MINUTES
Health Policy Oversight Committee

Monday, December 17, 2018

MEMBERS PRESENT

Senator Mark Costello, Co-chairperson
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 second of two statutorily mandated meetings of the Health Policy Oversight Committee of the Legislative Council for the 2018 interim was called to order by Co-chairperson Mark Costello at 8:04 a.m. in room 116 of the State Capitol, Des Moines, Iowa. Co-chairperson Costello reviewed the agenda for and the charge of the committee. Co-chairperson David Heaton noted that the meeting would be his last as an elected representative and thanked everyone for all they had done for him in allowing him to serve. The meeting was adjourned at 11:54 a.m.

II. Review of Provisions of SF 2418

Mr. Jerry Foxhoven, Director, and Mr. Michael Randol, Medicaid Director, Department of Human Services (DHS), reviewed the results of the supported community living tiered rates work group, the health home work group, and the level of care sampling analysis review required under Senate File 2418.

A. Tiered Rates Work Group

Overview. Director Foxhoven explained that DHS was directed to implement tiered rates in House File 593, enacted in 2017, to more appropriately reimburse providers based on the severity of the individuals they serve, and to incentivize providers to serve all levels, not only individuals with the fewest and least severe needs. Prior to implementation of tiered rates, there were 5,000 different rates with no relation to the severity of the member. Tiered rates were initially implemented in December 2017. The Iowa Association of Community Providers (IACP) was supportive of the shift to tiered rates and as the tiered rates were being developed, IACP, as well as service providers, participated in a work group in 2017 to direct implementation.

In legislation enacted in 2018, the General Assembly appropriated an additional $3 million of state funding to be used for tiered rates effective July 1, 2018. The original 2017 tiered rates work group reconvened in November 2018 to review tiers and make recommendations for expenditure of the additional funding. The 2018 legislation provided that if budget-neutral, the tiers could be adjusted based upon the results of the review. For the 2018 work group, Optumas reviewed over 116 cost reports which represented over 91 percent of the funds expended to determine the actual cost of care for members. DHS had been making many exceptions to policy relative to ID waiver individuals who were exceeding the level of care under tiers 1 through 6. During the work group meetings, Director Randol and the actuary walked the members through the recommendations. The analysis clearly indicated that there was a need to shift funds from tiers 1 and 2 to tiers 5 and 6 so the shift would be budget neutral. The changes approved by the work group should reduce the need for exceptions to policy since the actual costs for the higher tiers will now be covered to a greater extent. The work group meetings provided the opportunity for providers in tiers 1 and 2 to understand that they would receive lower reimbursement, but that DHS did not want tiers 5 and 6 to continue to lose money. Accordingly, the work group agreed to move forward with the shift beginning March 1, 2019. The 2018 work group report was submitted to the General Assembly on December 14, 2018.

Discussion. In response to a question by Senator Ragan regarding whether the costs of transportation were considered in developing the tiered rates, Director Randol responded that the $13 million of transportation costs were included in the overall standard rate, not as a separate rate. Representative Heddens stated that while providers agree that tiers 5 and 6 needed additional funding to meet member needs, providers are struggling with an underfunded system, will lose necessary reimbursement, and may potentially close their doors if funds are shifted from the lower tiers to provide funding for the higher tiers. Director Foxhoven responded that the rates developed were based on the actual costs

to the providers reflected in cost reports that demonstrated that lower tier reimbursements provided overpayment and higher tier reimbursements resulted in gross underpayment. Based on the cost reports, providers providing lower-tier services will be reimbursed at a lower rate, but will not lose money. Instead, the department is just right sizing reimbursement based on actual costs which should also eliminate the disincentive to provide services to members with higher acuity. Director Randol added that when the shift was made from thousands of rates to the tier system in 2017, tier 1 and 2 providers saw a reimbursement increase of anywhere from 8 percent to 22.4 percent and tier 5 and 6 providers saw a decrease of 10 to 12 percent. Co-chairperson Costello asked if the rates in place are the final rates or if they will change. Director Randol stated that the actuary wanted to ensure that the current and previous analyses were comparing apples to apples, so the $7.3 million appropriated for the revised rates beginning July 1, 2018, was not included in the analysis. Once the $7.3 million is added to the tiered rates system, on average each tier will realize a 2.4 percent increase based on the rates included in the actuary's report. The actuary also suggested reviewing the lower tiers again to ensure that the rates are correct. In response to a question by Senator Ragan regarding what goes into the cost report and whether it includes all of the costs of doing business, Director Randol stated that DHS could provide a copy of the cost report to the members of the committee and that he assumed it was the cost of doing business including administrative costs, not just the cost of the service. In response to a question by Representative Forbes regarding whether there are plans to make providers of tier 5 and 6 services whole based on their losses in the past, Director Foxhoven stated that since that was the population for whom DHS granted many exceptions to policy, some of the additional costs had already been reimbursed. He noted that just as DHS will not go back and recoup money from the lower-tier providers for overpayment, DHS will not go back and reimburse the higher-tier providers for costs they incurred above the prior reimbursement rate. In response to a question by Co-chairperson Heaton regarding whether the actuary determined if the lower-tier rates were sufficient when reviewed, Director Randol noted that there is a table in the report that demonstrates that the lower-tier rates will still provide a slight profit margin of 1.4 percent, and reiterated that when the $7.3 million is added, there will be an approximate 2.4 percent increase in the rates across the board. Co-chairperson Heaton said he has heard from some providers that their rates going forward will be less than prior to the realignment and that he thought that when he and Representative Fry were working on the budget, the intent was that the $7.3 million would go to more adequately reimburse the higher tiers, but the lower tiers would remain status quo. Director Foxhoven reiterated that based on the cost reports, the lower tiers were being overpaid and the higher tiers were being grossly underpaid, so that if the lower tiers were held harmless, the gross underpayment of the higher tiers would continue. Representative Heddens concurred with Co-chairperson Heaton that the intent of the General Assembly was not to decrease rates for the lower tiers in order to provide increased rates for the higher tiers, but rather to hold the lower tiers harmless while increasing the rates for the higher tiers. Representative Heddens asked that the incoming chairpersons for the Health and Human Services Appropriations Subcommittee schedule a presentation on the tiered rates for the Budget Subcommittee to provide more detail and to review the report of the work group. In response to a question by Senator Ragan regarding whether the new rates will sustain providers and not result in providers discontinuing services, Director Randol stated that he thought that especially for tiers 5 and 6, which have been underfunded, the rates will help providers to continue to provide services and even with decreased rates for the lower tiers, those providers will continue to provide services. Co-chairperson Heaton stated that he was glad to see the increased rates for the higher tiers, but that as other committee members expressed, he did not want to see the lower-tier providers being paid below their costs and endangering provision of services.

