Disability Rights IOWA

Law Center for Protection and Advocacy™

COMPARISON BETWEEN

IOWA HIGH QUALITY HEALTH CARE INITIATIVE SCOPE OF WORK

AND

NATIONAL COUNCIL ON DISABILITY GUIDING PRINCIPLES

MARCH 6, 2015 (REV. MARCH 31, 2015)

INTRODUCTION

The Iowa Department of Human Services (DHS) released a Request for Proposal (RFP) for Governor Branstad's Medicaid Modernization on February 16, 2015. The RFP, which is entitled the Iowa High Quality Health Care Initiative, asks for bids from potential vendors as the state moves toward a comprehensive risk-based managed care approach for Iowa's Medicaid program. You can access the RFP (MED-16-009 Attachment 1 (SOW) 2-16-15.pdf) and the revised RFP (MED-16-009 Attachment 1 (SOW) Incorporating Amendment 1, 03-26-15.docx) on the State Bid Opportunities website at: http://bidopportunities.iowa.gov/?pgname=viewrfp&rfp_id=11140.

According to DHS' Fact Sheet on the RFP at http://dhs.iowa.gov/sites/default/files/IME_ModernizationFactSheet_03042015.pdf , the goals of the Initiative include:

- Improved quality and access
- Greater Accountability for outcomes
- Create a more predictable and sustainable Medicaid budget

To analyze how the RFP might affect Iowans with disabilities or mental illness, Disability Rights Iowa (DRI) compared the provisions in the RFP to the twenty "Guiding Principles for Successfully Enrolling People with Disabilities in Managed Care Plans," prepared by the National Council on Disability (NCD). The Guiding Principles can be found at http://www.ncd.gov/publications/2012/Feb272012/. This Comparison, through footnotes, also indicates what the expectations of the Center for Medicaid and Medicare Services (CMS) are with respect to each topic covered by the NCD principles. CMS GUIDANCE TO STATES USING 115 DEMONSTRATIONS OR 1915(B) WAIVERS FOR MANAGED LONG TERM SERVICES AND SUPPORTS PROGRAMS, Version 1.0 (05/20/13)("CMS Guidance").http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf The comparison is arranged according to:

- The number of the Guiding Principle in the NCD document, along with the text of that principle;
- The relevant provisions in the RFP:
- The determination of whether the RFP satisfied the NCD guiding principle; and
- An explanation of why/why not the RFP satisfied the NCD principle.

This is DRI's first attempt to analyze the RFP in light of these principles. Therefore, DRI is issuing this document as a draft and expects to revise it as DRI receives comments from other stakeholders in the disability community. This side-by-side was revised on March 30, 2015 to take into account DHS' revision to the RFP on March 26, 2015. Notes regarding the revisions are in *red italics*. If you have any comments or suggestions, please send them to info@driowa.org. Thank-you.

COMPARISON

NCD GUIDING PRINCIPAL	*RELATED RFP SECTIONS*	*DOES RFP SATISFY THE PRINCIPAL?*	*WHY/WHY NOT?*
#1 **<u>COMMUNITY LIVING</u>** The central organizing goal of system reform must be to assist individuals with disabilities to live full, healthy, participatory lives in the community.[1]	§ 1.2 Goals § 3.2 Covered benefits § 4 Long-Term Care Services and Supports § 4.3.12.1 Case Management Requirements	No, insufficient	According to the Iowa Department of Human Services, the main goals of Medicaid Modernization are to improve quality and access, achieve greater accountability for outcomes, and create a more predictable and sustainable Medicaid budget. Unfortunately, DHS has not taken full advantage of the opportunity to simultaneously transform its long-term care system to a less institutional, more integrated community-based system as required by the Americans with Disabilities Act (ADA) and the U.S. Supreme Court's *Olmstead* decision.. Admittedly, DHS has taken some steps in that direction. The RFP contains several aspirational statements about emphasizing individual member choice and independence and requiring contractors to provide health care services in the least restrictive environment. In addition, DHS has incentivized contractors to provide more integrated, community-based services by: - Including as eligible enrolls those individuals who are institutionalized in a hospital, nursing facility, psychiatric institution or IDF/ID and who are eligible for SSI (RFP, Exhibit C, Eligible Enrollees); - Blending the institutional and Home and Community-Based Services (HCBS) population into one rate cell (RFP, § 2.3.3.1); - The Contractor is required to work with the Agency (DHS) to ensure that the number of members assigned to LTSS is managed in such a way that ensures maximum access, especially for HCBS community-integrated services, while controlling overall LTSS costs; - Identifying and addressing service gaps, on an individual basis, and ensuring that back-up plans are being implemented and are functionally effective (RFP § 4.4.7), and - Authorizing the Contractor on its own, without authority from DHS, access to any HCBS waiver to serve an additional individual that requests such services and meets the level of care requirements when the contractor adequately demonstrates to DHS that it has reduced the corresponding number of nursing facility, ICF/ID, or PMIC beds. (RFP, §4.2.3.1.2) Despite these incentives, DHS has undermined its attempts to encourage managed care

