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| Managed Care Organization (MCO)  Reporting Manual  SFY24 (July 2023 to Jun 2024)  **Version 20** Published October 2023 |

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# Overview

This manual provides information for all reporting requirements required by the Iowa Department of Health and Human Services (HHS) Iowa Medicaid for Iowa Health Link Medicaid Managed Care Organizations (MCOs). All submitted reports must be specific to the Iowa Health Link program only and must meet the ***Performance Targets and Reporting Requirements*** identified in the Iowa Health Link Contract.

Each managed care organization is required to adhere to Iowa Health Link Contract reporting requirements, but is not limited to:

Section N.02 - Reporting Requirements

The Contractor shall comply with all reporting requirements, including but not limited to those requirements found in the Reporting Manual, and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures, and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate.

Section N.04 - Other Reporting and Changes

The Agency will provide at least 30 Days’ notice to the Contractor before changing or adding any reporting requirements for reports that are anticipated as routine or are intended to be included in the Reporting Manual. The Agency will provide reasonable notice in advance but may request ad hoc reports at any time. The Reporting Manual will detail reporting requirements and the full list of required reports.

**Notice**: Submitting questions related to reporting does not preclude a report from being due. All parties will work together to ensure that all questions are answered but, to the extent that there are outstanding questions as of the due date of required reports, it is the expectation that the managed care organization document assumptions made and submit the report by the communicated due date.

# Submission Requirements

Unless otherwise noted, the MCO must submit all reports using the formats specified by Iowa Medicaid. If Iowa Medicaid changes the reporting templates, formats, or definitions, Iowa Medicaid will provide the MCO with new electronic versions of the templates or formats.

To minimize the impact of mid-year changes Iowa Medicaid Staff and/or MCO’s should recommend changes to templates, formats, or definitions at least 30-days prior to the start of the new state fiscal year.

Decommissioned Reports

In the event an MCO exits the market, a separate “decommissioned” document will be created to outline final reporting requirements.

File Names

MCO must submit reports using the following Iowa Medicaid prescribed naming conventions.

**File Name Construction**:

[MCO] [Template name with applicable version] - [Reporting Period] - [Date Report Submitted]

* **MCO**: AGP or ITC
* **Template Name**: AccQual A1 A5 D1 E4 Care Coordination V12
* **Reporting Period**: Data reflects covered timeframe
  + Monthly Reports: **MMM** SFY**YY** (Jan SFY21)
  + Quarterly Reports: Q**1-4** SFY**YY** format (Q1 SFY21)
    - Quarters will be defined as follows:
      * Quarter 1 (Q1): July, August, and September
      * Quarter 2 (Q2): October, November, and December
      * Quarter 3 (Q3): January, February, and March
      * Quarter 4 (Q4): April, May, June
  + Annual Reports: Indicate the covered timeframe by using either **Annual** CY**YY** (i.e., Jan-Dec), **Annual** SFY**YY** (i.e., Jul-Jun), or just A**nnual** if neither CY or SFY (i.e., COI effective dates are 3/1/20 to 3/1/21)
* **Date Report Submitted**: Use DD.MM.YYYY format

**Examples**:

* AGP PI1-PI7\_Program Integrity Report V1 - Jul SFY21 - 08.30.2020
* ITC AccQual A1 A5 D1 E4 Care Coordination V12 - Q1 SFY21 - 10.30.2020
* AGP AccQual E10 Employment V4 - Biannual Jul 2020 - 11.30.2020
* ITC FinAdm B3 Insurance Premium Notice V2 - Annual - 07.15.2020

Submitting Reports to Iowa Medicaid

As of June 2022, all reports must be uploaded to the **Iowa Medicaid Portal** **Access** (**IMPA**) site; however, a project is in progress that will eventually transition all reporting from IMPA to a new **Secure File Transfer Protocol** (**SFTP**) site.

Quality Assurance Samples

* MCOs must use sound research methodology.
* The annual sample size will then be divided into 12 equal parts and the random draw would be done monthly.
* Each year the sample size will be recalculated so sample sizes are approximate.
* Random samples would also be weighted by consumers who are newly enrolled and consumers with ongoing utilization of services.
* Random samples will be weighted by geographical areas of the state and age.
* For member surveys, members do have the right to decline interviews however a sample with a 95% confidence level is the goal of completed interviews.
  + For this reason, ***a separate random sample will be pulled*** and used as a resource to replace consumers declining the QA interview.
  + This sample will remain intact as a resource until exhausted. At that point, another random sample will be drawn.

Resubmitted or Corrected Reports

* The department may initiate requests for report resubmission for reasons including but not limited to accuracy or completion
* Report resubmissions that are not initiated by the department require a written request from the MCO and authorization for resubmission by the department
  + Resubmitted or corrected reports are accepted without a written request on or before the report due date only
* Report resubmissions will result in liquidated damages at the discretion of the department when resubmission is related to at least one of the following compliance issues: completion, accuracy, timeliness, or failure to meet performance standards

If the MCO is submitting a corrected report replace the initial **Date Report Submitted** date with “**- Resubmitted** (**MM.DD.YYYY**)” behind the file name

Examples:

* AGP PI1-PI7\_Program Integrity Report V1 - Jul SFY21 - Resubmitted 09.09.2020
* ITC AccQual A1 A5 D1 E4 Care Coordination V12 - Q1 SFY21 - Resubmitted - 11.09.2020
* AGP AccQual E10 Employment V3 – Biannual SFY21 - Resubmitted 09.09.2020
* ITC FinAdm B3 Insurance Premium Notice - Annual SFY21 - Resubmitted 07.21.2020

Rounding Standards

Reported measures may include percentages, whole numbers, or numbers expressed to a specific decimal place; however, standard numerical rounding rules apply to all reported measures. The only exception is when a specific measurement explicitly states that the number must be absolute, and rounding is not to be used. For example, all pharmacy prior authorizations must be completed within 24 hours:

8,525 Rx prior authorizations/ 8,500 Rx prior authorizations completed timely = 99.7%, not 100%

Templates

Prescribed Templates

In the cases where Iowa Medicaid prescribes a template, the MCO must adhere to the following guidelines:

* Iowa Medicaid requires that the MCO submit its data in these templates ***without changing the template format*.**
* Iowa Medicaid will supply these templates electronically to the MCO. If the MCO submits data with incorrect file or worksheet names, or in formats that have been altered in any other way except to provide the performance data for the current reporting period, Iowa Medicaid will require the MCO to re-submit the data under correct file or worksheet names and in correct formats.
* Each report template has a Data Definitions worksheet that indicates:
  + Contract reporting requirement
  + Measure definitions
  + Measure calculations
* MCOs should only enter data in the identified cells. Do not insert new worksheets, columns, or rows, except where instructed.
* MCOs wishing to resubmit previous reporting period data must provide Iowa Medicaid with the reason for restatement and must label files consistent with the file naming convention outlined below.
* **No Date**/**Blank Spaces** (Where there is no data to report):
  + **Text Fields**: Indicate **N**/**A** or a sentence expressing that there is no information to report
  + **Numeric Fields**: Key **0**
  + **Exceptions**:
    - “Comment” fields may be left blank
    - If template instructions allow

