



# Iowa Department of Human Services

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Terry E. Branstad  
Governor

Kim Reynolds  
Lt. Governor

Charles M. Palmer  
Director

February 23, 2016

Victoria Wachino, Director  
DHHS, Centers for Medicare and Medicaid Services  
7500 Security Boulevard, Mail Stop S2-26-12  
Baltimore, MD, 21244-1850

Dear Director Wachino:

For the past year we have worked collaboratively with you and your team at the Centers for Medicare and Medicaid Services (CMS) for successful implementation of Iowa's High Quality Health Care Initiative. In your December 17, 2015, letter you laid out 16 conditions for waiver approval and the path for implementation of our modern managed care plan in Iowa. Three general categories emerged from the conditions: Communications; Network Adequacy, and Long-Term Services and Supports.

Iowa has worked diligently to address these three areas by focusing on the conditions laid out. We have worked with CMS daily to not only meet the needs of our members, but also to monitor progress in tandem. Iowa has improved our communications strategies and capabilities, vastly increased our health networks, and we have enhanced our long-term services and supports to meet the needs of our members. Simply put, having met the conditions laid out in your December letter, we seek certainty for our members and your approval of our waivers.

## **Background**

As you referenced in your December 17, 2015, letter for over two decades, CMS has approved Medicaid managed care in 39 states and the District of Columbia. Managed care is not new to Iowa and our Medicaid program. Since 1986, a portion of Iowa's Medicaid population has been under managed care. In the 1990s, Iowa was a pioneer in transitioning our Medicaid behavioral health population to managed care. We have seen how coordinating care for all of the member's treatment significantly improves the health and well-being of our most vulnerable. Our own state employees benefit from a managed care system, including the Governor, Lt. Governor, and other elected officials. Medicaid modernization allows Medicaid members access to this same high quality and modern coordination of care.

Iowa's Medicaid Modernization effort was announced by Governor Branstad in January 2015, a full year before implementation. Since the request for proposal was announced on February 16, 2015, over 350 public meetings, trainings, and listening sessions with members, providers, stakeholders were organized by the Iowa Medicaid Enterprise (IME). The outreach has been conducted by the entire state government team including agency heads from the departments of Human Services, Public Health, Aging, Inspections & Appeals, Insurance Division, and Office of the Long-Term Care Ombudsman. All involved have worked diligently to ensure members, providers, and stakeholders have the right information and understand

the transition. We will continue to meet with willing members, providers, and stakeholders to answer questions and proactively communicate as our 30/60/90 day communications plan details, particularly in our continuing commitment to clear and effective communication efforts leading up to implementation and beyond with our "Coverage Has Begun" campaign beginning Day 1. Further, our Medicaid Assistance Advisory Council (MAAC) will hold monthly meetings around the state in urban and rural settings as the primary opportunity to gather feedback on our initiative. We will continue to drive further progress just as other states have done in the final days before implementation and after implementation. The implementation of our initiative is just an interim milestone in our active monitoring, management, and improvement of our Medicaid system. Iowa has taken great strides since December 2015 and we are ready to implement our plan, however without a full approval by CMS, some providers will continue to sit on the sidelines and block efforts to grow provider networks throughout the State.

### **Enhanced Communication**

We recognize the importance of comprehensive communication to our Medicaid members. Communications focused conditions laid out by CMS focused on enhancing overall communications strategies, the IME call center, and the member selection process. With the plan now in place, including our improved IME call center and a clearer member selection process, Iowa has worked to meet CMS' expectations for communications.

The 30/60/90 day communication plan that we developed and reviewed with CMS has worked well. Iowa will continue to build on that plan to ensure Medicaid members continue receiving the information they need in a timely and clear manner before and after implementation. As our teams have discussed, the activities our communications plan were designed to provide timely, detailed, and accurate information for member and provider needs. Our 30/60/90 day comprehensive communications plan took on 11 different critical efforts including:

- 11 member education events between January 4 - February 9,
- assisted individual members in one-on-one meetings,
- communicated on social media platforms,
- periodically updated state government enterprise department and agency staff so they could communicate clear information about this transition to various stakeholders,
- held numerous update meetings with legislators and their staff to ensure they have the right information to communicate to their constituents,
- held numerous conference calls with the congressional staff to ensure constituents contacting them had the right information,
- collaborated with association groups around the state to get information to Medicaid members, and
- utilized our weekly Medicaid e-newsletter to inform members, providers, and stakeholders.