[1] CMS has stated that "all MLTSS programs must be implemented consistent with the Americans with Disabilities Act (ADA) and the Supreme Court's Olmstead v. L.C. decision." According to CMS, the law requires that "MLTSS must be delivered in the most integrated fashion, in the most integrated setting, and in a way that offers the greatest opportunities for active community and workforce participation."

			contractors to deliver LTSS in the most integrated manner by allowing them to merely "consider individual member choice and community-based alternatives "within available resources." (Philosophy in the Design and Delivery of Behavioral Health services and supports. (§ 3.2.8.1). The RFP should be amended to include systemic Olmstead reform as one of its goals and it should: • Cap the contractors' profits and require excess profits to be spent on the development of integrated community-based residential and employment services (the first year could be the establishment of a baseline, but subsequent years requiring community investment with excess profits ; • Require contractors to pay higher rates for supported employment services than for segregated facility-based employment; • Require contractors to transition more than just 12 individuals from the state resource centers to community-based services each year; • Require contractors to develop integrated community-based services for a specific number of individuals who are currently receiving services in the state resource centers; • Deny payment for new admissions to the state resource centers; • Require the contractors to pay for Money Follows the Person Services for a second year for individuals with significant behavioral health challenges; • Similar to the capacity building sections of the TennCare contract, including the demonstration of the contractor's efforts to develop and enhance existing community-based residential services and specifying related activities ,including provider recruitment activities and status updates on capacity building. (http://www.tn.gov/tenncare/forms/MCOStatewideContract.pdf) *Revised RFP (3/26/15). Slightly improved regarding Olmstead compliance:* *§ 1.2 (Goals) Goals still does not include Olmstead goal to serve individuals in the most integrated setting.* *§ 1.4.1 (Federal and State Laws and Regulations) In addition to specifically identifying compliance with Medicaid laws, DHS has added compliance to specific laws including the Rehabilitation Act of 1973 and the Americans with Disabilities Act.* *§ 3.2.8.1 (Philosophy in the Design and Delivery of Behavioral Health Services and Supports)* *-"Olmstead" is still spelled wrong as "Olmsted".* *-DHS has added the underlined phrase:*

			Funding decisions by the MCO shall consider individual member choice and community-based alternatives within available resources to promote the State's goal of maximum community integration. *§ 4.1 (Long-term Care Services and Supports) DHS added the underlined phrase:* *Funding decisions by the MCO shall consider individual member choice and community-based alternatives within available resources to promote the State's goal of maximum community integration.* *However, DHS did add that "the contractor shall be responsible for nursing facility members' options counseling and transition activities when a member has been identified through the quarterly screening of MDS Section Q. Participation in assessment and Goal setting to return to their home and/or community of their choice." (§ 4.3.12.1).* *DHS added that the Contractor must provide ongoing and at a minimum annual education and training to the provider network on HCBS settings per CMS regulations. (§ 6.1.6.4.10).*
#2 **PERSONAL CONTROL** Managed care systems must be designed to support and implement person-centered practices, consumer choice, and consumer-direction.	§ 3.2.8 Covered Benefits – Behavioral Health Services § 3.2.11 1915(i)Hab Services and 1915(c) Children's Mental Health Services § 4.3 Community-Based Requirements § 4.4 1915(c) HCBS Waivers § 4.4.8.	Generally yes	Throughout the RFP, there are requirements for person-centered practices, consumer choice and consumer direction. The RFP also has a section on offering HCBS waiver enrollees the option to self-direct services. (§ 4.4.8) *Revised RFP (3/26/15) DHS added that the "contractor shall allow each enrollee to choose his or her health professional to the extent possible and appropriate."* *The revised RFP also added that the Contractor will develop a self- assessment tool for members who want to receive self-directed services. (§ 4.4.8.2)* *The contractor is also responsible for recouping any unspent funds month for service accounts and annually for savings accounts for self-directed services. (§ 4.4.8.9)* *DHS added that the Contractor must provide ongoing and at a minimum annual education and training to the provider network on the Person Centered Planning Process. (§ 6.1.6.4.9).*

