# MINUTES
# Health Policy Oversight Committee

## Monday, December 18, 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 second 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 Co-chairperson Mark Costello. Representative Joel Fry acted 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 10:00 a.m. on Monday, December 18, 2017, in Room 116 of the State Capitol, Des Moines, Iowa. The minutes of the HPOC meeting of November 8, 2017, were approved as distributed. The meeting was adjourned at 3:06 p.m.

## II. Medicaid Managed Care Update — Transition and Other Issues for the 2018 Legislative Session — Department of Human Services (DHS)

**Introduction.** Mr. Jerry Foxhoven, Director, DHS, introduced the new Medicaid Director, Mr. Michael Randol, to the committee. He noted that Mr. Randol is an accountant and also has an MBA. He said that Mr. Randol was the director of the Medicaid program in Kansas for the past five years, is very experienced, and has hit the ground running in his new position in Iowa.

Mr. Randol said that 47 states now utilize managed care for their Medicaid programs. His focus is on ensuring that the Iowa Medicaid program is sustainable so members continue to have access to and receive high-quality services in the future. He believes that managed care is the means by which to achieve sustainability, subject to adequate oversight. Mr. Randol said that he plans to meet with stakeholders to learn about their concerns, and suggested that there are ways to utilize technology, such as telemedicine, and other opportunities to ensure sustainability. Given his education and expertise, Mr. Randol relies on data to make decisions. DHS is also reviewing the services being provided through the Medicaid program to determine if they are appropriate from an efficiency standpoint, and to make any changes necessary to realize expected outcomes. In moving to managed care, the state not only wants to achieve sustainability and quality outcomes, but to establish efficiencies over time in the delivery of those services.

**Transition.** Mr. Foxhoven, Mr. Randol, and Ms. Mikki Stier, Deputy Director, DHS, provided an update on the Medicaid managed care organization (MCO) transition following the exit of AmeriHealth Caritas Iowa (AmeriHealth) from the Iowa Medicaid program effective December 1, 2017. Mr. Randol reviewed the progression of the transition to date, including seeking and receiving approval from the Centers for Medicare and Medicaid Services United States Department of Health and Human Services (CMS) to temporarily suspend choice for members until such time as Amerigroup, Iowa, Inc. (Amerigroup) has sufficient capacity to enroll new members. Ms. Stier said that DHS is monitoring data concerning Amerigroup's network adequacy.

In response to questions from committee members about the transition, Mr. Randol explained that all members who were receiving services through AmeriHealth, with the exception of approximately 10,000 members who chose Amerigroup in November and have been reassigned to fee-for-service Medicaid, have been temporarily assigned to UnitedHealthcare Plan of the River Valley, Inc. (United) until such time as Amerigroup has increased its capacity to enroll new members, including by ramping up their call center and provider network. DHS is concerned about members' access to long-term services and supports (LTSS) and hospitals in rural areas.

Mr. Randol said that he anticipates that CMS will issue Iowa a corrective action plan concerning the temporary suspension of choice in the program and that by spring 2018, those Medicaid members electing to do so, will be able to transition to Amerigroup, thus reestablishing compliance with the requirement that members have a choice when selecting an MCO. Ms. Stier clarified that DHS

requested a suspension from CMS of the member choice of MCO requirement under the Medicaid program and CMS will establish a compliance plan to move the state back toward compliance. The two factors that must be met to achieve compliance are that Amerigroup has an adequate provider network and that DHS has issued a Request for Proposals (RFP) to select an additional MCO. DHS is developing an RFP process to select a third MCO to be available beginning July 1, 2019. Ms. Stier added that DHS is in weekly contact with AmeriHealth and that AmeriHealth will continue to have a presence in the state until November 30, 2018, to ensure that providers are paid pursuant to their contracts with AmeriHealth and to manage a member services call center. DHS has been in regular communication with all three MCOs to address transition questions and to ensure continuity of care for all members. DHS is reviewing the remaining MCOs' provider networks to ensure provider network adequacy.

