MINUTES
Health Policy Oversight Committee

Wednesday, November 8, 2017

MEMBERS PRESENT

Senator Mark Costello, Co-chairperson
Senator Mark Chelgren
Senator Liz Mathis
Senator Amanda Ragan
Senator Mark Segebart
Representative Joel Fry, Acting Co-chairperson
Representative John Forbes
Representative Lisa Heddens
Representative Rob Taylor

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I. Procedural Business

The first of two statutorily mandated meetings of the Health Policy Oversight Committee (HPOC) of the Legislative Council for the 2017 Legislative Interim was called to order by Representative Joel Fry, acting as Co-chairperson of the committee in the absence of Representative David E. Heaton, who was excused for the day. The meeting was called to order at 10:02 a.m. on Wednesday, November 8, 2017, in Room 103 of the State Capitol, Des Moines, Iowa. The minutes of the HPOC meeting of December 13, 2016, were approved as distributed. The meeting was adjourned at 3:29 p.m.

II. Review of Transition Plan and Iowa Health Link Quarterly Report — Department of Human Services

Introduction. Mr. Jerry Foxhoven, Director, Department of Human Services (DHS); Ms. Mikki Stier, Deputy Director and Acting Medicaid Director, DHS; and Ms. Jean Slaybaugh, Chief Financial Officer, DHS, provided an overview of recently concluded contract negotiations with the three managed care organizations (MCOs) and the transition plan that is being implemented as a result of the decision of AmeriHealth Caritas, Iowa (AmeriHealth) to terminate its contract with the state effective December 1, 2017. They also reviewed the Iowa Health Link MCO Report on fourth quarter (April through June 2017) performance data, published October 18, 2017.

Transition Plan. Mr. Foxhoven told the committee that DHS conducted contract negotiations with Amerigroup Iowa (Amerigroup), UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare), and AmeriHealth throughout the summer and reached agreements with UnitedHealthcare and Amerigroup for state fiscal year (SFY) 2018. DHS was not able to reach an agreement with AmeriHealth, which exercised its option to terminate its Medicaid contract. AmeriHealth gave the required 60 days' notice of termination, but continued to negotiate with DHS in the mutual belief that an agreement could be achieved. It was not apparent until 30 days before the contract termination that negotiations would not be successful. The new 2018 contracts with the remaining MCOs require 90 days' instead of 60 days' notice if there are future contract terminations. Although AmeriHealth will no longer provide health care coverage for Medicaid members, it will maintain a presence in the state for up to a year to process and pay claims.

Mr. Foxhoven said that to accomplish an orderly transition, DHS is tentatively reassigning all members who were covered by AmeriHealth to UnitedHealthcare. But those members have up to 90 days after that reassignment to choose coverage with Amerigroup instead. Letters have been sent to affected members informing them that they will be reassigned to UnitedHealthcare, but if they elect to change their coverage to Amerigroup by November 16, 2017, their coverage with Amerigroup will begin on December 1, 2017. Also, DHS has issued an a request for proposal (RFP) to add a third MCO beginning July 1, 2019. In the meantime, UnitedHealthcare is building its capacity to meet the demands of covering additional members. DHS is focusing on providing the best services for members, is confident that UnitedHealthcare can meet the demand, and will do everything it can to make the transition as smooth as possible. Director Foxhoven noted that these types of transitions happen in all states with managed care, but it is not due to problems with the managed care system. He said that the transition may seem bumpy, but it is not devastating and there is no reason for panic. There is a lot of oversight of the MCOs built into Iowa's Medicaid system, more than anywhere else in the country, to achieve the right balance between oversight and the flexibility to allow the MCOs to do what they do best, which is manage health care.

DHS is working with the MCOs to ensure that the data files from AmeriHealth are transferred seamlessly to avoid any gaps in coverage for affected members. Long-term Services and Supports (LTSS) members

with care plans will continue to receive the level of care and services being provided under their current plans until those plans have been reviewed.