	Self-Direction § 6.2.1 Member Choice		
#3 **EMPLOYMENT** For non-elderly adults with disabilities employment is a critical pathway toward independence and community integration. Working age enrollees must receive the supports necessary to secure and retain competitive employment.	§ 3.2.8.1 § 3.2.8.2 § 3.2.8.8 § 3.2.11.2.8.12 § 4.4.3.1.1 § 14.7 § 8.10.8	No	The RFP contains general language to help the member gain employment in competitive settings through service planning and core activities supporting employment, but there are no specific requirements about rates or modifying the definitions of supported employment. The Contractor is expected to adhere to the following principles related to the delivery of behavioral health services: (iv) services for adult members who have a serious mental illness and members that are children with a severe emotional disturbance (SED) should focus on helping the member to maintain their home environment, education/employment and on promoting their recovery (§ **3.2.8.1);** Rehabilitation, Recovery and Strengths-Based Approach to Services. The Contractor must provide the following core activities as part of its effort to provide recovery-based services to members: … (v) activities to support the development and maintenance of healthy social networks and skills, employment, school performance or retirement activities**. (§ 3.2.8.2)** The Contractor shall implement a certified peer support/counselling program to empower members to take an active role in their recovery from mental illness and return to active roles in their community, where possible. Certified peer specialists will work to establish recovery self-help groups, peer support/counseling, Recovery/Wellness Centers where members can learn coping skills for all aspects of life, including employment skills, and warm line counseling to assist members in distress. **(§ 3.2.8.8)** The contractor shall ensure that the service plan: Reflects that the setting in which the individual resides is chosen by the member. The Contractor must ensure that the setting chosen by the member is integrated in, and supports full access of individuals receiving Medicaid HCBS to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving Medicaid HCBS; **(§ 4.4.3.1.1)** The RFP requires contractors to comply with laws regarding member's rights and states that members have the "right to fully participate in the community and to work, live and learn to the fullest extent possible. (§ **8.10.8),** but the RFP does not provide any incentives for developing supported employment services in integrated settings at minimum wages or more.

			The RFP states that DHS intends to develop reports, baseline data and performance targets, including data on the number of members who gain and maintain competitive employment as performance target. (§ **14.7**) However, there are no requirements or incentives to assist individuals who want to gain or maintain competitive employment. *Revised RFP (3/26/15) No significant changes regarding employment. But, DHS does require the Contractor to record employment discussions and options in the service planning process:* *§ 3.2.11.2.8.12 Records discussion and options provided for meaningful day activities, employment and education opportunities. Members shall be offered choices that improve quality of life and integration into the community ~~the alternative home and community-based settigns that were considered by the member.~~*
#4 **SUPPORT FOR FAMILY CAREGIVERS** Families should receive the assistance they need to effectively support and advocate on behalf of people with disabilities.	§ 3.2.8.1 § 3.2.8.3 § 3.2.8.9	yes	The RFP requires the contractor's to assist and engage families to participate in treatment planning and development and encourages the involvement of natural support systems including providing compensation if appropriate.
#5 **STAKEHOLDER INVOLVEMENT** States must ensure that key disability stakeholders -- including individuals with disabilities, family members, support agency representatives, and advocates -- are fully engaged in designing, implementing and monitoring the outcomes and effectiveness of Medicaid managed care services and service delivery systems	2.6 4.3.2 1.4.2.1 2.11 8.12	yes	The RFP requires stakeholder involvement involving community organizations, provider networks and others. It also requires that the Contractor develop a plan for a Stakeholder Advisory Board in a manner and timeframe prescribed by the state. (§ 8.12) *Revised RFP (3/26/15). DHS has added specific timeframes and requirements to the development of the Stakeholder Advisory Board:* *The Contractor shall develop a plan for the Stakeholder Advisory Board and submit it to the Agency for review within 30 days after Contract execution. The plan shall identify the steps to be taken and include a timeline with target dates. A final plan, incorporating any changes requested by the Agency, shall be submitted to the Agency within 90 days after the first submission of the plan. The Contractor shall execute, adhere to, and provide the services set forth in the Agency-approved plan. Changes to the plan must receive prior approval from the Agency, and the Contractor shall make any updates to maintain a current version of the plan. The plan shall include, but may not be limited to, procedures for implementing the Stakeholder Advisory Board and details discussing how the Contractor will ensure meaningful representation from member stakeholder groups.*

