



Dubuque IA Health Link Public Comment Meeting

Tuesday, May 10, 2016

Time: 3 p.m. – 5 p.m.

Grand River Center

500 Bell Street

Dubuque, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Debbie Johnson – present	Amerigroup Iowa, Inc. - present	Kristie Oliver - present
Lindsay Buechel - present	AmeriHealth Caritas Iowa, Inc. - present	Anthony Carroll – Present
Sean Bagniewski - present	UnitedHealthcare Plan of the River Valley, Inc. - present	Gerd Clabaugh- Present
Nicole Kaplan – present		

Comments:

Case Management:

Providers from long term care (LTC) facilities stated they did not know the necessity of case managers when there were already social workers in the facility to assist members. LTC facility administrators have to spend additional time updating the new MCO Case Managers and handling new Pre-Admission Screening and Resident Review (PASSR) requests instead of doing their assigned jobs. One Integrated Health Home (IHH) provider expressed concern that the MCOs were contacting the IHH before the April 1, 2016, implementation date and the provider did not have access to member’s information until April 1, 2016.

Prior Authorizations:

Providers expressed concern that the sending of a Prior Authorization (PA) and approval of a PA had been time consuming in that each MCO required different information for their PAs. Providers stated that they are not able to receive a response in a timely manner for what services a member is currently authorized for. Providers expressed that they did not have time to do their job because they were spending a large portion of their time requesting PAs. Members and providers expressed that if a member could not have a PA approved quickly, the member should go to the emergency room. Members and advocates also stated that members were unable to work as they were not able to get their Support Employment Services approved by the appropriate MCO. A provider

stated that the MCO's staff needs to receive better training as they are giving out different answers. A provider stated that they cannot get authorizations for children so children have not been receiving services since April 1, 2016. Providers and members stated that PA's are taking too long, especially pharmacies (with mental health needs). A provider stated that for the *hawk-i* members they are unable to receive PA's for immunizations. Lastly, one member stated that she had spent up to 20 hours on the phone with an MCO trying to get her PA for a prescription approved.

Claims:

A provider discussed having trouble with the MCOs when the provider was out-of-network. The provider had faxed a PA to a specific MCO and the provider had received a response stating the PA needed to be sent in by a provider who is in-network. Some MCOs would allow out-of-network providers to submit PAs while others would not. Providers stated that Current Procedural Terminology (CPT) codes were not being paid by the MCOs and that they all differed. A provider stated that Amerigroup is not paying the current IME fee schedule and not allowing CPT 16415 at all. Providers stated that the MCOs had allowed providers to reprocess their claims, but it was time consuming. Several providers stated that Amerigroup Iowa's online claims process was not user friendly or did not always work properly. One provider stated that their claims to an MCO were denied as they were done incorrectly and would need to be resubmitted. A vision provider stated that some of their claims submitted for vision services were covered as medical services and others were classified under vision services. A provider stated that 92 percent of their patients received Medicaid and that they had submitted claims to the MCOs for the last five weeks without receipt of payment to-date. A member stated that she had been told by a provider that she would have to pay for an eye exam first the claim would then be submitted to the MCO, and the member would be reimbursed after the claim had been approved. Another provider stated that the IME fee schedule for vaccinations is ridiculous, as the vaccines are expensive. A provider mentioned that the UnitedHealthcare contacted them back and stated that their fee schedule for rehab agencies was loaded as the physician fee schedule instead and they were fixing that problem. The same provider received a response back from UnitedHealthcare about their claims and that they had several errors but they were all on UnitedHealthcare's end. Some of them were paid with the incorrect fee schedule, some were paid out-of-network when they should have been paid in-network and some of them paid with tax id number errors. Providers stated that rehab agencies have timed code 92507 had not been paid correctly from Amerigroup. Lastly, a provider requested that *hawk-i* reexamine their per diem rates for evaluations and treatment for physical, occupational and speech therapy. The current rates not cover the time spend or to coverage the salaries of

their therapist and supportive staff submitting authorizations, claims or taking care of accounts. They are hoping that they would follow the same fee schedule set out by IME.

Provider Networks:

A member stated they weren't able to see their primary care provider (PCP) as the provider was out-of-network with the member's MCO. However, the provider's clinic was in-network. Another member stated that they felt they did not get to choose an MCO as a majority of Dubuque providers signed with only one MCO. A member stated that the providers were refusing to work with the MCOs and that it was negatively impacting patient care. Members also expressed that they were unable to find available vision providers in their area. One vision provider stated that the MCOs had informed the vision providers that they were required to under a vision plan prior to being contracted with an MCO.

NEMT:

Members and providers expressed concern that there were not enough Non-Emergency Medical Transportation (NEMT) providers in their area. When the members scheduled a ride to an appointment the members were being told to be ready an hour and a half before their ride would pick them up and that they may have to wait up to an hour and a half after their appointment to be picked up for their return trip home. Providers mentioned that they had to wait at the clinic after hours until the member's NEMT arrived for the member. Others expressed that some members were arriving to their appointments late because of NEMT and other members had been cancelling appointments due to issues with NEMT.

Communication from MCO's:

Providers stated that they had not been receiving responses from the MCOs for questions posed several weeks ago. When the providers had received contact from the MCOs for questions, they were transferred to multiple departments before reaching the correct representative. Providers and members also expressed that the answers they had received from the MCOs were inconsistent. Providers expressed that they were not staffed to spend all day on the phone for claims questions, PAs or to assist members with their MCO concerns. Providers and members also stated that when guardians of members had tried to call the MCOs, the MCO would not release member information as they did not have guardianship information on file and the information had not transferred from the Iowa Medicaid Enterprise (IME) to the MCOs.

Additional Comments:

Many providers expressed that they were not being contacted in a timely manner by the MCOs. Providers had faxed, emailed, and called the MCOs

and the providers either had not received communication back, the matter was no longer within a reasonable time frame when the response was received, or the MCOs continued to transfer the provider to different departments. Another comment was made that a provider would like to appeal for the MCO to not take over the pass through dollars for hospice room and board. Providers and members expressed that the MCO call center CSRs and IME were giving incorrect information. A provider stated that the IME Preferred Drug List (PDL) is outdated and members were not able to fill their medications. A provider mentioned that the recent Integrated Health Home (IHH) State Plan Amendment went against the Iowa Administration Code Chapter 90 for case management and limited who was able to speak face-to-face with the members. A provider also mentioned that they are receiving conflicting information regarding IHH from provider services. Lastly, a caregiver stated that the IA Health Link should have rolled out providers first and then the members instead of everyone at once.

Questions:

1. What is the turnaround time for Prior Authorizations (PAs)?

MCOs answered that the maximum number of days for a PA to be approved was seven days. For an escalated PA, the maximum number of days was two-three days. Emergency room services did not require a PA. PAs were not to be the member's responsibility; it is the responsibility of the provider to obtain a PA.

2. Does the transfer of a member from a Nursing Facility (NF) to Hospice require a PA?

The MCO's stated that they would follow up.

3. If the provider has waited for seven days and the PA has still not been approved should they continue to give care to the member?
4. Who determines nursing home admission?
5. Who completes the Level of Care (LOC) assessment?
6. Who is approving the Activities of Daily Living (ADL) for the HCBS Elderly Waiver?
7. Will pharmacies be told how long a PA is good for?
8. Where can we find information regarding who is on the Medical Assistance Advisory Council (MAAC)?

https://dhs.iowa.gov/ime/about/advisory_groups/maac

9. Are UnitedHealthcare and Amerigroup expanding to specialist locally in the Dubuque area? The main clinics have signed up with AmeriHealth Caritas.