MINUTES
Health Policy Oversight Committee

Friday, September 20, 2019

MEMBERS PRESENT

Senator Mariannette Miller-Meeks, Co-chairperson
Senator Mark Costello (by phone)
Senator Liz Mathis
Senator Amanda Ragan
Senator Mark Segebart
Representative Joel Fry, Co-chairperson
Representative Timi Brown-Powers
Representative John Forbes
Representative Shannon Lundgren
Representative Ann Meyer

LSA CONTACTS: Organizational staffing provided by: Patricia Funaro, Senior Legal Counsel, 515.281.3040 and Adrienne Seusy, Legal Counsel, 515.281.3444; Minutes prepared by: Patricia Funaro, Senior Legal Counsel, 515.281.3040

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I. Procedural Business

The first meeting of the Health Policy Oversight Committee of the 2019 interim was called to order at 10:02 a.m. in Room 116 of the Capitol and adjourned at 12:43 p.m.

II. Department of Human Services (DHS) Presentations

Following opening comments by Mr. Gerd Clabaugh, Interim Director, Department of Human Services (DHS), noting the recent selection of Ms. Kelly Kennedy Garcia as the new DHS Director, Mr. Michael Randol, Medicaid Director, DHS, provided an overview of the Medicaid program, reviewed state fiscal year 2020 Medicaid cost drivers and managed care contracts and rates, provided an update on changes to the Medicaid program based on recent legislative changes, and provided an update on the transition resulting from UnitedHealthcare (UHC) terminating and Iowa Total Care (ITC) commencing Medicaid managed care coverage in the state.

A. Transition

Overall Review. Director Randol noted that DHS had learned from prior transitions of Medicaid managed care organizations (MCOs) in the state so that the transition from UHC terminating coverage on June 30, 2019, and ITC commencing coverage on July 1, 2019, went well, with little disruption or impact on Medicaid members. There were several issues with very specific provider types regarding claims payments, but no systemic issues with provider payments or member services have been identified. DHS continues to monitor the transition and to meet with each MCO twice weekly to work through issues that develop and to address them through system changes or provider education. Medicaid members were initially distributed by attributing 50 percent of the members to each of the two MCOs, with the intent that no one MCO have a disproportionate number of members from a specific population. However, members were provided a choice and still may change their MCO membership until September 30, 2019, without cause. Currently there are approximately 618,000 Medicaid members with 355,000 (57.4 percent) Amerigroup (AG) members and 263,000 (42.6 percent) ITC members. DHS will continue to monitor the membership including by rate cell. The Medicaid program gains approximately 8,000 to 9,000 members per month and DHS will alter the distribution algorithm if necessary to ensure the population distribution is as equal as possible. Director Randol reported that all entities involved in the transition went above and beyond to make the transition as seamless as possible.

ITC Transition. One of the biggest concerns with the transition was providing continuity of care for the long-term services and supports (LTSS) population. ITC contacted 97 percent of their 15,000 LTSS members within the first five weeks of the transition and by early September had completed 2,300 level of care assessments for these individuals. ITC has contracted with over 37,000 providers and has a network adequacy of approximately 98 percent. One area of continued focus is elderly waiver level IV provider capacity, but ITC continues to work to add these providers. As of early September, there were only 64 practitioners and six providers that remained to complete the credentialing process. ITC has paid over 500,000 total medical claims totaling $128 million and over 680,000 pharmacy claims totaling over $52 million. As ITC set up its claims processing system, an issue with claims processing for specific provider types was identified, but a process is in place with designated timelines for correction. The affected providers are involved in the process and ITC has worked with the providers who have experienced significant cash flow issues to either issue manual checks or transfer funds to those providers. During the first week of the transition, a provider of home-delivered meals decided to terminate service, affecting approximately 100 members. ITC sent case managers out into the community to contact all of these members, took meals to the members, and contracted with another

provider to deliver the meals. Additionally, there were several providers who had signed contracts with but were not credentialed by ITC by July 1, 2019. ITC had a process in place to pay these providers until they are credentialed.

AG Transition. DHS has continued to meet with AG and AG has been involved in the meetings with both ITC and UHC throughout the transition. AG had a member who transitioned from UHC, did not yet have a new ID card, but required insulin. AG ensured that the member received insulin during the transition.

Resource Guide. Director Randol noted that the committee members had received an Iowa Health Link Legislative Resource Guide with contact information for constituent and provider resources, and encouraged committee members to use the resource guide or to contact him so DHS can track and resolve issues as they develop.

