



Executive Committee Meeting

Friday, November 4, 2016

Time: 12:30 p.m. – 2:00 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

- 12:30 Introductions
- 12:35 Approval of Minutes from Previous Meeting
 - Executive Committee: September 28, 2016
- 12:40 Administrative Rules Draft Review and Approval
- 1:00 Action Items Update
- 1:10 Public Comment Listening Sessions Summary
- 1:20 Update on Required Legislative Reports
- 1:55 Public Comment (Non-Executive Committee Members)
- 2:00 Adjourn



Executive Committee Summary of Meeting Minutes September 28, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – present	Chuck Palmer – present
David Hudson – present	Mikki Stier – present
Dennis Tibben – present	Deb Johnson –
Natalie Ginty – present	Liz Matney –
Shelly Chandler – present	Matt Highland – present
Cindy Baddeloo – present	Lindsay Buechel –
Kate Gainer –	Sean Bagniewski –
Lori Allen – present	Amy McCoy –
Richard Crouch – present	Luisito Cabrera – present
Julie Fugenschuh – present	Alisha Timmerman –
Jodi Tomlonovic – telephone call-in	

Introduction

Gerd called the meeting to order and performed the roll call. He welcomed the new members of the Executive Committee to their first meeting. Executive Committee attendance is as reflected above.

Approval of the Executive Committee Meeting Minutes of August 18, 2016

Minutes of the Executive Committee meeting of August 18, 2016 was approved with correction to the spelling of Natalie Ginty's last name.

Transition of the Executive Committee Members

MAAC Meeting Guidelines and Administrative Rules

Gerd asked the earlier Committee members that were involved in the draft document of the rules and guidelines to take up the responsibilities of drafting the final version of the document reflecting the changes as discussed in the last Full Council meeting. He cited himself, Shelly, and Dennis to take up this task but also suggested one additional person from the public members. The aim is to get the final draft ready in three weeks in time for the October 18 Executive Committee meeting. David volunteered to be part of the group. Gerd stated that a meeting will be scheduled prior to October 18 to further discuss this point.

Action Item:

- Previous members of the Executive Committee plus one new member will meet to draft the final rules and guidelines document (Gerd, Shelly, Dennis, and David) for October 18.

Work Plan and Action Items

Gerd gave the new members a brief overview of the purpose of the work plan document as a tracking tool for all the MAAC work in progress. He explained how the work plan itemized the work that is in the pipeline and that it worked hand in hand with the action items document which gives a status report on items that require action. As a briefing for the new Committee members, Mikki reviewed the Action Items document starting with all the items that have been completed and then with the items that are still outstanding. Mikki mentioned the various Medicaid work processes flow charts that have been developed and completed that can be found on the [DHS website](#)¹ under the “News and Announcements” section. Chuck Palmer gave a brief overview of the role of the Executive Committee and its function as part of the larger Full Council in making recommendations to him. The Executive Committee is an arm of the Full Council therefore speaks and makes recommendations on behalf of the Full Council.

MAAC Minutes Summary

Mikki stated that this document is a summary of the MAAC Executive Committee and Full Council work pertaining to the managed care transition. She stated that the MAAC is required to provide this summary of the MAAC’s managed care transition implementation activities for 2015 and 2016. She mentioned that the 2016 document will continue to be updated until the end of the year. Cindy inquired about the appointment of a member and a provider liaison. Mikki stated that these positions have been in place now for a while:

Member Liaison: Stephanie Madsen / **Provider Liaison:** Inde Seedorff

Gerd stated that these are summaries of already approved minutes and therefore do not require further approval. Mikki stated that both a quarterly report and an annual report are required. David inquired about how issues are brought to the MAAC and if the administrative rules specify this point. Chuck provided insight regarding this process and stated that any member of the MAAC or the public can make a public comment and bring any issue for discussion. He stated that this may develop into an actual recommendation to the DHS. Dennis inquired about a more concrete date for in-depth discussion on these summaries for the purpose of making a recommendation. Gerd stated that the October 18 Executive Committee meeting would be the opportunity to have this substantive discussion to meet the November 15 report deadline.

Action Item:

- Begin in-depth discussions on summaries and potential subsequent recommendations for meeting the November 15 report deadline

Data Workgroup

Chuck stated that this work group resulted from asking the question, “what kind of information do we need to do the job as the MAAC and to come to some conclusion about how the program is working?” He stated further that answering this question will allow us to come up with a set of recommendations. He stated that the MAAC was viewed as the natural body to carry out this task of oversight. Chuck provided an overview of the process for the data workgroup. He suggested that the “data” is essentially asking, “What do you think do you need to arrive at recommendations”. Gerd stated that this has been discussed in the context of a “work group” and that it might be useful to start appointing persons from the Executive Committee and the Full Council to begin the process. Gerd suggested four from the Executive Committee and perhaps two from the Full Council. He asked for any volunteers to be part of this work group. Anthony Carroll and Jim Cushing indicated that they would like to be part of this work group. Gerd stated that almost everyone in the room indicated that they wish to be part of the work group (except David). Cindy suggested that perhaps a good start would be to simply identify a list of data groups or data points solicited from the larger MAAC group before appointing a select work group. Dennis recommended that at the next MAAC Full Council meeting – ask everyone to prepare to share data points for drill down. Not to debate but to outline as Executive Committee and drill down as Full Council and tie it to the goals.

Action Item:

- Request MAAC Full Council members to prepare to share data points and appoint Executive Committee and Full Council members to form part of the Data Work Group.

¹ <https://dhs.iowa.gov/ime/about>

Public Comment Listening Sessions

Matt provided a quick review of the last two Public Comment Meetings in Fort Dodge and Waterloo. He provided some of the key issues that were raised in the meetings as reflected in the summary documents. It was pointed out that there have been a diminishing number of attendees but this may be emblematic of the fact that providers now have more sources to obtain information and more mechanism for feedback which can explain the decrease in attendance at formal public meetings. Laurie sighted the challenge that is posed by a 3pm-5pm meeting time slot for members and suggested that the meetings should perhaps focus on members given that providers have more avenues for information. Cindy volunteered to join Dennis for the October meeting in Sioux City and Shelly volunteered for the November meeting in Ottumwa. Summaries of all completed public comment meetings are found on the [DHS website](#)².

Action Item:

- Need another Executive Committee member for the November Public Comment meeting in Ottumwa.

Public Comment (Non-Executive Committee Members)

Dan Britt stated that things have been going quite well with AmeriHealth and United Healthcare but are still encountering ongoing systemic challenges with AmeriGroup on speech therapy claims. Dan wanted to know if the IME monitors recoupment data and how this information is being monitored. Gerd and Mikki stated that this will be checked and will reach out for feedback.

Action Item:

- Reach back to Dan Britt regarding his query involving recoupment data collection and monitoring by the IME.