B. Health Home Work Group

Overview. Director Randol noted that the Health Home Work group report was submitted to the Governor and the General Assembly on December 14, 2018. He provided a high-level summary of the report, noting that there are two types of health homes (HHs), chronic condition health homes (CCHH) and integrated health homes (IHH), and that providers receive a per member, per month (PMPM) payment for providing services. As of September 2018, there were approximately 20,000 IHH members and 2,000 CCHH members. The initial CCHH was launched in 2012 and the initial IHH was launched in 2013. The 2018 legislation instructed DHS to review the two state plan amendments (SPAs) for the health homes and to conduct an analysis of the program. The stakeholder work group met twice in October 2018, and consisted of approximately 20 providers, the MCOs, and DHS staff. In addition to review of the SPAs, the work group was convened to review the results of the department's analysis of: the structure, completed through provider file review; the process, completed through member file review; and outcomes, completed through statistical value analysis based on total costs of Medicaid services for similar members receiving and not receiving health home services. In each case, the analysis involved a treatment group and a control group. Following the two work group meetings in October 2018, a draft report was shared with work group members in November 2018 to seek additional feedback.

The findings included that providers admittedly did not understand the full array of health home requirements in the two SPAs, there were inconsistencies in documentation of the requirements, the PMPM payment was disconnected from the delivery of the six core health home services, there were PMPM payments made for members for whom no services were provided in some cases for 90 days or more, the cost of services for IHH members was significantly higher than for non-health home members, and there was not a statistical difference between the CCHH and similar non-CCHH member costs. With respect to next steps, DHS and the work group will continue to review the SPAs and may potentially combine the two SPAs due to the similarities between the two. DHS will continue to work with the MCOs to provide better communication and assistance to providers including the development of guidance materials for HH providers, increased technical assistance and oversight, and the holding of regular meetings.

Committee Discussion. Senator Mathis noted that in her review of the work group report, PMPM payments were made to IHH in months when no core services were provided in about 8 percent of the claims reviewed, but approximately 89 percent of IHH members had an ongoing relationship with a personal provider in their IHH. She suggested that the HHs are working and asked what flaws Director Randol observed. Director Randol responded that it was not necessarily a flaw, but that the Centers for Medicare and Medicaid Services (CMS) will not allow providers to receive a PMPM for which services are not provided, even if it only involves 8 percent of members. He also suggested that for the 89 percent who were "connected," there must be a review of whether "connected" means a member was actually provided a service. One of the lessons learned is that additional analysis is needed. Senator Mathis noted that Senator Mark Chelgren had sponsored a bill during the 2018 session to "pause" the health homes. She opined that when HHs were started as a pilot, there might not have been sufficient technical assistance, guidance, or data provided to providers. She asked why between 2014 and 2018, DHS had not collected the data necessary to determine if HHs are working. Director Randol stated that his understanding is that there were three phases in the HH rollout and that by the third phase, there was not as much assistance provided to providers. Accordingly, one of the work group recommendations is for more guidance, more technical assistance, more communication, and more specific expectations. It is an opportunity for DHS to improve HHs and to edit the SPAs so that expectations are clear. DHS will continue to do the data analytics, including for outcomes,

not just a review of cost. Senator Mathis asked if DHS would include the General Assembly in the decision-making process about health homes. Director Randol responded that it is incumbent upon DHS and Medicaid to continue to analyze the value of health homes and put forward recommendations, but that he would continue to move forward in making changes in the structure of HHs in the next few months, including any changes to or realignment of the SPAs and determining if providers are complying to mitigate any risk. He stated that one of the first things he noticed was that sufficient data was not being collected, including whether the six core services were being provided. This data needs to be collected in the encounter data, so going forward DHS will assign a Current Procedure Technology (CPT) code to each of the core services to be able to determine which service is being provided. Senator Mathis asked DHS to consider provider recommendations to the same extent as the MCO recommendations moving forward. She said there was a disagreement over UnitedHealthcare taking over care coordination for the HHs and suggested that before that decision is made, DHS work with the providers to provide guidelines and expectations. Director Randol stated that one concern early on was duplication of services related to care coordination. He said there would be no sweeping changes without communication with providers and transparency and that even though providers might not always like the direction things are going, DHS will consider their concerns before moving forward. Representative Forbes asked if Director Randol will make changes before the total analysis is done, and Director Randol reiterated that there will be some structural changes, including requiring CPT codes for services and potential changes in the SPA, before a further analysis is completed. Director Randol noted there were indications that some providers had better outcomes than others, but the further review is an opportunity to understand why.

