MINUTES
Health Policy Oversight Committee

Monday, December 2, 2019

MEMBERS PRESENT

Senator Mariannette Miller-Meeks, Co-chairperson
Senator Mark Costello
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, Legal Counsel, 515.281.3040; Minutes prepared by: Patricia Funaro, Legal Counsel, 515.281.3040; Mitch O'Hara, Legal Counsel, 515.725.0479

CONTENTS

I. Procedural Business

The second meeting of the Health Policy Oversight Committee of the 2019 Legislative Interim was called to order at 10:01 a.m. in Room 116 of the State Capitol and adjourned at 12:08 p.m. The committee welcomed newly appointed Department of Human Services (DHS) Director Kelly Kennedy Garcia to Iowa.

II. Department of Human Services (DHS) Presentations

Mr. Michael Randol, Medicaid Director, DHS, reviewed several documents with the committee including those entitled "Medicaid Enrollment," "Medicaid Eligibility Overview," "Iowa Health Link Legislative Changes," "Iowa Health Link Managed Care Organization Report: SFY 2019, Quarter 4 (April-June) Performance Data," and "Dental Plans Report: State Fiscal Year 2019 Performance Data."

A. Medicaid Enrollment Update

Director Randol reviewed enrollment trends in traditional Medicaid, the Iowa Health and Wellness Plan, and the hawk-i program between the years 2013 and 2019. He noted that in November 2019, enrollment by managed care organizations (MCOs) was 58.85 percent for Amerigroup and 41.5 percent for Iowa Total Care. In response to questions and requests, Director Randol agreed to provide the breakdown by MCO for each population group, stating that he does not know of any changes to the hawk-i program from the federal government but he is always looking for ways to improve the program, and he agreed that when the time is appropriate and disruption can be minimized, he would like to add a third MCO.

B. Medicaid Eligibility Overview

Director Randol reviewed Medicaid eligibility including general eligibility requirements, the income and assets verification processes, eligibility renewal, required reporting of changes in eligibility, the information technology (IT) system used to verify and process eligibility, the external verification process, presumptive eligibility, and Medicaid coverage for inmates and refugees. Director Randol stated that Medicaid is the payor of last resort, so members are required to report changes that may affect their eligibility. A member must be given at least 10 days' notice prior to any adverse action being taken such as cancellation or reduction of benefits. With regard to nonfinancial eligibility, an applicant must be a United States citizen or have qualified alien status, have a social security number or an application for a social security number, meet age, disability, and level of care requirements, and be a resident of Iowa, even though there is no requirement that the applicant live in the state for a minimum amount of time. Income is verified through federal and state resources and through the Modified Adjusted Gross Income (MAGI) income verification process. If the result is compatible, eligibility is approved. If the result is not compatible, a request for information is sent to the applicant or member to provide verification. With regard to assets, unless specifically exempt, all resources are considered countable for non-MAGI groups and are determined as of the first moment of the first day of the month that an application is submitted. Iowa uses the asset verification system (AFS) to verify resources and assets from financial institutions. Verification of eligibility must be received by DHS prior to the expiration of a member's eligibility period, and a member has an additional 90 days to provide their renewal form before being subject to filing a new application. Members must report changes in circumstances within 10 days and unreported information may result in overpayment that the member must repay.

For individuals residing in a medical facility, receiving waiver services, or for whom eligibility is based on eligibility for the state supplementary assistance program or for the medically needy program, the system used to process their eligibility information is Iowa's automated benefit calculation system.

The Eligibility Integrated Application Solution (ELIAS) system is used to process eligibility for all other individuals, including for the Iowa health and wellness plan and hawk-i programs. DHS also utilizes income verifications at times other than when a change is reported. Computer data matching occurs with a variety of state and federal sources and at different frequencies, including daily, monthly, and quarterly. The outcome of a data match could result in a redetermination of eligibility.

With regard to inmates of public institutions, Director Randol noted that if a person is incarcerated for over 30 days, their Medicaid eligibility is suspended. He reviewed the attributes of individuals who are considered inmates. He stated that individuals who are incarcerated may be eligible for limited Medicaid coverage when they are admitted to a medical institution such as a hospital, but that payment is limited to inpatient hospital services only. When DHS becomes aware that a Medicaid member is incarcerated, DHS suspends Medicaid coverage to limited Medicaid benefits only. A monthly data file is received from the Iowa Department of Corrections and county jails to alert DHS of the member's incarceration status. When an inmate is released into a nonincarcerated status, Medicaid benefits are reinstated to full benefits as soon as DHS is made aware of the change in status.

