



Iowa Department of Human Services
Process Improvement Working Group Work Plan
 Group 2 – Benefits and Eligibility/Reimbursement

ID	Issues	Start Date	Action Items	Category	Owner	Notes
1	Transportation providers not showing or late for appointments.	4/23/2018	Providers requested evaluation of educational needs of the populations using the non-emergency transportation option.	Benefits/Eligibility	MCO/Broker	Transportation process was explained. Member can call MCO customer service. Member can see which care service is picking them up. And care service sends a reminder. Some members are confused or uncertain about process. Many members don't complain to Provider. Provider has a complaints process on missed pick ups. Documentation will be posted to webpage.
			Providers requested the pulling together of data on outreach calls on follow up and data on number of missed pick ups by provider. Tracking of reminders (follow up).	Benefits/Eligibility	MCO	Some members are non-verbal and the responsibility falls on their caretaker (who may care for multiple people). Some use neighbor or family members phone to call for transportation. So, Uber or app may not be helpful.
			Providers requested review processes and educational components to get members to the correct place to register complaints.	Benefits/Eligibility	MCO/Broker	Educational materials on appointment scheduling and escalation as well as statistics shared. Documentation will be posted to webpage. The IME and MCOs to bring back solutions in scenarios on how to prevent or mitigate transportation issues when appointment is long distance and for an event difficult to reschedule.
2	Seeing additional denials for Technical Component for radiology services done in an office setting. FROM PARAMOUNT: MCO: MMC seeing additional denials for TC Care done in	4/23/2018	IME to find original issue and, if possible owner. Move issue to bottom of list.	Benefits/Eligibility	IME	Original issue found and Provider contacted on April 25. She is not a member of this group, but has been invited to participate and explain the issue in greater detail.
			Received explanation of the issue from Provider on May 14.	Benefits/Eligibility	Provider	
3	Inconsistencies in covered services between MCOs and FFS. Not just between MCOs and FFS.	4/23/2018	DME to send an example on materials.	Benefits/Eligibility	Provider	IME and MCOs are working through DME issues to ensure consistency across programs. Materials will be posted to website.
			Examples received on May 11 were incomplete. IME requested that they send more detailed information.	Benefits/Eligibility	Provider	Pending.
			Provider (caller) to send example of delay on admission to ICF. In this example, MCO didn't feel it was medically necessary but IME determined level of care.	Benefits/Eligibility	Provider	Iowa Medicaid makes the initial determination of LOC for all programs. Iowa Medicaid additionally makes all final determinations if the MCO believes level of care has changed.
			Provider to send example of: only being able to bill for one procedure or the other. IME used to pay for both but MCOs pay for one or the other. Following CMS policy on CCI Edit, many codes cannot be billed in same service Primary service is considered inclusive of all codes. Speech and Language code denied but testing paid, for example. MCO and IME should be communicating changes.	Benefits/Eligibility	Provider	MCOs to provide information of policy at November meeting.
			Providers to ID examples to be shared and come back with updates. What can MCOs and IME do differently?	Benefits/Eligibility	Providers	MCOs should cover, at minimum, the same services that Iowa Medicaid providers and sets policy for. Please provide examples.
			Provider submitted examples of service paid for by IME and Magellan but not paid for by AGP or UHC.	Benefits/Eligibility	Provider	Review in process.



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4	Need clarification on the appeals process as it is cumbersome. Inconsistency with MCOs. <ul style="list-style-type: none"> Require that member appeals can end up with an independent 3rd party. (29) 	5/11/2018	MCO requested to provide a flow chart diagram of the appeal, Utilization Management (UM), and claims dispute processes at the next meeting	Benefits/Eligibility	MCO	Provider manual on the process is included in all mailing and on MCO websites. Second appeal with MCOs is within 30 days, but delay in mail gives them only 20 days. Patient in system and appeal sent. Provider (Caller) stated that while appeal is in process, they have to request it in a shorter time than the 30 days. UHC would like to breakdown process into appeal or claims dispute or other similar issues. MCOs presented workflow. Documentation will be posted to webpage. MCOs to bring forward recommendations on how to address what providers believe to be inconsistent utilization management and appeal determinations. MCOs to bring forward suggestions on how to improve peer to peer process as well as pull statistics on peer to peer outcomes. Information to be posted on website.
			Provider to send an example of administrative denial. Provider asked for clarification on what MCO can issue an administrative denial on.	Benefits/Eligibility	Provider	MCOs to provide examples of what would be classified as an administrative denial in November meeting.
5	Concern for when reimbursement is reduced when members go home, go on vacation, or are hospitalized for a period of time. Example: HCBS/ICF setting: limit in number of days you can go home, etc.	5/11/2018	This is a policy issue. Moved to Parking Lot	Benefits/Eligibility		No action at this time.
6	MCOs not paying for crisis stabilization services.	5/11/2018	Provider to talk with MCOS and provide IME with update with timeline to resolve issue, and provide a summary of what occurred with crisis services.	Benefits/Eligibility	Provider	IME has been closely monitoring enrollment of crisis providers with the state and credentialing with the MCOs. If a provider believes that the process is not proceeding as expected, please reach out to IME Provider Services and/or the MCO.
			Provider discussed a letter from a member with issues with crisis stabilization. Member back in queue and needs to be reaudited. Provider to send this example.	Benefits/Eligibility	Provider	Please send examples.
7	Concern with new extrapolation process when providers have an overpayment. IMEs role for overpayment for managed care payments instead of MCOs. Original Wording: IL 1879 specifies IME's program integrity role in review of	5/11/2018	IME requested to research IL 1879 and get back to group. Clarification of wording requested by Provider.	Benefits/Eligibility	IME	Complete.
			IME will put together interaction with MCOs and IME and roles of IME.	Benefits/Eligibility	IME	IME will put together interaction with MCOs and IME and roles of IME. Clarification of wording was requested from a Provider. Providers concern is duplication of effort. There are meetings so that efforts are not duplicated.
8	MCOs not authorizing necessary prosthetic inserts or liners.	5/11/2018	IME to bring back policy on what is covered for prosthetics	Benefits/Eligibility	IME	IME and MCOs are reviewing examples submitted by providers. As a result of conversations with providers, the IME and MCOs are additionally developing a crosswalk of DME products that will be posted to the website.



