Survey Responses
MEDICAID MANAGED CARE ENVIRONMENTAL SCAN

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BACKGROUND

The responses included in this document represent answers provided in a survey distributed in September 2016. The purpose of the survey was to describe a point in time related to the experience of Iowa’s public health providers and partners with the implementation of Managed Care. This data was presented at the Public Health Law Conference in Washington, D.C. on September 16th.

The survey used questions from the Situation Assessment from Technology of Participation’s Approaches to Environmental Scanning Manual. This set of questions explores the past, present and future surrounding a situation with 6 main factors as headings for creating the questions.

The answers were received within 1 week from 60 providers in public health, transportation, home health, physical therapy, and other related service providers. The responses are provided within this report as written by the respondents.
QUESTION 1:
PRIOR TO MANAGED CARE IMPLEMENTATION, WHAT DID YOU CONSIDER TO BE THE STRENGTHS OF IOWA'S MEDICAID?

RESPONSES:

- Quick payments, easy to read remittances, easy to understand denial codes, paid the correct amount every time.
- System had been in place for many years...from a billing perspective, we do electronic claims with payment in 1 week....few issues.
- Knowing how to bill was easier and payment came faster.
- Consistency of services and billing procedures.
- One entity to report to and receive reimbursement.
- The ease of billing and the online capabilities.
- Prior to managed care implementation, the strengths of Iowa Medicaid includes: ease in billing and quick turnaround for payment; no prior authorizations required for home health services.
- Prompt and complete payments. Well known system and process.
- Timeliness with service authorization and correct payments.
- More eligibility for our Patients in need.
- Accurate payments in a timely fashion.
- Simplicity of billing, Timely payment, One place to call with questions, Phone line for member eligibility status. Low administration costs at the state level.
- Easier to work with than several different entities, they all need something different. Easier to work with .All the pts. needs were met.
- One stop shopping. The system was understood by most.
- a well known flow of information, policies and procedures, etc. was in place.
- It was easier for clients to understand. Providers could be assured that they would receive payment for services.
- Clients received needed services including coordinated care! Also, quicker turn around with paid and accepted service claims; Claim issues were immediately addressed when requested clarification; Staff were able to answer questions and were knowledgeable about claim processes.
- Sound process in place; known communication route; paid for services provided.
- Claims were paid on one remit, within the same month billed. Very few claim processing errors. Dealing with one claims processor as opposed to three.
- Prompt and correct payment of clean claims without having to purchase billing software or clearinghouse services. Accessible avenue for resolution of issues. Supportive annual education for providers and billers.
- Ease if access to medical providers and specialists across the state. Patients had a much broader choice in providers for all types of care. Local agencies were the experts in their area and could provide care coordination and assistance to those living in their communities for reimbursement.
- Turn around time was no more than 7 days. Very few denials, if there were denials it was because the member was not eligible for services. We were paid at the maximum Medicaid reimbursement rate. If the person at IME was not able to answer my question, they would let me speak to their supervisor to resolve the issue. The IME staff was very knowledgeable and very easy to understand.
- Their willingness to build reimbursement rates for Title V MCH services such as care coordination, developmental screenings, depression screenings.
- Their staff. For the most part the people there were hard working and dedicated to their job.
- Emphasis on high quality well-care. Ease of access for patients and providers. Collaboration with Iowa Department of Public Health, Title X, and Title V-one of the best if not the best in the country.
- No prior authorizations were required for PT, OT and SLP services. Quick claim processing and payment, knowledgeable staff. Easy to get answers to problems as they came up.
- Strong preventative services. Strong service to optimize outcome for children's long term health and academic success.
- Billing was not complicated. Everything was managed in one "spot".
• There was always state control, and typically someone who could answer a question directly, someone who had a vested interest in getting individuals the services they needed.
• Billing was simple. The staff were knowledgeable if you had questions. Claims were paid promptly.
• Timely payment; PC-ACE was a wonderfully SIMPLE billing tool for small agencies.
• Timely payments, straightforward rules for coverage
• Met the needs of low income or no income individuals of all ages who needed home care and hospice services to meet their health care needs.
• It went to the people who truly needed it or the disabled. Now it even goes to 21 y.o.’s who are able bodied and should be able to work!
• We serve a lot of waiver clients, it seemed like the system overall worked well for our Medicaid clients on the waiver. We were able to provider services immediately to meet the client’s needs.
• We had good communication between idph and IDHS; it might take time but issues were normally resolved and we were paid the amount we were expecting.
• Continuity of care
• Case Management at a local level. I had established relationships with Case Managers and it was easier and more efficient to get and give information.
• Medicaid had a set of standards and policies that could be referred to for patient benefits.
• Ease of billing.
• Very timely payments and apparent understanding of children with long term disabilities and/or need. We typically received payments in 1-3 weeks for most of our patients.
• As we are a Home Health Agency, Preauthorization was not required and billing and payment was easy, with a very quick turnaround.
• Saving money for Iowa
• Received payment weekly, claims denied for valid reason(inactive eligibility, billing error, etc.) No Prior Authorizations required, primary eob not required,
• Medicaid had expanded to provide waiver services and then after the ACA to reach more low income families.
• One of the better programs in the country, progressive leadership; on the path to making PCMH happen, AND most importantly, paying upfront to help the PCPs accomplish what was needed (like care management). Had received substantial Federal funding to move forward on changes.
• primarily 1 payer source with exception of billing for mental health clients. We had local case managers and knew who we could work with.
• Iowa is unique in providing access to transportation, both in the available options of state wide public transit, but also in how medicaid covers transportation to waiver services.
• Home Health- The ability to implement care immediately, and knowing that the services will be reimbursed as long as we followed the guidelines for services.
• Easy to file, easy to communicate with caseworkers to meet needs with service, customers were able to call in to request services without being treated any differently.
• Care coordination efforts to assist clients and the strong outcomes as demonstrated by the results in children getting their preventive care and screenings.
• The ability to financially cover individuals who have chronic illnesses and are unable to afford other health insurance.
• The overall coverage for those who qualified
• We had a robust system that provided quality services to all. The system allowed local agencies and providers to provide care coordination, transportation and interpretation to link clients to services.
• One set of rules, and nobody was denied care. Or lapses in coverage between MCO's. Every patient had access to care and medical needs.
• From a business perspective, when you are dealing with one supplier, your admin/billing costs are reduced. Familiarity of what could be covered by Medicaid, which afforded the opportunity to educate members about preventative care they could access. It provided coverage and a safety net for those members of society that were at risk of not receiving medical attention.
• Prompt, correct payments, no prior authorization requirements with regular Title XIX skilled services, 1 payer instead of 3 different ones with different billing guidelines/rules, billing form set up.
• Timely payments that has improved in the last 5 years. Seamless way with everything it was all consistent with payment and visits no units and etc and you did not need these auths.
• Helped support public health prevention model of case finding and care coordination.