Committee members said they have received complaints that integrated health home (IHHs) services are not being covered by United. Ms. Stier responded that IHHs were initially established pursuant to the state's previous contract with Magellan. Some of the IHHs are out of compliance with the current state plan standards and need to be aligned with those standards. DHS is reviewing all programs and services to determine where they can increase efficiencies and eliminate duplication of services. Mr. Randol said that DHS is reviewing data, including mapping out where Accountable Care Organizations (ACOs) and IHHs are located, and working closely with the MCOs to ensure that members have access but are not receiving duplicate services. Ms. Stier explained that there is duplication in services between the care coordination provided by the MCOs and the IHHs, and DHS is working on aligning these services. ACOs are also involved in moving IHHs for persons with mental illness and chronic condition health homes into their delivery models, and this can potentially lead to duplication of services in wrapping services around members. Contract amendment number three requires that the very principles of health homes have to be accounted for and maintained to ensure member stability in that program and in those services. How the MCOs design the model or modify the model has to be worked through with the state so the MCOs meet the state plan requirements. DHS has asked United to show DHS how they are doing this. United has a blended role with their care coordination in IHHs. Currently with IHHs for persons with mental illness, chronic condition health homes, ACOs, and MCOs all providing case management, there is potential for a member to have duplication in care coordination. As an MCO begins to look at level of care and service plans for members, they may determine that a member has duplication in care coordination. The state has a full-time staff person looking at the IHHs to determine what the requirements are, if the state is in compliance, and how best to comply without duplicating services. When presented with concerns from providers about changes to the IHHs, DHS immediately asked United to delay the changes, propose a stronger communication plan, evaluate its strategy, and determine whether the changes comply with the contract amendment. As long as an MCO meets state plan requirements, the MCO does have flexibility in providing required services. Mr. Foxhoven and Ms. Stier said they have told United to improve communications with providers and members going forward.

Committee members questioned the impact on providers and members resulting from the state's movement to a tiered-rate reimbursement system based on an individual's needs as determined through the support intensity scale (SIS) for supported community living, day habilitation, and adult day services. Committee members commented that some providers may not have realized the importance of the SIS score in the past and do not know how to obtain a new SIS score for a member. Mr. Randol said DHS began implementation of tiered-rate reimbursements December 1, 2017, and is implementing the system over a three-year period to allow providers to adjust to the new system. There is a process in place if a provider or member believes that the member needs an SIS assessment or reassessment because the member's needs have changed or the original SIS score does not adequately reflect the member's needs. Ms. Stier added that SIS scores are reevaluated automatically every two years, and

DHS is encouraging care coordinators, care teams, family members, and others to actively participate when the SIS score is being developed to ensure the score adequately reflects the member's needs. A care coordinator may assist with requesting a reevaluation if a member or provider feels the score no longer adequately reflects the member's needs or condition. In response to a question as to whether a request for a reevaluation of an SIS score, required an actual change in needs or a determination that the score did not adequately reflect the member's needs, Director Randol stated that they would review this issue with the MCOs. Director Foxhoven added that DHS is being more flexible with the SIS scores now, and they want to correct the SIS scores that might not have been adequately determined. The SIS scores were always important in determining what services would be provided, but now they are also important in determining the reimbursement for those services. However, he noted that once providers and members understand that the SIS score is important, going forward, DHS will not allow people to play games with the SIS evaluation and only if a person's needs change, will DHS change the SIS score. DHS is working with the Attorney General to establish an appeals process for SIS evaluations so members can work with their care coordinators to request a reevaluation.

Mr. Randol clarified that the legislation authorizing movement to a tiered-rate system did not provide for a phased-in approach, but DHS instituted this approach because the new methodology results in differing impacts on providers. The new tiered-rate system is budget neutral to the state, so under the new system, one-third of the providers will receive increased reimbursements, one-third will receive the same reimbursements, and one-third will receive lower reimbursements.

Mr. Randol added that he would look to data to drive decision-making and that in moving forward in Medicaid managed care, the state not only wants to see sustainability and quality outcomes, but also certain trends in the delivery of those services. Examples include trends relating to utilization of certain services such as a reduction in ED visits and inpatient hospitalizations, a significant increase in primary care physician utilization for preventive and wellness services, and increases in transportation utilization. DHS will look at efficiencies that develop in the program over time, analyze what services are not providing the quality outcomes expected, and then provide different services, add different service and reimbursement codes, and increase rates to attain the outcomes they are looking for. He said that first and foremost, while in Kansas he communicated with stakeholders to understand exactly what their concerns are. It is important to have a dialogue even if everyone is not in agreement. Mr. Randol noted that in Kansas, movement of members needing LTSS into Kancare, that state's managed care plan, was delayed for one year to allow communication with members and providers before implementation.