Since implementing our comprehensive 30/60/90 day communications plan, we have daily and weekly communications to members, including mailings, display advertising, call center scripting, stakeholder and provider engagement, and webinars. Those will continue through implementation. Our comprehensive 30/60/90 day communications plan also includes a "Coverage Has Begun" campaign once we go live. This campaign will differ from the State's continued comprehensive communication plan for years to come as we will focus on the member choice period when members can switch MCOs for any reason at any time. This

campaign will help members be knowledgeable about their continued MCO choice options during and after the choice period, understand on Day 1 the modern Medicaid program, and how to get answers to their questions. Our comprehensive “Coverage Has Begun” campaign includes:

- communicating on current platforms (e.g., call center, member educational material),
- email marketing,
- social media,
- monitoring of e-metrics,
- a review of web content,
- meeting with association groups and other stakeholders,
- meetings with legislators and staff,
- display advertising,
- Google analytics,
- legislative correspondence, and
- informational letters.

We will also rely on our MCO partners to communicate the launch as well in coordination with the State’s “Coverage Has Begun” Campaign. Our work is not over in this area and we will continue to monitor communications and stand ready to ensure members and providers have information and support to transition to the Iowa High Quality Health Care Initiative.

A primary way for members to get answers to their questions will be through our member call center. Your December letter included a condition surrounding our joint goal of improving the effectiveness and capabilities of the IME call center. Since December, our member call center has doubled the size of the staff, improved training, and ensured accurate communication is in place for our call center staff to provide. In fact, since January our call center meets call standards above industry standards. This success is owed, in part, to the improved training we conducted. The steps Iowa has taken to increase staffing, increase training, and streamlined our call practices means our Medicaid members are better positioned than ever to get the right answer at the right time.

Iowa seeks clarity and certainty for our Medicaid members. In your December letter, you laid out conditions for giving members greater clarity and certainty in the member selection process. In November 2015, Medicaid members were auto assigned to one of our four MCOs while maintaining the choice to select a different MCO. Earlier this month members previously assigned to WellCare received their new assignments. This choice period will remain open after implementation. Even after implementation, members may change plans if the member can demonstrate good cause. In keeping with our commitment to clarity and certainty around member selection we will continue highlighting the options for member choice as an integral component in our “Coverage Has Begun” campaign. As you can see, through our efforts enhancing our communications plan, improving the capabilities and capacity of our call center and our member friendly plan selection process we are constantly working to give our members and providers the best information possible. This was the goal of the conditions set by CMS and we have met them and stand ready to communicate implementation with our members.

## **Network Adequacy**

The heart of Medicaid rests in the providers who deliver care to our members. Ensuring our members have access to the right care at the right time and in the right place is critically important to all Medicaid programs. Your December letter laid out eight network and care conditions for Iowa. The conditions surrounding the network, network development, identification of network gaps, and a thorough analysis of providers were intended to help Iowa meet the shared goal of greater certainty in care for our members. The networks built by our partner MCOs now include meaningful percentage of historical Medicaid utilization. Simply put, we believe that Iowa has met the expectations of CMS and stands ready to meet the care needs of our members.

Iowa has worked to ensure the network built for our members ensures access to right providers in the right places. Contracting with Medicaid providers by the MCOs' began when they received confirmation of a bid award from the State in August 2015. Over the past eight weeks, we have worked to enhance network adequacy. First, we must have Medicaid providers for our members to see. Over 101,500 provider contracts have been signed; a number has doubled since December 2015. But simply having providers isn't enough. Of the providers that have submitted claims in the past 12 months, more than 90 percent have signed with at least one MCO and more than 70 percent have signed with at least two MCOs. In the past three weeks alone, we have seen all three MCOs make significant gains in this historical utilization report. The critical areas the MCOs have made the most gain have been: primary care for adults and children, hospitals particularly in the central and western regions of the state, immediate care facilities for the intellectually disabled (ICF/ID), and behavioral health providers. In many cases, the MCOs have surpassed 75% market share for a provider type in a specific region (i.e., east, central, west) based on the most recent analysis of the historical utilization report. Further, the State believes the Long-Term Services and Supports (LTSS) providers have strong networks based on historical utilization. In the historical utilization report, provider type for LTSS is reported by waiver type (i.e., AIDS/HIV, brain injury, elderly, health disability, intellectual disability, physical disability) and level of care. In the most recent report, most of the provider types in a region are at or above 90% historical utilization. Critically important is that these health care providers are in the right places. Additionally, on a weekly basis, Iowa has provided CMS detailed mapping of the networks our members can access demonstrating we are ensuring adequate time and distance standards for Medicaid members.

