August 24, 2015

Mikki Stier, Iowa Medicaid Director
c/o Rick Riley
Iowa Medicaid Enterprise
Iowa Department of Human Services
100 Army Post Road
Des Moines, Iowa 50315

RE: AARP Iowa Comments Concerning Iowa Department of Human Services (DHS) Iowa High Quality Health Care Initiative 1915(b), 1915(c), and 1115 Waiver Requests to Federal Centers for Medicare & Medicaid Services

Dear Director Stier:

As a nonprofit, nonpartisan social welfare organization with a membership and offices in all 50 states, AARP's mission is to help people 50+ have independence, choice and control in ways that are beneficial and affordable to them and society as a whole. We seek to help older Americans live long and healthy lives. AARP Iowa, representing over 370,000 members, is Iowa's largest organization representing the needs, views, desires, and hopes of Iowa's 50+ population.

We greatly appreciate this opportunity to comment on the Iowa High Quality Health Care Initiative (the "Initiative") 1915(b), 1915(c), and 1115 waiver requests to the federal Centers for Medicare & Medicaid Services (CMS). Together, the waivers set out the state's plan to enroll the majority of Iowa Medicaid beneficiaries in managed care organizations (MCOs) for the delivery of health care services and long-term services and supports (LTSS). AARP Iowa has been heavily engaged over the years to advocate for a health care system that adequately serves the needs of older Iowans and their families, and we believe that such a major change to Iowa's Medicaid system as is proposed in the Initiative deserves considerable thought, attention, and planning.

Medicaid managed care provides many opportunities and challenges in care delivery and financing. AARP does not support or oppose a transition to managed care, but rather seeks to ensure that any changes to the state's health care and LTSS systems are person and family-centered and allow individuals to live as independently as possible and to exercise control over their own care arrangements.

Many of the stated goals of the Initiative, such as increased integration of care across the health care delivery system and improvement in quality of care and health outcomes, align well with AARP policy principles. In particular, we are encouraged by the state's commitment to address the historical LTSS institutional bias when we know that an overwhelming majority of Iowans would prefer to receive services in their homes and communities. In fiscal year 2013, Iowa spent 49.1 percent of its total Medicaid LTSS dollars on home and community-based services – a significant improvement from past years, but still in the bottom half of states nationwide.[1] Equally troubling is the fact that this spending imbalance is even worse for older adults. Data from the same year shows that the state spent only 30.4 percent of its Medicaid LTSS

dollars on home and community-based services for adults over age 65 and people with physical disabilities.[2] Correcting this imbalance, especially for older adults, should be a top priority for the Initiative.

We also note that CMS recently proposed the first major update to Medicaid managed care regulations in more than a decade. While these rules are not yet final, we urge Iowa to proactively incorporate elements of these proposed rules into the Initiative, especially those provisions that seek to protect individuals enrolled in managed care.

We urge Iowa to clarify, modify and expand the plans for the Initiative in the following key areas before final waiver applications are submitted to CMS:

Enrollment, Choice, and Disenrollment

AARP believes that informed consumer choice should be a key principle guiding all aspects of design and implementation of the Initiative. We appreciate that all enrollees will have a choice of at least two MCOs and that an enrollment broker will be available to provide choice counseling and assist enrollees in this important choice. We urge the state to continue to ensure that any person or entity serving as an enrollment broker must be independent from MCOs and providers to be able to best serve the needs of the enrollees without a conflict of interest. We are also concerned that allowing only 10 to 45 days for enrollees to choose an MCO before being auto-assigned is insufficient for what will be, for some enrollees, such an impactful and difficult choice.

In order to best highlight the opportunities for enrollee choice, we urge the state to first set out the enrollee's MCO options in the initial notice and clearly explain that the enrollee will be able to change MCOs in the first 90 days of enrollment. Only after this information is set forth should the notice mention the enrollee's potential auto-assigned MCO assignment. We suggest framing the notice to encourage and emphasize that enrollees have a MCO choice and that enrollees are only auto-assigned to a MCO if they fail to make a choice, rather than framing the notice as if enrollees are already in an auto-assigned MCO that they will need to take steps to change.