In response to an inquiry by a committee member regarding whether MCOs are providing bonuses to case managers and care coordinators to reduce services, Ms. Stier responded that she was not aware of this and that DHS does monitor the MCOs to make sure that they are not incentivizing the reduction of services provided to members. Any change in level of care is required to be reviewed and authorized by the state.

In response to committee members' concerns about the severe delay in payment to providers and the severe denial of service to members, the impact delayed payments have on providers that are small businesses, and the expectation DHS has for providers to be paid in a timely manner, Mr. Randol responded that the contract an MCO has with a provider contains specific metrics concerning claims payment and the state does not dictate the payment cycle. DHS expects providers to receive appropriate payments in a timely manner. It is not acceptable for providers to be paid incorrectly or late. Mr. Foxhoven added that there are still old claims that have not been addressed but thought that current claims are being paid more quickly. In response to an inquiry regarding whether those members temporarily receiving services based on the fee-for-service methodology might be able to remain on fee-for-service permanently, Ms. Stier said that DHS does have the capacity to deal with the 10,000

members temporarily since the situation is short-term and will likely end in the spring. Mr. Foxhoven added that DHS does not currently have the infrastructure to continue the temporary arrangement on a permanent basis, had not considered what resources DHS would need if the 10,000 members remained on fee-for-service permanently, but said DHS could provide that information to the committee.

## III. Managed Care Ombudsman Program

Ms. Cynthia Pederson, State Long-Term Care Ombudsman, noted that she is new to the position and reviewed recent reports published by the Managed Care Ombudsman Program (MCOP) as well as issues the program has noted with Medicaid managed care. She said that the purpose of the MCOP is to advocate for the rights and concerns of Medicaid members receiving home and community-based services (HCBS) waiver services or receiving facility services. The goal of the program is to provide information about Medicaid managed care options and members' rights, serve as a resource for answers regarding managed care rules, and advocate for managed care members by investigating and attempting to resolve complaints made by, or on behalf of, members.

As the State Long-Term Care Ombudsman, Ms. Pederson is statutorily required to submit an annual executive summary of the MCOP's work to DHS for inclusion in the DHS Medicaid managed care annual report. The most recent executive summary provides information on the 4,187 contacts received by the managed care ombudsman between October 1, 2016, and September 29, 2017. The report details the number of contacts per month as well as the top three concerns raised by those contacting the managed care ombudsmen.

Ms. Pederson said that the most recent executive summary also reported two trends to watch: the impact of payments being made to Consumer-Directed Attendant Care (CDAC) providers on access to services, and an increase in the number of contacts regarding grievance, appeal, and state fair hearing processes. Ms. Pederson noted that while members have the right to legal representation during these processes, they often do not have the resources to secure it. If a contact requires legal services, the managed care ombudsman does refer members to both Legal Aid and Disability Rights Iowa. She explained that as an advocate, the managed care ombudsman can only take the action that a member will allow. Going forward, the MCOP will be adjusting the way that contacts are recorded in a manner that is more consistent with the overall Long-Term Care Ombudsman (LTCO) Program so that they might be better able to resolve issues for members and collect outcomes data. Ms. Pederson also noted that there was a reduction in their staff with the elimination of their program manager, that the current staff of two managed care ombudsmen is having some success, but that they do have general concerns about the future budget for their program.

Ms. Pederson also reviewed the Managed Care Ombudsman Program Quarterly Report covering July through September 2017. This report provides a high-level overview of the data aggregated over the prior three months and includes examples of issues resolved by the managed care ombudsman, the number of contacts for the quarter, the top three issues about which the program was contacted, to which MCO the contacts related how many contacts related to each MCO, and the average resolution time. The quarterly report also tracks trends for the quarter and community partnership and outreach efforts.