Enhanced stakeholder outreach has helped Iowa providers participate in the Iowa High Quality Health Care Initiative and as a result members will have access to a provider network that will deliver the right care, at the right time, and in the right setting. The state held over 350 public meetings, trainings, and listening sessions for provider and members leading up to our original implementation date. Thousands of providers attended these sessions and were provided with the necessary information for a successful implementation and in addition these trainings are available through the Iowa Department of Human Services (DHS) website. Further, our MCO partners held scores of trainings and one-on-one meetings with providers since signing contracts with the state in October 2015. These representatives will continue to conduct those meetings and meet with provider in their offices to make this process as convenient as possible. In January and early February of this year, the State held 11 additional training sessions around the state to further inform members and providers about the transition, provide technical assistance, and give providers the opportunity to listen

and work with our three MCO partners. These additional State trainings held in the past four weeks alone were attended by over 2,400 providers and over 5,000 providers also successfully called our Iowa Medicaid Enterprise Provider Services Call Center since January 1, 2016. Video trainings are also available for providers through the DHS website. We will continue to work together with our MCO's to ensure call centers can address provider concerns as well continue our efforts to hold provider listening and training sessions. We are committed to giving providers clear communication and providing support through the transition as demonstrated by our proactive outreach efforts, contacts to our call centers, and the monitoring the effectiveness of these efforts. In short, our commitment to proactive communications will continue through implementation.

Iowa has also taken steps to ensure our transition gives members and providers the most certainty possible in this transition to better health outcomes. The practices surrounding out-of-network administration and prior authorization procedures give certainty to our providers and members. When we developed our transition to Medicaid Modernization, we established a thoughtful coordination, continuity of care contract provisions, and any willing provider contract provisions to ensure providers and members maintain their relationships during this transition.

Despite the significant progress in building provider networks, MCOs are still pursuing a small group of additional providers to sign contracts giving members accessible providers who will deliver improved health outcomes. An analysis of the mitigation reports submitted by the three MCOs provides significant evidence that key Medicaid providers are holding out until Federal approval. A significant number of targeted provider contracts are unsigned due to the provider's unwillingness and desire to wait for CMS approval. It is clear that after many months of negotiations the providers who have not signed contracts will not sign until an approval decision is clearly communicated by CMS.

The MCOs continue building toward provider networks better than the Medicaid fee-for-service network. This data shows that Iowa has met CMS' requirement of covering meaningful percentage of historical utilization Medicaid providers. Our commitment to our members and CMS is to continue working with our partner MCO's and health care providers to develop the best networks possible for our members. To continue down this path of improving access for our members and build on our recent success Iowa seeks approval and a certain implementation date so we can all move forward together.

### **Long-Term Services and Supports**

Members served with LTSS are among the most vulnerable Medicaid members. Ensuring continuity and confidence in their care is important to both Iowa and CMS. The conditions laid out in your December letter are aimed at doing just that, ensuring Iowa can confidently meet the needs of our LTSS members. Through our work together, enhancing contracting, training, and reporting, Iowa has met the expectations laid out by CMS and we stand ready for implementation.

