# MINUTES
# Health Policy Oversight Committee

**Monday, December 21, 2020**

## MEMBERS PRESENT

Senator Mariannette Miller-Meeks, Co-chairperson
Senator Mark Costello
Senator Jeff Edler
Senator Liz Mathis
Senator Amanda Ragan

Representative Joel Fry, Co-chairperson
Representative John Forbes
Representative Shannon Lundgren
Representative Ann Meyer

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## I. Procedural Business

The second meeting of the Health Policy Oversight Committee of the 2020 Legislative Interim was called to order on December 21, 2020, at 12:31 p.m. and adjourned at 2:26 p.m. The meeting was held by videoconference.

## II. Director Garcia Comments

Ms. Kelly Garcia, Director, Department of Human Services (DHS), praised the efforts of the DHS team during the pandemic and the derecho to keep legislators and caucus staffs updated.

### A. Iowa Total Care (ITC) Withhold

Director Garcia began by discussing the ITC withhold. At the beginning of 2020, DHS withheld $44 million from ITC due to claims processing issues. An outside vendor, Myers and Stauffer, worked with ITC to conduct an audit at the request of DHS, but ITC paid for the audit. There were two phases of this project. Phase I encompassed claims testing of providers identified by the Iowa Medicaid team. The providers submitted detailed outstanding claims for services provided from July 1, 2019, to May 2020. A sample of claims for each issue was used to determine whether the claims were processed correctly by ITC and to identify the root causes for incorrect processing. Myers and Stauffer provided a listing of outstanding claims identified as similar to those verified as having been processed incorrectly during the sample testing. Due to the manual nature of claims processing and the high number of claims that are reprocessed, Myers and Stauffer was unable to determine if the system was properly configured to accurately process claims, which led to phase II. In phase II of the project, Myers and Stauffer verified ITC's claims system corrections and worked to understand the initial systems issue and the configuration corrections through documentation requests and reviews, follow-up questions, and discussions with ITC staff. Myers and Stauffer identified claims elements including procedure codes, modifiers, and other more technical items to identify the universe of claims impacted by the issue. Myers and Stauffer has requested processing claims data extracts from ITC, large sample sizes, and data pulls. They have randomly sampled these claims within the universe of impacted claims, and have recalculated sample claims payments based on adjudication rules, rates, fee schedules, and other relevant information. Myers and Stauffer is reprocessing the claims to provide a control group to compare with the claims they pulled. Myers and Stauffer reviewed the ITC claims payment amount against the recalculated claims payment amount and is in the final phases of completing this information. ITC's data team has been incredibly helpful and accommodating in providing the claims information requested as well as supplemental data. DHS expects the audit to be completed within the next several weeks. Director Garcia has met with the status team along the way, with ITC, and with the Attorney General's office as they determine how to proceed with the audit findings as soon as they are completed.

### B. Managed Care Capitation Rates

Director Garcia spoke about the rate-setting process with the MCOs. Many are interested in the profit margin for the MCOs, both during and beyond COVID-19. She first addressed the capitation rates, then the factors that impact the medical loss ratio (MLR), and then came back to specific MLR information related to the Iowa MCO contracts.

Director Garcia indicated that everyone understands that providers have been impacted by the pandemic. DHS has worked with the governor to support providers, including assisting smaller providers with personal protective equipment (PPE) at no cost to these providers. Different provider types have been impacted in different ways and services have also been impacted including decreased utilization, and eligibility groups have also been impacted differently, simply due to the mix of services that a member utilizes. DHS has also made program changes to make services more readily available