Director Randol noted that refugees are provided up to eight months of refugee medical assistance if they are not eligible for any other coverage group. However, this coverage is funded entirely by the refugee resettlement program and no federal Medicaid or state matching funds are used.

In response to a question by Representative Lundgren regarding residency, Director Randol noted that an individual must attest to being a resident but DHS does not have information regarding whether the individual is actually a resident. Representative Lundgren also asked Director Randol to provide information regarding those who are eligible for Medicaid but do not use the coverage.

In response to a question by Senator Ragan regarding whether, with the increase in utilization of the Iowa health and wellness plan, DHS has information regarding the employers of these members and whether the employer offers or provides health insurance coverage, Director Randol stated that he would have to review the information DHS has available but this might require a data match with Iowa Workforce Development. Senator Mathis also asked Director Randol to provide information regarding the employment status of those on Medicaid to determine how many working poor are receiving Medicaid.

In response to an inquiry from Senator Segebart regarding the issue of inmate health care coverage and suspension of Medicaid, Director Randol encouraged the members of the committee to make county supervisors and other local leaders aware that if an individual is incarcerated 30 days or more, their Medicaid eligibility will be suspended, and that DHS needs to be informed of a change in an individual's incarceration status so that Medicaid eligibility can be restored.

With regard to a question by Representative Forbes regarding presumptive eligibility and a patient who was discharged from the hospital having problems with Medicaid coverage for their prescriptions, Director Randol noted that there is a quick turnaround time for the processing of presumptive eligibility claims, but that he would look into the particular case. Representative Forbes noted that two weeks later the individual did receive their Medicaid card.

In response to inquiries by Representative Fry regarding what happens if an individual does not report changes and whether overpayment information is available, Director Randol responded that if a change is caught through the eligibility matching system, a request for information is sent to the recipient, but that if a match is not made and an individual does not report a change, changes can be difficult to determine. He noted that DHS does not currently track overpayments but that he would look into how DHS could track and report overpayments in the future.

C. Legislative Changes

Ground Emergency Medical Transportation. Director Randol reported that pursuant to 2018 Iowa Acts, HF 2285, requiring DHS to work with the Centers for Medicare and Medicaid Services (CMS) of the United States Department of Health and Human Services to provide prospective payments for ground emergency medical transportation (GEMT) claims submitted to the Iowa Medicaid Enterprise (IME) and the MCOs, CMS has approved the program, and the prospective payments will cover the difference between a provider's actual and allowable costs per transport and the allowable amount received from IME or an MCO for covered emergency ground transport. Interested providers need to complete an intergovernmental transfer agreement and submit cost reports for SFY 2018 and 2019 to the Iowa Medicaid program to participate. The date for submission of the cost reports has been extended from December 31, 2019, to January 31, 2020.

Medication-Assisted Treatment (MAT) Prior Authorization. 2019 Iowa Acts, HF 623, required DHS to adopt administrative rules to allow one form of each drug for MAT to be prescribed without prior authorization. The rules, anticipated to be effective February 1, 2020, will not require a clinical prior authorization for one form of the currently covered MAT drug under the Medicaid pharmacy benefit.

Hospice Payment. 2019 Iowa Acts, HF 518, required DHS to work with CMS to allow for payment of the nursing facility room and board expenses for a dually eligible Medicare and Medicaid member of 95 percent of the nursing facility's Medicaid fee-for-service (FFS) rate rather than indirectly as a pass-through payment from the hospice provider. DHS has had discussions with CMS, but at this time it does not appear that CMS will approve this policy change. DHS will continue to work with CMS to pursue this policy change.

Elimination of Brain Injury (BI) Waiver Budget Maximum. 2019 Iowa Acts, HF 570, directed that BI waiver recipients no longer be required to request an exception to policy to exceed the monthly maximum under the BI waiver. A BI waiver recipient may now access the medically necessary services and supports identified in their comprehensive person-centered service plan. This policy is effective for dates of service beginning July 1, 2019, and thereafter for both MCO and fee-for-service members.

