Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2019, Quarter 4

(April-June)

Performance Data

Published October 9, 2019

Department of HUMAN SERVICES

CONTENTS

EXECUTIVE SUMMARY

Legislative Requirements:
This report is based on requirements of 2016 Iowa Acts Section 1139. The legislature grouped these reports into three main categories:

- Consumer Protection
- Outcome Achievement
- Program Integrity

The Department grouped the managed care reported data in this publication as closely as possible to House File 2460 categories but has made some alterations to ease content flow and data comparison. This publication content will flow in the following way:

- Eligibility and demographic information associated with members assigned to managed care
- Care coordination related to specific population groupings (General, Special Needs, Behavioral Health, and Elderly)
- Consumer protections and support information
- Managed care organization program information related to operations
- Network access and continuity of providers
- Financial reporting
- Program integrity actions and recoveries
- Health care outcomes for Medicaid members
- Appendices with supporting information

This report is based on Quarter 4 of State Fiscal Year (SFY) 2019 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

- Amerigroup Iowa, Inc. (Amerigroup, AGP)
- UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare, UHC)

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS®[1] CAHPS[2], and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However,

[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a standardized, nationally-accepted set of performance measures that assess health plan performance and quality.
[2] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized, nationally-accepted survey that assesses health plan member satisfaction.

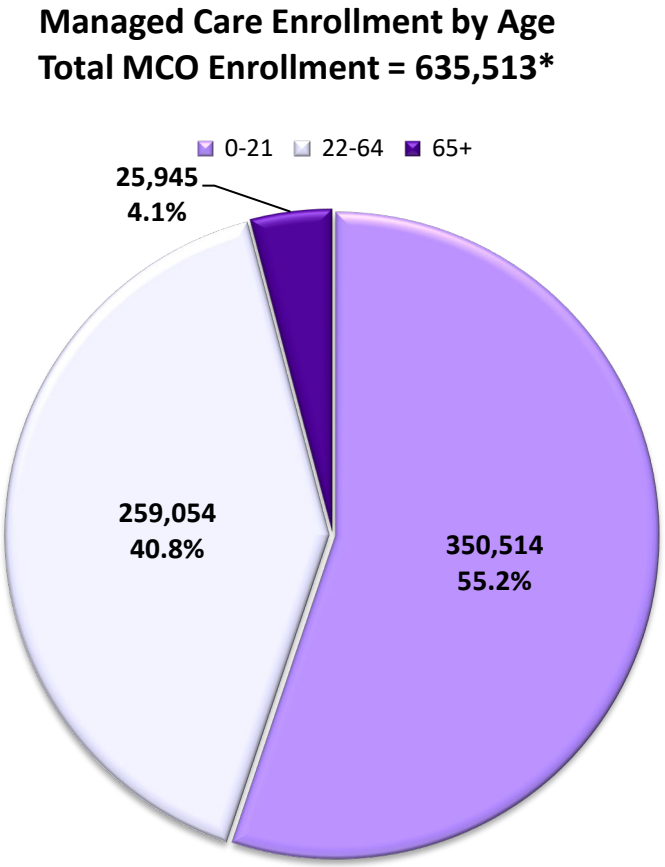
based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available Fee-for-Service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.

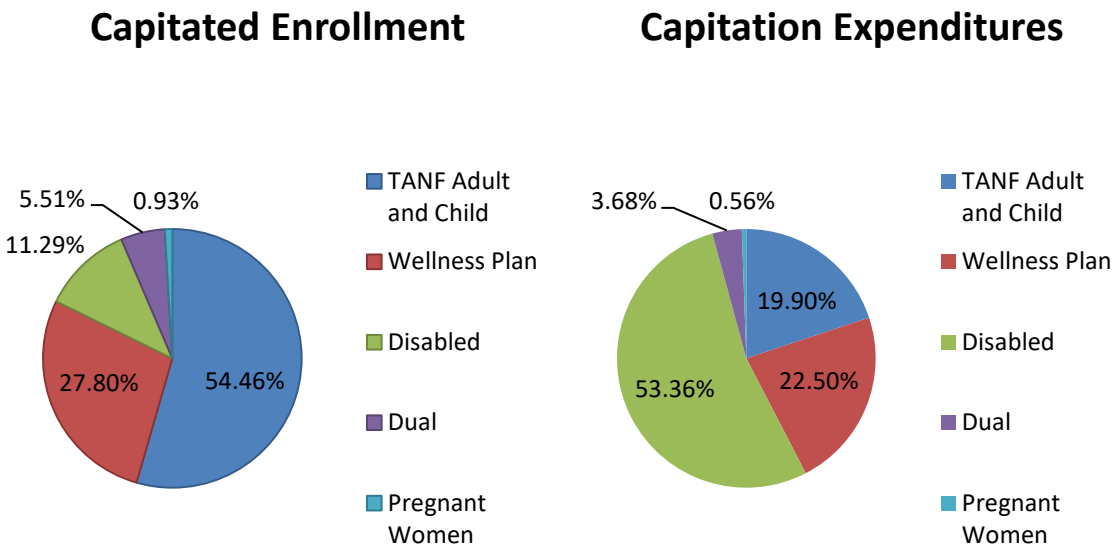
More information on the move to managed care is available at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization.

Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink.

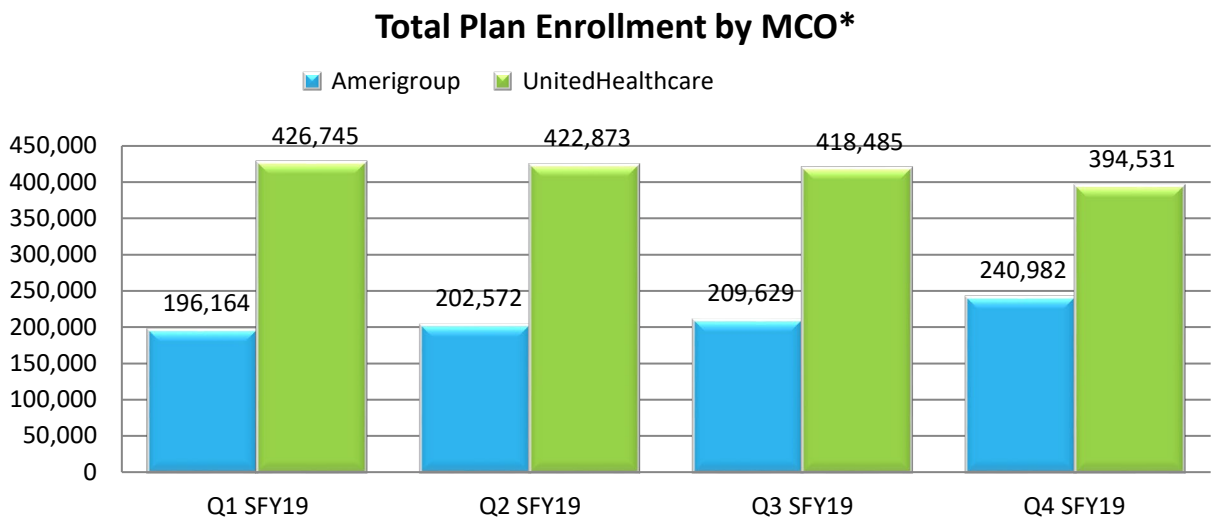
PLAN ENROLLMENT BY AGE



*June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes Hawki enrollees. 56,074 members remain in Fee-for-Service (FFS).

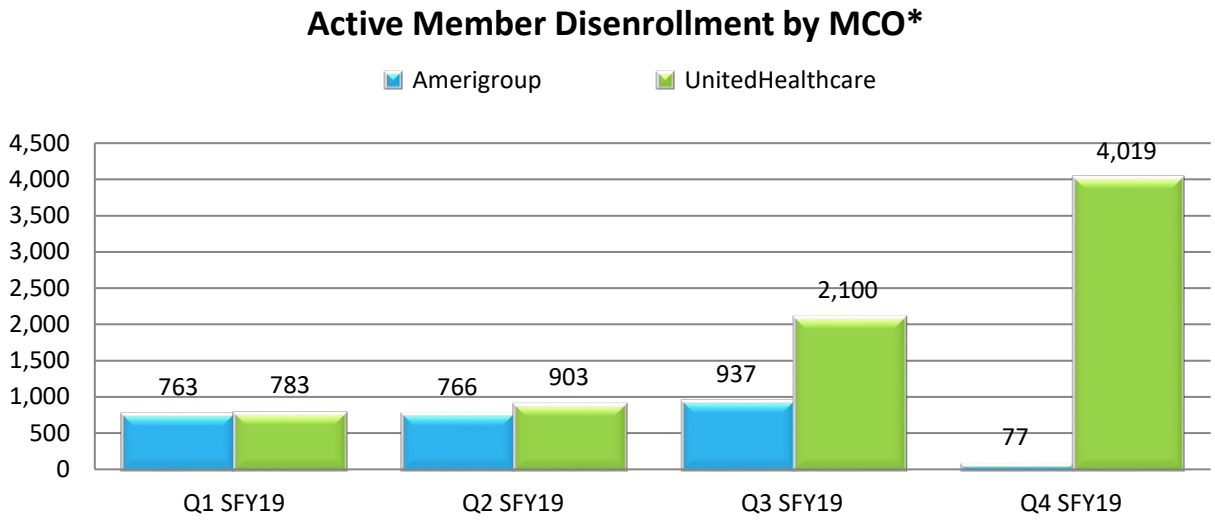


Plan Enrollment by MCO



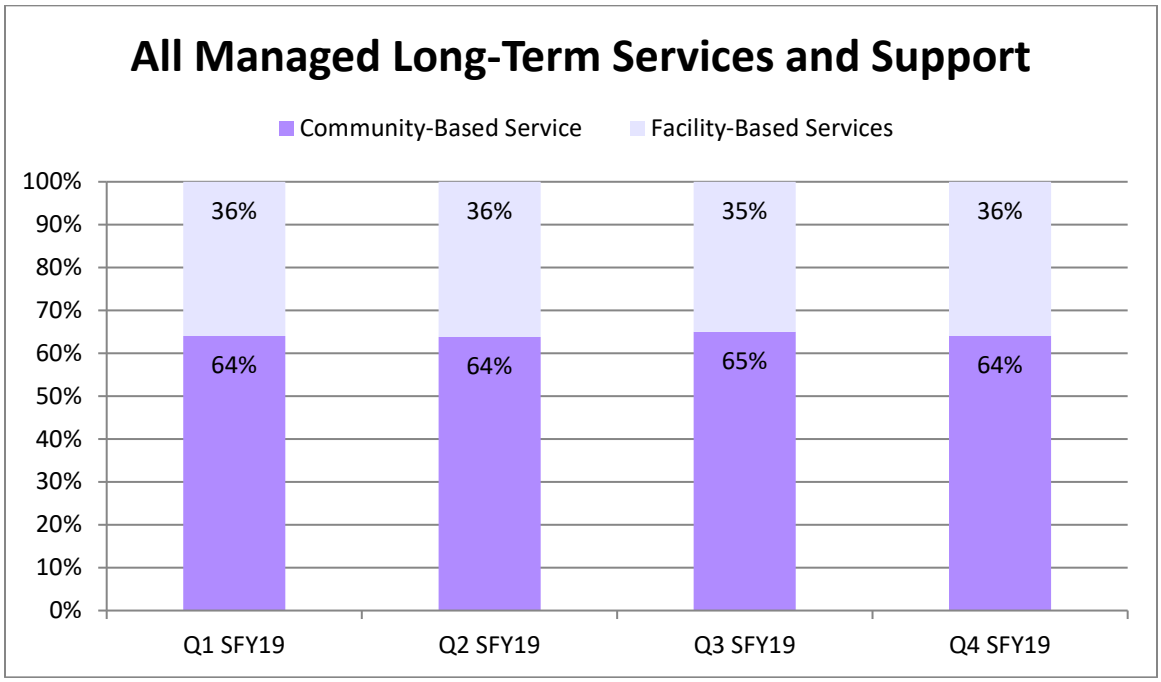
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Plan Disenrollment by MCO



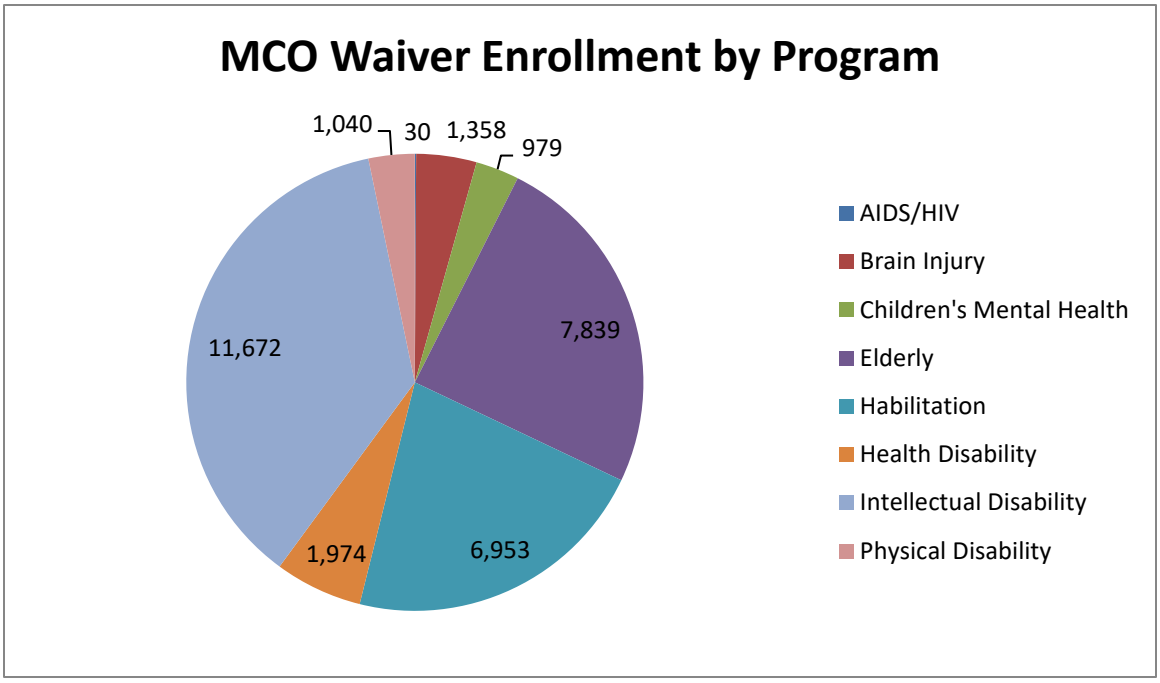
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

