MINUTES
Health Policy Oversight Committee

Monday, August 29, 2016

MEMBERS PRESENT

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

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I. Procedural Business

The first of two statutorily mandated meetings of the 2016 interim of the Health Policy Oversight Committee (HPOC) of the Legislative Council was called to order by Co-chairperson Heaton at 12:30 p.m. on Monday, August 29, 2016, in Room 103 of the State Capitol, Des Moines, Iowa. The meeting was adjourned at 4:13 p.m.

Opening Comments. Co-chairperson Heaton noted that managed care is a new way of managing the state's Medicaid program. He said that while change is hard and there have been some hiccups in adopting the new process, the time for partisanship is over. It is time to move toward the path of better health for Medicaid recipients.

Co-chairperson Ragan said that she remains skeptical of handing over the Medicaid program to out-of-state for-profit companies. She observed that Medicaid is the health care safety net for all Iowans, currently provides health care coverage for one-sixth of Iowans, and affects tens of thousands of workers and hundreds of Iowa businesses. Co-chairperson Ragan said that having attended listening posts and spoken with and listened to Medicaid members and providers, privatization of Medicaid is a broken system.

The co-chairpersons noted that the following legislators who are not members of HPOC were present at the meeting and would be invited to ask questions if there was sufficient time: Senators Julian Garrett and David Johnson; and Representatives Marti Anderson, Timi Brown-Powers, Mary Mascher, Art Staed, and Cindy Winckler.

II. Review of Iowa Health Link Quarterly Report — Department of Human Services (DHS)

Mr. Charles Palmer, Director, DHS; Ms. Mikki Stier, Iowa Medicaid Director, DHS; Ms. Jean Slaybaugh, Chief Financial Officer, DHS; and Ms. Liz Matney, Managed Care Organization (MCO) Oversight and Supports Bureau Chief, DHS, reviewed the Iowa Health Link Managed Care Organization Report on First Quarter Performance Data published August 26, 2016. Mr. Palmer and Ms. Stier began by thanking Iowa health care providers for their commitment and cooperation in providing health care services despite some administrative and billing issues.

The report reflects the first three months of Medicaid managed care and is the first report of its kind for Iowa Medicaid. Ms. Matney and Ms. Slaybaugh highlighted information in the report. Data elements reviewed included member enrollment; population reporting, including adult, child, elderly, and special needs populations; case management ratios; assignment of health care coordinators and completion of initial health risk assessments for members; grievance and appeals processes and outcomes; critical incidents reporting; timely completion of service plans for members receiving waiver services; level of care assessments; helpline services, including secret shopper calls; medical and pharmacy claims paid, denied, or suspended and the reasons for denials; utilization of value-added services; provider network adequacy and utilization; prior authorization; minimum medical loss ratio and administrative loss ratio; program cost savings to date; program integrity activities to ensure appropriate billing and payment and to eliminate fraud, waste, and abuse; value-based purchasing; health care outcomes; and remedies. Ms. Matney noted that as time passes and additional data is collected, DHS will have more robust data to better measure outcomes, identify trends, and adjust information reported.

Committee Questions. Ms. Stier and Ms. Matney responded to a number of questions from HPOC members and other legislators present. In response to questions, Ms. Stier and Ms. Matney discussed pharmacy claim denials and drug substitution requirements; use of value-based purchasing contracts

with health care providers rather than a fee-for-service system; and how MCOs become eligible for additional monetary rewards under their contracts by meeting certain enhanced benchmarks involving timely claims processing, prior authorization, credentialing, health risk assessment completion, and network access. Fulfillment of each benchmark accounts for one-fifth of the 2 percent reward that it is possible for an MCO to obtain.

In response to questions about program integrity, Ms. Matney said that DHS has contracted with external review vendor Health Services Advisory Group to conduct ongoing validation and a yearly compliance review of performance data reported by the MCOs. Ms. Matney said it takes about 18 months to collect performance data before clinical outcome data can be calculated.

Ms. Matney also discussed tracking of adverse events and what is required for a submitted claim to be considered a clean claim. Clean claims payment measures do not reflect whether the amount paid was the same as the amount claimed. Ms. Stier said that MCOs are helping providers with claims and payment issues through liaisons and account managers, and through additional training.

Ms. Stier responded to questions about why sanctions were not imposed on MCOs as provided in their contracts and why this decision was not reported to legislators. Ms. Stier said that while oversight of the program is very important, during the initial transition period covered by the report, DHS did not implement contract sanctions against MCOs but instead chose to work collaboratively with the MCOs to attain contract compliance. DHS did not make a formal decision not to impose sanctions.

In response to a question about how program integrity in the new program compares with the previous Medicaid fraud and abuse program that was in place, Ms. Stier said that in addition to the existing state program, each MCO has a separate program integrity process. Program integrity costs are built into the capitation rates for each MCO to recoup the cost of fraud and abuse. Mr. Palmer added that the Health Services Advisory Group was hired to deal with program integrity and to work with the MCOs. Generally, fraud is viewed as an intentional act as opposed to waste and abuse which may be more unintentional, such as mistakes in making incorrect payments or paying for inappropriate services. With prepayment edits in place, these claims problems should be caught on the front end.