The MCOP also provides monthly reports to DHS regarding contacts received for that month including the number of contacts received in the categories of access to services/benefits; billing; care planning; customer service; eligibility; enrollment; guardianship; and other issues. The program is transitioning into tracking contacts based on the reason for the contact. Contacts are also tracked in the individual categories of grievances, appeals, and fair hearings, and which MCO the contact concerns. Beginning

with the monthly report for December 2017, the report will also include the number of fee-for-service contacts the managed care ombudsman receives. The monthly report also includes the program discussed during the contact, the average resolution time, any referrals to another entity, the service provided to the contact, and the services provided to stakeholders. All of the reports are available on the managed care ombudsman Internet site.

Ms. Pederson highlighted details from her review of the reports. She noted that of the 4,187 contacts during the year covered by the annual executive summary, over 1,819 related to services being reduced, denied, or terminated; 455 related to lack of participation in care planning; 933 related to the elderly waiver; and 883 related to the Intellectual Disabilities waiver. The number of contacts relating to a specific managed care organization was 2,332 for AmeriHealth; 864 for United; and 737 for Amerigroup.

Ms. Pederson said she has not noticed an overall increase in contacts but the content of the contacts has changed to being transition-related with an increase in contacts concerning transition services/coverage inadequate or inaccessible, increasing from 43 contacts in November 2016 to 59 in November 2017. In addition, there has been an increase in the number of contacts regarding selecting or changing an MCO from 5 in fiscal year 2017 to 58 during the last two months. The MCOP is monitoring these trends.

In response to a question about why there are more contacts related to AmeriHealth, Ms. Pederson said data-gathering by her office has been limited and it is difficult to know if some contacts are duplicates. The managed care population is over 560,000 members and with less than 5,000 contacts it is difficult to comment on trends but there has been an upswing in contacts concerning the reduction, delay, and termination of services. Their system does not track successful resolution of contacts. The long-term care ombudsman uses a separate reporting system from the MCOP and makes a separate report, so some additional contacts may be reflected in the long-term care ombudsman report, as well.

In response to a question about how members find out about the services the MCOP offers, Ms. Pederson said that when the program was initially implemented, her office did mailings to the population they serve. They also have an Internet site, have ombudsmen personnel out in the field, and are planning a marketing effort in conjunction with the long-term care ombudsman program next year.

## IV. Committee Discussion with Managed Care Organization Representatives

The committee discussed various issues with the representatives of the MCOs: Ms. Kim Foltz, Chief Executive Officer, United and Ms. Cynthia McDonald, Plan President, Amerigroup.

Ms. Foltz said United is very proud of its work during the transition in the short span of 19 days. They have hired 400 new employees, reached out to over 25,000 individuals to help them through the transition, collaborated with their state partners to make sure that members are transitioned effectively, transitioned over 200,000 members, engaged over 5,000 LTSS members even before United assumed management of those members on December 1, 2017, and have identified few issues to date. Ms. McDonald said that she was happy to answer questions the committee had about the transition and that after analyzing the reality of Amerigroup's capacity to take on additional members on December 1, Amerigroup declined to take on additional members.

Members of the committee expressed concern about the status of the IHHs under United's management and the effect of the changes to or elimination of the IHHs on providers of those services. Ms. Foltz responded that there should not be any impact on members' clinical services such as peer support and therapy services provided by the IHHs, and characterized the care coordination services provided by IHHs as an administrative function, not a clinical service, already encompassed in the case management

provided by United either through an ACO or through internal resources. She stated that under the state plan, care coordination is an administrative service and is incorporated into the administrative load of the capitation fee. United enrolls members with chronic mental illness and those who are receiving habilitation waiver services in the IHHs because they are currently carved out of the ACOs as part of the agreement with the state. During the first 20 months of Medicaid managed care, United has found, through data mining, that members are not having their needs met by the IHHs, and Untied is not attaining the outcomes expected from IHHs, such as reduced emergency department visits and inpatient admissions. However, United does now understand that they approach IHHs differently than AmeriHealth did. United received final files from AmeriHealth on December 1, and issued a standard notification about changes involving the IHHs on December 7. Once providers began contacting them with issues, United agreed to take a short pause during December in making changes that affect case management and care coordination. There is no benefit to United from members not receiving services, and they are addressing differences in how they will manage the IHHs. In hindsight, she conceded, United could have used a process other than the standard notification process in alerting providers and members about changes to the IHHs.