All MCO Long Term Services and Supports (LTSS) Enrollment



Information on individual waiver enrollment and waitlists can be found at the dedicated webpage: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

All MCO Home and Community-Based Service Waiver Enrollment



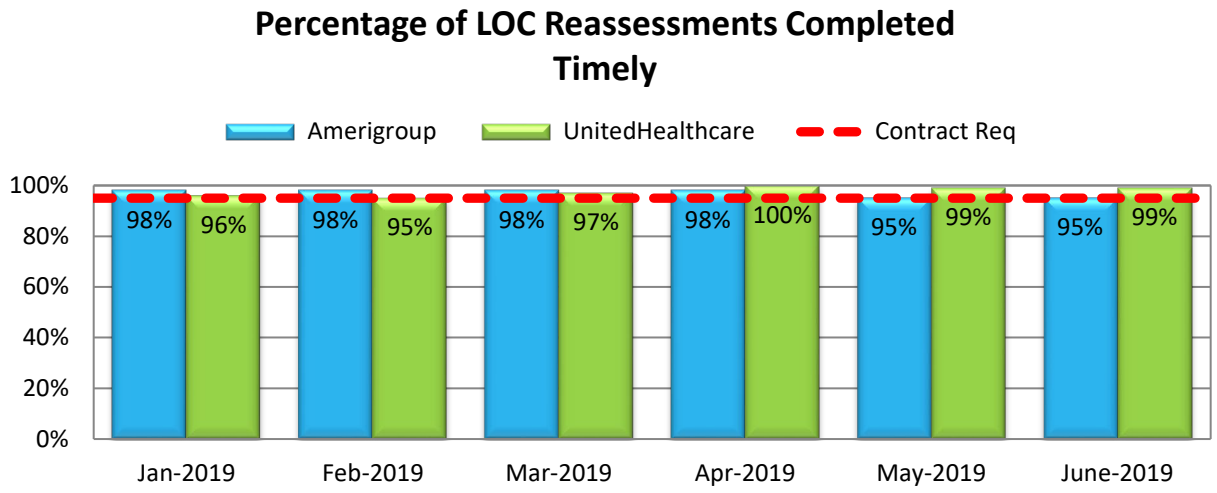
CARE COORDINATION AND CASE MANAGEMENT

Average Number of Contacts		
Data Reported as of June 30, 2019	**Amerigroup**	**UnitedHealthcare**
Average Number of Care Coordinator Contacts per Member per Month	2.1	0.4
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.1

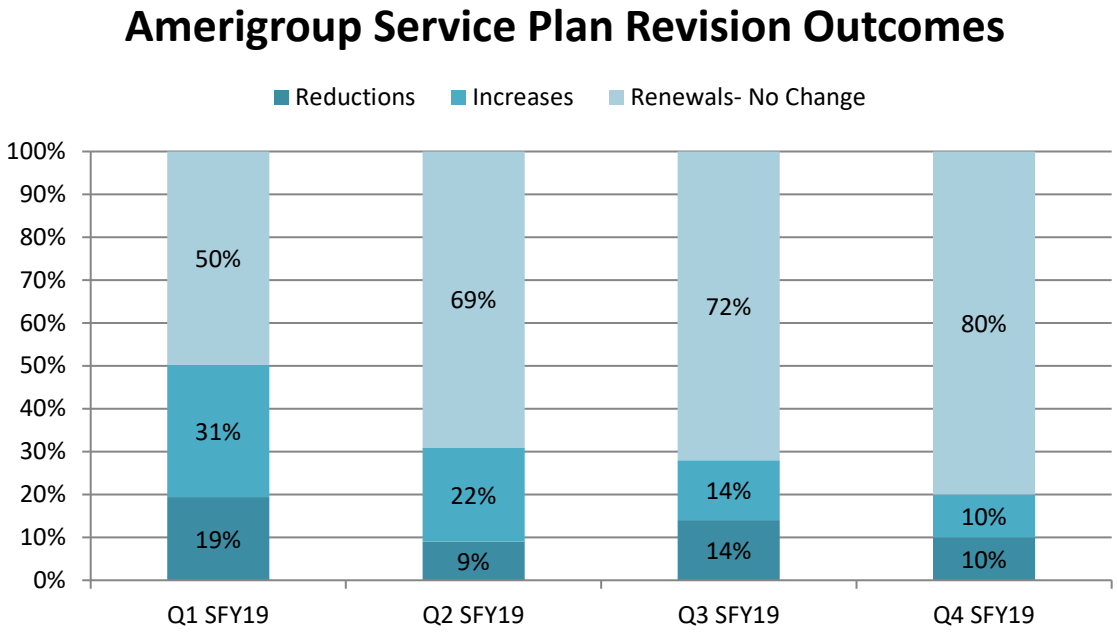
Member to Coordinator Ratios		
Data Reported as of June 30, 2019	**Amerigroup**	**UnitedHealthcare**
Ratio of Members to Care Coordinators	9	130
Ratio of HCBS Members to Community-Based Case Managers	64	95

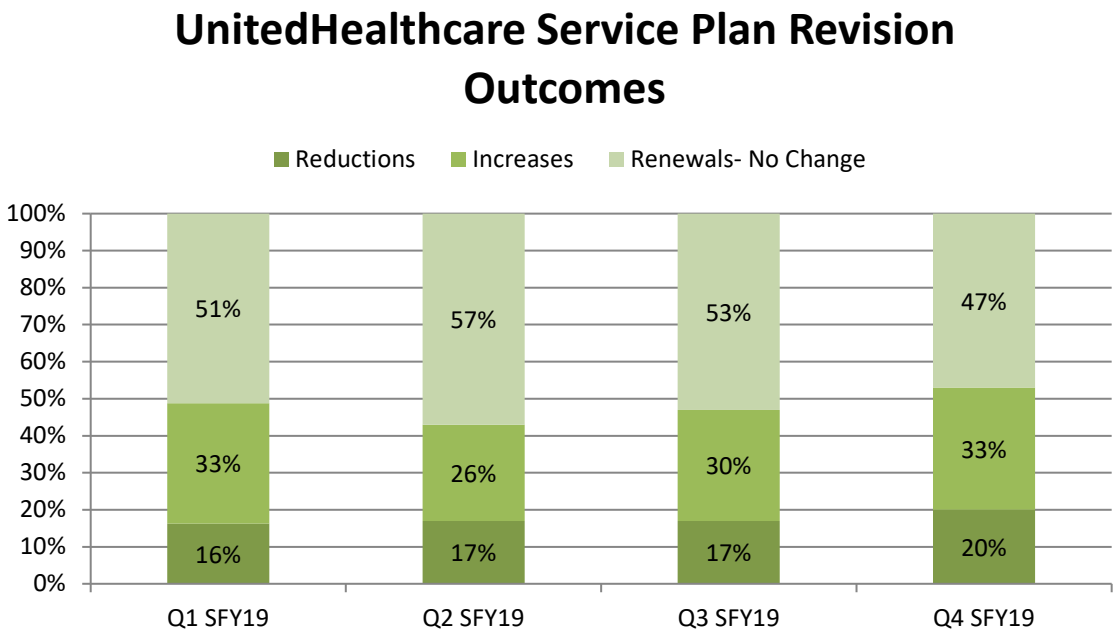
Level of Care

Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change.



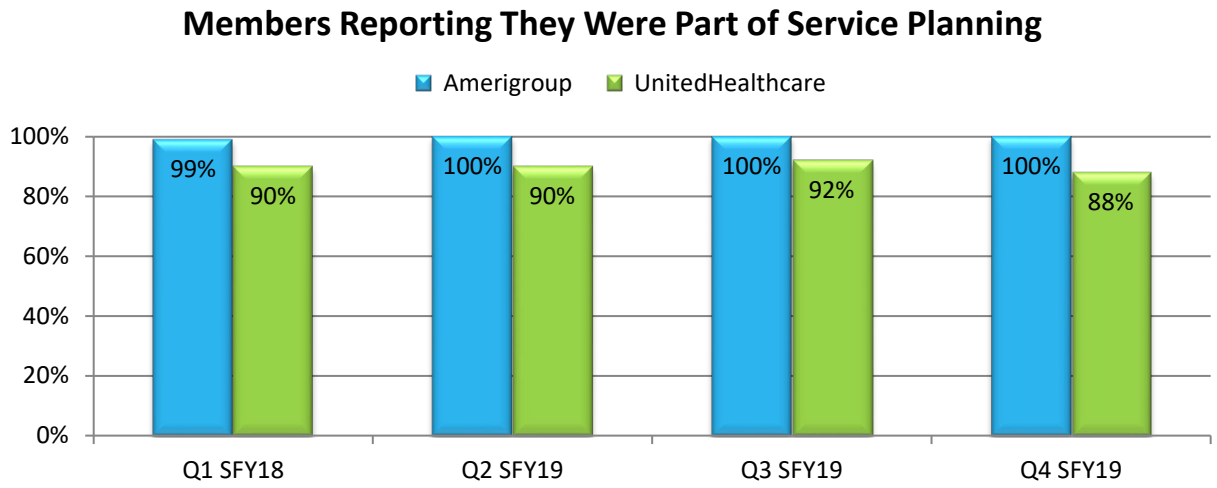
Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving Home and Community Based Services (HCBS). These are new measures for SFY 2019.

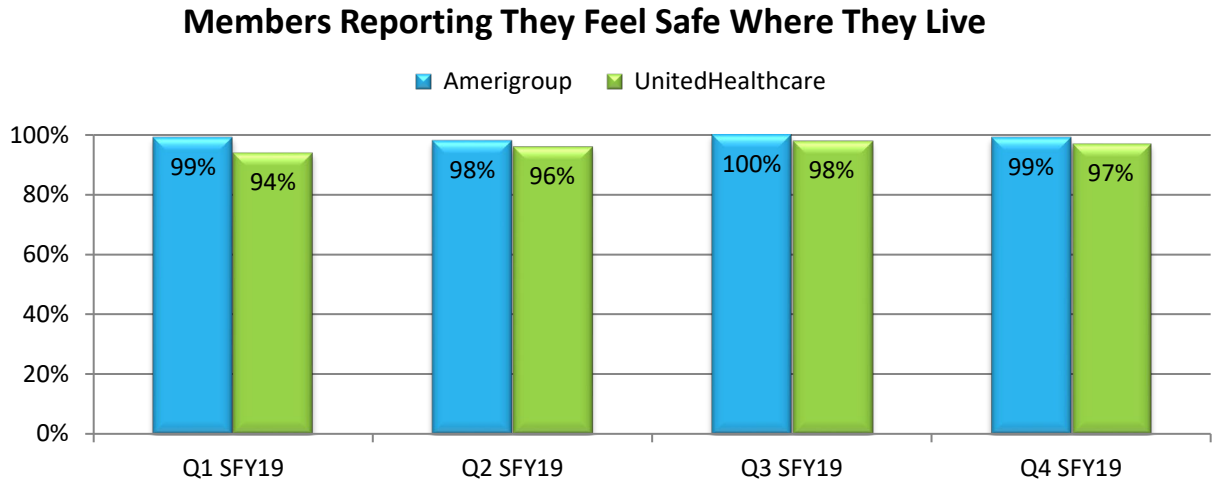


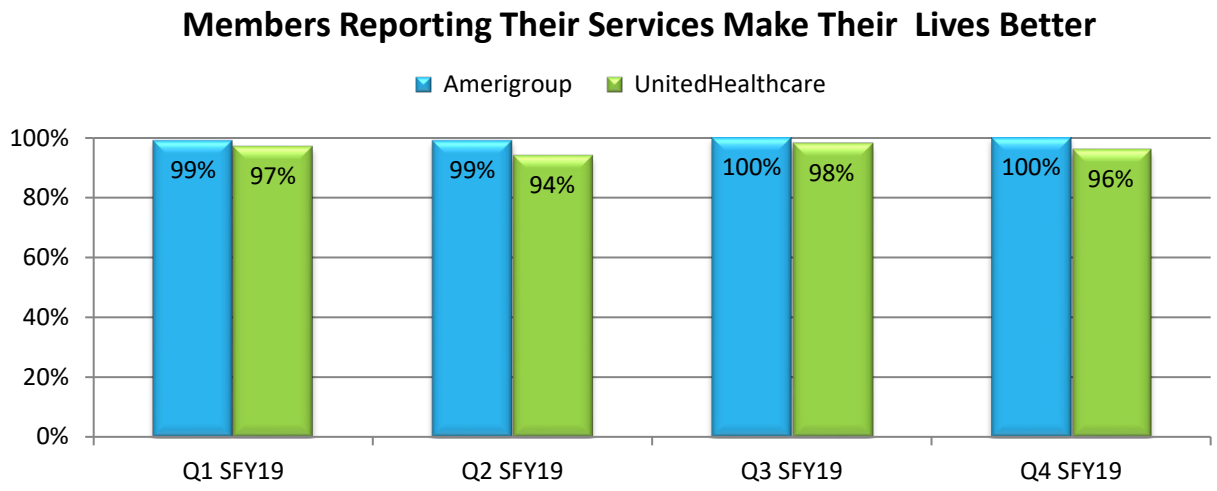

UnitedHealthcare Service Plan Revision Outcomes
Reductions
Increases
Renewals- No Change
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
51%
33%
16%
57%
26%
17%
53%
30%
17%
47%
33%
20%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

Iowa Participant Experience Survey Reporting

The data below reflect the results of Iowa Participant Experience Survey (IPES) activities and results. IPES results are one component of the Iowa Department of Human Services Home and Community Based Services quality strategy. Surveys are conducted to achieve a statistically significant representative sample by waiver with a 95% confidence level and a 5% error rate. Percentages reflect the number of survey responses in the quarter from all applicable waivers indicating "yes". Other valid survey responses include "no," "I don't know," "I don't remember," and "No/Unclear response."