and to ensure access to services including to telehealth, home-delivered meals, and companion and homemaker services. Retainer payments have been provided to HCBS providers and add-on payments have been provided to nursing facilities. There are still uncertainties around pent-up demand related to deferred services and the increases in hospital costs due to COVID-19. All of these factors play into the capitation rate paid to the MCOs and the claims paid as a result. States have implemented a variety of measures to address the uncertainty in capitation rates, including risk corridors. At the onset of the pandemic, Director Garcia decided to maintain the current MCO capitation rates through the first six months, or through January, of fiscal year (FY) 2020-2021. Other states also made this decision. This decision was related to the data sets at the time, but no one appreciated at the time how long the pandemic would last and the ongoing uncertainty on all levels. DHS is still awaiting federal approval of the capitation rates for the first six months of FY 2020-2021. There have been multiple rounds of questions from CMS to which DHS has responded promptly. DHS has also been working diligently on the capitation rates for the second six months of FY 2020-2021. The actuarial vendor has been working to understand all of the impacts of the pandemic and there is a meeting scheduled for Wednesday, December 23, 2020, with Optimus, the department's Medicaid actuary vendor and with the MCOs to finalize discussions on the capitation rates.

**C. Medical Loss Ratio (MLR)**

The MLR for each MCO is reported in the quarterly managed care report and is an unaudited point-in-time snapshot. The 88 percent MLR is an annual contractual requirement. For SFY 2019-2020, Amerigroup is very close to 88 percent of the actual MLR requirement and DHS is monitoring this closely. The final claims runout will affect the final MLR rate. Due to COVID-19, DHS has given providers 270 days from the date of service to submit claims, so providers are still able to submit fourth-quarter claims. At the end of the claims runout period, the actuary will conduct a final review of MLR. Contractually, if Amerigroup falls below the 88 percent MLR, they will have to pay money back to the state. Director Garcia noted that the MLR requirement has been increased to 89 percent for SFY 2020-2021. DHS is also in the process of conducting an analysis of MCO MLR and profit and will share the SFY 2020-2021 results when the analysis is completed.

**D. Assessment of Medicaid Expertise**

Director Garcia noted that Iowa Medicaid has an incredible team, but the team is very lean with fewer than 50 state staff. This presents some risk and also prevents DHS from doing some really important work. Recently, the team conducted a targeted psychiatric medical institution for children (PMIC) rate review, which was incredibly helpful and needs to be done across other programs. Director Garcia envisions broad rate reviews across programs, but DHS does not have sufficient state staff to perform these reviews. The low volume of state staff makes procurement and reprocurement challenging as DHS has outsourced much of its expertise. While much of their work is managing contracts, many on the team are expected to be contract managers, policy experts, and work on requests for proposals (RFPs), which is too much for any one person. So, DHS has been working with a consultant to provide an in-depth assessment of recommendations which will allow DHS to bring true policy expertise in-house to help better leverage federal funds in a way they have not been historically able to do. Director Garcia stated that in some cases, she believes the state is leaving federal dollars on the table. She received a final draft of the report on Friday, December 18, 2020, and an updated report on Saturday, December 19, 2020, and she thinks the consultant did a tremendous job providing thoughtful rationale, reviewing other states, identifying risks, and providing a means for building a path forward. This will set the stage for DHS to do some targeted efforts to lead to outcomes that everyone wants. This is one of the director's top priorities this session and she looks forward to talking with legislators further to move to a mature program.

### E. Derecho Response

When the derecho hit, DHS team members stepped up to help displaced families. This was particularly important for the refugee population. Team members from all over the state came together to set up a very successful disaster supplemental nutrition assistance program (SNAP) operation ultimately providing relief to 67,000 Iowans in over 24,000 households in 11 counties. DHS issued over $11,000,000 in benefits relating to the derecho. Federal partners were incredibly complimentary of the team across all of the programs.

### F. Committee Discussion

**Consultant's report.** Co-chairperson Miller-Meeks asked that Director Garcia present the consultant's report to the appropriate legislative committees during the legislative session.

**Risk corridors, MLR, contract items, Medicaid director.** Representative Fry asked about risk corridors and how this would work with the MLR, who increased the MLR to 89 percent for FY 2020-2021, and if the director could provide an update on the Medicaid director position. Director Garcia responded that the MLR was increased by DHS as part of negotiations with the MCOs, instead of implementing a two-sided risk corridor. However, DHS is looking at other ways to ensure strong oversight of the MCO contracts and will continue to look at additional options such as a two-sided risk corridor in the future. Director Garcia said that Texas explored these other options and DHS would like to explore them in Iowa, too. DHS is still in the investigation phase and this option might not work in Iowa but it is something to consider. Representative Fry formally requested that DHS provide the general assembly with a list of all of the contractual changes with the MCOs. Director Garcia agreed to provide these and also offered to talk to legislators about themes in a more strategic approach to oversight of the contracts.

