MINUTES
Health Policy Oversight Committee

Tuesday, December 13, 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 second 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 Ragan at 12:06 p.m. on Tuesday, December 13, 2016, in Room 103 of the State Capitol, Des Moines, Iowa. The minutes of the HPOC meeting of August 29, 2016, were approved on a voice vote. The meeting was adjourned at 4:16 p.m.

Opening Comments. Co-chairperson Ragan stated that privatization of Medicaid is moving faster in Iowa than in any other state, and it is the duty of the HPOC to ask how things are going. She said that providers are not being paid on a timely basis and are being paid the wrong amount, there are too many hoops for patients to jump through to receive services, information given by the Managed Care Organizations (MCOs) is incorrect, and there are higher administrative costs. She stated that intense, ongoing oversight of privatized Medicaid is important and must continue.

Co-chairperson Heaton thanked everyone for attending the meeting and stated that the meeting provides an opportunity to look at privatization of Medicaid by hearing from the Department of Human Services (DHS), the MCOs, and affected patients and providers. He said that DHS has collected the type of verifiable data that has never been available before. This data will help the HPOC to hold the MCOs accountable. He commented that a recent estimate from the Revenue Estimating Conference indicates that expected state revenues will decrease by $96 million which will impact next year's budget.

II. Review of Iowa Health Link Quarterly Report – Department of Human Services

Mr. Chuck Palmer, Director, DHS; Ms. Mikki Stier, Medicaid Director, DHS; Ms. Jean Slaybaugh, Chief Financial Officer, DHS; and Ms. Liz Matney, MCO Oversight and Supports, Bureau Chief, DHS, reviewed the MCO Report based on the first quarter of state FY 2016-2017, published November 30, 2016. The report reflects the second quarter of the Medicaid managed care program.

Ms. Stier noted that refinements have already been made to the data collection process and that the executive summary includes additional details. Ms. Matney noted that during the first quarter of state FY 2016-2017, the department worked with the MCOs to move more members off the home and community-based services waivers waiting lists; had weekly Strengths, Weaknesses, Opportunities, and Threats (SWOT) meetings; continued to work on, but decided to push back the implementation date of the Eligibility and Verification Information System (ELVS) until late in calendar year 2017; and worked with the State Innovation Model grantees to increase the number of value-based contracts.

DHS updated and clarified the methodology of data reporting for several of the data elements in the current report compared with the initial first quarter report. Data elements highlighted by DHS representatives included adult members assigned to a health care coordinator; the number of community-based case manager contacts and community-based case management ratios for adult members; MCO member grievances and appeals; timely completion of service plans; timely completion of level of care assessments; timely answering of helpline calls and the top reasons for members contacting helplines; medical claims and pharmacy claims payment; utilization of value-added services; provider network access; prior authorization; medical loss ratio and administrative loss ratio; and program savings. While health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation, now all members will receive a risk assessment.

Ms. Matney indicated that DHS continues to proactively address systemic issues including ensuring that the provider rates loaded into the system are current and accurate rates.

Ms. Matney reviewed the grievance and appeals processes in place under Medicaid managed care. She explained that the grievance process comes into play when a member or member's representative submits a complaint based on dissatisfaction with the way the member's care was handled. A grievance is submitted to the MCO, and the MCO works to resolve the member's concern and issue an outcome.

If the member's concern cannot be resolved, the member can request a disenrollment and enroll with a new MCO. The appeals process comes into play when a member asks an MCO to take action on its decision to deny or limit services. The MCO will notify the member or member's representative of the resolution in writing. If the member is not happy with the outcome of an appeal with an MCO, the member can file an appeal with the state through the State Fair Hearing Appeals Process. This process is the same process that was in place under the Medicaid fee-for-service system.

Service plans are still not meeting benchmarks for timely completion, but DHS expects improvement over the next quarter or an MCO not meeting its benchmarks will be penalized. Ms. Matney noted that even if a service plan is not updated in a timely manner, a member's services are not disrupted.

In response to questions about MCO helplines, Ms. Matney explained that there are high volumes of calls to the helplines but this was true under fee-for-service, too. The top five reasons that members contact helplines are the same now as they were under fee-for-service. DHS was asked to provide the HPOC with data about service levels on the helplines under the MCOs compared to under fee-for-service.

In response to questions about clean claims, Ms. Matney said that 90 percent or more of clean claims are being paid or denied in a timely manner. The data collected does not include a measure for the accuracy of the payment, however. In response to a request for information about what percentage of claims are paid at 100 percent, Ms. Matney said that DHS is still looking at how to collect that data, considering that providers may have negotiated rates that are different than their rates for fee-for-service. In response to a question about the number of providers that are not being paid their contractual amounts, Ms. Matney said that the problem is not systemic, 89 percent of such claims have been paid, and DHS is working on the 11 percent of claims that are still pending. Ms. Matney clarified that 180 days is the cutoff for first-time submission of a claim for payment. Ms. Stier indicated that she would follow up with legislators

regarding specific provider payment issues. Mr. Palmer said that DHS would like to sit down and talk with providers about claims issues.