No Prescribed Templates

In the cases where a template is not prescribed, the MCO must adhere to the following guidelines:

* Each report should be submitted in a single document containing all elements
* Include a detailed Table of Contents that lists all sections and subsections and their corresponding, correct page numbers for lengthy documents
* Indicate clearly which data is Health Link if reporting for multiple lines of business or states
* Define terms that may not be familiar to the lay reader
  + **Example**: The consumer satisfaction survey was completed using the Mixed Methodology
* Spell out acronyms upon first use
  + **Example**: MRR = medical record review
* Eliminate typographical errors and tracked changes, unless track changes have been included to facilitate Iowa Medicaid review
* Number all pages in consecutive order, including appendix pages
* Include a footer with the report name, year, and submission date
  + **Example**: 2015 [MCO name] Annual Program Evaluation, 10/1/15
* Regarding charts, graphs, and data tables within these documents the MCO’s will follow the guidelines below:
  + Include a header for each chart or table, with an explanation for the data presented in the table and the timeframe represented
  + Label clearly both the horizontal and vertical axis on each table
  + Include detailed data charts and graphs, including trended data which compares more than the most recent two years, in an appendix (**Example**: Do not include a table listing all 80 languages spoken by providers and the number of providers speaking each language in the body of the report)
  + Include the targets for tables and charts comparing actual performance to targets,
  + Reference the header name of the table or chart in the narrative when referring to data represented in a table or chart
  + Provide a key to tables and charts which use unfamiliar terms or acronyms, defining those terms or acronyms (**Example**: Den = denominator)
  + Shade charts and graphs so that the reader can easily distinguish data and rate comparisons if printing in black and white
  + Include the header(s) on each page for tables and charts that comprise more than one page (**Example** to correct: Header for data table is on the bottom of one page with no data, and data for table is on the following page with no header)

Timeframes

The MCO must submit reports by the dates due as indicated in the report descriptions and in the specified formats. The Required Reporting below provides information on timeframes for submitting the reports. In the event the report submission date falls on a weekend or a holiday, the report must be submitted the next business day

# Financial and Administrative (FinAdm) Reporting

This section outlines definitions for the following reports:

1. Physician Incentives
2. Program Integrity
3. Claims Processing
4. Financial Reporting
5. Electronic Visit Verification

A. Physician Incentives

C-1. Provider incentives

|  |  |
| --- | --- |
| Purpose | Monitor how the MCO has utilized provider incentives |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) FinAdm C-1 Provider Incentives V7 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: June 2021  First Reporting Period: Q1 SFY2022  First Production Due: 10/30/2021 |

C-2. CMMI Reporting

|  |  |
| --- | --- |
| Purpose | Gather and Report State Innovation Model Activities as Required by the Center for Medicare and Medicaid Innovation (CMMI) |
| Frequency | Annually |
| Timeframe | No later than **September 30th** of the reporting year. |
| MCO Report  Template  Filename | (MCO) FinAdm C-2 CMMI Reporting V4 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: 07/11/20019  First Reporting Period: n/a  First Production Due: n/a |

B. Program Integrity

PI\_1 Investigative Activities

|  |  |
| --- | --- |
| Purpose | Utilized for tracking the progress of tips, investigations and providing next steps once an investigation is closed. If the tip progresses to requesting records, this tip is moved to the investigation phase for the purposes of this report as described below. |
| Frequency | Monthly |
| Timeframe | Thirtieth (30th) calendar day after the close of the month |
| MCO Report  Template  Filename | (MCO) PI1-PI7\_Program Integrity Report V15 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI2\_FWA Provider Notices

|  |  |
| --- | --- |
| Purpose | The Provider Notice tab is a way to track FWA provider notices submitted, supplemental information provided to MFCU without provocation, overpayment letters sent to providers and/or education letters sent to providers.  \*See **PI\_1** for shared template. |

PI3\_Recovery

|  |  |
| --- | --- |
| Purpose | The Recovery tab is used to track the amount and number of recoupments made throughout the reporting timeframe. \*See **PI\_1** for shared template. |

PI4\_Credible Allegation of Fraud (CAF)

|  |  |
| --- | --- |
| Purpose | This tab is to detail the CAFs that each MCO or DBM has in place. \*See **PI\_1** for shared template. |

PI5\_Iowa Medicaid Provider Action

|  |  |
| --- | --- |
| Purpose | This section describes actions that Iowa Medicaid has taken against a provider that the MCO or DBM implements. \*See **PI\_1** for shared template. |

PI6\_MCP Provider Action

|  |  |
| --- | --- |
| Purpose | This section highlights actions that the MCO or DBM has taken against a provider for program integrity reasons. \*See **PI\_1** for shared template. |

PI7\_Requests for PI Information

|  |  |
| --- | --- |
| Purpose | This section is to provide Iowa Medicaid with information that has been requested from the MCO or DBM relevant to program integrity. \*See **PI\_1** for shared template. |

PI14\_Non-PI Recoveries

|  |  |
| --- | --- |
| Purpose | This report shows the amount of money recovered due to a variety of non-program integrity related reasons. Although this section shows non-PI recoveries, these recoveries may show trends that do involve PI in the future. |
| Frequency | Monthly |
| Timeframe | Thirtieth (30th) calendar day after the close of the month |
| MCO Report  Template  Filename | (MCP) PI14\_Non-PI Recoveries V5 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI8\_Cost Avoidance Cost Savings

|  |  |
| --- | --- |
| Purpose | This section shows the amount of money saved as cost avoidances or cost savings. At the top of this report, there is a spot to update the MCO/DBM name and add the SFY.  Categories are broken down into Data Mining, Payment Policies, Internal Policy and Rule Changes and Proprietary Payment Edits (Non-CCI). There is a spot for categories listed below for categories not covered in those listed. Examples are SIU Pre-Payment Review and Audit Services, among other avoidance and saving techniques. |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCP) PI8-PI10\_Program Integrity Cumulative-Quarterly Update and Reporting V5 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI9\_PI Activity

|  |  |
| --- | --- |
| Purpose | This portion of the template shows activities completed surrounding member outreach, provider outreach, education, and prevention. At the top of this report, there is a spot to update the MCO/DBM name and add the SFY.  \*See **PI8** for shared template. |

PI10\_Algorithms

|  |  |
| --- | --- |
| Purpose | This section highlights each algorithm run by the MCO or DBM. There must be enough information reported to understand what was reviewed. At the top of this report, there is a spot to update the MCO/DBM name and add the SFY.  The definition that Iowa Medicaid is using for algorithms is as follows: Running data and identifying a pattern in your data that shows a potential program integrity concern. These are not to be confused with system edits.  \*See **PI8** for shared template. |

