MINUTES
Health Policy Oversight Committee

Friday, November 30, 2018

MEMBERS PRESENT

Senator Mark Costello, Co-chairperson
Senator Mark Chelgren
Senator Liz Mathis
Senator Amanda Ragan
Senator Mark Segebart
Representative David E. Heaton, Co-chairperson
Representative John Forbes
Representative Joel Fry
Representative Lisa Heddens
Representative Shannon Lundgren

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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 2018 Legislative Interim was called to order by Co-chairperson David Heaton at 10:02 a.m. on Friday, November 30, 2018, in Room 116 of the State Capitol, Des Moines, Iowa. The meeting was adjourned at 2:53 p.m.

II. Rate Setting 101 — Department of Human Services (DHS)

Overview. Mr. Jerry Foxhoven, Director, and Mr. Michael Randol, Medicaid Director, DHS, discussed the rate-setting process for Medicaid managed care including federal regulation and actuarial requirements, the data sources used, the base validation process, the components of capitation rate development (rate cells), and the monitoring process (medical loss ratio or MLR). Director Randol explained when applying the regulation standards, the Centers for Medicare and Medicaid Services (CMS) utilizes three principles: the capitation rates are reasonable and comply with all applicable laws for Medicaid managed care; the rate development process complies with all applicable statutes and regulations for the Medicaid program including eligibility, benefits, financing, and any applicable waivers; and the documentation is sufficient to demonstrate that the rate development process meets the requirement of federal managed care laws and generally accepted actuarial principles and practices. Additionally, federal law requires the rates to be actuarially sound, meaning that the capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the managed care plan for the time period and the population covered under the terms of the contract. Actuarial soundness is not a budget-driven process, a methodology that has a predetermined outcome, or a process that eliminates all rate variance between managed care organizations (MCOs). Instead, rate setting is a methodology performed by qualified actuaries to better match payment to risk and to minimize unexplained variances between MCOs.

Final Rule. Director Randol discussed various requirements under the new federal Medicaid and CHIP Managed Care Final Rule (Final Rule). As an example, beginning July 1, 2018, rates must be certified as a specific point not as a range. However, feedback is still being received by CMS and state Medicaid directors and the industry have suggested that the specific point requirement reduces state flexibility in potentially negotiating lower rates. Director Randol also discussed the provision effective July 1, 2019, that requires CMS review for an 85 percent MLR floor. Director Randol clarified that the requirements in the Final Rule apply to state rate setting undertaken, prospectively, after the various applicable effective dates in the Final Rule. The Final Rule introduces a new level of federal review and approval similar to CMS review of Medicare bid submissions. This level of review is meant to facilitate more transparency, produce a more rigorous and collaborative process, and is also less ambiguous and more efficient.

Data. Director Randol stated that the actuary, Optumas, and the Iowa Medical Enterprise (IME) use an actuarial control cycle to monitor and evaluate risk within the Medicaid managed care program. The actuary's data sources include multiple years of detailed historical enrollment data, encounter (claims) data, supplemental data extracts if needed, and audited financial statements and financial templates. The department also provides an MRT, which is a very detailed spreadsheet, to the MCOs for completion so that their expenses can be crosschecked.

Components of Capitation Rate Development. The components of capitation rate development include rigorous validation of base data, identification of policy changes and quantification of their impact on rate development, development of projection factors efficiency adjustments, and development of non-medical load (NML).

Base Rate Development. The actuary conducts a rigorous validation process to ensure that only appropriate reimbursement for and utilization of covered services are included in the base data.

Validation includes a durational review as well as comparison of encounter data to financials to ensure consistency over time.

Once the base data is validated, the actuary recommends a base data time period to use as the starting point of the rate development, normally a 12-month period. Next, the actuary reviews changes in the program, including significant policy changes, to determine impacts and includes them within the rate development. The actuary then uses data to develop trends or projection factors efficiency adjustments, to project the base data into the contract period and arrive at projected net medical cost. Finally, the actuary uses financial data from the MCOs to develop appropriate levels of non-medical load (NML) which includes administration as well as care coordination and quality assurance costs.

