COUNCIL ON HUMAN SERVICES

MINUTES

September 14, 2016

COUNCIL

Mark Anderson
Phyllis Hansell
Alexa Heffernan
Kimberly Kudej
Guy Richardson
Kim Spading (absent)
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

Representative Joel Fry (absent)
Representative Lisa Heddens (absent)
Senator Mark Segebart (present)
Senator Amanda Ragan (absent)

STAFF

Chuck Palmer
Sandy Knudsen
Amy McCoy
Jean Slaybaugh
Mikki Stier
Liz Matney
Markie Channon

GUESTS

Sandi Hurtado-Peters, Department of Management
Jess Benson, Legislative Services Agency
Angel Banks-Adams, Legislative Services Agency
RG Schwarm, Brown Winick
Ashley McGuire, UnitedHealthCare
Kris Bell, Senate Democrat Caucus

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 9:00 a.m.

ROLL CALL

All Council members were present with the exception of Spading. All Ex-officio legislative members were absent with the exception of Senator Segebart.

MANAGED CARE OVERSIGHT:

Introduction and Role of Council

Chuck Palmer, Director, read for the Council the legislation related to their oversight duties per House File 2460:

"The council on human services shall regularly review Medicaid managed care as it relates to the entity's respective statutory duties. These entities shall submit executive summaries of pertinent information regarding their deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15, annually, for inclusion in the annual report as required under this sections."

And also: *"The council on human services shall submit to the chairpersons and ranking members of the human resources committees of the senate and the house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of their respective meetings during which the council or board addressed Medicaid managed care."*

The language above instructs the Council to submit an executive summary of the Council's deliberations related to managed care to the Department no later than November 15. A way to look at it is, is managed care achieving its primary goals in improving the health status of Medicaid-eligible Iowans and is the program sustainable going forward? The Council plays an important role and each member comes with their own rich perspective.

Responsibility of Iowa Medicaid Enterprise (IME)

Mikki Stier, Medicaid Director, distributed copies of the table of organization for the Iowa Medicaid Enterprise (IME). The Bureau of Managed Care Oversight and Supports is headed by Liz Matney.

27 staff support the IME along with key vendors that support much of the managed care oversight. Stier provided a listing of the primary contracts pertaining to fee for service and Managed Care Organizations (MCOs) to assist in oversight responsibilities:

- External Quality Review Organization (EQRO)
- Core Services
- Medical Services
- Member Services
- Milliman (Actuarial)
- Pharmacy Medical Services
- Program Integrity

- Provider Cost Audit and Rate Setting
- Provider Services
- Revenue Collections
- 3M
- University of Iowa

A small portion of Medicaid is still fee for service.

Stier reported that IME staff review the reports produced by the MCOs (Monthly, Quarterly and Annually). Staff take a comprehensive approach to reviewing timely payments, remedies and compliance. Staff meet weekly with the MCOs and Stier and Matney meet monthly with each MCO Director individually.

Role of Other Oversight Entities

Paige Thorson, Policy Advisor, noted that HF 2460 also speaks to Medicaid Assistance Advisory Council (MAAC) membership changes, and an addition of another position for the managed care ombudsman's office (for a total of three). The Citizen's Aid Ombudsman also has a role in oversight as well as the Hawk-i board (focusing on children only) and the Mental Health and Disability Commission.

The Legislature's Health Policy Oversight Committee meets at least twice during the legislative interim (August and December) to provide continuing oversight for Medicaid managed care. "Listening Posts" are occurring statewide. The Department has responded to over 2,000 'Requests for Information" with the majority on managed care.

External Communications

Amy McCoy, Public Information Officer, reported to the Council on the multiple communications used in regard to managed care. Highlights of some of the communications:

- In 2016 350,000 family mailings
- On-going monthly mailings (10,000 mailings each month)
- Outreach pamphlets, etc. provided by the MCO's
- 28,000 calls per month at DHS call centers (MCO's also have their own call centers)
- E-news garners 5,000 views each month
- "IA Health Link" garners 16,000 views each month
- 130 Informational Letters sent
- Two provider trainings provided (3,000 providers attended)
- Quick Reference Guides available for "Prior Authorization"
- Listening Sessions held

- 365 Public Meetings held
- 12 Press Releases
- CMS hosted calls

Review of the "Managed Care Organization Report on First Quarter Performance Data" Report (dated August 26, 2016)

Liz Matney, Managed Care Director, reviewed the "Managed Care Organization First Quarter Performance Data" report, published August 26, 2016.

A copy of the report can be found on the Department's website: http://dhs.iowa.gov/news-releases/story_2

Much of the data in the report is self-reported by the Managed Care Organizations (MCOs). Additional data on demographics and level of capitation payments was provided by the Iowa Medicaid Enterprise. An independent audit will be conducted beginning in November and a report will be available early next year.

This report signifies the first set of comprehensive data since the program started.

Discussion of member enrollment took place. Members may change from one MCO to another for any reason in the first 90-days, or at their annual re-enrollment. Members may also make a switch for 'good cause.'

In response to the question regarding an explanation for the number of patients leaving United Health Care (UHC): Members may be choosing to leave due to their providers not being in the UHC network. It is a competitive market and the other MCOs might be offering a value-added service or soft skills that the member wants. This change may also have to do with the fact that AmeriHealth is leveraging external case managers long-term and members may choose to switch to maintain relationships with those case managers.