C. Level of Care Sample Findings Review

Overview. Director Foxhoven provided a high-level overview of level of care issues. DHS reviewed data for FY 2017 and FY 2018 for the MCO members who received waiver services. By rule, level of care reassessments are to be completed at least one time annually, as well as whenever the member's condition changes in a manner that warrants a reassessment. If a level of care change is indicated, documentation is submitted to DHS and DHS makes the final reassessment determination. The Iowa Medicaid Enterprise (IME) completes all of the initial level of care determinations and reassessments and uses national best practices when completing the level of care reviews to ensure the appropriate and necessary services are provided to meet the member's needs.

Director Randol noted that a report from the review was submitted to the Governor and the General Assembly on December 14, 2018. For FY 2017 and FY 2018, there were 6,069 review determinations of MCO members seeking level of care eligibility in a waiver program and of those about 98 percent were initial determinations and 2 percent were redeterminations. There were 3,590 for FY 2017 and 2,479 for FY 2018. Director Randol also reviewed trends and noted that more detailed information is provided, including by MCO, in the report.

Committee Discussion. In response to a question regarding the limitations in reimbursement in administrative rules for members requiring a higher level of care, Director Randol clarified that the rules could be changed to increase the amount provided as reimbursement for a specific waiver, but there will still be times when a member's needs exceed the reimbursement amount. Under these circumstances, Director Randol is authorized to grant an exception to policy so that the member's needs will be met. He suggested that some of the denials of requests for reassessments might have been due to a misunderstanding of the administrative rules.

III. Process Improvement Work Group

Overview. Director Foxhoven provided an overview of the process improvement work group noting that when he began as director there were many issues regarding Medicaid managed care. When Director Randol began as Medicaid director, he suggested convening providers to address their problems. The first meeting was a three-hour meeting in February 2018 with 75 to 80 providers specifically chosen because they were either the most vocal or had the greatest concerns. The group identified 150 issues that were then prioritized by the group to work through to resolution. There were eight common themes identified and at the subsequent meetings, the themes were divided into four subgroups to be more manageable. Some of the areas identified were provider credentialing, appeals and grievances, prior authorizations, member benefits, and others. The subgroups have been meeting monthly and the work group will continue in some form to provide for feedback and input from providers, MCOs, and the IME. Those in attendance have been individuals who are able to understand the issues and have the authority to make decisions for the organization they represent. One of the findings was the need for additional training and communication. There will now be quarterly, rather than annual, tailored trainings due to the high degree of staff turnover. Some additional next steps include the MCOs streamlining a number of processes including credentialing, appeals and grievances, and prior authorizations. The MCOs have added information on their websites to accelerate the resolution of issues. Director Randol has implemented monthly meetings with the MCOs together and individually. Prior authorizations will continue to be tracked, and if a prior authorization is approved a large percentage of the time, the prior authorization may be eliminated unless there is a legitimate reason for it to continue. If a prior authorization is eliminated, it will be eliminated consistently across all of Medicaid. Director Randol stated that he would provide the list of any prior authorizations eliminated as well as statistics on the overall approval rate of prior authorizations to the committee. Specifically with regard to Suboxone, Director Foxhoven stated that the federal government requires prior authorization so DHS is trying to address the issue. Representative Forbes reminded the committee that there is a federal law providing a three-day emergency treatment provision to help to counteract the prior authorization requirement.

Committee Discussion. Representative Forbes asked if the directors could review the change to a calendar year rather than a fiscal year for the future MCO contracts. Director Randol responded that the goal is to have the contracts signed sometime in January to allow the General Assembly to more precisely budget. DHS has been meeting with the actuary and will meet again on Wednesday, December 19, 2018, with the actuary and the MCOs to walk through draft rates. Director Randol stated that the calendar year provides more transparency for the General Assembly in budgeting, and provides administrative simplicity for the department, the MCOs, and providers. Senator Mathis familiarized Director Randol with an issue regarding hospitals and observation status. She said that she recalled in 2017, data showed that hospital admissions had decreased, but hospitals clarified that the admissions had only decreased as the result of disagreements over prior authorization. A patient would come into the emergency department and, pending prior authorization, would be placed on observation status, not admitted. Once the hospital had absorbed all of the costs for holding the person for three days under observation status, the MCO would deny the prior authorization, resulting in the hospital absorbing the costs for the initial three days.

In response to a comment from Co-chairperson Heaton regarding issues that the University of Iowa Hospitals and Clinics (UIHC) has with requiring a physician to address prior authorization requests, Director Randol stated he has a monthly meeting with the UIHC and if they can provide details, he will work through this issue with them. Co-chairperson Heaton said that the Medicaid MCOs, as well as private insurers, are also stepping in more frequently to direct the care of the patient instead of the doctor doing so. Co-chairperson Heaton noted that he has received communications that, especially

in rural areas and small towns, the quality of the transportation might not fit the needs of the patient. He suggested that Director Randol continue to meet with the providers to determine how things work in practice.