Monitoring Process (MLR). Director Randol noted that under the Final Rule, states are required to monitor the minimum loss ratio (MLR) on a regular basis. The actuary is expected to consider historical MLRs when developing capitation rates. The intent is that rates are set in a manner that reduces the probability of projection error so the MLR is more predictable. In Iowa, the MLR is contracted at 88 percent. There is a misconception that states must align the MLR requirement with the NML. However, having an 88 percent MLR does not directly correlate with having a 12 percent nonmedical load. The calculation is more complex than dividing traditional medical expenditures by revenue. The numerator of an MCO's MLR for a reporting year is the sum of the MCO's incurred claims, expenditures for activities that improve health care quality, and fraud reduction. The denominator is the adjusted premium revenue which consists of the MCO's premium minus the MCO's federal, state, and local taxes, and licensing and regulatory fees. Additionally, states are not required to implement rebates along with the MLR.

Calendar Year Contract. Director Randol explained that DHS has decided to base the new MCO contracts on a calendar year rather than a fiscal year in hopes of having the new capitation rates in

place before the end of a General Assembly session. Director Foxhoven added that this should avert the need for a supplemental appropriation and provide for more precise budgeting.

Committee Discussion.

MLR. In response to whether additional funds appropriated for FY 2019 are being used to provide additional medical services, Director Randol clarified that currently the MLR of 88 percent is a point that the MCOs cannot go below, but this does not mean that 88 percent of the budgeted appropriation is exactly what the state will expend for medical services. Instead, the 88 percent MLR is a point of reference to be monitored. Director Randol assured the committee that the 88 percent MLR minimum is still in the MCO contracts. Director Randol also explained that a "rate cell" is a cohort and when rates are set they are set based on a cohort of members with common characteristics. He clarified that base rates and capitation rates are separate from the reimbursement rates for providers and that only the General Assembly has the authority to increase or decrease provider rates. Director Randol noted that there have been some legislative changes to provider reimbursements for certain provider types since managed care began. Additionally, an MCO may contract with a provider for a higher reimbursement rate due to provider shortages or for other reasons, but the encounter data will then reflect this and inform the development of future capitation rates.

NML. Director Randol stated that the total non-medical load rates for FY 2019 range from 7.3 to 7.6 percent, including traditional administration which ranges from 5.3 to 5.6 percent and care coordination and quality assurance costs which range from 1.7 to 2.0 percent. A request was made for DHS to provide the NML ratios for FY 2016 and FY 2017.

Actuary Replacement — Milliman vs. Optumas. Various committee members inquired about the replacement of the actuary for Medicaid managed care. Directors Foxhoven and Randol stated that Optumas replaced Milliman in January 2018, initially without a request for proposals (RFP) process, and

then as the result of an RFP process, from October 2018 forward. Director Randol said he is confident in the actuary now that a process is in place to develop rates and the process is not budget driven.

Director Randol noted that he was not Medicaid Director when Milliman was the actuary and in his opinion there was a lack of necessary data provided, conclusions were drawn from inappropriate sources, and incorrect and potentially aggressive assumptions were made by Milliman. Director Foxhoven added that DHS is partly responsible for not having the necessary data available for Milliman to use. Director Randol stated that in the interest of full transparency, he worked with Optumas in Kansas and thought they did a good job there. In response to questions regarding concerns expressed by providers that when capitation rates were initially developed, the data used was not reflective of current provider cost trends, Director Randol stated that in contrast when Optumas set the FY 2019 capitation rates, they used historical data and actual experience so he is confident in the process and the rates developed. Director Foxhoven added that the new contract includes additional requirements to improve payment to providers.

Improved Health Outcomes. In response to a question regarding whether members are actually achieving better health outcomes with the onus being on DHS to demonstrate such improved outcomes since managed care was initiated by the executive branch, Director Randol responded that he believes the state is moving in the right direction. As managed care matures, the state is looking more at quality measures than process measures and, to date, utilization trends are going in the right direction. Emergency department and inpatient rates are decreasing and primary care visits are increasing. Transportation service utilization is also increasing, which is a positive sign.

