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ASK Resource Center
Access for Special Kids

Access News

MEDICAID 2015, PART 1 of 3

Iowa's Proposed Plan to Change Medicaid: Part One

This edition of Access News *is the first part of a three-part series that focuses on the state's proposed changes to Medicaid managed care. These proposed changes are part of a health care initiative that the Iowa Department of Human Services (DHS) is referring to as Medicaid Modernization. ASK Resource Center (ASK) is publishing this series in an effort to share information and resources, and to help provide an understanding of the emerging issues related to the proposed changes to managed care. Part one of the series addresses basic questions surrounding those emerging issues, part two will examine the process Iowa must use to make any changes, and part three will focus on what you can do to share your thoughts, concerns and ideas.*

There are changes being proposed to the way health care services and Home and Community Based Service (HCBS) Waivers will be approved and delivered through Medicaid. HCBS waivers are also often described as "community based long-term services and supports." These proposed changes will impact all seven of Iowa's Waivers, and any child, youth or adult with a disability, chronic illness or special health care need.

Governor Branstad's office proposed making these changes and directed the Iowa Department of Human Services (DHS) to initiate the required legal steps for all current health care and waiver services to be carried out and managed by private companies, referred to as managed care organizations (MCOs). The state claims this change will save $51.3 million dollars in the first six months. This claim is just one of several controversial issues emerging as advocates study the proposed change and its impact.

WHAT IS MANAGED CARE?

According to Medicaid.gov, managed health care provides the delivery of Medicaid health benefits through contract agreements made between state Medicaid agencies and MCOs. The purpose of this system is to:

- Improve the quality and access to health care
- Establish greater accountability for patient outcomes
- Develop a more sustainable and predictable Medicaid budget

Many states, including Iowa, view the managed care program as a way to provide health care benefits to individuals with complex medical needs, behavioral issues, substance abuse, developmental disabilities and long-term care needs which were either difficult to obtain and/or reimburse within the current fee-for-service system.

The $51.3 million savings in the Iowa Medicaid Modernization Initiative is to be a result of a value-based system rather than a volume-based system. In a value-based system, treatment is individualized and outcomes are based on what matter to the patient and their overall quality of life. This type of system works to reduce the duplication of services and unnecessary hospitalizations. On August 17, Iowa will select two to four MCOs that have demonstrated the ability to coordinate care statewide and provide quality outcomes for consumers.

EMERGING ISSUES RELATED TO THE PROPOSED CHANGES TO MEDICAID

1. How will this proposed change save over $51.3 million? The current Medicaid program covers 564,000 Iowans at an annual cost of $4.2 billion. The new proposed contract language will allow MCO companies to charge up to 15% overhead. This overhead percentage means Iowa will pay MCO companies more than $4 billion to provide Medicaid administrative services. Critics have stated under the proposed changes, Medicaid health costs could increase to over $6 billion. Iowa DHS will still need some personnel to work with the MCOs in oversight and coordination, so administrative money will continue to be spent in addition to the MCO contract payments. The actual amount of DHS administrative expenses is not known at this time. To learn more, read the following policy briefs:

- Medicaid Managed Care: Costs, Access, and Quality of Care
- People with Disabilities and Medicaid Managed Care: Key Issues to Consider

2. Will there be service coverage changes or cuts to the services currently provided in health care or HCBS services? Disability advocates express concern that any cost savings under the proposed Medicaid managed care service model will come from cutting the level of current services to individuals with disabilities. Iowa's current Medicaid services are approved and delivered through a fee-for-service model. About a year ago, Kansas made a switch to a managed care plan similar to the one proposed for Iowa. There are two recently published reports from the University of Kansas, studying whether managed care limited or cut services. Read those reports here:

- Survey: Switching Medicaid to managed care leads to difficulties obtaining medical services
- Medicaid Managed Care: Issues for beneficiaries with disabilities

3. How will the state of Iowa oversee the job performance level of MCOs chosen to deliver these Medicaid services? Oversight could be done in a variety of ways. There are no published, written guidelines or contract language to tell Iowans how DHS will make sure they are holding MCO companies accountable to taxpayers at the present time. A legislative bill, Senate File 452, proposed a structure to create an oversight committee; however, the bill failed to pass, so there is still no clear information on how the oversight will be put into place.

