We proposed to codify readiness requirements in our June 1, 2015 notice of proposed rulemaking updating our Medicaid managed care regulations, because we believe demonstrating readiness is critical to a successful transition. In addition, in 2013 we established specific readiness policies related to managed long term services and supports in the document *Guidance to States using 1115 Demonstrations or 1915(b) Waivers for Managed Long Term Services and Supports Programs* (Version 1.0, 5/20/2013).

To assist the state in meeting CMS' readiness criteria, we also described these readiness requirements in our November 6th letter. The Gate 2 readiness requirements established in that letter are the same functional areas and operational activities that CMS applies to every state transitioning from fee-for-service to managed care, because they have proven successful in ensuring a smooth transition. We have worked actively with you and your staff for many months by holding at least weekly calls with senior staff since March, providing flexibility to focus only on the highest priority readiness activities, reviewing draft authority documents, minimizing paperwork burdens, and offering additional flexibility so the state could file state Medicaid plan amendments (SPAs) with retroactive effective dates after go-live. Last week we assigned eight CMS and HHS staff to spend four days in the state conducting an in-depth readiness assessment. All of these activities and flexibilities were provided to the state to help facilitate a smooth transition and respect its desire to act quickly, and throughout the process we have offered concrete suggestions to promote a smooth transition.

Assessment of Readiness to Implement Managed Care

Over the past several months, Iowa has made progress in its work toward MCO operational readiness. Findings from our site visit show that all of the MCOs' enrollment systems appear fully configured and tested to support implementation. In addition, the MCOs' claims processing systems have been configured and tested to meet the unique structure of the Iowa Medicaid program. We also appreciate the state's willingness to temporarily suspend its planned payment reduction to out-of-network providers for the first 90 days of the program. These efforts provide a strong basis on which to build toward more complete readiness.

However, in our assessment, Iowa's managed care implementation has not yet met some key readiness requirements and needs additional time and effort before CMS can be confident that managed care implementation supports quality of and access to care for beneficiaries. Most significantly, evidence CMS reviewed during the site visit that ended December 11th indicates that MCOs' provider networks are not fully developed and lack key providers. The state has not ensured that each MCO has contracted with a network of appropriate providers that is sufficient to provide adequate access to all services covered under the MCOs' contract as required by CMS regulation under 42 CFR §438.206, and has not met the Gate 2 requirement that MCOs have a meaningful percentage of providers under contract and credentialed. Adequate provider networks are a fundamental component of accessible, quality care for beneficiaries.

Specifically, we found that, as of December 11:

- Only one MCO provider network contained more than 42% of non-critical access hospitals.
- Only one MCO provider network contained more than 18% of critical access hospitals and no network contained more than 34% of critical access hospitals
- No MCO s reported contracting with more than 36% of elderly waiver agency providers and intellectual disability waiver agency providers for home and community based Long-Term Services and Supports (LTSS) services
- MCOs had only contracted 13-33% of intermediate care facilities serving individuals with intellectual disabilities, with three of the four plans below 20%.
- The MCOs had small behavioral health networks. The MCOs only had 27-51% of habilitation service providers under contract and 15-36% of community mental health centers and mental health agencies.

As a result of these network inadequacies, GeoAccess coverage maps showed that significant areas of the state did not have many provider types within a reasonable distance. CMS also noted that the MCOs did not have the necessary information about their anticipated enrollment and those enrollees' claims history to more accurately evaluate the extent to which their provider networks could cover beneficiaries' expected utilization. This lack of information made it impossible to fully evaluate the MCOs' provider networks. The adequacy of the MCOs' provider networks will determine whether individuals have access to care, which in turn is paramount to their health, safety, and wellbeing.

We understand the state's intent to permit beneficiaries enrolled in MCOs to access out-of-network providers and to require the MCOs to pay for the out-of-network services. However, delivering a substantial portion of services to beneficiaries through out-of-network providers is an insufficient strategy to overcome the gaps in network adequacy that we identified. Out-of-network providers serve to supplement, not substitute for, an adequate provider network. Relying too heavily on out-of-network providers is likely to create confusion among beneficiaries and providers, result in access issues for beneficiaries, and disrupt continuity of care for beneficiaries.

