Iowa Medicaid
IOWA HHS

Medical Assistance Advisory Council

MEETING MINUTES
AUGUST 19, 2022

CALL TO ORDER AND ROLL CALL

MAAC Chair Angie Doyle Scar, Division of Public Health, called the meeting to order at 1:00 p.m.. Angie called the roll, attendance is reflected in the separate roll call sheet and a quorum was achieved.

APPROVAL OF PREVIOUS MEETING MINUTES

Angie called for a motion to approve minutes from the May 19, 2022, meeting. Shelly Chandler, Iowa Association of Community Providers, motioned to approve, Brett Barker, Iowa Pharmacy Association, seconded the motion, the minutes were approved.

MANAGED CARE ORGANIZATION (MCO) QUARTERLY REPORT QUARTER 3 STATE FISCAL YEAR 2022

Kurt Behrens, Iowa Medicaid, reviewed the MCO Quarterly Report for Q3 SFY 22. Kurt began by reviewing MCO enrollment, which stood at 787,187 members, an increase of 11,680 or 1.51 percent between Q2 and Q3 of SFY 22. Moving on to the financial summary of the report, Kurt noted that Amerigroup Iowa, Inc. (Amerigroup) had increased their third-party liability (TPL) claims recovery by $6.4 million, a 38.76 percent increase. Amerigroup attributes this recovery to a rise in the number of major medical claims from the previous quarter, which in turn resulted in more recovered dollars. Kurt then discussed pharmacy prior authorizations (PAs), which have a federal requirement for all such PAs to be completed within 24 hours. Iowa Total Care (ITC) met this requirement for two out of the three months of the quarter, missing one PA in February, completing 6,789 of 6,790 Pharmacy PAs for that month. Amerigroup performed similarly, missing one PA in January, completing 9,593 of 9,594 for that month, and three Pharmacy PAs in February, completing 9,240 of 9,243. Call center performance metrics were reviewed next, Kurt highlighted the performance of both MCOs non-emergency medical transportation (NEMT) helplines. Amerigroup and ITC both contract with Access2Care for their NEMT helplines; for the past several quarters Access2Care has had difficulty meeting the required 80 percent service level threshold due to staffing issues. This quarter both MCOs NEMT Helplines operated by Access2Care exceeded the 80 percent service level threshold for all three months.

Brandon Hagen, Iowa Health Care Association, asked about Value Based Purchasing (VBP) metrics, specifically what constitutes VBP. Kurt answered that several factors go into it, and he'd be happy to send Brandon the specific data definitions via email, but generally the measure presented in the report is the percentage of members that interact with a VBP contract negotiated by their MCO. Director Elizabeth Matney added that the number in the report reflects the number of members covered under a

VBP agreement and is not the number of contracted services, but the number of their members that can access a VBP contracted service. Shelly asked to receive the VBP data definitions from Kurt as well.

Jason Haglund, public member, and co-chair, asked about network access metrics, specifically measuring differences between access in urban and rural areas. Kurt answered that many different layers of data analysis go into evaluating the difference in access between urban and rural settings, and that the quarterly report does not show this difference for every type of service, and it does not make sense to ask this question for some specialty services. Director Matney added that Exhibit B of the managed care contract contains the network adequacy standards broken down by provider type. Most of these standards do not differentiate between rural and urban settings. For primary care physician access, the standard is 30 minutes or 30 miles from the person's place of residence. Hospital and emergency services standards are slightly different. Director Matney quoted Exhibit B for hospitals:

> "Transport time shall be the usual and customary, not to exceed 30 minutes or 30 miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions shall be justified and documented to the State based on community standards."

Director Matney noted that community standards means that the members' access to services must be the same whether they were on Medicaid or not.

Jason stated he was curious how workforce issues were affecting member's access to care. Director Matney agreed that is an issue but noted a silver lining of the Public Health Emergency (PHE) has been the rapid deployment of telehealth which should help bridge some gaps for members, especially in rural areas.