PI11\_Single Case Agreement (SCA)

|  |  |
| --- | --- |
| Purpose | This Excel spreadsheet is used to document all the single case agreements that the MCO or DBM had during the previous SFY. |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCP) PI11\_Single Case Agreement Quarterly Report V2 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI12\_Program Integrity Annual Work Plan

|  |  |
| --- | --- |
| Purpose | This template is in Excel and should be a brief plan to show what activities the MCO or DBM will complete throughout the year. |
| Frequency | Annual |
| Timeframe | No later than **July 30** for the prospective state fiscal year plan. |
| MCO Report  Template  Filename | (MCP) PI12\_Program Integrity Annual Work Plan V2 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI13\_Program Integrity Compliance Plan

|  |  |
| --- | --- |
| Purpose | This form is a word document that allows for an explanation for each section in each MCO or DBM Compliance Plan. |
| Frequency | Annual |
| Timeframe | No later than **July 30** for the prospective state fiscal year plan. |
| MCO Report  Template  Filename | (MCP) PI13\_Program Integrity Compliance Plan V3 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

PI15\_Annual Member Lock-in Report

|  |  |
| --- | --- |
| Purpose | This form is an Excel document that captures the members that have been locked throughout the previous State Fiscal Year. |
| Frequency | Annual |
| Timeframe | No later than **July 30** for the prospective state fiscal year plan. |
| MCO Report  Template  Filename | (MCP) PI15\_Annual Member Lock-in Report V2 |
| Definitions | Reference the ***Program Integrity Reporting Companion Guide*** |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

C. Claims

E-1. Claims Processing

|  |  |
| --- | --- |
| Purpose | Report and assess MCO claims processing activities |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) Consumer Reports V8 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

E-5. Claim Reprocessing and Adjustments

|  |  |
| --- | --- |
| Purpose | Monitor MCO processing of provider-initiated adjustments. \*See E-1 for shared template. |

E-6. Correct Coding Initiative Details

|  |  |
| --- | --- |
| Purpose | Monitor MCO correct coding initiatives |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) FinAdm E-6 Correct Coding Initiative Details V7 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

D. Financial Reporting

F-1. Iowa Financial MRT

|  |  |
| --- | --- |
| Purpose | Report and assess MCO revenue, income, expenses, program integrity, and third-party liability.  MRT = Medicaid Reporting Template |
| Frequency | Quarterly |
| Timeframe | Due 5/15, 8/15, 11/15, & 3/1 |
| MCO Report  Template  Filename | (MCO) FinAdm F1 Iowa Financial MRT V3 |
| Definitions | Reference the templates ***Data Definitions*** tab  **Special Note**: The new template includes previously reported B3 Insurance Premium Notice requirements and requires all MCOs to document effective and renewal dates of all their commercial lines insurance policies (e.g., GL, Auto, Property, WC, etc.). In addition to this requirement all MCOs must also submit copies of their Certificate of Insurance (COI) for each policy. MCOs will need to create a folder in **IMPA** titled “**Certificates of Insurance** (**COI**)” separate from monthly, quarterly, and annual report folders. Within 30-days of each policy renewal upload a copy of each certificate of insurance copy into this folder and send an FYI email to your account manager. The date files are loaded in this COI folder is the date that should be listed on the F-1 template.  **Attestation**: Print the **16. Certificate** tab to PDF, Sign, and date. Submit the printed attestation separately in the same folder for where we will deposit the reports.  Example filenames:  (MCO) FinAdm F1 Iowa Financial MRT V2 Q1 SFY24 – 11.15.2023  (MCO) FinAdm F1 Iowa Financial MRT Attestation Q1 SFY24 – 11.15.2023 |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: September 2023 |

B-2. Annual Independent Audit

|  |  |
| --- | --- |
| Purpose | Audit MCO financials |
| Frequency | Annually |
| Timeframe | Within six months following the end of each calendar year (**June 30**) |
| MCO Report  Template  Filename | (MCO) FinAdm B-2 Annual Independent Financial Audit V1 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed  Template | Yes |
| Report Effective Date | Template provided to MCO: 09/28/2016  First Reporting Period: n/a  First Production Due: n/a |

E. Electronic Visit Verification (EVV)

G-1. Method of Verification

|  |  |
| --- | --- |
| Purpose | Monitor use of Electronic Visit Verification (EVV) by verification type |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) FinAdm G1 EVV Verification Methods V2 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

G-2. EVV Maintenance and Operations

|  |  |
| --- | --- |
| Purpose | Provide information on oversight of EVV maintenance and operations |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) FinAdm G2 EVV Maintenance and Operations  \* **No Prescribed Template** |
| Definitions | For EVV maintenance and operations oversight, MCOs have submitted a report that includes the following data and visualizations. Please provide the Iowa Medicaid approved maintenance and operations report quarterly.   1. Executive summary    1. Visits/ Claims by provider type    2. Enhancements    3. Change order requests    4. Trends/ Insights 2. Monthly visit summary/ check in method by provider type 3. On time/ late (1-3 hrs)/ missed (3+ hours) visits 4. Manual entry reason codes    1. Caregiver error    2. Forgot to clock in/out    3. No access to application or IVR    4. Technical error    5. Other 5. Claimed visits 6. Claimed amounts 7. Visits with pre-billing edits 8. Open & resolved pre-billing alerts 9. Pre-Billing Edits/Alerts (Top 5 Cumulative) for Providers 10. Pre-Billing Edits/Alerts (Top 5 Cumulative) for Payer 11. Glossary of terms |
| Prescribed Template | No |
| Report Effective Date | Template provided to MCO: n/a  First Reporting Period: Q1 SFY2022  First Production Due: 10/30/2021 |

G-3. Claiming and Attestation for Service Codes Included in EVV

|  |  |
| --- | --- |
| Purpose | To track payments made on claims that were not submitted via the EVV system and to assure that attestations for not using an EVV system have been received. |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | See G-1 template |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

# Access and Quality (AccQual) Reporting

This section outlines definitions for the following reports:

1. Member Support and Satisfaction
2. Provider Network Access and Credentialing
3. Quality Management
4. Health Outcomes
5. Long Term Care Services and Supports
6. Prior Authorizations

A. Member Support and Satisfaction

A-1. Completion of Initial and Comprehensive Health Risk Assessment (Senior, Adult and Child)

|  |  |
| --- | --- |
| Purpose | Monitor MCO health risk assessment activities |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A1 A5 D1 E1 Care Coordination V15 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

A-5. Reassessments and Update of Care Plans (Senior, Adult and Child)

|  |  |
| --- | --- |
| Purpose | Monitor MCO care plan updates. \*See **A-1** for shared template. |