Discussion. Members of the committee expressed concern about what provider services AmeriHealth will maintain after their coverage ceases and how members will be affected by reassignment to UnitedHealthcare. Ms. Stier said that AmeriHealth will maintain provider services and a call center in the state for at least one year to ensure timely, accurate payment of claims. Claims appeals will also continue and providers will be paid pursuant to the contract that existed with AmeriHealth. AmeriHealth will keep its call center open on Veterans Day and it may be open on Thanksgiving, too. A top priority of the transition is to provide members with new enrollment cards so they have access to services and especially to prescriptions. Mr. Foxhoven added that UnitedHealthcare would like members to choose to remain with them and has an incentive to hire some of the case managers that were employed by AmeriHealth to maintain continuity for members going forward. UnitedHealthcare is also expanding its network of providers.

Mr. Foxhoven said that DHS may conduct an exit interview with AmeriHealth, but will ask all three MCOs what DHS can do better to help the MCOs succeed in Iowa. The Medicaid system must be sustainable to ensure that a person who requires long-term services and supports today will still receive that care in 20 years.

In response to a question about the cost of Medicaid managed care, Mr. Foxhoven said that the remaining MCOs will receive a 3.3 percent increase in payments for the contract year ending June 30, 2018. In comparison, prior to the change from fee-for-service to managed care, in the previous five-to-eight-year period, Medicaid costs had been increasing by about 10 percent each year. He opined that the Medicaid program is not sustainable if costs are not controlled.

Iowa Health Link Quarterly Report. Ms. Stier reviewed the Iowa Health Link MCO Quarterly Report covering April through June 2017 data. Ms. Stier pointed out that during the quarter, total MCO enrollment was 568,686, over half of those enrolled were children, and MCO LTSS enrollment was 37,664. Some of the data elements highlighted by Ms. Stier included: number of adult members assigned to a health care coordinator; number of community-based manager contacts and ratios of adult members to community-based case managers; number of members utilizing integrated health homes and behavioral health services; ratios of members to integrated health home care coordinators; number of members with special needs assigned to a community-based case manager; top reasons for member grievances and resolution of appeals with particular attention to provider issues; timeliness of responses to provider and pharmacy helpline calls and the use of secret shoppers; timeliness of medical claims and pharmacy claims payments; top reasons for denial of medical and pharmacy claims; timeliness of responses to requests for prior authorization; utilization of value-added services; medical loss ratios and administrative loss ratios of each MCO; total reimbursements by provider type; health care quality outcomes based on hospital admissions, emergency room visits, and out-of-state placements of members; and reduction of members on Home and Community-Based Services (HCBS) waiver waiting lists.

Ms. Stier also highlighted success stories from the new MCO system. Over 249,000 members have completed a health risk assessment, enabling them to receive preventative care and avoid higher-cost services. There has been an increase of 5 percent in the number of members of the LTSS population remaining in home and community-based settings instead of entering long-term care facilities. Over 124,000 value-added services have been utilized by members during the four quarters that the managed care program has been in effect. These services are intended to improve member health and well-being. In the past two years, DHS has been actively working to reduce the HCBS waiver waiting lists. DHS

has also been trying to more accurately match an applicant, at the time of application, to the waiting list that most closely meets the individual's needs and for which the individual qualifies, rather than placing the individual on all waiting lists. DHS instituted a waiver Strengths, Weaknesses, Opportunities, and Threats (SWOT) team to work with individuals with very complex needs and place them on the correct waiver waiting list, opening up additional waiver slots on other waiting lists.

Ms. Stier noted another success with regard to the elderly waiver, where there had been an issue with holding a slot open for a member during a hospital stay or rehabilitation that exceeded the 30-day hold period. DHS changed its rules to extend the hold period from 30 to 120 days, thereby ensuring that after a lengthy hospital stay or rehabilitation, the member could still return home under the waiver, without a gap in waiver coverage. DHS is moving into the next phase with managed care now that Medicaid managed care is established, by reviewing the Medicaid program to determine what further changes can be made to enhance quality and improve the program for all stakeholders.