Members Reporting Their Services Make Their Lives Better
Amerigroup
UnitedHealthcare
100%
80%
60%
40%
20%
0%
99%
97%
99%
94%
100%
98%
100%
96%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

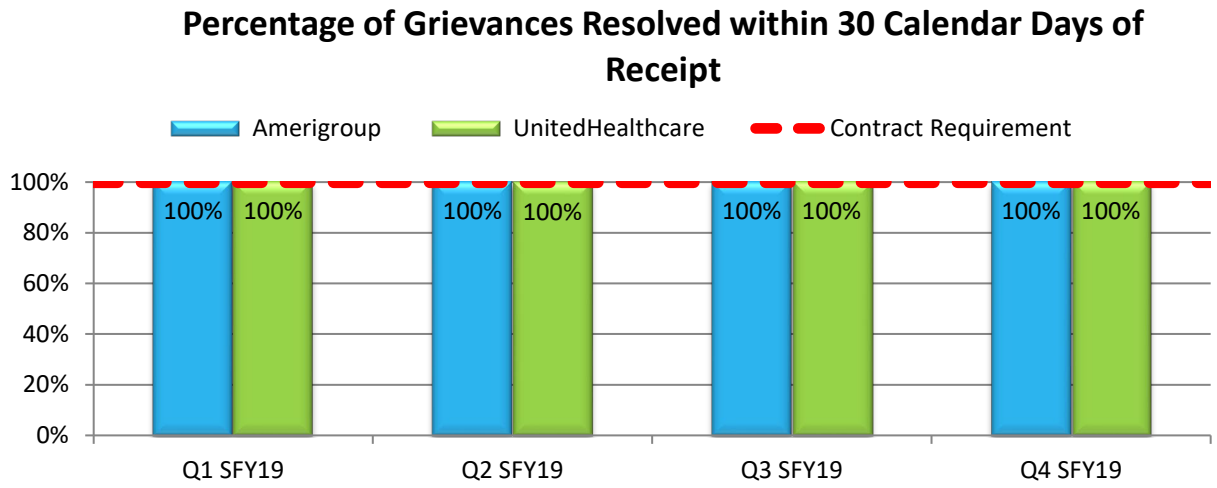
MCO Member Grievances and Appeals

Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the MCO.

Grievance: A written or verbal expression of dissatisfaction.

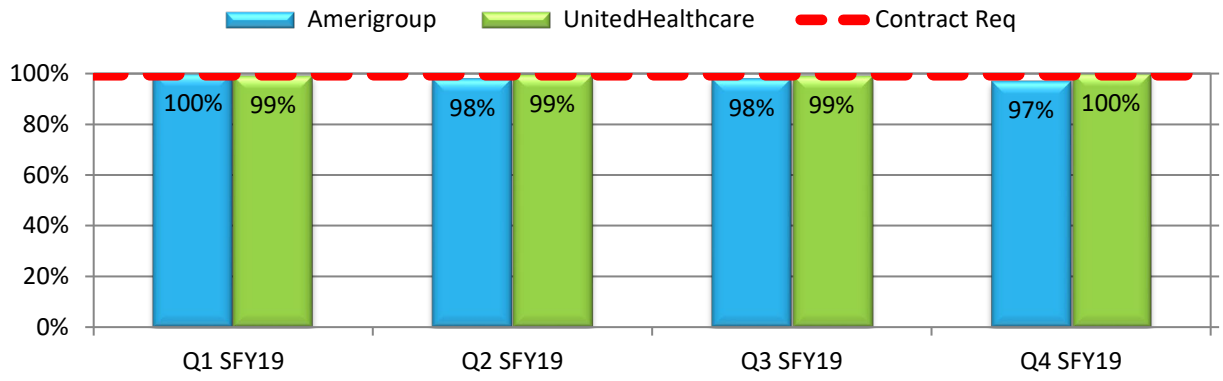
Appeal: A request for a review of an MCO's denial, reduction, suspension, termination or delay of services.

Resolved: The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.



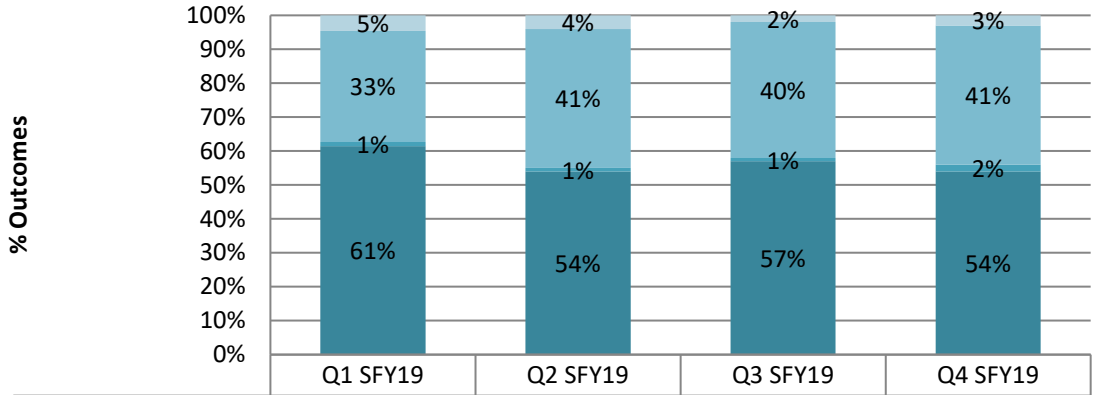
Supporting Data				
	Amerigroup		UnitedHealthcare	
Metric	**Count**	**% Pop**	**Count**	**% Pop**
Grievances Received in Q1 SFY19	228	0.10%	471	0.10%
Grievances Received in Q2 SFY19	280	0.13%	474	0.10%
Grievances Received in Q3 SFY19	314	0.14%	307	0.07%
Grievances Received in Q4 SFY19	248	0.09%	205	0.05%

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



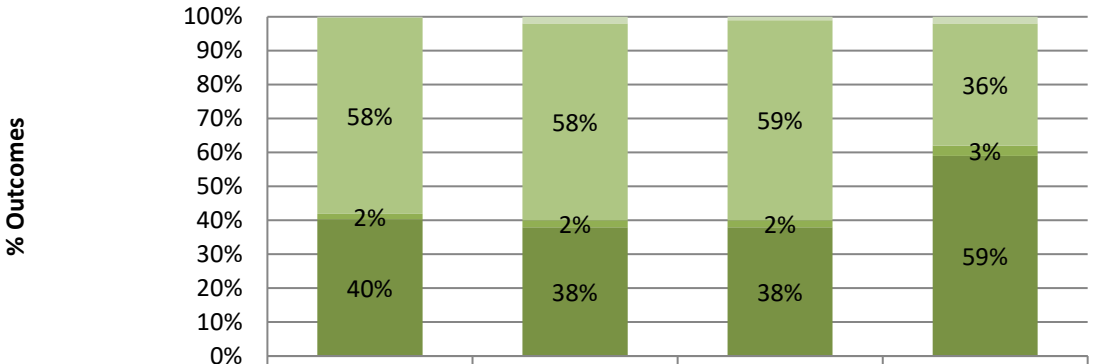
Supporting Data				
	Amerigroup		**UnitedHealthcare**	
Metric	**Count**	**% Claims**	**Count**	**% Claims**
Appeals Received in Q1 SFY19	285	0.01%	385	0.01%
Appeals Received in Q2 SFY18	239	0.01%	317	0.01%
Appeals Received in Q3 SFY19	233	0.01%	252	0.01%
Appeals Received in Q4 SFY19	211	0.01%	225	0.01%

Amerigroup Appeal Outcomes



	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	5%	4%	2%	3%
Upheld	33%	41%	40%	41%
Partially Overturned	1%	1%	1%	2%
Overturned	61%	54%	57%	54%

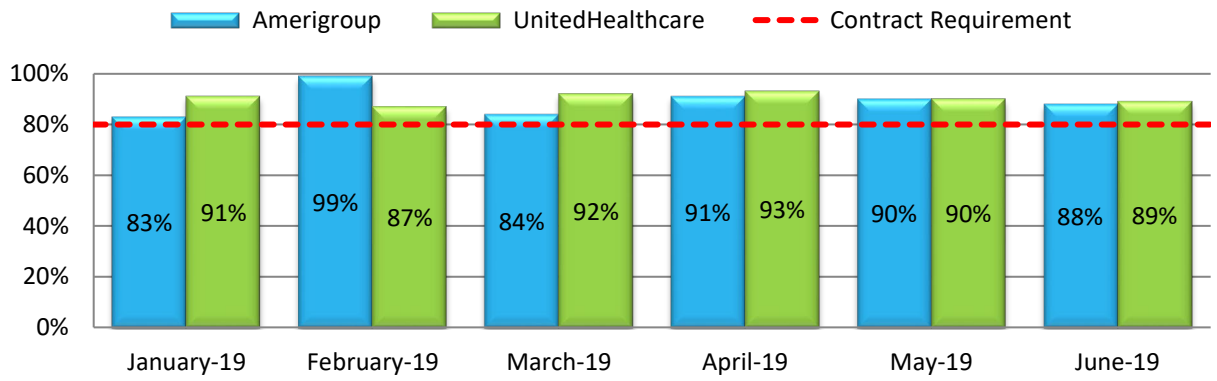
UnitedHealthcare Appeal Outcomes



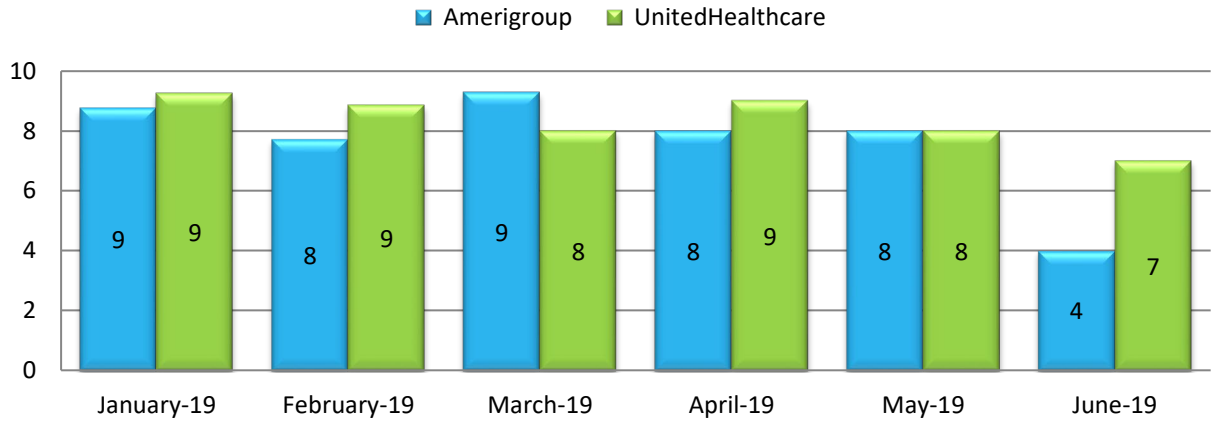
	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	0%	2%	1%	2%
Upheld	58%	58%	59%	36%
Partially Overturned	2%	2%	2%	3%
Overturned	40%	38%	38%	59%

