

Members of the Health Policy Oversight Committee:

On November 14, 2016, the Johnson County Task Force on Aging and the Johnson County Case Management hosted a forum "Iowa's Medicaid Modernization: An Update and Look Ahead," Our purpose was to get a realistic picture of where Iowa was in its implementation and to explore ways of improving the system. Below you will find the suggested solutions that were suggested. We formally submit these to the committee in hopes that they will help steer the conversation toward what can be done to improve the system. We offer these suggestions for consideration. Many of them, for example, would help reduce the increased administrative costs of providers. We hope you, IME and the three MCO's will carefully consider these suggestions.

Bob Welsh, Program Chair

SUGGESTED SOLUTIONS TO IMPROVE MEDICAID MANAGED CARE IN IOWA
November 14, Forum in Johnson County, Iowa

We wish to thank all who participated in the November 14th Forum. We were delighted that Mikki Stier referenced that Iowa Medicaid Enterprise (IME) have issued informational sheets anytime they made a change in practice. We hope that the November 14th forum will lead to some more changes that will improve Medicaid Modernization in Iowa.

Below is a listing of the changes we hope that IME and/or the MCO's will consider making:

1. Application for a waiver -
 - a) When a person applies for a waiver, provide them an opportunity to choose their MCO, if they have a preference, and with the right to change selection in 30 days. OR
 - b) Provide this option only for the elderly waiver.
2. Letter - The waiver approval letter is misleading and needs to be improved. It lists the approval date. The funding date is most important. The letter is in a very small font with a difficult to understand format. It never says Elderly Waiver, which leaves persons confused. The applicants are told to call the "case manager" they are assigned in ISIS. They really don't have a case manager until they are under MCO funding.
3. Application – The applicant should be provided an opportunity to designate a person to receive a copy of the information they receive. This would address three problems: 1) Some do not open mail, 2) Some do not understand and need someone to help them, 3) Often by the time they are approved, they have been moved and cannot be found. (Note: An additional contact person would help and probably save some time and money.)
4. As IME and the MCO's have moved toward common forms in some areas and you use common coding, explore ways of moving to common forms *that can be keyed into each MCO's national data base*.
 - a) Do all you can to reduce the added administrative costs that providers are experiencing!
 - b) Explore ways of compensating providers for their added administrative costs. Call it what you will: pass through, value added. (Increased administrative cost has been the number one negative impact on providers and needs to be addressed.)
5. Utilize a common taxonomy and a uniform coding system while exploring ways to use uniform forms for non ICD-10 billed services.

6. MCO's invest in updating their data base to ensure that consumer information is correct and all provider contract information is accurate.
7. Extend the authorization period, after the initial 3 month period to one year for stable cases. For others to extend to six months. A move to one-year authorization would be helpful to providers.
8. Recommend to the General Assembly changes in the waiver system to allow recipients more access to HCBS. MCO's/providers should be required to first offer/pursue HVBS rather than an institutional setting. Explore increasing the caps. Explore the feasibility of removing/eliminating waiting lists in some or all of the waivers.
9. When giving an error code, direct the provider to the specific section of your (the MCO's) guide and to a knowledgeable person who can assist them. MCO's should have staff dedicated specifically to billing issues.
10. List guardians in IME and MCO systems. Update rules and guidelines to enable them to speak on behalf of a client.
11. Each MCO to give each provider the name and contact information of **the person** who can help the provider address any and all issues they have, recognizing that the suggested person may need to call them back within 24 hours. This would give each provider one person for each MCO and would address many of the problems that have been identified. (Note: It would be helpful to have a specific person assigned to a specific area (city, county) who would sit down with providers on a regular basis or as needed to address their concerns.)
12. All MCO's should have the same requirements for "prior authorization."
13. All MCO's should use the same definition for Medical Necessity.
14. As tiered reimbursement is explored, include providers, as well as associations.
15. Authorization should match the requests from Case Managers. It appears that some providers are being authorized only a part of the services previously deemed necessary. This reduces the quality of care and also negatively impacts the bottom line of the providers.
16. Improve system so providers are paid the contracted fee. Invest what is needed to get this corrected.
17. When a correction in payment is made, link it to a person. Failure to do so is a burden on the providers.
18. Look at a per member per monthly rate vs. a per contact rate.
19. Adapt MCO systems to the new Chapter 24 rules to decrease duplication.
20. Contract with needed providers. (There seems to be a limited number of nursing homes that have MCO contracts, making it difficult to place clients close to home.)

21. Review the 14-day contact rule which restricts Case Management visits/contacts and is a tracking nightmare and revisit the CCO daily rate rule which limits 24-hour care in the family home.
22. On value-added service, list the location where the service is available. Example: Membership in a fitness club. Consumer selects an MCO that offers this – only to find out that the service is in Iowa City and the consumer lives in Cedar Rapids, and has no transportation.
23. Consider adding non-waiver transportation services, like Uber, to transport patients to their appointments. Consider providing grants to public health and county social service agencies to support consumers in getting groceries and medication.
24. Make an exception to policy or some provision to address transgender persons. Example: a sex-assigned-at-birth of female does not have a prostate. Their need for medication is constant and yet pre-approval is required again and again for each prescription. (NOTE: UIHC has persons who will be happy to provide education for the MCO staff to facilitate training and communication.)
25. There is a need for persons who are reviewing requests for authorization to be Applied Behavioral Analysis (ABA) trained. Twelve month authorization would be helpful for goals in which the data supports critical developmental need for core skills for clients with ASD. More than 3 hours needs to be authorized for evaluation with psych, when wanting ADOS testing and all other comprehensive testing.
26. Develop consistent guidelines for requesting and obtaining authorization for services, Example: type of information or documents needed, maximum length of authorization period, how far in advance can preauthorization be requested. (Note: prior to 4/1/16 there was no authorization required for home health.)
27. That IME explore potential conflicts of interest. There is concern about a conflict of interest when the payer is the one identifying the need for referral and additional services (case manager, payer, providers and oversight). (Note: In the Older Americans Act case managers cannot work for a company that provides direct service.)
28. MCO's should ensure providers that their care rates will not decrease for the life of their contract with Iowa, and that they will continue to contract with willing providers (not cut them off) without good cause. (The concern is that MCO's will start providing direct service and cut out the present providers.)

SUMMARY:

We appreciate the opportunity to have hosted the November 14th forum. We appreciate IME and the three MCO's attending. We appreciate those who attended and those who offered SOLUTIONS that they believe will help improve managed care in Iowa.

We hope that IME and the MCO's will give serious considerations to the possible implementation of these solutions. And we hope to have continued dialogue.

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