Approximately 25,000 Iowa Medicaid LTSS members are assigned a case manager under fee-for-service and those services will be maintained under managed care. We know 70 case management agencies, including more than 730 case managers, are willing to work with Medicaid members in managed care. In addition, the MCOs have added 340 case managers

to their own teams as of February 9, 2016. Often, case managers in a Medicaid fee-for-service program have limited resources to support their work. With our Medicaid Modernization system, case managers will now have much more support, including access to clinical expertise, assistance with care planning, and a supportive system to monitor and assess quality of care. As stated above, members may maintain their current case manager for the first six months if that case manager is a willing provider. We have identified all case management entities willing to provide services to existing members after Medicaid Modernization implementation and are helping to facilitate the contracting process. The State is monitoring the contracting between the MCOs and case management entities to ensure that agreements are reached and data is collected to demonstrate case manager-to-member ratios. Furthermore, the State has reached out to the MCOs to ensure their plans can meet the needs of all their members by waiver type and the number of contracted and MCO employed case managers that will be needed with a focus on the six month transition.

Every Medicaid member has been assigned a case manager. If a member likes their case manager, and that case manager wants to continue working with Medicaid members, then that relationship between patient and case manager remains intact. If a member does not have a willing case manager to serve under managed care, that member has been assigned an MCO case manager who is contractually required to be conflict-free. All members will be served by their assigned case manager through implementation. We will continue to monitor the assignments of individuals to LTSS case managers as we understand the market is changing with the agencies and hiring at the MCOs. The state will also continue tracking case manager staffing reported by MCOs and will receive regular updates and monitor training, the curriculum components of those trainings, and feedback on the quality of trainings.

CMS asked the State to develop and implement a strategy to communicate to members their assigned case manager. To make this possible, the State received clarification of federal regulations (42 CFR 438.104) from CMS in January, so the MCOs could communicate directly. In late January, the Iowa Medicaid Enterprise provided a uniform letter for the MCOs to send to members clarifying the transition and who the member's case manager would be after implementation. As of February 16, 2016, that mailing from the MCOs had gone out contacting the individual members they are serving. We will continue monitoring the communication by the MCOs to the case management entities and the LTSS population and continue adjustments to improve health outcomes for the most vulnerable Iowans.

The Office of the Long-Term Care Ombudsman (OSLTCO) has two managed care ombudsmen to serve the LTSS population as a result of the bipartisan legislation passed and signed into law Iowa in 2015. The state has provided CMS the OSLTCO's Managed Care Policy and Procedure Manual and we believe we have met expectations for the Ombudsman action item. Further, we have provided a listing of trainings that have occurred to date and hope that the trainings meet CMS's expectations. Additional trainings are scheduled through implementation. Furthermore, your office held a conference call with the OSLTCO to discuss the primary responsibilities and unique role the OSLTCO plays in other states for Medicaid managed care. The OSLTCO is prepared to assist LTSS Medicaid members when our initiative is implemented and will be an important part of a much broader support network for Iowans served by Medicaid.

Serving LTSS members must come with a commitment to continuous improvement. Iowa is making that commitment by modernizing our Medicaid system and in the delivery of that system. We will continue working with CMS ensuring the LTSS members in Iowa are served by a system that meets the needs of members and providers. We have taken the first steps with a renewed focus on the contracting of case managers, enhanced training for the MCOs and case managers and ensuring we are reporting the right information. These steps have ensured Iowa met the LTSS expectations laid out in December.

Iowa is ready to implement the Iowa High Quality Health Care Initiative. By better managing and modernizing Medicaid, Iowans will get the right care, at the right time, and in the right setting. Managed care means more doctors for Iowa's Medicaid members. Managed care means better care for Medicaid members by improving access and quality. Managed care means improved oversight and accountability for the outcomes of the health challenges Iowa's most vulnerable face. Iowa and partner MCOs have worked extensively to build a program Iowa Medicaid members can believe in at implementation and into the future. We have diligently worked and met the conditions you laid out in December to begin our plan on March 1, 2016. Though we remain open to your suggestions and collaboration for the best path forward in serving Iowa Medicaid members, it is time to give our members and providers the certainty they deserve on implementation. Your approval will do just that. We have worked towards a March 1, 2016, implementation date and believe we are ready for full implementation based on our progress. However, based on consultation with CMS, we ask for approval of our outstanding waiver requests with an April 1, 2016, implementation date.