Members of the committee questioned when the Medicaid program will achieve a value-based structure since some services like the IHHs are still being paid for on a fee-for-service basis and asked about the geographic locations of ACOs in Iowa. Ms. Foltz responded that the MCOs are moving toward a value-based system through the use of ACOs, which are value-based agreements that include shared savings with providers. Ms. McDonald echoed that they are all moving down the path to a value-based system and trying to figure out how IHHs fit into that system. Ms. Foltz said that United has mapped out seven ACOs that are the large health systems covering a large swath of the state and is conducting value-based contracting with those entities. Ms. Foltz noted that there is a 100 percent overlap between the care coordination provided by chronic condition health homes and the ACOs. Where there is overlap of ACOs with chronic condition health homes, United has transitioned the member to the ACO shared savings model that is more favorable to the system and for the provider because they can share in the collective savings. Those individuals who are carved out of the ACO arrangements are in IHHs or are provided care coordination through United's internal resources. If a member is being provided with a targeted case manager and a community-based IHH case manager, they are being provided the same service by two different entities. Ms. McDonald added that Amerigroup is newer to the IHH model and is only in the development stage trying to determine how to engage community providers in the system to move toward value-based reimbursement. Ms. Foltz said United will pay December claims for IHHs and is willing to continue to pay such claims through January 31, 2018, but federal and state guidelines need to be met in the future to avoid program duplication. United is working on a notification to be approved by DHS regarding changes that will be made to the IHHs to avoid such future duplication. Ms. Foltz reiterated that no clinical services to members are being affected, that IHH services are not being eliminated, that IHHs are just an administrative function, and that as the MCOs evolve, they will continue to look at ways to be more effective and efficient in moving to a value-based, shared-savings system.

Members of the committee questioned Ms. McDonald on Amerigroup's progress in reaching capacity to transition in new members. Ms. McDonald said Amerigroup is concerned about serving existing members and will not take on additional members until they have the capacity to do so. They do not have a firm date yet, but hope to reach such capacity in spring 2018. Amerigroup is recruiting and hiring staff but it is especially challenging to do so in rural areas and it takes time to hire and train new employees. Amerigroup is still in the planning phase, has held two job fairs, and is working with DHS and CMS to make sure they have sufficient capacity. They do not know how many additional members to expect and want to ensure they have sufficient contracts with providers in place before accepting new members. They are doing an analysis to ascertain where their provider network has gaps. Amerigroup

is still in contract discussions with UnityPoint and is hopeful they will have a value-based contract with UnityPoint in place by December 31, 2017. If not, Amerigroup has a contingency plan.

In response to questions about how SIS scores are determined, Ms. Foltz said that SIS assessments are administered both in-house and through a third-party provider, Teligen, which was previously used by the state Medicaid program. Ms. McDonald responded that Amerigroup uses its own dedicated assessment team that meets national standards to perform SIS assessments.

In response to committee questions about conflicts of interest when the person performing the SIS assessment and the person reviewing that assessment are both employed by the same entity, Ms. Foltz and Ms. McDonald emphasized that assessments and reviews are conducted by separate, distinct teams within their respective companies to avoid conflicts. Ms. Foltz disagreed that reductions in services have been arbitrary and posited that Iowa has some of the strongest oversight of its MCOs of any state in the country. Ms. Foltz explained that any reduction in the level of care must be approved by the state. Some members are perceiving that there has been a reduction in services, when instead the state has been realigning services to be paid through the appropriate Medicaid hierarchy of payment.

In response to a specific question concerning rumors that case managers for the MCOs are being paid bonuses for what is called “increasing independence” for members but is really a reduction in services, Ms. Foltz and Ms. McDonald both emphatically denied that this is happening and said that they found such allegations very concerning.

Ms. McDonald also responded to a question about rumors that Amerigroup is planning to terminate its contract with the state. She said that Amerigroup is sometimes confused with AmeriHealth, that such rumors are concerning to Amerigroup’s employees, and that these rumors are not true.