In response to a question about providers who are going out of business, Ms. Stier said that DHS is tracking such providers and can provide the HPOC with a list of these providers.

Ms. Matney indicated that over 40,000 members accessed value-added services provided by the MCOs this quarter. This number should increase with increased care coordination.

In response to a question about prior authorization, Ms. Matney said that the MCOs must receive DHS approval of their prior authorization processes before implementing them. Many services do not require prior authorization.

Ms. Slaybaugh discussed the financial performance of the MCOs. She indicated that the data indicates a total estimated annual cost savings of $118.8 million and a second quarter estimated cost savings of $29.7 million relative to what the state would have spent under Medicaid fee-for-service. Ms. Slaybaugh indicated she cannot point specifically to where the savings are occurring within the program, but that the savings reflect what is being paid to the MCOs, not what is being paid to the providers.

In response to questions about why the MCOs are receiving additional moneys from the state beyond the agreed contract amount, Ms. Slaybaugh explained that the Governor increased capitation payments to the MCOs by $33 million based on more recent and more complete information. Some of the increases are due to pent-up demand for services by members of the Iowa Health and Wellness Program including for pharmaceuticals and hospital services. Ms. Slaybaugh said that DHS will provide the HPOC with a breakdown of the drivers of the capitation rate readjustment, including the percentage amount of the readjustment attributable to each factor.

Program integrity data encompasses activities to ensure appropriate billing and payment. With only three to six months of data, the program is still ramping up and attempting to identify outliers.

DHS will monitor hospital readmission data to compare with readmission data under Medicaid fee-for-service. DHS was asked to provide readmission data broken down between readmissions of adults and children.

III. Discussion with Managed Care Organizations

The committee discussed various issues with the representatives of the MCOs: Ms. Cheryl Harding, Market President, AmeriHealth Caritas Iowa; Ms. Cynthia McDonald, Plan President, Amerigroup; and Ms. Kim Foltz, Chief Executive Officer, UnitedHealthcare Plan of the River Valley, Inc.

The representatives of the MCOs indicated they did not have a formal report but would answer questions. Concerning losses suffered by the MCOs pursuant to their contracts with the state thus far, the MCO representatives indicated they assumed that there would be losses initially as they built a new managed care system. Iowa is unique in that it encompasses seven waiver programs and the transition is challenging. Members will be better served as capacity is expanded. The goal is to maintain high contact levels with members and provide care at the right time and the right place.

There are national trends promoting a focus on health and wellness. Rising pharmacy costs are a trend not only in Iowa but nationally. Case management can help address pharmacy costs by providing a holistic approach to care.

The MCOs are working with DHS to build capacity to provide mental health services in the state, including psychiatric medical institutions for children. There are gaps in mental health services but these can be filled through value-based purchasing and quality incentives. It is important to include cost-efficient services such as family therapy, to avoid the need for psychiatric beds. Case management provides an opportunity for success by coordinating physical and behavioral care. The MCOs have the flexibility to provide services that are not usually covered under traditional programs. Exceptions are regularly made to provide transportation for members to ensure that the members have

access to care, and that home and community-based services are provided as an alternative to more costly residential services.

The MCOs are achieving cost savings by preventing waste and abuse on the front end before providers are paid. This is different than fraud, which typically occurs on the back end. By using value-based purchasing, the MCOs are paying only for quality services.

The committee discussed ongoing complaints from providers about payment issues. The MCO representatives noted that problems with providers receiving payment could be a systemic issue or an issue with an individual provider. Payment schedules utilized are industry standards. Providers are given training in filing claims and MCO representatives are available for individual sessions with providers. MCO representatives will follow up on any specific complaints at the request of committee members.

There was discussion about when and how it will be possible to know if managed care is working in Iowa and saving money. The MCO representatives responded that improvements have already been made due to coordination of care through case managers and better program integrity. There is very transparent reporting in Iowa of quality and consumer measures and the program is audited. Once a baseline is established, it will take time to track progress and the evolution of the program.

The MCO representatives said that they were not in a position to discuss whether they will be asking for rate increases for FY 2018; that is a business decision that will be resolved through negotiations with the state.