B. Review of New Contracts and Legislative Requirements, State Fiscal Year (SFY) 2020 Cost Drivers, and Medicaid Program Overview

Director Randol reviewed the documents entitled "IA Health Link: Summary of New Contracts and Legislative Requirements," "State Fiscal Year 2020 (SFY 2020) Cost Drivers," and "Overview."

Rates and Cost Drivers. AG and ITC signed contracts for SFY 2020. The capitation rates under the contract are based on actual experience of members for SFY 2018, incorporate legislative and policy changes, and are actuarially sound. The new capitation rates are reflected in a $386 million total increase with the state share being $115 million, or a total increase from SFY 2019 of 8.6 percent (state share 6.5 percent). In reviewing the "State Fiscal Year 2020 (SFY 2020) Cost Drivers," document, Director Randol noted that 50.9 percent ($196 million) of the cost increase was due to legislative, program, and policy changes and 49.1 percent ($189 million) was due to health care costs. The document also demonstrates the nonmedical load or medical loss ratio (MLR) as 7.8 percent including 2.35 percent for care coordination, case management, and medical management; 3.7 percent for traditional administration; and 1.75 percent for profit/risk/contingency.

Contract Changes and Improvements. Specific policy changes made regarding contract changes and improvements include: new protections in MCO contracts requiring that LTSS members may choose to have others of their choice present during the performance of a level of care assessment, that LTSS members are provided more timely notice of their level of care assessment (at least 14 days' prior notice), and that LTSS members receive a copy of their assessment within three days of completion from the MCOs; requiring MCOs to load provider rates within 30 days (previously 60 days), and to complete provider credentialing and load those provider rosters timely; assessing liquidated damages relating to timely and accurate submission of encounter data; and assessing additional penalties for reoccurrence of prior authorization and claims payment system issues.

House File 766. Legislative requirements resulting in expenditure increases from 2019 Iowa Acts, House File 766, include an increase of $59.8 million (23 million state dollars) due to rebasing of nursing facility rates; an increase of $12.8 million in mental health funding for year two implementation of changes to the adult mental health system and implementation of the groundwork for the children's mental health system including elimination of the waitlist for the children's mental health waiver; an increase of $3.8 million (1.5 million state dollars) for additional reimbursement to critical access hospitals using a cost adjustment factor; an increase of $540,000 (211,000 state dollars) to update the fee schedule amounts for Current Procedural Terminology (CPT) Codes related to assertive community treatment effective July 1, 2019, pending federal approval; and an increase of $2.6 million (1 million state dollars) for tiered rates for intellectual disability waiver providers distributed equally across all six tiers. As required, DHS is also working to adopt rules to require both MCO and fee-for-service (FFS)

Medicaid to utilize a uniform prior authorization (PA) process. A PA workgroup convened in August and is meeting every two weeks. As required by the legislation, rules will be noticed in October and tentative implementation of the process is planned for July 2020.

House File 518. 2019 Iowa Acts, House File 518, required DHS to work with the Centers for Medicare and Medicaid Services of the United States Department of Health and Human Services (CMS) to allow for the payment of the nursing facility room and board expenses for dually-eligible Medicare and Medicaid members at 95 percent of the nursing facility's FFS rate rather than indirectly as a pass-through payment for the hospice services provider. This change requires federal approval, but DHS has been told by CMS that this policy cannot be implemented through a Medicaid state plan amendment or a 1915b or 1115 waiver. DHS is continuing to work with CMS to determine if this policy can be implemented and will update the General Assembly as information becomes available.

House File 570. 2019 Iowa Acts, House File 570, requires DHS to eliminate the monthly budget maximum or cap for individuals eligible for the Medicaid home and community-based services (HCBS) brain injury waiver. Effective July 1, 2019, for both MCO and FFS members, these members no longer are required to request an exception to policy to exceed the monthly maximum, but instead may access the medically necessary services and supports identified in their comprehensive person-centered services plan. Providers were notified of this change in DHS Informational Letter 2030. The change is budget neutral as required under federal law.

Program Changes and Required Rate Increases. Other changes accounting for an increase of 83.1 million state dollars include providing access to Hepatitis C treatment for a greater number of Medicaid members by expanding eligibility for services from a fibrosis score of F4 to an F2, and rebasing of the rates for federally qualified health centers, rural health clinics, and intermediate care facilities for persons with an intellectual disability.