- Bill creating Medicaid oversight commission dies in House
- Iowa Medicaid plan is full of empty promises

4. Do consumers and family members of individuals with disabilities, chronic illness, and special health care needs have a meaningful role and voice as a stakeholder when managed care decisions are made? This can and should happen. Administrators, service providers, consumers, and families need to be part of the decision-making process, and be considered equal partners in all decisions about the managed care plan. One way to do this is to create a state advisory committee and require each MCO to do the same; each of those committees should be required to have a majority of their members be consumers and family members of individuals with disabilities. Kansas has done this, and consumers and families state it is helping to make the system better. There are various committees throughout Iowa that use the consumer partnership engagement model. One example is the State Education Advisory Panel (SEAP), which, in Article III, Section 1 of their bylaws and operating procedures, clearly outlines the need for and necessary language for consumers to be the majority of the membership. This language could be easily be adopted and used in the oversight of Medicaid managed care. To learn more, read SEAP's membership bylaws, found on page seven:

- SEAP Bylaws

5. Should Iowa's Medicaid Managed Care proposal include all ages and disability groups? Thirty-nine states have adopted a Medicaid Managed Care model to approve and deliver services to individuals with disabilities, chronic illness, or other special needs. Some of the states have not required certain disability groups or age groups to participate in the managed care model. This is known as "carve out." Iowa is not seeking a carve out. However, Iowa *is* seeking changes to some of it's Medicaid programs and all waivers. The process to do so requires the state of Iowa to receive approval from the Center for Medicare and Medicare Services (CMS). The following policy brief from the Kaiser Family Foundation offers more information about "carve outs" and care standards:

- Medicaid Managed Care: Key Data, Trends, and Issues

How Does Iowa Currently Pay for Services?

The current way Iowa Medicaid pays for the delivery and the expense of services is through a model known as "fee-for-service." A fee-for-service Medicaid plan means you can go to any doctor, hospital, or clinic that accepts Medicaid. The service provider bills Medicaid for the care or service, such as a medical test you receive, and Medicaid pays the bill. If the proposed change to managed care is approved, this process will change. With a Medicaid managed care model, you will be asked to select a plan to join. The plan you join will be in charge of your medical care. There will be rules about which doctors you can see, and how you get care. Some of the rules you can expect:

- **You select a primary care doctor from the list your plan gives you.** It is important to check that the plan you chose includes the doctor you want.
- **The primary care doctor, generally known as a primary care provider (PCP), will be in charge of your care.** The PCP gives you regular care, such as routine check-ups, shots, etc. If you need another type of doctor the PCP will refer you. Your PCP should know your history and health care needs.
- **The doctors you see must be on the managed care plan's list.** This is also known as your health care plan network. Your managed care plan will only pay doctors, hospitals, and other health care providers that are in your network. There will be an exception to this rule if you need emergency room care. Managed care plans use the "prudent layperson" standard. This standard means if a person with average knowledge of medicine and health thinks not seeking immediate medical attention could result in death or injury, then you have the right to get care. Your plan must pay the bill, even if the doctors providing care are not on your plan's list of approved doctors.

Source: The Legal Aid Society

FURTHER READING: MEDICAID MODERNIZATION IN THE NEWS

Iowa to hire private firms to help run Medicaid
Tony Leys, *The Des Moines Register,* January 20, 2015

Is Medicaid privatization about money or heath?
Tony Leys, *The Des Moines Register,* March 6, 2015

Iowa Senate seeks legislative oversight for Medicaid changes
William Petroski, *The Des Moines Register,* March 18, 2015

Poll: Iowans Reject Branstad's plan for Medicaid, closing MHIs
William Petroski, *The Des Moines Register,* April 29, 2015

Contact Obama administration to stop plan to privatize Medicaid
Editorial, *The Des Moines Register,* May 23, 2015

TIMELINE: IOWA'S MOVE TO MANAGED CARE

February 16, 2015
Request for Proposal (RFP) released

February 25, 2015
Bidder comments on RFP due

March 11, 2015
Letter of intent to bid due

March 11, 2015
First round of questions due

March 20, 2015
Stakeholder/public comments on RFP due

March 26, 2015
First round of answers posted

April 2, 2015
Second round of questions due

April 10, 2015
Second round of answers posted

April 13, 2015
Payment arrangement rates released

May 8, 2015
Proposals due

August 17, 2015
RFP awards published

Fall/Winter 2015
Contracts negotiated and signed

Prior to Jan. 1, 2016
Successful MCOs build networks

Jan. 1, 2016
Medicaid Modernization takes effect

NOTE: The future dates listed on this timeline are subject to change.