The Medicaid director application process closed recently. DHS did not originally receive the number of applications that they had hoped for so DHS reposted the job knowing that there is always a bit of churn post-election from other states. DHS now has a strong pool and will set the interviews soon. Director Garcia would like to have a director on board as soon as possible, and offered tremendous kudos to Julie Lovelady, who has stepped into the interim role. There is a lot of work to be done over the next year, so DHS will proceed to get the new Medicaid director on board quickly.

**Thanks.** Senator Mathis again thanked DHS, including local DHS workers, for all of the help with the derecho. In Marion when SNAP assistance was enhanced, Senator Mathis noted that there was a tremendous line for this assistance. Senator Mathis listened to some of the interviews the DHS team was doing and there was a lot of empathy and compassion being shown and a lot of problem solving, especially when it was difficult for consumers to locate the information they needed to apply for assistance. There are still food insecurity issues in the area and Senator Mathis is hoping some of the federal money can be used for this.

Director Garcia said she grew up in Florida but never saw anything quite like the derecho. The devastation was unbelievable and the in-person connections were absolutely needed because the traditional lines of communication were down. The derecho also left a lasting benefit for teambuilding. In terms of food insecurity, Director Garcia is working collaboratively with the education system to address the school lunch program and the use of electronic benefit transfer cards.

## III. Legislation Implementation and Program Updates

**Pharmacist immunizations.** Dr. Susan Parker, Medicaid Pharmacy Director, DHS, noted that there are currently two methods for a pharmacy to bill for an immunization. For children, a pharmacy may

bill under medical claims billing using a vaccine for children, limited to the flu vaccine only and will be paid under the fee schedule. For adults, the pharmacy may bill through pharmacy point-of-sale for limited-payable vaccines like flu, pneumonia, and shingles. For adults, a pharmacy is paid as are other drugs at the pharmacy, including the product cost and the dispensing fee. Both options require either a patient-specific prescription for the vaccine or a prescription under a physician-signed protocol with a specific pharmacy.

Under the upcoming Medicaid billing process, the Iowa Board of Pharmacy, in collaboration with DPH, developed statewide protocols for pharmacists to be able to order and administer vaccines as recommended by the Advisory Committee on Immunization Practices (ACIP). In order to allow these expanded pharmacist practice protocols under Medicaid, rule changes are in process with an effective date of June 1, 2021. The rules will allow a pharmacist to order all vaccines. Pharmacists are currently enrolling in Medicaid as a new provider type in preparation for these changes. Once the rules are in place, all billing and reimbursement of vaccines, regardless of provider type, will be handled through the same process. Billing will be under the professional medical claims billing to ensure consistency among providers as well as a coordinated Medicaid immunization record for the member.

With regard to the COVID-19 vaccine, the federal Public Readiness and Emergency Preparedness (PREP) Act permits a pharmacy/pharmacist to order and administer COVID-19 vaccines, regardless of state law limitations. For Medicaid, both the prescriber and the billing provider must be enrolled in Medicaid. The Iowa Medicaid Enterprise (IME) is currently working on a process to operationalize the vaccine billing in advance of the pharmacist enrollment rules going into effect in June 2021.

**Iowa Health Link waiver renewal.** DHS operates the state's Medicaid managed care program under 1915(b) waiver authority which began in April 2016. DHS has submitted its extension application to the Centers for Medicare and Medicaid of the United States Department of Health and Human Services (CMS) to continue to operate the Iowa Health Link program for another five years. No modifications to the current program design are being proposed. DHS provided a separate handout to the committee regarding the 1915(b) waiver renewal. As part of the renewal process, the state was required to conduct an independent assessment of its managed care program and submit the findings to CMS. The report was conducted by a third party, Health Services Advisory Group (HSAG), the department's external quality review vendor, along with Optimus, the Medicaid actuary vendor. The report can be found on the DHS website. Upon approval from CMS of the waiver continuation, the Iowa Health Link program will be authorized to continue for another five years through March 31, 2026.