Other Medicaid Program Changes. The Medicaid program instituted passive assignment of new members effective July 1, 2019, meaning that new members are automatically assigned to an MCO rather than being first assigned to FFS for an initial 10-day to 45-day period, thereby allowing members to access services sooner.

The Medicaid program instituted mandatory electronic claims submission on August 1, 2019, for providers under both FFS and MCOs, excluding Consumer Directed Attendant Care (CDAC) providers. Dental providers will be subject to mandatory electronic claims submission beginning February 1, 2020.

Medicaid Overview. Director Randol reviewed the document entitled "Overview." Director Randol stated that DHS wants to provide an overview of Medicaid on an annual basis, and developed the overview document to do so. The overview document includes information compiled by DHS over several months regarding the number of Iowans enrolled in the Medicaid program; the differences between Medicare and Medicaid; who is covered, by population and by county, and the number of uninsured; the cost of care by population, service, and setting including waiver populations and services; and quality and outcomes data.

C. Member Discussion

Transition. In response to an inquiry by Representative Fry regarding the process for UHC to exit the state, Director Randol responded that to ensure that member services continued and providers were paid during the transition, DHS instituted a claims reserve table and timeline for all UHC provider claims. UHC will update DHS on a monthly basis as claims are paid. The reserve fund will be retained until claims are paid in full, which could extend beyond the end of the year. The approximate current amount in the claims reserve fund is $55 million.

In response to a question by Senator Ragan regarding when final payments from Amerihealth will be made, Director Randol responded that DHS met with the Legislative Services Agency (LSA) at the end of May 2019 and asked that LSA communicate to legislators that Amerihealth would be exiting the market August 1, 2019, and that if legislators knew of providers who had not been paid, they should contact Director Randol directly. There were providers who resubmitted claims, but Amerihealth has resolved those claims either by paying the claim or appropriately denying the claim. DHS has retained a small amount of funding from Amerihealth, but at this time, Director Randol is not aware of any other outstanding provider claims. Director Randol encouraged legislators to have any provider with a new claim contact him directly. In response to whether DHS is working to add a third MCO, Director Randol stated that, unfortunately, Iowa Medicaid has already been through two MCO transitions in a short period of time, and each time it has disrupted member care. He believes there should be a third MCO, eventually, to provide choice for members and to provide a competitive market. However, in order to allow the system to stabilize, a third MCO will not be added anytime soon.

In response to an inquiry by Representative Forbes regarding issues with payment of specific ITC providers during the transition, Director Randol responded that when provider payment issues were identified during the transition, DHS contacted the provider associations and providers to let them know the timeline for correction of the issue and asked affected providers if they had issues with cash flow and payroll. If a provider did have such issues, ITC advanced payment to these providers, many of whom were CDAC providers, in the form of a manual check or wire transfer based on claims submitted. Director Randol was not aware of Amerigroup doing this during the transition. Representative Forbes also inquired about the MLR and Director Randol noted that in comparison to surrounding states, Iowa's MCO MLR rates are low with some states averaging 10 or 11 percent. Representative Forbes expressed support for adding a third MCO to better position the state for negotiations, and Director Randol reiterated his support for adding a third MCO, but doing so with the least amount of disruption.

In response to a question by Senator Mathis noting the reoccurring and lingering theme since April of 2016 of denial of payment, late payments, or a long process for payment to providers, and whether the MCOs or providers are responsible for the issues, Director Randol responded that there is responsibility on both sides. DHS monitors these issues and if the problem is on the side of the MCO, establishes a timeline for resolution. With the recent transition, the issues with provider payments have not been widespread and systemic, but rather have been very specific to provider types. DHS has set up a project plan and a listing of these projects and reviews the listing two times per week. If an issue persists, DHS works with the MCO to contact the provider and either educates the provider or determines the reason for the payment issue. In reality, all claims submitted will not be paid, but DHS wants to achieve a normal denial rate. Pharmacy denials are higher due to their point of sale nature. DHS maintains data on denial rates by provider. These rates are not yet where they should be based on surrounding states, but they are improving. Senator Mathis encouraged Director Randol to more thoroughly examine payment denials of providers who have been involved since the inception of managed care in Iowa and are still having issues with payment, are frustrated with the process, and along with low reimbursement rates are at a tipping point regarding whether to continue providing services. Senator Mathis asked if DHS could provide data regarding how many of the providers who were providing service before April 2016 are still providing services to Medicaid members as of July 1, 2019, by provider type, and Director Randol agreed to provide the information.