A-8. Helpline Performance

|  |  |
| --- | --- |
| Purpose | Monitor call center performance |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A8 B6 Helplines V4 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

A-10. Member Grievances and Appeals (Adult and Child)

|  |  |
| --- | --- |
| Purpose | Monitor the volume of MCO member grievances |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A-10 Grievances and Appeals V11 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

A-11. CAHPS Survey Results

|  |  |
| --- | --- |
| Purpose | Monitor MCO CAHPS rates |
| Frequency | Annually |
| Timeframe | No later than **July 15th** of reporting year |
| MCO Report  Template  Filename | (MCO) AccQual A-11 CAHPS Annual V4 |
| Definitions | CAHPS survey results; Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: May 2022 |

A-12. Value-Added Services

|  |  |
| --- | --- |
| Purpose | Monitor value-added service provision and utilization |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A-12 Value-Added Services V6 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: 06/28/2019  First Reporting Period: SFY2020 Q1  First Production Due: 10/30/2019 |

A-13. Revised Assessments

|  |  |
| --- | --- |
| Purpose | Monitor assessment revisions |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A-13 Revised Assessments V3 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: 09/29/2017  First Reporting Period: SFY 2018 Q1  First Production Due: 10/30/2017 |

A-14. Revised Care Plans

|  |  |
| --- | --- |
| Purpose | Monitor care plan revisions |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual A-14 Revised Care Plans V5 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: 07/24/2018  First Reporting Period: SFY 2019 Q1  First Production Due: 10/30/2018 |

A-15. Care Plan Reductions

|  |  |
| --- | --- |
| Purpose | Report reductions or terminations in services |
| Frequency | Monthly |
| Timeframe | Thirtieth (30th) calendar day after the close of the month |
| MCO Report  Template  Filename | (MCO) AccQual A-15 Care Plan Reductions V7 (aka **Step 1**):  **Step 1**: MCO sends **all** Care Plan Reductions and Terminations for a specific month.    (MCO) AccQual A-15 Sample Care Plan Reductions V6 (aka **Step 2 - 4**):  The Sample template is used to go back and forth between Iowa Medicaid and MCO.  **Step 2**: Iowa Medicaid will take a **random sample** from the Step 1 template and apply to the Sample template. File is then renamed Step 2.  **Step 3**: MCO completes additional information and sends completed file back to Iowa Medicaid. The MCO does not rename file.  **Step 4**: Iowa Medicaid completes review process, renames file to Step 4, and returns to MCO for their records.  **Note**: If applicable, the MCO will be notified if an additional response is required. |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | **Step 1**:  Template provided to MCO: May 2022  **Sample**:  Template provided to MCO: May 2022 |

A-16. Planned Coordination Events

|  |  |
| --- | --- |
| Purpose | Document observations of the service planning process |
| Frequency | Monthly |
| Timeframe | Thirtieth (30th) calendar day after the close of the month |
| MCO Report  Template  Filename | (MCO) AccQual A16 Planned Coordination Events V9 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

B. Provider Network Access and Credentialing

B-3. 24-Hour Provider Access

|  |  |
| --- | --- |
| Purpose | Monitor MCO provider network for providers available 24 hours, seven days a week. |
| Frequency | Annually |
| Timeframe | No later than **July 15** of the reporting year |
| MCO Report Template Filename | No prescribed template |
| Definitions | MCOs must monitor 24-hour provider access throughout the year and provide an annual report of monitoring activities. The MCO is required to submit a report that includes the following:   1. Providers Reviewed [Count]    1. Providers Identified with Less than 24/7 Availability [Count and %] 2. Corrective Action Plan Submitted    1. Yes    2. No 3. Date Corrective Action Plan Submitted to DHS |
| Prescribed Template | No |
| Report Effective Date | Template provided to MCO: n/a  First Reporting Period: n/a  First Production Due: n/a |

B-4. Provider Credentialing

|  |  |
| --- | --- |
| Purpose | Monitor MCO provider credentialing procedures |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual B-4 Provider Credentialing V6 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

B-5. Subcontractor Compliance Reporting

|  |  |
| --- | --- |
| Purpose | Monitor MCO subcontractor compliance |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual B5 Subcontractor Compliance V1 |
| Definitions | Reference the templates **Data Definitions** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

B-6. Provider Helpline Performance

|  |  |
| --- | --- |
| MCO Report  Template  Filename | Member and Provider Helplines are now consolidated using the AccQual A8 B6 Helplines template to also include NEMT. See section A-8.  \*See A8 for shared template. |

B-10. Geographic Access & Exceptions

|  |  |
| --- | --- |
| Purpose | Monitor geographic access of the provider network. |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the month |
| MCO Report  Template  Filename | (MCO) AccQual B10 Geographic Access and Exceptions V4 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

C. Quality Management

C-1. Quality Management / Improvement Work Plan

|  |  |
| --- | --- |
| Purpose | Monitor MCO plan for quality management and quality improvement activities |
| Frequency | Annually |
| Timeframe | No later than **July 15** |
| MCO Report  Template  Filename | No Prescribed Template |
| Definitions | The MCO is required to submit a Quality Management/ Improvement Work plan that includes an analysis and evaluation of the last year’s quality strategies and outcomes.  Additionally, the MCO is required to submit a report that includes the following elements for the prospective year:   1. Scope of population 2. Planned activity name 3. Goals/Measurable objectives 4. Person responsible 5. Data source 6. Data collection methodology 7. Reporting frequency 8. Start date 9. End date 10. Status |
| Prescribed Template | No |
| Report Effective Date | Template provided to MCO n/a  First Reporting Period: n/a  First Production Due: n/a |

D. Health Outcomes

D-1. Care Coordination Report (Adult and Child)

|  |  |
| --- | --- |
| Purpose | Monitor MCO care coordination and community-based case manager procedures. \*See **A-1** for shared template. |

D-11. Annual HEDIS Report

|  |  |
| --- | --- |
| Purpose | Monitor MCO HEDIS rates |
| Frequency | Annually |
| Timeframe | No later than **July 15th** of reporting year |
| MCO Report  Template  Filename | Plans must provide HEDIS data to the Agency based on current National Committee for Quality Assurance (NCQA) reporting measures in an **Excel Workbook** format. |
| Definitions | MCO HEDIS report |
| Prescribed Template | Refer to **NCQA** (Excel Workbook format) |
| Report Effective Date | n/a |

E. Long-Term Care Services and Supports

E-1. PASSR Evaluations and Specialized Services

|  |  |
| --- | --- |
| Purpose | Monitor MCO PASSR Evaluations and Specialized Services. \*See[**A-1**](#A_1_A_5)for shared template. |

E-2. MDS Section Q Screens

|  |  |
| --- | --- |
| Purpose | Monitor MCO MDS Section Q screens |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter  All measures suspended |
| MCO Report  Template  Filename | (MCO) AccQual E2 E6 E9 Waivers V13 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: October 2023 |

