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February 22, 2019

Jennifer Steenblock
Iowa Department of Human Services
Iowa Medicaid Enterprise
100 Army Post Road
Des Moines, IA 50315

RE: 1915(b) Waiver Amendment to the Iowa High Quality Healthcare Initiative, posted January 23, 2019 at https://dhs.iowa.gov/public-notices/MCO-enrollment

Submitted electronically via jsteenb@dhs.state.ia.us

Dear Ms. Steenblock,

UnityPoint Health (UPH) is pleased to provide input in response to the public and tribal notice regarding an amendment to the Iowa High Quality Healthcare Initiative 1915(b) Waiver. UPH is one of the nation's most integrated healthcare systems. Through more than 30,000 employees and our relationships with more than 290 physician clinics, 32 hospitals in metropolitan and rural communities and home care services throughout our 9 regions, UPH provides care throughout Iowa, Illinois and Wisconsin.

As stated in the public and tribal notice, the 1915(b) Waiver amendment "proposes to amend the managed care enrollment process for Medicaid eligibility groups mandatorily enrolled in managed care, adds an additional managed care organization, and makes technical edits effective July 1, 2019." UPH appreciates the time and effort of Iowa Medicaid Enterprise (IME) in developing and proposing this amendment. We respectfully offer the following comments.

PASSIVE ENROLLMENT PROCESS

With the addition of a third Managed Care Organization (MCO), the State proposes to redistribute Medicaid members mandatorily enrolled in managed care among all available MCOs, while prioritizing continuity of care. This is proposed to be accomplished through a passive enrollment process for eligibility groups mandatorily enrolled in managed care and elimination of the initial Fee-For-Service (FFS) period.

- **Comments**: We understand the State's desire to rapidly incorporate a new MCO and completely agree that the MCO enrollment process should prioritize member continuity of care and assure timelier access to care. As proposed and given implementation mishaps during the initial transition from FFS to MCOs in 2016, we do not agree that this amendment provides sufficient detail to assure that member continuity of care will be prioritized nor do we support the elimination of the initial FFS period as a means to provide timelier access to efficient care coordination without further safeguards.

Insufficient Notice: This amendment fails to respond to the guidance set forth in the CMS amendment template. In the description of the passive enrollment process, the State's amendment does not "indicate the factors considered and whether or not the auto-assignment process assigns persons with special health care needs to an MCO/PIHP/PAHP/PCCM who is their current provider or who is capable of serving their particular needs." Although the amendment states that the process will be "designed in accordance with requirements at 42 CFR 438.54(d)(6)-(d)(8)," this amendment fails to specifically identify which factors will be considered and how providers are assigned to members with special health needs. Because this description is not responsive, it does not provide adequate notice to the public to enable stakeholders – both members and providers – to offer meaningful input. We urge the State to revise its amendment to describe which factors will be considered, how factors will be prioritized and the algorithm's assignment of providers to members with special health care needs.

Elimination of the Initial FFS Period: We oppose this portion of the proposal. This initial FFS period is important and embeds a safeguard to assure that members are covered for timely access to direct care and that providers are paid during this initial enrollment period. We believe this amendment mistakenly prioritizes process over service – more efficient care coordination (over a short span) should not be prioritized over timely access to quality, direct care. At issue is a relatively small window of time that often represents a very important window of services, particularly when an acute episode of care occurs. Our concern is that health care providers will provide services without knowing that a member has been assigned to a MCO and therefore fail to obtain the required prior authorization. Although we would prefer that the initial FFS period be maintained, the State could alternatively consider waiving prior authorization requirements during this initial period, reinstating retroactive coverage provisions, or delaying the effective date of any MCO reassignment until after the 90-day period for self-selection. We encourage the State to adopt one of these alternatives.

Continuity of Care: It is unclear how this amendment will support continuity of care and avoid member confusion. Although we are not opposed to the concept of passive enrollment if properly and thoughtfully executed, we are concerned that the passive redistribution of members from existing MCOs to a new MCO for the sole purpose of achieving an equitable member distribution and risk allocation will create unnecessary member confusion. The amendment does not clearly delineate the actual individuals targeted for this redistribution. While initial redistribution exclusions include "members receiving treatment for cancer, pregnant women, members with serious health conditions, and members recently transitions out of a facility," this exclusionary list is not exclusive and these terms are not defined. For instance, "serious health conditions" are subject to interpretation and even "receiving treatment for cancer" does not specify what "treatment" entails and if all cancers are included (from cancerous skin moles to brain cancer). During the 2016 implementation of the Iowa High Quality Healthcare Initiative (i.e. the initial transition to mandatory managed care beyond behavioral health), our providers, care coordinators and office staff had to divert numerous hours away for direct patient care and services to advocate on behalf of our Medicaid patients with the State during the initial enrollment phase and to revisit and obtain payment for denied claims. During the 2016 auto-assignment process, members were unintentionally omitted, families were often enrolled in different MCOs, assignments failed to respect existing provider-member relationships and some members voluntarily participating in the Program of All-inclusive Care for the Elderly (PACE) were

inadvertently enrolled with MCOs. We are concerned that these issues will reoccur without further definition. We would request that the State indicate in this amendment how it will monitor this new transition process and be held accountable for its pledge to provide member continuity of care.

Member Choice: We also seek clarification related to member choice and the establishment of minimum and maximum enrollment standards within the assignment algorithm. The amendment states "While the system will be modified to assign within these parameters, a member always has choice even if a maximum threshold has been reached." We agree that members should have choice and it appears that this language is absolute and permits member choice regardless of established caps. What this language does not address is what happens when an MCO does not have capacity – under what circumstances would a member not have a choice of MCO. We request that the State include a description of how member choice relates to MCO capacity and we would reserve comment on this issue until further information is provided.

IMPLEMENTATION DUTIES PRIOR TO EFFECTIVE DATE

The State proposes that this amendment request be effective starting July 1, 2019. To operationalize this amendment, the State proposes that "members will receive notices in March 2019 regarding new MCO assignment effective July 1, 2019 and will have the ability to change July 2019 assignment until the system cut-off in June."

- **Comments**: As drafted, we have concerns with implementation duties occurring prior to amendment's effective date and encourage the State to reconsider issuing member notices which request member action prior to July 1, 2019. First, this is particularly troublesome because the State public comment period ends February 22, 2019, and this amendment must still must undergo the CMS submission, public notice and approval process. A member notice that is to occur prior to CMS approval blatantly disregards a meaningful two-step public notice process with CMS approval and instead assumes that CMS will rubber stamp this amendment without considering public comment. Second, since this amendment does not have a split effective date, the member notice and cut-off date cannot occur before the amendment's effective date on July 1, 2019. As proposed, the effective date and amendment content are not aligned, and notices and cut-off dates should occur after the July 1, 2019 effective date.

We appreciate this opportunity to provide comments to the proposed amendment and its impact on our providers and integrated health care system as well as our Medicaid patients and communities. To discuss our comments or for additional information on any of the addressed topics, please contact Sabra Rosener, Vice President of Government & External Affairs at Sabra.Rosener@unitypoint.org or 515-205-1206.

Sincerely,

Sabra Rosener, JD
VP, Government & External Affairs