In the initial enrollment notices and any information provided by the enrollment broker, it is also critically important that individuals be provided with clear and complete information on their options, details on provider networks, and objective quality and credential data on the MCOs and their provider networks. This includes a list of the care providers the prospective enrollee has used during the preceding 12 months, if such information is available in state Medicaid data, and an indication of which of these providers are part of each MCO's network. While we commend the state for requiring that all MCOs extend contract offers to all current Iowa Medicaid-enrolled providers as a way to preserve existing provider-enrollee relationships, individuals should be made aware of whether each MCO has already secured a contract with the individual's existing providers or whether an MCO is pursuing such a contract. If any of an individual's current and recent health care providers are not already part of an MCO's network, the notice should explicitly state that fact and whether the MCO is currently pursuing a contract with the provider. Similarly, the algorithm that determines the tentative MCO assignment provided to individuals in the initial enrollment notice should also take into account which MCO's existing provider network best preserves the individual's existing provider relationships.

The most highly valued protection in any consumer situation is the ability of the dissatisfied to take their business elsewhere. We appreciate that the Initiative allows members the opportunity to change MCOs in the first 90 days of enrollment without cause, and thereafter for cause, including poor quality of care, lack of access to services covered under the contract, or lack of access to providers experienced in dealing with the member's health care needs. As the waivers note, Iowa will want to guard against any MCO that might

attempt to encourage disenrollment by consumers who are medically challenging and expensive to care for. As part of Iowa's monitoring of this issue, the state should conduct exit interviews of those who disenroll and require corrective action in response to any enrollment manipulation. The state should monitor MCO retention rates as a key indicator of quality and consumer services and should make this information public and provide it to consumers during the enrollment and enrollment renewal processes. The responsibility of the MCO and their networks should not end with disenrollment. The MCOs should be required to develop and implement a seamless transition plan with no gaps in care for those changing MCOs or those who are determined medically needy or who otherwise transition back to the fee-for-service system.

Network Adequacy

AARP believes that states must ensure that all network-based health plans offer adequate and appropriate access to providers who can meet the needs of the enrolled population. We applaud the state for its focus on MCO network adequacy and oversight, including readiness reviews prior to enrollment, requiring monthly geo-access maps from MCOs, and requiring that MCOs maintain accreditation from the National Committee for Quality Assurance (NCQA) or the Utilization Review Accreditation Commission (URAC). After a period of initial implementation, we urge the state to do a further review of the requirements of these accrediting bodies to assure that they are equally rigorous, lest there be an incentive for plans to "venue shop" for the easiest path to accreditation.

We understand that the Initiative requires MCOs to have an open network until the MCO demonstrates that it meets access requirements, and that the 1115 amendment for the Iowa Wellness Plan requires that MCOs extend contract offers for the first six months to all currently enrolled Iowa Medicaid providers in good standing, at minimum, at Medicaid fee-for-service rates. After initial network adequacy has been achieved, we believe that providers in MCO networks should be held to minimum quality standards. We ask the state to consider adopting standards that, for example, exclude those practitioners with the worst track records for avoidable hospitalizations and readmissions, which could help attain the twin goals of improved care and lower costs. CMS maintains quality data on nursing homes, including, for example, rates of infections and pressure sores and the use of psychotropic drugs, and on hospitals and home health agencies that could be used to build high quality networks. Other available and objective quality data from state and federal sources could also be used. This is an appropriate counterbalance to any incentive to build networks based predominately on cost.

As the Initiative waiver process moves forward, we call on the state to include more detail on its proposed oversight and monitoring of network adequacy, including stating the specific time and distance measures and the provider number, mix, and geographic distribution, including general access standards that the state plans to use. We encourage the state to make all network adequacy information, and any information related to network quality, such as the results of the required Consumer Assessment of Healthcare Providers and Systems (CAHPS) survey, easily available to the public and to potential enrollees through MCO report cards or other consumer-friendly formats.

