



April Executive Committee Meeting

Tuesday, April 19, 2016

Time: 2:30 p.m. – 4:30 p.m.

Hoover State Office Building

A-Level, Conference Room #5

1305 E. Walnut St., Des Moines, IA

Dial: 1-866-685-1580

Code: 515-725-1031#

AGENDA

- 2:30 Introductions
- 2:35 Approval of Minutes from Previous Meeting
 - Executive Committee: March 15, 2016
- 2:40 Committee Updates
 - a. Nominating Committee and Open Executive Committee Slot
 - b. Vice Chair Nominating
 - c. Meeting Schedule Adjustments and Workplan
- 2:50 Transition Updates from DHS
- 3:00 Updates from MCOs (15 minutes each)
 - a. Amerigroup Iowa, Inc.
 - b. AmeriHealth Caritas, Iowa, Inc.
 - c. UnitedHealthcare Plan of the River Valley
- 3:45 Full Council Operating Guidelines
- 3:55 Full Council Polling Method
- 4:00 Public Comment Listening Sessions
 - a. Mason City
 - b. Burlington
- 4:05 Ombudsman Office Report Review
- 4:10 Development of a Visual Display – How Customer Service Works
- 4:15 Iowa Health and Wellness Plan
- 4:25 Public Comment (Non-Executive Committee Members)
- 4:30 Adjourn



Executive Council Committee Summary of Meeting Minutes March 15, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – present	Mikki Stier – present
Dennis Tibben – present	Julie Lovelady –
Nancy Hale –	Jennifer Steenblock –
Kristie Oliver – present	Deb Johnson – present
Paula Connolly – present	Liz Matney – present
Shelly Chandler – present	Matt Highland – present
Anthony Carroll – present	Lindsay Buechel – present
Jim Cushing – present	Sean Bagniewski – present
Kate Gainer –	Amy McCoy –
Cindy Baddeloo – present	
Sara Allen – present	
COUNCIL MEMBERS	OTHERS

Introduction:

Roll call of Executive Committee members that were present or on the telephone and the list above reflects the attendance for the meeting. Gerd declared that the group had a quorum.

Approval of Executive Committee Meeting Minutes from February 16, 2016

Gerd invited the group to voice comments or changes to the February 16, 2016, meeting and no comments or changes were voiced. Gerd declared that the meeting minutes of the Executive Committee meeting held on February 16, 2016 stands approved as submitted.

IA Health Link Public Comment Meeting Schedule Assignments

Lindsay went over the Public Comment Meeting schedule and informed the group of the first meeting to take place in Mason City on March 22, 2016, and of the change in location for the Dubuque meeting. An Attendee Schedule for the Public Comments Meetings was handed out with designation of two Executive Committee members assigned to each meeting; necessary changes could be made with Lindsay. Anthony requested clarification on the role of Executive Committee members at the meetings. Lindsay stated that Committee members will be given a formal comment document to fill out at the meetings regarding information presented about member access, provider issues, and a general

category to summarize comments. Executive Committee members will not have formal speaking roles at the meetings and comments will be collected at the end of meetings to be combined for the purpose of reporting each meeting for the corresponding location. Up-to-date versions of the comment documents were to be sent to Committee members and posted to the website. Gerd suggested a review of the first two comment meetings at the Executive Committee meeting in April for recommendations on improvements to future meetings and to serve as insight for Committee members. The Committee agreed to place said discussions as a standing agenda item for the remainder of the year, and per recommendation by the Senate File, a quarterly report regarding Public Comment Meetings will be generated.

Update from the Office of the State Long Term Care Ombudsman (OSLTCO) (Deanna Clingan-Fischer)

Deanna spoke of the Health Consumer Ombudsman Alliance Report that was generated and submitted to the Legislature and the Governor in December 2015. Deanna reviewed the purpose of the multiagency alliance workgroup and the role of the OSLTCO to gather information and provide recommendations on various aspects of the bill. Deanna's PowerPoint presentation highlighted the five recommendations made in the Alliance Report

- 1) Establish a Health Consumer Ombudsman Alliance
- 2) Develop a Medicaid Managed Care Information Program
- 3) Implement a Statewide Single Point of Entry
- 4) Expand the Managed Care Ombudsman Program
- 5) Expand the Current Legal Assistance Network