Jim indicated that there seems to be a disconnect between the IME staff, the MCOs with respect to the status of individuals as they move out of elderly waiver facilities and back to their homes. He cited the issue of the 30-day trigger but evidently this required them to go through the entire Medicaid approval process all over again. He stated that this needs to be looked into. Cindy: agreed that this is happening more frequently. Mikki stated IME will look into this.

Action Item:

- Look into the Medicaid re-application process that is being triggered when someone in Elderly waiver facility moves back home.

Adjourned

4:40 PM

² <https://dhs.iowa.gov/iahealthlink/IHL-Public-Comment-Meetings>

441—79.7(249A) Medical assistance advisory council.

79.7(1) Officers.

a. Definitions.

(1) Co-chairpersons: The director of public health and a public member of the council.

(2) Public co-chairperson: Individual selected by the other publically appointed members of the council.

(3) Public health director co-chairperson: The director of the department of public health.

b. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

c. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a non-voting member of the council.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. The public co-chairperson shall be filled by one of the ten publically appointed council member positions.

(1) Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department of human services staff.

f. The co-chairpersons shall also serve on the executive committee and will serve as the co-chairpersons of that committee.

g. Responsibilities. The co-chairpersons shall be responsible for development of the agenda for the full council. Agendas will be developed and distributed in compliance with the advance notice requirements of the Iowa Code section 21.4.

(1) The co-chairpersons shall be responsible for agenda creation, which will be developed in consultation with the staff and director of the department of human services, taking into consideration the following tasks of the council:

i. Workplans. Agenda items will be added to the council agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a timeframe to allow the executive committee to receive the council's feedback, make recommendations to the director, and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services, the governor, as well as for upcoming legislative session.

ii. Requests from the director of human services.

iii. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time and after the draft agenda is distributed. The agenda will be distributed in draft form five (5) business days prior to the council meeting, with the final agenda being distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council and executive committee meetings, calling roll, determining quorum, counting votes and following the agenda for the meeting.

- ii. The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and participate in workgroups and subcommittees as appropriate.

79.7(2) Membership. The membership of the council and its executive committee shall be as prescribed at Iowa Code section 249A.4B, subsections 2 and 3.

a. Council membership of professional and business entities shall consist of those outlined in Iowa Code section 249A.4B, subsection 2 and 3.

(1) Professional and business entities shall identify their representative and report information to the department of human services.

i. If an entity's representative does not attend more than three (3) consecutive meetings, the department of human services will notify the entity and representative and verify if an alternative contact is needed.

ii. Professional and business entities shall determine the length of their representative's appointment. The department of human services will confirm representative participation every two years, regardless of meeting attendance.

iii. All professional and business entities will be voting members of the council.

(2) Council membership of public representatives shall consist of ten (10) representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented in subsection 2 and 3 and a majority of whom shall be current or former recipients of medical assistance or member of families of current or former recipients.

i. All public representatives will be voting members of the council.

(3) A member of the *hawk-i* board created in section 514I.5, selected by the members of the hawk-I board shall be a member of the council.

i. The *hawk-i* board member representative will be a voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, department on aging, the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

i. Partner agency and medical school representatives will be non-voting members of the council.

ii. If an agency or school's representative does not attend more than three (3) consecutive meetings, the department of human services will notify the agency and school.

iii. Partner agencies and medical schools shall determine the length of their representative's appointment. The department of human services will confirm representative participation every two years, regardless of meeting attendance.

(5) Members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B

- i. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.
 - ii. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.
 - iii. Members appointed from the general assembly will serve as non-voting members of the council.
- b. Executive committee membership shall consist as follows:
 - (1) Five professional and business entities identified in Iowa Code section 249A.4B, subsection 2. The entity is selected for membership on the executive committee, not the individual. The entity shall appoint their individual representative.
 - (2) Five individuals appointed as public members, pursuant to Iowa Code section 249A.4B, subsection 2.
 - i. One of the five public member positions on the executive committee will be held by the co-chairperson identified in section 79.7 (1).
 - ii. At least one public member shall be a recipient of medical assistance.
 - (3) The co-chairpersons identified in section 79.7(1) shall serve as the co-chairpersons of the executive committee.
 - (4) The executive committee will be elected for two (2) year terms, beginning at the start of a state fiscal year.
 - i. All voting members of the council will be eligible for election to the executive committee, based on the criteria outlined in this section.
 - ii. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by the department of human services staff.
 - iii. Should any vacancies occur on the executive committee, a special election will be held following the same standards outlined in this section.

79.7(3) Responsibilities, duties and meetings. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services through the executive committee of the council.

a. Recommendations made by the executive committee from council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations:

- (1) The director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and
- (2) Implementation of medical assistance program policies.

b. *Council.* The council shall be provided with information to deliberate and provide input on the medical assistance program. The executive committee will use those considerations in making final recommendations to the department of human services.

- (1) Council meetings
 - i. The council will meet no more than quarterly.

ii. Meetings may be called by the co-chairpersons, upon written request of at least 50 percent of members, or by the director of the department of human services.

iii. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given. Meetings will also be made available via teleconference, when available.

iv. Written notice of council meetings shall be electronically mailed at least five (5) business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(3) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(4) The council shall perform other functions as may be provided by state or federal law or regulation.

(5) Pursuant to 2016 Iowa Act, ch. 1139, sec. 94, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15, annually.

(6) Pursuant to 2016 Iowa Acts, ch. 1139, sec. 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

(7) Review the recommendations submitted by the executive committee regarding feedback received at the IA Health Link statewide public comment meetings outlined in 2016 Iowa Acts, ch. 1139, sec. 94.

c. Executive Committee

(1) Executive committee meetings

i. The executive committee shall meet on a monthly basis.

ii. Meetings may be called by the co-chairpersons, upon written request of at least 50 percent of executive committee members, or by the director of the department of human services.

iii. Meetings shall be held in the Des Moines, Iowa, area, unless other notification is given. Meetings will also be made available via teleconference, when available.

iv. In the month when a council meeting is held, the executive committee shall meet after the council meeting, allowing committee members to discuss and make recommendations based on the topics discussed by council members.

(2) Based on the deliberations of the full council, the executive committee shall make recommendations to the director regarding budget, policy, and administration of the medical assistance program. Such recommendations may include:

i. Recommendations on the reimbursement for medical services rendered by providers of services.

- ii. Identification of unmet medical needs and maintenance needs which affect health.
- iii. Recommendations for objectives of the program and for methods of program analysis and evaluation, including utilization review.
- iv. Recommendations for ways in which needed medical supplies and services can be made available most effectively and economically to the program recipients.
- v. Advise on such administrative and fiscal matters as the director of the department of human services may request.