Withhold, Disputed Payments, Additional Funding. In regard to whether the MCOs have received the 2 percent withhold amounts, Director Randol stated that the MCOs did not initially meet the enhanced performance measures so did not receive the withhold amount, but did meet the performance

benchmarks in the contracts. Director Randol stated that for FY 2017 the MCOs have met the majority of the enhanced performance measures and DHS is still reviewing FY 2018 relative to the withhold payment.

In response to a question regarding Amerihealth Caritas Iowa and the $13 million of provider payments still in dispute, Director Randol said that DHS would provide a status report to the committee.

Director Randol confirmed that any increased funding for tiered rates, home health, and other increases provided for FY 2019 would be included in the capitation rates under the FY 2019 MCO contracts.

In response to a question regarding outstanding payments to providers, Director Randol explained that over the last seven to eight months he has instituted an escalated review process for provider payments. In the majority of the cases reviewed, there were provider challenges including filing claims for individuals who weren't eligible for Medicaid, missing the timely filing deadlines, and not receiving prior authorization. He worked with the MCOs to resolve these disputes in a reasonable manner, so that if there was miscommunication and the MCO could validly still pay the claim, he asked the MCO to pay it. Director Randol will continue to meet with the necessary parties to resolve payment issues, but there have been fewer complaints about these issues.

III. Review of FY 2019 MCO Contracts — DHS

Overview. Directors Foxhoven and Randol reviewed the MCO contracts for FY 2019. Director Foxhoven began by noting that in the new contracts, a number of provisions were built in to address problems identified by both DHS and the General Assembly. The department's obligation is threefold: to make sure that members receive the services they need, to keep providers in business, and to make sure the Medicaid program is sustainable so that the department is fiscally responsible to the state.

Director Foxhoven specifically noted that the new contracts include requirements for increased mental health services pursuant to House File 2456, as enacted by the 2018 General Assembly. The plan

when the bill was enacted was to have regions pay to build the system and to have the Medicaid program sustain the system. The MCO contracts also include new performance measures for the MCOs to meet, including those for timely payment.

State Audit. Director Foxhoven mentioned that there had been a request for the Auditor of State to audit the Medicaid program to determine how much Medicaid managed care was saving the state. When Director Randol became the Medicaid director 11 months before, he determined the state was calculating the managed care savings incorrectly by not comparing apples to apples. Director Randol developed a methodology to use in calculating the savings and, following review by the Auditor of State, agreed that the new methodology was the correct methodology. Based on the methodology, the savings to the state was $128 million in FY 2018. Director Foxhoven said that now that the state is past the point of asking if managed care saves money, the state can concentrate on providing better care to Iowans, making payments to providers in a timely manner, and moving into a more mature program to improve outcomes for members. In response to a question as to how unpaid claims were addressed in the audit, Director Randol responded that he was unsure.

New Contract Specifics. Director Randol noted that, based on legislative directives and identified issues, the FY 2019 contract improvements address claims reprocessing, pay for performance measures to address long-term services and supports concerns, home and community-based waiver services increased employment and service planning, how often case managers must have contact with a member in person or by phone monthly and every three months, contract improvements relative to mental health based on 2018 legislation, payment for court-ordered mental health treatment for the first three days of treatment as directed by 2018 legislation, a directive to work collaboratively with the regions to support intensive residential treatment homes and access centers, timely payment and reprocessing of claims based on a system error or system reconfiguration issue, revised continuity of care requirements to align with the Final Rule, well-child visits, and children's behavioral health

strategic planning based on the Children's System State Board recommendations. When Iowa Total Care begins as the third MCO in Iowa on July 1, 2019, they will also be subject to the new contract requirements. Provisions will be consistent across both Medicaid managed care and fee for service. As Iowa Total Care is onboarding, Director Randol has emphasized learning from the past and not making the same mistakes. Iowa Total Care is beginning to build a provider network.

Plan for Distribution of Members. As the state moves toward adding an additional MCO, there is a plan to distribute membership across the MCOs so that no one MCO has a disproportionate share of members of any single population. In order to minimize disruption to members, 140,000 members in certain populations will not be included in the auto-assignment algorithm including pregnant women, individuals with very serious illnesses, and members who have transitioned from facility to home and community-based services. These members will still have choice as required by federal law, but they will not be auto-assigned initially. Also, as required by federal law, those who are auto-assigned will have choice and be able to select their preferred provider.