**QUESTION 2:**
**DID YOU HAVE ANY ISSUES WITH IME IN THE PAST? HOW DID YOU RESOLVE THEM? WERE YOU SATISFIED WITH THE RESULTS?**

**RESPONSES:**

• Staff for the most part was able to help you however when they couldn't it was kind up left up to us to figure it out. Most of the time they were able to help resolve the problem. We were usually satisfied with the results.
• Very few issues - Provider Relations helpful
• I didn't have any problems with IME paying my claims.
• No significant IME issues have been noted.
• Past practices were streamlined and efficient for easy resolutions and satisfaction.
• I have no issues with IME
• We occasionally had issues but was much easier to resolve and usually faster. It may have taken a few phone calls but not the numerous telephone calls, emails, and the frustration associated with the managed care organizations.
• We had people who we could call if there were any issues. I thought they did a good job.
• We had very few problems but now that is all we seem to have.
• No
• on occasion we had to work to provide enough information to get pst on programs, not very often
• Takes a while for a newly enrolled person to get into the system.
• no unresolvable issues. My involvement with IME was mostly through waivers and communication was done through the case managers with positive results.
• If we didn't get paid for a service, our financial people would make calls, and resubmit the bills. Then they were paid.
• Approved Maternal Health and Child Health screening services we provided were paid; A few that were denied we were able to communicate effectively with IME, troubleshoot the issue, and resubmit claims. We were typically satisfied with results and our clients were too.
• We would have our occasional issues, but we always knew who to contact to resolve them and we knew that eventually they would get resolved.
• No
• Issues with correct payment or any payment for certain provider types. Had to involve state staff to get a resolution which took many months, particularly the newly created Public Health Agency provider type. Eventually we were able to get payment, but the support and education piece was never completed. Overall, 80% satisfied with results for that issue.
• Occasional billing issues. Issues were resolved by a simple phone call or email; IME was always helpful in helping resolve billing issues and provided guidance on how to do so.
• Small issues, it was always something that could be fixed by filling out a recoupment/adjustment form, and were resolved in a short amount of time.
• Not usually. We were able to resolve any issues with the help of IDPH staff as needed.
I have had a number of issues with IME. The primary issue was fragmentation based on their model of service. They used a model in which many of the tasks performed were assigned to subcontractors. This would have been alright if there had been a strong leadership insuring that each role contributed to the common purpose. That was not the case. The diagram of their structure looked like a spider without a head. Each leg went its own way.

Rarely, phone call or email - quickly resolved. Very satisfied - didn't always like the answer (usually I did) but it was fair, consistent, and quick.

When issues came up, we could contact IME and verbally receive an answer. If errors were made on IME’s end, they reprocessed the claims internally. They were easy to work with in most situations

Denials now and again. Corrected errors and resubmitted.

I did not have any issues with IME in the past.

Not many issues, and a phone call to member services usually resolved the issue, never had any trouble with issues being resolved.

No real issues. If we had a question, we would call in and get our answer promptly.

Speaking to someone on the phone was frustrating.

can’t say that we had a lot of issues

Did not pay the full cost of care needed by individuals. Provided less service. Will need to use county funds to help pay for the service. Only have a certain amount of county funds to use, and may run out before June 30, 2017. This means clients may go without service, and not achieve favorable health outcomes.

No issues

From a nursing stand point it would be trying to get certain things authorized like the MD2. I understand we need to justify why we need them and we were usually able to get this resolved with documentation.

Most often if we had a problem, we were able to communicate them to Janet who was able to take them directly to DHS. Usually with clear results.

No

No issues.

There were some issues that were resolved by letter or by contacts at IME.

No issues noted in the past.

Yes, for a period of time, they were not apply the PPR reduction of 10% per DOS. A representative from IME called me and set up a schedule for us to repay it back to IME. We were close to finish this process when the transition to MCOs happened. I had been fairly satisfied with the plan but now, the contact people that I had at IME are all gone and I need assistance getting some payments clear up (payments to our clinic) and no one seems to know how to assist. I have left many, many messages with no returned phone calls.

Many years ago I had some issues with billing and getting claims paid, but as soon as electronic billing was in place all issues were resolved. Very satisfied!

Billing, still an issue to get paid. 3 different systems.

No, the billing and reimbursement processed without many errors or issues. We would reach out to IME if there were any problems for resolution. Yes we were very satisfied.

In a previous position, I provided skill building and community support services billed at that time to Magellan. My office was in the school. The program filled a great need in supporting and providing conflict resolution, stress management and anger management skills, among others to students and their families. I was told that due to Medicaid fraud, Magellan would no longer allow those services to be billed within the school. Now a huge gap remains for those low income students in that rural community who are without services.

We had excellent communication channels with IME.

Biggest problem was authorizations and billing for mental services for our home health clients. Not good communication from Merit Behavioral Health about the process and why claim would be paid one month then not the next.

We had few problems with medicaid and they were resolved with short phone calls to provider help desk.
IME would make errors on coding which resulted in a resubmission, but this was not timely and they would assist us in correcting errors.

The only issue I had with IME was my own mistake when billing and mis-keyed the number of units. This was easy to fill out a form and have corrected, no issue and very timely.

Periodically. Usually we were able to resolve in one to one conversations.

No

Some, works best to have a contact person to resolve issues.

If we had billing or payment issues with IME in the past they were resolved timely.

overall with IME, we have known the rules and outcomes.

When there were changes, it appeared as if we needed to spend time trouble shooting for billing and getting codes adjusted. In most cases, we were able to get these adjustments completed.

Minimal issues that with a phone call could be resolved easily.

Yes, we encounter a slow payment system to our agency without explanation about 5 years ago and we did get this correct.

There are always some small issues that arise, but overall, no big issues on policy matters.

QUESTION 3:
WHAT MILESTONES HAVE BEEN THE MOST TROUBLESOME WITHIN THE IMPLEMENTATION OF MANAGED CARE? PLEASE DESCRIBE THESE.

RESPONSES:

- Non payment of services - Amerigroup has not paid for any of our child/maternal health services and United Healthcare has not paid our home health claims. Not full payment of services - United Healthcare is not paying the full reimbursement on some service for child/maternal health services. And some of our home health services are not being paid at full reimbursement either. Authorizations are not being approved for what we need. For example we had a person that with a doctors order required us to go in and sponge bath them twice a week and one of the MCO's would only approve one time a week. Another was a blood pressure check from a doctors order and again the required amount of visits was denied.

- Claims are slow to pay, except for AmeriHealth Caritas and they have been great from April 1. We have trouble with 1 code and continue to work on this. We continue to work with UHC and Amerigroup on getting issues resolved, but a slow process. Both are working on our specific codes for MCAH to make sure we are set up in the system correctly. Pay and chase issues are working on being resolved.

- Knowing the correct coding and information needed for a clean claim. Taking much more of my time as a billing clerk.

- We have experienced significant payment delays due to challenges in implementing the billing process for each MCO. The challenge of converting from 1 entity to 3 - who all have different billing processes has been a little overwhelming. Due to confusion within the MCO's regarding prior authorization, we have also experienced delays. MCO staff learning curves have also created challenges - information may differ depending upon who you are asking.

