Thank you for the opportunity to submit comments on the dire situation in the state of Iowa as there is a dangerous and reckless push to Medicaid privatization on a timeline that defies all logic.

The provider community is absolutely not ready in the state of Iowa. A delay in the implementation is the only logical, prudent measure.

There is not a safe Provider network for clients in this transition. We have spent countless hours trying to work through the endless red tape/paperwork to enroll our 6 service locations with each MCO, given the added challenge of the inability of the MCOs to answer even basic questions. Yet we are being coerced with threats of 10% payment cuts if the contracts are not signed by completely unrealistic timelines. This is coercion and creates duress at a time that the contracting and relationship between the providers and MCOs are being formulated and setting the tone for ability to work together in the future to serve our most vulnerable beneficiaries.

Provider manuals are not complete as published 10/27/15 , yet they serve as the outline of covered benefits, billing, etc. The Provider community just received these manuals on 10/27/15 but they are shamefully inadequate. For example, the benefit description for home health coverage, waiver service descriptions, EPSDT services, are next to non-existent.

IME/DHS are putting communication out at reckless speed to the point where the provider community cannot keep up, information is highly confusing and incomplete, incorrect and then rescinded, and the provider agencies lack the infrastructure to keep up and assure internal readiness for the transition. Today I am at a state association meeting and the entire room of home health agency leaders are at a complete loss as to the facts with no consensus on what the most current information is, there are no answers to our questions, etc. However, we are all being told to have 2-3 payrolls in reserve due to the issues that are certain to paralyze our accounts receivable come 1/1/16. Every leader in these ~50 home health agencies represented today stated they could not survive any delay in cash flow. We do not have reserves on such a low margin business. Yet there is no contingency plan in place by the state for when claims are not paid due to filed claims processing.

Unethical hiring practices of the MCO community have been evidenced. The reality is that agencies are losing staff at a time when that internal infrastructure is critical for readiness in this transition.

There has been no claims testing of home health agencies. Our state association representative just returned from meeting with the governor and there is a statement that claims testing has been done, yet no one in this meeting had any knowledge of any provider that has participated in claims testing in Iowa. The governor's panel was unable to provide any data to back up that statement. Claims testing in any state other than Iowa is pointless, as Iowa has unique billing requirements and our software systems required programming to meet those unique requirements.

CMS hosted listening sessions. We are being told, even by members of the governor's team, that those sessions will have no impact on the ability to delay this transition. I have more faith in our government than that, and my hope is that CMS truly listened and takes the only logical step and delays this transition based on the unified and clear message at those listening sessions.

Thank you for your consideration.

From: Tina Coleman
Sent: Thursday, November 19, 2015 6:33 PM
To: rokcmmch@cms.hhs.gov
Cc: Tina Coleman
Subject: Iowa Medicaid Transition to Managed Care

Thank you so much for the opportunity to provide feedback re: concerns of the proposed transition from Medicaid to Medicaid Managed Care in Iowa.

While the state has verbalized this initiative has been in the works for a year, it has only been in the recent couple weeks that any of the information required for Providers to prepare for this transition has been released. The Provider manuals were just released on October 27, 2015. The manuals are incomplete, and do not provide the needed detail re: covered services, claims submission, etc. Without that detail, the home health agency (Provider) is completely unable to plan the medically necessary care and other ancillary services for our waiver clients, EPSDT high tech pediatric clients, mental health clients, and the over 1100 Medicaid clients we serve on a daily basis that need care in order to remain at home and out of a nursing home.

The timeline is highly unreasonable in relation to the amount of infrastructure change that will be needed as a result of this transition for individual providers. Less than 2 months' notice in sending the CRITICAL information providers need on such a massive initiative is unreasonable and unrealistic. At least a 6 month delay is the only answer given such an unrealistic timeline.

When we transitioned to electronic billing in Iowa, our software vendor had to make significant software upgrades in order to support that ability to bill electronically in Iowa. Without even the details to identify what, if any, software upgrades are needed to meet the HMO demands, we are completely unable to address this in a proactive manner. If upgrades are needed, there is almost no possibility of meeting the 1/1/16 deadline to be able to submit claims. And, again, without any claims testing to date, there is no assurance that there will be adequate cashflow in order to remain viable. And, there exists the real possibility that there will be multiple issues and software upgrades needed.