In regard to how the state will balance membership across the MCOs if many of those already assigned to an MCO do not want to change to the new MCO, Director Randol responded that the distribution plan is not an exact science. DHS will monitor the distribution, and if a member does not want to be reassigned, they will not be forced to do so. One concern is that risk across all MCOs must be as equitable as possible, so risk will continue to be monitored from an acuity perspective. In July 2019, DHS will reassess distribution and determine if changes need to be made. Director Randol confirmed that time and distance to a primary care provider or specialist is not part of the auto-assignment algorithm.

No Wrong Door. Directors Foxhoven and Randol responded to committee questions about the proper channels for a member or provider to address concerns related to MCOs by explaining they operate on a "no wrong door" policy. While there are various processes in place through the MCOs, DHS, and other

state entities to address concerns, anyone may contact Director Randol or Director Foxhoven directly. Director Randol established a process improvement work group to work with providers on issues, as well.

Short-Term Residency and Medicaid Eligibility. In response to a question concerning the provision of Medicaid services to individuals relocating from other states, the directors responded that they were not sure if DHS maintains data based upon a member's length of residency. They stated that if an individual comes into Iowa from another state and meets the eligibility requirements for Medicaid, the individual cannot be denied benefits.

IV. Dental Wellness Plan (DWP) — DHS

Overview. Directors Foxhoven and Randol reviewed recent changes to the Medicaid Dental Wellness Plan (DWP) implemented with the goal of providing preventive care to the greatest number of adult Medicaid recipients. Director Foxhoven began by noting that the DWP is a classic example of how Iowa Medicaid is trying to focus on providing services to members to improve their health. In the new DWP contract, DHS attempted to ensure that members are receiving preventive care, and that if a provider is not meeting a certain level of provision of preventive care, that provider is required to elevate that percentage. Director Randol explained that Iowa is one of only 13 states that provides a carved out dental benefit for adult Medicaid recipients with about 300,000 members receiving dental services. The initial Medicaid DWP was implemented on May 1, 2014, for the Iowa Health and Wellness Plan population. In July 2017, the DWP was expanded to all Medicaid adult recipients 19 years of age and older. The changes in the new contract require members to complete two healthy behaviors, including an oral health self-assessment and one preventive dental visit each enrollment year, in order to maintain benefits. Members who do not complete the healthy behaviors will be charged a monthly premium during the next enrollment period. The changes to the DWP also limit each member to a $1,000 annual cap for services. The cap does not apply to costs for preventive, diagnostic, or emergency dental services,

anesthesia, or fabrication of dentures. The DWP is now provided through two dental carriers, Delta Dental and MCNA Dental.

Committee Discussion. Co-chairperson Heaton noted that in 2014 and 2015 there was a rapid sign-up of dentists for the DWP, and wondered if the changes to the program are resulting in a decrease in dentist participation. Director Randol stated he was unaware of any reduction in participating providers and that network adequacy requirements are monitored.

Updates. In response to a request from Representative Heddens, Director Randol agreed to include an update on the DWP with the quarterly updates for Medicaid managed care.

Recruitment. Representative Lundgren asked what DHS is doing to recruit dentists for the DWP program, to provide dentists with information that dental care is part of the Medicaid program, and to ensure that the DWP program is not cumbersome. Director Randol responded that he had met with the dean of the college of dentistry at the university of Iowa, and, while the DWP does not have specific recruitment efforts in place, DHS continues to monitor and communicate with the dental MCOs and to update providers on changes in the DWP. Representative Lundgren clarified that she was specifically asking about recruiting dentists who are already operational in the state into the Medicaid program to accept Medicaid members. Director Randol noted that, based on the data, one of the DWP carriers had a significantly lower penetration rate in the state and in reference to national standards than the other carrier, so the new contract requires that carrier to increase the penetration rate over the next two years. Additionally, dental providers are part of the process improvement work group, so DHS will continue to review other avenues to improve the program.