E-6. Fall Risk Management

|  |  |
| --- | --- |
| Purpose | Monitor MCO fall risk management. \*See **E2** for shared template. |

E-8. Level of Care/ Functional Assessment

|  |  |
| --- | --- |
| Purpose | Monitor MCO hospital admissions |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual E8 LTSS V8 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: 07/15/2020  First Reporting Period: SFY 2021 Q1  First Production Due: 10/30/2020 |

E-9. Care Plans Completed

|  |  |
| --- | --- |
| Purpose | Monitor MCO completion of care plans. \*See **E2** for shared template. |

E-10. Employment

|  |  |
| --- | --- |
| Purpose | Monitor MCO employment outcomes for LTSS members |
| Frequency | Quarterly |
| Timeframe | Data collection periods should cover the last 2 full weeks of the listed month beginning on Sunday and ending on Saturday (see example below). Submit completed reports with all other quarterly reports.   |  |  | | --- | --- | | Data Collection Periods | IME Due Date | | Last 2 full weeks of **July** | Submit with **Q1** Reports (10/30) | | Last 2 full weeks of **October** | Submit with **Q2** Reports (1/30) | | Last 2 full weeks of **January** | Submit with **Q3** Reports (4/30) | | Last 2 full weeks of **April** | Submit with **Q4** Reports (7/30) |   A calendar with numbers and a red line  Description automatically generated with low confidence |
| MCO Report  Template  Filename | (MCO) AccQual E10 Employment V5 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: June 2021  First Reporting Period: See table above  First Production Due: See table above |

E-12. Non-Emergency Medical Transportation (NEMT)

|  |  |
| --- | --- |
| Purpose | Monitor MCO non-emergency medical transportation |
| Frequency | Quarterly Split-by-Month |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual E-12 NEMT V6 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: 09/29/2017  First Reporting Period: SFY 2018 Q1  First Production Due: 10/30/2017 |

E-14. Iowa Participant Experience Survey (IPES)

|  |  |
| --- | --- |
| Purpose | Monitor MCO IPES results. |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter |
| MCO Report  Template  Filename | (MCO) AccQual E14 IPES V4 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: June 2021  First Reporting Period: Q1 SFY2022  First Production Due: 10/30/2021 |

E-17. CMS NEW 1915c and 1915i Reporting

|  |  |
| --- | --- |
| Purpose | Monitor MCO performance in CMS evidentiary measures. |
| Frequency | Quarterly |
| Timeframe | Thirtieth (30th) calendar day after the close of the quarter  \***Note**: E-17 data is reported quarterly; however, measures are reported with a 90-day lag |
| MCO Report  Template  Filename | (MCO) AccQual E-17 CMS NEW 1915c and 1915i V10 |
| Definitions | Reference the templates ***Data Definitions*** tab |
| Prescribed Template | Yes |
| Report Effective Date | Template provided to MCO: May 2023 |

F. Prior Authorizations

F-1. Prior Authorizations

|  |  |
| --- | --- |
| Purpose | Monitor MCO service prior authorization performance. \*See E-1 for shared template. |

G. Managed Care Program Annual Report (MCPAR)

G-1. MCPAR – Plan Level Information

|  |  |
| --- | --- |
| Purpose | The annual **Managed Care Program Annual Report** (**MCPAR**) reporting template contains data from various departments within the state to include all participating MCOs.  **Iowa Medicaid Responsibility**  Iowa Medicaid is responsible for consolidating all reported data and will submit the completed report to CMS no later than 180 days after the end of the State Fiscal Year. A completed copy will also be posted to the DHS website.  **MCO Responsibility**  Each MCO is responsible for completing **Topics IV** and **X** of the **D1\_Plan\_set-indc** tab only. The template itself provides all instruction to include the exclusion of CHIP data, if possible.  **Topic IV. -** Grievance, Appeals, and State Fair Hearings  **Topic X**. - Program Integrity |
| Frequency | Annual |
| Timeframe | No later than **September 30** |
| MCO Report  Template  Filename | Download and complete the template from Medicaid.gov. Rename template to MCO Abbreviation + MCPAR + SFY + Date Submitted. **Example**: AGP MCPAR SFY2022 10302022 |
| Definitions | Reference the macpar-reporting template |
| Prescribed Template | See <https://www.medicaid.gov/medicaid/managed-care/guidance/medicaid-and-chip-managed-care-reporting/index.html>  **Note**: Look for an Excel document link within the Managed Care Program Annual Report section. |
| Report Effective Date | First Reporting Period: SFY2022 (Jul 1, 2021, to Jun 30, 2022)  First Production Due: 9/30/2022 |