#6 **CROSS DISABILITY/ LIFE SPAN FOCUS** The service delivery system must be capable of addressing the diverse needs of all plan enrollees on an individualized basis, including children, adolescents and adults with physical disabilities, intellectual and developmental disabilities, traumatic brain injuries, mental illnesses, substance use disorders, and other types of severe, chronic disabilities.	1.4.2.1 1.4.2.2 3.2.7 3.2.8.1 3.2.8.18 3.2.8.21 3.2.9.1 3.2.9.1 3.3.7 4.3.12.1	No, Insufficient	The RFP complies with basic Medicaid law which prohibits the contractor from placing limits on medically necessary services solely on the basis of diagnosis, type of illness, or condition of the beneficiary (§ 3.2.1). The RFP has sections on behavioral health, EPSDT and long-term care services. The RFP states that the contractor will be responsible for administering and funding health homes which target adults and children with chronic conditions and integrated health homes for adults and children with serious and persistent mental illness. However, the RFP does not require the contractors to develop comprehensive strategies for serving members across their life spans or for assisting members to seamlessly transition to different services as they age. The Contractor also should be required to develop specific services for individuals with different needs, e.g. ABA services for individuals with behavioral challenges.
#7 **READINESS ASSESSMENT & PHASE-IN SCHEDULE** States should complete a readiness assessment before deciding when and how various sub-groups of people with disabilities should be enrolled in managed care plans. A state's phase-in schedule in turn should be based on the results of this assessment.	2.14	No	NCD states a phase- in schedule should be based on results of readiness assessment; RFP has a short paragraph about a contractor passing a readiness review process and have a proposal for implementation of proposed services. However, there is no phase-in schedule. In addition, the time between the award and implementation is too short (only 6 months).
#8 **PROVIDER NETWORKS** The network of providers enrolled by each managed care organization should include those who furnish health care, behavioral health and,	Section 6 (Provider Network Requirements) 8.8.2 (Quality Information)	Yes	The contractors must provide and ensure the provision of all covered services specified in the contract, demonstrate that they have the capacity to serve the population covered by the contract and must maintain a sufficient number, mix and geographic distribution of providers in accordance with the general access standards. The contractor must comply with all member requests for a second opinion from a qualified professional. If the provider network does not include a provider who is qualified to give a second

where applicable, long term supports. The network must encompass both providers of institutional and home and community-based supports. Each network should have sufficient numbers of qualified providers in each specialty area to allow participants to choose among alternatives.	Section 11.2.5 (Prior authorization requests)		opinion, the Contractor must arrange for the member to obtain a second opinion from a provider outside of the network at no cost to the member. (§ 11.2.5.2.1.2). The contractor must allow members with special needs, who are determined to need a course of treatment or regular care monitoring, to directly access a specialist for treatment via an established mechanism such as a standing referral from the member's PCP or an approved number of visits. (§ 11.2.5.2.1.3) --During the first 2 years of contract, must allow all current provider types that are DHS providers opportunity to be part of provider network -Rural services—states must have provider outreach in rural areas and assure equality and availability of services - § 6.3 lists provider types and § 6.3.12 states must demonstrate efforts to develop community based residential alternatives within 60 miles of a members home before entering a facility. - Provider quality information must be made available to members. *Revised RFP (3/26/15) DHS added that the Contractor must document any changes in services, changes in benefits, changes in payments, enrollment of a new population and must submit this to DHS. (§ 6.2.3)* *General access standards have been switched throughout from "miles" to "minutes." For example, outpatient behavioral health services must be within 30 minutes (not 30 miles) from the personal residence of members except where community standards regarding the lack of availability apply. (RFP, Exhibit B)*
#9 **TRANSITIONING TO COMMUNITY BASED SERVICES** States planning to enroll recipients of long-term services and supports in managed care plans should be required by CMS to include providers of institutional programs as well as providers of home and community-based supports within the plan's scope of services. This requirement should be built into the "terms and conditions" governing waiver approvals.	6.3.12 2.3.3.1 3.2.8.1 4.1 general 4.2.3.1.1 4.2.3.1.2 4.3.12.3 4.3.12.4 8.10.7 8.10.8 14.6.3	Yes its mentioned in several places; No to extent it says "based on available resources"	The RFP does include institutional services (nursing facilities, state resource centers and psychiatric medical institutions for children) within the scope of work. However, the Contractor shall not pay for residents of the mental health institutes between ages 21 and 65 (since Medicaid does not cover institutions for mental disease for this population. The contractor must provide long-term services and supports regarding the effectiveness in implementing institutional diversion strategies and promoting the provision of HCBS. DHS will establish a base line rate for admissions to nursing facilities, ICF/IDs and PMICs, as well as length of care. Contractor is required to demonstrate a decrease in numbers. However, there are no consequence for contractor not meeting performance targets. In addition, there is no process outlining the consequences if the Contractor does not meet the performance targets. Also, See comments in #1.