Guiding Principles: Successfully Enrolling People with Disabilities in Managed Care Plans

The National Council on Disability (NCD), an independent federal agency committed to disability policy leadership since 1978, offers Guiding Principles: Successfully Enrolling People With Disabilities in Managed Care Plans, a publication that outlines the best practices for effectively designing and carrying out managed care initiatives for individuals with disabilities. The main criteria for the 20 principles outlined in the NCD's guide are listed below; access the full publication by going to the following web address: www.ncd.gov/publications/2012/Feb272012.

I. Personal Experience and Outcomes

A. Community Living
B. Personal Control
C. Employment
D. Support for Family Caregivers

II. Designing and Managing a Managed Care System

A. Stakeholder Involvement
B. Cross-Disability, Lifespan Focus
C. Readiness Assessment & Phase-In Schedule
D. Provider Networks
E. Transitioning to Community-Based Services
F. Competency & Expertise
G. Operational Responsibility & Oversight
H. Continuous Innovation
I. Maintenance of Effort & Reinvesting Savings
J. Coordination of Services & Supports

III. Managed Care Operating Components

A. Assistive Technology & Durable Medical Equipment
B. Quality Management

IV. Participant Rights

A. Civil Rights Compliance
B. Continuity of Medical Care
C. Due Process
D. Grievances & Appeals

ACRONYM DIRECTORY

ACO	Accountable Care Organization	**MFP**	Money Follows the Person
CHIP	Children's Health Insurance Program	**MTM**	Medication Therapy Management
CMS	Centers for Medicare & Medicaid Services	**NEMT**	Non-Emergency Medical Transportation
DHS	Department of Human Services	**PA**	Prior Authorization
DUR	Drug Utilization Review	**PAHP**	Prepaid Ambulatory Health Plan
HCBS	Home & Community Based Services	**PCC**	Primary Care Case Management
IME	Iowa Medicaid Enterprises	**PDL**	Preferred Drug List
IT	Information Technology	**PHIP**	Prepaid Inpatient Health Plan
LTSS	Long-term Services & Supports	**RFP**	Request for Proposal
MCO	Managed Care Organization	**RHEP**	Recipients Health Education Program

ASK Resource Center, Inc.

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MEDICAID 2015, PART 2 of 3

Iowa's Proposed Plan to Change Medicaid: Part Two

This edition of Access News *is the second publication in a three-part series that focuses on the state's proposed changes to Medicaid managed care. These proposed changes are part of a health care initiative that the Iowa Department of Human Services (DHS) is referring to as Medicaid Modernization. ASK Resource Center is publishing this series in an effort to share information and resources, and to help provide an understanding of the emerging issues related to the proposed changes to managed care. Part one of the newsletter series addresses basic questions surrounding those emerging issues, part two examines the process Iowa must use to make any changes, and part three will focus on what you can do to share your thoughts, concerns and ideas.*

Iowa DHS Receives Bid Proposals From MCOs

Iowa DHS announced they received bids from the managed care organizations listed below by the May 8, 2015 deadline, and from these 11 bid proposals, a minimum of two companies, but no more than four, will be selected to implement Iowa's health care delivery under managed care.

The announcement of the private companies chosen to implement Medicaid managed care is scheduled for August 17, 2015. Media outlets across the state will broadcast the announcement, and the information will be posted to the Iowa DHS website, as well as shared via ASK social media.

Aetna Better Health of Iowa, Inc.
Amerigroup Iowa, Inc.
AmeriHealth Caritas Iowa, Inc.
Gateway Health Plan of Iowa, Inc.
Iowa Total Care (Total Care)
Magellan Complete Care of Iowa
Medica Health Plans
Meridian Health Plan of Iowa, Inc.
Molina Healthcare of Iowa, Inc.
United Healthcare Plan of the River Valley, Inc.
WellCare of Iowa, Inc.