In response to an inquiry by Senator Miller-Meeks regarding whether the PA process will be less cumbersome for providers once MCOs have more experience in the state, Director Randol responded that a 90-day continuity of care process was instituted during the transition so that PA was not required during that period and members could continue services uninterrupted. He agreed that when an

MCO comes into a marketplace, the MCO may require PA for certain benefits based on experience in other states, but once the MCO gains familiarity with the state, PA requirements may be adjusted. Additionally, as the result of the 2018 process improvement work group, DHS continues to work with the MCOs to evaluate PA requirements and to eliminate those requirements the MCOs determine to be unnecessary. Senator Miller-Meeks shared that in a survey of her own patients, those assigned to ITC were pleased with the transition and their services.

MCO Contracts. In response to a question by Representative Fry regarding the process and expectations for the mid-year review of capitation rates, Director Randol responded that DHS committed in the contract to have a mid-year review of the rates to determine if the trend was accurate. Toward the end of October or November, DHS will meet with the actuary and review data to compare the projected trend for SFY 2020 rates and what the actual data is showing. Then, DHS will bring in the MCOs to begin discussions about what DHS and the MCOs, respectively, are experiencing, reconcile the differences, and determine how to proceed. Director Randol stated that even though these discussions are part of negotiations, he can share where they are in the process with the General Assembly moving forward.

In response to a question about the social determinants' initiatives included in the contracts, Director Randol responded that this is exciting work but requires full implementation in the next couple of years of the Medicaid Management Information System (MMIS) modernization in order to perform the necessary data analytics. DHS changed the health risk assessment used by the MCOs by adding 13 social determinants of health questions. Once the results of the assessments are received, the data is inputted and analyzed relative to what is impacting the member's health, such as food insecurity, housing, or transportation, so that the results may inform future changes in the Medicaid program.

With regard to program integrity efforts, Director Randol responded that when he began as director, he did not think program integrity efforts were sufficient. So, the contracts now include additional program integrity features, and program integrity expectations will be incorporated into rate setting.

Senator Ragan asked Director Randol to comment on whether an increase in capitation rates for the 2021 contract period is contemplated. Director Randol stated that he did not have sufficient information to know if there would be an increase in capitation rates because the contracts are on a state fiscal year rather than a calendar year cycle. Director Randol agreed to provide a capitation rate cost per member to the committee. He reiterated that 92.2 percent of the capitation rate is paid out to providers, and that the increase in capitation rates is driven by utilization, and does not result in a large increase in profit to the MCOs.

Representative Brown-Powers shared that durable medical equipment (DME) providers have told her that there have been delays in payment and asked if the MCO contracts could specifically include required timely payment to such providers. Director Randol responded that there is currently language in the contract that requires that a certain percentage of clean claims be paid within a certain time frame, but that DHS could consider additional language to address the DME issue. He also suggested that with the increase in the number of provider trainings, the trainings can be made specific to provider type to address their particular issues.

Representative Forbes noted that capitation rates were not available for the General Assembly before adjournment of the 2020 Legislative Session and wondered if Director Randol could provide some assurance that the capitation rates would be available before the 2020 Legislative Session adjourns. Director Randol responded that he could not provide any assurance, but that part of the delay in setting rates had been the exit of UHC and its impact on the entire negotiations environment. Because the state operates on a fiscal rather than a calendar year, DHS needs a complete base year of data upon

which to determine rates. Director Randol stated that rather than place a deadline on negotiations, he prefers to have appropriate negotiations.

Senator Mathis stated that at the first Health Policy Oversight Committee meeting with the initial three MCOs, she had asked when the program would evolve to the stage of innovation. She noted her support of the incorporation of social determinants of health, which term has been around for at least 15 years, into Medicaid managed care. She recently read the North Carolina waiver which includes a social determinants of health billing code. She has been working to build a coalition to move toward innovation, and possibly this could reflect work with social determinants of health. She asked if moving ahead with social determinants of health, Director Randol envisions pilots, billing codes, or other alternatives. Director Randol stated that as they collect and analyze the data, certain areas of the state might be targeted for innovation if they present specific medical issues or chronic conditions, rather than focusing statewide initially. Senator Mathis encouraged Director Randol to consider the areas of maternal health and children's mental health in these efforts.