- Transportation- Cumbersome, non-efficient, inflexible, non persons served oriented. Authorizations- Untimely, many persons w/o services. Vocational Services- Not in alignment with regulations, unable to receive authorizations and those received are not accurate. Reimbursement- Untimely and not accurate, processes cumbersome and manpower to submit is extensive. Portals- Three different systems that are not user friendly.

- Talking to multiple people from all MCOS asking for the same information. I have copies of emails showing 4 different people requesting the same information from the same company. Very frustrating

- There are 3 MCOs with three billing procedures; none of the contracts were clearly for home health or public health (which has resulted in billing issues); the web sites are not easy to navigate; one MCO has started 4 "projects" on the same billing issue with still no resolution or payment;
Changes were constant. Decisions were made with little insight to what/how things were going to happen. From our perspective it felt like decisions were made off-the-cuff to take care of immediate issues. However, these created issues down the road. When those issues where encountered the process was changed again from another off-the-cuff decision. The process was then repeated. Now we have MCOs reporting huge losses and signs being hung in Provider windows saying they no longer accept "Iowa Medicaid/MCOs"

Payment. We were told we would bill "just like Medicaid" by all 3 and none of our billings now look the same. Some services are still not being covered because of "known issues"

Confidentiality for our confidential Patients...the process for insurance and the issues with MCO'S

MCO representatives not knowing answers when being asked. Incorrect payments. Getting contract information into the system to show as in network. Lack of response or timeliness of response from representatives.

The time involved to apply for accreditation with all of the MCO's. Hours of administration time were needed. Each MCO required different documentation and had a different contract to review. The training sessions were not informational or helpful. Prior authorizations require more staff time and increase costs. The process was too rushed. Inconsistent answers from IME and the MCOs- if you even got answers to questions. The focus on fraud, when all of the MCOs have been accused of this in other states.

The time it takes to prior auth all the patients and then the billing is a nightmare. DME is ridiculous to get dressing and wound supplies.

Providers who do not accept certain MCOs, delay of payment, not knowing who to call with questions, long hold times.

denied payments with several reasons being given, none the same. Being told the MCO is working on the issue for literally weeks with no payment. Then, once a payment is received, it is only partial payment with no reasonable explanation. Impossible to verify and balance books. and no one to call with explanation if you are fortunate enough to get ahold of anyone.

It was pushed through too quickly, with too little education for clients and providers. As a provider, we were not given any information to share with clients until the managed care was already started. Also, in our area, many of our providers did not sign a contract until managed care had already started.

Getting our contracts in place with the right NPI numbers and understanding our services and what we do- we have signed contracts but our services are still not clear with one MCO. We get different responses depending on who you talk to when asking questions. Also, getting claims paid that were always approved before with IME/getting denials for codes/services that were approved codes in our MH or CH screening center with IME but we do not understand the denial reasons. Also, we are getting no responses at all from one MCO for all claims submitted since April.

The lack of knowledge by the MCOs to understand the services that are being provided and the inconsistency of process. You can get a different answer to the same question repeatedly.

Contracts not being correct, programs not being set up (elderly waiver) for claims processing, payment errors and timeliness

Contracting - still struggling to get contracts in place. Billing - having to purchase contracted services in order to bill electronically. Payment - incorrect payment amounts and issues of no payment at all. Each MCO having separate requirements for various services, i.e. documentation requirement for services previously paid by IME with no additional documentation required. Administrative costs - billing workload more than quadrupled.

Billing--delayed payments are utterly ridiculous! We are waiting on payment from services provided in May 2016 and forward despite assuring with the MCOs that the claims were submitted properly and that they were "clean claims." VERY frustrating and not financially feasible.

Getting signed up with the MCO's. Being recognized as a screening center. Follow through on denials after being reprocessed. Inconsistent payments/payment amounts and timeframe of being paid.

Our ability to get reimbursed for the care coordination/follow up

Overall the speed and disregard for the opinions of those already serving in the field. The State has maintained that this is a smooth implementation and they are completely wrong. It is hard to determine whether this is political rhetoric or just an extension of the lack of respect for existing opinions. There are a significant number of gaps that will need to be repaired and those solutions will never happen as long as the State denied the problems in the first place.

Lack of consistency among and within MCOs. Long delays in getting information/resolution - many still not resolved. Decrease in access to services through prior authorization requests that we cannot obtain due to unresponsive MCO, changes to FFS coverage going to MCO eligibility (that wasn't supposed to changed) during
PE. Amerigroup refusing to pay any Medicaid Screening Center claims; lack of transportation for families - barriers to the new transportation brokers. Lack of payment, mismanaged payment.

- Obtaining authorizations is a timely manner, getting claims paid in a timely manner and per the correct fee schedule, secondary claims denying for billing issues that did not occur when billing an MCO as primary. Finding a reliable contact, getting someone to call you back regarding claims processing and/or payment issues.
- I am not sure what you mean by milestones. Care coordination as the MCO activitie shas just resulted in agencies not being paid for the service that they provide. It is unethically to engage in a preventive relationship without following-up on the referrals provided to the member. It now becomes an unpaid service in a system that has paid minimal rates to begin with. The staff time to track the reimbursements and denials has tripled and is cumbersome. The rate of denials has been very high. What we provide is a preventive service focused on positive birth outcomes and early detection. It would seem that this is where the money should be spent
- receiving payment
- Getting a definite answer, every time a call is made, a different customer service worker gives a different answer. No one really knows for sure what is going on. The 90 day transition time for manditory payment of services under Medicaid to MCO’s did not happen.
- There is no uniform billing. Every MCO wants things a bit differently. There is no one to tell us what we are to be getting reimbursed. We should have been given a copy of a contract that included billing codes and reimbursement rates for those codes, but we did not get that. None of the MCO’s really seem to be able to answer your question when a claim is denied. They just read the denial reason to you which doesn't help. If it did, we wouldn't be calling in to ask.
- BILLING!!!!! No one knows what the billing units are supposed to be, so getting pre-auths are a crap shoot. Getting the MCO’s to understand that the clients to NOT need to sign Elderly Waiver forms was nearly impossible. The people who are assigned as our provider reps know as little about what is going on as the rest of them - we are always told to contact someone else. Having to learn THREE different electronic billing programs has been ridiculous, so we are doing paper billing. We get at least two, sometimes three, paper copies of every notice of decision -- each in a separate envelope with separate postage. How can that save the state any money? We have received payment on ONE immunization administration claim out of all the claims for four months of service.
- Frustration for patients to understand when and how to sign up and to understand what each vendor had to offer to them to meet their needs. For providers, understanding what each vendor will pay for HHC, HME services.
- Starting July 1, 2016, the MCOs are approving less visits for skilled nursing and home health visits than what is needed and ordered by the physician in the plan of care. MCOs are contacted to obtain approvals for service, the approvals are late, after the start date of service or after the recent date.
- We bill our vaccines through the two local clinics. It has added additional work, as we have to go into Passport, then dig further to find the MCO they are with and whether vaccines are covered. According to VFC, they say we can use VFC vaccine if a child/teen has primary or secondary Medicaid. The clinics say since the MCO’s have started, they MUST file with primary insurance which means we have to use private insurance. I am concerned if their primary insurance does not cover parents are going to be left with a big bill and will not return for vaccinations - exactly why VFC was started for in the first place!
- The length is takes to get authorizations back from the MCO’s is unacceptable, when we know there is a need we cannot wait weeks for an authorization. The MCO’s want a denial from Medicare when we determine the payer should be Medicaid. If they are not homebound our payer is the MCO.
- Iowa failed to plan the transition. They failed to have a plan, and they had a terrible implementation. The MCOs still are not sure what we do, our contract is signed, yet they still find reason reason to not pay us. They clearly do not “get” Title V agencies and their purpose and function. They are too hard line medical model in their thinking.
- Amerigroup in general, hard to get auths timely, hard to get amount of visits needed for home health sometimes, the keep changing their rules
- Several issues: Determining who the Case Managers are; poor communication with MCOs and case managers (few responses to e-mails or voice messages); receiving authorizations for services; getting paid in a timely manner.
- Consistency among the MCOs. MCOs understanding what Home Care is. Payment
- Problems with prior authorizations and receiving payment for services rendered. Also, difficulty with patients switching between the MCOs and having to redo all prior authorizations which may or may not change services for the patient. This creates a lot of confusion for patients and providers.
Getting paid by the correct fee schedule. Our payments have been delayed by many months. For some of the MCOs, we are still waiting for payments from almost 5 months ago.