"MEDICAID MODERNIZATION" TO BE REBRANDED AS "IA HEALTH LINK"

Currently, Iowa DHS refers to the proposed changes to Medicaid managed care as "Medicaid Modernization"; however, plans are under way to phase out that name and rebrand the health initiative as IA Health Link. The IA Health Link name and logo are already being used by Iowa DHS for a number of their other Medicaid programs; the transition to is expected to happen over the next few months.

WHAT HAPPENS AFTER THE CHOSEN MCOs ARE ANNOUNCED?

The state of Iowa is legally required to notify the federal Centers for Medicare and Medicaid Services (CMS), consumers, families, and other stakeholders of their intent to change existing Medicaid programs which include the Home and Community Based Service (HCBS) Waivers. DHS must also share in writing the word changes to the existing rules they are proposing to make. The Medicaid statue is part of the Social Security Act and there are some basic requirements that every state Medicaid program must follow, too. The federal government has an interest in making sure these requirements are met. There are two ways a state can change their existing Medicaid programs either by a state plan amendment or through a specifically designed waiver.

What is a state plan amendment?

A state plan outlines the details of the Medicaid programs each state implements. The plans are different from state to state because of the level of flexibility the Federal government gives states. States can file amendments to existing Medicaid programs at any time. The amendment to a state plan is a fairly straightforward process. Pages from the existing plan that will be changed are submitted to CMS. Within 90 days of receiving the amendment, CMS will reviews the changes. If CMS has any questions or concerns about the submitted changes or about any other aspects of that Medicaid program, they can issue a request for information. This starts a process where CMS works closely with the state to address concerns so that the amendment can be approved. The request for information automatically stops the 90 day clock and it resumes when the state completes their response to the questions or concerns.

What is a 1915(b) managed care waiver?

Iowa DHS has announced they are using this CMS waiver tool as part of multi-step process to change Iowa's existing Medicaid programs from a fee-for-service model to managed care. This waiver vehicle allows CMS to approve programs for a state that do one or more of the following:

- Restrict Medicaid program participants (beneficiaries) choice of health providers
- Allow a county or local government to act as a broker to help people in Medicaid to select a managed care plan network
- Restrict the number and type of providers for specific Medicaid services, such as the number of companies providing transportation
- Allow the state to use the savings achieved through the managed care system to provide additional services to Medicaid eligible individuals

A 1915(b) managed care waiver also provides the legal authority for a state to require all Medicaid eligible individuals enroll in a managed care plan network. The new waiver will officially be referred to as the Iowa High Quality Healthcare Initiative Waiver when it is submitted. If CMS grants approval of the proposed changes, the waiver will be in place for five years.

Besides filing for a 1915(b) waiver, state plan amendments will be used to make changes to the following existing Iowa Medicaid programs:

- The seven current Home and Community Based Service (HCBS) Waivers transition to managed care will be submitted as a 1915(c) amendment concurrently with a 1915(b) managed care waiver application
- An 1115 Demonstration Waiver will be submitted for the Iowa Wellness Plan Demonstration Waiver and the Family Planning Demonstration Waiver

Both the state plan amendments and the managed care waiver are required to be published for the public to review. Iowa DHS released the documents July 27th, 2015. View them here: http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Public Hearings, Written Comment Periods Are Required by Law

Part of the process to receive CMS approval to make changes to existing Medicaid programs includes advertised public hearings and a 35-day time period for individuals with disabilities, family members, and other stakeholders to submit written comments after reviewing the proposed changes.

At the time this newsletter was published, four public hearings had been held to hear comments about the state's request to CMS to change Iowa's Medicaid programs. The only HCBS Waivers currently ready for the hearing and comment period are as follows:

PUBLIC HEARINGS HELD ACROSS IOWA

July 27, 2015	Bettendorf
July 31, 2015	Des Moines
August 3, 2015	Cedar Rapids
August 5, 2015	Sioux City

- 1915(b) High Quality Healthcare Initiative Waiver (name of the new managed care waiver)
- Children's Mental Health (CMH) Waiver
- Intellectual Disabilities (ID) Waiver
- Elderly Waiver
- Iowa Wellness Plan Demonstration Waiver
- Iowa Family Planning Demonstration Waiver

Written comments can be submitted through **Monday, August 24, 2015** via:

Email: ModernizationWaiverComment@dhs.state.ia.us

Regular Mail: Iowa Department of Human Services Iowa Medicaid Enterprise
Attention: Rick Riley
100 Army Post Rd, Des Moines, IA 50315

There will be another set of hearings and a comment time period for the proposed changes in the remaining HCBS Waiver programs being proposed by Iowa DHS. The documents have not been released publicly yet. Families interested in reviewing these documents should monitor the DHS Medicaid Modernization link for the expected announcement. The pending HCBS waivers that will be released for review are as follows:

- Health and Disability (HD) Waiver
- Physical Disability Waiver
- Brain Injury (BI) Waiver
- HIV/AIDS Waiver

How will this change impact my family?