Legislative Changes and Updates. In response to a question by Representative Fry about receiving information about the number of children on the children's mental health waiver on an ongoing basis, Director Randol responded that the DHS website provides updated information on the number of individuals on each waiver. Representative Fry also asked about expediting the process for implementing a uniform PA process. Director Randol noted that he had been candid about the complexity of implementing the process during the legislative session, and therefore the legislation requires that rules be adopted by October 1, 2019, but the process is not required to be implemented until July 1, 2020. Representative Fry encouraged DHS to implement the process sooner, if possible, and Director Randol agreed to do as much as possible to implement the process by July 1, 2020, or earlier.

In response to a question by Senator Segebart regarding how much of a role the Governor's office plays in MCO contract negotiations, Director Randol responded that the individuals present during negotiations do not include the governor's office, but instead include only himself, Iowa Medicaid Enterprise (IME) employees, the actuary, and the MCOs. Senator Segebart also commented that timeliness of payment to providers seems to be the lingering issue.

Senator Miller-Meeks asked if information about provider reimbursement rates by categories, both prior to and after privatization, could be provided to the committee. She also noted that if there is a requirement that clean claims be paid within 30 days, the payment might not be received by the provider within that 30 days, so it would be helpful to have information about how many claims are approved within 30 days and the time frame in which the claims were actually paid. Director Randol responded that DHS does not set the payment terms between the MCO and the provider, but instead those terms are set between the individual provider and the MCO in their contracts. So, the payment time frame might be more or less than 30 days. He said there is a requirement that if provider rates are changed, they must be loaded into the payment system within 30 days. He offered that DHS could collect information on the average turnaround times on payment of claims by provider type.

Representative Lundgren noted that DHS had informed the General Assembly about the time spent on reviewing exceptions to policy for the brain injury waiver, thereby precipitating the change in law to eliminate the cap on that waiver. She encouraged DHS to review waiting lists for other waivers to determine if changes might be made to other waivers to ensure continuity of care going forward.

Representative Forbes noted his work regarding issues with reimbursement of Medicaid MCO pharmacy benefit managers (PBMs) and asked if DHS is still working on these issues. Director Randol responded that he has an encounter data officer whose only duty is to review encounter data to reconcile data and

provide appropriate reimbursement. He also noted that to ensure that spread pricing does not happen, the actuary reprices every pharmacy claim back to the appropriate reimbursement amount and these edits are used to set the capitation rates. This monitoring is done on an ongoing basis so Director Randol is confident that spread pricing is avoided and does not influence the capitation rates. Representative Forbes reiterated that based on the data DHS provided to him, while a pharmacy was paid correctly, the PBM was paid an inflated rate. Director Randol responded that any such inflated rate would be edited out and not included in the development of the capitation rate. Representative Forbes reiterated that spread pricing has happened in Iowa as well as Ohio and he remains concerned that the state of Iowa and its citizens not be overcharged. Director Randol agreed to meet with Representative Forbes to review pharmacy claims and ensure they were rebilled correctly.

III. Amerigroup Provider Quality Incentive Program

Mr. Jeffrey Jones, President, AG, provided an overview of AG's value-based purchasing (VBP) opportunities and results in the Iowa Medicaid program. He reviewed the goals of VBP, noted that VBP is based on a partnership model that involves collaboration and development of long-term relationships, and emphasized that VBP agreements, including shared savings models and quality incentive programs, are based on a continuum to fit the provider type and to include measurement tools tailored to the specific provider. AG used calendar year 2018 to strategically focus on expanding and transitioning from the sole use of the unit-cost model in which fees are paid for services, to an outcomes-based model in which incentives are paid for value represented by improved outcomes and quality of service. These efforts align with the IME goal of an MCO achieving a target of 40 percent of eligible members associated with a provider that participates in a VBP contract, which goal AG exceeded last year. Two types of approaches are used in VBP: quality incentive programs which are provider-type specific, and negotiated savings arrangements. Value is a journey and not all providers will reach the highest level of risk on the continuum due to limitations in data capabilities and other issues. AG has quality incentive program agreements customized by provider type that include measurement tools tailored to the specific provider. Two of these are nursing facility and personal attendant care pilot programs. AG also has negotiated shared savings agreements that are available for more complex and sophisticated providers, groups, and systems that are interested in contracts dependent on quality and performance. Mr. Jones reviewed specific types of quality incentive programs by provider type. AG's value-based arrangements include 48 percent of its Iowa members and approximately $1.5 million has been paid out as incentives to providers enrolled in value-based arrangements. In 2018, participating providers met goals for categories including children and teens visiting doctors or a well care appointment, improved access to preventive care, and higher rates of cervical cancer screenings. Future goals include increasing program participation and the statewide footprint; improving provider engagement, care coordination, and physical and behavioral health integration; continuing to lower the medical loss ratio; and continuing on the continuum towards risk with providers who are ready to move forward.