(3) Pursuant to 2016 Iowa Acts, ch. 1139, sec. 94, the executive committee shall review the compilation of the input and recommendations of the public meetings convened statewide and shall submit recommendations based upon the compilation to the director of human services on quarterly basis through December 31, 2017.

79.7(4) Procedures.

- a. Procedures shall apply to both the council and the executive committee.
- b. A quorum shall consist of 50 percent of the current voting members.
- c. Where a quorum is present, a position is carried by two-thirds of the council members present.
- d. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the full council.
- e. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) Expenses, staff support, and technical assistance. Expenses of the council and executive committee, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council and the executive committee.

- a. The department shall provide the council with reports, data and proposed and final amendments to rules, laws, and guidelines, for its information, review and comment.
- b. The department shall present the annual budget for the medical assistance program for review and comment.
- c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.
- d. The department shall maintain a current list of members on the council and executive committee.
- e. The department shall be responsible for the organization of all council and executive committee meetings and notice of meetings.
- f. As required in Iowa Code Section 21.3, minutes of the meetings of the council and executive committee will be kept by the department. The co-chairpersons will review minutes before distribution.
- g. The department shall compile input and recommendations received at the public meetings established in 2016 Iowa Acts, ch. 1139, sec. 94 and submit the information to the executive committee for review.

[ARC 8263B, IAB XX/X/XX, effective XX/XX/XX]

Iowa Department of Human Services
 Medical Assistance Advisory Council (MAAC)
 Action Items from the Executive Committee Meeting of September 28 2016

OUTSTANDING ACTION ITEMS				
Date Added	Action Item	Item Category (Process, Systemic, Legislative)	Who is Responsible for Follow-Up	Status (Outstanding/Complete)
5/19/2016	One pager regarding the role of MAAC that members can use with the organizations in which they are representing and stakeholders		Medicaid Director	Outstanding- One pager in drafting process and is to be based on the Administrative Rules. At 9/28/2016 EC meeting, determined that previous members of the EC plus one new member will meet to draft the final rules and guidelines document (Gerd, Shelly, Dennis, and David) for October 18, 2016.
6/21/2016	Clarification whether each MCO will have their own Electronic Visit Verification (EVV) process, the standards of each MCO's EVV, and variations among each.		Medicaid Director	Outstanding - Informational Letter 1739-MC released on 11/1/2016 regarding EVV.
7/21/2016	Report on deliberations of prior year need to be submitted by November 15, 2016.		Chair of MAAC and Medicaid Director	Outstanding- Draft handout presented at 8/18/2016 EC meeting. Drafted summary of MAAC minutes for previous year presented at 9/28/2016 EC meeting. Discussions on summaries and potential subsequent recommendations for meeting the November 15, 2016 deadline to take place at next EC and FC meetings.
7/21/2016	Develop a workgroup comprised of Executive Committee and Full Council members to review the role of the Committee and their oversight in analyzing data.		EC Members and FC Members	Outstanding - Disussed in 9/28/2016 EC meeting that a request would be made to MAAC FC members to prepare to share data points and appoint EC and FC members to form part of the Data Work Group.
9/28/2016	Determine Executive Committee members to attend Public Comment meetings		EC members	Outstanding - Ongoing

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COMPLETED ACTION ITEMS				
Date Added	Action Item	Item Category (Process, Systemic, Legislative)	Who is Responsible for Follow-Up	Status (Outstanding/Complete)
5/19/2016	Email Address from FC and EC for connecting with one another		Medicaid Director	Completed- Email addresses determined after 6/21/2016 EC meeting.
5/19/2016	Request opinion from the Attorney General's office as to which body can make recommendations		Chair of MAAC and Medicaid Director and AG	Completed- Addressed in the drafted Administrative Rules handed out in EC meeting on 7/21/2016.
5/19/2016	Utilize the administrative process to clarify role of Co-chair and Vice-chair		Medicaid Director and AG	Completed- Addressed in the drafted Administrative Rules handed out in EC meeting on 7/21/2016.
5/19/2016	Job descriptions		Medicaid Director and AG	Completed- Addressed in the drafted Administrative Rules handed out in EC meeting on 7/21/2016.
5/19/2016	Information on the 834 file and process for the waiver programs		Chair of MAAC	Completed- discussed and completed at 6/21/2016 EC meeting.
5/19/2016	Information from the Ombudsman		Medicaid Director	Completed - Report revied at 6/21/2016 EC meeting. Document available in 6/21/2016 MAAC documents on DHS MAAC webpage.
5/19/2016	Process of member changing MCOs - how member, provider, and MCOs are aware of change and potential updating of member-facing materials		Medicaid Director	Completed - Flow charts reviwed at 6/21/2016 EC meeting.
5/19/2016	Is it possible to make choice period cut-off dates for members changing MCOs		Medicaid Director	Completed - Flow charts reviwed at 6/21/2016 EC meeting.
5/19/2016	Data on how many members are switching MCOs and if possible information as to why		Medicaid Director	Completed - Flow charts reviwed at 6/21/2016 EC meeting.

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5/19/2016	What does ISIS capture, what does IMPA capture, and who has access to it			<p>Completed: ISIS - individualized Services Information System. Its purpose is to support LTC facilities and Waivers programs. Within ISIS, IM Workers, Case Managers, and others involved in establishing individualized service plans have access. It is a web-based system. Both Level of Care and Service Plan workflows are built into the system to step users through these two core processes. ISIS then provides LOC information back to IM Workers to support eligibility determination and sends authorized service plans for FFS members to MMIS that supports claims processing. We have around 1,000 daily ISIS users. IMPA - Iowa Medicaid Portal Application. Our primary user base are Medicaid Providers. Several different role-based functions/business processes are supported within IMPA. Some of the main support items within IMPA include: (a) MCO Look-Up tool. This web based programming uses web services for real-time access to eligibility information, child welfare information, IM Electronic Case File, and IME Services data; (b) Provider Re-Enrollment and certification. The re-enrollment process is supported through structure work-flow/programming to capture all the information necessary from providers to support re-enrollment; and, (c) Remittance Advices - All Medicaid Providers use IMPA to electronically access their remittance advice. There are other sets of functionality and business processes supported as IMPA is a roles-based portal. We currently have about 17,000 registered IMPA users; some use it daily, some weekly or other periodic users.</p>
5/19/2016	A designated email account that can be used for MAAC business		Medicaid Director	Completed- discussed and completed at 6/21/2016 EC meeting.