**Uniform prior authorization.** Ms. Julie Lovelady, Interim Medicaid Director, DHS, noted that House File 766, enacted in 2019, required DHS to adopt rules to require both managed care and fee-for-service (FFS) Medicaid to utilize a uniform process to request medical prior authorization (PA). DHS met with providers and the MCOs and developed a set of unified forms for PA: one for outpatient services, one for inpatient services, and a supplemental form for additional information. The PA forms are universal such that they can be sent to either MCO or to the IME for FFS. Providers may still request PAs through the provider portal or by telephone. The forms were available starting in July 2020, but due to COVID-19, they were not required to be used by providers until October 1, 2020. The only change to the current PA process is the request form. There is no change in any of the current PA requirements or approvals that are already in place, including time frames. DHS continues to review MCO PA requirements on an annual basis and to encourage the MCOs to remove any PAs that are approved 95 percent of the time.

**Ground emergency medical transportation (GEMT).** Ms. Lovelady reported that the GEMT supplemental payment program was required in House File 2285, enacted in 2018. The state plan amendment (SPA) for the program was approved by CMS in July 2019. It is a voluntary program that

allows publicly owned or operated emergency ground ambulance transportation providers to receive supplemental payments to cover the difference between a provider's actual costs per GEMT transport and the Medicaid base payment, mileage, and other sources of reimbursement. This includes nonstate government-owned emergency medical service providers. Payment is made on a per claim basis for eligible transports. Seventy-two providers voluntarily participated in FY 2019-2020, the first year of the program, with approximately $20.4 million being paid to the GEMT providers. DHS expects 72 providers to again voluntarily participate in FY 2020-2021. Providers have until January 31, 2020, to complete and submit the required cost report to IME. Recently, there have been some questions about "dry runs" which occur when an ambulance run does not result in the transport of a patient. Per CMS, a GEMT transport does not include dry runs so these claims cannot receive the supplemental payment rate. DHS provided information to providers that if dry run costs are included on the GEMT cost report, the dry run must be included in the transport count in the cost-per-transport calculation. If the dry run count is excluded on the GEMT cost report, the dry run does not need to be included in the transport count in the cost-per-transport calculation.

**Waiver monthly budget caps.** Ms. Paula Motsinger, Bureau Chief, Medical and Long-term Services and Supports (LTSS), DHS, reported that effective July 1, 2020, under House File 2269, DHS eliminated the monthly budget maximum or cap for individuals eligible for the Medicaid home and community-based services (HCBS) elderly waiver, meaning that members who exceed the budget cap no longer have to request an exception to policy for approval. Over 8,000 individuals are currently enrolled in the program. The overall average cost per HCBS elderly waiver recipient for the first quarter of SFY 2020-2021 was $1,147.31 per waiver recipient compared to $1,130.39 during the first quarter of FY 2019-2020, which is an average increase of $16.92 per waiver recipient for the first quarter of FY 2020-2021.

Similarly, the budget cap for the brain injury (BI) waiver was removed effective July 1, 2019, pursuant to House File 570. Currently, there are more than 1,500 individuals enrolled in this program. A year-to-date comparison shows total BI waiver expenditures increased about $1.2 million compared to SFY 2018-2019. The average annual cost per BI waiver recipient increased to $20,628 per member during SFY 2019-2020, which is an average increase of $416 per waiver member per year. The increase is mainly due to an increase in daily supported community living services.

**Health Home (HH) Office of Inspector General (OIG) Audit.** Iowa has two health home programs, one for chronic conditions (CCHHs) and an integrated health homes (IHHs) program. CCHHs provide coordinated care for individuals diagnosed with chronic conditions or individuals who require care coordination to address substance use disorders or behavioral health needs. There are currently over 1,400 individuals enrolled in the CCHH program.

IHHs provide coordinated care to children who have been diagnosed with a serious emotional disturbance and adults diagnosed with serious mental illness. There are currently over 19,000 individuals enrolled in the IHH program.