2019 Iowa Acts, HF 766.

- **Non-State Government-Owned (NSGO) Nursing Facility Quality of Care Rate Add-on Program.** This program would allow a qualifying nursing facility to be paid prospectively through an intergovernmental transfer the difference between the state Medicaid payment and the Medicare upper limit payment, beginning late 2021, pending CMS approval. Director Randol reported that CMS has concerns about the program, that approval is not guaranteed, but DHS has a meeting with CMS on December 13, 2019, and will continue to work with CMS to a resolution.
- **Medicaid for Legal Permanent Resident (LPR) Pregnant Women.** This policy change would allow LPR pregnant women to be eligible for Medicaid, pending CMS approval. Director Randol reported that CMS' initial response was that there cannot be a specific carve-out of this subset of individuals, but DHS is continuing to work with CMS on possible implementation.
- **Pharmacist Immunization.** Pharmacists are currently reimbursed for the provision of limited vaccines under the Medicaid program. This policy would allow pharmacists, as a new provider type, to order and be reimbursed for payable vaccines similar to all other provider types. The Board of Pharmacy and the Department of Public Health have developed administrative rules changes and DHS has submitted a Medicaid state plan amendment with an expected July 1, 2020, implementation date.

- **Nursing Facility Reimbursement Rate.** This provision increased the total reimbursement for nursing facility providers by $23 million in state dollars ($59.8 million in state and federal dollars combined).
- **Critical Access Hospital Cost Adjustment Factor.** This provision directed DHS to utilize a cost adjustment factor to increase reimbursement of critical access hospitals by $1.5 million in state dollars ($3.8 million in state and federal dollars combined).
- **Assertive Community Treatment (ACT) Reimbursement Rates.** This provision updated the fee schedule amounts for three current procedural terminology (CPT) codes for ACT. The increases total $211,000 in state dollars and $540,000 in state and federal dollars combined. The policy was effective for days of service on or after July 1, 2019.
- **Tiered Rate Increase.** This provision required DHS to distribute an additional $1 million in state dollars to the Intellectual Disability (ID) waiver daily supported community living tiered rates. The policy was effective for dates of service on or after July 1, 2019.
- **Uniform Prior Authorization (PA) Process.** This provision directed DHS to require MCOs and FFS Medicaid to utilize a uniform PA process. The department adopted rules by the required October 1, 2019, date, and pending feedback from the MCOs on shared drafts, which is expected soon, the process will be implemented in early 2020, ahead of schedule.
- **Children's Mental Health Waiver.** Director Randol reported that, even though the uptake has been slow, DHS is continuing to release the additional funding appropriated to implement reductions in the Children's Mental Health Home and Community-Based Services Waiver.

Representative Fry thanked Director Randol for expediting implementation of the uniform PA process and asked him to provide the amount of federal funding being provided through the Ground Emergency Medical Transportation Supplemental Payments Program. Director Randol stated that the Ground Emergency Medical Transportation Program was advertised through associations, fire chiefs, and others.

Senator Mathis noted that in meetings with HCBS waiver recipients in her district, some constituents feel that their services are being reduced, and she asked Director Randol to comment on how elimination of the BI waiver cap may have had this result. Director Randol stated that the removal of the cap only resulted in individuals no longer having to request an exception to policy and that recipients continue to receive the services specified in their service plans. He noted that data trends in the quarterly report do not seem to indicate that services are being reduced or denied for waiver members, and that a member can appeal a denial of or reduction in services.

D. Iowa Health Link Managed Care Organization Report: SFY 2019, Quarter 4 (April-June) Performance Data

Director Randol reviewed the quarterly report, which he noted was the final quarter during which UnitedHealthCare (UHC) was still providing coverage in the state. He highlighted plan enrollment and disenrollment; long-term services and supports enrollment; level of care reassessments noting the low percentage of reductions in services; grievances and appeals; helpline data acknowledging that there were issues during the transition with having appropriate information available; claims denials and status; value-added services acknowledging that these need to be reviewed with the MCOs if they are not being utilized; and value-based purchasing.