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6/21/2016	New legislation and MAAC administrative rules to be reviewed by EC workgroup and suggestions to be brought back to Council		EC Workgroup	Completed- Addressed in the drafted Administrative Rules handed out in EC meeting on 7/21/2016.
6/21/2016	How can providers process batch verifications of members' MCO		Medicaid Director	Completed- Addressed and discussed utilizing online verifications through Electronic Data Interchange Support Services (EDISS) in 6/21/2016 EC meeting. Information will be posted to the DHS website.
6/21/2016	Setting up a workgroup consisting of mostly EC members and some FC members to determine roles of the committee and their oversight per legislation. Initial volunteers from the EC include Jim Cushing, Anthony Carroll, Cindy Baddeloo and Shelly Chandler.		EC and FC Workgroup Members	Completed- Information has been updated to the DHS website.
6/21/2016	Review flow charts to see if additional revisions are necessary		Chair of MAAC	Completed- Information has been updated to the DHS website.
7/21/2016	Reformat the Action Items Reporting Grid to clearly show when items have been completed. Suggested to move previously completed items to the end of the grid		Medicaid Director	completed- Reformatted prior to 8/18/2016 EC meeting
5/19/2016	Create a mechanism for consistent reporting from MCOs such topics as claims, call times and reasons for cases that are escalated		Medicaid Director	Completed- Reports created
5/19/2016	Tracking and dashboard moving forward		Medicaid Director	Completed
5/19/2016	Prior Authorizations		Medicaid Director	Completed- Copies of Prior Authorization grid handed out at
7/21/2016	Post the copy of the tracked- drafted version of the Administrative Rules on the MAAC web page.		Medicaid Director	Completed- posted to the DHS web page

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7/21/2016	Executive Committee to call a special meeting by phone to discuss legislation regarding five professional positions and five public/consumer positions of the MAAC Executive Committee. Meeting is to take place prior to August Full Council meeting.		EC Members and Medicaid Director	Completed- Held on 8/5/2016
7/21/2016	Executive Committee members to review details of the new Administrative Rules and provide feedback to discuss at the special meeting to be held prior to August Full Council meeting. Recommendations to be presented at the Full Council meeting on 8/17/2016.		EC Members	Completed
8/18/2016	Follow up on Electronic Visit Verification (EVV) systems		Cindy Baddeloo	Completed - Informational Letter No. 1718-MC released on 9/14/2016 and discussed in EC meeting on 9/28/2016; IL in meeting materials.
8/18/2016	Outstanding Status of the Public Comment Summary		Anthony Carroll	Completed - To be discussed in EC meeting on 9/28/2016.
8/18/2016	Additional Items to add to the Oversight Committee presentation		Gerd Clabaugh	Completed
5/19/2016	Listening sessions - how to address concerns raised in sessions in both FC and EC meetings		Chair of MAAC and Medicaid Director	Completed - Summaries of listening sessions to be reviewed at the FC meeting on 11/21/2016 and suggestions will be made by members to EC. Upon final review of suggestions by the EC, final suggestions to be made to the Department.



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?



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.



Council Bluffs IA Health Link Public Comment Meeting

Tuesday, June 7, 2016

Time: 3 p.m. – 5 p.m.

Hilton Garden Inn Hotel
River City Ballroom, 2702 Mid America Dr.
Council Bluffs, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Jennifer Steenblock – present	Amerigroup Iowa, Inc. - present	Paula Connolly- present
Julie Lovelady - present	AmeriHealth Caritas Iowa, Inc. - present	Jim Cushing- present
Lindsay Buechel - present	UnitedHealthcare Plan of the River Valley, Inc. - present	
Sean Bagniewski - present		
Sarah Belmer – present		

Comments:

Terminology:

The terminology that is being used in conversations (Hospice in house vs. in patient) with AmeriHealth Caritas is confusing and they want to make sure they are saying things correctly so they get paid accordingly.

Prior Authorizations:

They are finding that the process for Prior Authorizations is different for each member and they want to make sure they file the Prior Authorizations the correct way with the MCOs. Skilled nursing and Long Term Care (LTC) are concerned with authorization in a timely manner. They have waited over a week for them to go through and all the while the members sit in the hospital.

In the past LTSS providers received per month authorizations. They understand that it is now supposed to be per cycle. The provider feels as the authorizations are being updated that there may need to be another no authorization period like when the transition occurred.

Two out of the three MCOs require verbal authorizations and one MCO lets them do it online or by fax and for the small hospital that is a long time to be on the phone.

A provider would like training on the Prior Authorization process so it can be expedited.

Floor Rates:

A provider stated they are not being reimbursed the Medicaid Floor Rate by the MCO. Many other providers also said that they were not getting reimbursed the full amount of the Medicaid Floor Rate.



Transportation:

Providers are having issues with setting up transportation and an HCBS provider says they have had instances where 2 entities will show up for the same member at the same time to take them to their appointment.

DME (Durable Medical Equipment):

Medicaid eligible member started the process for getting a wheel chair prior to the transition. When the transition happened the members MCO, UnitedHealthcare, denied the wheel chair. The DME provider stated that they have not had any issues with Amerigroup or AmeriHealth Caritas.

One provider who has been dealing with Amerigroup states that they have to send a Prior Authorization for every piece of the wheel chair.

Language Barrier:

Providers have run into issues with getting materials in Spanish for Spanish speaking families. Members will get packets and letters in English when they need it in Spanish and they end up throwing away the information.

MCO Phone numbers:

It is hard to navigate through the phone lines in order to get to who they need to speak with.

Claims:

Many providers are running into road blocks with not having claims paid correctly or at all.

Systems:

ISIS changed over this past weekend (6/4/2016-6/5/2016) and since the change providers are not able to get in and view information on members and the MCOs do not have the information yet.

Additional Comments:

A state senator has received several calls about issues with vision services. Vision provider will have a member in the chair and find out that they will need a Prior Authorization for that service and getting a PA approved while a patient is in the chair does not happen often. Members are frustrated and a certain provider has considered no longer accepting Medicaid Patients.

Questions:

1. How long does it take for a member to switch to another MCO and could that processed be looked at?
2. When denials occur, will there be reports that will come out?
3. Can providers bill the MCOs when they use their own in house interpreters?



4. Can the MCOs let their call center staff know that when they get a call from a member/provider asking about dental that the IME covers dental services?
5. Are the MCOs going authorization cycle or by monthly authorized units and are they looking at extending the no Prior Authorization period to the end of June?
6. Can the IME stop sending out informational letters that take effect immediately or with in the following couple of days?
7. Could interpreter costs be added to the MCO/provider contracts?
8. What is the process for a waiver member to get home modifications and Durable Medical Equipment (DME)
9. Is UnitedHealthcare working to sign CHI locally?
10. How soon will the MCOs get the daily rates updated and will they then do automated adjustments or will they need to be sent back through?



Cedar Rapids IA Health Link Public Comment Meeting

Tuesday, July 19, 2016

Time: 3 p.m. – 5 p.m.