Member Helpline

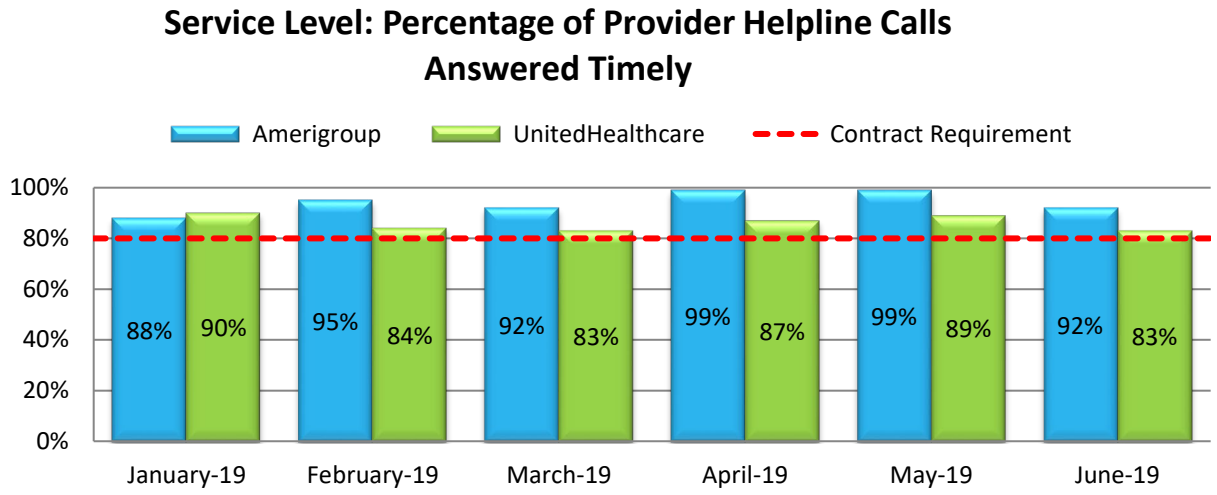
Service Level: Percentage of Member Helpline Calls Answered Timely

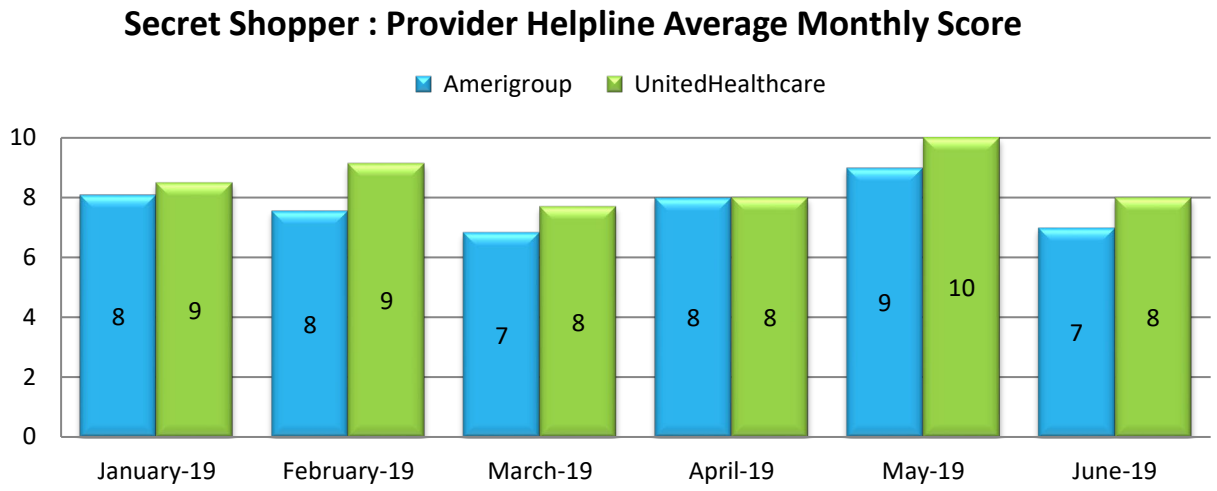


Secret Shopper: Member Helpline Average Monthly Score

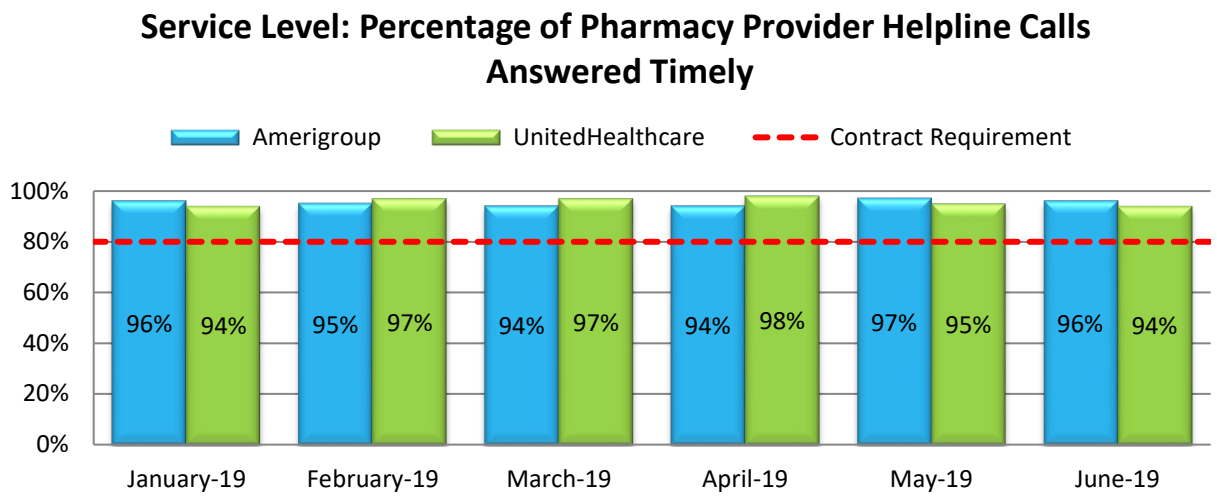


Provider Helpline





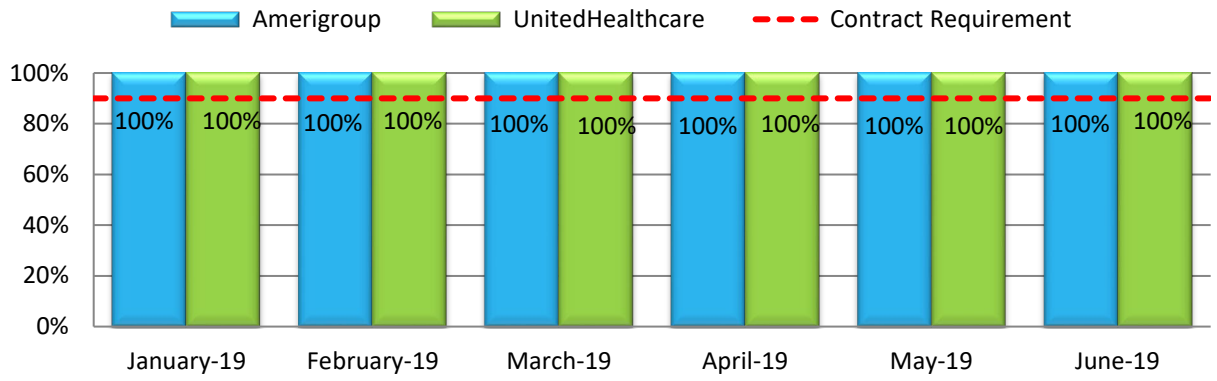
Pharmacy Services Helpline



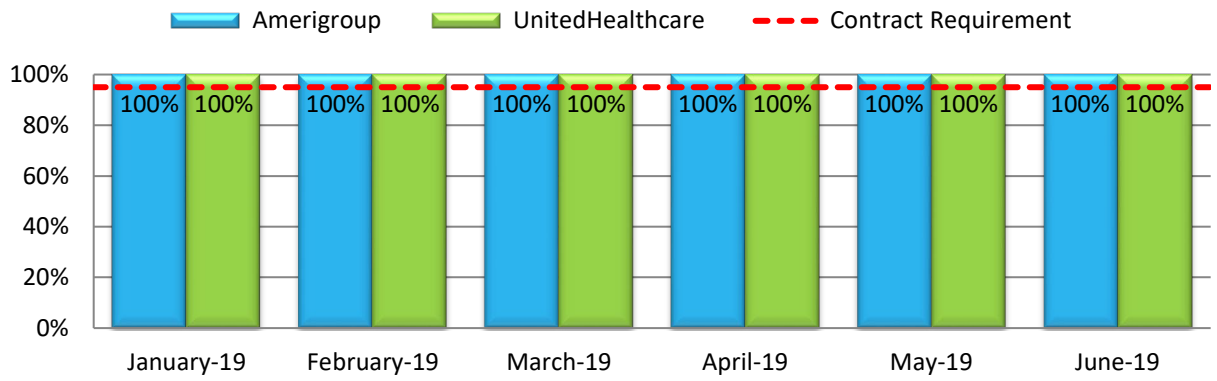
Non-Pharmacy Claims Payment

Non-pharmacy claims processing data is for the entire quarter.

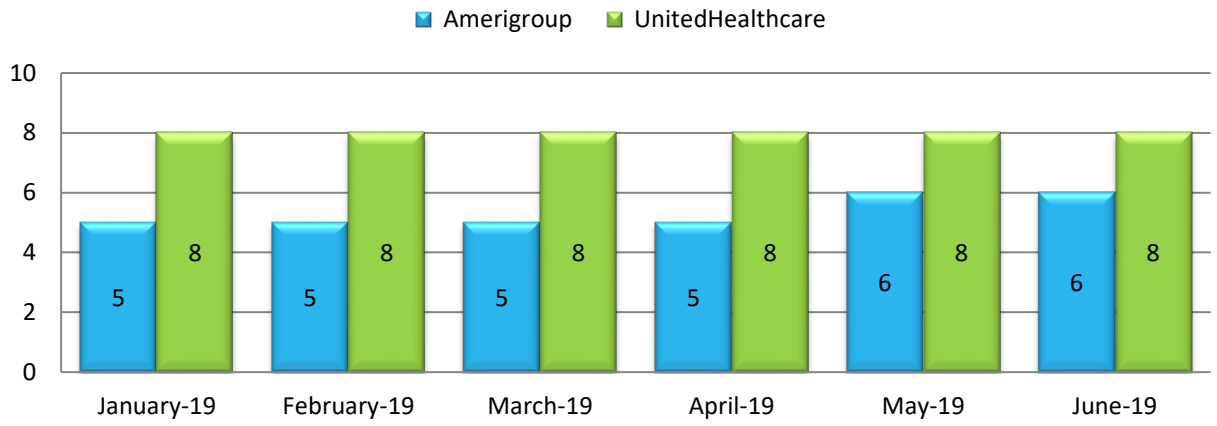
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days



Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 45 Calendar Days

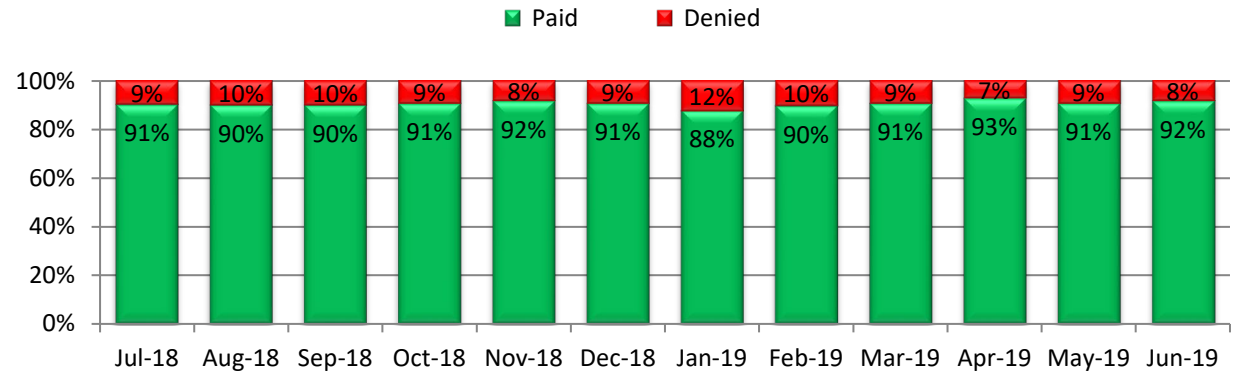


Average Days for Non-Pharmacy Claims Payment



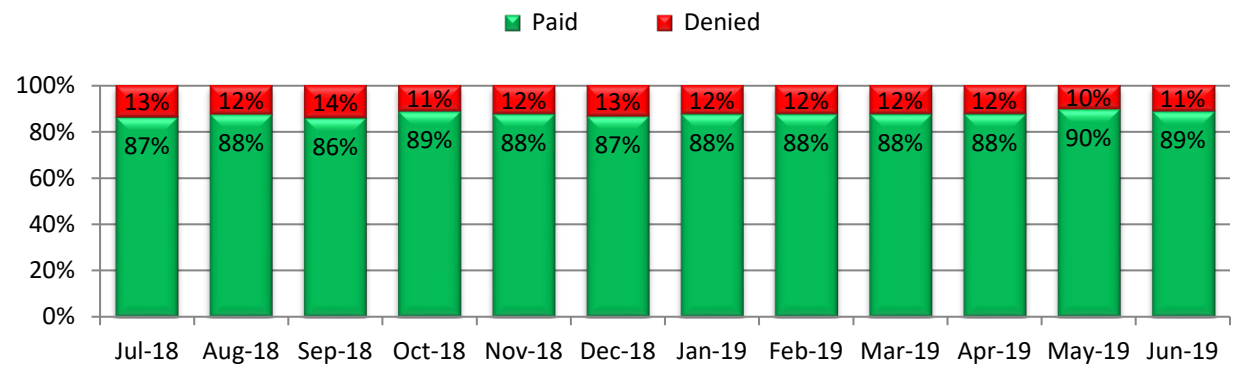
Amerigroup Non-Pharmacy Claims Status

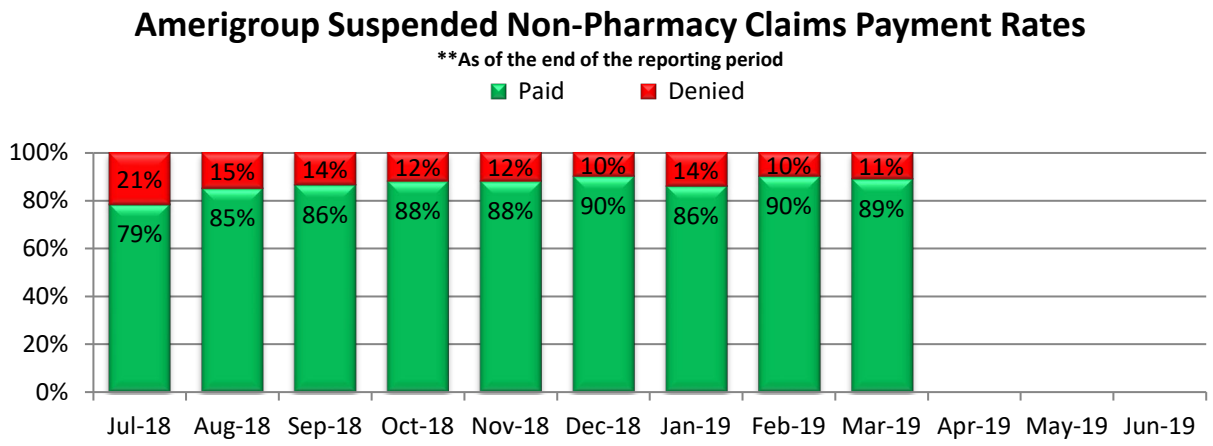
**As of the end of the reporting period

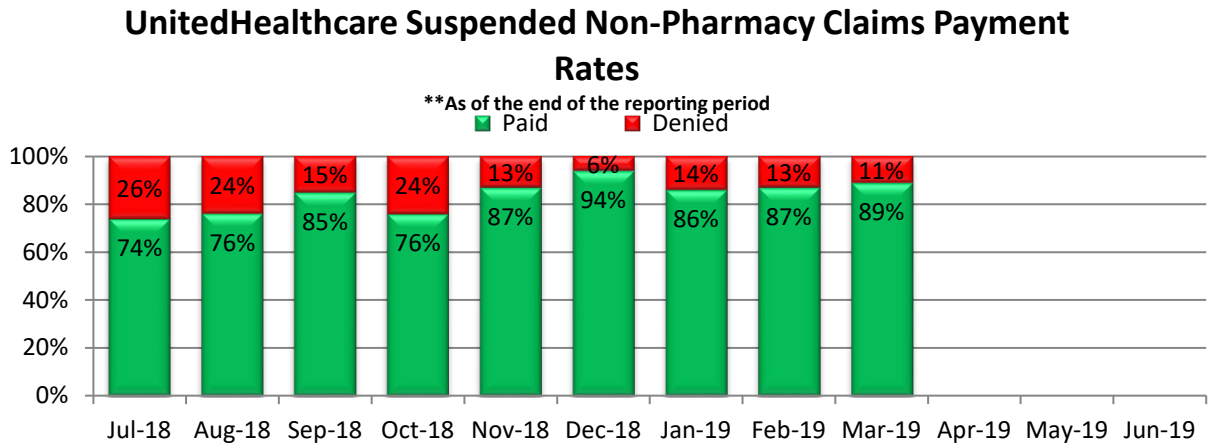


UnitedHealthcare Non-Pharmacy Claims Status

**As of the end of the reporting period







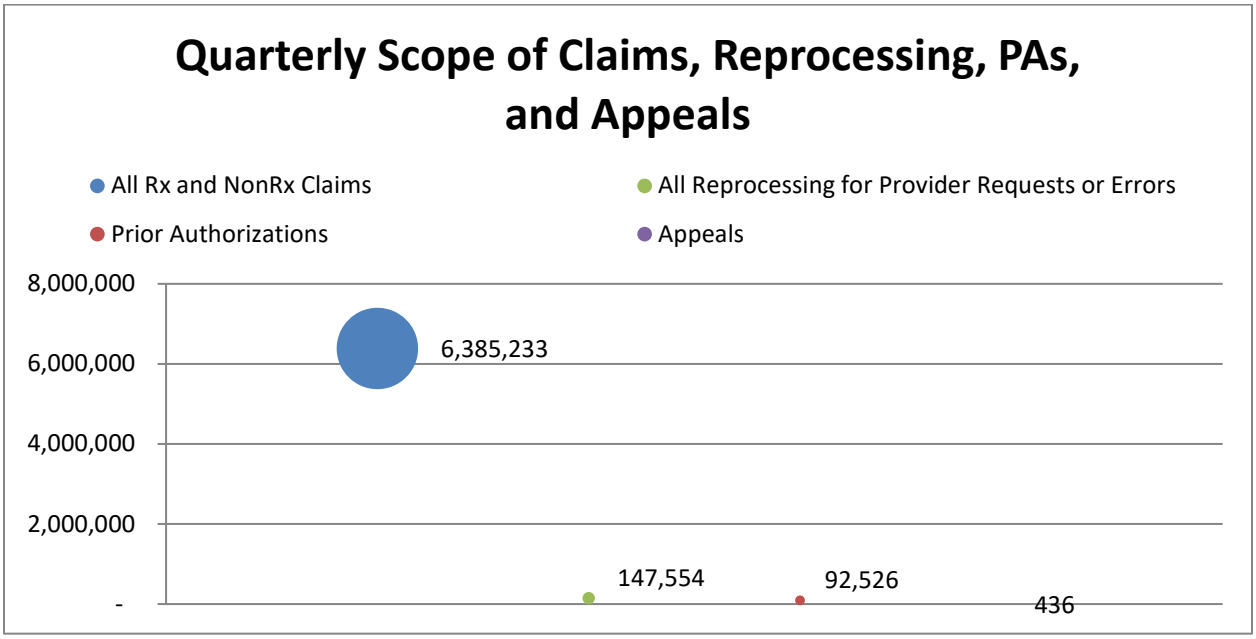
Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	30%	CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim	15%
2.	27-Expenses incurred after coverage terminated	15%	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary	13%

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			payer. The information was either not reported or was illegible.	
3.	252-An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) N479-Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)	9%	CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.	12%
4.	256-Service not payable per managed care contract	6%	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service	11%
5.	45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges	6%	CARC-29 The time limit for filing has expired.	6%
6.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	5%	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.	6%
7.	29-The time limit for filing has expired	5%	CARC-256 Service not payable per managed care contract. RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	4%
8.	197-Precertification/authorization/notification absent	5%	CARC-97 The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately billed services/tests have been bundled as	3%

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			they are considered components of the same procedure. Separate payment is not allowed.	
9.	97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present N432-Alert: Adjustment based on a Recovery Audit	3%	CARC-23 The impact of prior payer(s) adjudication including payments and/or adjustments.	2%
10.	16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present MA130-Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information	1%	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.	2%

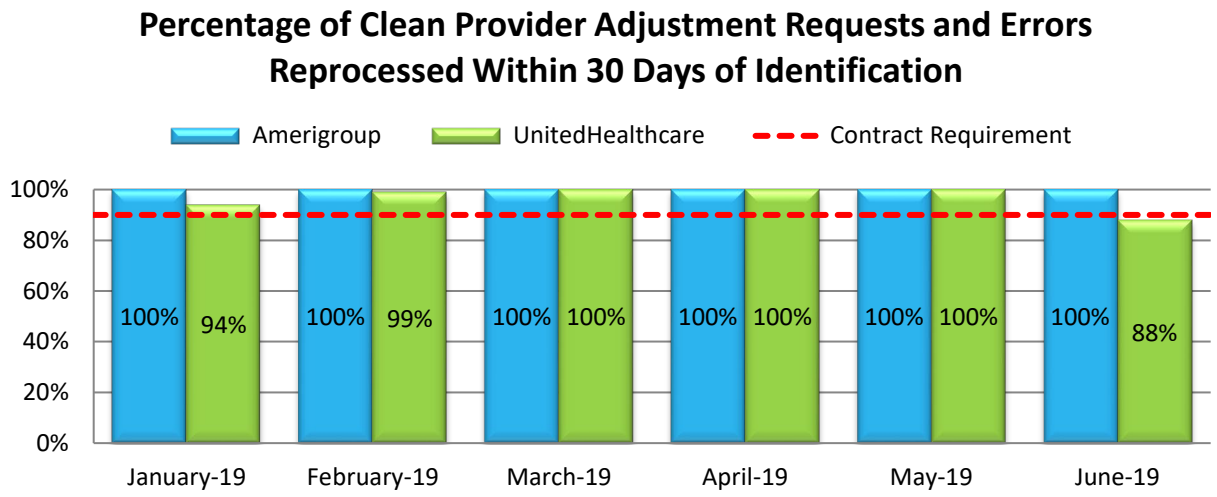
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/



Quarterly Volume of Claims, Reprocessing, PAs, and Appeals depict at scale the universe of actions that may be associated with paid or denied claims. Some claims require prior authorizations for services while other claims may be reprocessed due to provider requests or errors, and still others may be appealed by members. These numbers with the illustration provide context on the volume of these actions in the combined managed care universe of claims.

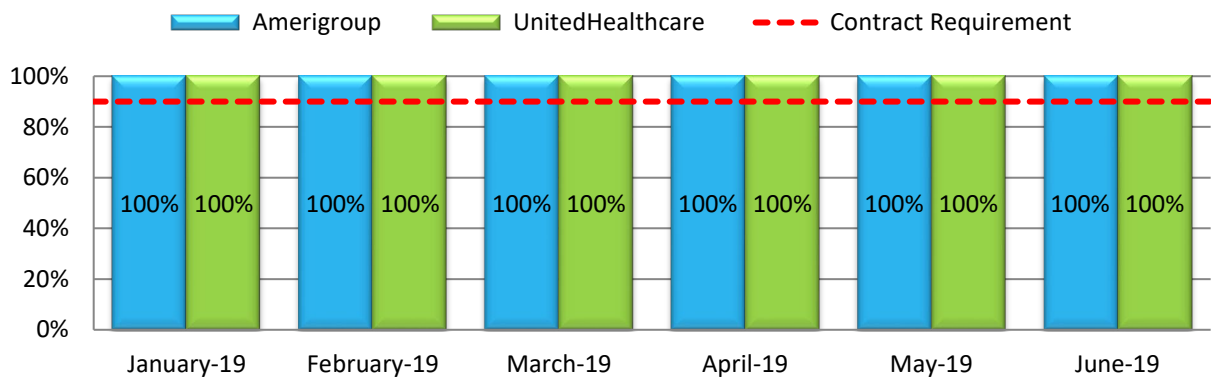
Supporting Data		
All Rx and NonRx Claims	6,385,233	**% of Claims Universe**
All Rx and NonRx Reprocessing for Provider Requests or Errors	147,554	2.31%
All Rx and NonRx Prior Authorizations	92,526	1.45%
Appeals	436	0.01%


Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification
Amerigroup
UnitedHealthcare
Contract Requirement
100%
80%
60%
40%
20%
0%
100%
94%
100%
99%
100%
100%
100%
100%
100%
100%
100%
88%
January-19
February-19
March-19
April-19
May-19
June-19

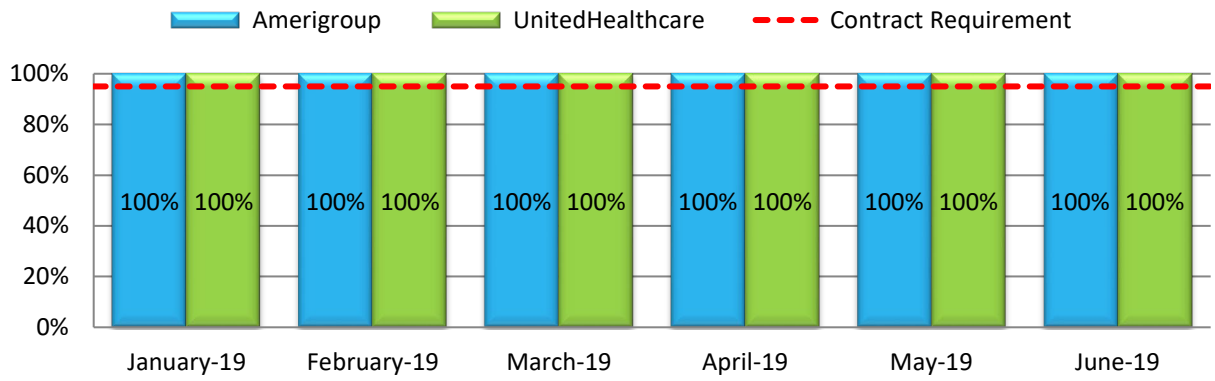
Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