The inconsistent information which was sent out. I have a printout from the Healthlink page dated March 31, 2016 which states No authorization needed by Home Health agency for Amerihealth Caritas. Found out later that was not the case. Amerigroup I have had no problem with, authorizations completed in timely matter and billing and payment has been fairly smooth. Caritas, as of this month, pre-authorizations completed and they now have the correct codes for billing and payments for July were correct-only took 4 months to accomplish! United Health care as of today still do not have the codes and payments correct I have a complete folder of email correspondence, since April. Today I received incorrect remittance advice again. I emailed contact today and asked if rates will be corrected or do I need to drop being a provider and notify patient of discharge! I have given them 4 1/2 months and they still are not reimbursing correctly!

Getting paid

claims denying for invalid reason(i.e. not covered under your contract and the service is), the requirement to have the primary EOB attached to the MCO claim is causing more work for our organization since we have to print the claims to attach the EOB. We can no longer submit them electronically. Rates are paying out incorrectly for our therapy services. We have to call the MCO's when we receive an RA. Multiple units of speech are not being paid out correctly.

From my perspective, as a provider, the local case manager’s “hands are tied.” Before managed care the case manager was able to help our clients get services in a much more seamless manner. That system made more sense to me as the community case manager knows the client, client's family and area resources best. I feel like I have had to educate the MCO's case managers the client, our local resources and even the managed care system.

Program was unnecessary in the first place. This was a political decision, not a well thought through policy decision, which is the most frustrating part. Now, way too complicated, costing us more to administer the program than ever before - weeks and weeks of staff time, provider efficiency damaged by constant authorizations, poorly planned and way too rapid roll-out.

No consistency in authorization process or billing processes between companies.

We have experienced problems at almost every turn. Simple challenges such as lacking NOD's, unpaid claims, partial paid claims, confused members, the system is too difficult for them to maneuver. Additionally, there

The agency has had difficulty in obtaining pre authorizations for care, that has resulted in no admission due to lack of authorization or delay of care for up to two weeks. This is also a violation with Conditions of Participation which results in a deficiency with Department of Inspections and Appeals. This includes mental health clients that need injections. Having to pay a private company to assist with billing.

We no longer have the relationship of working directly with the clients to set up service. Billing is a nightmare, no one to talk to to give clear direction, a lot of finger pointing as to who is responsible for answering questions that 4 months later are still unanswered as well as the time consuming and repetitive steps to take to get billing filed.

The inordinate amount of administrative time that has taken away from time spent on clients. Not only pre-auths but the billing process and constant follow through needed to collect payment for our services.

1. The pre-authorizations for home health visits as some of the authorizations have taken much longer than what we were told would occur. 2. We have one patient who is no longer receiving nursing or personal cares as the Medicaid support is now only for the cost of her Medicare coverage and she does not quality for Medicare to cover nursing and personal cares. After over 1 year of no hospitalizations, within 1 month of being discharged from Medicaid she has experienced 2 hospitalizations. 3. Major decreases in productivity of the nurses and management and loss of billable time to accommodate for the MCO program. HOURS of non-reimbursable time have been spent attending meetings, completing applications, completing certifications, trying to contact representatives of MCO’s to ask questions, having to explain to representative who we are and that we do have contracts with the MCO, requesting pre-authorizations, completing faxes for pre-authorizations, developing tracking mechanisms of when the pre-authorizations run out, how far in advance new requests need to be made so the authorization does not run out, and recording when the authorizations are finally received, and now we are having to contact to all of the MCO’s to add respite and immunizations to the current contract as no one was able to answer how these services were going to be implemented prior to the implementation of the program, and completing new contracts. This is NOT due to a lack of asking about how to address respite and immunizations services both in prior meetings and by emails. 4. Proper consideration for home health and public health services was NOT provided by the state or the MCO’s prior to the implementation of the program. I realize the
monies are in providers and hospitals, but Iowans still need home health and public health services with financially viable organizations to provide the services.

- So many people to deal with now with IME as well as each MCO. Also a lack of understanding at the MCO's (i.e. they talked as though all Medicaid coverage was waiver coverage)
- Getting credentialed correctly with each MCO to provide services. As a result of improper credentialing or "glitches" with the MCO payment systems; payment for services has been denied, paid incorrectly and/or delayed.
- Three set of rules and lack of communication between Iowa medicaid and coverage with MCO's.
- Contracting - Amerigroup has had our signed contract and supporting documentation since June 21, 2016. Even with followup, we are told that they are still in the credentialing process which takes around 30 days. We are now at 60 days and no response. United - We had an existing contract with them, but hey had us classified as a medical provider and not ancillary. We have worked with them to get this adjusted, which they claim is happening, but at this point in time, we are not able to bill for our services. AmeriHealth Caritas - this is the first one that we signed with and as of yet have not received any payments for services provided.
- The MCO staff uninformed regarding previous billing processes; poor knowledge of MCO staff with home health services and programs, misinformation given when calling customer support. No consistent processes with the MCO's. Patients have not understood the programs/payers.
- Authorization for services- such as not receiving auths in a timely manner and clients have break in service do the auth process. Payments and then resubmitting d/t each MCO's has their own form and process. MCO's have no consistent way visits vs 15 units. The MCO's do not want to pay for services. There is many hoops to jump through with the process. Going through 4 people for approval and still they do not understand. Sometimes you might get a foreign person or someone from the South in Mississippi or Georgia. I have experience this with United Healthcare. They keep moving case managers from one area to another specially Amerigroup - then the clients have to start with trust issues with them. Also Telligen is coming out to assessment clients if they need services.. Clients will get a letter or phone call and they very fearful of these people and state they are coming to take away my help, same with case manager. Case managers and Telligen do not communicate very well at all with agencies. Trouble is that MCO's opening up clinic's and home health agencies to compete with others that are established, so they do not have to pay the agencies that are doing the work for them. This is rotten. This is socialized medicine. The providers are very frustrated.
- Clients seemed overwhelmed initially with differentiating the three MCOs and some of them expressed that the communication was not thorough or timely. Some of our biggest concerns have been with reimbursement. All three companies do things differently and little assistance is being offered to help with the transition.
- Jumping through all of the different hoops and bureaucracies of the MCOs. The public thinks government is a red tape nightmare - HA! It seems like they were never satisfied with the documentation provided. This was primarily because they didn't have a nice neat category for Public Health Department. They are stuck in clinical care/sick care mode. Despite what they say about prevention and care coordination, their systems are not set up to handle it.