Senator Mathis asked how committed Director Randol is to continuing the DWP, at what point the DWP might be eliminated, and who would make the decision to keep or eliminate the DWP. Director Randol responded that he is committed to providing services to Medicaid members, but that dental services are

optional under the Medicaid program. He said that no one person would make the decision to eliminate the DWP. Director Foxhoven added that the decision would come from the General Assembly and that if the General Assembly did not provide sufficient funding for the DWP, DHS would have to ask the General Assembly what services should be eliminated to meet the budgetary limitations. Senator Mathis said that since the General Assembly did not have any choice in moving from Medicaid fee-for-service to managed care, she is a bit suspicious and the lines of communication need to remain open. She continued that she thought a number of legislators shared her support of continuing the DWP and agreed with Representative Lundgren that the state needs to look at ways to recruit dentists to the DWP. Co-chairperson Heaton agreed with Senator Mathis that it is important, especially as dentists retire who have been involved in the DWP, to recruit dentists and noted that reimbursement is very important to the recruitment effort. He said whatever was right with the DWP initially in 2014, should be continued because he did not think that dentists are as interested in the program since the recent changes were made. Representative Forbes added that in his discussions with dentists in the Des Moines area, it all boils down to reimbursement. Participating dentists are receiving only 30 to 40 percent of their usual fee and cannot afford to participate. He noted that under the hawk-i program, dentists are more willing to participate because reimbursement is higher than under the DWP for adults. He suggested continuing to review ways to make reimbursement equitable for dentists to participate and not lose money. Some dentists will continue to provide services at no or a minimal charge to long-standing patients who become eligible for Medicaid, but dentists can only do so much as small business owners. Director Randol agreed and stated the state has done the analysis and there should be equity between the hawk-i and Medicaid adult populations for dental services. Representative Forbes suggested this issue should be addressed in the budgeting process during the upcoming 2019 Legislative Session, because dental care is so integral to the health care of Iowans. Director Foxhoven reiterated that other states do not provide carve out dental care due to fiscal constraints, so the General Assembly needs to review its priorities

and decide if the state can afford to reimburse dentists at a higher rate to provide dental care to adults under the DWP.

V. Review of Value-Based Purchasing — MCOs and Large Health System Provider

Mr. Jeffrey Jones, Plan President Amerigroup Iowa, Inc. (Amerigroup), and Ms. Alissa Weber, Chief Financial Officer, and Ms. KellyAnn Light-McGroary, M.D., Chief Medicaid Officer, UnitedHealthcare Community Plan of Iowa (UHC), discussed moving from a fee-for-service methodology to a value-based purchasing methodology from the perspective of an MCO.

Amerigroup: Mr. Jones noted that in 2018, Amerigroup focused on transitioning from a solely unit cost-based fee-for-service model to an outcomes-based model where payment is based on improved health outcomes of members and increased quality of services delivered. In alignment with the state contract, Amerigroup set a goal of having 40 percent of its members attributed to a provider in a value-based arrangement and is on track with that goal for the current year. Amerigroup will expand to other populations including behavioral health and substance use disorder in the future. Amerigroup offers two types of programs: quality incentive programs and shared savings arrangements. The quality incentive program offers an adaptable, flexible, and measurable tool that conforms to the provider type and targeted population. This program is in place with primary care physicians, nursing facilities, and personal attendant care providers. Resulting improvements include lower inpatient readmissions through higher quality of care coordination postdischarge, and personal attendant care providers exceeding member satisfaction goals to earn their bonus payments. The second category, shared savings arrangements, are typically targeted toward providers in larger health care systems, operating with their own information systems and care coordination infrastructure. Amerigroup is very happy with the progress on value-based purchasing and foresees its expansion in 2019, utilizing existing and new and innovating approaches to targeted populations. Mr. Jones responded to committee questions

related to the risk to providers. He confirmed there is a shared risk standpoint where the provider risks a loss if the provider does not meet target expectations and this is why value-based purchasing must be adaptable to the provider. He noted that there is an appetite for value-based purchasing among providers in Iowa and that Amerigroup is learning from other states to adapt best practices and target more providers in the state.