# MCO Reporting Manual - Change Log

| **Version** | **MCO Reporting Manual - Change Log** |
| --- | --- |
| V2 | * Original Published to MCOs |
| V3 | * Added **E-9. Staff Resource Monitoring** report * Added **E-10. Communications** report * Added **A-13. Revised Assessments** report * Added **A-14. Revised Care Plans** report * Added **A-15. Care Plan Reductions** report * Added **A-16. Planned coordination Events** report |
| V4 | * Updated **A-2. Care Coordination** definitions * Updated **A-3. Setting and Service** definitions * Updated **B-1. Population Descriptive** (**Adult and Child**) definitions * Updated **B-2. Care Coordination** (**Adult and Child**) definitions * Updated **B-5. Health Care Outcomes** (**Adult and Child**) definitions * Updated **B-6. Member Outcomes** (**Adult and Child**) definitions * Updated **C-2. Care Coordination** (**Adult and Child**) definitions * Updated **C-5. Health Care Outcomes** (A**dult and Child**) definitions * Updated **C-6. Member Outcomes** (**Adult and Child**) definitions * Updated **D-2. Care Coordination** (**Adult and Child**) definitions * Updated **D-3. Setting and Service** (**Adult and Child**) definitions * Updated **D-4. Health Care Outcomes** (**Adult and Child**) definitions * Updated **D-5. Access and Provider Satisfaction** (**Adult and Child**) definitions * Updated **B-6. Financial Ratios** definitions * Updated **C-1. Physician Incentives**:   + Switched from using “no prescribed template” to FinAdm C-1 Physician Incentives   + Updated definitions * Updated **E-1. Claims Processing** definitions * Updated **E-3. Point of Sale** (**POS**) **Claims** (**Pharmacy**) definitions * Updated **E-6. Correct Coding Initiative Details** definitions * Updated **E-7. Provider Type Reimbursement** definitions * Updated **A-12. Value-Added Services** definitions * Updated **A-15. Care Plan Reductions** definitions * Updated **D-5. Children’s Health Outcomes** definitions * Updated **D-6. Prenatal and Childbirth Outcomes** definitions * Updated **D-7. Chronic Condition Management** definitions * Updated **D-10. Adult Preventive Care** definitions * Updated **E-8. Level of Care/Functional Assessment** definitions * Updated **E-12. Non-Emergency Medical Transportation** (**NEMT**) definitions |
| V5 | * Removed the following quarterly population reports:   + **Pop A-1-A-6 Elderly**:     - A-1. Population Descriptive     - A-2. Care Coordination     - A-3. Setting and Service     - A-4. Critical Incidents     - A-5. Health Care Outcomes     - A-6. Member Outcomes   + **Pop B-1-B-6 Special Needs**:     - B-1. Population Descriptive (Adult and Child)     - B-2. Care Coordination (Adult and Child)     - Purpose     - B-3. Setting and Service (Adult and Child)     - B-4. Critical Incidents (Adult and Child)     - B-5. Health Care Outcomes (Adult and Child)     - B-6. Member Outcomes (Adult and Child)   + **Pop C-1-C-7 Behavioral Health**:     - C-1. Population Descriptive (Adult and Child)     - C-2. Care Coordination (Adult and Child)     - C-3. Setting and Service (Adult and Child)     - C-4. Critical Incidents (Adult and Child)     - C-5. Health Care Outcomes (Adult and Child)     - C-6. Member Outcomes (Adult and Child)     - C-7. Evidence Based Practice (Adult and Child)   + **Pop D-1-D-5 General**:     - D-1. Population Descriptive (Adult and Child)     - D-2. Care Coordination (Adult and Child)     - D-3. Setting and Service (Adult and Child)     - D-4. Health Care Outcomes (Adult and Child)     - D-5. Access and Provider Satisfaction (Adult and Child) * Updated **A-1. Third Party Liability Payments and Recoveries** report frequency from “quarterly and annually” to quarterly * Removed **A-2. Third Party Covered Members** report * Updated **B-6. Financial Ratios** definitions * Updated **C-1. Provider Incentives** definitions * Added annual **FinAdm C-2 CMMI Reporting** * Several Program Integrity Updates:   + Removed **FinAdm D-1-D-8, D-11 Program Integrity** report     - D-1. Summary     - D-2. TIPS     - D-3. Audits-Investigations     - D-4. Provider Referrals Made     - D-5. Overpayments     - D-6. New PI Actions     - D-7. List of Involuntary Terms     - D-8. All Other Cost Avoidance     - D-11. Credible Allegation of Fraud (CAF)   + Removed **FinAdm D-9-Member Program Integrity** report     - D-9. Members Referred to DIA- Iowa Medicaid   + Updated **D-10. Program Integrity** (**Compliance**) **Workplan** report from monthly to annual to include changes to definitions   + Added **FinAdm D-1-D-5 Program Integrity** report   + Added **FinAdm D-6 - Cost Avoidance** report     - **Note**: Reporting Manual stated monthly, but is a quarterly report * New monthly **Consumer Reports AccQual A8-B6 F1-F4 FinAdm E1-E5** template replaces the following:   + **FinAdm E-1-E-5 Claims Processing**     - E-1. Claims Processing     - E-2. Claims Denials     - E-3. Point of Sale (POS) Claims (Pharmacy)     - E-4. POS Claims Denials – Top 10 Reasons for Claims Denial   + **AccQual A-8 B-6 Helpline Performance**     - A-8. Member Helpline Performance     - B-6. Provider Helpline Performance   + **AccQual F-1-F-4 Prior Authorization**     - F-1. Prior Authorizations     - F-2. Prior Authorization Denial and Modification     - F-3. Pharmacy Prior Authorization     - F-4. Pharmacy Prior Authorization Denial and Modification * Updated **E-6. Correct Coding Initiative Details** definitions * Removed **E-7. Provider Type Reimbursement** report * Removed **E-8. Utilization** report * New **AccQual A1 A5 D1 E4 Care Coordination** template replaces the following:   + **AccQual A-1-A-2 Risk Assessment**     - A-1. Completion of Initial Health Risk Assessment (Adult and Child)     - A-2. Completion of Comprehensive Health Risk Assessment (Adult and Child)   + **AccQual A-3-A-4 Risk Assessment Attempts**     - A-3. Attempts to Contact Members for Initial Health Risk Assessment – No Assessment Completed     - A-4. Attempts to Contact Members for Comprehensive Risk Assessment – No Assessment Completed   + **AccQual A-5 Updated Care Plans**   + **AccQual D-1 Care Coordination** * Removed **A-6. Value-Based Purchasing** (**VBP**) **Enrollment** (**Adult and Child**) report * Removed **A-7. Primary Care Provider** (**PCP**) **Assignment** report * Removed **A-9. Member Enrollment and Disenrollment (Adult and Child**) report * Updated **A-10. Member Grievances and Appeals** (**Adult and Child**) definitions * Updated **A-12. Value-Added Services** definitions * Updated **A-15 A. Care Plan Reductions** title to include “A” * Added **A-15 B. SAMPLE Care Plan Reductions** report * Replaced **B-2. Geographic Access – Key Issues** with **AccQual B-2 – MCO Provider Exception** Request * Several **B-3. 