In April 2020, the OIG filed its final report of the HH audit. The audit reviewed payments from CY 2013 to CY 2016 and concluded that 62 of the 130 payments reviewed did not comply with federal and state requirements. The majority of the noncompliance was specifically related to documentation of services. The final report recommended that DHS refund $37.1 million to the federal government and take other steps relating to oversight of the HH program, more clearly define documentation requirements in the state plan, and educate providers on these requirements. In response, DHS aligned the SPAs to reduce the administrative burden and improve the ability of the state to gather the data needed to illustrate SPA compliance. These steps were approved by CMS on December 9, 2020. DHS also revised the IHH and CCHH billing guides on July 1, 2020, to include informational-only codes which reflect one of

the six core services provided during a month, revised the IHH and CCHH provider agreements, and added annual data analysis as an oversight measure to provide an understanding of value and utilization as well as allow for data-driven program improvements. DHS also improved communication between the MCOs and HH providers; MCOs developed tools and guidance documents to assist providers in understanding HH expectations; an annual workgroup meeting was implemented in 2020 to provide stakeholders with data and to elicit feedback; a provider self-assessment that aligns with the updated SPA will be implemented with a chart audit process to ensure HH services are appropriately documented; and a full learning collaborative model was made available to provide technical assistance to providers. DHS has received positive feedback to date from providers.

### A. Presentation

**Implementation of Electronic Visit Verification (EVV).** The federal 21st Century Cures Act (Cures Act), enacted in December 2016, required states to implement electronic visit verification (EVV) beginning January 1, 2020, for personal care services and January 1, 2023, for home health services. EVV utilizes technology to electronically record when attendants begin and end providing services to Medicaid members. It is used to monitor utilization of services in nontraditional settings, such as the Medicaid member's home, to ensure program integrity, and to streamline billing for providers. Iowa was granted a one-year good-faith exemption from implementation such that Iowa's implementation date for EVV for personal care services was extended to January 1, 2021. Implementation is only required for Medicaid managed care, not for fee-for-service Medicaid. DHS is using a managed care implementation model for EVV and both MCOs will use the same EVV vendor, CareBridge. EVV will be required for attendant care services, homemaker services, and personal care services. Home health services and waiver providers including consumer directed attendant care and consumer choices option providers will be required to use EVV. These providers will use the CareBridge mobile application to record their service provision. If the internet is not available at the time of service provision, the mobile application will securely store the information until the internet is available. Providers may also call in using the member's phone if the mobile application is not available. Providers using a federal Cures Act-compliant EVV system, may continue to use this system instead. Assisted living providers were an optional provider type to include in EVV. DHS decided to include assisted living providers and the deadline for assisted living programs to use the EVV solution has been delayed to July 1, 2021. In-depth training started in October 2020 for providers and has been offered on several different dates and times and through a variety of methods. Self-guided training is available as well. Once a provider has successfully completed training, they can begin using EVV. DHS, the MCOs, and CareBridge have been monitoring implementation to ensure providers will be ready by January 1, 2021, so claims will not be denied.

### B. Committee Discussion

**EVV.** Senator Ragan asked why, if EVV is optional for assisted living, the state chose to require assisted living programs to use EVV. Senator Ragan noted there have been quite a few problems with this, including that the person providing the service is not generally the same person doing the billing, so streamlining is not happening in that setting. Ms. Lovelady responded that DHS is working closely with the assisted living association to address the issues, and these issues are one reason why DHS delayed implementation for these providers so as to give them additional guidance in billing for services.

**Iowa Health Link waiver renewal.** Senator Ragan commented that when the state began with Medicaid managed care in 2016, it was with the goal to save $50 million annually and to have better outcomes. Senator Ragan asked if DHS could report how much money the state has saved since April 2016. She added that providers have not saved money. Ms. Jean Slaybaugh, Chief Operating Officer, DHS,

responded that DHS could provide an updated savings estimate based on the methodology that the state has used.

Senator Ragan added that because Medicaid managed care has been in effect since 2016, there should be good data, beyond estimates for the program, especially if the state is renewing the waiver without any changes. Senator Ragan suggested that providers could provide more than estimates on what they have not seen as savings. Additionally, MCOs can provide samples of outcomes but the state needs better statistics if the state is just casually moving forward.