In response to a question about non-compliance noted in the report: When there are contractual non-compliance issues, the Department assures the MCO's meet the terms and obligations of the contracts. The Department could take several steps including:
- review if IME made correct calculations
- remedy recommendations
- corrective action plans
- assessment of liquidated damages
- continual monitoring by the IME

On health risk assessments: MCO's are required to document at least 3 attempts to contact members for the risk assessment. The Department recognizes that there are some external limitations to the MCOs' ability to make contact as a number of members that do not actively update their addresses and phone numbers.

There was discussion about the number of special needs, elderly and behavioral health patients enrolled in AmeriHealth. The question was that while they may get paid more for these patients via the capitation schedule, they are higher risk groups with very high costs and that is concerning. Other health plans have "collapsed" due to having disproportionate risk. Why is there this disparity and what is the contingency plan if one of these companies withdraws? Ms. Matney responded that this is why a risk adjustment is completed for capitation rates. Risk adjustment evaluates the acuity of the members assigned to each plan and adjusts the rates accordingly to be budget neutral.

There was a question noting that the company with the highest number of children with special needs has the lowest reimbursement. Has this been a concern from providers? Matney responded that DHS is looking into whether the correct data was received. This may change with time as it is based on paid date and is point in time and not all claims for the period may be paid. As more claims are filed and are paid by the MCOs these figures will change.

Palmer noted that compliance is a subject the Department takes seriously, and that decisions are made publicly.

Community-based Case Management ratios are monitored very closely. For this reporting period all plans are within appropriate case management ratios where defined. MCOs can have different ratios and must meet requirements set forth in their contracts.

If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization. Appeals are usually due to prior authorization denial. The Department will be looking at trends to see why certain programs receive more grievances from members than others.

Members can appeal through the State Appeal Process - with an Administrative Judge if they are unsatisfied with the resolution of their MCO appeal. If a member is not satisfied with the resolution of their grievance they can request disenrollment for cause from the MCO or contact member services with their complaint.

Timeliness of claims processing is an important issue. The Department looks to timeliness of payment as well as if the full amount was paid and at the right rate. IME has dedicated staff to review escalated issues and encourages providers to provide IME as much information as possible.

A “suspended claim” is pended in the system for further review to dig deeper. Often claims that are in suspense are reviewed to determine if more information can be submitted by the provider so that the claims does not deny.

There is a difference between denials and rejections. Claims are rejected because there is a technical issue with the minimum required fields or these fields are missing; an MCO’s claims processing system cannot consider these claims for payment until these issues are resolved. Right now the MCOs are at a less than 1% rejection rate. Denials occur for a variety of reasons at the MCO system level and include pre-pay edits that avoid fraud, waste, and abuse at the front end where it is easier to manage. Denial reasons include duplicate claims submitted, no prior authorization found, exceeds service limit, etc. These are claims that never should pay.

The Department continues to work to correct member helpline call issues. We are engaging in member and provider helpline secret shopper calls and provide that feedback to the MCOs for correction as issues are identified. Additionally, each plan is required to conduct a consumer satisfaction surveys and the Department as well as our external quality review vendor will monitor and review each year.

The Department is keeping a close eye on ‘Prior Authorizations’ (PAs) as PAs must be completed within 7 calendar days of request.

Regarding significant differences in payments among groups, DHS will address further as data is collected over a period of time.

In response to the question: “Are all of the companies reporting these numbers the same - Some seem to be reporting aggregate data each month, while United Healthcare is reporting individual month? (See how the other two seem additive?)” DHS responded that they are investigating this possibility.

Jean Slaybaugh gave an overview of the plan’s financial performance measures (pages 47-50). A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

In the next quarterly report, the Department will work with the MCOs to standardize reporting of financial metrics and minimize controllable variances. This will enhance benchmarking of performance across the plans.

HF2460 requires that the Department submit quarterly reports to the Legislature; the outcome achievement component of the report is to include program cost savings. Absent the previous fee-for-service program from which to draw an exact savings number, the Department must estimate savings. First quarter savings from managed care were reported at $22.3 million (State share). Speaking in broad terms, savings result from the difference between:

- Fee-for-service expenditures (projected per member per month expenditures)
- Reduced health care expenditures due to the impact of managed care (which is a decrease in per member per month expenditures) and offset by the administrative load paid on the capitation rates

The calculation does not consider what the MCOs have paid in claims; rather it is a calculation of what the state has paid to MCOs versus estimated payments under fee-for-service

Council Discussion and Wrap Up Role of Council

Anderson thanked staff and noted that the report is very helpful in meeting the goals on oversight.

Hansel also thanked staff and noted that the Council is receiving good information. She is concerned for the providers in the system and the energy they are expending to succeed and are in need of encouragement.

Council Update

Hansel reported she has had good connections with UnitedHealthCare and IME liaisons to resolve issues.

Director's Report

Director Palmer thanked the Council for their engagement over the last two days. This meeting was designed to begin to give the Council some exposure to the complexities and layers of the managed care system. He encouraged the Council to give their feedback to Mark Anderson as the agendas for the next meetings are crafted.

NEXT MEETING/ADJOURNMENT

The next meeting of the Council on Human Services will be Wednesday, October 12, 2016.

Council adjourned at 1:45 p.m.

Submitted by Sandy Knudsen
Recording Secretary