MINUTES

Health Policy Oversight Committee of the Legislative Council

November 3, 2015

MEMBERS PRESENT:

Senator Amanda Ragan, Co-chairperson
Senator Joe Bolkcom
Senator Mark Costello
Senator Liz Mathis
Representative David E. Heaton, Co-chairperson
Representative John Forbes
Representative Joel Fry
Representative Lisa Heddens
Representative Linda J. Miller

MEETING IN BRIEF

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I. Procedural Business

Call to Order and Adjournment. The first meeting of the Health Policy Oversight Committee of the Legislative Council (HPOC) was called to order by Co-chairperson Heaton at 10:06 a.m. on Tuesday, November 3, 2015, in Room 116 of the State Capitol, Des Moines, Iowa. The meeting was adjourned at 3:41 p.m.

Adoption of Rules. Members of the committee adopted procedural rules which are available from the Legislative Services Agency and posted on the committee's Internet website at https://www.legis.iowa.gov/docs/publications/IH/699047.pdf.

Opening Comments. Co-chairperson Heaton noted the intent of the legislation establishing the HPOC is to receive information, review data, consider public comments and concerns, and make recommendations for improvements to and changes in current Iowa law and administrative rules relating to the transition to Medicaid Managed Care. He added that although there have been many public comments about the issue of whether the state should privatize Medicaid, that is not the purpose of this committee. Co-chairperson Ragan expressed concern that the privatization process is generating much concern from tens of thousands of Iowans and is moving too quickly and trying to accomplish too much. She has been contacted by many Iowans about the impact the privatization process will have on a great number of consumers, as one in six Iowa consumers as well as their family members and loved ones, and the provider community will be affected.

II. Department of Human Services Panel Discussion of Medicaid Managed Care

Ms. Sally Titus, Deputy Director, Department of Human Services (DHS) (representing DHS Director Charles Palmer); Ms. Mikki Stier, Iowa Medicaid Director, DHS; and Ms. Jean Slaybaugh, Chief Financial Officer, DHS; presented information regarding Medicaid Managed Care (known as the Iowa High Quality Health Care Initiative) including information relating to the goals and design of managed care, federal waiver requirements, Managed Care Organization (MCO) selection and status including readiness review timelines and requirements, member and provider information and outreach, managed care oversight, conforming code changes and updates to the administrative rules, and MCO financing.

Goals and Design. Ms. Stier stated that the overall goals in privatizing Medicaid through contracts with MCOs are to improve the quality of and access to health care, promote accountability for outcomes, and create a more predictable and sustainable Medicaid budget. MCO contracts with providers create business incentives for both MCOs and providers, sustain existing member and provider relationships, provide financial stability through the establishment of reimbursement rate floors, and support a member's ability to choose an MCO based upon the member's specific health care needs.

Federal Waiver Approval. Ms. Stier noted that DHS submitted a new waiver request as well as multiple waiver amendments to the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) in September 2015 for approval for the state's transition to managed care. The submissions included a new section 1915(b) Iowa High Quality Health Care Initiative Waiver, nine section 1915(c) Home and Community-Based Services

(HCBS) waiver amendments, and two section 1115 waiver amendments relating to changes in the Iowa Wellness Plan and the Family Planning demonstration waivers. DHS held four public hearings and accepted written comments on the waiver submissions and these comments were subsequently submitted to CMS. DHS expects CMS to approve the new Iowa High Quality Health Care Initiative Waiver in early December 2015 and the remaining waiver amendments at the end of December 2015.

Managed Care Organization Selection and Contracts. DHS announced the awarding of contracts on August 17, 2015, to the following four MCOs: Amerigroup Iowa, Inc.; AmeriHealth Caritas, Iowa; UnitedHealthcare Plan of the River Valley, Inc.; and WellCare of Iowa, Inc. Ms. Stier discussed MCO contract terms including but not limited to MCO reimbursement, provider payments, and CMS requirements. DHS held "onboarding" meetings with the MCOs to ensure the MCOs have a clear understanding of Iowa's services and providers with a specific focus on long-term services and support needs, due to specific federal requirements. DHS has the responsibility to approve all aspects of MCO operations in conducting MCO readiness reviews including desk reviews, onsite audits, and systems testing. The readiness reviews include assessments in the key areas of organization and administration, staffing, and provider networks. DHS implemented a 90-day timeline within which the readiness reviews will be conducted with the assistance of Navigant, a nationally experienced consultant in the field. A participating MCO will be subject to a fine for each day the MCO cannot demonstrate readiness beginning December 1.