Kirkwood Community College

234 Cedar Hall

6301 Kirkwood Blvd SW

Cedar Rapids, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Jennifer Steenblock - present	Amerigroup Iowa, Inc. - present	Dennis Tibbin- present
Lindsay Buechel - present	AmeriHealth Caritas Iowa, Inc. - present	Sarah Allen- present
Sean Bagniewski - present	UnitedHealthcare Plan of the River Valley, Inc. - present	
Korey Buchanan – present		

Comments:

Billing

A provider stated that they have had zero claims paid by Amerigroup Iowa. Provider stated that they were told that they were mailed to incorrect address. Provider stated they asked that the address be corrected and was told only one provider out of five were corrected under the same group NPI. Provider stated they are not contracted with Amerigroup. Provider stated that they are contracted with AmeriHealth Caritas Iowa and crossover Medicare claims are not being paid correctly.

Additional Comments:

- Provider stated that there is a lack of written policy with the MCO's and two out of three MCO's don't really have written policies. Provider stated that when asked of the MCO's for written policies they are told that it is proprietary information.
- Provider stated that there are inconsistencies with answers from MCO's when calling the MCO's. Provider stated AmeriHealth has no medical policies on their website. Provider stated that procedures that Medicaid paid for the MCO's are inconsistent with paying the same procedure.
- Provider had comment about assisted living and elderly waiver services. Provider stated that traditionally they would receive a notice of decision that would tell them which services are provided for a patient and then they would be able to bill Medicaid. Now patients get approved and are not getting a notice of decision until they are with an MCO and are not able to get a clear answer from Medicaid on how to get the notice of decision or what to bill. Provider stated that they are having trouble finding out from Medicaid rather they can bill Medicaid for the same services when the patient is in limbo.



- Provider had a comment tied to the elderly waiver. Provider stated that there is a specific DHS practice which is confusing to individuals. Provider stated that people which applied for the elderly waiver get a letter from DHS stating that they are approved, but it's misleading and they are not eligible for MCO funding. Provider stated that she's spoken to families that have received this letter and provider is not able to provide services. Provider stated that communication between DHS and the MCO's needs to improve as well as DHS and the consumer needs to improve. Provider stated that a patient was told it was up to the provider to approve the elderly waiver. Provider stated that DHS is giving inaccurate communication.
- Provider stated that as a presumptive provider they are being asked for patient information by the MCO's.

Questions:

1. When will caseloads be cut?
2. Who should be called to get an address changed?
3. Is UnitedHealthcare Plan of the River Valley (UHC) and Amerigroup Iowa Inc. going to have a system that providers can access to view approvals?



Fort Dodge IA Health Link Public Comment Meeting

Tuesday, August 23, 2016

Time: 3 p.m. – 5 p.m.

Fort Dodge Public Library

424 Central Ave.

Fort Dodge, IA

Meeting Comments and Questions

IME/DHS Staff	MCO Representatives	MAAC Representatives
Debbie Johnson - present	Amerigroup Iowa, Inc. - present	Anthony Carroll - present
Matt Highland - present	AmeriHealth Caritas Iowa, Inc. - present	
Allie Timmerman - present	UnitedHealthcare Plan of the River Valley, Inc. - present	

Comments:

Billing and Claims

A provider stated that they had been contacted by the Managed Care Organizations (MCOs) when claims issues arose without the provider having to contact first and they were appreciative. A different provider and their colleague had reviewed a claim for accuracy prior to submitting to an MCO however, when submitted to the MCO the claim had been denied; this had happened on more than one occasion. Another provider stated that a number of services had also been declined due to there not being a Prior Authorization (PA) on file before rendering services however, per the PA listing provided by the MCO, a PA was not required for that service. Also, a request was made to delay implementation of the Electronic Visit Verification (EVV) systems as they were having billing issues with the MCO's and the hardware for EVV would increase costs associated with serving Medicaid recipients. In regards to Rural Health Clinic (RHC) claims, there had been incorrect or untimely payments made in various degrees and this was of concern due to a majority of the clinics in the area were RHCs.

Contracting and Contracted Rates

Rates had changed from those previously provided by Iowa Medicaid following implementation and this had caused greater time spent in communication between a provider's Accounts Receivable department and the MCOs. Different providers had also stated that they were being paid below their contracted rates with the MCOs and had to review prior claims individually to ensure they were paid accordingly.



Inconsistency in Information

A provider had called in multiple times to the same MCO and spoke with a different person each call and received a different answer depending upon whom he had been speaking to.

Services and Coverage

Mental Health patients had informed their provider that they were not able to receive the benefits they had prior to implementation. An issue raised by more than one provider had been that some of the providers' patients who were considered medically exempt and were now enrolled in MCOs were not receiving the same benefits as they had with Iowa Medicaid.

Questions:

1. Has optical coverage changed with the transition?
2. Does Medical Exemption change in the IA Health Link managed care program transition?
3. How were the member's MCO assignments determined and what benefits they would receive?
4. Why did the members' benefits change following implementation?
5. Can a provider be dually certified in different provider areas or are they only able to certified under one provider type?
6. If medical exemption status for a member has crossed over to an MCO, will the member be required to attest again?
7. Will there be a delay in Electronic Visit Verification?
8. Are the notes taken at the IA Health Link Public Comment Meetings taken back to Senate?
9. Has there been any progress on identifying performance indicators for the Integrated Health Homes (IHHs)?



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?



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?



MAAC Meeting Minutes Summary: Medicaid Modernization 2015

February 27, 2015 – SPECIAL MEETING

The MAAC Full Council called a special meeting. This is the first formal briefing of the MAAC Full Council on Medicaid Modernization. The meeting revolved around the RFP with questions by Council members around what is in the RFP.

May 14, 2015 – EXECUTIVE COMMITTEE

Liz Matney recapped the status of the RFP and all relevant amendments. Jennifer Steenblock reminded the group of the requirement for a public comment/review period by early July and that there are now weekly operational meetings to ensure problems are identified early.

May 28, 2015 – FULL COUNCIL

Liz Matney provided an RFP status update and that bidders are being given more time. She informed the group of the eleven proposals that have been received. She informed the Council that the plan is to read bids thoroughly and have awards announced August 7. Jennifer Steenblock informs the Council of the draft of 1115 Demonstration waiver to be submitted to CMS and also submitting new 1915(b) waiver that will incorporate LTC, physical and behavioral health care. She informed the Council that the Department is planning to do public hearings and post information in early July. Lindsay Buechel discussed the branding and communications plan for the transition.

July 15, 2015 – EXECUTIVE COMMITTEE

Lindsay Buechel discussed the rationale behind the new branding, IA Health Link, and how it effectively conveys the narrative of linking all the different parts that make up Iowa Medicaid to generate a positive health outcome. Liz Matney provided an update on amendments to the RFP and informed the Council that there is an upcoming rate conference with the bidders. There were discussions of the rules changes that will occur and that will go through the public process to ensure transparency.

