



Waterloo, IA Health Link Public Comment Meeting

Wednesday, September 14, 2016

Time: 3 p.m. – 5 p.m. Fort Hawkeye Community College

Tama Hall, Room 105

1501 East Orange Road, Waterloo, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Matt Highland - present	Amerigroup Iowa, Inc. - present	Anthony Carroll - present
Luisito Cabrera - present	AmeriHealth Caritas Iowa, Inc. - present	Natalie Ginty - present
	UnitedHealthcare Plan of the River Valley, Inc. - present	

Comments:

Billing and Claims

A provider from Manchester stated that the transition has been a nightmare for them. Denial rate has tripled and our billers are just overwhelmed by the rate of denial. They said that they have not been paid for so many of their claims like rural, rural health claims and critical in-patient and out-patient claims. The problems have been reported multiple times to the provider representative but with no clarity on how to solve the issues. The provider is repeatedly being told that they are not in-network when they are registered with all three MCOs. Another provider brought up the issues they are encountering regarding Prior Authorization (PA) and approval taking 60 days and wanted to know how to handle.

General Comments

A provider commented that they still think this whole transition happened much too fast and not enough consideration was given to the debilitating issues that we all now are facing. Expressed concern as to whether this transition will actually work and wanted reassurances that these are all just “growing pains”. A provider asked about Medicare Advantage Plan and clarity on application of co-pay versus co-insurance.

Case Management

A provider commented that now that the MCOs have taken over case management, MCOs have their own case managers and it is difficult to make a determination on who these managers are and how to get in touch with them. Provider brought up conflict encountered involving 60 day on PA and 45 days on appeals.

hawk-i

A provider sought clarity on the cap on *hawk-i* insurance regarding Occupational Speech Therapy.

Good Cause

A provider commented that good cause is really good for the members but pose some significant billing issues for provider that are not notified in time and result in denials.

ELVS

We have encountered issues regarding members that are not actually enrolled with the MCO reflected in ELVS because that member has changed MCO. This poses a lot of issues for us providers. We would like this situation addressed.

Questions:

1. Has there been any consideration given to reconsidering the whole Medicaid transition?
2. What do MCOs intend to do to resolve these claims denials issues?
3. Is the system actually designed to work or are these issues simply “growing pains” in trying of the implementation?
4. What will happen if these issues continue to remain unresolved? (We providers cannot afford to remain in business).
5. How does Medicaid save money considering all these issues?
6. What is being done and what do you (MCOs) recommend to resolve the continuing PA problems?
7. Are MCOs collaborating is resolving these issues?
8. What do you recommend we do to resolve claims denial issues?
9. If a member is in process of re-enrolling in Medicaid – will that member be assigned to the same MCO?