Sincerely,



Mikki Stier MSHA, FACHE  
Medicaid Director  
Iowa Department of Human Services  
Iowa Medicaid Enterprise

Attachment: Iowa High Quality Healthcare Initiative Project Plan

**Iowa High Quality Healthcare Initiative  
Project Plan – Readiness Actions Required by CMS for IA Health Link Implementation**

Topic	Issue	Action Steps	Status
<p>Communications Plan (1)</p>	<p>Development of 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. The plan needs to ensure consistent information is provided to beneficiaries and providers from different MCO staff and state staff.</p>	<ol style="list-style-type: none"> <li>1. Develop 30/60/90 day communication plan. Updates made as needs identified. Tracking of what has been produced and what is planned.</li> <li>2. Develop 2-week communications plan</li> <li>3. Initiate Daily “Communications Rapid Response” calls to ensure coordination of messaging and monitor communication activities</li> <li>4. IME to receive weekly Communication Plans from each MCO, to monitor and ensure detailed, accurate information is planned.</li> <li>5. Review all planned communications to members and providers; identify purpose of communication, target group for communication, method of communication, anticipated dates of communication.</li> <li>6. Schedule member/provider trainings – 11 cities</li> <li>7. Update FAQ page prominently featured on website (ongoing)</li> <li>8. Scripting coordination between IME and MCO’s to ensure consistent/accurate info shared</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE - Ongoing monitoring</li> <li>2. COMPLETE</li> <li>3. COMPLETE</li> <li>4. COMPLETE</li> <li>5. COMPLETE</li> <li>6. COMPLETE</li> <li>7. COMPLETE</li> <li>8. COMPLETE</li> </ol>

**Iowa High Quality Healthcare Initiative  
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Topic	Issue	Action Steps	Status
<p>IME Call Center (2)</p>	<p>Enhance and monitor the capacity of its beneficiary call center to provide beneficiaries information and support necessary to transition to managed care. Enhancements to include, at minimum:</p> <ul style="list-style-type: none"> <li>a. Call center infrastructure to handle actual volume</li> <li>b. Call center fully staffed and trained</li> <li>c. Staff access to scripts, tools and information to assist beneficiaries in understanding the transition</li> </ul>	<ul style="list-style-type: none"> <li>a(1) Order 12 additional T1 lines</li> <li>a(2) Implement IVR selection option</li> <li>a(3) Identified that 6 of the new T-1 lines were blocked and later fixed</li> <li>a(4) Order additional 24 T-1 lines</li> <li>a(5) Order/installed 2 new routers</li> <li>a(6) Order/installed 4 new local T1 circuits</li> <li>a(7) Move circuits from older hardware</li> <li>a(8) Create new training room for new agents.</li> <li>a(9) Move old circuits (5) to new routers</li> <li>b(1) Trained and hired ESRs to conduct in-person meetings and assistance</li> <li>b(2) Initial new training class of 31</li> <li>b(3) Additional 11 new staff hired</li> <li>b(4) Refresher training for staff</li> <li>b(5) Additional new staff hired</li> <li>b(6) Trained/ temporarily transferred 10 staff from DHS Contact Center</li> <li>b(7) Refresher training for staff</li> <li>b(8) Trained/temporarily transferred 5 staff from Provider Services</li> <li>b(9) Additional 16 staff hired</li> <li>b(10) Additional 11 new staff hired</li> <li>b(11) Refresher training</li> <li>b(12) Additional 24 new staff hired</li> <li>b(13) Secret shopping daily to monitor call center</li> <li>b(14) Additional 11 new staff hired</li> <li>b(15) Additional 13 new staff hired</li> <li>b(16) Additional 18 new staff hired</li> <li>c(1) Initial FAQ's/talking points on enrollment packets</li> <li>c(2) Access to sample enrollment pkt.</li> <li>c(3) MCO Comparison Chart available</li> <li>c(4) Updated FAQ/Talking Points</li> <li>c(5) Internal Provider Search Directory</li> <li>c(6) Updated Scripts on 3/1 delay</li> <li>c(7) Access to member delay letter</li> <li>c(8) Access to provider Info Letter on delay</li> </ul>	<ul style="list-style-type: none"> <li>a(1) COMPLETE</li> <li>a(2) COMPLETE</li> <li>a(3) COMPLETE</li> <li>a(4) COMPLETE</li> <li>a(5) COMPLETE</li> <li>a(6) COMPLETE.</li> <li>a(7) COMPLETE</li> <li>a(8) COMPLETE</li> <li>a(9) COMPLETE</li> <li>b(1) COMPLETE</li> <li>b(2) COMPLETE</li> <li>b(3) COMPLETE</li> <li>b(4) COMPLETE</li> <li>b(5) COMPLETE</li> <li>b(6) COMPLETE</li> <li>b(7) COMPLETE</li> <li>b(8) COMPLETE</li> <li>b(9) COMPLETE</li> <li>b(10) COMPLETE</li> <li>b(11) COMPLETE</li> <li>b(12) COMPLETE</li> <li>b(13) COMPLETE</li> <li>b(14) COMPLETE</li> <li>b(15) COMPLETE</li> <li>b(16) COMPLETE</li> <li>c(1) COMPLETE</li> <li>c(2) COMPLETE</li> <li>c(3) COMPLETE</li> <li>c(4) COMPLETE</li> <li>c(5) COMPLETE</li> <li>c(6) COMPLETE</li> <li>c(7) COMPLETE</li> <li>c(8) COMPLETE</li> </ul>