In response to a question by Representative Fry regarding how Iowa compares with other states regarding long-term services and supports and the balance between facility and community-based care, Director Randol agreed to provide information regarding surrounding states, but noted that based

on his experience as Medicaid director in Kansas, Iowa is doing much better than other states in our geographic region.

In response to a question by Senator Miller-Meeks regarding what information the quarterly report covers, Director Randol noted that the report only covers the current period.

In response to a question by Senator Mathis regarding how to know whether value-added services are working and are actually being utilized, Director Randol stated that DHS is hampered by a 40-year-old Medicaid Management Information System (MMIS) as far as data collection and analysis, and there are many opportunities from a population health perspective that could be undertaken if a strong data foundation were available.

In response to a question by Representative Fry regarding the wrap-up of UHC providing Medicaid coverage, Director Randol stated that it is going well because UHC still has a presence in other markets in the state. Director Randol is maintaining a claims reserve amount in the several millions of dollars to pay outstanding claims. He has only been contacted by two providers for follow-up since UHC left the Medicaid program.

In response to a question by Senator Segebart regarding how to estimate an average capitated rate per member in the Medicaid managed care program, Director Randol noted that while there are approximately 56 rate cohorts, a basic division with the total amount expended as the numerator and the total number of members served as the denominator could provide a general estimate. Director Randol stated that DHS could provide an estimate of the average to the committee as well as the data points not otherwise included in the quarterly report.

E. Dental Plans Report: State Fiscal Year 2019 Performance Data

Director Randol provided the Dental Plans Report at the request of the committee, but did not review the entire report. Senator Mathis noted that in Marion, there are no longer any dentists who take Medicaid recipients. Director Randol stated that DHS tries to hold the dental plans accountable in providing network adequacy. Director Randol also noted that he is not pleased with some of the statistics on participation in well-being behaviors, but noted that his barometer is if FFS Medicaid is having trouble with network adequacy, then he cannot expect more from the dental wellness plans. He stated that the plans may offer increased reimbursement to attract providers, but the capitation rate is limited by the managed care actuarial analysis. He asked that if members have suggestions for changes in the Dental Plan Report for the future, he will try to incorporate them.

III. Managed Care Organization Updates

A. Iowa Total Care (ITC)

Mr. Mitch Wasden, President and CEO, Iowa Total Care, provided an update including a handout on ITC operational statistics including ITC plan size, local ITC staff, and operational metrics. Mr. Wasden noted that there were initial issues with claims processing, but that in order to avoid delaying payment to providers, ITC issued over 350 checks for a total of over $11 million to providers and will subsequently reconcile the payments. ITC also has updates on their webpage to post any known system issues and the expectated resolution date. ITC continues to rebalance staffing and will add staff to address public relations. ITC is excited about the future in moving more toward pay for performance, measuring outcomes, and collecting and analyzing data to more directly affect population health. Data analytics can be challenging if the correct type of data is not being collected or if there are gaps in the data. He said ITC is very encouraged by the collaborative approach and the focus on innovation in the state.

B. Amerigroup

Mr. Jeffrey Jones, President, Amerigroup, reported that the transition was successful and that Amerigroup membership has increased to over 340,000 members with a doubling of long-term services and supports (LTSS) membership from 12,000 to 23,000 members. With this increase, Amerigroup is increasing its associates for LTSS to a target number of 200, with 177 currently employed. Amerigroup has worked hard to match existing case managers with existing members. Amerigroup did have some issues in September and October with a slowdown in claims payments for nursing facilities due to the almost doubling in volume of claims, but worked with IME and the Iowa Health Care Association to address these issues. Amerigroup also worked through other provider-specific issues. Amerigroup transitioned to a new pharmacy benefits manager, Ingenio Rx. With the change, Amerigroup increased its provider network and currently only 11 pharmacies are not included in its network. Amerigroup is continuing to support health plan innovations and will have more innovations to report at the next meeting of the committee. In response to questions regarding turnover and outstanding payments from one nursing facility, Mr. Jones responded that he can provide follow-up information and that although provider claims issues are not systemic, Amerigroup will work with individual providers to reconcile claims.

IV. Public Comment

Mr. John Johansen, Ms. Martha Mitchell, and Ms. Karla Vansice presented public comments that are available on the committee webpage.

V. 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