Timeframe

Based on other states' experiences adopting comprehensive Medicaid managed care including LTSS, AARP believes the Initiative has an overly aggressive time frame for transition and implementation. Less than five months from the August 17, 2015 announcement of successful bidders to a January 2016 implementation of service delivery is likely inadequate for the MCOs to: fully develop and implement the necessary protocols, information systems, staff, and infrastructure; build the necessary provider network needed to ensure continuity of care and/or transition to community-based services for seniors and persons with disabilities (especially if MCOs do not have prior experience providing LTSS to a vulnerable population);

appropriately educate new enrollees and their families about the changes taking place and their rights and responsibilities; and take necessary steps to ensure quality. Kentucky, for example, transitioned to a statewide Medicaid managed care program in a similar timeframe as what is being proposed for the Initiative. An evaluation from the Urban Institute and the University of Kentucky found that this "extremely rapid" timeline contributed to many of the implementation problems faced in that state.[3] If Iowa determines that MCOs are not adequately prepared in the lead up to implementation or thereafter, the state should consider and publicly share back up plans to address changing and challenging realities. For example, the state could stagger the rollout geographically to begin with those areas that are more prepared for the transition.

Savings Projections and Reinvestment

The waivers state that the Initiative is expected to save $51.3 million in the first six months of State Fiscal Year 2016 through improved management of the health care needs of enrollees without reducing medically necessary services. Recent research suggests that a state's ability to save money by implementing mandatory Medicaid managed care is influenced by a variety of factors,[4] and we are concerned that an overly-ambitious effort to achieve savings in the short term could have adverse consequences for beneficiaries' access to needed care. While better coordination and high-quality care within the Initiative may make reductions in total care, services and costs possible, a capitated system's inherent financial incentive to simply spend less remains. In all aspects of design and implementation of the Initiative, we urge the state to deemphasize the expectation of savings, especially in the short-term, and instead ensure that the Initiative prioritizes member health and well-being above the potential for financial savings.

If Iowa's Initiative is able to achieve its stated goals, as well as generate cost savings for the state, AARP strongly believes that the state should commit to using these savings as an opportunity to continue to improve access to quality health care and home and community-based care on a larger scale. Transition to managed care must not be a way to gradually decrease the state's investment in, and availability of, health care, LTSS or other services available to these populations. This commitment should be demonstrated by including specific language in the waivers that direct that any savings achieved through the success of the Initiative be reinvested to improve the network and quality of services and supports available to those in need of health care and LTSS. In specific, savings should be allocated to increase eligibility for and access to services so that more individuals (especially older adults) can receive home and community-based services. While we understand that savings may not accrue the first few years, we strongly believe that the commitment to reinvest in the target population should be made upfront.

State Oversight

We are encouraged by the creation of the legislative health policy oversight committee enacted earlier this year in Senate File 505 and by the plans to convene monthly state-wide public meetings beginning in March 2016 to receive input and recommendations from stakeholders and members of the public regarding the Initiative. Legislative oversight committees are active in Indiana, and were a valuable vehicle for advancing Tennessee's transition to managed care plans. AARP urges the state to continually monitor the effectiveness of the oversight committee and the public meetings to ensure that they are an effective channel for stakeholder input and that needed modifications and adjustments are made to improve the Initiative for members.

In shifting to a comprehensive managed care program, robust MCO contract oversight and monitoring is also critical to ensure that capitated payments do not create incentives for MCOs to stint on needed care and services for this very vulnerable population. Robust oversight is also imperative to ensure that all reporting requirements and performance standards are being complied with and that they are leading to improved quality and access.

Based on the experience of states that have successfully implemented Medicaid managed care, we are convinced that state governments must take a hands-on management approach to effectively oversee managed care contracts. The various reporting requirements set forth in Section B of the 1915(b) waiver (including reporting on member disenrollment, grievances, coverage/authorization and quality of care) are a solid start to effective oversight, but the state must be committed and take steps (both from a staffing and knowledge perspective) to actively monitor and use all of the enforcement tools available to ensure that Iowa consumers receive the right care, in the right place, at the right time. A recent AARP Public Policy Institute report points out that "although contracts between states and MCOs establish standards and requirements, such contracts are empty promises if states are unable to monitor and enforce plan compliance and performance."[5] AARP is concerned that the waivers lack detail on the corrective action plans, their specific triggers, and other mechanisms that the state may use to enforce MCO requirements. Iowa (or any other state) should not be permitted to reduce its Medicaid role and responsibilities by simply paying MCOs and relinquishing all functions to them. Final accountability for the performance of its contractors, including managed care plans, must remain with the state. As the waivers are revised prior to submission to CMS, we call for more detail on how the state intends to conduct oversight, including a description of the resources it can dedicate to this effort, particularly under the tight implementation timeline.