A member of the committee expressed concern that the representatives of the MCOs have referred to problems occurring during the transition as “bumps” when in fact those “bumps” are members who are not receiving promised services and providers who are not getting paid. The member noted that the number-one issue highlighted in the managed care ombudsman’s report is services being reduced, denied, or terminated. Ms. Foltz said that it is inaccurate to state across-the-board that United is not delivering services. United is delivering the services that members need, but members may feel aggrieved at not receiving services they think they need. Those perceptions and feelings are important and need to be acknowledged.

Members of the committee asked why they are still receiving complaints that providers have not been paid and asked who can see the data reported by the MCOs to the state because the number two concern in the MCOP report is lack of information sharing and access to information. Ms. Foltz responded that Iowa has robust reporting requirements and information provided by the MCOs to the state bears out their delivery of services. The MCOs cannot release information directly to legislators and others due to privacy concerns.

In response to committee questions about what constitutes a sustainable program in Iowa, both MCO representatives indicated that sustainability means that the state understands the services it wants delivered to members over the long term and ensures those services are appropriately funded. The program must have appropriate funding to align with the expectations of the delivery model. They acknowledged that neither MCO can operate at a loss in Iowa in perpetuity. A member of the committee opined that a concern is that down the road the MCOs will come before the general assembly and say the only way that managed care can continue is if a significant increase in funding is provided.

A committee member asked what the data demonstrate concerning the incidence of ED visits. Ms. Foltz responded that their data suggests that in some cases there were not reductions in ED visits which is

not the same as an increase in such visits. With regard to the effect of IHHs on reductions in ED visits, the MCO representatives responded that out of 37 IHH programs, some show better outcomes than others.

In response to a question about how United will utilize the 3.3 percent increase in payments under its new contract with the state, Ms. Foltz said that the increase is not an across-the-board adjustment but was risk-adjusted based on the population that each MCO serves. The increase covers expenses that are already being incurred in the program by the MCOs.

In response to a question regarding having an appeals process for SIS reevaluations, the MCO representatives noted that it is the state's program, so it is up to the state to make this determination and to provide the resources necessary for the process.

In response to a question regarding the results of the External Quality Review report recently completed, Ms. McDonald responded that it was important to note that the review was for the first six months of the program and is a first-level review. She said that it is uncommon to have such a review so early in a program, but that from a programmatic level, the results of the review were very positive.

## V. 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 Internet site.

Ms. Shelly Chandler, CEO, Iowa Association of Community Providers (IACP), said that the organization supports 30,000 community providers that, in turn, support over 140,000 Medicaid members receiving behavioral health and disability-related services throughout the state. IACP is unique in that the vast majority of their funding comes from the Medicaid program and they do not receive third-party or private pay reimbursement. Ms. Chandler limited her comments to covering just the previous month, stating that since December 1, 2017, a Friday, four major systems changes occurred that affected IACP providers and the consumers they serve. The first change was the exit of AmeriHealth as an MCO in the state. Approximately 80 percent of IACP providers and clients were contracted with AmeriHealth, so this is a massive transition for them. Second, providers were not informed about a change with the IHHs until December 7, 2017. Third, reimbursement is being changed to a tiered-rate system for the persons with intellectual disabilities (ID) waiver population. And fourth, transportation costs were incorporated into the new tiered rates. With regard to the IHHs, she noted that United has decided to delay changes, but IACP is concerned. IHHs were developed in 2013 to address the fact that people with mental illness die 25 years sooner than the general population because the traditional medical model, including the big health systems and their ACOs, were not properly treating this population. IHHs provide wraparound services, 24/7 care coordination, clinical peer support, and other services. Regarding the way the Medicaid state plan amendment and rate methodology were developed, about 25 percent of those receiving IHH services are receiving waiver services such as the children's mental health waiver, habilitation, or behavioral health intervention services (BHIS), and the remaining 75 percent receiving IHH services are not receiving these waiver services. So, if United takes away the 75 percent of the population served by IHHs that have lower-intensity needs, the IHHs that remain in place with the 25 percent of the higher-intensity needs population will not be sustainable to continue to support the services. Ms. Chandler noted that this is a very vulnerable population and December is a very difficult time for people with mental illness when ED visits and suicide attempts increase. She said IACP wants to be a partner with the MCOs and the state, but having had no notice is not the way to go about a large system change. With regard to the tiered rates and the SIS, Ms. Chandler stated that providers are not receiving the SIS reports nor the scores in many cases, so it is difficult to determine the level of service to be provided

and the providers are not sure how to bill for services. Ms. Chandler stated that she would submit the remainder of her comments in writing due to the five minute limitation on public comment.