August 26, 2015 – EXECUTIVE COMMITTEE

Lindsay Buechel provided a detailed schedule of the member enrollment mailings for IA Health Link, timeline of the mail drops, mailing quantities, and population groups that will be targeted in various mailing phases.

August 31, 2015 – FULL COUNCIL

Liz Matney made a formal announcement of the four MCOs that have been awarded the contract for Medicaid Modernization. Liz outlined the various key areas of implementation – PMO, IME contracts, branding and communications, stakeholder and external relations, collaboration with federal partners, alignment with other initiatives, and MCO onboarding. She announced Navigant as the readiness assessment consultant to thoroughly

assess and ensure that MCOs are operationally ready for January 1, 2016. Liz discussed the importance of compliance with federal guidelines with respect to LTC services and explained operational areas for review such as member services, enrollment/disenrollment processes, reporting requirements, members grievances and appeals, adequacy and meeting privacy standards, coordination of care including Case Managers. She discussed the modernization oversight and LTC ombudsman for HCBS providers. She explained that IME will be leveraging state staff and account managers, and integrated MCO account managers, how MAAC will fit into oversight structure, development of a public facing dashboard to show managed care compliance, and member advantage in choosing a health plan. She stated that CMS waiver submissions will be sent by end of week and gave a summary of all waivers to be submitted to CMS. Lindsay Buechel provided an update on outreach and member/provider communication and the new branding IA Health Link.

September 17, 2015 – EXECUTIVE COMMITTEE

Discussion revolved around Annual Provider Training, and Stakeholder and Member Meetings Lindsay outlined planned Stakeholder and Member meetings to be held in various locations throughout the state in early October and confirmed that stakeholder/provider education meetings will be in eleven locations and member education and enrollment events in eighteen locations. She outlined more details about other member outreach efforts that are on schedule.

September 22, 2015 – EXECUTIVE COMMITTEE

Lindsay confirmed that IME is currently in the process of setting up stakeholders and provider meetings and member meetings on Medicaid Modernization. She provided details of the stakeholder/provider meetings as well as the member meetings. She stated that members will get letter late November or early December regarding enrollment and that dental will continue to be available but not transitioning to MCOs. She informed the Committee that MCOs have started doing more outreach and will be organizing their own provider training sessions and provided an update on the member mailings, drop dates, quantities, and components. There was discussion on the December 17 choice deadline and the MCO enrollment packets for providers. The Committee raised questions on providers not signing up or cooperating with MCOs and issues hinging on “payment process set-up” and concerns about the confusion around contract signings and disconnect on the timeline of coverage. Lindsay explained the “good cause” as a federal requirement and the need to discuss “choice counseling” because members may have to face making choices and will require assistance in making these choices. Questions were raised by the Committee on the issue regarding credentialing and how MCOs are to address it.

October 28, 2015 – EXECUTIVE COMMITTEE

Discussions involved member enrollment and communications timeline and the MCO choice process. Lindsay provided update on the member mailings and information being posted on the MEDMOD web pages and sent out through Medicaid Modernization (MM) email alerts. Jennifer Steenblock informed the Committee that MCOs were interested in getting all this information pushed out to providers to continue through credentialing and contracting process. More discussions on Provider Rate Floor. Provider MCO Agreements. Provider Universal Application. Provider MCO Manuals. And Provider Fact Sheet

November 16, 2015 – EXECUTIVE COMMITTEE

Jennifer Steenblock provided an update on the current status of the member enrollment campaign and expected timelines for completing the mailings. Initial discussion was on the logistics of introductory mailings and the mailing lists that were used. She confirmed that the initial mailings were Long Term Care (LTC) and summarized the member education meetings and that additional meetings will be added to the schedule if necessary. There were discussions on the CMS Listening Sessions, Provider Rate Follow-Up Discussion, Provider Credentialing/Enrollment, Process and Network Discussion. The Committee also focused on the re-enrollment process for providers and review of the credentialing issues from the September 22 Executive Committee meeting.

November 25, 2015 – FULL COUNCIL

Lindsay Buechel provided a comprehensive update on the IA Health Link activities including member enrollment mailings to all Medicaid populations indicating completion of all enrollment mailings by the end of November. She reviewed details involving the member choice timeline and the choice counseling process and provided a review of all the member and provider/stakeholder outreach activities that have either been completed or are still currently in progress. Liz Matney discussed more detailed information regarding provider rates that covered areas such as managed care plans, hospital rebased rates, EPSDT including palliative care. She also discussed Iowa Medicaid fee schedule plans, nursing facility rates, and HCBS providers and the “weighted average” reimbursement rates given to the four MCOs. Sean Bagniewski discussed the recently released application process that allows simultaneous provider enrollment with Iowa Medicaid and the MCOs through use of a jointly developed “universal” application (developed with input from MCOs). All four MCO representatives introduced their companies and gave an overview of the “current state of affairs” within each MCO with regard to the transition.

December 15, 2015 – EXECUTIVE COMMITTEE

Discussions centered on IA Health Link Member Enrollment Update (Enrollment packets, Requests for new packets, February assignments, Member Services update). IA Health Link Provider Update (Safe Harbor, Universal Application and Enrollment, MCO Trainings). Implementation Update. Mikki updated the group that CMS conducted their site visit and we are now awaiting their decision.



MAAC Meeting Minutes Summary: Medicaid Modernization 2016

January 12, 2016 – SPECIAL MEETING

Director Palmer addressed the Executive Committee with the main objective of establishing a dialogue with the members of the Committee about how to work together constructively and with more frequency. Mikki provided a quick update on IA Health Link member and provider activities.

January 19, 2016 – EXECUTIVE COMMITTEE

Discussions included an update regarding Prior Authorization and the informational letter that is being developed specifically addressing PA. Matt Highland provided an update on IA Health Link and the various members and provider outreach activities including the hawk-I program MCO choice options. Gerd discussed the public listening sessions that are scheduled in March.

February 16, 2016 – EXECUTIVE COMMITTEE

A packet of communication materials was distributed out to the Executive Committee members in attendance. Mikki stated that the purpose of this packet is to get a better sense of the scope of the member as well as the provider communications effort surrounding the managed care transition. She stated that the IME has been working directly with providers to ensure that enrollment, claims, and billings issues are addressed. She acknowledged recent billing issues with providers and said that the IME has been asking associations to notify the department that if they have members encountering billing issues, to contact the IME directly and that these will be dealt with individually and quickly. Discussion also included the WellCare reassignment process. Mikki clarified the choice process and Lindsay reviewed the plan, objectives, and logistics of the Public Comment meetings including a reporting template. Mikki provided a Medicaid Modernization update that covered everything from credentialing, PAs, electronic verifications, claims processing, and Case Management transition.