Ms. Sarah Dixon, Chief Strategy Officer, Iowahealth+ (IH+), provided an overview of IH+. IH+ is an integrated primary care network that is a voluntary business venture owned and managed by 11 Iowa federally qualified health centers (FQHCs) and the Iowa Primary Care Association (PCA). IH+ has partnered with the IME, the Medicaid MCOs, and others to transform the care delivery system and to share in the financial rewards of the work as one of the largest accountable care organizations in Iowa Medicaid. Organizational alignment of Iowa PCA, IH+, and INConncert care is necessary to leverage the resources to participate in a value-based arrangement. The alternative payment methodology framework is important because it demonstrates the levels of participation. IH+ is a category 2 participant. Ms. Dixon noted the history of innovation and partnership that enables IH+ to

be successful. She reviewed the IH+ Provider Quality Incentive Program (PQIP) focus areas which include four Healthcare Effectiveness Data and Information Set (HEDIS) measures, selected by AG, plus improvement in the medical loss ratio focusing on reduction in emergency department use; the IH+ model of care which includes a focus on integration of care, ensuring access to care, managing patient care transitions, improving high-risk care coordination, providing high-quality care, and social determinants of health, and which is supported by health information data and analytics and by patient engagement strategies; the investments made to participate in the PQIP including an interdisciplinary team to support the health centers, sharing of best practices, network and shared decision-making, meeting of clinical and other care teams, focusing on payor partnership metrics, models of care, and a mutual investment in a shared data analytics platform; and the AG PQIP results. The results include that IH+, which served over 170,000 patients and had more than 58,000 attributed Medicaid lives in 2018, reduced its MLR by nearly 9 percent from 2017 to 2018, saving nearly $6 million in medical expenses and receiving a shared savings amount of over $651,000. Although IH+ is very happy with the results, IH+ left about $300,000 on the table due to insufficient performance, so IH+ is focusing on closing the care gaps and continuing to improve. The shared savings are being reinvested in network capacity and distributions to each member/owner health center of IH+. Ms. Dixon noted that future plans include optimizing data systems, securing partnerships, continuing progress on quality and performance improvement, continuing progress across the value-based pay spectrum, and supporting leadership development and enhancing change management capacity.

Representative Fry commented that the information presented is exciting and reflects what the state has been working toward for a few years. Representative Fry asked what provider types AG is moving toward including in VBP next and what barriers still exist. Mr. Jones stated that AG wants to move farther into the LTSS population as well as obstetrics/gynecology. Some of the barriers have been not moving fast enough and that sometimes those interested in VBP are not willing to take the risk necessary to move to the next level. Ms. Dixon added that one barrier is the issue of not providing timely payment to providers. VBP also requires a lot of data analysis and data sharing. Changes in PA would also be helpful. Representative Fry asked the presenters to provide suggestions to the legislature regarding how the legislature can be helpful in moving VBP forward.

Senator Miller-Meeks commented that data analytics are important and asked if IH+ chose the quality measures involved, if AG chose them, or if it was a collaboration, and if the determination was made based on the outcomes that IH+ was focusing on because of its member population data or if the decision was driven from the insurance side to increase savings. Ms. Dixon responded that in 2018, AG reviewed the prevalence of the IH+ patient population and the largest gaps in measures. So, in 2018, the measures were selected by AG and IH+ was supportive of using these measures. For the 2019 VBP arrangement, IH+ did negotiate the HEDIS measures used, so the contract includes the four HEDIS measures, a measure relating to total cost of care, and a more formalized measure relating to reducing emergency department utilization. Mr. Jones said that the determination of the measures should be all of the factors that Senator Miller-Meeks stated and the approach should be much more dynamic.

Senator Mathis thanked the FQHCs for being involved in VBP. She noted that when Medicaid was expanded, FQHCs took on more patients and now have waiting lists which, hopefully, will be addressed through the VBP arrangements. She asked about the ongoing strategic continuum and AG's proposal for focusing on the LTSS population. She noted that it is difficult to demonstrate improvement in the LTSS population and asked how AG was going to approach this. Mr. Jones said there is work going on now to develop the approaches and that moving forward will take flexibility. AG will look to other states to determine what is working as well and will have more concrete information soon.