Kurt showed the council the Iowa HHS' Access and Quality Reporting tool, which measures access and quality by provider type. The tool shows the ratio of members to providers, how many units of service were performed, and how many claims went through each MCOs provider network versus how many were processed from providers outside their networks. Director Matney offered to share the Access and Quality Reporting template with anyone that is interested.

Shelly commented that the information on network adequacy and standards in rural versus urban settings was interesting, but currently the larger issue is whether providers are willing to accept members into service because of workforce shortages; stating whether a member can access care because of a provider's waitlist is a different question than traditional network adequacy. Director Matney agreed with Shelly, and said Iowa HHS is working on ways to measure this issue, part of this effort ties into Iowa Medicaid's modernization efforts.

Brandon asked about non-pharmacy claims denials, specifically the category "charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement". Brandon stated that pharmacy providers follow a billing practice wherein they bill customary amounts for services and receive back a payment at the contracted amount, and if this is the case for non-pharmacy providers, why would a provider receive a denial for billing this way no matter how much the provider submitted for their customary charges? Kurt answered that he would investigate and get a summary for the MAAC. John McCalley, Amerigroup, said he'd have to take the question back as well.

Brandon asked if there is any way to look at the appropriateness of claims denials, from a provider perspective there are many denials received that are inaccurate. Kurt answered that such an analysis would require Iowa HHS to evaluate claims denials on a case-by-case basis, but that he would ask Amerigroup and ITC to look into putting together such a summary.

Angie highlighted the inclusion of mental health and behavioral health data provided on the report, noting that Dr. Shriver and Dr. Beeman had previously called for the presentation of this data. Angie invited Dr. Beeman to comment on the mental and behavioral health data in the report. Dr. Beeman said he was excited to see the inclusion of this data and has plans to review and track this data from quarter to quarter.

Dee Sandquist, public member, asked to make a comment: Dee sits on the Regions Mental Health Board for Southeast Iowa and at their last meeting a comment was made that the local Coordinator of Disability Services (CDS) had a client who was a case manager/parent. They couldn't figure out all the systems and services and the bottom line of the comment was a request to simplify the systems, specifically the systems associated with child mental health. Angie asked if the parent was having trouble accessing the providers or the benefits. Director Matney asked Dee to send her the parents contact information, and she would follow up with the parents.

Marcie Strouse, public member, commented that she also loved having the mental and behavioral health data for children but asked if this data was available for adults. Kurt said there are no current plans to share this data in the MCO Quarterly Report, but that this data could be added to dashboards available on Iowa HHS' website. Director Matney praised Kurt for his work building out reporting projects for Iowa HHS, specifically a project that translates data provided in quarterly reports into a live dashboard on the agency's website. Marcie added that the data for mental health is going to be especially important once the legislature is in session, citing an ongoing and increased need for mental health services around the state.

MEDICAID DIRECTOR'S UPDATE

Director Matney began her update by discussing the re-alignment of the Iowa Department of Public Health and the Department of Human Services into one agency known as the Department of Health and Human Services (HHS) effective July 1, 2022. Director Matney stated that uniting the two agencies into one organization will allow for improved collaboration, data sharing, increased efficiencies and better collaboration between the two departments. Branding for the new agency will be released shortly along with tables outlining Iowa HHS' new organization.

The PHE has not ended and is currently extended through the middle of October, however, the Centers for Medicare and Medicaid Services (CMS) has not given notice that it will end in October, which indicates it will likely be extended again through the rest of the calendar year. Communications regarding plans for the unwinding process for the PHE are being developed. Iowa Medicaid is in the process of evaluating which flexibilities, such as telehealth flexibilities, implemented during the PHE will stay in place, and which flexibilities will end.

Once the PHE ends, Iowa Medicaid will be required to redetermine the eligibility of most members. When the PHE ends, members who have had an eligibility redetermination within the last 12 months will not need to have their eligibility re-examined until a further 12 months have passed. Iowa Medicaid has created work plans for these eligibility processes. Currently staff are focusing on ensuring members have their current address updated in the system, as eligibility redetermination forms will be mailed to affected members.