Ms. Stier said that while some individuals perceive that HCBS waiver services are being reduced or changed, the reason for the change is the Title XIX payment hierarchy. This hierarchy requires that if the state provides a service under the Medicaid state plan and pays for the service through traditional Medicaid funding and that service is also included in a member's HCBS waiver services plan, the service should be provided and paid for through traditional Medicaid and not through the HCBS waiver. Some Consumer Directed Attendant Care (CDAC) providers may perceive this as a loss of services, when instead the services are being provided and paid for through traditional Medicaid. The Medical Assistance Advisory Council (MAAC) is reviewing this shift in policy to assist members and providers with their questions and concerns.

Ms. Stier noted that provider billing issues are one of the top five reasons for grievances being filed. DHS and the MCOs have organized a claims benefit workgroup to develop a more seamless process. When Medicaid was changed to a managed care model, billing forms were standardized across both managed care and fee-for-service Medicaid. The workgroup is also developing standardized best practices coding to increase consistency and efficiency. As of July 2018, Medicaid will transition to all-electronic claims processing and billing, in part, because the electronic visit verification system must be in place by January 2019.

Discussion. Members of the committee asked whether data concerning payment of claims to providers includes information about inaccurate or partial payments made and the percentage at which providers are actually being paid. Ms. Stier responded that DHS will attempt to obtain this information and the reasons for denial of claims and provide the information to the committee.

In response to a question about what it means when a claim is "resolved," Ms. Stier said that resolution of a claim may mean that a claim has been investigated and vetted and that services are being provided pursuant to the criteria of medical necessity or that the claim has been denied and the member is not receiving some or all of the services requested. Each MCO applies its own criteria of medical necessity which is not standardized between the MCOs. Also, each MCO has different prior authorization requirements. Mr. Foxhoven added that denial of a claim by an MCO can be appealed to the state. Medical necessity is applied on a case-by-case basis. Even physicians do not always agree on what constitutes medical necessity. Ms. Stier said that MCOs may conduct a peer-to-peer or physician-to-physician review regarding a medical necessity determination that involves a clinical review of the member's record.

In response to a question requesting data reflecting why claims are rejected, Ms. Stier said that DHS does not track that data but will attempt to collect that information in the future.

III. Iowa Association of Community Providers

Mr. Craig Syata, Policy Director, Iowa Association of Community Providers (IACP), discussed issues arising from the transition of their providers' clients, since more than 80 percent of those clients are enrolled with AmeriHealth. IACP represents 143 organizations throughout the state that provide Medicaid-funded services to people with intellectual and developmental disabilities, brain injuries, and mental illness. IACP clients are a static population with long-term, chronic conditions that will not improve.

Medicaid is the primary, if not the only, revenue source for the LTSS population that IACP members serve. Mr. Syata said that whatever entity manages Medicaid, the IACP has pledged to work productively with that entity. The transition to Medicaid managed care has been difficult for IACP members and their clients, especially for the Intellectual Disability (ID) waiver clients. A major concern is that the rate cell developed to pay the MCOs to cover ID waiver services was based on outdated data, resulting in the waiver being grossly underfunded. AmeriHealth is leaving the state, in part, due to the underfunding of the ID waiver and the disproportionate number of waiver clients who enrolled with AmeriHealth. Based on an IACP analysis, the ID rate cell was underfunded by $12-15 million just for daily community living services, which are only one of the many services available under the ID waiver for IACP clients. MCOs are losing substantial amounts of money on waiver services and rates paid to providers are insufficient to sustain services to higher-need clients. If the waiver rates are not adjusted, these clients will end up living in an institution or in an out-of-state placement.

IACP is concerned about the December 1 transition because some of its providers do not have contracts with either Amerigroup or UnitedHealthcare and probably will not have contracts in place by that date. IACP recommends that providers that contracted with AmeriHealth only and met AmeriHealth's credentialing requirements be deemed by the remaining MCOs to meet credentialing standards at least until the remaining MCOs' credentialing processes are completed. Providers without a contract with the two remaining MCOs on December 1 will be considered out-of-network and will only be paid 80 percent of the contracted reimbursement rate for their claims. IACP asks that this 20 percent penalty be waived while the providers negotiate contracts with the remaining MCOs. An additional concern is expiring authorizations for client services. IACP requests automatic extensions during the transition for those with expiring authorizations until the new MCO reviews the authorization. An additional concern is the new tiered rate payment system, based on clients' assessed needs as determined by the Support Intensity Scale (SIS), which goes into effect on December 1. Although IACP supports the concept of a tiered rate payment system that is based on clients' assessed needs, IACP does have some concerns. Providers do not have assessment scores for over 2,600 current clients. DHS needs to ensure that clients' new MCOs and their service providers have assessment scores prior to December 1 that are accurate, adequate, and subject to appeal. The tiered rate payment system was developed to be budget neutral and is therefore underfunded.

