HEALTH POLICY OVERSIGHT COMMITTEE

Meeting Date: November 8, 2017

Purpose. *This compilation of briefings on legislative interim committee meetings and other meetings and topics of interest to the Iowa General Assembly, written by the Legal Services Division staff of the nonpartisan Legislative Services Agency, describes committee activities or topics. The briefings were originally distributed in the Iowa Legislative Interim Calendar and Briefing. Official minutes, reports, and other detailed information concerning the committee or topic addressed by a briefing can be obtained from the committee's Internet page listed above, from the Iowa General Assembly's Internet page at https://www.legis.iowa.gov/, or from the agency connected with the meeting or topic described.*

HEALTH POLICY OVERSIGHT COMMITTEE

November 8, 2017

Co-chairperson: Senator Mark Costello

Co-chairperson: Representative David E. Heaton

Background. The Health Policy Oversight Committee (HPOC) of the Legislative Council was established as a permanent legislative committee of the Legislative Council under Iowa Code §2.45 in 2015 Iowa Acts, chapter 137, §64, as amended by 2016 Iowa Acts, chapter 1139, §97:

"The legislative health policy oversight committee, which shall be composed of ten members of the general assembly, consisting of five members from each house, to be appointed by the legislative council. The legislative health policy oversight committee shall meet at least two times, annually, during the legislative interim to provide continuing oversight for Medicaid managed care, and to ensure effective and efficient administration of the program, address stakeholder concerns, monitor program costs and expenditures, and make recommendations."

In addition, under 2015 Iowa Acts, chapter 137, §63, as amended by 2016 Iowa Acts, chapter 1139, §102, the committee is tasked with receiving the quarterly compilations of the input and recommendations of the monthly public meetings convened by the Department of Human Services (DHS) beginning in March 2016, and the bi-monthly meetings beginning March 2017 and continuing through December 31, 2017. The Legislative Council appointed the 10 members of the committee, including Senator Mark Costello and Representative David Heaton as co-chairpersons.

Procedural Business. The members approved the minutes of the December 13, 2016, meeting as distributed. Representative Joel Fry assumed the position of co-chairperson for Representative Heaton who was excused for the day.

Department of Human Services (DHS) Review of Iowa Health Link Quarterly Report and Transition Plan. Mr. Jerry Foxhoven, Director, DHS; Ms. Mikki Stier, Deputy Director and acting Medicaid Director, DHS; and Ms. Jean Slaybaugh, Chief Financial Officer, DHS, provided an overview of the transition plan for reducing Medicaid coverage options from three managed care organizations (MCOs) to two due to AmeriHealth Caritas, Iowa, Inc. (AmeriHealth), terminating its contract and no longer providing health care coverage for members effective December 1, 2017, and reviewed the fourth quarter Iowa Health Link quarterly report covering the period April through June 2017.

Transition Plan. Director Foxhoven noted that all stakeholders are committed to making the transition work. DHS has developed a transition plan and ensuring continuity of care for members is a key focus. Letters have been sent to all affected members and all affected members will initially be assigned to UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare), but may elect to change their coverage to Amerigroup Iowa, Inc. (Amerigroup). Members must elect coverage with Amerigroup by November 16, 2017, for their coverage to begin with Amerigroup on December 1, 2017, or the coverage change may not take effect until the next month. However, a member may change their MCO for any reason until March 1, 2018. AmeriHealth will end its contract with the state on November 30, 2017, but will have a claims presence in the state for up to one year to reconcile its accounts. Provider Services and the Call Center, as well as the account manager within DHS assigned to AmeriHealth, will be available through the transition period to ensure stability of the provider network and accurate and timely payment of claims.

Director Foxhoven stated that the 2018 contracts with the remaining MCOs require notice of termination of the contract of 90 instead of 60 days to provide a more adequate transition period if there are future contract terminations. DHS is working with

the MCOs to ensure that the data files from AmeriHealth are transferred seamlessly to UnitedHealthcare to ensure there is no gap in coverage for affected members. Long-term Services and Supports (LTSS) members with care plans will continue to receive the level of care and services under their current plan until the plan is reviewed. Director Foxhoven noted that UnitedHealthcare is hiring more case managers to serve the new caseload and hopes to hire many of the case managers currently working with AmeriHealth so that former AmeriHealth members have the same case manager going forward.

UnitedHealthcare and Amerigroup have signed contracts through June 30, 2018, and these contracts include a 3.3 percent rate increase over the first year. Director Foxhoven noted that in looking back at the cost curve for the prior fee-for-service Medicaid program over the last five to eight years, there was roughly a 10 percent increase in costs annually, making the managed care approach much more sustainable. DHS will release a Request for Proposals (RFP) to recruit an additional MCO for Iowa's Medicaid program. Initially, the additional health plan option was going to be available July 1, 2018. However, DHS has determined that in order to create more stability in the program, a third health plan option will not be available until July 1, 2019.