Deanna stated that the Office was currently developing this database, using a case management software system, and that records of all call logs were being kept. Paula encouraged the Office to track data regarding the age of persons calling in and advocacy involving age span be collected clearly, as she had received feedback from families that LifeLong Links had not been a helpful resource. Kristie added that the report did not have information on children's help resources for families, and currently focused on the elderly; Shelly agreed. Jim stated the intent of LifeLong Link was to build an all-encompassing database for health and consumer information to connect all age categories and disability populations to helpful statewide resources. Jim and Deanna affirmed they continue to reach out to organizations to expand the database and network. Cindy asked how members knew to call the Managed Care Ombudsman's office if they needed an advocate, and Deanna replied it is listed in the MCO enrollment packets, IA Health Link Managed Care Handbook, MCO handbooks, and is listed on the OSLTCO website. Anthony suggested the Ombudsman's Office should come to another meeting to discuss LifeLong Links and a follow-up to the discussion; Jim and Sara agreed. Kristie asked how 211 worked in LifeLong Links. Jim explained the referral process and that LifeLong Links is under one government system focused on information resources for the ageing, with the primary purpose to link people with the resources they need in their communities. Jim stated that it will be a challenge for consumers to determine when to call the IME versus when to call the MCO, and that further clarification is needed when directing calls for LifeLong Link. Gerd invited Mikki to provide her thoughts on this point. Mikki stated that member eligibility, member enrollment, provider credentialing and provider enrollment go to the IME. Once a member is enrolled and assigned to an MCO, the member should contact their MCO. Once a provider is credentialed, they should contact their MCO(s). Paula stated the report did not address a connection for people between the IME and the MCO in terms of information or an advocate. Deanna stated this is the role of the managed care ombudsman. Mikki stated that Iowa Medicaid members have a case manager and care coordinator with the MCOs who will provide the care bridging and coordination, or members may still reach out to their providers. She stated that are many layers in place with this transition to help families. Kristie suggests an Informational Letter regarding this point. Gerd reminded the group of the motion made at the last Full Council meeting by Dr. Carlyle when he suggested that Medicaid consider their options relative to the ombudsman. The Full Council was to reach out to this group and see if further deliberation will be required on this topic. A phone comment was made by Dan Britt from the Occupational Therapy Association, he expressed concern for the occupational, physical, and speech therapy providers and prior authorizations (PAs) with secondary MCOs. Dan stated he received a letter stating a PA was not required but, on of the MCOs stated a PA will be required. Gerd affirmed follow up on the process for secondary PAs.

Provider Transition Update and Discussion

Mikki stated that the IME was in the process of drafting Informational Letters (ILs) and concerns regarding the transition should be addressed to the IME for clarification in future ILs. Current issues being addressed in ILs were crossover claims, cross reports, split billing, critical incident reporting, and so forth. Mikki suggested subscribing to the Medicaid e-News newsletter for regular updates on all developments and ILs, and to watch MCO webinars featured on their websites. She stated recent issues involving Integrated Health Homes (IHH) and Health Homes (HH), and future meetings to be held between MCOs and the IHHs and providers for clarification. Provider and provider association concerns were to be addressed to Mikki, Deb Johnson, or Liz Matney for assistance. Dennis stated concern about children's immunizations, and Mikki assured it was being addressed. Jim stated that "deemed credentialing" for 60 days was effective January 1, 2016, only and Sean confirmed deemed credentialing would no longer apply. Sara brought up the issue of "outlier payments" and Mikki stated that there was an RFI in progress. Paula questioned emergency medication practices, and what families should do for medication in an extreme emergency. Mikki stated that the IME would look into this. Dennis questioned accessing MCO patient lists prior to April 1, 2016, and NEMT. Mikki stated she would review to see what could be done. Cindy asked when MCO cards would be mailed. Matt confirmed Confirmation of Coverage letters were mailed, MCO cards would be mailed that week and handed out screen shots of MCO cards. Anthony questioned PA issues after May 1, 2016, due to initial 30-day grace period with MCOs. Shelly questioned IL 1628-MC on prior authorizations that did not previously require PAs (i.e. B3 Services), and requested further information on MCOs deeming services medically necessary. Liz Matney stated categorically that MCOs will not be able to arbitrarily recoup payments that have been made to providers. She stated that there is a process in place whereby if Iowa Medicaid Program Integrity determines that the provider, after having received payment, did not, in fact, provide a service, only then can there start a process for recouping payment; this process will be closely monitored by the IME. Liz stated this will be one of the data points being tracked and will be on the dashboard of oversight measures..

IA Health Link Communications Update

Matt said he did not have any additional updates aside from the Confirmation of Coverage letter and MCO card distribution. Jim requested a "checklist" to assist members in the MCO enrollment process and consideration for adding the value-added sheet to the enrollment packet.

MAAC Processes

- **Council Polling Methods**

Gerd said he would reschedule this agenda item regarding the Council Polling Methods to the April meeting.