#10 **COMPETENCY & EXPERTISE** The existing reservoir of disability-specific expertise, both within and outside of state government, should be fully engaged in designing service delivery and financing strategies and in performing key roles within the restructured system.	§ 1.4.2 Qualifications § 2 § 2.9.2	No Yes	The Contractor and any proposed subcontractors must be experienced in the business of furnishing Medicaid and CHIP capitated services comparable in size and complexity to the qualifications specified in the RFP, including working with existing and additional provider networks and stakeholders to successfully meet the needs of the members with a wide range of physical, social, functional, behavioral and LTSS needs. The RFP also has extensive general and administrative requirements. § 2.9.2 lists staffing plan and contractor must include local presence and staff knowledgeable in Iowa specific policies and operations

#11 **OPERATIONAL RESPONSIBILITY AND OVERSIGHT** Responsibility for day-to-day oversight of the managed care delivery system must be assigned to highly qualified state and federal governmental personnel with the decision-making authority necessary to proactively administer the plan in the public interest.	2.9.1 and 2.9.2 2.9.3 2.19 2.2.2 Section 12 generally Section 14 Performanc e targets 14.10	Yes as to Contractor; weak as to DHS oversight of contractor	There are several provisions about how the Contractor is to provide quality assurance and maintain program integrity. The contractor is required to file reports with DHS. The contractor is also required to meet performance targets. However, the RFP does not outline what the consequences are for the Contractor not meeting performance targets. DHS does reserve the right to conduct an audit, or utilize a subcontractor to conduct an audit, of 1915(c) HCBS waiver care plans and case notes to determine the Contractor's compliance with specified requirements. (§ 14.6.10) DHS should provide more detail to the public about how it plans to provide oversight of the Contractor. We are concerned that there will be inadequate DHS oversight and no consequence if the Contractor does not meet contractual requirements. *Revised RFP (3/26/15). DHS revised the RFP to add that the Contractor's policies and procedures are "subject to DHS review and approval." What is DHS' plan for having sufficient staff to provide timely and accurate approvals?* *DHS has expanded its requirement for the Quality Management and Improvement Program Work Plan, which documents the methods and processes the Contractor used to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by members and providers. Originally, the Contractor was simply required to have a plan that identified the goals of the contractor to address its strategies for improving the delivery of health care benefits and services, which was to be submitted prospectively each year, with quarterly updates and a final evaluation of the prior year. The revisions require the plan to be submitted with the RFP. DHS also required the Contractor to execute, adhere to and provide the services set forth in the DHS-approved plan.* *DHS added a provision that the Contractor must report on 1) Out of State Placements and Out of state Hospital Admissions after nursing facility discharge for both adults and children. (§*