Discussion and Motion. The committee discussed the recommendations made by Mr. Syata. Mr. Syata observed that within the last 10 days or so, IACP was notified that all providers' tiered rate reimbursements for supportive community living under the ID waiver now also must cover transportation expenses, reducing the total amount of money available to pay for a client's services even further. Members raised concerns with conflict-free determinations of clients' assessed needs if the assessment is performed by the MCOs and with the ability of a client to appeal an assessment. Mr. Syata noted that in order for an assessment to be appealable, it must be defined as an "adverse determination." Mr. Syata said that some clients do not have an assessment score, providers have not been provided with many clients' existing assessment scores, some of which may be outdated, and these scores have never been used in Iowa to determine reimbursement before. His concern, therefore, is how service

needs for clients will be determined and how providers will be paid for their services. The remaining MCOs will probably need at least 90 days to conduct their own credentialing of providers that were not already in their networks. IACP did not have any input into DHS contract negotiations with the MCOs.

A motion was made by Senator Mathis and seconded by Senator Ragan that the committee accept the requests made by Mr. Syata on behalf of IACP, and present a letter of support from the legislators on the committee to DHS recommending that DHS implement the requests. Following discussion, Senators Mathis, Ragan, and Segebart, and Representatives Forbes and Heddens voted aye on the motion. Senators Costello and Chelgren, and Representatives Fry and Taylor voted nay on the motion. Failing to be adopted by the affirmative votes of at least three members of each house as required by the committee's rules, the motion failed.

IV. Henry County Health Center

Mr. Robb Gardner, CEO; Mr. Dave Muhs, CFO; and Ms. Charlie Hammel, Revenue Cycle Director, Henry County Health Center (HCHC); and Mr. Brian Green, Principal from Seim Johnson, HCHC Auditor, discussed the impact of Medicaid managed care on the HCHC. They told the committee that HCHC is a 25-bed critical access hospital located in Mount Pleasant that has been in operation for 96 years. In October 2017, there were 4,225 Henry County residents who were eligible for Medicaid, an 11 percent increase in three years. These members comprise over 21 percent of Henry County's population. The HCHC is one of the county's biggest employers. With the increase in Medicaid patients and reductions in reimbursements under managed care, the hospital has suffered increasingly larger shortfalls. The hospital also operates ambulance services in the county, but the cost of providing these services far outweighs the reimbursement that the hospital receives from Medicaid. Settlements (shortfalls) to critical access hospitals under the current Medicaid MCO reimbursement formula are much greater than they were under the traditional Medicaid reimbursement model. Many emergency room claims have been denied as non-emergent, and appeals of those claims have been denied. Many claims have also been denied due to prior authorization issues. Henry County Health Center has had a tremendous increase in billing costs and often receives only partial payments. Mr. Muhs said that DHS' decision to stop retroactive Medicaid eligibility payments to providers will have a great impact on hospitals. Other critical access hospitals in Iowa that are providing access and services in rural communities are experiencing similar problems. The critical access hospital system in the state will be broken by these continuing shortfalls.

V. Committee Discussion with Managed Care Organization Representatives

The committee discussed various issues with representatives of the MCOs, including the transition of members' coverage to UnitedHealthcare due to the exit of AmeriHealth from the Iowa Medicaid program. The MCOs were represented by Ms. Cheryl Harding, Market President, AmeriHealth Caritas, Iowa (AmeriHealth); Ms. Cynthia McDonald, Plan President, Amerigroup Iowa (Amerigroup); and Ms. Kim Foltz, Chief Executive Officer, UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare).