Co-chairperson Heaton asked if Director Randol was considering adding any of the options to cover additional services available through SPAs discussed at the most recent national association of state Medicaid directors meeting. Director Randol responded that state Medicaid directors receive updates on an ongoing basis and the department evaluates them relative to resources available, what makes the most sense for the state of Iowa, and what are the greatest needs for the state of Iowa, and then moves forward with those identified as feasible. Co-chairperson Heaton suggested that during the next legislative session, DHS bring these options before legislative committees. Director Randol suggested that he provide an update on the federal landscape to the legislative committees.

IV. July Transition Information

Overview. Director Randol stated that he has been meeting with Iowa Total Care (ITC) about eight times per week since October 1, 2018. They have an information technology meeting once a week, six subject matter meetings per week, an overall project update meeting, and he has included ITC in meetings with the other MCOs. Some of the topics covered include policy areas such as long-term services and supports; home and community-based services, as well as community and facility, behavioral health, hospital, therapy, and pharmacy services; network adequacy; provider enrollment; case management; value-based purchasing; claims payment; provider rates; and member eligibility. The meetings will continue through January, and additional meetings will be scheduled if gaps in knowledge are identified or if follow-up questions are received. The readiness review from a desk review perspective will begin in February and onsite readiness reviews will begin in April 2019. The department is confident with Iowa Total Care being on board in July 2019. Open enrollment will begin in March and the department is trying to mitigate disruption to the members as much as possible. They have excluded about 130,000 to 140,000 members from the auto-assignment algorithm, including pregnant women and people with serious illnesses who have established relationships with providers. However, those excluded will still have the choice to change to another MCO. The auto-assignments will go out in March, and then, after July 1, members will have another 90 days to change. Director Randol noted that there will be a maximum percentage and a minimum percentage of each specific population that will be assigned to each MCO. There is a minimum total membership for each MCO of 25 percent, a maximum total membership for each MCO of 45 percent, and a maximum of 55 percent of any one population for each MCO.

Committee Discussion. Representative Heddens noted that there are many Medicaid members and their families who cannot handle another change, and asked what education will be provided to members for the transition. Director Randol said that the member enrollment packet will include a lot of information, but there will also be stakeholder meetings to walk members through the process. Representative Heddens asked if ITC has built up their provider network, and Director Randol replied that ITC has been actively negotiating contracts with providers. Representative Forbes asked about Medicare-Medicaid dual-eligibles and said that a constituent had been contacted by an MCO asking the individual to switch to a Medicare Advantage plan and offered $1,000 in products and services for the person to switch. Director Randol asked that he be provided with more specific information in order to follow up on the issue, but was unaware of such communications by any MCO. Representative Heddens provided that it is UnitedHealthcare (UHC) making the calls. Co-chairperson Heaton stated that one of the major insurance companies is coming forward with a Medicare-Medicaid dual-eligible policy and that he thought this might be confusing for consumers. He suggested that the insurance

commissioner be contacted about this issue. Director Randol noted that Medicare is the primary payment source for these dual-eligibles, with Medicaid only paying as a secondary source. He did not think there was any law or regulation to prohibit a Medicare insurer from marketing to a Medicare member. Representative Lundgren stated that communication is important during a roll-out and suggested that communications be kept as simple as possible. Co-chairperson Heaton noted that when one of the MCOs exited from Iowa, many people were switched over to another MCO and there was concern relative to case managers. He hoped that ITC would have adequate case managers when they come on board. Director Foxhoven said that UHC hired many of the case managers when the MCO exited to prevent disruption, and this time many of the most vulnerable members will not be included in the auto-assignment. Co-chairperson Costello noted that there would once again be a reshuffling and he asked if a case manager could tell a member that the case manager was moving to another MCO. Director Foxhoven said the case manager cannot ethically tell a member that the member should switch, but the case manager could share if the case manager is leaving and where they are going.

Senator Segebart stated that when he became a legislator, a nursing home provider shared the Medicaid application with him and it was very lengthy. It took about 30 days to complete the form and then another 30 days to receive approval. Senator Segebart asked if a member had to fill out the Medicaid eligibility form again if they switched to another MCO. Director Foxhoven clarified that IME determines Medicaid eligibility and the MCOs provide the services. So, if a member has already been qualified for Medicaid, there is no need for the member to reapply for Medicaid eligibility. In response to a question by Co-chairperson Costello regarding readiness of systems for the new MCO, Director Randol stated that as part of the on-boarding there will be much testing of systems to ensure that the claims payment, file transfers, encounter data submissions, and other processes run smoothly. In response to a question by Senator Mathis regarding what concerns UHC has expressed regarding the redistribution of their members and if they have talked about how this affects their bottom line, Director Randol responded that all of the MCOs are aware of how the process will work moving ahead. With respect to any agreement with the other MCOs when the decision was made to add a third MCO, Director Randol said the only agreement he was aware of was that the third MCO not come on board until a certain date. As to whether the MCOs have expressed the percentage of the member population they need to stay in business, Director Randol said that none of the MCOs had expressed great concerns. DHS will monitor the member distribution to each MCO on a quarterly basis. If an assignment to an MCO results in an MCO having more than the established maximum percentage but the assignment involves a family, the department will be flexible and allow all family members to remain with the same MCO. Senator Mathis asked if Director Randol had any concerns with a lower score on the application initially submitted by Centene, and Director Randol said he was not concerned, and ITC is very excited to be in Iowa.