**QUESTION 4:**

*WHAT DO YOU FEEL ARE THE MAJOR DRIVERS OF THE ISSUES YOU HAVE ENCOUNTERED WITH MANAGED CARE ORGANIZATIONS?*

**RESPONSES:**

- Pretty much everything. Its hard to call and talk to anyone because you get a different answer every time (this is with all the MCO's). NPI's numbers are not matched up with what they should be. This has gotten better though. Payments are delayed. Services not reimbursed at the correct rate. The MCO's do not understand our programs and what they are. For instance Title V. Amerigroup thinks Title V services should be paid by the grant and not them.
- I don't believe MCO's were ready to tackle this large project in Iowa. I believe they have hired more staff to accomodate the caseload.
- It is a new process for everyone, therefore it has been a learning curve for everyone.
- MCO staff are willing to assist, however, knowledge levels vary considerably. Our clients are completely lost in this process - they have had difficulties in obtaining cards and determining which MCO is best for them - they actually don't know they have a choice. I realize information has been mailed, however, client notification has not created client understanding.
- Managed care organizations were not prepared or given enough time or guidance to prepare for Iowa's administrative rules, regulations and waivers.
- Im unsure
- Lack of planning/preparation in the launching of the MCOs in Iowa; MCOs are not knowledgeable of the needs of home health/public health services; the contracts issued were not specific for home health and public health services
- Poor decisions. Governor Brandstad.
- Unpreparedness. They had no idea what services were offered in Iowa outside of the large money billers. They were ignorant of any smaller service and how to handle it.
- Conflict..misunderstandings of rules and regulations..confidentiality issues...rejections
- Iowa was not ready for the switch and testing should have been done.
- Lack of knowledge/familiarity with the process by DHS, IME, and MCOs. Lack of ownership for answers when problems are encountered. Extra staff time is needed. Case managers who are not familiar with the individuals they serve. Members do not understand the whole system.
- Too many hands working with authorizations. One person on the phone might say one thing and call back with a different person and get a different answer. No continuity.
- Rapid implementation
- I feel the Medicaid privatization was implemented before it was fully tested and ready to go live. Iowa should have communicated with other states who have a system working effectively and built Iowa's system accordingly.
- The companies don't seem to understand the needs of the population. The process should have been started gradually, with only one group of Medicaid recipients at a time.
- Not organized; No specific communication system in place that works to address issues- when you call they are not able to answer questions and we are typically given another name and phone number to contact about issues- which often happens several times- feels like we are getting passed back and forth. We feel they do not really understand our services and provider types. When we go to trainings and meetings with MCOs present- its not their claims people or those working with us. Its usually marketing people who are not understanding our issues or have answers or can offer solutions.
- Automated processes that were not built to meet the needs of the service providers.
- push to do it so fast, lack of communication, staff not being trained properly or prepared
- Ignorance and cost.
- I think that it was too much too soon. The fact that this process was so fast moving in terms of RFP issue and implementation doomed the process from the beginning.
- Not being recognized as a screening center. 2. Disconnect between the MCO's provider services, MCO's upper management, IME/IDPH.  3. Inconsistency in payments/denials, etc...
- Money. slow to reimburse. Asking for more documentation for services prior to billing. Reimbursing at lower rates than Medicaid. Not responding to inquiries on payment denials. Their "members" still do not understand what an MCO is, yet, we at the local level are tasked with the job of explaining it to the Medicaid recipients with no reimbursement for doing the MCO's job.
- Too short a transition period. Not enough testing for problem areas that could have been prevented from developing. Many of these were both predictable and predicted. A feeling of inadequacy on the part of the system of those who serve Medicaid recipients due to a lack of training and solid preparation for the change.
- MCO's unprepared, IME unprepared, lack of communication between the two. And I am fearful that all these "hiccups" are the way Iowa intends to show "cost savings". If people can't access care, and providers can't access payment - lots of money is short term, at the expense of the health of Iowans, meaning long term huge increased costs, but that will be long into the future for most, after the savings have been "celebrated" by politicians.
- Multiple MCO's operating under what appears to be different parameters.
- Since the transition to managed care has been instituted to save money. I would say money is the driver.
- The MCOs not wanting to pay the bills so they could make it look as though they were saving dollars for the state.
The program was implemented too quickly. It should have been in the process for 1-2 years before rolling it out. The MCO's hired staff quickly and they are not knowledgeable about the program at all. Quite honestly, it is a mess.

Insufficient training for the MCO staffs!!!!!!!!!!! If they don't know what they are doing, how are we supposed to know what we need to do??????

I think Iowa should have set up what their preferred plan should look like and ask for bid from vendors to provide a consistent product.

Funding. The MCOs are approving less number of skilled nursing and home health aide visits than what is needed by the client and as ordered by the physician. MCOs are late in providing approvals after requests are made for authorization of visits. Requested approval for visits prior to cert period and do not have approval for SN visits provided thus far in the first part of the cert period. There seems to be a pattern for the number of visits approved - MCOs have only approved SN visits 1 x wk, and Home Health Aide visits 2 x wk, regardless of the health needs and services needed by the clients.

We hear that an announcement is coming that Medicaid payments will be less. The MCO's are being paid to manage this - I feel they are going to make sure they make a profit by cutting payments.

They don't understand what they are supposed to be doing regarding Iowa Medicaid laws.

They do not understand Title V. They do not pay according to the agreements. They are hard to communicate with. They are unorganized. We had to submit the same information to one MCO five times, to different people. We kept getting letters saying we had not returned calls. It was them who did not return our calls. I have begun thinking they just might be disingenuous!

Money

Poor organization on the MCOs part and understaffing.

Delay of Payment

Having inconsistent processes. With 3 MCOs plus the fee for service there are 4 different prior authorization processes and 4 different billing processes and they are all very inconsistent.

There doesn't seem to be any cohesive department or program overseeing this transition. Each of the MCOs runs their programs differently which is very difficult for small clinics.

I feel the three private insurance companies were not ready April 1st to take this on and it was politically forced. They should have had rates set to codes that are used for Medicaid clients. As I have stated to United this cannot be that difficult!

finances

MCO's not being prepared seems to be the biggest issue. For instance, rates are setup incorrectly and we are not being reimbursed as a rehab agency.