Representative Forbes noted that VBP is the future of health care, but suggested that one area that was not discussed was medication management, since pharmaceutical costs are such a large factor in patient care and cost. Ms. Dixon noted that from a total cost-of-care perspective, there is a state formulary that is used for prescription drugs so there are some limitations on flexibility. Supporting patients in having access to and appropriately taking medications is important and some of the health centers have a clinical pharmacist as a partner in the care coordination methodology. They have done a lot of work on diabetes management but there is a lot of opportunity to address gaps. When they can obtain claims data, they will be able to more fully address this area. Mr. Jones stated that AG tracks pharmaceutical utilization by provider, population, and organization to monitor utilization and prescribing patterns and uses this information in their VBP arrangements.

Representative Lundgren asked how social determinants of health data is being incorporated into the value-based contracts and how this data will be shared with the state to provide a more holistic approach to member care. Mr. Jones stated that in conversations about a specific member base at a specific clinic, the conversation could turn into what the other external factors impacting the individuals are and where AG and the provider can intervene.

IV. Managed Care Organization Updates

Amerigroup. Mr. Jones provided an update including transition efforts. AG is very proud of its accomplishments to date. Mr. Jones reviewed the document entitled “Amerigroup Transition Snapshot” which includes information regarding total membership, LTSS members, LTSS annual assessments, claim volume and payment for SFY 2019 quarter 4 and claim volume and payment for SFY 2020 quarter 1 to date. The numbers include AG hawk-i membership. As a result of the transition, overall AG membership increased by 61 percent, with the LTSS membership increasing by 103 percent. It was critical that from the start, AG address recruiting, hiring, and training. AG added nearly 400 new positions with 288 home team Iowans and 120 staff supporting the broader infrastructure, so currently there are 640 associates in Iowa. In LTSS specifically, AG added over 174 positions including 130 community-based case managers. AG worked closely and successfully with UHC from a recruitment standpoint and leveraged the experience of the UHC existing staff. Since UHC staff were providing services until June 30, a delicate balancing act was necessary. AG tried to match existing case managers to LTSS members to preserve the relationship and continuity of care. Mr. Jones noted that claims volume and payment goals continue to be met. He noted their statistics reflect adjudication and payment of claims. Some of what AG has been navigating is the seven-day payment. If a provider was used to getting their payment in seven days, and it came later, the provider would be impacted. So, AG has been contacting providers to work with them to expedite payment. In some cases, this required prioritizing claims and escalating and processing them. AG does not issue manual checks, but did take some unique steps to address provider needs and will continue to address these needs until circumstances stabilize. Another issue specific to the transition is the continuity of care process put in place, including honoring PAs. AG tried to build in contingencies to catch any continuity of care provisions that might be missed. AG believes that in the next few weeks, claims issues will stabilize. Right before the transition, AG had a system modification that negatively impacted providers of Medicaid 1915(b)(3) or B3 services, behavioral health intervention services (BHIS), and habilitation services. AG responded quickly to correct this, and through August, 99 percent of these claims have been corrected.

During the transition, AG continued to work on innovations. AG has a health plan-wide committee working on opportunities in social determinants of health, focusing on identifying pilots with willing partners. AG is very focused on stable housing, food insecurity, and employment and is about to launch

the Champ pilot with a public elementary school in Des Moines to utilize the school as a community hub from which outreach is provided. Initially, the pilot will focus on housing, with the understanding that other issues such as food insecurity will emerge. AG is also involved in other partnerships including one with Iowa vocational rehabilitation/Iowa Works focusing on one-year apprenticeship programs for members, a reeducation coordination pilot focusing on transitioning formerly incarcerated members, utilizing opioid risk predictor models to monitor high-risk member opioid utilization and to identify them for high-risk case management, and providing access to certified peer support and wellness and recovery specialists. AG is focused on a variety of innovations from a social determinants-of-health standpoint and continues to move forward.

On October 1, AG is moving to Ingenio Rx, an Anthem-owned pharmaceutical benefits manager, and the provider network will be larger. Regarding the PA for outpatient therapy providers for some very specific services, AG has received feedback, and given the confusion about the policy, AG is pausing to review the policy and engage differently to identify the appropriate time to institute the policy with the appropriate measures.