Ms. Deb McMahon told the committee that she spoke two years ago against the state privatization of Medicaid. She speaks on behalf of her daughter Annie and her son-in-law Tim. Annie initially chose AmeriHealth, until they terminated their contract. Then she signed up for Amerigroup, but two days later, received a letter assigning her to United. Now she has been transferred to fee-for-service Medicaid. This will probably change again in a few months. She said that change is hard, especially for persons with disabilities. There are many vulnerable people affected by privatization and privatization puts profits over people. She said these vulnerable populations deserve decent health care which is a right, not a privilege. Ms. McMahon said that the government needs to stop pretending that privatized Medicaid works when in 2016 Iowa ranked last in the country for psychiatric beds, has many substandard nursing homes, and has cut ombudsman staff. She said that the poor, many of them children, are depending on the state to do the right thing. She implored the state to step up in 2018 to remedy the situation.

Ms. Flora Schmidt, Executive Director, Iowa Behavioral Health Association, told the committee that her organization represents addiction and substance use disorder providers, community mental health centers, and a variety of prevention and treatment programs across the state. She said that several providers who are members of the association are present at the meeting, including Ms. Chris Riche, who is with Crossroads Behavioral Health in the Creston area. Ms. Riche said that her agency serves low-intensity clients that are either not ready for 24-hour services or are working their way to independence. It is a very fluid population. IHHs provide services for these individuals that other agencies do not. Many of these individuals have exhausted community supports and have nowhere else to go. IHHs take the time to do things no one else will do, such as filling out applications for federal Social Security disability benefits, going with members to the housing and urban development offices to fill out paperwork, helping with transportation, and many other services. Their focus is to improve outcomes by building relationships with their clients and this cannot be done if membership changes each month. Ms. Riche said that her agency has contracts with all of the MCOs and has fee-for-service clients. Ms. Schmidt added that the ACOs are not equipped to take on this population at this time.

Ms. Dusty Marky told the committee that she is a certified peer support/recovery specialist for an IHH. The IHH model strives to address full-body health, holistically, with an emphasis on mental health. She serves two types of clients: those who receive habilitation services and those who do not. Clients who do not receive habilitation services do not receive them for a variety of reasons, including that they are not eligible, lack self-directing skills such as self-control and follow-through or make poor life choices, or they have made a choice not to participate in habilitation services because, in the end, it is their choice to do so. When she initially became a peer support specialist, she was certified and available to provide services to both of these populations. Just over a year ago, this changed, and the services she had been providing to those with habilitation plans were no longer billable unless she had a bachelor's degree. Since then, she has worked mainly with nonhabilitation members, but just because these clients do not receive habilitation services does not mean that their needs are any less important or intense as those who do receive habilitation services. She said she was advocating for those not receiving habilitation services to ensure there was not a reduction in services for them. The services provided to both those who receive and do not receive habilitation services are very similar such as mentoring; preventing loss in benefits by helping with paperwork; assisting with communicating with mental and physical health providers; coordinating as well as facilitating access to community resources such as food banks, agencies that assist with financial assistance, standing with them in court, attending important meetings, paying for housing for hard-to-place clients, and providing support groups as well as a shoulder to cry on when the days are just too hard. She also highlighted that even if these clients

were eligible or chose to participate in habilitation, they could be on a waiting list for as long as nine months because many agencies have closed due to lack of payment by the MCOs. In the meantime, while clients are waiting, it is IHH staff who provide these services without reimbursement in addition to normal job duties. What United is proposing in taking all of the non-intensive clients away from an IHH will strip vital services from thousands of clients in need of IHH services. United is attempting to take the choice of selecting a private provider directly out of the hands of the client and putting it directly in their own. Since the MCOs took over, what is or is not cost-effective in the eyes of the MCO has taken priority, not the person and the services they need. When the payer of the services is also the provider of the services, there is a serious conflict of interest and the clients will ultimately suffer. It is probable that there will be an increase in ED visits, urgent care visits, and hospitalizations for nonhabilitation clients. Each client deserves and is entitled to choose who they receive their services from. She has seen many clients using the IHH make great progress, and even as an employee she has grown immensely by working with and learning from the people she has engaged with. She asked that they be allowed to continue to provide this service.