UnitedHealthcare (UHC): Ms. Weber and Dr. Light-McGroary reviewed UHC's progress in 2018. Ms. Weber noted UHC has over 30 years of experience in the state including with Medicare, employer-based health coverage, and Medicaid. Currently, 48 percent of UHC Medicaid members, or over 200,000 members, are assigned to providers in value-based care arrangements. UHC is a strong supporter of value-based care and offers a variety of contract structures. The basic quality model provides incentives to providers for specific quality performance measures and allows UHC to be flexible with providers. Next on the continuum are accountable care organization (ACO) models with quality and total cost of care components. This model is compliant with state value-based purchasing definitions. For the future, UHC is considering a risk-based model for providers who are willing and able to take risks.

UHC provides information to providers on high-risk members and on inpatient and emergency department transitions so that their providers can follow up with members. Rates of follow-up after discharge from an inpatient stay or an emergency department visit are increasing for members. Efforts have also resulted in members being able to receive same-day access to care. This work with providers has also helped to develop deeper relationships between UHC and their providers, resulting in additional positive outcomes. The process of value-based care is an evolution and UHC is exploring risk-based care options and is open to moving forward in whatever way is most effective for and unique to Iowa.

Ms. Weber responded to committee concerns about rural and small providers participating in value-based care and the possibility that taking on too much risk could result in failure of these providers. She explained that value-based care models exist on a continuum to meet providers where they are and to improve the lives of members across the state. While current models involve primary care providers, UHC is open to expanding to other provider types and populations once they determine how to operationalize the expansion.

UnityPoint Health: Ms. Sabra Rosener, Vice President, Government Relations, UnityPoint Health (UPH), discussed value-based purchasing from the perspective of a large health system. She noted that value-based purchasing, and payment of physicians for services provided to Medicare beneficiaries based on value rather than volume, began with the passage of the federal Medicare Access and CHIP Reauthorization Act of 2015 (MACRA). At that point, the way physicians are paid under Medicare was totally changed by requiring that over time, in order for physicians to maintain the same Medicare rate of payment and not decrease payment, they must take risk. Taking risks is no longer an option for these providers and they are responsible not only for the quality of care provided but also for the total cost of care for their panel of patients. Medicaid is involved because providers have had to expand their patient base beyond the Medicare population to Medicaid and commercial populations to continue to meet threshold targets and share in the savings and, as the formula moves to a risk-based methodology, to avoid decreased reimbursement. Additionally, since Medicare reimbursement is so low in the state, it is even more important to maintain current reimbursement rates.

Ms. Rosener noted that the value-based contract that UPH has is directly with the federal government under Medicare for the 100,000 patients they serve. There are benchmark costs UPH must not exceed and quality metrics they must meet in order to share in the savings. Their incentive is to work more closely with the patient, which is why they have substantially developed their case management

capability. UPH receives data from CMS on Medicare patients to target higher risk patients. The UPH ACO is constantly working with physicians to meet quality metrics and manage patient care.

In response to a question regarding why the state would pay the Medicaid MCOs as a middleman when the ACOs are already managing care, Ms. Rosener stated that in UPH's view, managed care is here to stay in Iowa. The MCOs and the large providers in Iowa have not yet begun to tap into what their relationship could be, since there are activities that each could handle differently. UPH is proposing a collaboration with the MCOs to divide their duties and avoid duplication. UPH has recommendations for moving forward. Shared savings is not a good financing model since the total overall payment is continually reduced, and the model is not feasible, especially in Iowa with the low Medicare reimbursement and the existing high level of efficiency. Ms. Rosener mentioned that since UPH is capable of credentialing its own physicians, has its own utilization management company in Dubuque, Iowa, and has developed care coordination internally, UPC would like to enter into arrangements with the MCOs in which UPC can perform some of these administrative duties. She stated that once the MCOs and the large health systems work as a team, public complaints about the MCOs will decrease.

Ms. Rosener noted that an ACO is another construct that is hard to understand, but it is basically a network of providers. The University of Iowa Hospitals and Clinics is in the UPH ACO network. While value-based care is a complex topic, she feels some immediacy in developing options in the state because physicians have been involved with value-based care since 2015 and, on the hospital side, the federal Affordable Care Act included mandatory downward productivity adjustments that are designed to reduce hospital reimbursement by $196 million by 2036. Ms. Rosener clarified that UPH is in a down-side risk contract and would have to pay money back to CMS if they do not meet their benchmarks.