February 18, 2016 – FULL COUNCIL

Matt Highland provided a comprehensive update for the Council members regarding the communications outreach on IA Health Link to members and providers including call centers and scripting. He went over the provider training sessions on Medicaid Modernization and the member enrollment events. He provided updates on communication efforts involving the Medicaid e-News, member enrollment mailings, and various informational letters addressing key transition issues. He also provided some clarification regarding the WellCare reassignment process. Mikki Stier provided a details update on the Medicaid Modernization transition including development of CSR “soft skills”, Deb Johnson addressed concerns regarding Long Term Care and Case Management agencies.

March 15, 2016 – EXECUTIVE COMMITTEE

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. An Attendee Schedule for the Public Comments Meetings was handed out with designation of two Executive Committee members assigned to each meeting. She went over the process of what is expected of Committee members that are attending the Public Comment meetings. Deanna Clingan-Fischer of the LTC Ombudsman's Office addressed the Committee. Mikki provided an update regarding provider transition issues including crossover claims, cross reports, split billing, critical incident reporting. Matt provided an update regarding the Confirmation of Coverage letter and MCO card distribution.

April 19, 2016 – EXECUTIVE COMMITTEE

Mikki reviewed the April 1 implementation of the IA Health Link program and stated that there is an MC Bureau headed by Liz Matney, MCO Account Managers assigned to each of the MCOs, and the PMO within the department to deal with issues in real time. She stated since implementation, no systemic issues and specific issues, such as NEMT and pharmacy, had been addressed immediately. The CEOs from the three MCOs were given an opportunity to individually address the Committee and provide an update. Lindsay gave an update on the first two public comment listening sessions.

May, 17, 2016 – FULL COUNCIL

Mikki informed the Council that in the month and a half following implementation, the IME and MCOs had developed a rapid response team for issues communicated by members, providers or stakeholders that needed to be resolved. Representatives from each of the MCOs were given an opportunity to address the Council and provide initial managed care transition data. Lindsay provided a summary of the first three Public Comment meetings in Mason City, Burlington, and Dubuque.

May 19, 2016 – EXECUTIVE COMMITTEE

It was agreed by the Committee that a document be created outlining the process of when a member decides to switch to another. Lindsay reviewed the Public Comment meetings.

June 21, 2016 – EXECUTIVE COMMITTEE

Mikki cited billing issues due to transition from Magellan to MCOs, especially in instances of higher need individuals. She informed the Committee that a new position of Member Managed Care Liaison was developed to assist in communication between the Iowa Medicaid Enterprise (IME) Member Services and MCOs in handling member concerns. She further added that the position of Provider Managed Care Liaison may also be developed in the future to assist in communication between the IME Provider Services and MCOs in handling provider concerns. Mikki provided an update on Non-Emergent Medical Transportation (NEMT), Prior Authorizations (PAs), Billing, and Level of Care (LOC) tracking. Lindsay provided an update on the Public Comment meetings.

July 21, 2016 – EXECUTIVE COMMITTEE

Anthony provided feedback on the most recent public comment meeting in Cedar Rapids indicating the claims processing/payment/denial issue that providers are encountering. He mentioned the better responses from MCOs regarding the systems that each MCO has in place regarding PAs. Lindsay stated that the issues that have been expressed at these meetings have been consistent in theme.

August 5, 2016 – SPECIAL MEETING

This meeting did not address anything concerning IA Health Link.

August 17, 2016 – FULL COUNCIL

Representatives from the three MCOs were given an opportunity to provide an operational update on the managed care transition.

August 18, 2016 – EXECUTIVE COMMITTEE

Lindsay provided a brief update on the progress of the Public Comment meeting on IA Health Link.

c. The department of human services shall require each Medicaid managed care organization to authorize the national committee for quality assurance (NCQA) to submit directly to the governor, the general assembly, and the health policy oversight committee created in section 2.45, the evaluation report upon which the Medicaid managed care organization's NCQA accreditation was granted, and any subsequent evaluations of the Medicaid managed care organization.

4. INCLUSION OF INFORMATION FROM OTHER OVERSIGHT ENTITIES.

The council on human services, the medical assistance advisory council, the hawk-i board, the mental health and disability services commission, and the office of long-term care ombudsman shall regularly review Medicaid managed care as it relates to the entity's respective statutory duties. These entities shall submit executive summaries of pertinent information regarding their deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15, annually, for inclusion in the annual report submitted as required under this section.

5. PUBLIC POSTING OF INFORMATION REPORTED.

The department of human services shall post all of the reports specified under this section, as the information becomes available and to the extent such information is not otherwise considered confidential or protected information pursuant to federal or state law, on the Iowa health link internet site.

Sec. 94. ADDITIONAL OVERSIGHT.

1. The council on human services, the medical assistance advisory council, and the hawk-i board shall submit to the chairpersons and ranking members of the human resources committees of the senate and the house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of their respective meetings during which the council or board addressed Medicaid managed care.

2. The director of human services shall submit the compilation of the input and recommendations from stakeholders and Medicaid members attending the public meetings convened

C.F.R. §160.103 for the purpose of recipient case resolution. When providing assistance and advocacy services under this section, the office of long-term care ombudsman shall act as an independent agency, and the office of long-term care ombudsman and representatives of the office shall be free of any undue influence that restrains the ability of the office or the office's representatives from providing such services and assistance. The office of long-term care ombudsman shall adopt rules applicable to long-term care ombudsmen providing assistance and advocacy services under this section to authorize such ombudsmen to function in a manner consistent with long-term care ombudsmen under the federal Act.

MEDICAL ASSISTANCE ADVISORY COUNCIL

Sec. 99. Section 249A.4B, Code 2016, is amended to read as follows:

249A.4B Medical assistance advisory council.

1. A medical assistance advisory council is created to comply with 42 C.F.R. §431.12 based on section 1902(a)(4) of the federal Social Security Act and to advise the director about health and medical care services under the medical assistance program. The council shall meet no more than quarterly. The director of public health and a public member of the council selected by the public members of the council specified in subsection 2, paragraph "b", shall serve as ~~chairperson~~ co-chairpersons of the council.

2. The council shall include all of the following voting members:

a. The president, or the president's representative, of each of the following professional or business entities, or a member of each of the following professional or business entities, selected by the entity:

- (1) The Iowa medical society.
- (2) The Iowa osteopathic medical association.
- (3) The Iowa academy of family physicians.
- (4) The Iowa chapter of the American academy of pediatrics.
- (5) The Iowa physical therapy association.
- (6) The Iowa dental association.
- (7) The Iowa nurses association.
- (8) The Iowa pharmacy association.