V. UnitedHealthcare Update

Overview. Mr. Bror Hultgren, Interim Chief Executive Officer, UHC, provided an overview of UHC's activities in 2018, future plans, and value-based care. He noted that he has been with UHC for 18 years and prior to that spent 10 years on the frontlines of providing health care, starting in residential behavioral health, working as a case manager for the population with serious mental illness and as a case worker in the foster care system. All of this experience was powerful in demonstrating how the health care system can work to help the most vulnerable. At UHC he has worked on building and implementing programs for the most vulnerable populations, which has helped to inform him as to how to use the managed care system to meet the needs of these individuals. He has seen managed care work to help people get the services they need and to navigate the health care system. He spoke about how, in a nonmanaged environment, needs are addressed in silos but needs overlap, so the ability of

managed care to look at medical, social, and functional needs of a person and create a comprehensive care plan is where the power of managed care is realized. He spoke about how UHC was able to step in when one of the MCOs exited the state, and the challenges of the transition when UHC went from serving over 200,000 to over 400,000 members, all within 60 days. UHC hired hundreds of new employees, the majority of whom are case managers. During this time, UHC focused on the needs of the population, the majority of whom were LTSS members. UHC built a provider network in scope and size so that members can receive services and providers are paid accurately and timely. He also talked about value-based care. Value-based purchasing adoption is complex and requires a provider to understand how to take in data, understand high-risk individuals, interact differently with those individuals, and in many cases bear risk. An MCO approach to value-based purchasing allows the state to have a single accountable entity, or, in the case of Iowa, three, to begin to promote and scale value-based purchasing across all individuals and provider types. It also allows for consistency of quality performance metrics and ensures financial stability for the system overall. As value-based purchasing evolves, it is helpful to have a system that can be flexible in working with providers to meet them where they are, and is financially stable. UHC currently has about 19,000 contracted providers in Iowa and has used the value-based approach to enroll 48 percent of its Medicaid member population in value-based programs. UHC has developed a large infrastructure and this has enabled them to collect and record data. They have staff who work with physician offices to provide for practice transformation to make sure the practices understand and use the data to address the needs of high-risk members. Mr. Hultgren also shared member stories with the committee.

Committee Discussion. In response to a question by Senator Ragan regarding the 2018 complex needs legislation and UHC's role going forward, Mr. Hultgren responded that UHC is working with IME and is using information gleaned from other states where UHC has assisted with behavioral health, substance use, or physical health services to respond. UHC is looking forward to providing thought leadership to help find solutions. UHC currently works with the counties and regions to fill gaps in care and he sees opportunities, especially in providing least restrictive housing. Senator Mathis asked about training of case managers. Mr. Hultgren stated that UHC utilizes a comprehensive training that focuses on the role of the case manager. As UHC has worked to bring on hundreds of case managers they have been getting better and more consistent by using a performance measure system and a peer review process. In response to a question by Senator Mathis as to whether UHC is going to continue to pursue the health home business, Mr. Hultgren responded that last year UHC was concerned about potential duplication of case management with health homes. Senator Mathis asked how UHC is preparing for the redistribution of members and if Mr. Hultgren foresees layoffs. Mr. Hultgren responded, with relation to the redistribution, that UHC has been working with IME to understand the intent and embraces competition and supports choice for members. UHC does have concerns with the loss of the relationships they have worked hard to build with their members and heard Director Foxhoven talk about the need for the MCOs to serve members in a way that makes the member want to stay. The reality is there will be some redistribution, so the expectation is to be planful and share information and care plans for those members leaving to reduce interruption in services. It is likely that ITC will hire some of the staff who leave UHC due to the redistribution of members. In response to a question by Co-chairperson Heaton regarding value-based purchasing, Mr. Hultgren said that value-based purchasing is a partnership and no provider is forced to participate. He stated that there is a continuum of risk and value to meet providers where they are. At the higher-risk levels, such as Accountable Care Organizations (ACOs), there are specific requirements for providers to meet, but they can also share in the savings. Risk-bearing is the next level where there is upside and downside risk, but Iowa is not there yet. Managing risk is difficult and UHC would never put a provider at risk because they are too important to the system. He noted that anything done in value-based care

needs to address quality, cost, and outcomes. The goal is never to incentivize a provider to reduce services, but instead should be to promote the efficient use of services and effective improvement of quality. Value-based purchasing may require extra documentation, but UHC tries to use traditional measures for quality such as the Healthcare Effectiveness Data and Information Set (HEDIS) tool so that a provider does not have to maintain additional data.

