COUNCIL ON HUMAN SERVICES

MINUTES

October 11, 2017

COUNCIL

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

EX-OFFICIO LEGISLATIVE MEMBERS

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

STAFF

Jerry Foxhoven
Sandy Knudsen
Nancy Freudenberg
Wendy Rickman
Liz Matney
Connie Fanselow
Theresa Armstrong

GUESTS

Tony Leys, Des Moines Register
Natalie Koerber, Amerigroup Iowa
Sandi Hurtado-Peters, Iowa Department of Management
Kris Bell, Senate Democratic Caucus
Emily Hockins, Advocacy Strategies
Jess Benson, Legislative Services Agency
Molly Driscoll, BrownWinick
Paige Petitt, UnitedHealthCare
John Stoebe, University of Iowa Hospitals and Clinics
M Jennings, Amerihealth Caritas
Lisa Burk, Amerihealth Caritas
Matt Meyer, Amerihealth Caritas
Mary Nelle Trefz, Child and Family Policy Center
Charlotte Eby, LS2 Group
Sheila Hanson, Child and Family Policy Center
Jane Brown, UnitedHealthCare
Joyce Russell, Iowa Public Radio

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m.

ROLL CALL

All Council members were present with the exception of Wallace. All Ex-officio legislative members were present with the exception of Representative Heddens.

RULES

Nancy Freudenberg, Bureau of Policy Coordination, presented the following rules to Council:

R-1. Amendments to Chapters 52 and 54, Medicaid. Removes the requirement for an annual cost report for privately operated residential care facilities (RCFs) and changes the cost reimbursement methodology to be based on the maximum per diem rate per subrule 52.1(3)

Motion was made by Heffernan to approve and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

R-2. Amendments to Chapters 152, 156, and 202, Foster Care. Aligns program and payment changes under the competitive child welfare services procurement for supervised apartment living (SAL) based on child welfare crisis intervention, stabilization and reunification service request for proposal (RFP).

Motion was made by Hansell to approve and seconded by Kudej. MOTION CARRIED UNANIMOUSLY.

Notices of Intended Action

N-1. Amendments to Chapter 74, Medicaid, Amends definition of “Medical Home” and adds definition of “Personal provider,” “Primary care provider,” and “Primary medical provider.”

N-2. Amendments to Chapter 75, Medicaid. Implements process to compare costs to Managed Care Organization capitation fees. Also updates definitions and provides technical updates to the rule.

N-3. Amendments to Chapters 77, 78, 79, and 80, Medicaid. Adds two new provider types for the purpose of member’s cost-sharing protections related to Qualified Medicare Beneficiaries (QMB) and Health Insurance Premium Payment (HIPP) members.

N-4. Amendments to Chapter 78, Medicaid. Revises language used to describe the Home and Community Based Services (HCBS) Home-delivered meal benefit in order to provide clarity on how the benefit is to be administered.

N-5. Amendments to Chapter 155, Child Abuse. Updates technical language around procurement procedures and assists in maintaining compliance with federal and state laws that require program evaluation.

Motion was made by Heffernan to approve the noticed rules and seconded by Kudej. MOTION CARRIED UNANIMOUSLY.

APPROVAL OF MINUTES

A motion was made by Hansell and seconded by Kudej to approve the minutes of September 13, 2017. MOTION CARRIED UNANIMOUSLY.

REVIEW OF OLMSTEAD PLAN

Connie Fanselow and Theresa Armstrong, Division of Mental Health and Disability Services reviewed the Olmstead Plan.

Background:

- "Olmstead" is a 1999 US Supreme Court decision that interpreted part of the Americans with Disabilities Act (ADA).

- Olmstead is specifically concerned with Title II of the ADA, which prohibits discrimination against individuals with disabilities by public entities. Federal regulations require public entities to administer services, programs and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities.

- The "integration mandate" which goes beyond where people live, applies to daily activities, interactions, access to employment, transportation and other aspects of choice and community integration.

Olmstead Plan Framework:

- The DHS is committed to promoting the vision of "Life in the Community for Everyone."

- The Framework document is built on nine outcome goals: 1) access to services; 2) life in the community; 3) employment; 4) housing; 5) transportation; 6) person-centeredness; 7) health and wellness; 8) quality of life and safety; and 9) family and natural supports

Hansell requested a copy of Fanselow's presentation.

MANAGED CARE UPDATE

Liz Matney, Bureau Chief, Iowa Medicaid Enterprise, reviewed the "Managed Care Organization Report: SFY 2017, Quarter 4 (April-June) Performance Data" report. As this report is newly issued and Council did not have time to review prior to the meeting, Matney will continue the review of the document next month. Council members were encouraged to email any comments and questions to Sandy Knudsen who will forward to the appropriate staff so they can be prepared to discuss at the November meeting.

Highlights of the quarterly report:

Over 53,000 adults and 40,000 children health risk assessments have been completed this quarter (pages 10 -13).