IV. Report of Public Input Sessions and Other Activities of the Medical Assistance Advisory Council

Mr. Gerd Claybaugh, Director of Public Health and Co-chairperson of the Medical Assistance Advisory Council (MAAC) and of the MAAC executive committee, and Mr. David Hudson, public member and Co-

chairperson of the MAAC and the MAAC Executive Committee, provided information and the schedule regarding the public input sessions that will continue to be held throughout the state in 2017 to provide for input and feedback on Medicaid managed care. Director Claybaugh also reported that the MAAC and the MAAC Executive Committee are continuing to work on action items and a recommendations document.

Director Claybaugh said that the MAAC has been developing an implementation strategy to adopt rules and implement changes in statute. The MAAC Executive Committee has been recreated and includes public members. The MAAC continues to identify areas for improvement such as uniform credentialing, timely filing deadlines, and rates for home and community-based services. Listening sessions are being held to gather feedback and make recommendations. Summaries of this work are being provided to the General Assembly, as required, and recommendations are being made to DHS and the General Assembly. Specific recommendations will be included in the required report. Goals for the program are sustainability and health improvement for Iowans with a focus on data and performance.

V. Update from the Managed Care Ombudsman Program

Ms. Lynzey Kenworthy, Legislative Liaison and Policy Coordinator, Office of the State Long-Term Care Ombudsman (LTCO), provided an overview of the Managed Care Ombudsman Program, created in 2015 to advocate for Medicaid managed care members who receive long-term care services and supports in health care facilities or through one of the seven home and community-based services waiver programs. Ms. Kenworthy noted that Ms. Deanna Clingan-Fischer is the LTCO, but was unable to attend the meeting due to a family emergency.

Ms. Kenworthy said that the LTCO deals with Iowa's most vulnerable citizens and has been added to the membership of the MAAC. The Managed Care Ombudsman program is tracking systemic issues with Medicaid managed care and works with members to resolve issues. The Managed Care Ombudsman

program was directed to annually review Medicaid managed care and to provide monthly and quarterly reports on its Internet site. The Managed Care Ombudsman program identifies trends by giving a global view of how the system is working and by providing transparency and meaningful data.

VI. Public Comment

The committee received public comment in person and through submissions in writing. The public comments submitted in writing will be posted on the committee's webpage.

Ms. Michele Meadors, a Medicaid recipient, told the committee that transportation is still an issue for her. She has difficulty getting to Iowa City for appointments. There is a four to six-week delay in payments to her physical therapist and there are not enough home health care providers.

Mr. Jeff Hoebelheimrich said that while he has close ties to providers, he does not speak for any specific group. He said that the Legislature is not listening. Providers cannot stay open without being paid, and some mental health providers are not getting paid anymore. Mr. Hoebelheimrich continues to send in paperwork but has the same problems with receiving payment month after month. He has hired people to collect reimbursement and has taken out loans to stay in business. The MCOs define what is a "clean claim" and then determine none of the claims submitted meet that definition.

Ms. Michele Vinz read a letter on behalf of her sister Miranda Blackburn, who has special needs. Ms. Vinz said there are issues involved in being a host home for a family member. She gave up her business and opened her home to take care of her sister who is bipolar. Her sister requires less medical care since being moved out of a group home but the state will not pay Ms. Vinz to be a host home. The state should support and augment such family care.

Ms. Mary Schmidt testified that her 24-year-old son has cerebral palsy. He currently receives services through a health and disability waiver but would like to go to a group home. Ms. Schmidt is concerned that if he does so, he will lose his waiver services.

Ms. Rhonda Shouse, a Medicaid member, asked that the committee continue to meet and monitor the state's transition to Medicaid managed care.

Mr. Tom Pontow, Executive Director of Recovery Houses, Harbor of Hope, said that his organization has been successful in helping people become sober. There will always be issues with any monumental change but his organization has been successful in obtaining providers for mental and physical care and they believe the new system is working. Mr. Pontow is aware of two mental health providers they use who have not been paid since August which is squeezing those providers financially and may cause them to go out of business or stop taking Medicaid members. One of those providers specializes in addiction and incarceration which is a hard combination to find. Outcomes are improved by using mental, medical, and addiction processes.

VII. Committee Discussion and Next Steps

The committee discussed the need to continue to meet to provide oversight for Medicaid managed care. Concerns were expressed about the rollout of the electronic verification system and its potential cost to providers. The host home issue may require legislation or changes to administrative rules to be resolved. The State of Washington has put many long-term care patients in host home family care and achieved significant cost savings.

The committee will continue to meet on a quarterly basis to review data as it comes in. Committee members may also meet informally during session.

VIII. Materials Filed with the Legislative Services Agency

Documents distributed at the meeting are posted on the committee's Internet site: https://www.legis.iowa.gov/committees/meetings/documents?committee=24165&ga=ALL

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