Members of the committee expressed concern about the ability of UnitedHealthcare and Amerigroup to assume coverage of Medicaid members who were covered by AmeriHealth, particularly the LTSS population, on such short notice. Members also questioned whether the base rates across rate cells are set appropriately to cover actual Medicaid costs.

Ms. Foltz responded that UnitedHealthcare has a broad provider network in the state and is reaching out to make agreements with providers not already in their network. UnitedHealthcare is open to allowing a reasonable amount of time to pay out-of-network providers at the full Medicaid rate until

contracts with them are in place. Credentialing of new providers can be accomplished pursuant to national credentialing standards within 30 days. UnitedHealthcare's priority is to ensure that members have continuity of care after November 30. They will be flexible and will not cut off services due to the expiration of authorizations for services. UnitedHealthcare will be hiring many new employees to meet the workload requirements of the newly reassigned members. They hope to hire some of the case managers and other employees who will be terminated by AmeriHealth in order to maintain continuity for the reassigned members.

Ms. McDonald responded that Amerigroup also has a robust provider network, which was a requirement of being selected as an MCO for Iowa's Medicaid program. Amerigroup welcomes the addition of providers not currently under contract to minimize any gaps in its provider network. It will take reasonableness and common sense to make the transition work. Amerigroup can also perform expedited credentialing, subject to accreditation requirements. Amerigroup will take care of members who select Amerigroup, including annual evaluations of members who require LTSS. Since members are initially being automatically reassigned to UnitedHealthcare, Amerigroup is not sure what or how many new members to expect. Amerigroup is currently running models to see how they might meet these new demands. It may be necessary to hire temporary case managers. Amerigroup continues to be concerned about their payment rates. It is not yet clear what the true cost of Medicaid is in this state and what funding will make the program sustainable. Amerigroup signed a new contract for 2018 as a leap of faith.

Members of the committee said that they continue to receive complaints that providers are not being paid and members are not receiving services. Ms. Foltz said that UnitedHealthcare pursues perfection every day in paying for and providing services. Every issue is taken seriously. The MCOs follow explicit Medicaid policies. They have a great interest in continuing to manage the LTSS population rather than carving them out as some have suggested. UnitedHealthcare decided to continue its participation as an MCO in Iowa because they have been in Iowa for 30 years. Even though their continued participation is a significant risk, they are confident that the program can be sustainable. UnitedHealthcare has provided coverage for the hawk-i program in Iowa for many years and assumed that population under Medicaid managed care. They believe there is a pathway to reasonable profitability. After much discussion, UnitedHealthcare decided to stay in the state, viewing the risk as a long-term opportunity.

Ms. McDonald said that Amerigroup is working diligently to implement the program and pay providers. Amerigroup manages care in 20 other states with a particular interest in managing the LTSS population. They are interested in addressing the whole person and addressing social determinants of health through wraparound services, and their work in Iowa is of interest to the rest of the country. Amerigroup has met with representatives of HCHC. If Amerigroup knows there is an issue, they will be dogged about resolving it. Amerigroup feels that it has done a lot of heavy lifting in the last year and is proud of its staff of 400 Iowans. They will continue to improve program quality. Iowa is a strong leader in Medicaid.

Members of the committee asked how AmeriHealth will assist in the transition plan as it exits the Medicaid program. Ms. Harding said that AmeriHealth has been processing at least three million claims each month and the percentage of claims with issues is very small. AmeriHealth will continue processing claims in the state until November 2018, and will have staff in the state until that time to resolve disputes. She is not aware of any specific problems with HCHC, but explained that decisions regarding payment for emergency room visits are based on prescribed calculations, pursuant to a list of emergent and non-emergent conditions prepared by the United States Department of Health and Human Services, and are not a judgment call.

Ms. Harding said that AmeriHealth understands that the transition requires a free flow of information and they will be providing that information to the remaining MCOs and to DHS. They will participate in an exit interview with DHS to review their successes and mistakes. AmeriHealth has a very cooperative relationship with DHS and since the majority of their staff in the state will soon be without work, they will work with UnitedHealthcare to facilitate the rehire of as many of those employees as possible. AmeriHealth's primary focuses are to ensure that members and former employees have a smooth transition and that 100 percent of members' records are available to DHS and UnitedHealthcare, including case notes.