**Waiver caps and utilization.** Representative Fry, regarding the waiver caps, stated that he remembered when the legislation was passed, having a conversation about elimination of the waiver caps not costing more state money. He stated that if he heard the presentation correctly, there may have been a cost increase, and if so wondered where the cost increase came from. Ms. Motsinger responded that the majority of the increase was related to more individuals accessing the daily supported living service which is one of the more expensive services available under the BI waiver and which increased costs were unexpected by DHS. Representative Fry expressed frustration that he had been told the change would be cost-neutral and it was not.

Representative Fry asked what other increased utilization is being seen as it relates to the waivers in general. Ms. Motsinger replied that she would provide this information to the committee.

**Managed care.** Representative Fry said that while he heard Senator Ragan's concern and request about wanting to see the savings related to Medicaid managed care, he also wanted to reemphasize the fact that under the old fee-for-service system, the state would not have seen the response to the pandemic or the derecho nor have had the ability to be agile as far as a community's or provider's needs or the needs of telehealth, as has been the case with the MCOs.

## IV. Children's Dental Health Transition

Ms. Heather Miller, Iowa Dental Program Manager, DHS, presented on plans to transition the administration of children's dental benefits from FFS Medicaid to managed care. Currently, Delta Dental Plan of Iowa manages the hawk-i program and both Delta Dental of Iowa and Managed Care of North America (MCNA) administer the dental wellness plan which is the adult dental program benefit.

DHS released an informational letter in November 2020 about the transition of FFS Medicaid children to managed care. They are the only population remaining in the FFS dental program. On the dental side, MCOs are classified and referred to as prepaid ambulatory health plans (PAHPs).

The target implementation date for the transition is July 1, 2021, and this will impact children ages 1 to 19. It will not impact the hawk-i program.

The reasons that DHS believes this transition is in the best interest of the members include that members will have a choice of benefit administrator, families can now be enrolled with the same administrator to eliminate confusion, PAHPs will have more provider influence and stronger networks for better access to care for members, PAHPs will be able to adjust reimbursement rates and offer value-added services, PAHPs, in collaboration with DPH and the I-Smile infrastructure will be able to complete outreach and education to members and help alleviate barriers to care, and it will allow for more predictable budgeting for the state.

The benefit package will remain the same and will continue to meet EPSDT (early and periodic screening, diagnosis, and treatment) requirements.

The name of the program is the dental wellness plan (DWP) kids. The dental wellness plan will differ from the adult program in that there is no annual benefit maximum and completion of healthy behaviors is not required.

Currently, there are over 285,000 children enrolled in Medicaid. Both MCNA and Delta Dental will administer the dental benefits. DHS runs the dental contract on an open-contract basis which means that an additional administrator may be added. Distribution of the population between administrators will be based on a readiness review, and the algorithm will keep families together. Again, DHS will maintain the interagency agreement with DPH and the I-Smile program. Ms. Miller provided a tentative transition timeline including notices, public hearing, submission of the waiver, the readiness review, and communication and education provisions.

## V. Social Drivers of Health

Mr. Jeffrey Jones, CEO, Amerigroup, provided an overview of how Amerigroup is addressing social drivers of health. Amerigroup has strong community partnerships to address social drivers of health and began a pilot program with Monroe Elementary School in Des Moines and community partners, called CHAMP or changing health: Amerigroup-Monroe Elementary School partnership to address some of these drivers. The interventions started with addressing nutrition and housing, utilizing food bank and food pantry resources and the housing stability and homelessness diversion fund.

Given the pandemic, Amerigroup decided to expand the pilot in additional counties in the state, partnering with the Iowa Association of Community Action Agency directors to distribute housing stability funds. Amerigroup is also working to create new partnerships beyond the CHAMP program and with other community agencies. Amerigroup has expanded to four additional counties and will add 20 counties in 2021. The expansion in homeless diversion and housing stability projects will be done in tandem with Amerigroup's population health case management model.