If CMS approves the proposed changes outlined on the previous page of this newsletter, Iowa DHS will require Medicaid eligible individuals to become a member of a Medicaid managed care plan network. You will be notified through a letter in the mail. The letter will provide your tentative assignment to one of the managed care plan networks. Siblings and spouses will be assigned to the same network. You will be instructed to make a phone call by a certain deadline if you want to change your managed care plan network assignment. Make sure your primary care doctor is part of the managed care network you are assigned or that you chose when you call to make changes to your assignment. If you decide on another network that does not include your primary care doctor, make sure you build a strong professional relationship with the new doctor you pick. In managed care plan models, the primary care doctor serves as a "gate keeper" to other referred specialists.

Who is required to be part of a managed care plan?

Individuals receiving Medicaid health care and/or services through the following programs will be required to be part of a Medicaid managed care plan:

- HCBS Waivers
- Long Term Care
- Iowa Health and Wellness Plan
- hawk-i members (children, age 19 and younger)
- Medically needy

Individuals receiving care and/or services through the programs listed below will not be required to be part of a managed care plan. This is known as a "carve out." Health care and service delivery will not change from the way it is currently done:

- PACE (member option)
- Health Insurance Premium Payment Program (HIPP), Eligible for Medicare Savings Program only
- Undocumented person eligible for short-term emergency services only
- Members receiving dental care through the Dental Wellness Plan
- Students receiving school based medical services through Medicaid Reimbursement claiming
- Grant award programs such as Money Follows the Person

Refer to the Iowa DHS Request for Proposal fact sheet for additional information on the proposed initiative currently known as Medicaid Modernization.

Source: Some of the information presented throughout this newsletter was adapted from an original document published by the Iowa Health Care Association. The document was provided to ASK by Independent Insurance Services of Marshalltown, Iowa, and used with their permission.

IDEAs that Work U.S. Office of Special Education Programs

The contents of this newsletter were partially funded under grants from the US Department of Education, #H328M140017, Project Officer, David Emenhesier, and grant from the US Department of Health & Human Services, #H84MC24065, Project Officer, Letitia Manning. The contents of this newsletter do not necessarily represent the policy of those Departments, and the reader should not assume endorsement by the Federal Government. ASK's Family to Family Iowa Project also serves as Iowa's Family Voices State Affiliate Organization.

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MEDICAID 2015, PART 3 of 3

Iowa's Proposed Plan to Change Medicaid: Part Three

This edition of Access News *is the final publication in a three-part series that focuses on the state's proposed changes to Medicaid managed care. These proposed changes are part of a health care initiative that the Iowa Department of Human Services (DHS) is referring to as Medicaid Modernization. ASK Resource Center (ASK) is publishing this series in an effort to share information and resources, and to help provide an understanding of the emerging issues related to the proposed changes to managed care. Part one of the newsletter series addresses basic questions surrounding those emerging issues, part two examines the process Iowa must use to make any changes, and part three will focus on what you can do to share your thoughts, concerns and ideas.*

At ASK Resource Center, the recurring question we ask is, *"How will this impact our families and community?"*

The first two publications in this newsletter series focused on educating the reader about the proposed change to Medicaid managed care and how it will change the services our children, youth, and adults receive not only in their health care, but also in community-based services. The third and final newsletter provides opportunities to voice your thoughts, concerns, and suggestions for ways to potentially improve the proposed changes.

This newsletter series has most likely raised more questions than it has given answers. The unknown is the difficult part of thinking about change. ASK staff has interviewed some of the partner organizations in other states that have moved to a managed care model and shared what we learned. As consumers, parents, and family members, the only thing we know for sure is, **we are all in this together.** ASK staff promises to continue to share information and announcements related to the changes in managed care on our website, www.askresource.org, through ASK social media accounts, and in future newsletters and other printed publications.