Members of the committee questioned whether the Medicaid managed care program is sustainable with AmeriHealth leaving, especially since AmeriHealth covered 80 percent of members with LTSS, or whether those members should be carved out of the managed care program altogether. Ms. Harding said that while other states are implementing this type of carve-out, AmeriHealth continues to believe in Medicaid managed care and that it can be successful even with inclusion of the LTSS population, in the right situation. AmeriHealth recognizes that the LTSS population is more vulnerable and uses more services, but other members in Medicaid are also vulnerable and have higher needs than are found in the commercial health insurance population. Ms. McDonald said that Amerigroup cannot currently predict what the sustainability of the program will be next year. Amerigroup sustained a loss for this fiscal year and will calculate rates for next year from actual data compiled in 2017. Ms. Foltz said that UnitedHealthcare is currently taking a break from contract negotiations and will look ahead to 2019 after they have had an opportunity to understand the data that has been compiled. Sustainability is critical to the health of the program. Members of the committee thanked the representatives for the work of their organizations in the state during the past two years.

VI. Public Comment

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

Ms. Kay Marcel spoke to the committee and also submitted written testimony. Ms. Marcel has a 39-year-old son with a life-long disability who lives in Urbandale. Her son was covered by AmeriHealth and has been doing well with support services arranged by AmeriHealth. She is concerned about AmeriHealth's exit and who will provide services to her son going forward. Without proper case management to link him to the services he needs, he may require institutional care. Ms. Marcel recommended that the state identify a transition plan to support LTSS members that allows those members to maintain their current case managers to ensure continuity of care; urged the MCOs to prioritize connecting individuals with annual care plans that are up for review to ensure there is no loss of service; and recommended the state carve out the LTSS population from managed care and resume oversight and management of their Medicaid services.

Dr. Amy Shriver, a pediatrician, spoke on behalf of the Iowa chapter of the American Academy of Pediatrics. She said that in Iowa, 120,000 children comprise 51 percent of the Medicaid membership, so many children will be impacted by the departure of AmeriHealth. She expressed concern that there will be disruption in medication coverage and services for these children; other support services such as speech therapy, physical therapy, and occupational therapy may not be honored by the MCOs to whom the children are reassigned; and that prior authorizations and appeals in process may not be honored. Dr. Shriver said that she was speaking as the voice of concerned pediatricians across the state. They need workable solutions to care for their patients who are Medicaid members.

Mr. Geoffrey Lauer, Executive Director, Brain Injury Alliance of Iowa (BIA-Iowa), said that of the almost 570,000 Medicaid members covered by the MCOs, over 37,000 or 7 percent of those members require LTSS. Members who require LTSS account for 43 percent of Medicaid expenditures. This is consistent across the United States because this population cannot live without supports. The two main issues are the level of care assessments and case management. BIA-Iowa believes that it is necessary to use a separate assessment for individuals with brain injuries, possibly the Mayo-Portland Adaptability Inventory, but the MCOs have rejected this idea. The expansion of Medicaid in 2014 along with efforts to keep expenses down has inordinately impacted LTSS members.

Ms. Mary Schmidt said that she spoke to the committee last spring about her adult son who is a quadriplegic and was planning to move into an independent living situation. Since that time he has moved out and has gotten a job. She voiced concerns with the Consumer Choices Option Program dwindling, with the large number of new case managers whom her son does not know, and with the low reimbursement for workers at under $9.00 per hour, making it impossible to retain them.

Ms. Raima McCoy read a statement from her neighbor Ms. Connie Carney expressing concern about for-profit companies running Iowa's Medicaid program. Such companies put profits first and transparency suffers. Privatization has given taxpayer dollars to for-profit MCOs without the agreement of the General Assembly. When Ms. Carney came to Iowa, she was pleased and satisfied with the Medicaid structure and touched by how Iowa cared for its Medicaid members. She feels that the program has been degraded and eroded by privatization and this is not the Iowa way.

VII. Materials Filed with the Legislative Services Agency

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

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