Member and Provider Outreach. Ms. Stier discussed the DHS communications strategy to provide member and provider information and outreach; communications with members and providers and the timelines for these communications; member enrollment support provided by the enrollment broker Maximus which is tasked with providing information and conflict-free choice counseling in the selection of a member's MCO; the member enrollment timeline and ongoing member rights and supports including support from the State Long-Term Care Ombudsman for members who receive long-term services and supports and from the State Ombudsman; the transition of Magellan and Healthy and Well Kids in Iowa (hawk-i) members to one of the four MCOs and continuity of care provisions; provisions to sustain member and provider relationships including a six-month transition period for physical and behavioral health providers and case managers, and a two-year transition period for facility and HCBS providers.

Provider Information. Ms. Stier discussed the tools available to providers for negotiating and contracting, including DHS-approved template agreements to be signed and executed between providers and MCOs, provider manuals, universal applications, baseline rate information, and a provider network fact sheet. Using the experience of Kansas as a model, DHS developed a streamlined universal enrollment and credentialing process for new providers and existing providers.

Managed Care Oversight. Ms. Stier reviewed the various entities providing oversight for Medicaid Managed Care including the HPOC, DHS and the Iowa Medicaid Enterprise (IME), an External Quality Review Organization (EQRO), and stakeholder oversight through the Medical Assistance Advisory Council (MAAC). She noted the purpose of the HPOC is to receive updates, review data and public input and concerns, and make recommendations for improvements and changes in the law and rules relating to Medicaid Managed Care. Ms. Stier also provided an

overview of a new table of organization for the IME demonstrating the realigning and resizing of positions. She noted that there will be no state layoffs, IME will add seven new FTE positions and will add a Bureau of Oversight and Supports, and the MCOs will add approximately 2,000 jobs in the state. IME will provide oversight by collecting data to monitor individual MCOs and perform comparative analyses, and will develop and publish a comprehensive public reporting dashboard which will include quality measures. DHS is also contracting with an EQRO to validate MCO data performance, improvement projects, encounter data for quality and operational processes, and public interfacing materials. The MAAC Executive Committee will act as the primary stakeholder group to receive input and submit recommendations to DHS based on monthly stakeholder meetings to begin in March 2016. The recommendations will be compiled by DHS and submitted to the HPOC.

Administrative Rules and Code Revisions. Ms. Titus stated that DHS submitted two administrative rules packages to implement Medicaid Managed Care. One package is managed care-specific and the other is a combination of technical clean-up changes and substantive changes necessary to implement managed care. The rules were submitted to the Legislative Services Agency (LSA) on October 21, 2015; the DHS Council on Human Services will review the Notice of Intended Action on November 10, 2015; the rules will be published in the Iowa Administrative Bulletin on November 11, 2015; there will be oral presentations on the proposed rules on December 2-4, 2015; the Legislative Administrative Rules Review Committee will review the Notice of Intended Action on December 8, 2015; the DHS Council on Human Services will hold a special telephonic meeting to adopt the proposed rules on December 16, 2015; and the rules will be adopted on an emergency basis after notice, to become effective January 1, 2016.

MCO Capitation Rates. Ms. Slaybaugh reviewed the basis for the development of MCO capitation rates, noting that the rates must comply with federal requirements and be approved by CMS to ensure they are actuarially sound. Milliman, an independent actuarial and consulting firm, has worked with DHS in developing the rates based upon historical data, prior managed care experience in Iowa, and certain assumptions and adjustments. The capitation rates were established for an initial 18-month rate period to distribute the savings evenly, since savings are smaller in the earlier part of the 18-month period, and to coincide with the state fiscal year. Ms. Slaybaugh noted that if there are any future legislative changes to reimbursement rates, such changes will impact capitation rates and any such changes must also be approved by CMS. Ms. Slaybaugh also reviewed managed care strategies to reduce costs including by reducing unnecessary hospital use and ancillary health care services, by reducing pharmacy dispensing fees and drug costs, and by creating alternatives to long-term care. She also reviewed the breakdown of the capitation rates and current savings projections attributable to each portion of the overall rate, the medical loss ratio, the administrative loss ratio, and MCO administrative expenses, and provided a comparison of Iowa's provider reimbursement rates relative to national results.