Involvement of Family Caregivers

Family caregivers provide the vast majority of LTSS in the home and community, and should be seen as a key component and partner in any effective Medicaid system. We are pleased that the waivers call for "informal services/supports that are offered by providers, family/friends and other members of the natural support community" to be integrated into treatment plans, though services provided by family caregivers should only be included in the treatment plan if family caregivers have agreed to provide these services and have indicated their ability to carry out the actual tasks. We also appreciate that participants may "invite anyone of his/her choosing" including family members and friends to participate in the service plan development under the 1915(c) waiver and that health assessments for participants with special health care needs will include contact with family members and caregivers under the 1915(b) waiver.

In addition to these provisions, we recommend that the Initiative include other ways for the MCOs to involve and partner with family caregivers. We urge the state to improve the waivers and contracts with MCOs to ensure that:

- Family caregivers of **all** Initiative participants have the opportunity to participate in assessment of need of their family member;
- Family caregivers receive an independent assessment to determine how the MCO can work with the caregiver and support their needs;
- MCOs train their case managers on how to communicate and work with family caregivers;
- MCOs have regular communication with the family caregiver and require paid home care/health provider to communicate/consult with the family caregiver on service delivery;
- MCOs offer caregiver training to family caregivers that covers both effective caregiving techniques and stress reduction practices; and
- MCOs provide paid respite support for family caregivers on a regular basis.

As always, we are ready to assist in any way to help ensure that Iowa has the most appropriate, accessible and quality Medicaid program for Iowans. If you have any questions, I encourage you to contact our AARP Iowa Associate State Director for Advocacy, Anthony Carroll at 515-697-1015 or acarroll@aarp.org.

Sincerely,

Kent Sovern
State Director
AARP Iowa

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[1] Eiken, Steve, Kate Sredl, Brian Burwell, and Paul Saucier. "Medicaid expenditures for long-term services and supports in FY 2013." Center for Medicare & Medicaid Services, June 2015. Available at: http://www.medicaid.gov/medicaid-chip-program-information/by-topics/long-term-services-and-supports/downloads/ltss-expenditures-fy2013.pdf

[2] Id. at Table AP. Note: FY2009 is the last year for which HCBS expenditures for 65+ (separately and not grouped with people with physical disabilities) is available. HCBS expenditures represented 27 percent of LTSS spending for that group in FY2009. See Kaiser Family Foundation. "Medicaid's Role in Meeting the Long-Term Care Needs of America's Seniors." January 2013. Available at: https://kaiserfamilyfoundation.files.wordpress.com/2013/02/8403.pdf.

[3] See Palmer, Ashley, Embry Howell, Julia Costich, and Genevieve M. Kenney. "Evaluation of Statewide Risk-Based Managed Care in Kentucky." 2012. Available at: http://tpcprod.urban.org/UploadedPDF/412702-Evaluation-of-Statewide-Risk-Based-Managed-Care-in-Kentucky.pdf.

[4] Duggan, Mark, and Tamara Hayford. "Has the Shift to Managed Care Reduced Medicaid Expenditures? Evidence from State and Local-Level Mandates."*Journal of Policy Analysis and Management* 32.3 (2013): 505-535.

[5] Lipson, Debra J., Jenna Libersky, Rachel Machta, Lynda Flowers, and Wendy Fox-Grage. "Keeping watch: Building state capacity to oversee Medicaid managed long-term services and supports." Mathematica Policy Research, 2012. Available at: http://www.aarp.org/content/dam/aarp/research/public_policy_institute/health/keeping-watch-building-state-capacity-to-oversee-medicaid-managed-ltss-AARP-ppi-health.pdf