Iowa Medicaid will be awarding a contract for the recent managed care request for proposal (RFP) at the end of the month.

Mathematica is still working on the Community-Based Services Evaluation (CBSE). Liz said Iowa Medicaid is hoping to have this evaluation in hand for the next legislative session, as some issues may only be resolved through legislation.

Related to eligibility redetermination, Brandon Hagen noted that 180,000 members were added during the PHE and asked how many of these members Iowa Medicaid expects to stay on once the PHE ends. Liz said this is a difficult question to answer, but some organizations that study this topic estimate roughly 15 to 20 percent of members enrolled during the PHE will remain enrolled once the PHE ends, and eligibility redetermination processes have concluded. Iowa Medicaid has begun eligibility redetermination reviews and of the members reviewed so far, staff are reporting that this estimate of fifteen to twenty percent appears to be accurate.

Maribel Slinde asked about the onboarding of a new MCO. Liz said the managed care RFP is in evaluation and will have an announcement and letter of award at the end of this month.

UPDATES FROM THE MCOS

Amerigroup Iowa, Inc.

John McCalley, Amerigroup, began his update by noting the ongoing work collaborative efforts between Amerigroup and Iowa Medicaid to prepare for the end of the PHE. Amerigroup meets regularly with Iowa Medicaid and ITC to discuss these plans.

Amerigroup continues to collaborate with Iowa Medicaid, the State Resource Centers, and ITC to come into compliance with the Department of Justice transition of the State Resources Centers (SRCs). Amerigroup is looking to transition Glenwood Resource Center (GRC) members to Home-and Community-Based Services (HBCS) providers. These efforts include working with providers to build capacity. Capacity to accept new members requires training staff and as well as providing capital to develop infrastructure. Amerigroup has contracted with four intensive residential service homes (IRSH) providers, which complies with legislation requirements passed in 2019.

Amerigroup continues to implement health equity plans discussed at previous meetings, with a new partnership with private organizations to conduct outreach to high-risk members through a vendor named MedAware. This outreach will begin in Polk County, focusing on 446 members identified with high needs. Amerigroup plans to expand this outreach and case management work to other counties in both urban and rural areas in coming months.

Amerigroup has partnered with Reach Out and Read, providing a grant to purchase 3,000 books, and supporting programming to the Community Health Center of Southeast Iowa, located in Des Moines County. Amerigroup partnered with Reach Out and Read on this project in hopes of incentivizing well child visits on the part of Medicaid members, as Des Moines County has one of the lowest well child visit rates in the state.

Amerigroup continues its work on social determinants of health (SDOH) with their Champ Housing Stability Initiative. The initiative has served more than 650 Amerigroup members. Some of these members were at risk of eviction; others were houseless and in search of stable housing. John ended with a member story highlighting the impact of this program. One member working with the obstetrics (OB) case management team, was experiencing a high-risk pregnancy and a recent transplant to the area. The member was fully employed but found herself 27 weeks pregnant and homeless. She was living in her car, suffering from severe anxiety and behavioral disorders. Amerigroup found her transition housing in a hotel and within a week found an apartment for her. She only needed help with the deposit and could afford the rent. Amerigroup later received a note from her explaining the dire medical situation she was in when she began working with the case management team saying, “you have saved two lives”.

Iowa Total Care

Stacie Maass gave an update for ITC. Stacie began by discussing the collaboration between ITC, Iowa Medicaid and Amerigroup, highlighting the ongoing work to plan the transition out of the PHE. ITC is working on implementing the rate increases passed during the spring legislative session. ITC is

collaborating with Iowa Medicaid to distribute American Rescue Plan Act (ARPA) funds to providers. ITC continues to participate in regular meetings discussing operational and strategic ways to improve the Medicaid program, address work force issues and members access to services. Stacie discussed the work of ITC's quality team, both internally and in public facing settings. A major goal of the quality team is to improve member health outcomes. Part of this work is ITC's focus on health equities and SDOH. ITC is analyzing the impact of existing programs and searching for new ways to connect with members.