			14.6.12 and 14.6.6)
#13 **MAINTENANCE OF EFFORT & REINVESTING SAVINGS** CMS should rigorously enforce the ACA "maintenance of effort" provisions in granting health and long-term service reform waivers. The agency should require that any savings achieved through reduced reliance on high-cost institutional care, reductions in unnecessary hospital admissions and improved coordination and delivery of services be used to extend services and supports to unserved and underserved individuals with disabilities.		Yes, as to MOE No, as to reinvest savings	The State, not the Contractor, has the exclusive right to determine an individual's eligibility for Medicaid and CHIP. The state must comply with all federal laws, including the ACA. Never found any mention of reinvestment of savings.
#14 **COORDINATION OF SERVICES & SUPPORTS** Within a well-balanced service system, the delivery of primary and specialty health services must be effectively coordinated with any long-term services and supports that an individual might require.[2]	§ 1.2 § 1.4.2(11) § 2.8 § 3.2.4 § 3.2.8.1 § 3.2.8.9 § 3.2.8.21 § 3.2.9 § 3.2.11 § 3.2.14 § 8.3.5 § 9	Yes, except for nursing facility residents with mental illness, intellectual disabilities or related conditions	The goal of the RFP is for the Contractor to deliver covered benefits, including physical health, behavioral health and long-term services and supports in a highly coordinated manner and to integrate care and improve quality outcomes across the health care delivery system, in turn decreasing costs through the reduction of unnecessary, inappropriate, and duplicative services. For the most part, the RFP leaves up to the Contractor the manner in which this coordination is to be achieved, except that the RFP does require 1) an integrated help line, 2) an integrated database, and possibly integrated health homes. The RFP, in its current form, violates the principles of Nursing Home Reform Act and the federal regulations regarding Preadmission Screening and Resident Review (PASRR) because it makes the nursing facilities, rather than the State or its subcontractors, responsible for the provision of specialized services to nursing facility residents with mental illness, an intellectual disability or

[2] CMS also expects the MCO's to "provide and/or coordinate the provision of all physical and behavioral health services and LTSS (including the provision of all physical and behavioral health services and LTSS (including institutional and non-institutional) and must ensure that participants receive those services and supports in the amount, duration, scope and manner as identified through the person-centered assessment and service planning process." CMS also "expects that states to incorporate physical health, behavioral health, and LTSS services (including institutional and non-institutional LTSS) into the MCO capitation payment as this can promote service integration, increase efficiency, avoid cost shifting and disincentives to the provision of services, and enhance health outcomes and quality of life. "CMS GUIDANCE TO STATES USING 115 DEMONSTRATIONS OR 1915(B) WAIVERS FOR MANAGED LONG TERM SERVICES AND SUPPORTS PROGRAMS, Version 1.0 (05/20/13)("CMS Guidance"), p. 3 and pp.11-12. http://www.medicaid.gov/medicaid-chip-program-information/by-topics/delivery-systems/downloads/1115-and-1915b-mltss-guidance.pdf

			related services. § 6.1.2.1.6 *Revised RFP (3/26/15) DHS has added "community-based case management" in any provisions referring to "care coordination services." For example, in the definitions in Appendix A, the following changes have been made:* **Care ~~Management~~ Coordination.** Care coordination is the overall system of medical and psychosocial management encompassing, but not limited to: utilization management, disease management, discharge planning following restrictive levels of care, continuity of care, care transition, quality management and service verification. ~~Care Management is the overall system of medical and psychosocial management encompassing, but not limited to: utilization management, disease management, discharge planning following restrictive levels of care, continuity of care, care transition, quality management and service verification.~~ **Community-Based Case Management.** Community-Based Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides community-Based Case Management services to assist members in gaining timely access to the full range of needed services. For the purpose of this scope of work, Targeted Case Management activities are to be conducted through Community-Based Case Management. The Center for Medicare and Medicaid Services State Medicaid Directors' letter # 10-024 includes services definitions and provider standards that describes best practices and characteristics of integrated health homes (IHH). The MCO is encouraged to implement these practices and characteristics into community-based case management. The Agency intends to require these IHH characteristics and practices in the future. ~~Case Management is a collaborative process of planning, facilitation, and advocacy for options and services to meet a member's needs through communication and available resources to promote high quality, cost-effective outcomes. Qualified staff provides Case Management services to assist members in gaining timely access to the full range of needed services.~~ *DHS has also added a dispute resolution provision when disputes arise between either DHS or the Juvenile Court officer and the Contractor related to the appropriateness of services*