Claims testing has not occurred. There is a huge concern re: the impact on cashflow that could jeopardize the viability of providers during this transition period. Based on knowledge of the transition difficulties in other states, providers in Iowa are being told by state associations and consultants to have at least 3 payroll or 3 months of cash on hand in order to survive a likely lack of cashflow through this transition period beginning 1/1/16. Truly, in Iowa, there is no such margin for providers to survive this. Clients will lose and/or be unable to access services if the viability of the Providers that serve our very rural counties are put in jeopardy.

Another example of the billing reality to support the potential cashflow crisis: The HMOs have stated the Provider must submit an EOB for the denial from other third party payers in the situation where the client has other insurance. Of the over 1100 Medicaid clients served by our agency, a majority have a third party insurance. Many payers, including Wellmark, will not issue that EOB for denials. IME (Iowa Medicaid) had recognized that fact and had accepted verbal denials, which was all Wellmark would provide, in order for Providers to go ahead and submit the claim. This new requirement for the EOB by the HMO could potentially tie up cashflow for months, even years.

As a provider serving over 1100 T19 clients, about 75% of our clients have not received and/or have no information re: the HMO transition and options to choose. Less than one month is not adequate time for this population to study their options and make an informed choice of which HMO to move forward with.

Provider rates were just released on 10/27/15. There are concerns re: the waiver reimbursements and methodology. The basis of the payment rates for cost reports that are not settled is an unaddressed issue. The ability to budget for 2016 is almost nonexistent given all the unknowns.

To further address infrastructure. In Iowa, we have learned from the Medicare HMO experience, that each HMO has their own set of rules, requirements, internal "hoops" to jump through, etc. in order to provide service to needed beneficiaries and be paid for that service. All those extra and unique HMO demands create a great deal of cost to the Provider. However, reimbursement rates are not on the rise. In fact, the state of Iowa has publically stated they expect this transition to the HMOs to save $51 million dollars in six months. That publically stated cost savings creates almost paralyzing fear. As we face certain, inevitable rate cuts once the initial six month transition period is done, please realize this is also at a time that the infrastructure requirements to now meet not one payer's demands (IME) but ***four*** individual HMOs' demands is almost not sustainable. Iowa is known for its low cost, high quality care. There is no margin to support the demands this transition to 4 HMOs will create on the Providers.

We have also been told by the HMOs and IME that should a client not be signed up for an HMO as of 1/1/16, absolutely no payment will be made for services rendered. What is the contingency plan should one or more of the over 500,000 T19 beneficiaries in the state of Iowa fall through the cracks?

Each HMO has stated they will require authorization for services. Even with the current limited HMOs in Iowa, we have been in the unfortunate situation where the client had T19, enrolled in Meridian or was moved to Wellcare, and the Provider did not know. That has created write offs for this provider when that change in coverage information was in no way known, nor disclosed to us and the state's Eligibility line to check the insurance was updated retroactively or not at all. What are the safeguards and the contingency plans for Providers when this most certainly happens with the upcoming HMO transition? Further complicating the issue when clients have the ability to change their HMO for the first three months, etc.? The Providers will once again be caught in the middle of providing services in good faith, be denied reimbursement because the established systems for checking eligibility cannot keep up and then the required authorization by the HMO was not obtained? And, changes entered retroactively by the state are not a good faith effort nor a protection to Providers.

Contracts: the Providers will need to sign contracts with all the HMOs under which they are willing to provide services. The state association had legal review the contracts and there were a multitude of concerns with the contracts, to include a long list of which were labeled by the attorney as "Egregious Provisions." The HMO contracts are being offered as a "take it or leave it." That is highly concerning, given the nature of the issues outlined in the "egregious provisions" mentioned prior. And, considering professionally accepted contracting processes, Providers entering in to such major negotiations need more than 30 days to process, consult, consider, and truly analyze the contract offered and all its implications, infrastructure demands, etc. The contracts received formal approval just a few weeks ago. This process of contracting seems to go against all ethical and professionally accepted processes.

These are but a few of the concerns identified as a Provider for this looming transition to Medicaid Managed Care.

Please don't hesitate to contact me at this email tcoleman@iowahomecare.com or 641-777-4695 if you need further information or have questions.

Thank you in advance for your careful and considerate review of the facts presented above and their potentially disastrous effect on Providers and clients. I urge you to either not support this proposed change in Iowa, or ***at a minimum***, delay it for at least 6 months until all the critical facts and processes and details have been finalized.

For the love of home,

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