VI. Dental Wellness Plan

A. Delta Dental of Iowa (Delta Dental)

Overview. Ms. Gretchen Hageman, Director of Government Programs and Project Director for the Dental Wellness Plan, and Dr. Jeffrey Chaffin, Vice President of Professional Relations and Dental Director, Delta Dental of Iowa, presented information about the Dental Wellness Plan (DWP) for Medicaid adults. Ms. Hageman thanked the committee and specifically Co-chairperson Heaton for their support of dental coverage as part of the Medicaid program. Delta Dental helped to start the DWP in 2013 when Medicaid expansion began. Delta Dental is a nonprofit corporation, the largest insurer in Iowa, and provides the dental benefit for hawk-i members and for adults under Medicaid. Oral health is very important to overall health and research shows that investment in dental wellness reduces costs on the medical side. When reviewing emergency department use from 2013 to 2017 from the Iowa Hospital Association, there was a decrease of about 14.6 percent in the number of adults who presented at the emergency department for dental pain. Members will necessarily find a dental home and it saves money if their dental home is not the emergency department. For FY 2019, there is a two-benefit structure for the dental wellness plan: full benefits and basic benefits. Full benefits provide a comprehensive package with an annual benefit maximum of $1,000. Preventive services, dentures, emergency services, and sedation for oral surgery are among the services excluded from determining the annual maximum benefit. A member also has to complete healthy behaviors to demonstrate member accountability, including a self-assessment and a preventive service. Healthy behaviors must be completed each year of the enrollment period. If a member completes the healthy behaviors, they remain on full benefits for their enrollment year period. If a member does not complete the healthy behaviors, the member will pay a $3 monthly premium or may declare a hardship. If, for 90 consecutive days, a member does not complete the healthy behaviors, pay the premium, or declare a hardship, the member moves to basic benefits. Basic benefits consist of preventive services and emergency services, and the member remains at basic benefits until the end of the enrollment year. If a member does complete the healthy behaviors at some point during the remainder of the enrollment year, the member will then be eligible for full benefits in the next enrollment period. Currently, Delta Dental serves approximately 110,000 members of the over 300,000 adult members eligible under Medicaid. Twenty-seven percent of the members have had a service through Delta Dental in the first four months of FY 2019 with the goal being 30 percent for the fiscal year. Of the 27 percent, one quarter are new members who have never had dental services before. Sixty-two percent of the services these members have had are preventive services. About 95 percent of Delta Dental members are still at the full benefit level, and about 11,000 have moved to basic benefits as of December 1, 2018. Two hundred seventy-five members have reached their $1,000 maximum benefit, which started September 1, 2018. Delta Dental's outreach has focused on helping members to complete their healthy behaviors, utilizing text messages, mailings, phone calls, and postcards. If there are high-risk members, including pregnant women, people with disabilities, and those who have transitioned from hawk-i to dental wellness and need care coordination, Delta Dental provides this. Delta Dental has begun conversations with the medical MCOs to address care coordination. Currently, Delta Dental has about 1,000 providers in their network, and about 50 percent (500) are accepting new members. Those providers who are not accepting new members because their practices are full, are providing

services to 38 percent of the Delta Dental members. About 15 percent of the members are served through federally qualified health centers (FQHCs). Already in FY 2019, the percentage of participating providers who are not taking new patients has increased from 35 percent to 50 percent. Providers, who are generally small businesses, attribute this to administrative burden and the complexity of the plan because they have to check the member's benefits to determine if the member is eligible, if they have full or basic benefits, and whether the member has reached the benefit maximum. But providers do want to provide services to older Iowans and people with disabilities, so they continue to take members. Ms. Hageman ended with a member story of a wheelchair-bound 50-year-old man from eastern Iowa who was receiving services from the University of Iowa College of Dentistry and had to work with the medical MCO to provide transportation. It was a full-day process to receive one dental service, and he was only receiving emergency, not preventive, care. Delta Dental worked with him, and he now has a dentist 10 minutes from his home and is able to receive preventive services through an established dental home. This saves money for Medicaid and provides the member with services closer to home.

Committee Discussion. Senator Mathis thanked the presenters for the data provided and said that when Iowa began with Medicaid managed care, the first letters she received were from dentists who were concerned with reimbursement. A local dentist just retired and the dentist who bought his practice will not take Medicaid members because the reimbursement is too low to pay his staff. She asked how Delta Dental works with dentists to continue providing services when that dentist is considering terminating participation and the community needs a dentist in the Medicaid program. Dr. Chaffin responded that they work with the providers, and while they cannot change reimbursement, they try to help with the administrative complexity by reaching out and providing training and support. Senator Mathis asked if there are fewer dentists taking Medicaid members, and Ms. Hageman stated that when all Medicaid adults were brought into the program in 2017, Delta Dental increased the number of providers from 850 to roughly 1,100 dentists. However, in the last fiscal year, Delta Dental lost about 100 providers and in FY 2019 they have lost about 15 providers. Dr. Chaffin added that Delta Dental has about 1,680 dentists in their Iowa commercial network, so the 1,000 dentists in the Medicaid program is still a good percentage of overall dentists participating in the program. Senator Mathis asked what the chief complaints are with the program. Ms. Hageman stated that some of the issues are the complexity of the plan compared with the initial program, reimbursement, prior authorizations, and the high no-show rate of members. In response to a comment by Co-chairperson Heaton, Ms. Hageman stated that 47 states offer dental care under the Medicaid program, but Iowa is one of only 13 states that provide a carved out comprehensive benefit plan. The other states only provide a limited benefit consisting of emergency care.

B. MCNA Dental

Overview. Mr. Rene Canales, Associate Vice President of Network Development, MCNA Dental (MCNA), provided an overview of the MCNA Dental Wellness Plan. He noted that for over 25 years, MCNA has been a premier underwriter and administrator of dental benefits with a focus on providing services for Medicaid and Children's Health Insurance Program (CHIP) members. MCNA is a family-owned business headquartered in Fort Lauderdale, Florida, and serves over 4.5 million children and adults in nine states. MCNA takes a proactive approach to utilization management, emphasizing preventive dental care to improve the oral health outcomes of members and leading to long-term cost savings. Mr. Canales noted that MCNA has actual dentists reviewing claims and he reviewed the accreditations held by MCNA. He stated that MCNA provides leading-edge technology to assist providers with daily program administration, including through a web-based provider portal utilized by 99.6 percent of their Iowa providers. MCNA uses an integrated call center with locations in Texas and Florida to minimize wait times for Iowa members and providers, provides robust training emphasizing first call resolution and cultural competency, has many service representatives who are