Committee Questions to DHS Panel

Member Enrollment. In response to a question about the member enrollment process and timeline relating to member enrollment in the MCOs and whether there is not some concern about all 560,000 members actually receiving the enrollment information, Ms. Stier responded that members, guardians, or other designated persons will be mailed enrollment packets and that

mailings are being sent on a staggered basis by eligibility population category. She also emphasized the extensive public education and outreach DHS has conducted for members and associations including through town hall meetings, in-person counseling, webinars, conference calls, mailings, and the DHS website.

Readiness Review. In response to a question about what happens if one of the MCOs does not meet readiness review requirements, Ms. Stier replied that if this happens DHS will reassign the affected member to another MCO.

Reimbursement Rates. In response to a question regarding reimbursement rates including those being rebased, and whether all MCOs will honor the resultant rebased rates, Ms. Slaybaugh replied that the reimbursement rates for hospitals and nursing facilities will be adjusted to reflect rebasing, but that DHS is still trying to determine how to apply the $1 million increase to HCBS provider rates as directed under SF 505.

Transitions and Continuity of Care. In response to a question about how care is being transitioned from Magellan of Iowa and current Health Home models, Ms. Stier responded that DHS is working almost daily with Magellan of Iowa to provide a smooth transition and to ensure that service authorizations and the delivery of services are not interrupted. Certain Medicaid members will not be served by an MCO but will remain as fee-for-service Medicaid members, including members of the Health Insurance Premium Payment (HIPP) Program; members of the Medically Needy Program; members of the Program of All-Inclusive Care for the Elderly (PACE); members who are American Indian or Alaskan natives unless they choose to be served through an MCO, and undocumented persons eligible for short-term emergency services.

Dashboard Readiness. In response to a question about when the DHS dashboard containing MCO and provider data will be available for MCO oversight purposes, Ms. Stier responded that DHS is working with Navigant to build the dashboard, which will initially provide basic information.

Provider Contracts and Rates. In response to a question regarding how many providers have signed contracts with the MCOs, as many providers have reported they are waiting to sign contracts until they have specific rate reimbursement information, Ms. Stier responded that providers should have received that information last week. In response to a follow-up question as to whether, given the delay in providers receiving rate information, this will allow a sufficient amount of time for a provider to make an informed decision prior to the December deadline, Ms. Stier responded that many providers have already seen and are already familiar with core contract provisions, based upon their previous experience with Medicaid, and that the majority of the rates were set at what the providers received as of July 1, 2015. With regard to the issue of the 10 percent penalty providers will incur if they do not sign contracts with MCOs by the deadline, Ms. Titus responded that DHS established this penalty to encourage providers to participate in managed care and she is aware this penalty provision is a concern. Ms. Slaybaugh added that the decision to pay out-of-network providers at only 90 percent of the service payment fee was a joint decision within DHS and reiterated that this policy provides an incentive for providers to participate. She also noted that, as a part of the phase-in, members can continue to see participating physical and behavioral health care providers and case managers for up to six months, even if they are out-of-network, and for up to two years for long-term care services. Various members expressed

concern about the aggressive time frame and the need to allow consumers and providers more time to transition into the new system.

Moral and Religious Grounds. In response to an inquiry about whether MCOs will be able to deny services based on moral or religious grounds, Ms. Titus responded that none of the MCOs has this policy.