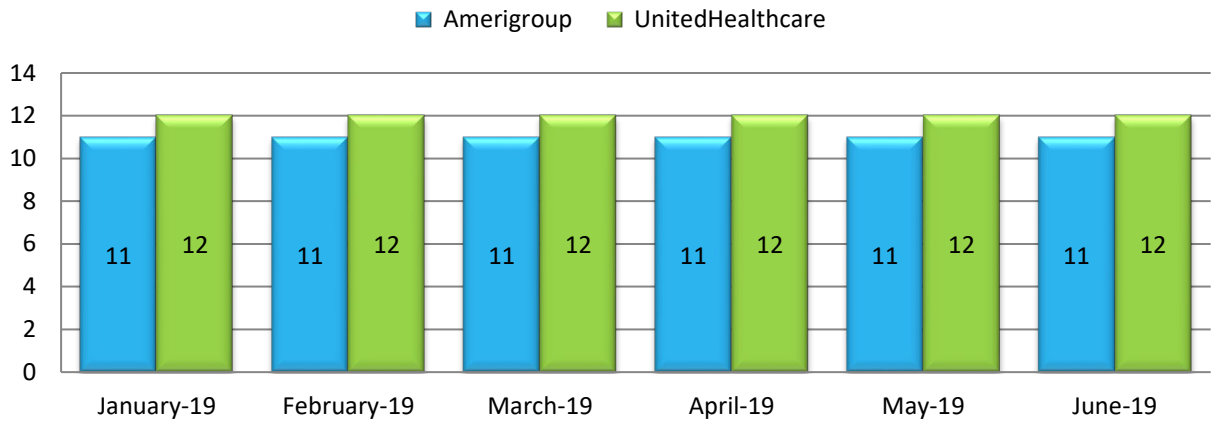
Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days



Percentage of Clean Pharmacy Claims Paid or Denied Within 45 Calendar Days

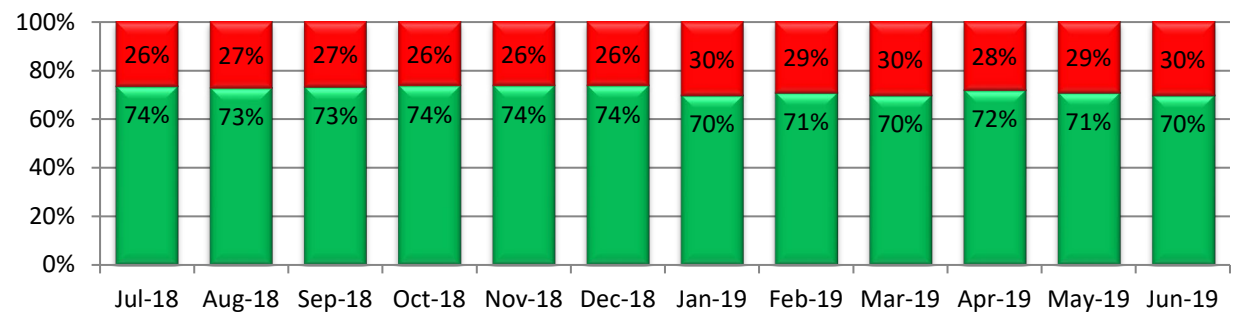


Average Days for Pharmacy Claims Payment



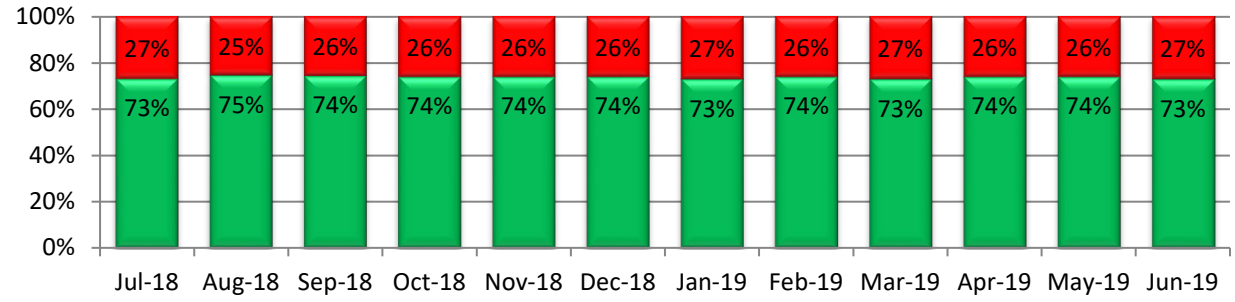
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	Refill Too Soon	31%	Refill Too Soon	40%
2.	Product Not On Formulary	12%	Prior Authorization Reqrd	15%
3.	Product/Service Not Covered – Plan/Benefit Exclusion	9%	Prod/Service Not Covered	13%
4.	Days' Supply Exceeds Plan Limitation	9%	Filled After Coverage Trm	10%
5.	Plan Limitations Exceeded	7%	Plan Limitations Exceeded	7%
6.	Submit Bill To Other Processor Or Primary Payer	5%	Sbmt bill to other procsr	5%
7.	Prior Authorization Required	4%	M/I Other Coverage Code	2%
8.	DUR Reject Error	4%	DUR Reject Error	2%
9.	Scheduled Downtime	3%	Non-Matched Pharmacy Nbr	1%
10.	This Medicaid Patient Is Medicare Eligible	2%	Prescriber is Not Covered	1%

Utilization of Value Added Services Reported Count of Members

MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q4 SFY19 Data	UnitedHealthcare
Baby Blocks	2,985
School/Camp/Sports Physicals	48
Non Emergent Transportation	932
Weight Watchers	105

Utilization of Value Added Services Reported Count of Members

MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q4 SFY19 Data	Amerigroup
Weight Watchers	169
Exercise Kit	45
Dental Hygiene Kit	35
Personal Bag for Belongings with Comfort Item	9
SafeLink Mobile Phone	83
Healthy Families Program	25
Community Resource Link	625
Live Health Online	25
Healthy Rewards	2,394
Taking Care of Baby and Me	4,671
Boys & Girls Club	67
Personal Care Attendant	7
Home Delivered Meals	10
Post-Discharge Stabilization Kit	1

The Department is in the process of reviewing how this information is shared on its website and will provide an updated link in the next report.

Provider Network Access

There are two major methods used to determine adequacy of network in the contract between the Department and the MCOs:

- Member and provider ratios by provider type and by region
- Geographic access by time and distance

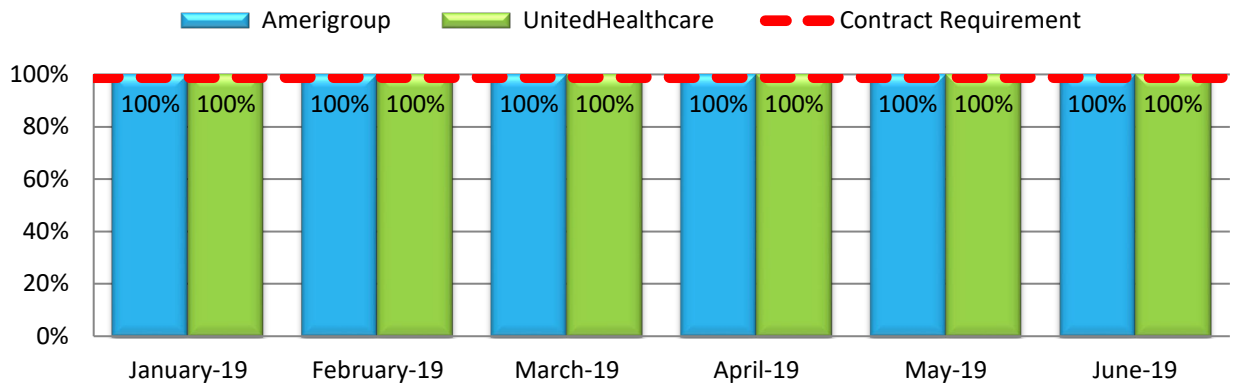
As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the Department when the MCO clearly demonstrates that:

- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

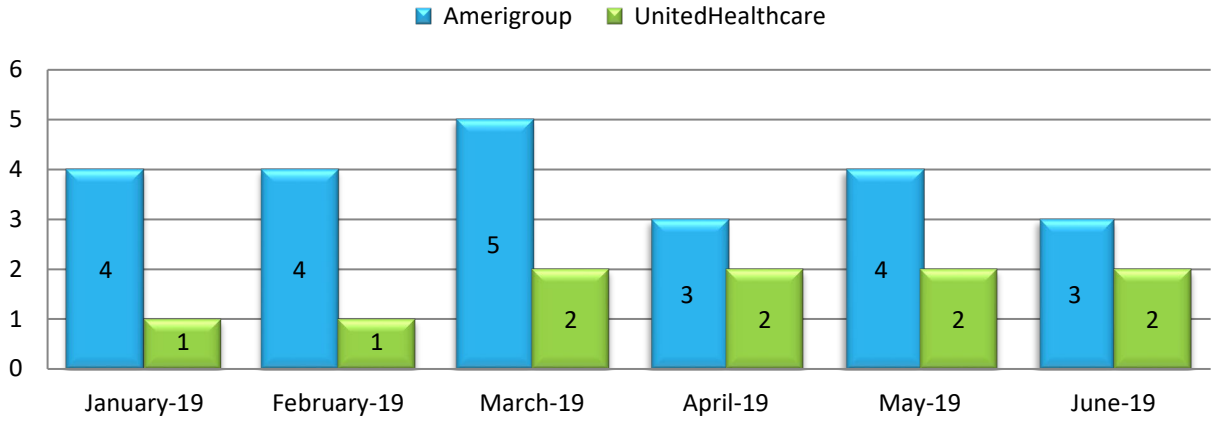
Links to time and distance reports can be found at: https://dhs.iowa.gov/ime/about/performance-data-GeoAccess.

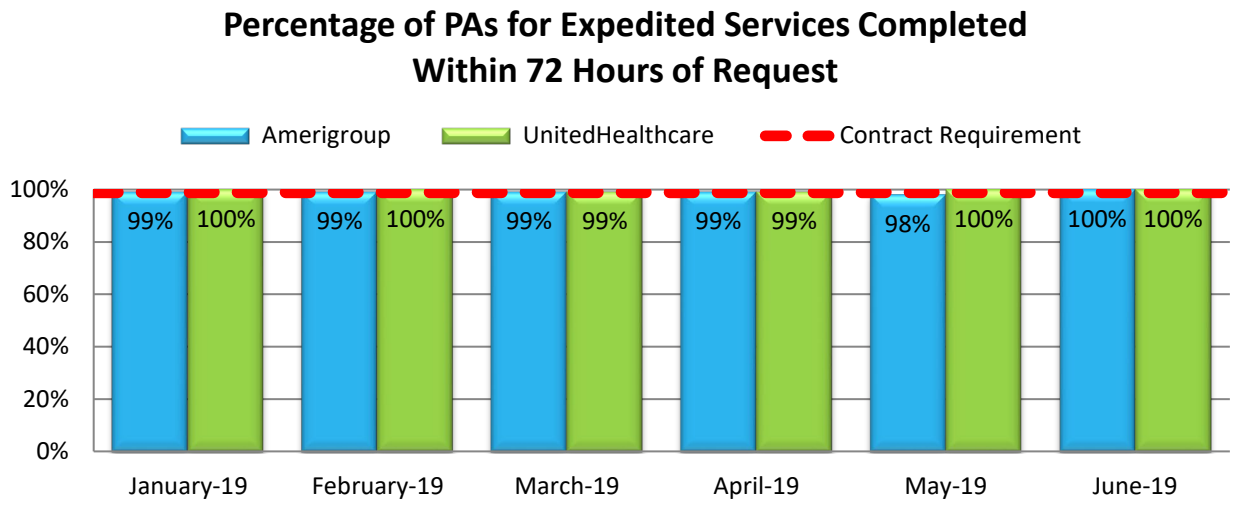
Non-Pharmacy Prior Authorization

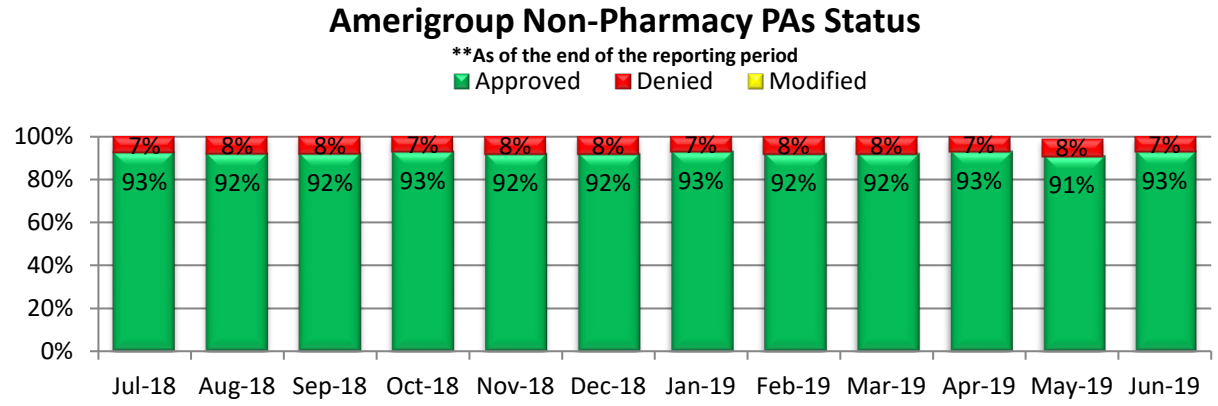
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request