- **Nominating Committee Appointment**

Gerd stated that he did not receive any interest in serving in the nominating committee for the election of the Vice Chairperson. Gerd stated that Paula volunteered. Gerd asked Cindy and Dennis to remain after the meeting to discuss the possibility of their participation as part of the nominating committee. Lindsay also reminded the group that the May meeting would involve the election to fill up the vacant Executive Committee seat.

- **Meeting Schedule Adjustments**

Lindsay stated that the schedule adjustment would happen in May and would flip the order of the meetings to have the Executive Committee meetings follow the Full Council meeting. The location was to be finalized and on the MAAC web page shortly.

Public Comment (Non-Member of the Executive Committee)

Dan Britt stated that UnitedHealthcare serving *hawk-i* stated they would honor BlueCross PAs but these claims came back as denied and UnitedHealthcare stating they were behind on claims. Barbara Nebel from the Iowa Speech, Language, Hearing Association stated that she had heard for small providers that TCA was going to be an alternative to two of the three MCOs and requested the progress. Mikki confirmed IL

being written to address this issue. Barbara then questioned if IL 1632-MC (Money Follows the Person (MFP) Program) had missing codes or was comprehensive. Deb Johnsons confirmed the IL was for MFP individuals although they are eligible for the state plan benefits, and she would confirm completeness of codes chart. Kevin Cruiser stated a representative from Amerigroup Iowa had told a member that there would not be automatic crossover for at least 90 days, and he was concerned about manual submission of claims. Matt replied that for crossover claims, CMS required three months of testing before it is automatically sent to the MCOs. During that period, claims would continue to be sent to the IME and they would all be denied and the providers will have to send their claims manually to the MCOs; an IL was to be released soon. A phone question from The Unified Therapy Services of Iowa stated that they were reaching out to the three MCOs but were still awaiting contract reviews and wondered if contracts were not signed by April 1st:

1. Could all members still continue to come to the facility for services?
2. Would they continue to be reimbursed at the current fee schedule?

Mikki stated that she would follow up and reach out with a response. Occupational Speech Therapy Association asked if there had been notice from the MCOs regarding PCAs. Mikki replied that the department had been working with them and but had not been able to get KID numbers to use for the PCAs program at that time.

Adjourn

4:37 P.M.



Mason City IA Health Link Public Comment Meeting

Tuesday, March 22, 2016

Time: 3 p.m. – 5 p.m.

Historic Park Inn, Ballroom

15 W. State Street

Mason City, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Debbie Johnson – present	Amerigroup Iowa, Inc. - present	Cindy Baddeloo - present
Jennifer Steenblock - present	AmeriHealth Caritas Iowa, Inc. - present	
Lindsay Buechel - present	UnitedHealthcare Plan of the River Valley, Inc. - present	
Sean Bagniewski - present		
Allie Timmerman - present		

Comments:

Case Management:

Members and providers expressed concern regarding if members still had a choice in selecting their case managers and how to go about this. Also, persons were unaware of who to contact after April 1, 2016, as case managers had difficulty contacting Managed Care Organizations (MCOs) regarding members before April 1, 2016. Case managers had been told that they were unable to contact MCOs about members until

April 1, 2016, and had experienced difficulty in being credentialed with the MCOs.

Prior Authorizations:

Magellan did not require Prior Authorizations (PAs), so providers are not used to obtaining a PA for every service. Providers stated concern for who to contact to obtain PAs and when to send for PAs.

MCO Enrollment and Provider Networks:

A member stated their son had not yet received his MCO enrollment packet. Members have also received a lot of mail from both the Iowa Medicaid Enterprise (IME) and their MCO, and were unsure of what information was important and what was simply informational. An issue that had been raised frequently was a member's MCO provider being out of their MCO's provider network, and whether the member would be charged for services rendered, or if they would be able to see providers that had not signed with any of the MCOs; such as the Mayo Clinic in Rochester.



Additional Comments:

Home- and Community- Based Services (HCBS) waiver members are unsure of how to obtain incontinence and Durable Medical Equipment (DME). Also, Senior Health Insurance Information Program (SHIIP) counselors had not been aware of which MCOs their members were assigned to and had been told by both the IME and MCOs that this information would not be available. Finally, concern was raised in regards to legislative oversight and whether concerns would be addressed moving forward.