III. Motion to Delay Implementation of Medicaid Managed Care

Senator Bolkcom moved that the HPOC request that Governor Branstad delay privatization of the Medicaid program until July 1, 2016. The motion was seconded by Senator Mathis. Representative Fry directed the members of the committee to the language in SF 505 establishing the HPOC and stated his belief that Senator Bolkcom's motion goes beyond the scope of the charge of the committee and is therefore not germane. Senator Mathis disagreed, pointing out language in the legislation relating to "recommendations for improvement" which should include recommendations for improvement relating to the implementation of managed care. Co-chairperson Heaton and Senator Costello commented that without implementation of Medicaid Managed Care on January 1, 2016, the state budget would have to be adjusted for the current fiscal year to absorb the approximately $52 million resultant projected savings. Co-chairperson Heaton also emphasized the need to rebalance the health care system infrastructure to reduce the reliance on institution-based care and services. Representative Heddens commented that she supported the motion and did not want to politicize the process when what the committee is really discussing is people—the 560,000 recipients affected by this change. She has received many constituent e-mails asking that the transition to Medicaid Managed Care be stopped or slowed down. The committee needs to do its due diligence in protecting the most vulnerable and ensuring they continue to receive services. This is a change in culture. Representative Forbes noted that in his own pharmacy practice, many of the Medicaid consumers have expressed their fears of the change to managed care and that the change is happening too quickly. Senator Mathis added that there must be fidelity in the underlying system and that consumers are afraid and have doubts about managed care. The change is a huge shift and consumers and providers do not have sufficient information to make the decisions that affect their lives so deeply. Senator Bolkcom reiterated the concern of moving too quickly and noted that all health care costs, not only those attributable to Medicaid, are increasing. He said there are legitimate disagreements regarding the shift to privatization, there is a lot of skepticism, and there are still many unanswered questions at the ground level. Following recess for a caucus and further committee discussion, Co-chairperson Heaton called the question. On a roll call vote of three ayes (Ragan, Bolkcom, and Mathis) to one nay (Costello) in the Senate and two ayes (Forbes and Heddens) to three nays (Heaton, Fry, and Miller) in the House, the motion failed.

IV. MCO Presentations

Mr. Jeffrey Jones, Chief Operating Officer, Amerigroup Iowa, Inc. (Amerigroup); Ms. Cheryl Harding, Market President and Ms. Karen Michael, Vice President, Corporate Medical Management, AmeriHealth Caritas Iowa (AmeriHealth); Ms. Lauralie Rubel, President, WellCare of Iowa (WellCare); and Ms. Catherine Anderson, Vice President of State Programs,

UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare), presented overviews of each of the four MCOs.

Amerigroup Iowa, Inc. Mr. Jones noted that all staffing positions at Amerigroup have been filled and those in leadership positions have an average of over 10 years of experience in Iowa. He noted the extra benefits available to members, including a free weight-management program, video chat options with doctors, and free stocked backpacks and comfort items for children, to name a few extra benefits. He also noted that members in certain waiver groups receive extra personal care attendant support to support in-home living and to assist members in taking advantage of community supports such as travel training and self-advocacy groups. He also spoke about how Amerigroup is reaching into communities by providing school supplies for teachers, encouraging youth wellness, and supporting local food pantries.

AmeriHealth Caritas Iowa. Ms. Harding and Ms. Michael emphasized that the mission of AmeriHealth is to provide an integrated approach to health care, coordinating care through ongoing collaboration with many different social service providers in the community, and treating members with dignity and respect. The MCO hires local community providers and utilizes community outreach specialists. AmeriHealth supports the use of telemedicine to improve access to care for rural populations and utilizes mobile health units to offer health care in geographic areas experiencing health care provider shortages.

WellCare of Iowa. Ms. Rubel noted that by January 1, 2016, more than 450 direct and indirect jobs will be filled to coordinate care for WellCare members in Iowa. She stated that WellCare operates under an integrated care model with an emphasis on holistic, member-centered coordination of care. WellCare has a community commitment to connect members to community resources to help them navigate local social support services to access the care and services they need. WellCare has opened "Welcome Rooms" in many communities. A Welcome Room is a neighborhood-based information and education center staffed by WellCare employees to answer Medicaid questions. Ms. Rubel noted WellCare's commitment to constant improvement of the health care delivery system by working with key advocacy groups and sponsoring provider education summits.