Amerigroup has also addressed gaps in youth transition from foster care. Amerigroup noticed the risks related to housing and employment by those aging out of foster care. Amerigroup is partnering with the Youth Policy Institute of Iowa to distribute Chromebooks to youth in aftercare programs. The Chromebooks support these youth in their education, applying for jobs, getting telehealth services, and staying connected overall. Amerigroup is also partnering with Achieving Maximum Potential youth councils to establish and manage Kinship Fundz to support families without resources to provide payment for college application fees, obtaining essential household goods, or participating in sports. This program will begin in 2021.

With regard to prenatal and postpartum care, Amerigroup is continuing its partnership with Count the Kicks, which partnership is now in its fourth year. The model is being reviewed for expansion to other states.

Amerigroup is expanding its value-added benefits. Starting in January 2021, Amerigroup will be covering, at no cost, electric breast pumps for pregnant women and recently delivered moms. Amerigroup is also enhancing the incentives for family and child care for 2021.

**Committee discussion.**

**Social determinants.** Senator Mathis asked, regarding integration of social determinants of health into the Medicaid program, where money is coming from, whether from profits or from Amerigroup's Medicaid spending. She also asked if provider z-codes are being used to code for some of the services relating to social determinants of health so that the services are integrated into a Medicaid member's case and their case managers can track and work on these issues and move the individual member forward.

Mr. Jones responded that value-added services are not Medicaid-funded. They are a sign of the MCO's commitment to the population and having an impact on the population. As far as integrating the social determinants of health analysis into individual member cases and billing, he said that the work Amerigroup is doing now through its pilots will help inform those decisions going forward.

## VI. Outreach Efforts

Mr. Mitch Wasden, President and CEO, Iowa Total Care (ITC) spoke about initiatives to engage members, including the SmartStart for Baby program in which a member is paid for providing a notice of pregnancy to ITC early in the pregnancy and the case manager then works to ensure a healthy pregnancy and first year of life for the baby. In the first 18 months of the program, the Neonatal Intensive Care Unit (NICU) rate for ITC members has dropped from 22 percent to 15 percent. Other programs include MemberConnections which imbeds community staff to provide high-touch interactions with members.

The latest program implemented by ITC is a texting program that was launched in June 2020. Only 3 percent of ITC members have opted out of the texting program. Much of the texting campaign has been focused on gaps in care, including appointment reminders, and going forward the texting program will be used for reminders when the COVID-19 vaccine becomes available.

One ITC value-added benefit is a 24/7 access to video appointments with health care providers for general medicine and behavioral health. Thirty-two percent of the visits to date have resulted in avoiding an ER or urgent care visit. More than 50 percent of these appointments are happening after-hours or on the weekends.

The My Health Pays program encourages members to engage in healthy behaviors and rewards them for their participation. This program provides a platform to address social determinants of health. Over 140,000 ITC members are involved in this program and ITC has to date awarded over $5.5 million in rewards to members.

It is difficult to track members with social determinants of health to provide assistance. So internally, ITC has been tagging members who answer "yes" on questions regarding social determinants of health in their annual health risk assessments. Since June 2020, to better address social determinants of health, ITC has begun outreach to members with unfavorable responses over the past few months. These members are then connected to housing, food programs, and other resources. ITC creates an action plan for identified members to help them address their needs. To date, ITC outreached to more than 1,200 members and connected over 400 members to community resources and services.

Another layer of outreach is ITC's community relations department, made up of six individuals assigned to different regions of the state. Most recently, this project has implemented Reading Rocks, and ITC has donated over 51,000 books to give children tips on healthy eating and activities. The staff have also connected ITC to over 205 community organizations throughout the state.

Mr. Wasden noted that engagement takes a layered approach.

## VII. Managed Care Organization updates

**ITC.** Mr. Wasden provided an update for ITC. He stated that as Director Garcia mentioned, ITC is currently involved in an audit for claims remediation. The audit is going very well. ITC is in communication with the auditors daily and hopes to have the audit completed in the next few weeks.

The ITC offices have a tentative date to go back to in-person work beginning April 1, 2021, depending on the availability of the vaccine. Currently, all 800 ITC employees are working from home.