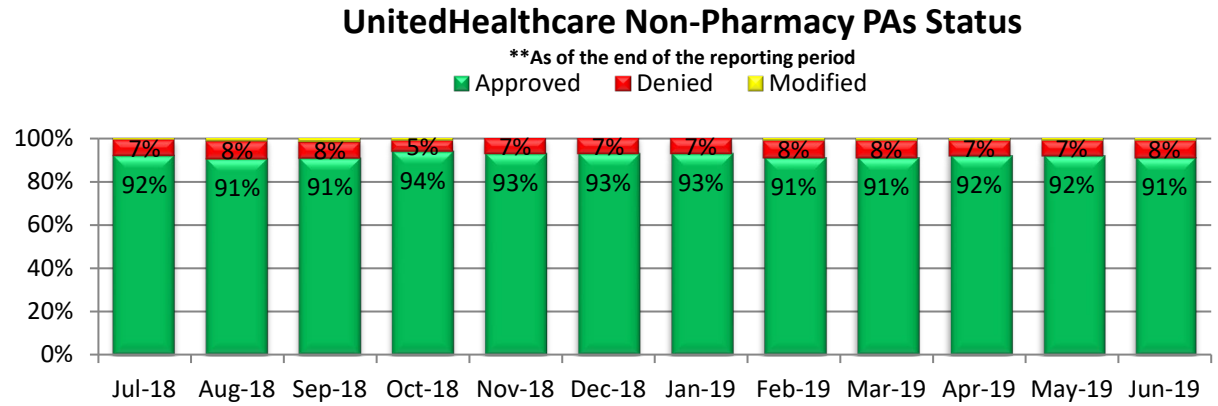


Average Days for Regular PA Processing



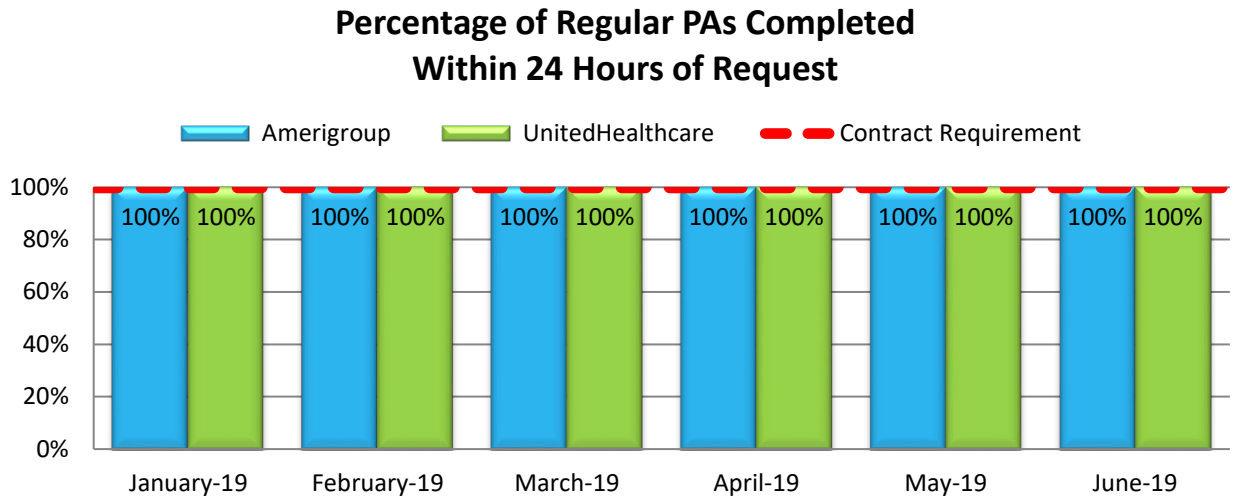




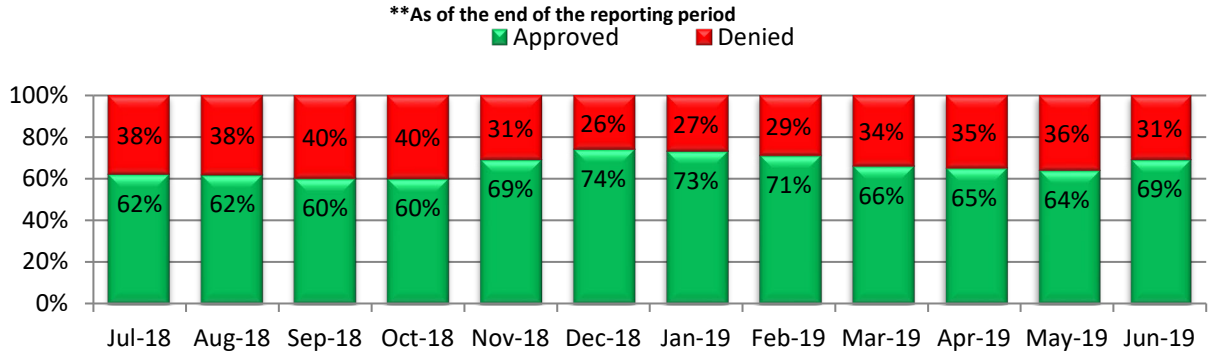


The Department has found and corrected an error in reporting percentages for Non-Pharmacy PA Status from October 2018 – March 2019. The graphs above contain the correct percentages.

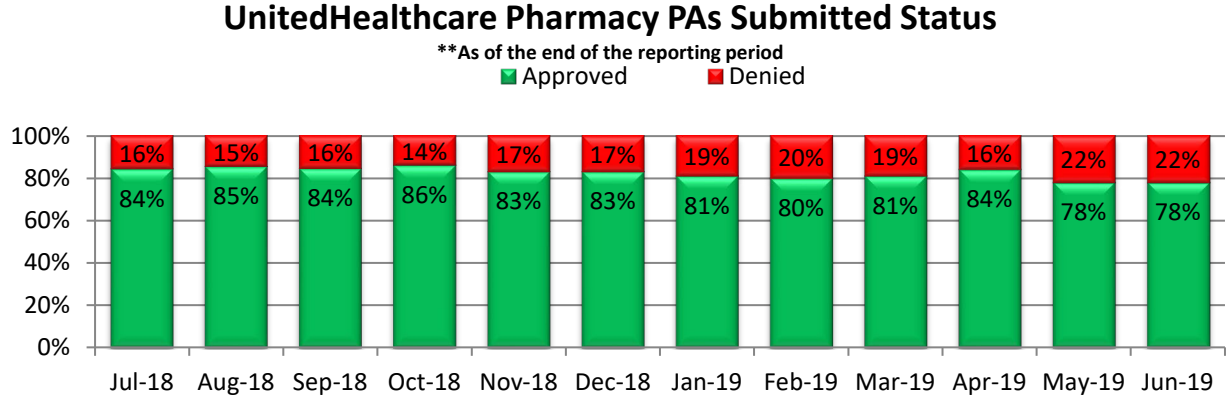
Prior Authorization - Pharmacy



Amerigroup Pharmacy PAs Submitted Status



UnitedHealthcare Pharmacy PAs Submitted Status



Encounter Data Reporting

Encounter Data are records of medically-related services rendered by a provider to a member. The Department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

Performance Measure	Amerigroup			UnitedHealthcare		
Encounter Data Submitted By 20th of the Month	Apr	May	Jun	Apr	May	Jun
	Y	Y	Y	Y	Y	Y

Value Based Purchasing Enrollment

MCOs are expected to have 40% of their population covered by a value based purchasing agreement by the end of Calendar Year 2018.

Data as of June 2019	Amerigroup	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards	47%	54%

MLR/ALR/Underwriting

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the Department and the MCOs.

- Medical loss ratio (MLR) reflects the percentage of capitation payments used to pay medical expenses.
- Administrative loss ratio (ALR) reflects the percentage of capitation payments used to pay administrative expenses.
- Underwriting ratio reflects profit or loss.

A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

Q4 SFY19 Data	Amerigroup	UnitedHealthcare
MLR	98.1%	92.2%
ALR	6.2%	9.1%
Underwriting	-4.3%	-1.3%

These measurements may be subject to change after the end of the reporting quarter due to out of period adjustments made by the MCOs.

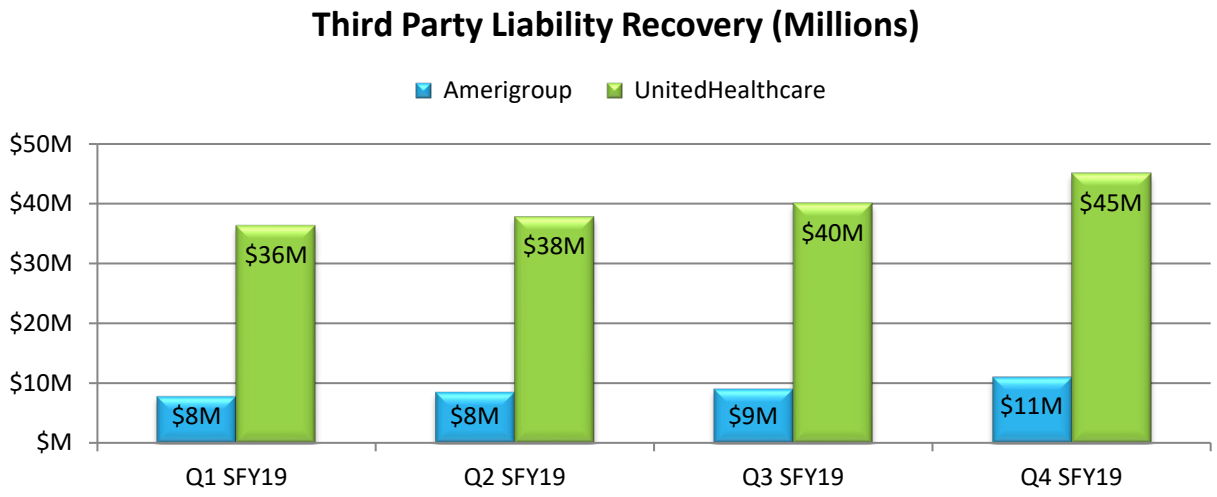
Capitation Payments Made to the Managed Care Organizations

Capitation payments include payments made for the reported quarter's enrollment, adjustments, and member reinstatements and retroactive eligibility. Quarterly Performance Reports in previous fiscal years only included payments for the current quarter's enrollment, which is why previous quarters are not provided.

MCO	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Amerigroup Total	**$417,598,591**	**$429,046,037**	**$376,525,389**	**$402,424,413**
Adjustments	$97,848,029	$72,262,766	($509,327)	($313,567)
Current	$312,420,560	$347,223,304	$365,336,282	$391,378,265
Member Reinstatements and Retroactive Eligibility	$7,330,002	$9,559,966	$11,698,434	$11,359,715
UnitedHealthcare Total	**$768,872,756**	**$865,012,150**	**$763,249,472**	**$497,225,366**
Adjustments	$78,327,083	$121,133,543	$673,460	($604,321)
Current	$671,528,707	$722,723,962	$738,949,197	$483,286,115
Member Reinstatements and Retroactive Eligibility	$19,016,967	$21,154,644	$23,626,815	$14,543,572

Managed Care Organization Reported Reserves

Data reported	Amerigroup	UnitedHealthcare
Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*	Y	Y


Third Party Liability Recovery (Millions)
Amerigroup
UnitedHealthcare
$50M
$40M
$30M
$20M
$10M
$M
$8M
$36M
$8M
$38M
$9M
$40M
$11M
$45M
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems which have a series of edits that reject inaccurate or duplicate claims.