I am assuming that because the MCOs have contracts with the state, they get to employee their own case managers. It looks as though these individuals are "out there on their own", working from home and using their cell phones to field calls from members and providers. This is new to them and there are learning curves along the way.

Money is all that matters. There are local MCO staff that want to do the right thing, but it is all about the profit the companies can make.

Managed Care companies are private insurance companies and are going to focus on making money for their organization. The company may offer 'perks' to individuals for participating in what they offer but there is no follow up for whether or not they continue to live a healthy lifestyle (ie quitting smoking).

The MCO's and brokers did not adequately understand how Iowa operates the medicaid program differently than other states. While the state was prepared for the transition, no one else was.

Working with private insurance companies which each have their own way of handling clients. The insurance companies did not understand completing how Iowa Medicaid implemented services for the clients.

The major drivers in my opinion have been the staff at these organizations are not very helpful. I have been overly corrected by an MCO for accidently calling them by a different MCO name, when I apologized he let me know "well we are NOT them, we do things very different!" It is never easy to get assistance or questions answered, webinars have been scheduled for 90 mins to train but have taken about 20 mins, even when I have asked them to slow down as I can't take notes that fact to learn their process it has been ignored.

The speed to which they had to implement, financial implications and not enough time spent understanding Medicaid services/ providers in Iowa.
• Trying to make home health and public health operate under the same rules as hospitals and medical offices. Patients discharged from hospitals with wounds, intravenous medications, new medications, etc. are unable to wait 14 days for an approval. 2. A MAJOR lack of understanding what patients who have lower incomes, lack of education, absence of family and friends for assistance, and chronic diseases require to stay healthy and in their own homes. 3. Ignorance of what home health and public health provides and how they are different from hospitals and medical offices. 4. Lack of preparedness for implementation. 5. And, as always, money.
• Lack of MCO's knowing what Iowa Medicaid covered...I believe Iowa’s Medicaid coverage is much more comprehensive than many other states.
• Managed Care implementation occurred across too short of a time frame and included the entire Medicaid population.
• Lack of knowledge and communication. (MCO's) Time consuming to get services covered and paperwork involved.
• Response time to requests and communications. This change has effectively changed it from billing from one entity, to needing to comply with four separate ones. We have only completed test billing (a small amount to see what goes through) and have discovered that we are only receiving about 30% of what we should have received for services.
• Prompt and correct reimbursement. Lack of knowledge of MCO contact people and their availability and response time.
• It was rolled out poorly. The MCO's were not aware of how many people were receiving Medicaid services in Iowa. There is no consistent operation amongst the MCO's. Brandstad needed to visit with stakeholders and agencies what is concerns were and how we could solve the problem with the spending on this problem. This would of be wise thing to do. Gov Brandstad needed to be educated from the field on how this program was running and who we served and IME did not know all the answers.
• Mentioned it in #3 above. They are still a "sick care" organization. There is no incentive for population-based prevention. If you are not enrolled in their system, you do not exist.

**QUESTION 5:**

**HAVE YOU DISCOVERED ANY ADVANTAGES TO MANAGED CARE? IF SO, PLEASE DESCRIBE THEM.**

**RESPONSES:**

• No
• Not yet, as still working the bugs out. I established contact people with the MCO's from the start, so this is helpful to me to talk with same person each time on claim issues.
• We are getting paid more per visit with managed care.
• We are exited about the possibility of increased health promotion for clients - however, have not seen that in action at this time.
• Not at time.
• Absolutely none
• No
• Not as of yet. The hits just keep coming to hurt providers and patients.
• None.
• Not at this time.
• None at the present time.
• NO!!!!
• no
• No
• It requires people to consider if they really have a true "emergency" before they go to ER, or they may be required to pay something.
• Transportation for clients seems to be more available and easier to navigate then when we had to use the TMS
• No
• No.
• I think that there are way too many issues right now that need to be ironed out before I can say that I see advantages, although I understand that there will be positive things related to managed care once the dust settles.
• From a billing standpoint we appreciate the ability to file claims via an online web portal, and from what claims we do receive, the remittances are easy to interpret.
• Not yet.
• I think that “managed care” as a model has a number of merits. It improves continuity of care and reduces fragmentation. It assists those living in a gray world to access services for a black and white system. There is acknowledgement of those gray areas and a desire to work towards outcomes rather than within rules. I believe in managed care as a medical concept. I am discouraged by politicians confusing privatization with managed care. They are not necessarily the same and in Iowa I believe this implementation of managed care will not succeed for some time if ever.
• none, except people in Iowa no longer take Medicaid for granted as a way to keep Iowan’s healthy.
• No
• no.
• No
• Difficult question, I usually only see individuals that are having difficulty. Some of the prescription drug coverage has been better now that initial claim submission issues were resolved.
• We have one MCO that we are getting better reimbursement from than we did with Medicaid. That is the only advantage I can see. But for the most part, payment is difficult to get and is never right.
• NONE!!!!!!!!!!!!!!!!!!!
• Not yet.
• None. Have not seen it. Case managers need to call and respond to our request for authorization, and consider the individual client needs.
• More people are covered, but I believe that is going to be an issue, as the MCO’s realize what this is costing them.
• Not yet, but I'm hopeful. When they discover home health is their friend I think we will see change.
• Not yet. I will keep looking.
• They are looking more at what is being done for the patient to cut down on fraud which I actually feel is good
• I haven't seen any advantages yet.
• The local case managers have been helpful for a few patients.
• None. This has created barriers for patients so I would imagine it will be a financial savings for the state in the short term but in the long term I do not see this being a benefit.
• Not yet.
• Absolutely not!
• No
• At this time, no. It has been a difficult transition for our organization. It took us over 3 months to get reimbursed for our skilled nursing services and we continue to receive denials and incorrect reimbursement for our therapy services.
• Yes. I understand that members will have more access to services, specifically preventive services. We have one client who is a double amputee, not able to get on a Ill and Handicap waiver because he does not require help with personal cares and too young to be on the Elderly Waiver. He would benefit from a Life Alert but cannot afford one. I am told he can get one, that Amerigroup provides that benefit to their members. Secondly, we had an Amerigroup representative make a visit to our office and I was impressed with the preventative benefits they offer.
• None are yet apparent
• We did have experience with one case manager who was truly trying to get services in place for an individual.
• The members now have access to private/for profit transportation options. This provides more options but comes with an increased cost.
• United Health Care not requiring prior authorization for home health services, so there is no delay in care for those clients.
• NO
• Not yet at this stage of implementation from a provider standpoint.
I am sure we will have advantages in the future as right now we are dealing with frustrations.
Not yet, but am optimistic.
Any time there is change service quality and processes are reviewed.
Delay in patient care by MCO’s-ETC eligibility, patients not getting medication and Increased use of ER services, because families not sure what to do in many cases due to lack of coverage.
The local staff have been friendly and willing to listen, but many times this goes no where.
Potentially we can see that some unnecessary may have been provided, a checks and balance system MAY have been needed.
I think it has helped with people not going to the Emergency Department for little concerns. Makes the individuals empowered and aware of their health issues and do more prevention. This is helped by some good case managers in the fielded.
Let me think, ummm, NO.

QUESTION 6:
WHAT FORCES ARE WORKING FOR US? HAVE THERE BEEN POLICY CHANGES OR STAKEHOLDERS THAT HAVE BEEN HELPFUL? WHAT PROGRESS HAS BEEN MADE?

RESPONSES:

- I am unsure about this.
- IDPH and IME have worked with us to make MCO’s aware of MCAH services. Coalition has worked on the DHS side of things and been very helpful. Many meetings prior to implementation of MCO’s were attended by staff and Provider Annual Training is in process currently.
- Trial and error and lots of patience has been my solution...It has gotten better for me.
- We have experienced positive interaction with community reps from all 3 MCO’s. They are trying to provide a link between Public Health and their facilities - we have appreciated their assistance.
- N/A
- None
- I believe that IAHC/IHA are working to trying to make legislators aware of the issues with the MCOs. I don’t believe that there has been much progress in resolving any of the MCO issues.
- No forces. No progress.
- After 5 months payments are starting to come through, however, none of them are correct. It is going to be a nightmare for billing and finance departments to reconcile.
- I wish I could say positive issues have happened but I can only say there is so much confusion
- some payments are coming correctly now. Not all of them thought
- Persistence on our part. Agency staff make numerous follow-up calls in order to get answers and advocate for the members (clients).
- NONE
- uncertain
- Ombudsmen/legislature trying to work for those affected, however this is slow and I’m not fully convinced of much progress yet.
- I’m not really aware of this.
- Not sure at this stage.
- There are representatives within each of the MCO that are truly trying to solve the issues; but at some point, just hearing the issues are “known issues” is not enough.
- None
- To my knowledge, there is very little support for us by anyone that can affect change.
- IDPH has been trying their best to advocate for us, as well as local legislators such as Pam Jochum and Liz Mathis. However, it seems like no matter what is said or how much advocacy happens, it doesn't matter. The
overwhelming response from the MCOs seems to be "well too bad; this is how it is." Hopefully one day people won't feel like they are wasting their breath when voicing their opinions and struggles.

- We appreciate Janet Beaman from IDPH working with us and MCO representatives to navigate us through this transition.
- Keep filling out everybody's survey to asking how we are doing with the MCOs.
- There is a feeling of frustration and in many cases anger on the parts of both providers of services and consumers. This common drive is improving, albeit slowly, our sense of team and networking is improving by necessity. I have yet to see any policy changes that are particularly helpful and I have not seen any real dialogue with State DHS in terms of where the problems lie. I believe we have good people here in Iowa ready and capable of fixing some of the problems. We need to acknowledge the problems to do so.
- Lesleyann Christenson and VNS of Iowa have been very helpful in bringing stakeholders together with the MCO's to try to resolve issues.
- There have been some additional services that have been covered, that Medicaid didn't always cover before such as substance abuse treatment. I do believe it is easier for individuals to contact their MCOs directly, was more difficult process with Medicaid in an area with no Department of Human Services office. I am not sure that the transition for most was as much of an upheaval as what they individuals thought it would be and for probably a majority was fairly seamless.
- It was helpful to have a single contact person assigned for each MCO that we could ask questions. However, they are extremely busy. I have one that doesn't ever answer my emails.
- Little progress!!!!!! At least we are receiving payment on SOME of the claims.
- Unsure!
- The IHA is collecting information, as hospitals are being reimbursed for less.
- Not feeling good about much of anything with them
- They have decided to go with the medicaid rules which they were refusing to do in the beginning
- I'm not seeing progress at my level.
- None noted. Clarification that comes from IME is specific to fee for service and has not been useful for the 3 MCO requirements that are consistently changing.
- I am a part of a Rehab Agency group that consists of providers from across the state. We have been able to help make some small changes but it has been a slow process.
- We had a site visit for re-enrollment, the outreach coordinator had me email my issues so she could send on to appropriate person which was helpful. The local representatives for United and Caritas have basically been of no help!
- Unknown
- We are working closely with our MCO provider reps and they have been working with their teams to get the issues resolved.
- I am skeptical of Governor Branstad's motives in implementing a reorganization of this magnitude without a vote from the legislature and in such a rush. He doesn't seem to really care about this state anyway, so I have a hard time trusting him to begin with. I am not so naïve that I don't think he could have personally benefited from managed care somehow. I truly hope that we are able to save $$, but I don't see how that is possible when there is increased bureaucracy and individuals on the payroll of the MCO's.
- The Iowa Primary Care Association has been trying to keep communication open with the MCOs and IME. Some local MCO staff do try to help, within their own limitations.
- Focusing on living a healthy lifestyle is working to some extent but the individual still needs to be committed to being accountable for their own health. There should be a uniform, easily understood insurance plan with uniform authorization and billing processes.
- IME staff has been helpful when we reach out to them.
- I have not seen any yet.
- Collaboration of providers and clients have been supportive and helpful although any comments or positive suggestions for improvements do not seem to go anywhere.
- United Healthcare Community stopped pre-authorizations
- Still pretty confusing. I think the idea that the MCO's are going to do case management/care coordination for their clients is great -- have yet to see this happen effectively but it is very early.
- As a result of Medicaid Modernization, a Medicaid Modernization stakeholders group was formed and has representation from community agencies, hospital systems, providers, the MCO's and IME. The stakeholders in
this group have worked together to identify issues during the transition and provided feedback to the MCO’s and IME.

- It helps to get together as a group to identify, the same problems across the board and address them.
- I cannot identify any
- Representative Dean Fisher, Iowa Alliance in Home Care, Marna Mitchell-Butler with Independent Insurance Services. Quicker response to issues have taken place with their assistance.
- Our agency is working on some updated policy changes.