ITC continues to support community events such as the Special Olympics. ITC uses community events as an opportunity to reach out to providers in the community and perform outreach and education to members on SDOH barriers such as transportation, food, rent and utilities. ITC has uses geographical data to target events, looking for areas where there is high concentration of members or potential members. ITC participated in Des Moines University's back to school events, providing free back to school physicals, along with information on free programs and other offerings.

ITC has been participating in the Iowa Stops Hunger Program, statewide initiative to combat food insecurity in Iowa. Launching a program working with women ages 21 to 24 who are food insecure, ITC is planning to provide 30 days of meals to those identified in the program.

ITC has bilingual staff who appear quarterly on Spanish speaking radio shows to highlight programs and information.

ITC has a new Doula offering piloting in three counties: Polk, Muscatine, and Johnson. The program sets up new mothers with a doula who can help identify barriers, provide birth support before after and during a pregnancy and work with care managers on other needs.

ITC had a health equity intern over the summer who was passionate about rugby. ITC and the intern partnered with community providers in Iowa City to hold a "Rugby Sports Clinic" for children ages six to 14. The event was designed to increase physical activity, improve mental health and support Iowa's healthiest state initiative. Stacie extended thanks to the members of the University of Iowa women's rugby team who made up most of the volunteers for the event.

ITC's quality team, in addition to direct member outreach, is meeting face-to-face with providers to talk about ways ITC can be more collaborative, inclusive of provider needs and discuss providers' thoughts on how ITC could better serve their members. Stacie said that providers have given feedback on what reporting they find useful and how ITC can tailor reports specific to each provider. One provider had had significant gaps in immunizations, and ITC developed a report to assist that provider with making operational changes to improve immunization.

ITC continues to run several successful texting campaigns for members. Currently ITC has around 200,000 phone numbers they send texts to. ITC is developing the capacity to focus these campaigns, partnering with specific providers to tailor messages members will be more likely to respond to. When they began their text campaigns, ITC targeted specific services one at a time. ITC is developing campaigns that look at the member, piloting a campaign based on women's health and an array of services rather than just one service.

ITC has recently launched new pay-for-performance measures with behavioral health providers. ITC is starting to see data returns from this behavioral health pay-for-performance measure and anticipates

developing further measures including providing incentives for: housing insecurity, homelessness, employment, and follow up after hospitalization for mental illness. Stacie said ITC will work with providers to see how they can help members together.

Stacie ended her update with a member story. This particular member has issues with balance. After multiple conversations with the member, over a period of months, ITC staff made the recommendation to find member a three wheeled bike. Staff found a provider who was willing to offer a donated bike. After biking and being able to spend more time with family, the member is exploring new places, has lost weight, and gained new confidence. The member recently gained a new driver's license to operate a specially-modified car.

Barb Niebel, Iowa Speaking and Hearing Association, commented that during the last meeting of the council she had informed Stacie of several issues that speech, occupational and physical therapists were having with pediatric prior authorizations. The National Imaging Associates (NIA) became involved to help facilitate PAs. Barb stated that NIA involvement has improved the situation, largely by providing education to providers on how to submit PA documentation. However, Barb noted, that there are still issue with PAs in this area. Stacie said she would circle back with Barb and her team.

MCNA

Sabrina Johnson, MCNA Dental, provided an update. Summer is a busy time for dental appointments in addition to a new contract period that began July 1, 2022. With the new contract period MCNA is in the process of reviewing updated language, working closely with Iowa Medicaid to ensure MCNA follows the new contract and expectations. MCNA recently completed an external quality review (EQR) audit, a contractual managed care requirement. Sabrina said the audit went well.

MCNA Provider Relations has been gearing up to do site contacts, MCNA likes to complete site contacts at least once a year, if not more. During the site contact MCNA updates and verifies information in their provider portal is accurate, reviews contact information, hours of operation and access and availability. MCNA also reviews whether the provider is accepting new members, this is reflected in MCNA's provider locator tool.

