



Sioux City IA Health Link Public Comment Meeting

Tuesday, October 11, 2016

Time: 3 p.m. – 5 p.m.

Western Iowa Tech Community College

4647 Stone Ave., Sioux City, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Matt Highland - present	Amerigroup Iowa, Inc. - present	Dennis Tibben - present
Lindsay Paulson - present	AmeriHealth Caritas Iowa, Inc. - present	
Sean Bagniewski - present	UnitedHealthcare Plan of the River Valley, Inc. - present	
Allie Timmerman - present		

Comments:

Contracting and Credentialing

Physicians were not loaded properly into at least one of the Managed Care Organization's (MCO's) systems and this had been causing numerous billing and patient scheduling issues. A provider stated that existing patients were not able to find their physician as they were not listed as a Primary Care Provider (PCP) in the MCO's systems. Some providers had also been listed as current providers within the MCO's system however, they were no longer Medicaid providers.

Services and Coverage

A provider offering imaging services had not been loaded properly in one of the MCO's systems so the provider was not able to obtain approval to provide the necessary services. As the provider was not loaded properly into the MCO's systems, they were having to send all Medicaid patient's assigned to that MCO to the local hospital for imaging services at a considerably higher cost. A caretaker for a quadriplegic had been experiencing difficulty in acquiring information regarding coverage and had consequently not received payment for her services; this had caused significant financial issues. A Community Mental Health Center (CMHC) stated they had prior experience with Magellan so the transition to the IA Health Link managed care program was not a new concept for them and they were not as concerned going into the new system. The CMHC's care coordinators were struggling to juggle the MCO's unique policies and administrative issues and this had been impacting patient care. Another provider affirmed that clients were not able to get authorizations for covered services in a timely manner so provider were performing needed services up front in the hope of being paid at a later date; thus putting providers at financial risk. The MCOs were also being slow to process Health Risk Assessments (HRAs) and care coordination documents which created discontent and conflict between providers. Providers were lead to believe that their colleagues were delaying the care plan and the component of care had not been completed however, the delays were due to the MCOs not processing documentation in a timely manner. A meal services provider had recently been receiving referrals via fax which only listed the member's name without contact information or the services being requested. The meal service had been in contact with the MCO's Provider



Services call centers to obtain additional information however, the information was not always available and they were not receiving call-backs from the MCOs when they had been told they would; members were therefore not receiving meals. The Elderly waiver program allowed Iowa Medicaid members up to 62 meals a month and the meals could come from multiple providers. When the meal service was submitting care plans with multiple meal providers, whether the total number of meals was within the 62 meal monthly limit, they were being consistently denied. The MCO staff told the service that the plans were allowed but they were still not able to get approval.

Billing, Claims and Contracted Rates

Venipuncture payment issues persisted. HRAs were not being paid properly. There were also issues with Medicare crossover claims being paid properly where crossover claims were receiving a 2% sequestration rate cut. Two of the MCOs were paying to backfill the rate cut, which was resulting in minor credit balances that were creating discrepancies in the providers' ledgers. Medicare claims were also crossing to the incorrect MCOs and the MCOs were inconsistent in their responses to the question of how to correct this issue. Another provider stated that claims that had initially paid incorrectly were not reprocessing as they were supposed to be and the 80 modifiers continued to be paid incorrectly. Payments that had been issued to the wrong physician in a practice were not recouped by the MCOs which resulted in credit balances. Flu shots were not being paid. An Integrated Health Home focused on population health stated that the new system was forcing new administrative burdens on staff that was not experienced with the administrative portions of operations. The organization no longer had enough staff to keep current on claims and billing so they were hiring a new administrative employee to deal specifically with Medicaid issues and billing. Another provider had been loaded into the MCO's system incorrectly and were being paid the out-of-network rate of 90%. The provider was told that if they wanted to get paid the full in-network rate, they would have to resubmit their claims. An administrative employee identified an issue in the organization's Accounts Receivable (AR) rate in that denial rates were excessive and claims were no longer being paid in a reasonable time frame.

Communications, Comments and Suggestions

A local physician clinic had been meeting individually with two of the three MCOs over the past few months and had seen success in getting some issues addressed, but still have many outstanding issues. The MCOs were not responding to requests to recoup incorrect payments that were issued to the wrong physician in a practice, resulting in credit balances. A provider expressed dissatisfaction with the implementation deadline and speed with which the program was executed. The MCOs were not to blame for the timeline however, there were outstanding problems that would need to be corrected by the MCOs. Some providers in the community were forced to leave the market, but not as many as initially expected. There were opportunities for creativity in managed care but for the time being, the system would need to be stabilized and outstanding issues addressed. A provider requested that the MCOs streamline processes and develop uniform policies and process wherever possible to reduce the administrative burden on practices. A physicians practice had been meeting with one of the MCOs for several months and the practice had outstanding issues dated as early as April 7, 2016, that had still not been resolved. In August 2016, the practice was told their issues would be resolved by early October 2016, and they had still not been resolved as of 10/11/2016. Providers were skeptical



of the accuracy of the State's oversight data on topics such as timely claims payments. Two of the MCO call centers were praised for their knowledge and customer service skills. MCO regional contacts would not respond to a provider's contact via phone, or email; phone calls were being sent immediately to voicemail. Patients continued to change their MCO which impacted the provider's ability to bill the proper MCO.

Questions:

1. When will providers be properly loaded into the MCOs' systems?
2. What are the MCOs' strategies to expedite resolution of long-standing issues?
3. Are the MCOs adding additional staff? What is the strategy moving forward to add more resources and get caught up?
4. Why do I talk to at the state level if I am not getting the answers that I would like from the MCOs?
5. IME provider services used to be very responsive; practices could get a call back within 24 hours. Now, this is not happening. Why?
6. One of the MCO's call centers is difficult to work with. Customer Service Representatives (CSRs) read from scripts; they can't or won't offer additional information beyond their scripts. They usually cannot find the patient record when practices call in for specific claims. What is going on?
7. Recently, IHHs were informed that their care coordinators were required to start reporting patient contacts beginning with July 1, 2016; this is not something they have had to do before and their systems were never set up to track this. The retrospective reporting is a significant burden and no rationale was given for reporting this new information?

Why was this new requirement put into place and why not make it effective starting January 1, 2016, rather than requiring retrospective reporting?

8. When Medicare is the primary insurance and Medicare processes the claim, if it is sent to the wrong MCO, how can they be sent to the proper MCO?
9. With Magellan, IHHs submitted the HAB assessments and an NOD was produced. Now, everything has to be entered into each MCO's system, which is time consuming. Why can't fax the information and produce our own NOD?