**Iowa High Quality Healthcare Initiative  
Project Plan – Readiness Actions Required by CMS for IA Health Link Implementation**

Topic	Issue	Action Steps	Status
Member Selection Process (3)	<p>IME must allow beneficiaries additional time to select an MCO with the network providers most likely to meet their needs. As MCOs expand networks, must allow beneficiaries continued opportunities to switch plans in order to mitigate access concerns by allowing beneficiaries to select MCOs that are contracted with their usual providers.</p>	<ol style="list-style-type: none"> <li>1. This will be specifically identified in Action Item # 1 “Communications Plan”, action step # 5. <ul style="list-style-type: none"> <li>• Member letter explaining dates for choice and WellCare changes</li> <li>• Updated FAQs to be posted on the website and in toolkits</li> <li>• Stakeholder communications</li> <li>• Provider Informational Letters</li> <li>• ISIS blast to Case Managers</li> </ul> </li> <li>2. Review/update as needed the Managed Care handbooks (both IME issued and MCO issued)</li> <li>3. Each MCO provide to IME how they are notifying enrolled members about network development and options to change plans (the 1<sup>st</sup> 90 days).</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE</li> <li>3. COMPLETE</li> </ol>

**Iowa High Quality Healthcare Initiative  
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Topic	Issue	Action Steps	Status
Network (4)	IME & MCOs to use anticipated enrollment information, based on MCO auto-assignment process, and enrollee claim history to evaluate the extent to which the MCOs' contracted, network providers cover the normal, expected utilization for the MCOs' expected enrollment (i.e., 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 1915(c) waivers.	<ol style="list-style-type: none"> <li>1. MCOs submitted recommended reports to state and discussed with CMS 12/24 for level of adequacy</li> <li>2. Preliminary gap analysis to be run by MCOs</li> <li>3. Outstanding membership will need to be reassigned between 3 plans.</li> <li>4. Revised 834 sent to MCOs.</li> <li>5. MCOs to do GeoAccess gap analysis by provider types and by each service for each of the 7 1915c waivers.</li> <li>6. MCOs to provide this feedback to the state on weekly basis.</li> <li>7. MCOs shall submit detailed plans to target gaps and progress made every other day.</li> <li>8. MCOs shall review detailed plans and progress with MCO Oversight Account Managers every other day.</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE, Ongoing monitoring</li> <li>3. COMPLETE</li> <li>4. COMPLETE</li> <li>5. COMPLETE</li> <li>6. COMPLETE, Ongoing monitoring</li> <li>7. COMPLETE, Ongoing monitoring</li> <li>8. COMPLETE, Ongoing monitoring</li> </ol>
Network Development (5)	MCOs to use 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.	See above.  Detailed plans to target gap shall include the number of providers expected to contact that week, mechanism of contact, and strategies to ensure and expedite contracting.	See above
Review of Network Gap Analysis (6)	IME and CMS will collaboratively review MCOs' gap analyses weekly over next 6 weeks to assess the extent to which MCOs' network providers cover the historical utilization of the anticipated enrollees.	IME MCO Oversight Account Managers will provide summary of strategies, barriers, and progress to Bureau Chief and Leadership Team on a weekly basis.  Weekly meetings to be set up with CMS to review gap analysis and progress.	See above