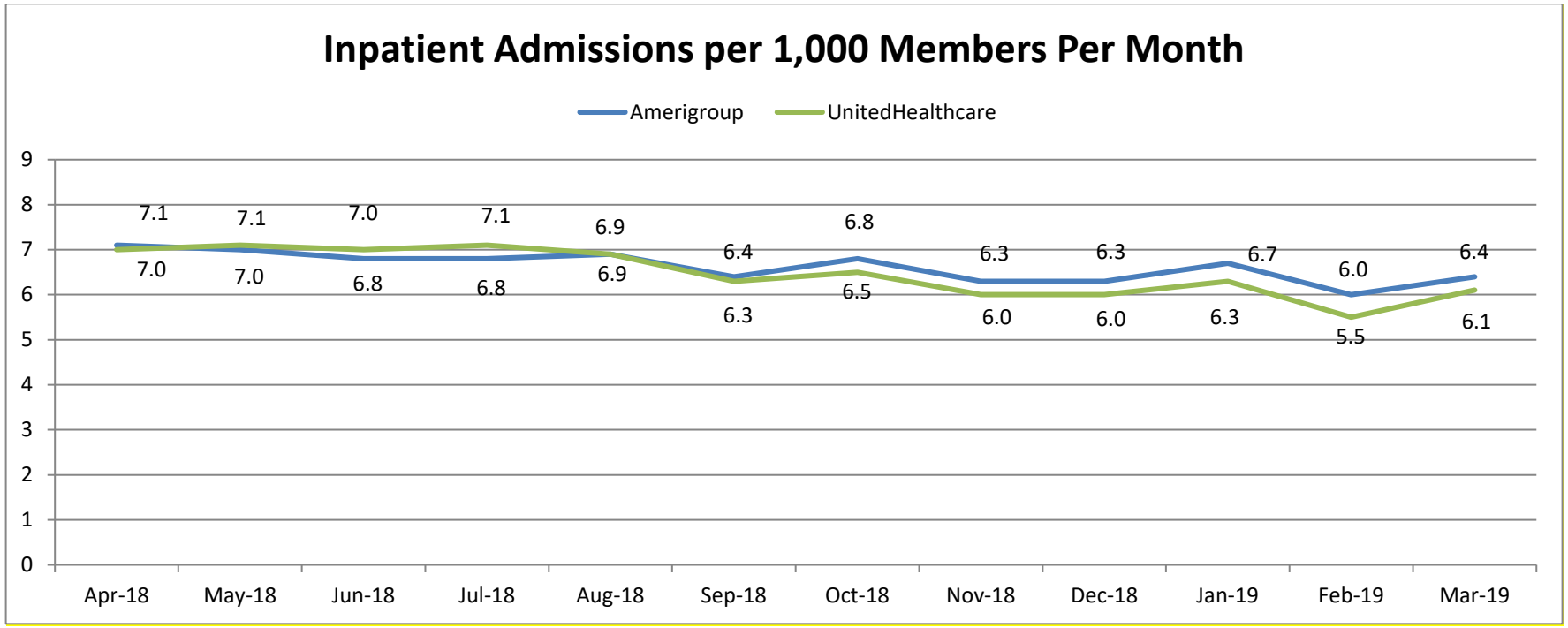
Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

Fraud, Waste and Abuse

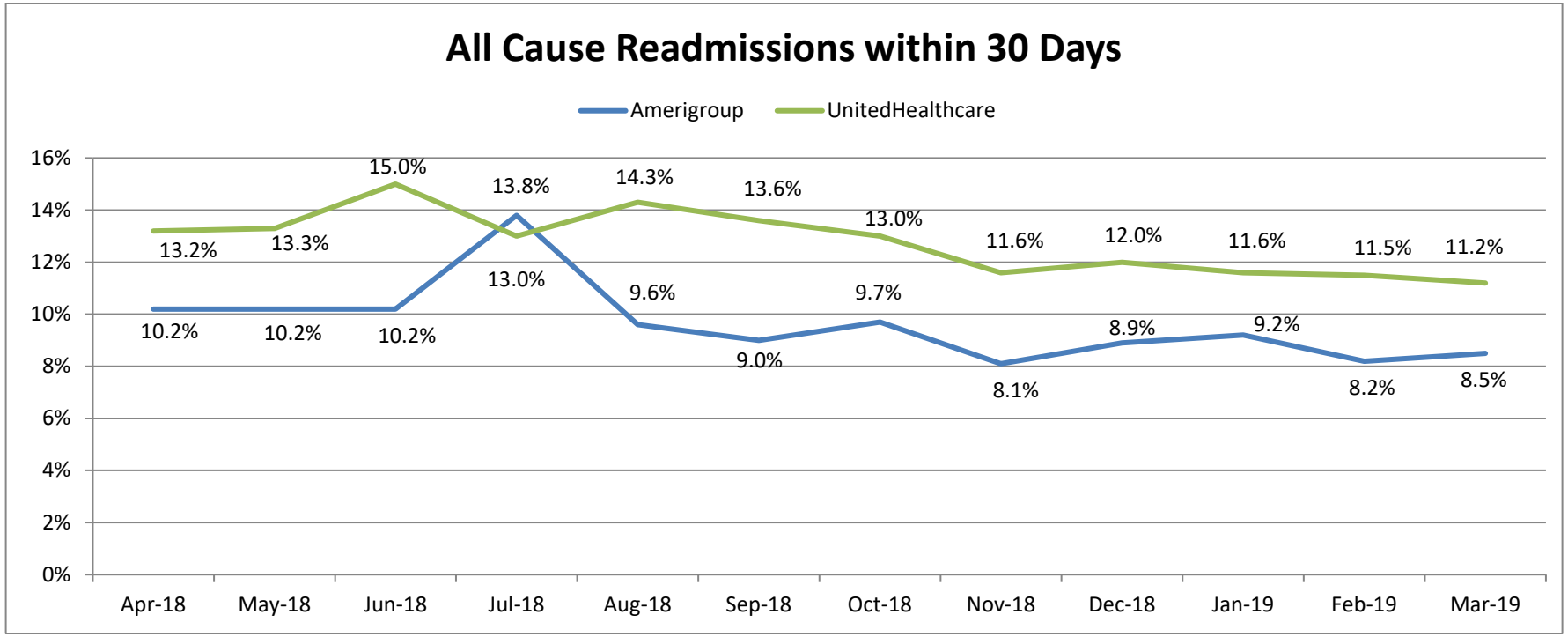
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.

Q4 SFY19 Data	Amerigroup	UnitedHealthcare
Investigations Opened During the Quarter	30	12
Overpayments Identified During the Quarter	14	10
Cases Referred to the Medicaid Fraud Control Unit (MFCU) During the Quarter	15	16
Member Concerns Referred to the IME	8	12

In prior reports, dollars recovered through program integrity efforts were reported on a quarterly basis. However, the MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The plans have initiated 42 investigations in the fourth quarter and referred 31 cases to MFCU. The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse; therefore, MCO investigations, overpayment recovery, and referrals to MFCU would not occur until there is sufficient evidence to implement.



Encounter Data Disclaimer: The data provided by the IME is provided "as is." The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.



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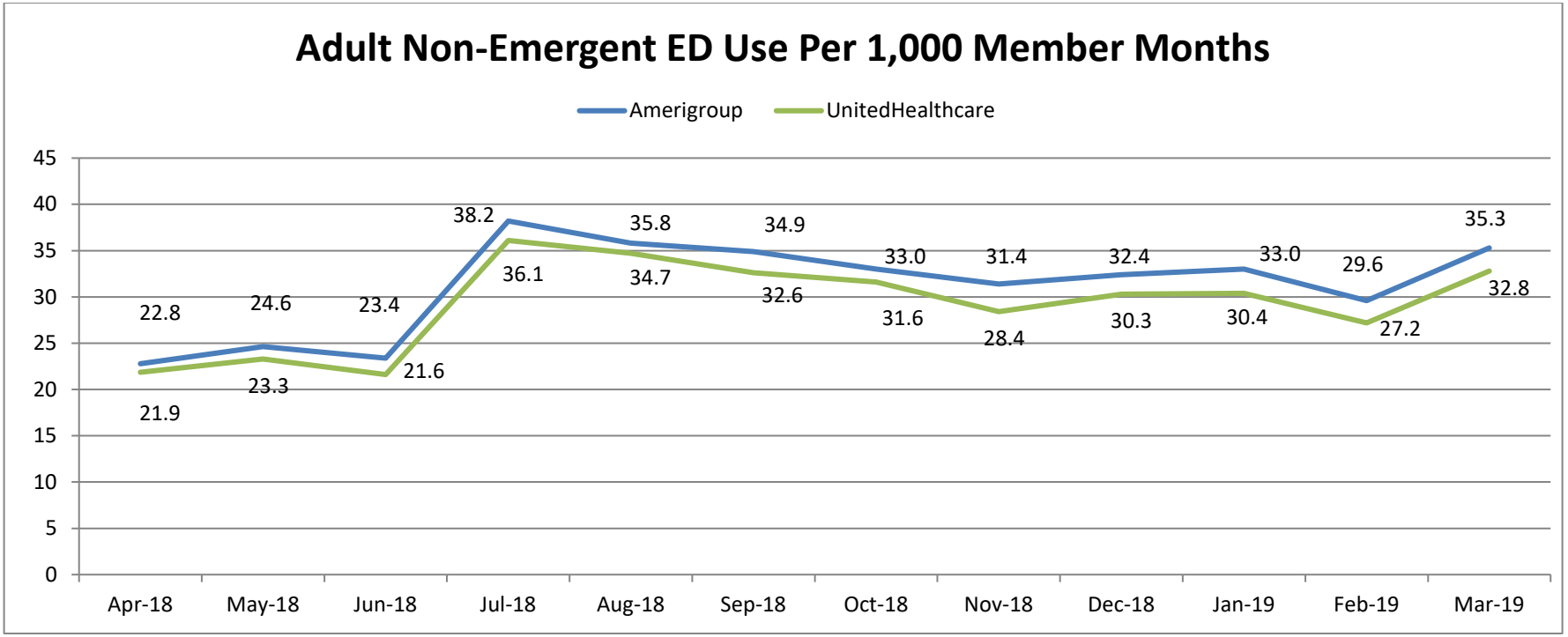

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As of July 1, 2018, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase for dates of service after that release.

As of January 1, 2019, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase for dates of service after that release.

APPENDIX

APPENDIX: GLOSSARY

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.
UHC: UnitedHealthcare Plan of the River Valley Iowa, Inc.

Glossary Terms:

Administrative Loss Ratio: The percent of capitated rate payment or premium spent on administrative costs.

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO.
Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time-frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network.

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with the Department of Human Services (DHS) or they may ask to ask for a state fair hearing.

Appeal process: The MCO process for handling of appeals, which complies with:

- The procedures for a member to file an appeal;
- The process to resolve the appeal;
- The right to access a state fair hearing, and;
- The timing and manner of required notices.

Calls Abandoned: Member terminates the call before a representative is connected.

Capitation Payment: Medicaid payments the Department makes on a monthly basis to MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member's eligibility.

CARC: Claim Adjustment Reason Code. An explanation why a claim or service line was paid differently than it was billed. A **RARC** – Readjustment Advice Remark Code provides further information.

Care Management: Care Management helps members manage their complex health care needs. It may include helping a member get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Clean Claims: The claim is on the appropriate form, identifies the service provider that provided the service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing facility or home supports.

Community-Based Case Management (CBCM): Community-Based Case Management helps Long-Term Services and Supports (LTSS) members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. Community-Based Care managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (CDAC): Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.
CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Critical Incidents: When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to

the HCBS member's MCO in a clear, legible manner, providing as much information as possible regarding the incident.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

DHS: Iowa Department of Human Services

Disenrollment: Refers to members who have chosen to change their enrollment with one MCO to an alternate MCO.

Durable Medical Equipment: Durable Medical Equipment (DME) is reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

ED: Emergency department

Emergency Medical Condition: An Emergency Medical Condition is any condition that the member believes endangers their life or would cause permanent disability if not treated immediately. A physical or behavioral condition medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or body part.

If a member has a serious or disabling emergency, they do not need to call their provider or MCO. They should go directly to the nearest hospital emergency room or call an ambulance.
The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Fee-for-Service (FFS): The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through FFS Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: Members may request to change their MCO during their 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.
Some examples of Good Cause for disenrollment include:

- A member's provider is not in the MCO's network.
- A member needs related services to be performed at the same time. Not all related services are available within the MCO's provider network. The member's primary care provider or another provider determined that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- The member's provider has been terminated or no longer participates with the MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by the member's MCO.
- The MCO plan does not cover the services the member needs due to moral or religious objections.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30

calendar days from the date the matter occurred. Examples include but are not limited to:

- The member is unhappy with the quality of your care.
- The doctor who the member wants to see is not an MCO doctor.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

HCBS: Home and Community Based Services, waiver services. Home and Community Based Services (HCBS) provide supports to keep Long-Term Services and Supports (LTSS) members in their homes and communities.

Hawki: A program that provides coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the Federal Poverty Level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology.

Health Care Coordinator: A Health Care Coordinator is a person who helps manage the health of members with chronic health conditions.

Health Risk Assessment (HRA): A Health Risk Assessment (HRA) is a short survey with questions about the member's health.

Historical Utilization: A measure of the percentage of assigned members whose current providers are part of the managed care network for a particular service or provider type based on claims history.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides and therapists.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services
- Observation services
- Outpatient surgery
- Lab tests.
- X-rays

ICF/ID: Intermediate Care Facility for Individuals with Intellectual Disabilities.

IHAWP: Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act.

IID: Iowa Insurance Division.

IME: Iowa Medicaid Enterprise.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Level of Care (LOC): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long-Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.
Long Term Care Services:
• Home and Community Based Services (HCBS)
• Intermediate Care Facilities for Persons with Intellectual Disabilities
• Nursing Facilities and Skilled Nursing Facilities

MCO: Managed Care Organization.

Medical Loss Ratio (MLR): The percent of capitated rate payment or premium spent on claims and expenses that improve health care quality.

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: Each MCO has a network of providers across Iowa who their members may see for care. Members don't need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

NF: Nursing Facility.

PA: Prior Authorization. Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription.

PCP: Primary Care Provider. A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member will see for checkups, health concerns, health screenings, and specialist referrals.

PDL: Preferred Drug List.

Person-centered Plan: A Person-centered Plan is a written individual plan based on the member's needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP) or individual education plan (IEP).

PMIC: Psychiatric Medical Institute for Children.

Rejected Claims: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

SMI: Serious mental illness.

SED: Serious emotional disturbance. Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.
SED does not include:

- Neurodevelopmental disorders
- Substance-related disorders
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED).

Service Plan: A Service Plan is a plan of services for HCBS members. A member's service plan is based on the member's needs and goals. It is created by the member and their interdisciplinary team to meet HCBS waiver criteria.

Skilled Nursing Care: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. The member must be medically and financially eligible. If the member's care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding their care, then a skilled level of care is assigned.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Suspended Claims: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

TPL: Third-party liability. This is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: A health plan accepts responsibility for paying for the health care services of covered individuals in exchange for dollars, which are usually referred to as premiums. This practice is known as underwriting. When a health insurer collects more premiums than it pays in expense for those treatments (claim costs) and the expense to run its business (administrative expenses), an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs.