



**Iowa Department of Human Services
Process Improvement Working Group Work Plan**

Issue Information			Requirements					Status
Issue	Category	Owner	Long Term/Short Term	State Plan Amendment	Waiver Change	Rule Change	Contract Revision	
Transportation providers not showing or late for appointments.	Benefits/Eligibility							
Seeing additional denials for Technical Component for radiology services done in an office setting.	Benefits/Eligibility							
Inconsistencies in covered services between MCOs and FFS	Benefits/Eligibility							
Need clarification on the appeals process as it is cumbersome.	Benefits/Eligibility							
Concern for when reimbursement is reduced when members go home, go on vacation, or are hospitalized for a period of time.	Benefits/Eligibility							
MCOs not paying for crisis stabilization services.	Benefits/Eligibility							
Concern with new extrapolation process when providers have an overpayment.	Benefits/Eligibility							
MCOs not authorizing necessary prosthetic inserts or liners.	Benefits/Eligibility							
Reduction in BHIS service authorizations impacting foster groups.	Benefits/Eligibility							
Services are being decreased when the level of care for members has not changed.	Benefits/Eligibility							
MCOs reducing hours for day programs including employment	Benefits/Eligibility							
Lack of continuity of care when member service setting changes, i.e.. waiver to skilled to waiver.	Benefits/Eligibility							
Members changing dental benefit managers (DBMs), MCOs or primary care providers (PCPs) during treatment plan causes coordination challenges.	Benefits/Eligibility							
Consistency in coverage of services for habilitative services thru the Hawk-I program (speech therapy).	Benefits/Eligibility							



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Transition between elderly waiver (EW) and nursing home cumbersome. MCO requiring action from IME, such as PASRR and LOC determinations, which can be problematic when admission is needed quickly.	Benefits/Eligibility							
Many of decisions made around managed care are based on how system works for adults.	Benefits/Eligibility							
Adopting a definition of Medical Necessity (MN) incorporating a preventive focus.	Benefits/Eligibility							
Concern regarding changes to Title V agencies billing and why care coordination is not a billable service.	Benefits/Eligibility							
Providers are required to return dollars paid (recouped) for services delivered to a member who was retroactively disenrolled.	Benefits/Eligibility							
Ensure appropriate supply of meds is allowed when starting new doses and ongoing maintenance.	Benefits/Eligibility							
Concern with caps on number of services including psychotherapy.	Benefits/Eligibility							
Psychology testing not adequately covered, unclear what will be approved.	Benefits/Eligibility							
Discontinue pre auths for 90837 (60 min psychotherapy) as this is and has been the standard by therapists/psychologists/psychiatrists doing psychotherapy.	Benefits/Eligibility							
Reduced support for higher needs members who have stabilized but still need the services for maintenance.	Benefits/Eligibility							
Refusal to pay for telehealth services, particularly for mental health.	Benefits/Eligibility							
Concern on use of waiver monthly and service caps.	Benefits/Eligibility							
Reconsideration process for support intensity scale assessments	Benefits/Eligibility							
Denial of psychological services to persons with Autism Spectrum Disorders.	Benefits/Eligibility							



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Require that member appeals can end up with an independent 3rd party.	Benefits/Eligibility							
Revise timely filing standards from 180 days to 365 days.	Claims							
Improve consistency in claims reviews/approvals and payment.	Claims							
Concern about claims payment delays.	Claims							
PAs not always linking to claims payment system.	Claims							
Recoupments and reprocessing of claims are difficult to track for providers.	Claims							
MCOs are incorrectly processing cross over claims.	Claims							
Providers having difficulty understanding and resolving claim disputes.	Claims							
Claims paid from manufacturer invoice not paying correctly.	Claims							
Having to submit multiple copies of documentation to get claims paid.	Claims							
Oxygen not being paid correctly.	Claims							
For some services, MCOs auditing every claim, all have to be filed on paper creating administrative burden.	Claims							
Provider contracts not properly linked up with MCO payment system resulting in incorrect payment or denial of claims.	Claims							
Once an MCO has identified a claims processing error, resolution and reprocessing of claims are slow.	Claims							
Incorrect rates loaded into MCO system.	Claims							
Inconsistent billing policies, e.g.. date spans vs no date spans.	Claims							
Claim denial reasons are not always clear or comprehensive.	Claims							
MCOs deviating from IME payment guidelines.	Claims							
Paid claims reports from MCOs - providers haven't been receiving paid claims reports.	Claims							
Concerns with third party liability application/processing.	Claims							