Iowa Total Care. Mr. Mitch Wasden, Plan President, ITC, provided an update on the Medicaid managed care transition effective July 1, 2019. Mr. Wasden noted that as the new MCO in Iowa, ITC is focused in the first year on getting the plan up and running. Mr. Wasden shared that his background is in 20 years of running hospitals and health systems at academic medical centers and safety net hospitals, some of which have been integrated delivery systems that include a hospital, a medical group, and a health plan. It is an exciting time to be in Iowa because he has seen the power that comes from provider and payor integration and collaboration. Sometimes on the provider side, necessary data is lacking to perform true population health management. So, when the health plan side, which has claims and other data that the provider does not have access to, collaborates with the provider, the strengths of both can be leveraged to the advantage of the member. He is excited as the next phase of innovations and value-based care begins to work with providers to determine both how to provide timely and accurate data and what incentives to include. Through a local focus and national expertise, ITC is hoping to be a positive change agent in the state as part of the larger entity, Centene. Iowa is one of the largest MCO launches that Centene has been involved with. Initially, ITC thought 500 local staff would be needed. But, when UHC announced termination of services in the state, ITC determined 820 staff and a second location for its health center would be needed. Today, ITC is fully staffed and operating effectively. Mr. Wasden shared success stories and noted that ITC observes successes daily due to the public health focus of the payor and provider partnership. ITC has been in operation less than 90 days, and has positive metrics to show for this time period. But, as is often the case, ITC has identified opportunities for improvement. With regard to claims payment, ITC has been paying 99.8 percent of claims within 30 days. However, the setup of the system, which required the loading of thousands of contracts and information for tens of thousands of providers, did create some issues and unintended errors. ITC has been working closely with providers to ensure that if there is an error when processing claims due to a setup issue, ITC will make a hardship payment to the provider. To date, $2.5 million in hardship payments have been made to over 91 providers, many of whom are CDAC providers. An ITC team from the corporate office in St. Louis has been on-site and will remain for the next several weeks to identify issues and initiate remediations in the start-up claims situation. To date, 60 percent of the known issues have been remediated and the remaining 40 percent will be remediated in early October. ITC membership is currently 262,000, and ITC has network adequacy across the entire state with 37,000 providers. One area ITC is working on is the provider network for the elderly waiver in one part of the state that is currently at 68 percent network adequacy. For member services, ITC has taken 54,000 calls with an average speed to answer of 6 seconds, and has taken 23,000 provider calls with an average speed to answer of 16 seconds. In terms of claims paid, ITC

has processed over 500,000 medical claims totaling over $160 million and has processed over 680,000 pharmaceutical claims totaling over $52 million. The LTSS staff has completed over 2,300 level of care assessments. Due to the large influx of assessments that must be completed, ITC has agreed that LTSS members will continue to receive services under their existing care plans until new assessments can be completed. Another area of progress is in completion of health risk assessments that include the new 13 social determinants of health-related questions. ITC has completed over 30,000 health risk assessments, utilizing over 312,000 calls to members. One member, who is homeless, has several behavioral health and substance use disorder diagnoses. The ITC outreach group set up an in-person meeting with the member and completed a health risk assessment. From that assessment, the member was connected with a behavioral health provider to have medications billed because the member had not been to a provider in 12 months. The member was also set up with a primary care physician to schedule a wellness check-in. In terms of transportation, which is key to the Medicaid population, ITC has facilitated over 107,000 trips to medical appointments, about 70,000 of which were nonemergency medical appointments and 37,000 of which were for waiver patients. Another story Mr. Wasden shared was of a member who did not realize transportation was a benefit of the Medicaid program. He had a chronic condition but was failing to set up or go to medical appointments due to lack of transportation. The ITC case manager reached out to him and let him know that transportation is a covered benefit and that the case manager could help him arrange transportation. The member is now making and going to appointments with a provider who can address his chronic condition. Mr. Wasden noted that the 820 ITC staff are excited to be in Iowa and are 100 percent committed to being the best partners with members, providers, and the state.

V. Public Comment

Ms. Denise Rathman, National Association of Social Workers, stated that her comments were in regard to the prior authorization issue that Mr. Jones addressed during his presentation. Given the fact that Amerigroup had decided to delay commencement of the new policy, she stated that she would submit her comments to Amerigroup directly, rather than offering them as public comment.

VI. 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=88