			that may be proposed at a pending court hearing: The Contractor is responsible for the provision of all covered and required mental health services ordered for members through a court action. When a disagreement exists between either the Agency or Juvenile Court Officer and the Contractor related to the appropriateness of services that may be proposed at a pending court hearing, the Contractor shall identify specific, effective, available service alternatives for the Agency or Juvenile Court Officer to consider prior to the court hearing. The Contractor may, if requested, testify in court regarding the appropriateness of court-ordered services and identify specific, effective, available service alternatives for the court to consider. *DHS deleted the provision that "the Contractor shall propose strategies to facilitate coordination and communication among member's physical health, substance abuse and behavioral health providers treating the member." However, the contractor is still responsible for coordinating services or individuals with multiple diagnoses.* *DHS also added that, as one of the Contractor's care coordination responsibilities, the Contractor must "coordinate care with other Contractors and or Agencies." (§ 9.1)* *DHS also added that the Contractor's care coordination program must include "catastrophic" case management. (§ 9.1.3)* *With respect to member identification, DHS deleted that "the Contractor shall utilized risk stratification levels, subject to the Agency approval, to determine the intensity and frequency of follow-up care that is required for each member participating in the care coordination program." However, the contractor can use, at a miniumum,industry standard predictive modeling, claims review, member and caregiver requests and physician referrals. (§ 9.1.5)* *With respect to care plan requirements, DHS added that "the care plan must be approved by the Contractor in a timely manner and in accordance with applicable quality measures and utilization review standards. For enrollees determined to meet a course of treatment or regular monitoring, the Contractor shall have direct access to a specialist as appropriate for the enrollee's condition an identified needs. (§ 9.1.6.2)*
#15 **ASSISTIVE TECHNOLOGY & DURABLE MEDICAL EQUIPMENT** Participants in managed care plans	**Exhibit D: Covered Benefits** includes "durable medical equipment and	Not sufficient.	The RFP requires the Contractors to cover certain types of durable medical equipment, but there is no definition for "assistive technology" and no mention of the types of assistive technology covered. For example, a waiver recipient may need assistive technology to perform daily living activities.

must have access to the durable medical equipment and assistive technology they need to function independently and live in the least restrictive environment**.**	supplies" **Exhibit D2 Iowa Wellness Plan**. Durable Medical Equipment Covered, with some exceptions. **§ 3.2.14 Value added services**.		There should also be a requirement that the Contractor assess a beneficiary's need for durable medical equipment and assistive technology, as well as providing set-up, maintenance and user training. If the individual cannot use the equipment, then it is the same as the individual not having the equipment at all.
#16 **QUALITY MANAGEMENT** The state must have in place a comprehensive quality management system that not only ensures the health and safety of vulnerable beneficiaries but also measures the effectiveness of services in assisting individuals to achieve personal goals.	**§ 10.2.1. State Quality Review**. § 2.13 (Written Policies and Procedures) § 2.18 Ongoing Monitoring **§ 14 Reporting Requirements**	No.	To ensure that the State has a comprehensive oversight system, the State should provide more information in the RFP as to 1)how the state itself intends to staff and provide QI/QM and 2) how the Contractor should coordinate its QI/QM system with State agencies (the Iowa Department of Human Services, Iowa Medicaid Enterprises, the Iowa Department of Inspections and Appeals and all other relevant State quality initiatives and systems. There are also no provisions in the RFP for the State and/or the Contractor to provide MCO report cards to the public, which are transparent, easily-understandable and useful to participants in choosing an MCO. DHS will conduct ongoing monitoring of the Contractor to ensure compliance with Contract requirements and performance standards. The method and frequency of monitoring is at the discretion of DHS and may include, but is not limited to, both scheduled and unannounced on site visits, review of policies and procedures and performance reporting. (§ 2.18) Reporting requirements are detailed in Section 14. *Revised RFP (3/26/15) DHS added a provision that the contractor, upon request, must be able to provide evidence to DHS that all policies and procedures have been implemented.* ***(§ 2.13)*** *DHS also added that a work plan for the Contractor's Utilization Management program must identify specific steps to be taken and a timeline with target dates. A final work plan, incorporating changes from DHS, must be submitted within 30 days after the first submission of the plan. Changes to the plan must receive prior approval from DHS. (§ 11.1.3)*
#17 **CIVIL RIGHTS COMPLIANCE** All health care services and supports must be furnished in ADA	§ 1.4.1 General Contractor Responsibilities, Federal and State Laws and	No, the RFP only has a general requireme	The RFP should expressly require The Contractor and participating providers to comply with the Americans with Disabilities Act (and the implementing regulations), Section 504 of the Rehabilitation Act (and implementing regulations), and U.S. Department of Justice Guidelines, including access to health care facilities and services.