Other ITC updates include that Centene recently engaged a third-party consultant, HMA, to review the health scores of all 30 of Centene's managed care organizations. Many of the innovations in Iowa must be working because the outcome of that survey was that even though ITC is relatively new, it is projected that ITC will have the 2nd best total overall quality rating of all of the 30 Centene plans based on the data. Mr. Wasden conjectured that this is because of the layering of engagement of the members, providers, and the community, and the resulting cumulative effect on closing the care gap.

This year, 84 percent of ITC's primary care providers are enrolled in their Pay For Performance program, paying providers for good outcomes. Health-risk screenings are how ITC collects helpful data on how to outreach and get members into case management. So far, there are about 200,000 households that have conducted a health-risk screening and the medical management team has contacted 97 percent of those members to make sure that they are screened for case management as necessary. ITC has also reached out to all of their members who have been recently hospitalized, contacting 95 percent of these members within 10 days after they were discharged. Some other initiatives relate to medication adherence which is based on ITC's Wisconsin plan which recently became a five-star Medicare plan. ITC asked the Wisconsin plan what they did to attain this rating and the response was that they built their own plan, so ITC built a similar program. In 2021, ITC will be launching a barrier removal fund, a fund of about $100,000 to allow providers, especially smaller providers, to submit requests for reimbursement of upgrades such as ramps, automatic doors, etc., at a facility that the facility might have trouble affording.

**Amerigroup.** Mr. Jones stated that as Amerigroup moves into 2021, it continues to look for ways to modernize, but also to step back to see where Amerigroup wants to go in its sixth year in the state. One of the first areas Amerigroup will address is a partnership with Iowa Health Plus for members accessing health care at federally qualified health centers (FQHCs). Amerigroup is designing programs to help address health disparities with an initial focus on diabetes and hypertension as well as the social drivers of health. The program also has an interpreter service platform component. For children's mental health, Amerigroup is going to expand the services available in PMIC facilities to help children return home as quickly and successfully as possible by allowing the family to remain connected to their child. Amerigroup is also focusing on population management and educating members on when to use emergency services versus urgent care or a telehealth visit. Amerigroup is also connecting with members with opioid use or who have an opioid prescription fill to ensure they are staying connected to appropriate outpatient care and therapy services to help them to continue to complete their treatment curriculum in tandem with their medication utilization. In 2021, Amerigroup will explore the remote patient monitoring space. There are a lot of emerging technologies in this health space, specifically. Amerigroup is looking at remote monitoring that focuses on congestive heart failure, where a member receives equipment at home at no cost to them and then the information becomes a real time connection point to assist the member. Amerigroup is also looking at an opportunity to use technology to assist asthmatic members.

In 2021, Amerigroup will focus on value-based programs and intends to expand as much as possible. About 58 percent of Amerigroup's membership is being served by a provider who is involved in a value-based arrangement. Amerigroup also wants to identify some long-term services and supports and community-based provider-specific programs. Amerigroup is reviewing value-based programming through a partnership with the Community Pharmacy and Services Network (CPSN) around a community based model with pharmacies and pharmacists to focus on medication adherence, education, and effective counseling, utilizing technologies to make it much more efficient for the member. Representative Forbes helped to shape this effort and partnership.

Amerigroup cannot forget the basics. There have been bumps along the way but they do not want to go backward from the progress they have made. Amerigroup will continue to identify opportunities for efficiencies and limiting or removing administrative burdens on providers will continue to be a focus. Amerigroup will also focus on legislative and DHS priorities.

**Committee discussion.**

**Medication compliance.** Representative Forbes commended both MCOs on addressing medication compliance adherence.

**Resignation.** Senator Miller-Meeks announced that she is resigning as co-chairperson of the Health Policy Oversight Committee because she may be going elsewhere in the near future. She said it has been a pleasure to work with her colleagues in the general assembly on both sides of the aisle, as well as those in the lobby.

She thanked Director Garcia and DHS staff and the MCOs and wished everyone happy holidays and asked that everyone be safe, be well, and get back to normal as soon as possible.

## VIII. 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