- (9) The Iowa podiatric medical society.
- (10) The Iowa optometric association.
- (11) The Iowa association of community providers.
- (12) The Iowa psychological association.
- (13) The Iowa psychiatric society.
- (14) The Iowa chapter of the national association of social workers.
- (15) The coalition for family and children's services in Iowa.
- (16) The Iowa hospital association.
- (17) The Iowa association of rural health clinics.
- (18) The Iowa primary care association.
- (19) Free clinics of Iowa.
- (20) The opticians' association of Iowa, inc.
- (21) The Iowa association of hearing health professionals.
- (22) The Iowa speech and hearing association.
- (23) The Iowa health care association.
- (24) The Iowa association of area agencies on aging.
- (25) AARP.
- (26) The Iowa caregivers association.
- (27) The Iowa coalition of home and community-based services for seniors.
- (28) The Iowa adult day services association.
- (29) Leading age Iowa.
- (30) The Iowa association for home care.
- (31) The Iowa council of health care centers.
- (32) The Iowa physician assistant society.
- (33) The Iowa association of nurse practitioners.
- (34) The Iowa nurse practitioner society.
- (35) The Iowa occupational therapy association.
- (36) The ARC of Iowa, formerly known as the association for retarded citizens of Iowa.
- (37) The national alliance for the mentally ill of Iowa on mental illness.
- (38) The Iowa state association of counties.
- (39) The Iowa developmental disabilities council.
- (40) The Iowa chiropractic society.
- (41) The Iowa academy of nutrition and dietetics.
- (42) The Iowa behavioral health association.

(43) The midwest association for medical equipment services or an affiliated Iowa organization.

~~b. Public~~ Ten public representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, ~~equal in number to the number of representatives of the professional and business entities specifically represented under paragraph "a",~~ appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented under paragraph "a", and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients.

c. A member of the hawk-i board created in section 514I.5, selected by the members of the hawk-i board.

3. The council shall include all of the following nonvoting members:

~~e~~ a. The director of public health, or the director's designee.

~~f~~ b. The director of the department on aging, or the director's designee.

c. The long-term care ombudsman, or the long-term care ombudsman's designee.

~~e~~ d. The dean of Des Moines university — osteopathic medical center, or the dean's designee.

~~f~~ e. The dean of the university of Iowa college of medicine, or the dean's designee.

~~g~~ f. The following members of the general assembly, each for a term of two years as provided in section 69.16B:

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

~~3~~ 4. a. An executive committee of the council is created

and shall consist of the following members of the council:

(1) Five of the professional or business entity members designated pursuant to subsection 2, paragraph "a", and selected by the members specified under that paragraph, as voting members.

(2) Five of the public members appointed pursuant to subsection 2, paragraph "b", and selected by the members specified under that paragraph, as voting members. Of the five public members, at least one member shall be a recipient of medical assistance.

(3) The director of public health, or the director's designee, as a nonvoting member.

b. The executive committee shall meet on a monthly basis. The director of public health and the public member serving as co-chairperson of the council shall serve as ~~chairperson~~ co-chairpersons of the executive committee.

c. Based upon the deliberations of the council and the executive committee, the executive committee shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program.

~~4~~ 5. For each council meeting, other than those held during the time the general assembly is in session, each legislative member of the council shall be reimbursed for actual travel and other necessary expenses and shall receive a per diem as specified in section 7E.6 for each day in attendance, as shall the members of the council or the executive committee who are recipients or the family members of recipients of medical assistance, regardless of whether the general assembly is in session.

~~5~~ 6. The department shall provide staff support and independent technical assistance to the council and the executive committee.

~~6~~ 7. The director shall consider the recommendations offered by the council and the executive committee in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3 and in implementation of medical assistance program policies.

Sec. 100. APPOINTMENT OF PUBLIC REPRESENTATIVES TO

MEDICAL ASSISTANCE ADVISORY COUNCIL — 2016. The director of human services shall make recommendations to the governor for appointment of public representatives to the medical assistance advisory council pursuant to section 249A.4B, subsection 1, paragraph “b”, in order to fill all public representative positions on the council no later than June 30, 2016.

Sec. 101. EFFECTIVE UPON ENACTMENT. The following provision of this division of this Act, being deemed of immediate importance, takes effect upon enactment:

1. The section of this division of this Act directing the appointment of public representatives to the medical assistance advisory council no later than June 30, 2016.

CONTINUATION OF STATEWIDE PUBLIC MEETINGS

Sec. 102. 2015 Iowa Acts, chapter 137, section 63, is amended to read as follows:

SEC. 63. HEALTH POLICY OVERSIGHT — MEDICAID MANAGED CARE.

1. The department of human services shall partner with appropriate stakeholders to convene monthly statewide public meetings beginning in March 2016, and bi-monthly statewide public meetings beginning March 2017 and continuing through December 31, 2017, to receive input and recommendations from stakeholders and members of the public regarding Medicaid managed care, ~~beginning in March 2016~~. The meetings shall be held in both rural and urban areas, in small communities and large population centers, and in a manner that is geographically balanced. The department shall encourage representatives of Medicaid managed care organizations to attend the public meetings. The input and recommendations of the public meetings shall be compiled by the department of human services and submitted to the executive committee of the medical assistance advisory council created in section 249A.4B .

2. a. The executive committee of the medical assistance advisory council shall review the compilation of the input and recommendations of the public meetings convened pursuant to subsection 1, and shall submit recommendations based upon the compilation to the director of human services on a quarterly basis through December 31, 2017.

b. The director of human services shall submit the compilation and the recommendations made under paragraph "a" to the legislative health policy oversight committee created in section 2.45 through December 31, 2017.

Sec. 103. EFFECTIVE UPON ENACTMENT. The sections of this division of this Act amending 2015 Iowa Acts, chapter 137, section 63, being deemed of immediate importance, takes effect upon enactment.

HAWK-I PROGRAM

Sec. 104. Section 514I.5, subsection 8, paragraph d, Code 2016, is amended by adding the following new subparagraph:

NEW SUBPARAGRAPH . (17) Occupational therapy.

Sec. 105. Section 514I.5, Code 2016, is amended by adding the following new subsection:

NEW SUBSECTION . 10. The hawk-i board shall monitor the capacity of Medicaid managed care organizations to specifically and appropriately address the unique needs of children and children's health delivery.

DIVISION XXIII

FOOD PROGRAM

Sec. 106. IOWA EMERGENCY FOOD PURCHASE PROGRAM. There is appropriated from the general fund of the state to the department of agriculture and land stewardship for the fiscal year beginning July 1, 2016, and ending June 30, 2017, the following amount, or so much thereof as is necessary, to be used for the purpose designated:

1. For purposes of supporting an Iowa emergency food purchase program:
..... \$ 100,000

2. The purpose of the Iowa emergency food purchase program is to relieve situations of emergency experienced by families or individuals who reside in this state, including low-income families and individuals and unemployed families and individuals, by distributing food to those persons.

3. The Iowa emergency food purchase program shall be managed by an Iowa food bank association selected by the department. The department may enter into a contract with the Iowa food bank association. The Iowa food bank association managing the program shall distribute food under the program