Iowa Health Link Quarterly Report. Deputy Director Stier reviewed the report covering the fourth quarter of the Medicaid managed care program, April through June 2017. Some of the data elements reviewed by Deputy Director Stier included adult members assigned to a health care coordinator; the number of community-based case manager contacts and community-based case manager ratios for adult members; MCO member grievances and appeals; medical claims and pharmacy claims payment; utilization of value-added services; prior authorization; medical loss ratio and administrative loss ratio; timely answering of helpline inquiries and the use of secret shoppers; and the number of members utilizing integrated health homes and behavioral health services.

Deputy Director Stier also noted the following:

- Over 249,000 MCO members have completed a health risk assessment enabling them to receive preventative care and avoid higher cost services.
- There has been an increase of 5 percent in the number of members of the LTSS population remaining in home and community-based settings (HCBS) rather than entering long-term care facilities.
- While some individuals feel that HCBS waiver services are being reduced or changed, the reason for the change is due to the Title XIX hierarchy of payment. This hierarchy requires that if the state provides a service under the Medicaid state plan and pays for the service through traditional Medicaid funding and that service is also included in a member's HCBS waiver services plan, the service should be provided and paid for through traditional Medicaid and not through the HCBS waiver. Some Consumer Directed Attendant Care (CDAC) providers and others may perceive that they are losing services, but instead the services and payment for these services are being provided and paid for through traditional Medicaid. The Medical Assistance Advisory Council (MAAC) is reviewing this shift in policy to assist members and providers with their questions and concerns.
- Provider billing issues are one of the top five reasons for grievances being filed. DHS and the MCOs have developed a claims benefit workgroup to make this more of a seamless process. When the move was made to managed care, billing forms were standardized across both managed care and fee-for-service Medicaid. The workgroup is also developing standardized best practice coding to increase consistency and efficiency. As of July 2018, Medicaid will transition to all electronic claims processing, coding, and billing. This is in part because the electronic visit verification system must be in place by January 2019.
- Over 124,000 value-added services have been utilized over the four quarters of the managed care program. These services are intended to improve member health and well-being.
- In the past two years, DHS has been actively working to reduce the HCBS waiver waiting lists. DHS has also been trying to more closely match an applicant at the time of initial application to the waiting list that best meets the individual's needs and for which they qualify, rather than placing the individual on all of the waiting lists. DHS instituted a waiver Strengths, Weaknesses, Opportunities, and Threats (SWOT) team to work with individuals with very complex needs to place them on the right waiver initially, thereby opening up additional waiver slots.
- Relative to the elderly waiver, there had been an issue with holding a slot open for a member during a stay in the hospital or in rehabilitation that exceeded the 30-day hold period. DHS changed the rules to extend the hold period from 30 to 120 days, thereby ensuring that a person with a long hospital or rehabilitation stay could return home under the waiver when their stay was complete, rather than face a gap in waiver coverage.
- DHS is moving into the next phase with managed care, now that Medicaid managed care is established, by reviewing the Medicaid program to make changes that enhance quality and make improvements to the program for all of the stakeholders.

Iowa Association of Community Providers. Mr. Craig Syata, Policy Director, Iowa Association of Community Providers, discussed issues with the transition of members from coverage through AmeriHealth since more than 80 percent of their providers' clients are enrolled with AmeriHealth; and the tiered rate system going into effect December 1, 2017, for some waiver services. A copy of Mr. Syata's written comments is available on the committee webpage.

Henry County Health Center. Mr. Robb Gardner, CEO, Mr. Dave Muhs, CFO, and Ms. Charlie Hammel, Revenue Cycle Director, Henry County Health Center; and Mr. Brian Green, Principal from Seim Johnson, public accounting partner for Henry County Health Center Auditor; discussed concerns with Medicaid managed care billing, coding, prior authorization, and reimbursement to the 25-bed critical access hospital, which has been providing care in Mount Pleasant for 96 years. A copy of Henry County Health Center's presentation is available on the committee webpage.

Committee Discussion with Managed Care Organization Representatives. The committee discussed various issues, including the transition of members' coverage to UnitedHealthcare due to the exit of AmeriHealth from the Iowa Medicaid program, with the representatives of the MCOs: Ms. Cheryl Harding, Market President, AmeriHealth Caritas, Iowa; Ms. Cynthia McDonald, Plan President, Amerigroup Iowa; and Ms. Kim Foltz, Chief Executive Officer, UnitedHealthcare Plan of the River Valley, Inc.

Public Comment. The committee received public comment in person and through submissions in writing. The public comments submitted in writing will be posted on the committee's webpage. Those public comments presented in person at the meeting but not in writing will be summarized in the minutes of the meeting.

Committee Documents. Documents distributed at the meeting are posted on the committee's webpage: www.legis.iowa.gov/committees/meetings/documents?committee=24165&ga=ALL

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