III. Report on Public Input Sessions — Medical Assistance Advisory Council (MAAC) Executive Committee

Mr. Gerd Claybaugh, Director of Public Health and current chairperson of the MAAC and of the MAAC Executive Committee, and Mr. Anthony Carroll, current member of the MAAC and of the Executive Committee, provided a report on implementation of changes to the MAAC and the Executive Committee created in Iowa Code chapter 249A, which were required pursuant to 2016 Iowa Acts, chapter 1139, sections 99 through 102, and the results of the public input sessions being held throughout the state to provide for input and feedback on Medicaid managed care.

Mr. Claybaugh said that the 2016 changes to the MAAC include changes in membership of the MAAC and the Executive Committee. The full MAAC now consists of 55 members who meet quarterly, while the Executive Committee is comprised of 11 members and meets monthly. Mr. Claybaugh said that the MAAC is working to implement a platform to engage providers and the public and to provide a centralized provider enrollment process into the MCOs. The MAAC has worked with Medicaid staff on processes in the new environment, is developing administrative rules, and has elected new members to the Executive Committee. Members of the Executive Committee attended the Iowa Health Link public comment meetings around the state.

Mr. Carroll said that as a member of the Executive Committee he has been attending public meetings and listening to the public, especially local health care providers. Issues he has heard about most often include timeliness and sharing of information by the MCOs, and requirements for prior authorization. The MAAC Internet site contains meeting notes.

Mr. Carroll said that MAAC will be conducting future meetings in Sioux City in October, Ottumwa in November, and Des Moines in December. A suggestion was made that a meeting be held in Spencer. Mr. Claybaugh said that the meetings will continue into 2017. The MAAC schedule and the Medicaid public input meetings schedule will be provided to the HPOC Committee.

IV. Update on Managed Care Processes and Time Frames — Managed Care Organizations (MCOs)

The committee received updates on managed care processes and time frames from representatives of the MCOs including: Ms. Cheryl Harding, Market President, AmeriHealth Caritas Iowa; Ms. Cynthia McDonald, Plan President, Amerigroup; and Ms. Kimberly Foltz, Chief Executive Officer, UnitedHealthcare Plan of the River Valley, Inc.

The MCO representatives discussed the advantage of filing claims electronically instead of by paper. Ms. Harding said that electronic filing is faster and once a claim is approved, payment can be immediately transferred electronically into the provider's account. Ms. McDonald said that the MCOs will work with providers to transition to electronic claims filing. There was initial confusion with so many providers signing up for electronic filing at once, but the dedicated assistance lines for signups do not receive as many calls now. The MCO representatives also discussed clearinghouses, claims submissions, and processing time frames.

Committee Questions. In response to a question, Ms. Stier compared claims filing procedures under a fee-for-service system with those now being used by the MCOs. In the past, a health care provider submitted claims to Medicaid on paper or electronically, monthly, and was paid with a paper check or electronically, with an approximate seven-day turnaround. Now, a provider can submit claims to an MCO on a daily basis. The MCO representatives said that the average turnaround time from filing to payment of clean claims is presently five days for AmeriHealth, 6.9 days for Amerigroup, and 7.9 days for UnitedHealthcare. Funds can be transferred within a week if there is an urgent request to do so.

In response to questions about providers who are having problems dealing with electronic filing and with multiple claims processes, the MCO representatives discussed how they are dealing with those issues. Ms. Foltz said that UnitedHealthcare is providing weekly outreach to providers who need assistance, but that need is decreasing with time. Ms. McDonald said that Amerigroup has expended much effort on education and outreach for providers, and the need for that assistance has also decreased. Amerigroup continues to work on a handful of issues and system fixes and is sensitive to the needs of small and community providers. Ms. Harding of AmeriHealth echoed that her company is dealing with similar issues in the same manner, and after dealing with some systemic issues is now working on resubmitted claims.

In response to questions about prior authorization processes and whether there is a possibility of having a uniform prior authorization procedure and form, Ms. Stier explained that each MCO is allowed to have its own prior authorization procedure. Prior authorization is a way to monitor that people are receiving the care they need, and each MCO has its own way to determine this. Prior authorization for procedures such as CT scans is not required in emergency situations, but otherwise the circumstances of each case are reviewed individually. The MAAC has put together a grid for providers that explains how each MCO's prior authorization process works.

In response to questions about “medical necessity,” the MCO representatives discussed use of that concept in approving or denying claims. Ms. Foltz said that UnitedHealthcare uses industry standards and peer-to-peer procedures to determine medical necessity. Claims often lack the precise detail necessary to support a finding of medical necessity. Ms. Harding said that each MCO may use different criteria in interpreting industry standards. Ms. Stier added that the MCOs allow internal appeals of such denials, followed by a further right of appeal to DHS for a determination by the DHS medical director.