multilingual, and offers translation services in nearly 300 languages. Mr. Canales reviewed call center operational statistics and their targeted outreach methods, focusing on increasing the oral health literacy of their members and the community at large. To date in 2018, MCNA has processed over 210,000 claims for DWP members, with an average turnaround time of 11.65 days, and the majority of those receiving services received a diagnostic or preventive service. MCNA conducts member and provider satisfaction surveys and to date in 2018, the overall member satisfaction rate is 96.46 percent and overall provider satisfaction rate is 81.4 percent. MCNA has 502 unique providers and is looking to increase participation by continually outreaching to noncontracted providers, which is a challenge due to the issues identified earlier by Delta Dental including missed appointments, low reimbursement, and administrative burdens. MCNA is considering launching an Elite Provider Program in Iowa, if approved by IME. The program would recognize stellar providers as preferred providers and reward such providers with an AuthPass to allow them to bypass clinical review processes for qualifying services based on their history of superior clinical performance. MCNA hopes to implement the program in January 2019. Mr. Canales reiterated that MCNA is currently in nine states and will soon expand to Washington state. MCNA contracts only in states that carve out the dental benefit as a stand-alone benefit. MCNA works with all of their partners, including IME and Delta Dental, to make the program more efficient and more successful.

Committee Discussion. In response to a question by Representative Forbes noting the low reimbursement of 30 to 40 percent of the dentist's usual fee and asking who sets the fee, Mr. Canales responded that in most states, the state hires an actuary to determine a fair fee. However, the dental insurance provider is not prohibited from providing higher reimbursement. With regard to administrative fees, Mr. Canales said he thought the fees were about 15 percent, but that he would provide this information to the committee. In response to a question regarding how Iowa reimbursement rates for dentists compare to other states, Mr. Canales stated that most states have low reimbursement rates, but Texas has a higher reimbursement rate because they have a very strong dental association lobby. Currently, MCNA does not participate in the hawk-i program. Representative Forbes noted that he had been told that the hawk-i reimbursement for dentists is higher and that is why dentists are more willing to participate. Mr. Canales agreed that reimbursement is one of their biggest challenges. Senator Mathis asked about the processing of claims and asked what "turn around" means. Mr. Canales stated that the number of claims paid does not include those denied and said that he will provide the committee with the total number of claims of each type.

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. Jim Fox, Options of Linn County, reviewed his written comments. He thanked Co-chairperson Heaton for his support for the disability community and wished him a happy retirement. Mr. Fox represents Options of Linn County, a day habilitation provider. He recommended that administration of reimbursement for long-term services and supports (LTSS) be removed from managed care and either returned to a fee-for-service (FFS) system or be provided through a separate managed care organization independent from traditional Medicaid, as LTSS services do not fit into the traditional Medicaid model. He noted that Director Foxhoven had once suggested that this was a good idea and that other states use this model. Mr. Fox recommended that the committee address the conflict of interest inherent in the tiered rate system. Individual tiered rate assignments are based on support intensity scale (SIS) scores, which he does not consider a reliable instrument. He stated that MCOs have a financial interest in the outcome of each SIS assessment and those who administer the SIS

are employees of the MCOs. He stated that the same conflict of interest exists in case management services. He suggested that the state develop an independent assessment process as well as an independent case management system to address these conflicts. He also asked that the state address the effect of tiered rates on day habilitation programs. When the tiered rates went into effect for supported community living, these programs were given 18 months to adjust to the new rates, but day habilitation programs had to adjust from day one. When additional funding was appropriated for supported community living programs, none of the increase went to day habilitation programs and they have had to initiate a number of cost-containment activities, including staff layoffs, and for the first time are turning members away because their tier assignment will not fund the level of support his organization needs to provide. Many of their members are at tier 2, which might be losing funding. He asked the committee to review the decisions that have adversely affected day habilitation services and treat them the same as other HCBS providers.

Ms. Flora Schmidt, Executive Director, Iowa Behavioral Health Association (IBHA), provided comments in three areas: the recommendations of the Substance Use Disorder (SUD) work group, the health home work group, and issues regarding timely and accurate payment.

Ms. Schmidt stated that the IBHA is in full support of the work of the SUD work group and the findings and recommendations of the work group, and she extensively reviewed the work group's recommendations for the committee. She also noted that with regard to whether Medicaid requires prior authorization for Suboxone treatment as stated earlier in the meeting, on review with the Department of Public Health it was confirmed that while this is a requirement for Medicare, it is not a requirement for Medicaid. She added that several states already allow for no prior authorization for Suboxone, but Iowans are dying because of the continued prior authorization requirement. She noted the SUD work group also suggested a review of Operating While Intoxicated assessment reimbursement rates and a review of parity of SUD treatment services.

With regard to the health home review, Ms. Schmidt noted that while DHS was required to facilitate a work group and address four charges, the meeting time was limited to only four hours during two meetings held within a two-week span. IBHA also has concerns with contract adherence of the health homes lead entity, the MCOs; requests that any changes to the SPA be thoroughly vetted prior to submission to CMS; that changes to payment from a PMPM to an amount based on CPT code be thoroughly vetted since this is a step backward and away from the movement toward value-based care; and requests that the work group continue to meet in open, public meetings to work toward continued collaboration. On the positive side, IBHA is encouraged with the data regarding IHHs that overall costs of care are trending downward and that reviews illustrated provider compliance, although there is recognition of the need for improvement in oversight and communication.