There are also significant operational challenges in overreliance in out-of-network providers. By definition, out-of-network providers do not have written agreements with MCOs that set forth billing procedures and timeframes, utilization management rules, payment rates, and dispute resolution processes. When providers do not have a contractual relationship with MCOs, they are unaware of the MCO-specific provider requirements in each MCO's provider and billing manuals. The clinic or facility's administrative staff have not developed procedures, trained staff, or modified their billing systems to comply with the MCOs' requirements for submitting claims and receiving payment. When claims are submitted and fail to satisfy billing requirements, the claims are often held until the provider works with the MCO to resolve the issue. For some providers this can be expensive and time consuming. Additionally, providers are often unsure of MCO limits or requirements for some clinical services. The administrative burden, time requirements and added expense of trying to work with an MCO as an out-of-network provider is likely to make many providers reluctant to serve as a source of care for MCO enrollees. During our meetings in the state, providers told CMS that they are likely to

refuse, delay or defer providing care to beneficiaries. Therefore, we have significant concerns that beneficiary access to care will not be sufficient until provider networks are adequate.

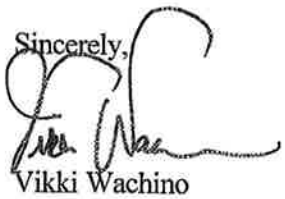
As you know, CMS has conducted listening sessions for beneficiaries, advocates, and providers; met with affected providers during our recent site visit; and received thousands of e-mails from beneficiaries, their families, caregivers and providers. CMS has heard directly from providers that there are still significant problems with communications about the transition. Some providers that signed contracts have not heard from MCOs until recently, others have indicated that they are reluctant to contract over concerns about rate issues and administrative uncertainties. We have also heard from some providers that they are already having problems referring and scheduling patients for necessary care in January with providers who have not yet signed contracts with MCOs.

CMS has also heard directly from many beneficiaries through the listening sessions. Beneficiaries have expressed frustration, confusion, and fear about the transition to managed care and the lack of information available to them to make decisions required as part of the initial enrollment process. Beneficiaries have also had significant problems getting assistance through the state's call centers. During the readiness review, CMS learned that the state call center had a 49% abandonment rate and had 10,000 calls dropped in the first nine days of December. Even when beneficiaries were able to get through the system to call center representatives, there was often little information available about whether or not their usual providers were in the MCOs' networks. Finally, we are concerned that the state does not yet have a fully-functioning LTSS Ombudsman, which CMS believes is essential to supporting access to seniors and people with disabilities during the transition.

We understand that the state is taking actions to resolve these issues, but CMS does not believe that there is sufficient time for the state to take action and give beneficiaries and providers the information and support needed to effectuate a January 1 implementation date. Indeed, challenges in communications were a central concern we heard from stakeholders last week. We think significant confusion could have been avoided if the state had waited until it fully met all of the Gate #1 readiness conditions before mailing the enrollment packets to beneficiaries, as CMS had requested in its November 6th letter.

In summary, Iowa is not yet ready to implement the transition to managed care as of January 1, 2016, and CMS cannot at this time approve the 1915(b) and 1915(c) waivers necessary for the state to do so. We will continue working closely with the state on an approach to readiness that provides a smooth transition for beneficiaries, MCOs and providers. By implementing the actions in the attachment of this letter, we believe that Iowa can be prepared to implement the program March 1, 2016. My team is prepared to continue to work with yours to that end.

Sincerely,



Vikki Wachino
Director

Attachment
Readiness Actions Needed for March 1, 2016 Implementation

Between December 8th and December 11th, CMS and HHS staff conducted a site visit to review Iowa's readiness to implement managed care for 560,000 Medicaid beneficiaries in the state. This site review followed on ten months of discussions between CMS and Iowa, and CMS' review of extensive information Iowa provided over that time to demonstrate readiness, including information responding to CMS' November 6th, 2015 letter. We also reviewed information obtained during listening sessions CMS conducted in the state in November; meetings with the Iowa Medicaid Enterprise (IME), Iowa's managed care organizations (MCOs); Iowa's Medicaid providers; and thousands of emails CMS received from beneficiaries, their families and caregivers and providers. Based on this review, the following actions are needed in order for the state to demonstrate readiness. To prepare for a March 1st start date, the state move forward with each of these recommendations. CMS is available to discuss and provide technical assistance to the state in implementing these, and would like to review with the state its written responses and summary of actions taken in response on or before February 15, 2016. CMS will continue to review information and updates from the state with respect to readiness and will work to quickly identify and work with the state to resolve any additional issues that impede readiness on March 1.

1. IME and the MCOs must develop more robust and comprehensive communication plans and capacities to get timely, detailed, accurate information to beneficiaries and providers, particularly as information changes and transition strategies evolve. This plan needs to ensure consistent information is provided to beneficiaries and providers from different MCO staff and state staff.