In response to a question by Representative Heddens regarding what happens if UPH does not meet the federal threshold by 2020, Ms. Rosener responded that UPH would need to contract with Wellmark,

other commercial payors, or others to reach the threshold. It would seem that the easiest way to meet the threshold would be to combine all of the government business that UPH does to meet the threshold through the other payor combination. However, the other payors have to meet three requirements, one of which is to bear more than nominal risk, which constitutes approximately 8 percent of the payor's revenues being at risk. Currently, none of the Medicaid managed care contracts meet the nominal risk threshold under the federal law.

VI. MCO Update — Amerigroup Iowa, Inc. and Iowa Total Care

Amerigroup: Mr. Jones provided an overview of key events from 2018 and upcoming plans for 2019 for Amerigroup. For 2018, he highlighted the transition of 10,000 members from Amerihealth to Amerigroup, expansion of core services and other mental health services, involvement in the process improvement work group, successful provider contracting, and involvement in the state innovation round table. Mr. Jones noted key accomplishments in 2018 include tackling substance abuse and that despite the increase in members requiring substance use disorder treatment, the use of emergency detoxification has flattened as the result of the provision of appropriate treatment. Additionally, while there has been a decline in inpatient and emergency department visits, there has been an increase in outpatient treatment and services for substance abuse and mental health services. He credited the increase in outpatient treatment and success to increased member contacts at critical times and post-inpatient discharge. Amerigroup has successfully returned members in facility care to the community and has expanded member benefits for older members who are already living in the community so the member may continue to live independently. Amerigroup has also brought 36 members placed out of state back to Iowa when appropriate care was available.

In an effort to address Amerigroup's priority and to improve the health outcomes of its members, Amerigroup has solicited feedback from providers related to their experiences. The consistent issue identified was the time taken to resolve an issue, so Amerigroup changed the complaint process to

escalate resolutions. For 2019, Amerigroup will take steps, working with DHS, to implement changes in anticipation of legislation related to the Children's System State Board and will focus on social determinants.

Iowa Total Care: Mr. Chris Priest, Interim Chief Operating Officer, Iowa Total Care (ITC) reviewed ITC's progress toward providing coverage in Iowa beginning July 1, 2019. Iowa Total Care is looking forward to building a partnership with the state by working cooperatively and transparently to improve health outcomes for members. Iowa Total Care has examined the difficulties MCOs experienced in the past, such as accurate and timely payments, and is working toward implementing policies and procedures to avoid similar problems. Iowa Total Care is hiring its senior leadership team and is building its provider network. Iowa Total Care will have providers submit test claims prior to going live on July 1, 2019, to mitigate any problems before actual claims are submitted. Mr. Priest agreed that finding quality staff is the foundation of success, but with a low employment rate, finding staff is a challenge. Responding to questions related to how ITC intends to promote itself, Mr. Priest said ITC will increase membership by demonstrated improved health outcomes and publicizing member success stories.

VII. 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.

Mr. Tom Moreland, CEO, Spirit Cares, reviewed his experience as a provider of home and community-based service (HCBS), consumer-directed attendant care, and other services. He noted he is a registered Republican, MCO supporter, and fiscal conservative. Spirit Cares employs approximately 180 individuals and serves individuals throughout the state. With no increase in provider reimbursement rates to HCBS providers since 2016 it has been difficult to take on new Medicaid patients and high staff turnover has resulted due to the inability to pay higher wages. One issue is

that MCOs reimburse providers only every 30 days, but he pays his employees twice each month. He urged the committee to examine the percentage of approvals for exceptions to policy, admitting that before managed care there were too many approvals of exceptions to policy. However, since transitioning to managed care, member hours of care have been reduced based on the assessments of MCO employees. He urged the committee to insist on using a third party, as opposed to the MCOs, to assess a member and determine how many hours of care that member is qualified to receive.

VIII. Future Meeting

Co-chairperson Heaton reviewed the agenda for the second Health Policy Oversight Committee meeting to be held on December 17, 2018, beginning at 8 a.m. Representative Heddens requested that the agenda include a report from the managed care ombudsman.

IX. 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/meetingsListComm?groupID=24165&ga=87&session=2