At ASK, the recurring question we look at, is "how will this impact our families and community?" We passionately believe information and resources are the heart of empowerment. Knowledge not only gives voice to thoughts, but it also forms questions that help empower you to decide what is best for you and your family. With that being said, it seems fitting to share the first core value in ASK's Vision, Mission, and Values, "*Passion and Fearlessness: We are not afraid. We embrace our values and convictions and we live them with grace. We see challenges as opportunities and approach them positively with creativity and solution–mindedness. We seek answers to the unknown and are willing and eager to try new approaches.*"

We urge you to contact our office with any questions or requests for information you may have regarding Medicaid managed care, or other disability-related issues—let us know how we can support you.

MCO Watch: What's Next and What You Can Do

If Medicaid Managed Care is Approved

If CMS grants Iowa's request to change our current Medicaid fee-for-service model to managed care, it will be effective January 1, 2016.

Family and Community Impact

As we think about this possible change, the best advice from our out of state partners is to make sure as consumers, families, and disability advocates, to actively engage in this process in every way we can. Advocate for accountability and oversight of the managed care companies, attend public meetings, submit questions to Iowa DHS on the Medicaid Modernization homepage, and log on to FIND and post on the MCO WATCH group (see below for details). Volunteer to be a member of the chosen managed care company advisory committees and continue to advocate for policies that include consumers and families as decision makers and evaluators at levels.

Set the bar high for companies to implement flexible policies to include all types of ways to engage consumers and family members. Transparency is crucial both in the information and communication shared with us. Remember not everyone can come to a meeting or has access to computers, or can read written information. Advocate for the creation of inclusive, cultural and linguistically diverse, across disability competency expectations and policies to make participation meaningful. It should be the standard for advisory groups to be made up of a majority of consumers and families—not a token representative. We will continue to share information and resources regarding best practices in order to support your engagement and advocacy.

It should be the standard for advisory groups to be made up of a majority of consumers and families—not a token representative.

Tips and Tools for Effective Advocacy

Check out the following web resources for some basic tips and tools to help you think about effective advocacy as the state moves toward the transition to Medicaid managed care. ASK particularly recommends the resources available through Advocacy University, the Grassroots Action Center, and Iowa's Disability Policy Resource, www.infonetiowa.org.

JOIN THE DISCUSSION ON FINDFAMILIES.ORG!

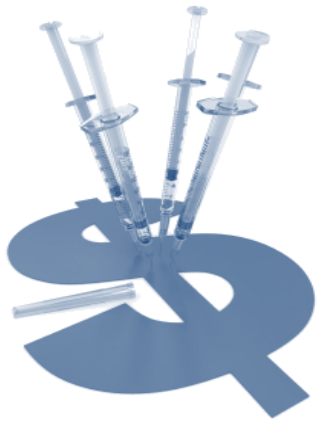
Log on to FIND at www.findfamilies.org and join the MCO WATCH group to see the most up-to-date information and announcements on the statewide changes in Medicaid managed care. The group is open to the public, but you must be a member of FIND and join the MCO WATCH group in order to comment and post within the group.

FIND, which stands for Families of Iowa Networking for Disabilities, is a no-cost social networking website for families of individuals with disabilities, and is a great place to share resources, seek information and feedback, search for events and activities in your area, create blog posts, and much more!

www.findfamilies.org/group/mco-watch

ADDITIONAL OPPORTUNITIES FOR PUBLIC COMMENT

Over the next several months, there will be a number of meetings, public hearings, and other types of forums for you to share, or listen to others share thoughts, opinions, feedback, and suggestions about the proposed changes to Medicaid managed care. Watch for announcements of public comment opportunities through the Iowa DHS website, advocacy organizations, and television, print, and social media outlets.



There will be another round of public hearings and a 35-day written comment period for the proposed changes in the HCBS Waiver programs listed below.

- Health and Disability (HD) Waiver
- Physical Disability Waiver
- Brain Injury (BI) Waiver
- HIV/AIDS Waiver

The dates and times of the public hearings and comment period have not yet been announced, but those interested in participating are encouraged to monitor the Medicaid Modernization homepage of the Iowa DHS website.