MCNA is adding information to the provider locator tool, which will now provide information on member accommodations, such as whether the location's bathroom has handrails and other accommodations.

MCNA has deployed a practice site performance summary (PSPS) over the last year. The PSPS is available to facilities that have seen 50 or more members in the last 12 months. The PSPS reviews various performance measures and is shared with the provider along with examples from comparative providers to allow providers to make changes to improve their performance. MCNA has increased the number of facilities receiving the PSPS from 76 at the beginning of this year to 125.

MCNA works closely with the Iowa Medicaid Communications team, participating in weekly calls to ensure information and updates for members are in line with Iowa Medicaid. In the last call it was discussed how the meeting could be beneficial for both the dental and medical plans. MCNA will provide the medical plans with information on what dental resources MCNA has available, and how to navigate MCNA's member and provider websites so that the medical plans can relay that to members and

providers as necessary. A self-equity assessment has been developed in partnership between MCNA, Delta Dental, Iowa Medicaid and a company called PreVisor. Each question on the survey provides an opportunity for MCNA to contact their members regarding the survey, for every answer there is an action MCNA must take. The assessment includes questions that were mentioned by ITC; assessing if the member needs resources or help with food insecurity or transportation.

As part of the new contract period MCNA is working to update their fee schedule, currently the new feed schedule is being reviewed by MCNA leadership, once this final review is completed the fee schedule will be sent to Iowa Medicaid for review and approval.

Delta Dental of Iowa (DDIA)

Gretchen Hageman, DDIA, provided an update, starting by noting that DDIA has been part of the managed care plan for the Iowa Dental Wellness Program (DWP) and the Hawki program for several years. DDIA began administering the Hawki program dental contract in 2008. Gretchen provided outcome data related to DDIA's reports, noting that Iowa Medicaid is developing a quarterly dashboard. DDIA has about 29 percent of adults that have had a dental service in Iowa. There are roughly a thousand providers under their network, and 69 percent of these providers are seeing 10 or more members. DDIA has a partnership with I-Smile, run through local title five agencies.They serve as infrastructure for care coordination and some direct services for members. Through this partnership 900 members have had a service through I-Smile.

Regarding quality measures for their adult population, DDIA has developed a risk assessment for members. Members fill out the assessment identifying various risk factors such as diabetes. Members are then provided with oral hygiene kits. DDIA works with members that haven't had any services and focuses their outreach and care coordination to get them into a dental home. DDIA is also working to formalize a partnership that would identify members requiring a dental service where the need was identified in an emergency room. This would allow the member to be referred to a dentist to perform the service within a specific timeframe.

DDIA is examining geographic data to identify areas where members have low access rates to dental services, looking for ways to get more members in these areas into the dentist. As far as DWP kids, roughly 47 percent of them have had a dental service. DDIA has contracted with around 1,000 providers to see DWP kids. 72 percent of these providers are seeing 10 or more members. I-Smile infrastructure has provided 15,000 DWP kids with around 70,000 services through clinics. DDIA has developed head start sealant clinics at the school childcare center to provide dental sealant services to children and identify high-risk members.

56 percent of Hawki members have had a dental service in the past year. The focus area for Hawki is adolescents with no dental services. DDIA is excited to have the risk assessment Sabrina mentioned in her update as well, looking forward to having additional data related to SDOH and using that data as they work with members. DDIA's efforts around providers have been focused on continuing to address access issues, particularly in certain geographic areas, developing incentives for providers to rejoin the Medicaid system. Angie commented that she is a fan of the I-Smile program.

OPEN DISCUSSION

Dr. David Beeman raised several concerns about the current composition of the council, specifically that he feels the current make-up of the council does not conform to state and federal regulations. Additionally, Dr. Beeman is concerned about the council's lack of diversity, being composed of primarily white middle class to upper middle-class members. Dr. Beeman is also interested in evaluating how well the council represents children and children's mental health. Dr. Beeman stressed that he does not want to raise these issues as an offense to anyone currently serving on the council.