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Hospice payments incorrect when members in facility (pass through).	Claims							
Incorrect client participation taken out.	Claims							
Websites for claim inquireies are not correct.	Claims							
Issues with claims back to April 2016.	Claims							
Providers would like to see better coordination of resolution of claims issues across disciplines to reduce duplication effort.	Claims							
Providers subject to timely filing when MCO errors are preventing claims processing.	Claims							
If providers request face-to-face payer mtgs, MCO should agree	Claims							
Without a common provider manual and universal billing and UM process the system is administrative burdensome and inefficient.	Claims							
Require MCO to participate in joint treatment planning and intensive telephonic care coordination.	Clinical/Quality Outcomes							
Lack of MCOs engagement w/post acute care providers.	Clinical/Quality Outcomes							
Concern with primary care provider (PCP) assignment and value based incentives.	Clinical/Quality Outcomes							
Lack of incentives for provider innovation and positive outcome measures.	Clinical/Quality Outcomes							
Need to ensure that providers can afford to serve members members who are expensive to provide care for.	Clinical/Quality Outcomes							
MCOs are managing BH and Primary care in silos - ensure all service delivery systems are coordinated.	Clinical/Quality Outcomes							
There's a large disparity in preventative care to a high risk population.	Clinical/Quality Outcomes							
Need effective case management in coordinating of LTSS, medical health and behavioral health.	Clinical/Quality Outcomes							



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Requesting process charts demonstrating how interventions and services meet the overall goal of each program.	Clinical/Quality Outcomes							
Providers are requesting comparative outcome measures.	Clinical/Quality Outcomes							
Provider reps not responding to providers timely or don't know the information requested to bring situation to resolution.	Communication s/Training							
Requesting more IME intervention when MCOs not addressing issues in timely manner.	Communication s/Training							
Advanced notice of any changes need to be communicated prior to implementation with opportunities for training, education and resolution of outstanding questions.	Communication s/Training							
Inconsistent interpretation and communication of Medicaid reimbursement policies across MCOs.	Communication s/Training							
Case managers not involving providers and/or not providing necessary contact information for coordination.	Communication s/Training							
SIS scores being done without the members present during the evaluation.	Communication s/Training							
MCO case managers could use education and training on LTSS, billing codes, NPI numbers, how to write individual service plans.	Communication s/Training							
MCO and DHS websites are difficult to navigate.	Communication s/Training							
Provide a portal to access claims and Medicaid info. We can proactively address eligibility renewals, etc. when we have that real time info.	Communication s/Training							
Ongoing turnover in MCO staff is significant issue in addressing issues and many times on rate, contract and credentialing issues. We have had to "start over" with the new staff.	Communication s/Training							
Inconsistent internal communication within MCOs. Responses are different for providers depending on who they talk to.	Communication s/Training							



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Utilization management team is making changes to individual service plans without interdisciplinary team agreement.	Communication s/Training							
Vague messaging from MCOs on when issues will be resolved.	Communication s/Training							
Unclear information when calling MCO providers relations. We have been told to start there but are sent to a nationwide call center that are not trained to handle specific Iowa situations and cannot read claims and answer our questions	Communication s/Training							
Telephone systems and written information is not designed for people with intellectual or mental disabilities.	Communication s/Training							
Improvements needed for providers to more easily verify member eligibility	Communication s/Training							
Need for better independent advocacy. Train provider types to provide advocacy assistance.	Communication s/Training							
Providers requesting quarterly training by MCO provider reps.	Communication s/Training							
Ongoing confusion or misinterpretation of IME DME policy by the MCOs.	Communication s/Training							
IME does not enroll some specialty providers, while MCOs are requiring them to be credentialed.	Credentialing							
Credentialing and contracting delays with MCOs.	Credentialing							
Standard uniformity needed in enrollment form and recredentialing procedures for providers	Credentialing							
IME giving inconsistent information on provider enrollment status.	Credentialing							
Credentialing/Enrollment with multiple MCOs or pre-ambulatory health plans (PAHPs) is delaying providers ability to provide services to members.	Credentialing							
MCOs are slow or incorrect in loading providers rosters.	Credentialing							
IME enrollment delays for new providers delays MCO enrollment.	Credentialing							



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Improve MCO provider enrollment and credentialing processes.	Credentialing							
Request a referral system between MCOs and pre-ambulatory health plans (PAHPs) to include a referral system and sharing of data for chronic disease members.	Data Transparency							
Analyze claim payment statistics by different categories for better snapshot of what is/isn't working.	Data Transparency							
Recommend MCO activities be audited and sampled by independent auditors.	Data Transparency							
Use data to measure progress towards program goals.	Data Transparency							
Considerations for measuring outcomes and making program decisions	Data Transparency							
Report on Medicaid access not only from a provider enrollment perspective but also including the number of providers accepting new members.	Data Transparency							
Share data on provider performance.	Data Transparency							
Members having issues with transport to dental and medical appointments when members are not eligible for transportation services	Parking Lot							
90 day retroactive period needs reinstated for patients for cost of care coverage	Parking Lot							
MCOs not consistently assisting members with eligibility redeterminations.	Parking Lot							
Add all children to DWP.	Parking Lot							
Providers would like a claims appeal process.	Parking Lot							
Direct Care Shortage: With current reimbursement, providers are unable to pay wages needed to keep staff.	Parking Lot							
Extend safe harbor provisions for LTSS beyond March 31, 2018 expiration.	Parking Lot							
Uniform authorization process and forms with electronic submissions	Prior Auths							