UnitedHealthcare Plan of the River Valley, Inc. Ms. Anderson noted that UnitedHealthcare serves more than 5.3 million individuals in 24 states and the District of Columbia. UnitedHealthcare combines modern health care benefits design, consumer engagement, targeted clinical management, and a modern approach to health care delivery to provide higher quality, more accessible, and more affordable care for more people. UnitedHealthcare focuses on patient-centered plans of care and offers many value-added benefits such as care and disease management, nonemergent transportation, NurseLine, and additional community rewards.

Committee Questions to MCO Panel

Provider Contracts and Rates. In response to a provider contracts and rates question regarding how many of the MCOs have signed contracts with providers, Mr. Jones responded that AmeriGroup is approaching 10,000 provider contracts with a goal of 37,000 providers but anticipates many more as the momentum is building. Ms. Rubel responded that WellCare is at about 40 percent of their goal in terms of provider contracts, and Ms. Harding responded that the

numbers are changing every day. All of the MCO representatives responded that they would provide more specifics to the committee. When asked how widespread the problem of providers not signing contracts due to concerns about lack of specific reimbursement rates is, Ms. Anderson responded that many of the rates are known and should not be a surprise to the providers, because the providers are all Medicaid providers and have been dealing with Medicaid for many years. Many of the providers are not starting from a blank slate on rates, are not new to the process, and know the Medicaid reimbursement rate floor.

When asked whether small nonprofit providers are at a disadvantage when it comes to negotiating the provider-MCO contracts, as they are less familiar with negotiating such rates, Ms. Harding responded that most of the larger providers have significant contracting experience. Ms. Anderson added that, while some smaller providers may not be as experienced with negotiating these contracts, Ms. Stier and DHS have safeguards in place to help to eliminate barriers in the contracting process including providing rate floors and universal applications. Ms. Harding noted that the contracts are value-based contracts, so the MCOs are working with providers to identify and acknowledge their value in the process.

Value-Added Services. In response to a question about the Teladoc option as a value-added service, Ms. Anderson responded that Teladoc is a commercial-specific telehealth product available in the commercial market, subject to state regulation. Telemedicine in general is a reliable tool to use when health care providers are not available in person.

Dashboard Participation. With regard to MCO participation in the IME dashboard reporting tools, Mr. Jones responded that, based upon his experience, the current IME dashboard is typical as far as the presentation of raw data in an Excel spreadsheet, and all MCOs have worked and are continuing to work closely with IME on the dashboard.

Manageable Deadline. When asked whether the January 1, 2016, deadline is a manageable deadline, all of the MCO representatives responded that it is absolutely a manageable deadline as DHS has done a very good job of providing a protracted and detailed implementation and phase-in plan that many other states have not provided in implementing Medicaid Managed Care.

Sharing of Information. In response to a concern about local health care provider boards being required to share sensitive personal information, including social security numbers, Ms. Harding responded that there are very tight federal confidentiality laws in place and the system has been set up with very tight security.

Health Care Workforce. When asked about the best way to increase the health care workforce in Iowa, especially direct care workers, Ms. Anderson and Ms. Harding responded that they intend to work with the state to provide grants to attract more health care workers including physicians into underserved areas of the state and will also utilize paraprofessionals and community health workers to supplement the workforce.

Continuity of Care. In response to a question regarding the need for continuity of care, especially with children who are in group therapy who may be covered through different MCOs, Ms. Anderson responded that all the MCOs will work to deliver the unique care each member needs.

Medication Therapy Management. When asked about how medication therapy is managed under the MCOs, the MCO representatives responded that medication therapy management is a value-added service.

Rate Increases. In response to an inquiry about the average rate increase each MCO will pass along to the state after an 18-month to two-year period, the MCO representatives responded that they would provide this information to the committee.

Conflict-Free Case Management. When asked how the MCOs can assure conflict-free case management, all MCO representatives agreed that they hope to be able to contract with existing case managers to provide case management services.

Accountable Care Organizations (ACOs). In response to a question regarding the State Innovation Model (SIM) Grant and how the MCOs will work with the ACOs that developed through the SIM, the MCO representatives answered that ACOs are one model of value-based purchasing that they will consider utilizing.