Dr. Beeman's first concern regarding the composition of the council is that in his interpretation of the federal and state regulations, they require at least once council member to be a recipient of Medicaid. Dr. Beeman stated that he is unsure if this definition extends to family members, and that he is unaware of anyone on the council receiving Medicaid. Director Matney replied that it is her understanding of the code that it does include family members.

Dr. Beeman's second concern is that the Iowa Code, in the paragraph that outlines requirements for the five public members of the council, states "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". Paragraph "a" here refers to the list of 41 professional and business entities outlined in Iowa Code as being statutory non-voting members of the council. Dr. Beeman stated that the five public members currently serving on the council include two physicians and a dietician, which conflicts with the cited requirement. Dr. Beeman's next concern is that the cited requirement contradicts federal regulations which require at least one board-certified physician to serve on the council. Dr. Beeman's reading of the federal regulation and the Iowa code taken together is that a board-certified physician is required but must be elected from among the 41 professional and business entities, and not appointed as a public member. Dr. Beeman asked the council to consider whether his concerns are correct or not, and if they are valid, what course of action will be taken to remedy the conflicts with federal and state regulations, adding that regardless of the council's response he is still concerned about the lack of diverse representation.

Angie stated that in the past she and Gerd Clabaugh, former director of the Iowa Department of Public Health, compared federal and state regulations concerning the council. Part of that examination was looking at how other states had structured their analogous councils, and Iowa had the largest council membership of any state they looked at. At the time the council had 60 members. The council retains this high membership, but the majority are non-voting members. Angie stated that due to this large statutory membership it would be very challenging to find public representatives that do not fall under one of the umbrellas of the wide membership base. Jason Haglund added that he was serving on the council with Gerd when the council was restructured in 2019, and discussions like Dr. Beeman's concerns regarding the council's compliance with regulations were had then, and Jason and Gerd were satisfied with the council's compliance at that time. Jason added that Dr. Beeman's concerns about inclusion and equity are something that should be considered further. Jason asserted that there are current public members who have adult children who receive Medicaid and have experiences with the Medicaid system.

Dr. Beeman stated that even if the council composition conformed to state and federal regulations at the time of the restructuring of the council in 2019, he feels that does not mean the council currently

complies with regulations. Dr. Beeman stated that he believes the state regulations are clear about composition requirements and asserted his belief that the intent is to foster a conversation between recipients, providers, and the Department to improve the Medicaid program in Iowa. Addressing the idea that a family member of a person receiving Medicaid fulfills the federal regulations, Dr. Beeman questioned the boundaries of the term, stating he has a sister who receives both Medicare and Medicaid, but believes that he does not fit the requirements of the federal regulations.

Angie stated that currently and historically, finding applicants to serve as public members of the council has been a struggle. Angie encouraged members of the council to reach out to people in their communities to find others who are willing and able to take the time to sit on the council.

Kady Reese, Iowa Medical Society, stated she found the conversation on diversity and inclusion very interesting. Kady previously served as a patient and family engagement champion with CMS. Citing her experience with CMS Kady encouraged the council to consider how prospective public members would engage with the council, how they could be empowered to engage, how they would be equipped to engage. Kady said this may be an opportunity for the council to work with the Iowa Primary Care Association (PCA) and federally qualifying health center (FQHC) partners who, by nature of their type of health center, have consumers serve on their boards and committees. These members may have the experience and interest required to be effective public members of the council.

Director Matney added that the council should remember the Hawki board and encourage the two groups to consider how they could work together collaboratively, suggesting a standing agenda item in which a Hawki board member could present to the council and vice versa. Director Matney also raised concerns about expanding membership too broadly, as the previous iteration of the council had issues meeting quorum requirements. Angie said that she serves on the Hawki board and may be able to facilitate collaboration between both boards. Dr. Beeman stated he was not advocating to returning to the previous iteration of the council, agreeing with the concerns about meeting quorum.

ADJOURNMENT

Meeting adjourned at 3:10 PM.

Submitted by,
Michael Kitzman
Recording Secretary
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