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Needed services have been denied or significantly reduced without specific details.	Prior Auths							
Ensuring Providers know which services require prior auths.	Prior Auths							
Members receive approval for facility services easier than HCBS.	Prior Auths							
LTSS priorities of MCO different than provider priorities.	Prior Auths							
LTSS authorizations not being entered timely.	Prior Auths							
Lack of consistency w/ policy for some items being provided.(e.g.. 90837 60 min psychotherapy)	Prior Auths							
MCOs are not following American Society of Addiction Medicine (ASAM) criteria.	Prior Auths							
Concerned about inconsistency and repetitive authorizations required for ongoing chronic care.	Prior Auths							
Timeliness on prior authorizations.	Prior Auths							
Review methods of submitting and tracking prior auths.	Prior Auths							
Concern retroactive prior authorization is reviewed with higher scrutiny.	Prior Auths							
When member switches MCO, should not have to repeat Rx step down process, but this is occurring.	Prior Auths							
Review effectiveness of prior auths on certain types of services, such as ICU level of care, transplants and hospice room/board.	Prior Auths							
Review one prior auth for all PAS needed in certain circumstances (i.e.. all supplies related to a particular treatment or all services to be received while in a PMIC).	Prior Auths							
Appropriate reimbursement not always included as part of authorization approval.	Prior Auths							
Simplify therapy authorizations - visit vs codes.	Prior Auths							



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Review administrative process of prior authorizations for potential reduction of administrative burdens (such as time on the phone; add step to provide more information before peer-to-peer is required; duplication of efforts in peer-to-peer reviews; peer-to-peer not done by same specialty) for services (i.e. PMIC auths for admission or continuing stay).	Prior Auths							
Review criteria for prior authorization on certain types of services, such as psych testing and short-term 1-1 staffing in PMIC vs. inpatient.	Prior Auths							
Review time frame requirements for MCOs to issue prior approvals, including for direct ongoing treatment.	Prior Auths							
Improvements needed to prior auths online processes.	Prior Auths							
Need MCOs to share data regarding prior auths with providers to help providers improve.	Prior Auths							
Authorization different from what was agreed upon by team.	Prior Auths							
Members prevailing in appeals resolution process come out to expired authorizations, or continued denials, of equipment for member in a facility. Need either automatic extensions or yearly auths for LTSS services.	Prior Auths							
Concerns when MCO reps tell agencies they are being directed to only authorize 89% of units prior authorized, regardless of the need of the member.	Prior Auths							
Require MCOS to pay providers for delayed authorizations, discharge planning and during appeals.	Prior Auths							



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Provide an approved number of CPT codes to use after an initial evaluation, so there is not a hold on starting treatment (i.e. speech therapy as OT and PT currently have a number of pre-approved CPT codes to use).	Prior Auths							
MCOs requiring initial evaluations and standardized testing on separate days for full payment.	Reimbursement /Fee Schedule							
Complex rehab/mobility items - majority are labor intensive to order, fit, repair and cost and are not covered by reimbursement.	Reimbursement /Fee Schedule							
Inconsistent Intermediate Care Facility (ICF) rate setting process.	Reimbursement /Fee Schedule							
Reimbursement rates don't allow for retention of direct support professional.	Reimbursement /Fee Schedule							
Network providers: in-network should be reimbursed 100%, out-of-network 95%.	Reimbursement /Fee Schedule							
Pricing of new codes for payment takes too long.	Reimbursement /Fee Schedule							
Update fee schedules on MCO websites.	Reimbursement /Fee Schedule							
Create accountabilities for MCOs to accurately adhere to IME rate files.	Reimbursement /Fee Schedule							
LTSS members have limited access to dental services. FQHC limit services for members.	Reimbursement /Fee Schedule							
Medical and dental providers not accepting new members due to low reimbursement.	Reimbursement /Fee Schedule							



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Some disciplines have rates lower than others for same codes despite some disciplines having greater amounts of education. Consider time in treatment to be more reflective of severity than quality.	Reimbursement /Fee Schedule							
Rates for certain services are significantly lower than needed for adequate therapy (i.e. ABA services)	Reimbursement /Fee Schedule							
Timeliness of hospital rate rebasing.	Reimbursement /Fee Schedule							
Review adequacy of rates and rate setting methodology (i.e. ICF ID, SUD, outpatient residential and B3). Some reimbursement rates are not keeping up with members needs.	Reimbursement /Fee Schedule							