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Topic	Issue	Action Steps	Status
Analysis of Network (7)	<p>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, MCOs and CMS will collaborate on the most appropriate methods to evaluate a meaningful percentage that accounts for:</p> <ul style="list-style-type: none"> <li>a. IME and MCO's evolving provider network mitigation strategies</li> <li>b. Normal variation in the MCOs' categorization of providers, operations and provider network analytics</li> <li>c. Accounts for the different Medicaid populations transitioning</li> </ul>	<ol style="list-style-type: none"> <li>1. IME to provide GeoAccess of current FFS membership, provider enrollment, and highest degree of utilization patterns.</li> <li>2. Comparative analysis conducted of the MCO GeoAccess and FFS GeoAccess to identify if network gaps are real or reflective of shortage zones.</li> <li>3. Feedback to be provided to MCOs and CMS.</li> <li>4. Collaborative strategies to address network gaps.</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE</li> <li>3. COMPLETE</li> <li>4. COMPLETE</li> </ol>
Out-of-Network Administrative Practices (8)	<p>IME and MCOs 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.</p>	<ol style="list-style-type: none"> <li>1. MAAC Exec Committee—Meet to review role and expectations as move to managed care. Identify how they can work collaboratively to ensure communication with providers and members.</li> <li>2. Establish meetings with key provider groups (Medical, Mental Health, LTSS, RHS/FQHC's). Goal of meetings will be to: 1. Problem solve issues; 2. Determine if there is value in continuing meetings during implementation; Discuss upcoming Provider trainings and get feedback on topics to ensure included; Address out of network administrative practice concerns</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE</li> </ol>

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<p>PA Requirements (9)</p>	<p>If IME and MCOs believe temporarily suspending some MCO PA requirements would facilitate beneficiaries’ access and coordination of care during the transition, IME and MCOs must develop, communicate and implement common strategy to temporarily suspending the relevant PA requirements and to inform providers of retrospective review.</p>	<p>(Refer to updated “PA Process Final” – Informational Letter 1607-MC)</p> <ol style="list-style-type: none"> <li>1. Process must be agreed upon by all parties and reflected in amendment.</li> <li>2. Process must be reflected in all provider and member manuals.</li> <li>3. Process must be reflected in IME and MCO call center scripts.</li> <li>4. Process must be communicated via Informational Letter 30 days prior.</li> <li>5. MCOs must submit an education and outreach strategy for OON providers to ensure that this process is communicated effectively to a wide audience.</li> <li>6. MCO plan must be submitted to the IME on how retrospective reviews will be handled. This plan must outline whether services are targeted for review, whether there is a cost/utilization trigger, timeframe for review, and process for recovery if service is found to not be medically necessary.</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE</li> <li>3. COMPLETE</li> <li>4. COMPLETE</li> <li>5. COMPLETE</li> <li>6. COMPLETE</li> </ol>
<p>PA Requirements – Implementation (10)</p>	<p>If IME and MCOs temporarily suspend some of the MCO PA requirements, IME and 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.</p>	<p>See #9</p> <ol style="list-style-type: none"> <li>1. This will also be identified in Action Item # 1 “Communications Plan”, action steps # 4 &amp; # 5</li> </ol>	<p>See above.</p>