Ms. Lori Bush spoke to the committee about her experiences as the director of the IHH at Plains Health Center in northwest Iowa which serves nearly 1,300 members in a 10-county area. Ms. Bush expressed concern that the MCOs are limiting the choice of IHH services for approximately 300 members of the IHH they serve. The mandate in Iowa was to provide member choice and person-centered care and with the recent changes, the IHH population is not receiving either. She disagreed with the assessment of the MCOs that an IHH provides only administrative functions and not services. She said that an IHH is a mobile, boots-on-the-ground team of professionals that works with members in their homes, communities, and environment and meets the members wherever needed. The team helps to identify needs prior to the escalation of issues that result in higher costs. The mobile part of the program is what has led to success because by providing services in a client's environment, they see needs such as housing, nutrition, social isolation, transportation, and mental health symptom exacerbation, and then refer members to resources that prevent the need for higher levels of care. Under Magellan, IHHs demonstrated tremendous outcomes with a 16 percent reduction in ED visits and an 18 percent reduction is inpatient mental health hospitalizations. With the MCOs, the good outcomes have continued. The initial report cards from AmeriHealth and Amerigroup indicate that IHH at Plains Health Center has met all Health Care Effectiveness Data and Information Set (HCEDIS) standards. Ms. Bush shared stories and data showing that ED visits have declined each year for members enrolled in the IHH. She is concerned about the lack of choice for members and the lack of communication that has characterized the transition so far.

Ms. Shauna Freitag, Executive Director, Young House Family Services (YHFS), told the committee that her agency is a small social services organization in southeast Iowa, serving approximately 4,000 children and their families each year. They also have a pediatric IHH program. Ms. Freitag said that on December 7, her organization received a telephone call from United in which the caller read a statement over the phone informing them that over 100 of the children they serve who were covered by AmeriHealth would no longer be receiving IHH services through their organization effective December 1, but would instead receive services through an ACO. She said that her organization was never told that they were not providing proper services or were in any way not in compliance with standards. Ms. Freitag said that her organization was given no explanation of how they would be paid for services already rendered, the future of their IHH program, and more importantly, how children and families would be notified of these changes. As of December 15, 2017, YHFS had not received anything in writing from United or from the state regarding changes to the IHH program. Ms. Freitag asked the committee to reconsider the decision to stop IHH services and to provide proper notice, in writing, to each IHH of any changes.

## VI. Committee Discussion

The committee discussed recommendations and next steps and determined that the members would review the comments made and develop recommendations to be submitted to the Legislative Council and the General Assembly.

Various committee members suggested that the recommendations might include consideration of the following: what the Governor's expectations were in privatizing Medicaid to achieve the goal of making the program sustainable; what the committee's expectations are for the MCOs and for DHS in implementing those expectations; using standard business practices such as proper notification and timely payments when dealing with providers; what threshold of need the state is capable of meeting through the Medicaid program; putting the members' needs first; ensuring that members get the services promised and that providers are paid promptly and accurately; how to redesign parts of the program to be more customized to Iowa, perhaps using a hybrid of fee-for-service and managed care models, including providers in the discussion; affirming that Medicaid is designed to care for the poorest and most vulnerable Iowans; delaying changes to IHHs to see how they can be integrated into the Medicaid design; providing affordable health insurance to persons not otherwise eligible for Medicaid, perhaps through a Medicaid buy-in program; requiring that the MCOs notify members and providers, in writing, at least 30 days in advance of any changes to the IHHs or any other service; and evaluation of the SIS process including who performs the evaluations and delineating an appeals process.

## 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/committee?ga=87&groupID=24165

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