24-Hour Provider Access** updates:   + Changed from quarterly to annual   + Switched from using the AccQual B-3 24 Hr. Provider template to “no prescribed template”   + Updated definitions * Updated **B-4. Provider Credentialing** definitions * Several **B-5. Subcontractor Compliance Reporting** updates:   + Updated report title   + Switched from using the AccQual B-5 Subcontractor Compliance template to “no prescribed template”   + Updated definitions * Added **B-7. Provider Market Share** report * Added **B-8. Provider Ratios** report * Added **B-9. GeoAccess Maps** report * Updated **C-1 Quality Management/ Improvement Work** **Plan** report frequency from quarterly to annual * Updated **C-2. Quality Management** (**QM**) **Committee Meeting Minutes** report   + Switched from using the AccQual C-2 QM Committee Meeting Minutes template to “no prescribed template”   + Updated definitions * Updated **AccQual D-2-D-4 Foster Children Health** Outcomes prescribed template by adding asterisk to advise can use interim HEDIS reports instead of required template:   + D-5. Children’s Health Outcomes   + D-6. Prenatal and Childbirth Outcomes   + D-10. Adult Preventive Care * Removed **D-7. Chronic Condition Management** report * Removed **D-8. Hospital Admissions** (**Adult and Child**) report * Removed **D-9. Emergency Department Use** (**Adult and Child**) report * Removed **E-3. Average Length of Stay/Days of Care** report * Updated **E-5. Out-of-State Placement (Adult, Child, Child in Need of Assistance** [**CINA**] **and Juvenile Court System** [**JCS**]) definitions * Updated **E-8. Level of Care/Functional Assessment** definitions * Several **E-10. Employment** updates:   + Changed from quarterly to biannual   + Switched from using the AccQual E-1-E-4 E-7 E-9-E-11 Waivers template to AccQual E-10 Employment   + Updated definitions * Added **E-14. Iowa Participant Experience Survey** (**IPES**) report * Added **E-15. CMS** **1915**(**c**) **Reporting** * Added **E-16. CMS Habilitation Reporting** |
| V6 | * Corrected the **D-6. Cost Avoidance** report to quarterly * Updated the **D-10. Program Integrity** (**Compliance**) **Workplan** report   + Changed from annual to “annual with quarterly updates”   + Updated definitions * Updated **Consumer Reports AccQual A8-B6 F1-F4 FinAdm E1-E5** to quarterly * Corrected **the E-3. Point of Sale** (**POS**) **Claims** (**Pharmacy**) template to **Consumer Reports AccQual A8-B6 F1-F4 FinAdm E1-E5** * Updated **A-1. Completion of Initial and Comprehensive Health Risk Assessment** (**Senior, Adult and Child**) definitions * Updated timeframe for the biannual **E-10. Employment** report |
| V7 | * Several Program Integrity Updates   + Updated **D-1. Fraud, Waste, Abuse** definitions   + Updated **D-6. Cost Avoidance** definitions   + Updated **D-10. Program Integrity** (**Compliance**) **Workplan** definitions * Updated **E-1. Claims Processing** from monthly to quarterly to include changes to definitions * Updated **E-2. Claims Denials** from monthly to quarterly * Updated **E-3. Point of Sale** (**POS**) **Claims** (**Pharmacy**) report frequency from monthly to quarterly to include updated definitions * Updated **E-4 POS Claims Denials – Top 10 Reasons for Claims** **Denial** from monthly to quarterly * Updated **E-5. Claim Reprocessing and Adjustments** from monthly to quarterly to include changes to definitions   + Updated **A-8. Member Helpline Performance** from monthly to quarterly to include changes to definitions * Updated **A-16. Planned coordination Events** from monthly to quarterly * Updated **B-1. Geographic Access – HCBS & Non-HCBS and B-2. Provider Exception Request** from monthly to quarterly * Updated **B-6. Provider Helpline Performance** definitions   + **Note**: Missed updating frequency and timeframe change from monthly to quarterly * Updated **B-7. Provider Market Share** from monthly to quarterly * Added **C-3. Stakeholder Advisory Board** (**SAB**) **Meeting Minutes** report * Removed **D-2. Foster Children Receiving 2+ Psychotropic Drugs** report * Removed **D-3. Foster Children Prescribed Medications for Behavioral Health Diagnosis** report * Removed **D-4. Foster Children Receiving EPSDT Screening** report * Updated **D-5. Children’s Health Outcomes** definitions * Updated name of the **D-6. Prenatal and Childbirth Outcomes** to **D-6. Adult Health Outcomes** to include changes to definitions * Changed name of the **D-10. Adult Preventive Care** report to **D-10. Adult and Child Health Outcomes** to include changes to definitions * Updated name of the **D-11. HEDIS Report** to the **D-11. Annual HEDIS Report** * Removed the **E-5. Out-of-State Placement** (**Adult, Child, Child in Need of Assistance** [**CINA**] **and Juvenile Court System** [**JCS**]) report * Updated **E-6 Fall Risk Management** report from monthly to quarterly * Updated **F-1. Prior Authorizations** report from monthly to quarterly to include changes to definitions * Updated **F-2. Prior Authorization Denial and Modification** report from monthly to quarterly * Updated **F-3. Pharmacy Prior Authorization** report from monthly to quarterly * Updated **F-4. Pharmacy Prior Authorization Denial and Modification** report from monthly to quarterly |
| V8 | * Added note that the **E-9. Staff Resource Monitoring** and **E-10. Communications** reports would have final production for SFY18Q1 due 10/30/17 * Updated **E-12. Non-Emergency Medical** **Transportation** (**NEMT**) report from monthly to quarterly * Updated **A-5. Non-LTSS Reassessments and Update of Care** **Plans** (**Senior, Adult and Child**) report name to **A-5. Reassessments and Update of Care Plans** (**Senior, Adult and Child**) * Corrected **B-6. Provider Helpline Performance** report to quarterly |
| V9 | * Updated **FinAdm C-1 Provider** **Incentives** definitions * Updated **D-11. Annual HEDIS Report** template requirement from “no prescribed template” to using the National Committee for Quality Assurance reporting template |
| V10 | * Several Program Integrity Updates   + Replaced **D-1-D-4 Program Integrity** reporting template with **D-1-D-4, D-6 – D-7 Program Integrity**   + Replaced **D-10. Program Integrity** (**Compliance**) **Workplan** reporting template with **D-10. PI Quarterly Work Plan Update**     - Changed from “annual with quarterly updates” to quarterly     - Added D-11. Algorithms report * Several **AccQual E1-E2 E6 E7 E9 E11** Waivers updates   + Removed E-1. PASSR Evaluations and Specialized Services   + Removed E-7. Self-Direction   + Removed E-11. Community Rebalancing * Removed **E-4. Return to Community** report * Removed **E-9. Staff Resource Monitoring** report * Removed **E-10. Communications** report * Replaced **E-15. CMS 1915**(**c**) **and E-16. CMS Habilitation** reporting template with **E-17. CMS NEW 1915c and 1915i Reporting** * Updated **A-16. Planned Coordination Events** from quarterly to monthly |
| V11 | * Added **FinAdm F-1 Monthly Financial Package Report** |
| V12 | * Added back **E-1. PASSR Evaluations and Specialized Services** report   + Previous report * Updated **A-12. Value-Added Services** definitions * Added F-1 Report to table of contents |
| V13 | * Corrected **B-9 GeoAccess Maps** from Monthly to Biannual |