In-Network Provider. When asked at what point a provider is considered to be in an MCO's provider network, Mr. Jones responded that a provider is in the network when the provider has signed a contract and is credentialed.

V. Public Comment

The committee received public comment. The majority of the public comments were submitted in writing and are posted on the committee's webpage. Public comments presented at the meeting included all of the following:

Ms. Kelsey Clark, Chief Executive Officer, Iowa Behavioral Health Association (IBHA), stated that although IBHA is not opposed to a managed care system, IBHA does have grave concerns about the accelerated timeframe for implementing managed care. Provider networks, CMS approval, and full public information are all lacking. She also expressed concern about confusing and conflicting information being provided to providers.

Ms. Marsha Oltrogge, Executive Director, Northeast Iowa Behavioral Health, expressed concerns about the no-win situation providers face if they do not sign contracts with MCOs by the deadline, become categorized as out-of-network providers, and are subsequently penalized with a 10 percent reduction in reimbursement.

Mr. Peter Brantner, Executive Director, Crossroads Behavioral Health Services, stated that, as a community mental health center in Southwest Central Iowa, Medicaid has reimbursed their costs through cost reporting since 2006, as required by legislation. Under Medicaid Managed Care, Crossroads will no longer receive cost-based reimbursement beyond the current fiscal year and it is unclear what the reimbursement rates will be beyond that time. He expressed concern about a member making an informed decision as to the appropriate MCO for a member's health care needs when providers like Crossroads do not know who they will be contracting with, coupled with the fact that many members have not yet received their enrollment letters. If members do not meet the enrollment deadline, members will be forced to access the most costly services to meet their health care needs.

Dr. John Bigelow, Psychologist, Southwest Iowa Mental Health Center, also expressed concern about how members will enroll in MCOs by the deadline as many members do not open their mail. He also expressed concern about the lack of information relating to provider reimbursement rates as he needs more complete information to determine what he will be able to pay his employees for the services they provide.

Mr. Noah Tabor, Director of Public Policy, Alzheimer's Association, Greater Iowa Chapter, commented that seniors with Alzheimer's and other dementia-related diseases rely on Medicaid at a rate nearly three times greater than other seniors. In Iowa, approximately 14 percent of all Medicaid spending is on people with Alzheimer's and other dementia-related diseases, and this is projected to increase to 33.4 percent by 2025. Statistics indicate that by the age of 80, 75 percent of this population will be admitted to nursing homes and states need to anticipate the demands of long-term care on the Medicaid budget.

Mr. Andrew Williams, Lead Organizer, American Federation of State, County, and Municipal Employees (AFSCME), Iowa Council 61, stated that Consumer Directed Attendant Care (CDAC) providers have been given little or no guidance and have been given inaccurate, confusing, and deceptive information about what will happen to the CDAC providers when the state outsources the waiver services they provide to MCOs. He reported that thousands of CDAC providers received letters from Amerigroup with a 47-page contract they were requested to sign, with no information about reimbursement rates. There was also confusion about whether the CDAC providers should have received the letters in the first place, as there has been speculation that the services provided by CDAC providers will be outsourced. Outsourcing will put financial and emotional strains on families and end up costing the state more money.

Mr. James Cushing, Executive Director, Iowa Association of the Area Agencies on Aging (AAAs), stated that while his more extensive comments have been posted to the committee webpage, in brief, the AAAs have been diligently preparing for the transition to managed care. He suggested that more time is needed for effective decision making, provider network adequacy and readiness are key for preparedness and a smooth transition, more timely and thorough communication is needed, it is important to utilize existing resources such as the AAAs to facilitate the transition, and that a transition plan to ensure community-based providers can serve consumers and stay in business is needed.

Ms. Kari Prescott, Webster County Health Department, expressed concerns from a "boots-on-the-ground" perspective. She noted the aggressive timeline is causing confusion and uncertainty; that complete information has not been made available to providers or consumers to be able to make informed decisions; that there is a need for MCOs to understand current resources, infrastructure, and local services to best utilize the already existing health care system including case managers and other existing services for the most vulnerable; and that the health care system is already stressed by the health care provider shortage.