2. IME must enhance and monitor the capacity of its beneficiary call center to provide beneficiaries the information and support necessary to successfully transition to managed care. The enhancements need to minimally include:

    a. The call center's infrastructure must be adequate to handle the actual volume of beneficiaries calls;

    b. The call center needs to be fully staffed with trained customer service staff; and

    c. The call center staff require access to scripts, tools, and information to assist beneficiaries in understanding the state's transition to managed care.

3. IME must allow beneficiaries additional time to select an MCO with the network providers most likely to meet their needs. As the MCOs expand their provider networks, IME must allow beneficiaries continued opportunities to switch plans in order to help mitigate access concerns by allowing beneficiaries to select MCOs that are contracted with their usual providers.

4. IME and the MCOs need to use anticipated enrollment information, based on the MCO auto-assignment process, and enrollees' claims history to evaluate the extent to which the MCOs' contracted, network providers cover the normal, expected utilization for the MCOs' expected enrollment (i.e., conduct a gap analysis using GeoAccess). The MCOs must conduct the gap analysis in greater detail and with more specificity (i.e., provider types) than has been reported previously, including separately for providers of each different service under the State's 1915(c) waivers.

5. The MCOs should use the gap analysis to target their network development and provider contracting efforts on the providers most critical to covering the historical utilization of the anticipated enrollees.

6. IME and CMS will collaboratively review the MCOs' gap analyses weekly over the next six weeks to assess the extent to which the MCOs' network providers cover the historical utilization of the anticipated enrollees.

7. IME must require that for all provider types in the MCOs' networks, those network providers cover a meaningful percentage of the historical or expected utilization of the anticipated enrollees. IME, the MCOs, and CMS will collaborate on the most appropriate methods to evaluate a meaningful percentage that accounts for:

    a. IME and the MCO's evolving provider network mitigation strategies;

    b. Normal variation in the MCOs' categorization of providers, operations, and provider network analytics; and

    c. Accounts for the different Medicaid populations transitioning to managed care.

8. IME and the MCOs need to jointly meet with providers; clinic, facility, and agency administrators; and provider associations to evaluate reasonable actions that all parties can take to minimize the administrative burden on out-of-network providers during the transition period, particularly for providers that serve individuals with special health needs.

9. If IME and the MCOs believe that temporarily suspending some of the MCOs' prior authorization requirements would facilitate beneficiaries' access and coordination of care during the transition, IME and the MCOs must develop, communicate, and implement a common strategy to temporarily suspending the relevant prior authorization requirements.

10. If IME and the MCOs temporarily suspend some of the MCOs' prior authorization requirements, IME and the MCOs must develop, communicate, and implement a common approach to ensuring program integrity during this suspension. IME and the MCOs need to clearly communicate this approach to providers before the transition to managed care.

11. If IME and the MCOs temporarily suspend some of the MCOs' prior authorization requirements, IME and the MCOs must have a comprehensive communication plan to minimize confusion and proactively address the fact that all of the MCOs' provider manuals and member manuals explicitly require all out-of-network care to have a prior authorization.

12. IME and the MCOs must ensure that long-term services and supports (LTSS) case managers are available, have the appropriate expertise, are trained on relevant case management systems, and are assigned to beneficiaries before the transition to managed care. IME needs to verify and monitor that the MCOs:

    a. Have a mechanism to ensure that 100% of beneficiaries are assigned a case manager before the implementation date; and

    b. Develop and implement a strategy to communicate to beneficiaries their assigned case managers as soon as a beneficiary is enrolled in an MCO.

13. IME and the MCOs need to develop and implement a plan for each MCO to compile and submit to IME a detailed report beginning January 20th, and biweekly thereafter until the implementation date, that shows:

    a. The case-manager-to-beneficiary ratios comply with the state standards for each 1915(c) waiver and behavioral health population; and

    b. The percentage of beneficiaries enrolled (or anticipated to be enrolled) in the MCO with an assigned, and appropriately-trained, case manager who is in-network, or has given agreement to provide case management as an out-of-network case manager.

14. Iowa must have a fully functioning LTSS Ombudsman available to assist beneficiaries prior to the implementation date. In order to independently assist beneficiaries with MCO issues, the LTSS Ombudsman needs to demonstrate that:

    a. It has fully developed protocols, policies and procedures; and

    b. Staff is fully trained and knowledgeable on the functions, responsibilities, and contractual requirements of MCOs.

15. One MCO did not have its pharmacy systems configured and tested for Iowa Medicaid's pharmacy benefit. IME needs to verify and document that the MCO has properly configured and tested its pharmacy system consistent with IME's contractual requirements.

16. IME and the MCOs must fully execute the contract amendments necessary to align the IME/MCO contract with the mitigation/contingency plans communicated by IME and the MCOs.