| V14 | * Submission Requirements   + Added **Decommissioned Reports** section   + Updated **File Name** section     - Clarified overall format     - Added examples   + Updated Iowa Medicaid’s SharePoint Site section to advise all reports are submitted to the SharePoint Site except for the **Member & Provider Tip Report**   + Updated **Resubmitted** or **Corrected Reports** with examples for corrected filenames   + Added **Rounding Standards**   + Updated Prescribed Templates section to address exceptions for when there is no data to report in text and numeric fields * All templates are now imbedded in Reporting Manual; Individual copies will still be maintained in **SharePoint** * If applicable, report “Definitions” were removed and replaced with “Reference the templates Data Definitions tab” * Updated **A-15 Care Plan Reductions** instructions * Updated A16 Planned Coordination Events template * Updated B3 Insurance Premium template * Several Program Integrity Updates   + Removed **FinAdm D-1-D-4, D-6 – D-7 Program Integrity**     - D-1. Fraud, Waste, Abuse     - D-2. CAF     - D-3. IME Provider Actions     - D-4. MCO Provider Actions     - D-6. Cost Avoidance/ Cost Savings     - D-7. Audit Recovery Report   + Removed **FinAdm D-5 Total Non-PI Recoveries**   + Removed **FinAdm D-8 Program Integrity Compliance Plan**   + Removed **FinAdm D-9 Program Integrity Annual Work Plan**   + Removed **FinAdm D-10 – D-11 Program Integrity Work Plan Quarterly Update**     - D-10. PI Quarterly Work Plan Update     - D-11. Algorithms   + Added **Program Integrity Member** & **Provider Tip Report**   + Added **PI1-PI7\_Program Integrity Report**     - PI\_1 Investigative Activities     - PI2\_FWA Provider Notices     - PI3\_Recovery     - PI4\_Credible Allegation of Fraud     - PI5\_IME Provider Action     - PI6\_MCO Provider Action     - PI7\_Requests for PI Information   + Added **PI14\_Total Non-PI Recoveries**   + Added **PI8-PI10\_Program Integrity Cumulative-Quarterly Update and Reporting**     - PI8\_Cost Avoidance Cost Savings     - PI9\_PI Activity     - PI10\_Algorithms   + Added **PI11\_Single Case Agreement Annual Report**   + Added **PI12\_Program Integrity Annual Work Plan**   + Added **PI13\_Program Integrity Compliance Plan** * **Several Provider Network Access Changes**   + Removed the following:     - B-1. Geographic Access - Non-HCBS     - B-1. Geographic Access - HCBS     - B-2. Provider Exception Request     - B-7. Provider Market Share     - B-8. Provider Ratios     - B-9. GeoAccess Maps   + Added B10 Geographic Access and Exceptions template * Updated E14 IPES template * Updated E10 Employment template |
| V15 | * Updated E8 LTSS template * Updated B10 Geographic Access and Exceptions template * Updated A16 Planned Coordination Events template * Updated Consumer Reports template/Shortened file name to “Consumer Reports” * Add new A8 B6 Helplines template * Updated E12 NEMT template |
| V16 | * All templates are imbedded in the Reporting Manual; Individual copies will also be maintained using **Iowa Medicaid Portal Access** (**IMPA**) * Updated E10 Employment template * Updated A15 Service Plan Reductions template * Added new G1 EVV Verification Methods template * Added G2 EVV Maintenance and Operations requirements (no prescribed template) * Updated C1 Provider Incentives template * Updated A8 B6 Helplines template * Added new D12 MCO Children Summary template * Updated E14 IPES template * Several Program Integrity Updates   + **Updated** - PI1-PI7\_Program Integrity Report V13   + **Updated** - PI8-PI10\_Program Integrity Cumulative-Quarterly Update and Reporting V4   + **New -** PI15\_Program Integrity Annual Member Lock-in Report V1 * Updated A1 A5 D1 E1 Care Coordination template * Updated E17 CMS New 1915c and 1915i template * Updated B6 Financial Ratios template * Removed **AccQual D-5 D-6 D-10 Health Outcomes** template |
| V17 | * All templates are imbedded in the Reporting Manual; Individual copies will also be maintained using **Iowa Medicaid Portal Access** (**IMPA**) * Replaced wording “**Enterprise**” and “**IME**” with “**Iowa Medicaid**” in updated templates * Removed **F-1 Monthly Financial** template. * Removed **G1 EVV Verification Methods** template from reporting manual * Removed requirement to submit **C-2 Quality Management** (**QM**) **Committee Meeting Minutes** on a quarterly basis. However, notes should be available upon request, as stated in contact. * Removed requirements to submit **C-3 Stakeholder Advisory Board** (**SAB**) Meeting minutes on a quarterly basis. However, notes should be available upon request, as stated in contact. * Several Program Integrity Updates   + Updated all **Annual Program Integrity** template due dates from **July 15** to **July 30** (PI11, PI12, PI13, and PI15)   + Updated **Program Integrity Provider Tip Report**   + Updated **PI14 Non-PI Recoveries** template   + Updated **PI1-PI7 Program Integrity Report** * Updated E-6 Correct Coding Initiative template * Updated Consumer Reports template * Added G1 MCPAR - Plan Level Information template * Updated A-15 and A-15 Sample templates * Updated AccQual E17 CMS 1915c and 1915i template * Added AccQual H1 Exceptions to Non-Covered Drugs template * Updated AccQual A11 CAHPS template * Updated AccQual A10 Grievance and Appeals template * Updated AccQual D12 MCO Children Summary template * Updated A1 A5 D1 E1 Care Coordination template * Updated AccQual E2 E6 E9 Waiverstemplate * Updated A16 Planned Coordination Events template |
| V18 | * Corrected Expedited Appeals "timely" formula on the **A10 Member Grievances and Appeals** template * Corrected Summary tab formula to include “**Other**” in total calculation on the **PI14\_Non-PI Recoveries** template * Updated **B4 Provider Credentialing** template. – New version suspended until 7/1/2023 * Updated **E17 CMS NEW 1915c and 1915i Reporting** template * Updated **A15 Service Plan Reductions** template   + Both A-15 templates * Added new **F1 Iowa Financial MRT** template   + Removed **B1 Iowa Insurance Division** **(IID**) **Reporting** template   + Removed **B3 Insurance Premium** template   + Removed **B4 Reinsurance** template   + Removed **B6 Financial Ratios** template   + Removed **A1 Third-Party Liability** (**TPL**) **Payments and Recoveries** template |
| V19 | * Updated several **Program Integrity Templates** with minor verbiage changes   + The most notable change is the **PI11\_Single Case Agreement Report** is switching from Annual to Quarterly * Updated **AccQual E17 CMS 1915c and 1915i** template * Updated **AccQual A-16 Planned Coordination Events** template * Updated **AccQual A8 B6 Helplines** template * Updated **AccQual A10 Grievance and Appeals** template * Updated **AccQual** **B4 Provider Credentialing** template * Removed **AccQual H1 Exceptions to Non-Covered Drugs** template * Removed **AccQual D12 MCO Children Summary** template * Removed **Program** **Integrity**’**s** **Member** and **Provider Tip** templates |
| V20 | * Updated F1 Financial MRT - Medical template and Supplemental Guide * Updated Appeals & Grievance Template * Updated Consumer Report Template * Created prescribed template to capture B5 Subcontractor Compliance * Adding back FinAdm G1 EVV Verification Methods V2 template   Quick update to “**Data Definitions**” tabs for the following templates. Under the “**Reporting Requirements**” section the verbiage has been updated by removing reference to specific numbered contract sections and replaced with generalized language (e.g., set forth in the Iowa Health Link contracts...):   * AccQual A1 A5 D1 E1 Care Coordination * AccQual B4 Provider Credentialing * AccQual A8 B6 Helplines * AccQual E2 E6 E9 Waivers * FinAdm E6 Correct Coding Initiative * B10 Geographic Access and Exceptions template |

# MCO Reporting Manual Calendar

\*Includes State Holidays.

| **Version** | **MCO Reporting Manual - Change Log** |
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| V34 |  |