Mr. John Cacciatore, Senior Vice President, PolicyWorks, commented that the state plan amendment for home health agency providers should reflect the directive to base rates on the low utilization payment adjustment (LUPA) methodology, as directed in SF 505, which would have a budget impact of $3.9 million.

Ms. Marissa Eyanson, Director, Case Management, and Interim Director, Quality Improvement, Easter Seals of Iowa, noted that while Easter Seals is accustomed to change in order to best meet the needs of their clients, and supports change that will create long-term systemic stability, she asked the committee to consider slowing down the implementation of managed care to allow the change to be carried out in a collaborative and thoughtful manner. People need a reasonable amount of time to better access information necessary to make informed choices. She asked that the state slow down the implementation, proceed with thoughtful policy implementation, and collaborate with Easter Seals to help facilitate a successful transition.

Mr. Dave Weiss, Legislative Committee Representative, Iowa Medical Group Management Association, expressed concerns about the aggressive timeline for implementation, the lack of information and communication, and the policy that providers who have not contracted with an MCO by the deadline will be considered an out-of-network provider and only be paid 90 percent of the cost of their services, thereby incurring a 10 percent penalty. He stated that until recently, the state had implied that during the open-network period, providers who had not yet contracted with an MCO would still receive 100 percent of the current Medicaid rate. He requested reinstituting the open-network transition period of six months. He asked why it is necessary to penalize physicians who care for their patients through the transition period.

Ms. Shelly Chandler, Executive Director, Iowa Association of Community Providers, expressed concern about members receiving timely and accurate information to ensure informed and good choices and noted that there is a fear in the unknown. An important strategy is to provide coordination of care to ensure members receive the appropriate care necessary to best meet member health care needs. Moving to four MCOs will place a significant new administrative burden on all providers.

Ms. Teresa Bomhoff, President, National Alliance on Mental Illness (NAMI), Greater Des Moines, stated that her greatest concern is the inadequacy of the health care workforce, especially the behavioral health workforce. She noted that the provider network lists identify some providers as behavioral health care providers, although that is not the case, and many lists contain duplications.

Rev. Brian Carter, Iowa United Methodist Church, stated his concerns about enrolling inmates with a mental illness into Medicaid Managed Care once they are released from prison so they receive the medications they so desperately need. Many end up without access to mental health care and services and wind up homeless and are often rearrested.

Mr. Chris Hoffman, Executive Director, Pathways (Waterloo), stated his concern about the adequacy of the health care workforce. MCOs are hiring management-level employees, but there is a real shortage of the clinical and direct care worker-level employees. He also stated he has had a difficult time negotiating reimbursement rates and getting responses to his questions about these rates.

Mr. John Hale, The Hale Group, noted that his comments are posted on the committee's webpage.

Mr. Aaron Todd, Iowa Primary Care Association, noted that the association's more extensive comments are posted on the committee's webpage and that, in short, they are supportive of innovation and stand ready to assist in this transition, but they are most concerned with member assistance, care coordination, and the administrative burden on providers.

Ms. Julia Duncan spoke about her son, Brandon, who is 25 years old, has severe schizophrenia, and was a resident of the Abbe Center in Marion for six years until it was closed. As a result, the family lost its ability to civilly commit Brandon. Brandon became homeless and, while living on the streets, was beaten and robbed. Hospitals would only admit Brandon for up to a week at a time. In December 2014, Brandon gouged both of his eyes out and is now completely blind. Brandon is now both mentally ill and completely blind. Ms. Duncan urged that privatization of Medicaid be stopped.

VI. Committee Discussion

The committee discussed the possibility of including provider and consumer panel presentations and addressing the topic of the enrollment process for consumers at the next meeting of the committee scheduled for December 7, 2015.

VII. Materials Filed with the Legislative Services Agency

Materials distributed at or in connection with the meeting are filed with the Legislative Services Agency. The materials may be accessed from the "Committee Documents" link on the committee's Internet site:
https://www.legis.iowa.gov/committees/meetings/documents?committee=24165&ga=ALL

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