She also asked the committee to continue to provide oversight regarding timely and accurate payment of providers.

Ms. Shelly Chandler, Iowa Association of Community Providers (IACP), spoke with the committee about the tiered rates discussion earlier in the meeting. She stated that as an association they are supportive of standardization of the assessment process as well as tiered rate reimbursement and funding of reimbursement for services to higher-needs members. She acknowledged the point Mr. Fox raised regarding the exclusion of the day habilitation programs from the impact of the tiered rate system, but limited her comments to the daily supported community living (SCL) or residential programs. She noted that 80 percent of members in daily SCL are in tiers 2 and 3. So, while the IACP is supportive of providing funding for the higher tiers, the program is mainly for members in levels 2 and 3 and the higher tiers are the outliers. IACP understands the dilemma of DHS to maintain budget neutrality and is grateful

for the additional funding of $7.3 million provided to partially make providers whole to FY 2014 levels. Ms. Chandler clarified that the original $15 million requested was not new money but would have made the providers completely whole only to the FY 2014 level. She noted that the cost reporting system is not an accurate reflection of the real cost of doing business. The cost reports for FY 2017 reflect the first full year of managed care and the vast majority of providers had negotiated rates that were put in place before managed care. Initially there were thousands of rates for providers, so they moved to a weighted average which was based on outdated rates, and then they moved to tiered rates that were set by the department based on 2014 cost reports. $7.3 million was added to the system July 1, 2018, and now the system is moving to another change. It has been extremely complicated for providers. IACP is looking forward to working with the General Assembly and is hopeful that the remaining funding will be provided to make providers completely whole to FY 2014 levels. She thanked the committee for its work with IACP.

Ms. Karen Walters Crammond stated that she has worked in the mental health and disabilities services system for 40 years, at various levels, and was a member of the health home work group as an independent subject matter expert. She noted that the HH SPAs appear to be similar in part because CMS prescribes a template for the SPAs, including the names of the six core services. However, the specific definitions of the target populations, the six core services, and the types of providers are significantly different between the two SPAs, by design, because of the populations served and the types of providers involved. IHH replaced targeted case management, which did not exist on the chronic condition side, and that level of member interaction and care coordination needs to be preserved. There is overlap in the six core services, but there should not be a preconceived notion that the services will be provided in equal amounts. If the IHH is doing a good job of keeping members out of the hospital and emergency rooms, the need for transitional services is minimal. Moving to the use of CPT codes for the six core services will add unnecessary increased administrative burden on the HHs and move them away from value-based purchasing arrangements. Further study of the HHs is needed, as recognized by DHS. She encouraged DHS to conduct the further analysis of compliance with the SPAs and of quality measures before moving ahead with any changes, including changes in the SPAs or going to separate CPT codes. The review of member records to determine compliance with the SPAs included less than 1 percent of members enrolled in each type of HH and combined the separate types of HHs into one data set. She also encouraged further studies of CCHHs and IHHs as the separate programs that they were designed to be. She suggested that less drastic measures might be taken to address any concerns raised in the review.

Ms. Ashley Thompson, Government and External Affairs Team, UnityPoint Health (UPH) and a member of the HH work group, noted that at the Health Policy Oversight Committee meeting in November, Sabra Rosener, Vice President, UnityPoint Health, discussed value-based purchasing in Medicare. Part of Ms. Thompson's role at UPH is working with behavioral health and the five community mental health centers that are part of the UPH network, including the Berryhill Center, Abbe Health, Black Hawk Grundy Mental Health, the Robert Young Center, and Eyerly Ball. All of these are also IHH centers and account for five of the 35 IHH providers and the provision of services to about 25 percent of the IHH population. UPH also provides services to Medicaid members at many levels of the health care system. She thanked DHS for the work group on IHH. She noted that the HH work group found some success, including that 100 percent of the HHs demonstrated evidence of quality improvement activities. None of the quality improvement or patient experience data was included in the review, so she appreciates that the future reviews will include a more holistic view of the work of the IHHs. Another critical piece in health care is using electronic health records to collect the data necessary to know where members are accessing care and their needs. Ninety-seven percent of IHHs are in the process of or are currently using electronic health records. She recommended pulling in the quality and performance data and

analyzing it before any changes are made to the HHs and the SPAs. Finally, she stated that she has gone out and spent time with IHH providers and has seen firsthand that when providers have access to data for the continuum of care as UPH providers do, it helps to drive down costs. UPC has internal data showing that with IHH there are fewer members coming into emergency departments and fewer inpatient stays. She encouraged the committee to support the department's continued review of HHs before any changes are made.

VIII. Closing Comments

Committee members thanked Co-chairperson Heaton for his leadership, his years of service, the tours around the state which enabled members to both be educated and bond with each other, and for all that he had done for all Iowans in health and human services policy and appropriations. Co-chairperson Heaton thanked everyone for their comments and stated that the work of the Human Services committees has always been bipartisan and that members worked together for the betterment of all Iowans. He said that new, exciting opportunities are coming, those involved will be lucky to work on these issues that will make big changes, and he will miss being involved from the legislative side. With regard to mental health, he stated that by Iowa adding mid-level services to the system, though implementation will be challenging, if successful, Iowa's mental health system will be one of the finest. He wished the committee members well, and thanked everyone involved for their work. He said he would be joining the advocates on the other side and was met with a standing ovation.

www.youtube.com/watch?v=9RM40EDGICM

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/documents?committee=24165&ga=ALL