In response to questions about pharmacy benefits and emergency refills of prescriptions, the MCO representatives discussed the use of prior authorization in this context. Ms. Harding opined that a three-day emergency refill is available while awaiting prior authorization but an extension of that to seven to 10 days would be too long. AmeriHealth assesses such refill requests on a case-by-case basis. Case managers are involved, especially to work with pharmacy benefits managers.

In response to questions about delays in payments to consumer-directed attendant care (CDAC) providers who provide in-home support to keep members independent, the MCO representatives agreed that such providers are very important to the system. Ms. McDonald said that Amerigroup is using a “soft hand” to work with such providers and will fix problems they are aware of. Ms. Foltz said that UnitedHealthcare has people assigned to deal with this issue and is committed to keeping members in the least restrictive setting. In assessing claims, there are misunderstandings and each situation has to be assessed individually by looking at what services were rendered. Ms. Stier added that a previous exception that allowed payment for a host home is no longer allowed.

In response to a question about why report data about resolution of grievances and appeals does not seem to match what is being heard from providers, Ms. Stier noted that a provider cannot file a grievance or an appeal, only a member can do so. The managed care appeal process does not have a benchmark to compare to historical fee-for-service appeal data since the managed care appeal process differs from the previous administrative appeal process.

In response to a question about increased delays in credentialing providers under the new system, the MCO representatives said that they are providing assistance to providers. Ms. Foltz said that issues in signing contracts with specific providers may involve what rates the MCO is willing to pay for a particular service.

In response to questions about payment of claims, Ms. Harding said that it is not possible to compile a list of what conditions require prior authorization for an inpatient hospital admission versus observation status because each situation needs to be looked at on a case-by-case basis. Ms. McDonald said that the length of time necessary to make 100 percent payment of a clean claim depends on what is causing the claim issue. A simple issue is that the claim is connected to the wrong fee schedule. A complex issue may require amending the contract to fix an error.

In response to a question about maximizing and expanding the use of health care coordinators for all members, all MCO representatives agreed that the use of case managers and care coordination is a critical part of managed care. Amerigroup works with providers to make sure that all needs of a member are met, including medications and visits. UnitedHealthcare is focusing on targeting individuals with chronic conditions.

Ms. Stier said that an electronic verification system verifying that a member actually received a billed service is not ready to be fully implemented and is currently being utilized by only one MCO as a pilot project. The MCO contracts require implementation of this system by September 1, but since that will not be possible, DHS is looking to add use of the system as a best practice.

In response to questions about whether the MCOs have sustained losses under their contracts to date, all representatives indicated that they have. One reason is that the startup of the program was pushed back several months and the MCOs had no revenue during that time. Ms. McDonald said that Amerigroup is looking for drivers of its losses. She pointed to the fact that premium rates were set two years ago when contracts were signed. Also, pharmacy costs have been a big cost driver. Second quarter information about revenue is not yet available. Ms. Harding said what while any loss is concerning, AmeriHealth is trying to understand the causes and has no plans to pull out of the state or to cut services.

In response to comments from several legislators that they are receiving numerous complaints from members and providers alike about the new system, all MCO representatives expressed optimism. Ms. Foltz said that UnitedHealthcare serves 190,000 members and she has heard positive comments and seen a dramatic decline in telephone calls to assistance lines from members and providers. Ms. Harding said that there is no provider billing problem that cannot be figured out. Only five months into the new program, she has heard positive anecdotes from members. Ms. McDonald echoed those sentiments and said that she wants members to feel that they get results from Amerigroup.

In response to a specific question about the outcome of outstanding payments to Orchard Place and to ABCM Corporation, both Ms. Harding and Ms. McDonald said they have made good progress in resolving any disputes.

V. Next Steps

The committee discussed the format and length of the second meeting to be held during the 2016 interim following receipt of the second Iowa Health Link Quarterly Report which is due to be available November 30, 2016. The co-chairpersons agreed that the next meeting will be longer in length, will provide sufficient time for more discussion, and will include time for public comment. A request was made that the next quarterly report separate out information about clean claims including the percentage actually paid of the total amount submitted for reimbursement.

VI. Public Comment

The committee received public comment at the meeting from Ms. Michele Meadors. Ms. Meadors said that she is a resident of downtown Des Moines and works at the YMCA. She was confined to a wheelchair after an automobile accident five years ago. She depends on a CDAC provider to help her with her activities of daily living. Her CDAC provider has not been paid for four months. Ms. Meadors said that under the new system she has also had to wait at least six weeks to obtain essential medical equipment such as catheters. Ms. Meadors said that the health care system has to work. She expressed frustration that there are now multiple claims forms when there used to be only one, and the whole claims process takes much longer.

The committee received additional public comments which were submitted in writing and are posted on the committee's Internet site.

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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