compliant settings.	Regulations (p. 15)	nt that the Contractor comply with federal law and state laws and regulation s.	The Contractor should also be required to conduct trainings to providers regarding these laws and guidelines.
#18 **CONTINUITY OF MEDICAL CARE** Enrollees should be permitted to retain existing physicians and other health practitioners who are willing to adhere to plan rules and payment schedules.[3]	**§ 3.3 Continuity of Care.** § 6.2.1 Member Choice § 6.2.4 Out of Network Providers **§ 7 Enrollment Apex**	Yes.	The RFP emphasizes member choice and allows transition times from one Contractor to another. These transition times may still be insufficient for some individuals so there should be modifications to the policy as required by the ADA if longer transition times are needed. *Revised RFP (3/26/15) (Ongoing operations). DHS added "If, for whatever reason, a member can no longer be served by his/her residential provider, it shall be the Contractor's responsibility to find and make available to the member an alternative residential provider that can meet the member's needs so there is no break in services."*
#19 **DUE PROCESS** Enrollees with disabilities should be fully informed of their rights and obligations under the plan as well as the steps necessary to access needed services.	§ 8.2 Member communications (pp 107-110) § 8.2.3 (p. 107) Alternative Formats § 8.2.6.8.1 the right and timeframes for filing grievances and appeals	Yes	The RFP contains requirements on member communications, including communications with new members. The RFP requires the Contractor to notify new members, among other things about their rights to file appeals and grievances. The RFP requires the contractor to make materials available in alternative formats. Also, information shall be provided to members who are limited English proficient through the provision of language services at no cost to the individual. *Revised RFP (3/26/15) DHS added that the "Contractor must provide members any reasonable assistance in completing forms and taking other procedural steps. This includes, but is not limited to providing interpreter services and toll-free numbers that have adequate TTY/TTD and interpreter capability." (§ 8.15.5.1)*
#20 **GRIEVANCES & APPEALS** Grievance and appeal procedures	Section 8.15 (pp 117-121)	YES, not required to keep data on	The RFP contains grievance, appeals and state fair hearing requirements, but there are no provisions that State must require the Contractor to maintain records of grievances and appeals; not is there any requirement that the Contractor of the State review such records as part of State Quality Improvement Strategy. Note that this is not found in maintenance of records provision in RFP , Section 2.4.

[3] CMS has stated that "provider network changes can have a significant impact on those enrolled in MLTSS programs, since such providers are typically integral to residential and work services and supports. Therefore, if the state does not permit participants enrolled in MLTSS to switch to another MCO at any time, states must permit participants to disenroll and switch to another MCO, whichever the state makes available as part of participant choice, when the termination of a provider from their MLTSS network would result in a disruption in their residence or employment. CMS GUIDANCE, supra, p. 10.

should be established that take into account physical, intellectual, behavioral and sensory barriers to safeguarding individual rights under the provisions of the managed care plan as well as all applicable federal and state statutes.		grievances and appeals	Definition of **"notice of action"** in Exhibit A should include significant decisions made by Contractor as "actions," giving rise to notice and hearing rights, e.g. moving to a tiered payment system which may result in a reduction of services. There is no mention of alternative formats or other modifications of policy so that individuals with physical, intellectual, behavioral and sensory barriers can file appeals. Also, there is no mention that enrollees who have limited English proficiency are provided language services throughout the appeals process including translated notices, oral language services at the appeal. *Revised RFP (3-26-15) DHS has deleted the requirement that exceptions to policy "may only be granted when all other options, including filing of a grievance and appeal, have been exhausted." (§*
Additional items: **Medications/Pharmacy Benefits**	§ 3.2.6.1		The contractor must provide coverage for all classes of drugs including over-the counter, to the extent and manner they are covered by the Medicaid FFE (Fee for service) pharmacy benefit. (§ 3.2.6.1.1) Iowa law permits DHS to restrict access to prescription drugs though the use of a Preferred Drug List with prior authorization. The contractor is required to follow and enforce the PDL under the Medicaid FFS Pharmacy benefit with prior authorization criteria, including quantity limits and days' supply limitations. (§ 3.2.6.2). *Revised RFP (3/26/15) DHS added:* *"Additional over-the-counter products may be covered at the discretion of the contractor."* *"The Contractor must identify the proposed PBM (Pharmacy Benefit Manager) and the ownership of the PBM. Before entering into a subcontract with a PBMS, the Contractor shall obtain the Agency (DHS) approval. …the Contractor shall develop a plan for oversight of the PBM's performance, including provider issues at a minimum, and submit it to the Agency for review within 10 days after Contract execution….* *Co-payments for non-preferred drugs is deleted (§ 5.3.3)*