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9	Reduction in BHIS service authorizations impacting foster groups care.		Author emailed and asked that IME move issue to the bottom of the list. Author will attend the June meeting.	Benefits/Eligibility		MCOs review medical necessity of BHIS and provide authorization for all medically necessary services at the level that is appropriate. If a member or member representative believes the MCO did not authorize at the level needed, appeal rights are afforded and the member may request a continuation of benefits pending outcome of the appeal.
10	Services are being decreased when the level of care for members has not changed. Benefit may be why services decreased - hierarchy.	5/11/2018	Provider to send example of following hierarchy then being told to appeal. She requested clarity on access when you follow hierarchy.	Benefits/Eligibility	Provider	IME explained hierarchy of services. Providers should access all state planned benefits first then go to waiver. Service need may change but level of care may not change.
			IME to clarify this issue at next meeting	Benefits/Eligibility	IME	Complete.
11	MCOs reducing hours for day programs including employment	5/11/2018	Several providers to send examples including case mgrs dictating reduction in their hours and some members being told they can do things at home and don't need to come.	Benefits/Eligibility	Providers	IME and MCOs are reviewing examples submitted by providers and will bring forward to group.
			IME to provide issues template to Providers.	Benefits/Eligibility	IME	Templates provided.
12	Lack of continuity of care when member service setting changes, i.e.. waiver to skilled to waiver. • Transition between elderly waiver (EW) and nursing home cumbersome. MCO requiring action from IME, such as PASRR and LOC determinations, which can be problematic when admission is needed quickly.			Benefits/Eligibility		The IME is reviewing potential improvements to this process and is aware of challenges, including facility providers submitting discharge dates untimely through the case activity report system.
						The IME is reviewing potential improvements to this process.
13	Members changing dental benefit managers (DBMs), MCOs or primary care providers (PCPs) during treatment plan causes coordination challenges.			Benefits/Eligibility		MCOs will present on ensuring continuity of care and information will be posted to website.
14	Consistency in coverage of services for rehabilitative services thru the Hawk-I program (speech therapy). • Many of decisions made around managed care are based on how system works for adults. HBCS services is a good example. Pediatric population is generally hab services usually based on adult model			Benefits/Eligibility		The IME is reviewing cost of including both rehabilitative and rehabilitative services in the hawk-I base plans.
17	Adopting a definition of Medical Necessity (MN) incorporating a preventive focus. (Need examples from Providers)			Benefits/Eligibility		Please submit suggestions on how this would be incorporated so that Iowa Medicaid can conduct a fiscal analysis. Medical necessity definition used by CMS for the Medicare program aligns with the medical necessity definition leveraged by Iowa Medicaid.
18	Concern regarding changes to Title V agencies billing and why care coordination is not a billable service.			Benefits/Eligibility		Will present at future meeting.



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20	Ensure appropriate supply of meds is allowed when starting new doses and ongoing maintenance.			Benefits/Eligibility		Will present at future meeting.
21	Concern with caps on number of services including psychotherapy. (Need examples from Providers)			Benefits/Eligibility		Please send examples. There should not be caps implemented on services that are not implemented by Iowa Medicaid.
22	Psychology testing not adequately covered, unclear what will be approved. (Need examples from Providers)			Benefits/Eligibility		Please send examples.
	Ongoing Issue with people no longer incarcerated but still listed as incarcerated. Issue not reflected.			Benefits/Eligibility		Iowa Medicaid is aware of this issue and has been working ongoing to find a solution. The eligibility processes are dependent on timely and complete reporting by the jails and corrections department.
135	Reimbursement Concerns: <ul style="list-style-type: none"> MCOs requiring initial evaluations and standardized testing on separate days for full payment. Complex rehab/mobility items - majority are labor intensive to order, fit, repair and cost and are not covered by reimbursement. Reimbursement rates don't allow for retention of direct support professional. Network providers: in-network should be reimbursed 100%, out-of-network 95%. Create accountabilities for MCOs to accurately adhere to IME rate files. 			Reimbursement		MCOs to present.
137	Rate Setting: <ul style="list-style-type: none"> Inconsistent Intermediate Care Facility (ICF) rate setting process. Pricing of new codes for payment takes too long. Some disciplines have rates lower than others for same codes despite some disciplines having greater amounts of education. Consider time in treatment to be more reflective of severity than quality. Rates for certain services are significantly lower than needed for adequate therapy (i.e. ABA services) Timeliness of hospital rate rebasing. Review adequacy of rates and rate setting methodology (i.e. ICF ID, SUD, outpatient residential and B3). Some reimbursement rates are not keeping up with members needs. 			Reimbursement		<p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p> <p>This is a state policy issue that will be reviewed. More to come.</p>



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143	LTSS members have limited access to dental services. FQHC limit services for members. Medical and dental providers not accepting new members due to low reimbursement.			Reimbursement		This is a state policy issue that will be reviewed. More to come. This is a state policy issue that will be reviewed. More to come.