**QUESTION 7:**

**PLEASE SHARE ANY OTHER THOUGHTS YOU HAVE HERE ABOUT HOW WE CAN MOVE WITH MANAGED MEDICAID IN A POSITIVE DIRECTION.**

**RESPONSES:**

- If they were more similar in practice it would be helpful. Train their staff to be able to answer questions in a correct manner every time. Pay quicker. Clearer remittances, authorizations straightened out, payments in full. Title V explained to them.
- I think we have to stay positive. It will work out. The media adds to the gloom and doom of the situation. I think contact people are very important for providers and the ones I have been working with have been helpful. I have had a slow response from Amerigroup, however and it was frustrating the first few months, but think this is better now. MCAH Title V Agencies have been a challenge for MCO’s, I believe, as they did not know how to set us up in their systems.
- Keep providers informed with information and changes.
- Payment for services, Efficiencies of authorizations, Trainings, One collective operating system.
- We have not seen that patients have seen the "managed care" or care coordination of care by MCOs. The issues and problems have well outweighed the benefits.
- A person's total health is essential to substantial life. Poor government decisions have taken this away from Iowans. It has caused Iowa-based businesses to go in the red and pushed to the brink of closing their doors. Iowan's have lost their jobs. It has forced some Iowan's away from their primary doctors because contracts were not agreed upon. It has caused fear in low-income Iowa families when they are unable to find a doctor/dentist that will accept their children when sick. Sometimes we make poor decisions and we have to admit it.
- Educate, educate, educate. All provider reps and anyone who answers a help line needs to know how to bill and how to problem solve. We are receiving incorrect information every time we call.
- My vote is to go back prior to MCO’S and Obama Care...I have been here over 30 yrs. and financially this is the worst we have ever been!
- No preauthorization. Streamline the billing process. We spent additional money in order to process the claims.
- The three companies need to allow the same paperwork. Could it go through a central location and then out to the MCO?
- You took a system that worked relatively well and made it into a system that is not widely accepted and has flaws.
- Listen to people, both recipients and providers of care. Educate people.
- It would be nice to have an effective communication system in place with each MCO with direct answers and assistance with our claims processes.
- The MCO’s could work together to establish consistent practices instead of each on having their own method. We could offer the same service to three clients and have one MCO demand we bill in 15 minute increments, one that would demand we bill in hour increments and another who pays us a capitated amount regardless of time....communicate and come up with the same standard for internal processes or let the state establish what they should be.
- The timeliness of claim payment is much worse, errors in processing has great increased,
- All directions, even best case scenarios, involve providers having to support more cost with less revenue. How can there be a positive direction?
- COMMUNICATION, EDUCATION, FOLLOW THROUGH, TIMELY/CONSISTENT PAYMENTS.
- I sincerely believe their job is to not pay a claim. That is the only method they have in order to show they are saving money. I cannot fathom how adding another layer of bureaucracy would save any money. I do understand
the need to scrutinize claims prior to payment. This could have been done within the system prior to MCO's. As public health we are mandated to take care of the vulnerable population, reduce the barriers to care and eliminate the social determents of health. Pretty hard to do with reduced funding.

- Stop pretending that this has gone well and that any of the people intended to benefit from these programs are actually doing so. Managed care is started and there is no way to go backward at this point as the previous system is largely dismantled. Let's sit down with our eyes wide open and address issues and work on road blocks that are preventing optimal outcomes.

- There are theoretically lots of ways, but they are no where close to the currently reality. (Care coordination for those with chronic illness, etc.)

- There are programs and services that have built a strong relationship with Medicaid that is unlike other states and had much success in protecting the health of children and family and lead to life long positive health outcomes. Those services should be carved out. Screening tools are best completed face to face. I believe there is a conflict of interest when the payor is the one identifying the need for referral and additional service such as a depression screening for a pregnant woman.

- I believe if they would just get some providers paid and stop giving providers and individuals the run around when they try to get services approved, that would be a big step. If assignment to an MCO would be looked at closer so that families would not have to deal with more than one, that would be of great help to the individuals we serve.

- When we call you and ask for something, get it to us. Don't say "You need to call another department." Assign more people to work one on one with each county agency to resolve their problems now so we don't continue to have problems in the future. Again, we need knowledgeable people and people who will reply promptly!

- Scrap the whole plan and start over with ONE organization!

- It takes more of my staff time to call for approvals, to call back again when approvals not obtained, to follow up and make more phone calls to the MCOs when they do not respond to our requests; and to then figure out what to do when the MCO does not approve all the visits and service needed by the individual clients. It would be helpful for the MCO case managers to call and respond to our requests for authorization in a timely manner, and to consider the individual client needs. Also requires time by our staff to audit EOBs to figure out if the agency received the full amount billed, or only a partial amount billed. This increases our agency cost for providing the care.

- The three MCO's could work on a more unified approach. I realize this is new and I am usually willing to adapt, but the process has not been clean. We still have families without cards and the MCO says the families have them. Others received 6 of the same mailings.

- They could learn about Title V They could pay according to a coating mechanism and the contract They could quit creating barriers to care and screening in order to avoid having to pay

- Get more timely auths, get confirmation of those auths without having to contact them

- Education about Home Care, Hospice, Public Health services and the guidelines for services.

- Preference would be to have universal billing practices and universal prior authorization processes.

- I would like to say that, after the decision to change to MCOs, I decided to close my clinic that I have owned for the last 6.5 years. My clinic was acquired by a larger company as I feel that they will be able to weather this transition better. In order for this transition to progress more smoothly in the future, I believe that there needs to be more cohesiveness between the various MCO and better communication for providers and consumers.

- As I stated the billing seems to be a major issue. United needs to talk to Amerigroup about codes for Home Health and reimbursement. I had no problems with Amerigroup and Caritas is now correct in reimbursement. United is such a mess we may not be a provider for them.

- We have had one admission already because a patient could not get their BP meds. If the PA process were changed to something like "Academic Detailing" (to manage med costs), it could be far more successful for all participants, especially the patients..

- It is not just with Medicaid, but with health care in general, but the reason health care expenses are so high is with all the hoops you have to jump through amount of time to get authorization and then bill for service. We spend so much time doing the paperwork and billing. The actual time spent providing good service is small relative to the amount of time spent on supporting services. Being Public Health as well as Home Care, our philosophy is providing good service and making ends meet more than making money as the free enterprise system allows.

- It would be helpful if we had some type of grievance line for providers, so IME could accurately track problems, concerns, issues with the MCO/Brokers. As it is now, our recourse is only to work with them and/or end contracts.
• I would strongly recommend that all three companies follow United Health Care, by not requiring prior authorization for home care so that services may start immediately.
• Train staff in customer service, streamline billing to something less repetitive and less time consuming.
• Standardizing policies and procedures for billing would save all much time and effort.
• Keep lines of communications open. The MCO staffs have been very helpful and polite--I hope that continues. Standardize authorizations—some MCO's are moving to approving visits for the length of the care episodes which helps the nurses tremendously. Provide education to MCO’s about home health and public health.
• I would like to communicate with and partner with MCO's and get their support on moving forward to address population health issues in our county/state. In turn, the population they serve may be able to be healthier overall.
• Credentialing, contracting and payment issues need to be remedied as soon as possible.
• I feel that there is alot of unknowns and families that have fallen the cracks. I'm really disappointed for the families who lack of knowledge and where to turn might not be getting the help that they need. I don't think it was implemented as well as it could be.
• This is been a long term challenge. It would have been beneficial if in the development of the RFP if IDPH had had focused conversations with DHS and included wording that outlined what they public health system was providing within the state. This would have included the Maternal/Child Health, Immunizations, Disease prevention and other strategies. It is now appearing as if there is a strong interest by the MCO's to cherry pick what population based approaches they are interested in implementing, but only providing these to their members. This is resulted in a changing target for public health and also a weakening of the infrastructure of the PH system.
• No pre-authorizations; standardized billing for all 3 MCO's for waiver type services & traditional home health services.
• The best way is to have consistently across the board with visits/units, coding, auths, payments system.
• The MCO's need to look beyond their enrolled populations. They need to cooperate to address the environmental and social constructs which keep people unhealthy.