Other Public Comment Opportunities Currently in the Planning Process

- **Medical Assistance Advisory Council (MAAC)** Legislation has passed directing Iowa DHS to hold monthly public meetings around the state to get input from stakeholders on the transition to managed care. The meetings will start in March 2016. The Executive Committee of MAAC is directed to take the feedback from these public meetings and turn it into recommendations for legislative or administrative action. For additional information, refer to the MAAC homepage of the Iowa DHS website.
- **Legislative Health Policy Oversight Committee** The intention of this committee is to review updates, data, and public input, and make recommendations for changes to the laws and rules governing Medicaid managed care. The committee will consist of Iowa Senators and Representatives appointed by the Legislative Council; however, each meeting will schedule time for public comment.

Consumers and Family Members Opposed to the Change

We are currently aware of two community-based grassroots efforts petitioning the proposed changes to from a Medicaid fee-for-service model to a managed care delivery model. The community advocates that initiated each petition will submit them to CMS once the official Iowa comment period is over.

Deny Iowa DHS application for concurrent 1915(b) and 1915(c) waiver application submitted to include in the Medicaid managed care program. This Change.org petition was initiated by an Iowa parent of a child with multiple, significant disabilities. In the introduction of the petition, the petitioner draws examples from Kansas' KanCare Medicaid transition "…and the issues that are now starting to surface surrounding it, particularly for persons with disabilities."

Iowa Governor Branstad's plan to privatize Medicaid to Managed Care should be slowed down and reevaluated with adequate state oversight. This petition, posted to MoveOn.org, was started by a community activist from Iowa, who is also an individual with a disability.

DID YOU KNOW?

All Access News *newsletters, including the newsletters in this series, are available in plain text by request. Contact Ashley Gill at ASK Resource Center by calling (800) 450-8667, or via email at ashley@askresource.org.*

UNDERSTANDING HOW TO NAVIGATE YOUR PLAN

The Patient Advocate Foundation's Managed Care Answer Guide was designed to help consumers make decisions about choosing a health care plan. Although the guide makes references to private insurance and employer health plans, the information is helpful for consumers of all types of health care coverage.

STEP 1 PRIORITIZE YOUR NEEDS

Make a list of you and/or your family's current and anticipated health care needs. Do you have a chronic illness that requires ongoing care? Are you anticipating having an elective surgical procedure or a pregnancy in the coming year? Are you interested in any specific health education services, such as weight loss or smoking cessation counseling?

STEP 2 EVALUATE YOUR MANAGED CARE OPTIONS

Assess the managed care plans available to you. Are they accredited? Can you use your current doctors and hospitals, or will you have to choose new ones? Which plans offer special programs that interest you, such as support groups or disease management for patients with cancer? What are the monthly premiums, co-payments and deductibles for each plan? Choose a plan based on your specific needs, plan qualifications and affordability.

STEP 3 CHOOSE YOUR PRIMARY PHYSICIAN

The plan may require you to select a physician from the plan's network, or it may allow you to continue seeing your current physician at an additional cost in the form of higher co-payments. Seek physicians who are qualified (board certified in the field of medicine you need), compassionate and who communicate well. When you meet with the physician discuss your expectations and preferences for your care. Ask questions about topics that are important to you, such as financial issues or concerns about your care.

STEP 4 ASSESS YOUR SATISFACTION WITH YOUR PLAN

If you are satisfied with the service provided by your plan, you should consider remaining enrolled. Take time to participate in consumer satisfaction surveys sponsored by your plan or your plan administrator. If you are dissatisfied with your plan, move to step 5.

STEP 5 ADDRESS YOUR DISSATISFACTION WITH YOUR PLAN

When dissatisfied with your plan, take action! First, file a complaint with the plan. If the plan does not resolve your complaint satisfactorily, then contact the state agencies that oversee managed care plans where you live. These include the state health and insurance departments and attorney general's office. The phone numbers for these agencies are in the state government listings in the phone book. File your complaint in writing, and document events as carefully as possible. Ask your physician(s) to advocate for you and provide the plan and state agencies with medical studies or expert opinion(s) that support your case in a dispute.

STEP 6 RECONSIDER YOUR MANAGED CARE CHOICES

When your complaint is resolved, reconsider whether you wish to leave your plan for another, or remain enrolled. Changing plans usually can be done only during open enrollment, which typically occurs annually or monthly. (Ask your plan administrator to find out for sure.) Provide feedback to your plan administrator about your problems with the plan.

IDEAs that Work U.S. Office of Special Education Programs

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