All MCOs are close to 100% of meeting the contract requirements of resolving grievances within 30 calendar days of receipt (and appeals within 45 calendar days of receipt). 'Transportation' continues to be the leading reason for grievances. Although all grievances are important, in SFY17 less than 1% of all members submit grievances. There was a suggestion to add 'national benchmarks' to this data for comparison. It was noted that 'provider' satisfaction information is found on page 46 of the report.

'Pharmacy' is high on the reasons for appeals in this quarter (page 41). Between 12 and 13% of appeals become certified to go forward with the ALJ (Administrative Law Judge). In SFY17 only 29 decisions were reversed.

Spading noted that what the report doesn't show is how much time providers are spending on prior authorizations and that providers may write-off an appeal due to the burdensome work required to appeal. She suggested that there should be discussions regarding what are meaningful measurements. Perhaps a survey of providers that would question how much time they are spending and at what point does it become too onerous.

Spading inquired as to what a 'service plan' entailed (page 43). Matney responded that the interdisciplinary team works together on a person-centered plan that incorporates the member's goals and all of the services they need to accomplish their activities of daily living, while working toward broader goals of services, who the provider is and how many units are required. The member is involved in this process.

All MCOs meet the contract requirements (80%) of member helpline calls being answered timely (page 45-47). Reasons for the calls are being reviewed to build training activities and include information in newsletters to highlight some of the issues. In response to a question from Heffernan on whether calls to the help desk are also resolving issues, efforts are being made to incorporate some of that information into the report to reflect the consistency and accuracy of the information communicated.

'Clean' claims must be paid or denied within 14 days. All of the MCOs are meeting the 90% requirement. Page 50 shows the top reasons for claims denials.

Ragan asked what are the most common value added utilized service. Matney responded that the provision of diapers, prenatal activities and gym memberships have all been popular. Matney offered to provide a more comprehensive listing.

Spading spoke to the 'Prior Authorization - Pharmacy' section of the report (page 65) stating that 'pharmacy' is challenging to quantitate. Submitted claims are completed within 24 hours most of the time, but if the result is a denial, then there is time spent writing appeal letters, etc. As much as 2-3 hours may be spent on each appeal because of the accessing of patient data, and pulling primary literature to support decisions - and staff involved could be physicians, nurses and sometimes the pharmacist or pharmacy technician. Spading expressed concern for the smaller providers who may not have the resources necessary for this effort. Matney offered to look into this issue.

Spading reiterated the importance of benchmarking and surveying provider and member experience.

In response to a question from Senator Segebart, 'duplication' is a leading cause of denials of electronic claim submissions. Much time is spent educating providers on how to follow-up on a claim.

Foxhoven noted that the State strives to reach a balance of being good stewards for Iowa taxpayers and providing appropriate services to the Iowans receiving Medicaid services.

REVIEW OF COUNCIL'S ANNUAL EXECUTIVE SUMMARY (REGARDING THE DELIBERATIONS OF THE COUNCIL ON HUMAN SERVICES RELATING TO MEDICAID MANAGED CARE)

Anderson requested that the Council review this draft document and email comments/revisions to Sandy Knudsen. Council will take action on the summary at the November 8, 2017 meeting.

COUNCIL UPDATE

Hansel shared that there was an interesting article in the Des Moines Register regarding the need for integration of mental health and substance abuse services. Staff will forward copies of the article to the Council.

Kudej reported that she attended a meeting of the Older Iowans Legislation (OIL) in which Director Foxhoven spoke. At this meeting, the topic of sexual offenders residing in nursing homes and at the Independence Mental Health Institution was discussed. She appreciated Rick Shults talking with her to clarify several issues on this topic.

Anderson spoke about families in crisis in local communities - often multi-generational with multi-diagnosis. He suggested that this topic be placed on a future agenda to discuss interagency collaborations striving to move families to more stability.

DIRECTOR REPORT

Jerry Foxhoven, Director, provided the following report:

Foxhoven has visited all the DHS facilities except for Independence MHI (which is on a future schedule). All of the facilities are operating at the bare minimum, and a difficult decision was made earlier in regard to the implementation of a reduction in force at the Cherokee MHI.

Foxhoven has been meeting with department social workers. In many instances, the caseloads are high and morale is suffering. In these meetings, the social workers are asked to identify things they can 'take off their plates' so they can concentrate their time on other things.

Deputy Director Mikki Stier has been asked to look for potential savings throughout the department so resources can be better managed (i.e. supplies, postage, printing, etc.) Sen Ragan, pointed out that the legislature last year cut $16M from the department's Field Operations budget (which is 94% staff) and that doesn't leave much room for additional savings.

The department continues to be in contract negotiations with the managed care organizations. Foxhoven's hope is to start earlier in the process for next year's contracting cycle.

ADJOURNMENT

Meeting adjourned at 1:00 p.m. The next meeting of the Council on Human Services will be Wednesday, November 8, 2017.

Submitted by Sandy Knudsen, Recording Secretary