Questions:

1. My son has been treated for a rare cancer at the Mayo Clinic in Rochester for the past five years under the Medicaid program. Have any of the MCOs contracted with Mayo? He is scheduled for a visit at Mayo in late April, will this be covered? Are members required to pay the difference when a member goes to an out-of-network provider?
2. Are case managers expected to be contracted within the first 90 days of April 1, 2016, implementation? What is a case manager's case load going to be? When will case managers begin contacting the MCOs? How are nursing facilities and case management going to work? Are case managers from each of the MCOs going to determine the patient's level of care? What is the difference between a case manager and community-based case manager? Will each agency or facility have someone that they can go to for problems, and will that case manager be able to give us that information?
3. How do members receive Durable Medical Equipment (DME) products and supplies? Are prior authorizations going to be required every time a member needs DME products and services? When do I start sending my prior authorizations to the MCOs?
4. How will Medicare/Medicaid crossover claims be processed? Will this be an automatic transfer of information as it is now?
5. Are members required to have both cards when they see their providers? Or, do they just need their MCO card? Are the MCO ID numbers different than the State ID numbers? When will MCO cards be issued?
6. Is DHS still going to be able to maintain the database for patient information? Can we still contact the IME for confirmation of a member's eligibility? When should I contact the IME and when should I contact the MCO?
7. What authority does the Medical Assistance Advisory Council (MAAC) have in this? How do they oversee this program? It is recommendations and they do not have power?



Burlington IA Health Link Public Comment Meeting

Tuesday, April 12, 2016

Time: 3 p.m. – 5 p.m.

Catfish Bend Inn & Spa / Pzazz Convention and Event Center
Hall B, 3001 Winegard Dr.
Burlington, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Debbie Johnson – present	Amerigroup Iowa, Inc. - present	Paula Connolly- present
Julie Lovelady - present	AmeriHealth Caritas Iowa, Inc. - present	Anthony Carroll- present
Lindsay Buechel - present	UnitedHealthcare Plan of the River Valley, Inc. - present	
Sean Bagniewski - present		
Stefanie Madsen – present		

Comments:

Case Management:

A provider stated a member who was on a waiver had not been contacted by a case manager yet.

Floor Rates:

A provider stated the established floor rates by DHS are less than what the provider actually receives and because of this; providers have not been able to contract with the MCOs. The provider takes a 10% penalty if not contracted with the MCO. The members are able to transfer to a different MCO but the providers/ organizations suffer.

HIPP Members:

Members enrolled in the Health Insurance Premium Payment Program (HIPP) are confused if they are enrolling with an MCO. Members on HIPP are receiving enrollment packets from the MCOs.

Credentialing:

A provider states they have received signed contracts back from the MCOs but have not received verification from the MCOs that their contracts have been approved.

Additional Comments:

Provider stated managed care transition was going well so far. Provider stated there was no indication the transition has been detrimental to members. Provider stated that they were pleased with the MCO's outreach efforts. A provider stated that administration costs are rising as there were previously two transportation sources and there are now seven. Provider stated that they use Association Agreements that exceed HIPAA and now MCOs are requiring a more expensive process. A member stated they were enrolled with two MCOs. Finally, more than one member stated that they have not yet received their member ID cards from their selected MCO.



Questions:

1. Why do providers have to go through the MCO and the Iowa Medicaid Enterprise for credentialing?
2. Why do providers have to wait to complete the MCO application until the IME application is completed?
3. What if a Hospital is not contracted with the MCO that members are enrolled with?
4. Where do providers send claims to? Should they be submitted to the payer or to the MCO directly?
5. Are EPSDT cases covered through UnitedHealthcare Plan of the River Valley (UHC)?
6. If providers submit Prior Authorizations (PAs), will the provider receive a fax if they get approved?
7. If providers have a 48 hour turnaround time and the Prior Authorization can sometimes take up to three days to be approved, how do providers stay in compliance?
8. How do providers know the member's quantity and timeframe eligibility for Durable Medical Equipment (DME) products and supplies?
9. How can providers find out approved quantities of products aside from calling the MCO's every day and when the information is not available in the MCO provider manuals?
10. If a provider has not received information on the process of their credentialing with an MCO, will their credentialing be retroactive, and will the provider receive the out-of-network rate during this time?
11. If services for a patient are not covered through the hospital will the Long Term Care facility the patient belongs to be responsible for those charges?
12. Why does UHC have a unique revenue code when compared to the standard billing guidelines?
13. There was a document stating providers could not allow clients to use their phone, fax or other office supplies to find out their MCO information. Where can members go to get the information if they need assistance?
14. Previously under Magellan, a substance treatment center was required to make contact when the facility was full or unable to take any more residents. Does a provider need to contact the MCOs now, or what requirements do they now follow?
15. Substance Disorder programs are required to do Prior Authorizations (PAs) because the program covers the state of Iowa. How are said programs going to receive their PAs back quickly?