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Topic	Issue	Action Steps	Status
<p>PA Requirements – Communications (11)</p>	<p>If IME and MCOs temporarily suspend some of the MCO PA requirements, IME and MCOs must have 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 PA.</p>	<p>See #9</p> <p>1. This will also be identified in Action Item # 1 “Communications Plan”, action steps # 1, # 4 &amp; # 5</p>	<p>See above.</p>
<p>LTSS Case Management (12)</p>	<p>IME and MCOs must ensure that 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 MCOs:</p> <ol style="list-style-type: none"> <li>Have mechanism to ensure 100% of beneficiaries are assigned case manager before implementation</li> <li>Develop and implement a strategy to communicate to beneficiaries their assigned case managers as soon as a beneficiary is enrolled in an MCO</li> </ol>	<ol style="list-style-type: none"> <li>MHDS will develop a list of current TCM/CM requirements compared with CBCM requirements and provide an analysis of the differences.</li> <li>Determine which case managers are available to continue CM for six months and assume they will continue.</li> <li>Determine which individuals will need an MCO CBCM beginning March 1<sup>st</sup>.</li> </ol>	<ol style="list-style-type: none"> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> </ol>

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<p>LTSS Case Management Reporting (13)</p>	<p>IME and MCOs need to develop and implement a plan for each MCO to compile and submit to IME a detailed report beginning 1/20 and biweekly thereafter until the implementation date, that shows:</p> <ol style="list-style-type: none"> <li>Case manager to beneficiary ratios comply with state standards for each 1915(c) waiver and the behavioral health population</li> <li>The percentage of beneficiaries enrolled (or anticipated to be enrolled) in the MCOs 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</li> </ol>	<ol style="list-style-type: none"> <li>MHDS will develop a list of current TCM/CM requirements compared with CBCM requirements and provide an analysis of the differences.</li> <li>Ensure case managers are appropriately trained.                             <ul style="list-style-type: none"> <li>IME has MCOs' Training Outline and Training Schedules.</li> <li>IME is ensuring enough training is occurring to ensure a smooth transition.</li> <li>IME monitoring the delivery of training.</li> </ul> </li> <li>Monitor beneficiary to CM ratio.</li> </ol>	<p>See Above</p> <ol style="list-style-type: none"> <li>COMPLETE</li> <li>On Track for completion before 3/1/16</li> <li>COMPLETE. IME continues monitoring.</li> </ol>

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Topic	Issue	Action Steps	Status
Ombudsman (14)	<p>Fully functioning LTSS Ombudsman available to assist beneficiaries prior to implementation date. Ombudsman needs to demonstrate:</p> <ol style="list-style-type: none"> <li>Fully developed protocols, policies and procedures</li> <li>Staff is fully trained and knowledgeable on the functions, responsibilities and contractual requirements of MCOs</li> </ol>	<ol style="list-style-type: none"> <li>Schedule bi-monthly onboarding meetings with the managed care/LTSS ombudsman staff.</li> <li>Offer assistance in developing policies and procedures and asked for a copy of the same when they are complete.</li> <li>Draft policies/procedures (P &amp; P) due from OSTLCO</li> <li>DHS review of draft policies and procedures (P&amp;P).</li> <li>DHS feedback regarding P &amp; P to OSTLCO</li> <li>DHS determination OSTLCO has fully developed protocols, P &amp; P.</li> <li>DHS determination OSTLCO staff are fully trained and knowledgeable on functions, responsibilities and MCO contractual requirements.</li> </ol>	<ol style="list-style-type: none"> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> <li>COMPLETE</li> </ol>
Pharmacy (15)	<p>One MCO did not have its pharmacy systems configured and tested for Iowa'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.</p>	<ol style="list-style-type: none"> <li>Request information from the plan to address the CMS Action item</li> <li>Receive information from the plan to address the CMS Action item <ul style="list-style-type: none"> <li>PDL data Load 100%</li> <li>UM data load 100%</li> <li>PDL/UM testing 100%</li> </ul> </li> </ol>	<ol style="list-style-type: none"> <li>COMPLETE</li> <li>COMPLETE</li> </ol>

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Topic	Issue	Action Steps	Status
Contract Amendment (16)	IME and 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.	<ol style="list-style-type: none"> <li>1. Comparative analysis.</li> <li>2. Contract revisions to be completed by 1/1 with all comparative analysis results and date revisions necessary.</li> <li>3. Contract revision to be reviewed by Leadership Team and AAG.</li> <li>4. Contracts to be fully executed.</li> </ol>	<ol style="list-style-type: none"> <li>1. COMPLETE</li> <li>2. COMPLETE</li> <li>3. COMPLETE</li> <li>4. COMPLETE, pending CMS approval</li> </ol>