Iowa Medicaid Enterprise

Managed Care
Annual Performance Report

(July 2019 – June 2020)

Published December 2020

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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 flows as follows:

- 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 (MCO) 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 includes the information for the two Iowa Medicaid MCOs:

- Amerigroup Iowa, Inc. (Amerigroup, AGP)
- Iowa Total Care (ITC)

Notes about the reported data:

- This annual report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- 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, 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 (MLR) information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available fee-for-service (FFS) historical baselines, encounter data, and by reviewing the source data provided by the MCOs.

Highlights:

- Percentage of Grievances Resolved Within 30 Calendar Days of Receipt: In all quarters for state fiscal year (SFY) 2020, both health plans resolved 100% of standard grievances within 30 calendar days of receipt.

- Non-Pharmacy Regular Prior Authorizations: Both MCOs met the contractual requirement to complete one hundred percent (100%) of regular non-pharmacy PAs within 14 days of request for all four quarters of SFY20.

- Percentage of Clean Non-Pharmacy Claims Paid Within 30/45 Days: This measure is being reported separately for ITC this year due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The Department will continue to monitor ITC's progress toward resolving this issue.

- Enrollment Increase/Disenrollment Decrease: Due to the effects of COVID-19 in Iowa, disenrollment from Medicaid was suspended in Iowa starting in March 2020. As a result, the total number of members enrolled increased in the second half of SFY2020, and the total number of members disenrolled dropped.

- ITC HEDIS and CAHPS: Due to ITC entering the Iowa market in July 2019, the first HEDIS and CAHPS measures to be reported for ITC (for calendar year 2020) will be in July 2021 and included in the December 2021 annual report.

Oversight Summaries:

Within the requirements of 2016 Iowa Acts Section 1139, the following oversight entities are required to submit executive summaries to be included in the annual performance report.

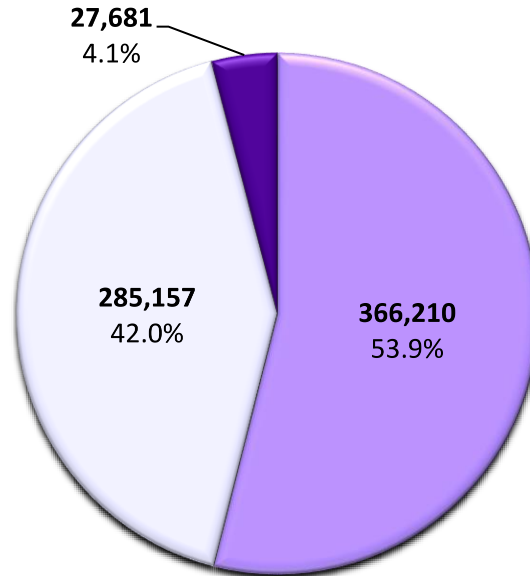
- The Council on Human Services
- The Medical Assistance Advisory Council
- The Hawki Board
- The Mental Health and Disability Services Commission
- The Office of the Long Term Care Ombudsman (data is not verified by the Department)

These summaries can be found in this report in the section titled "Oversight Entities Executive Summaries."

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

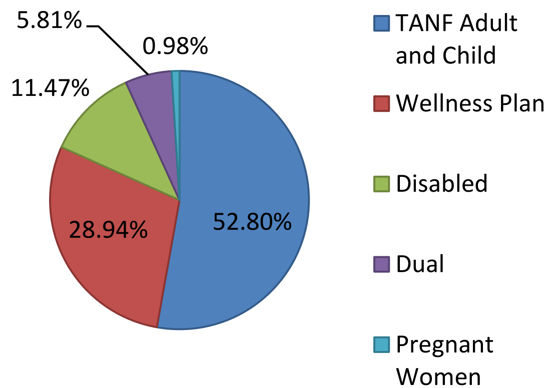
Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink

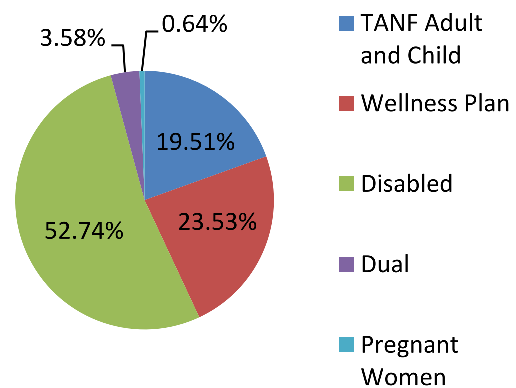
Plan Enrollment By Age



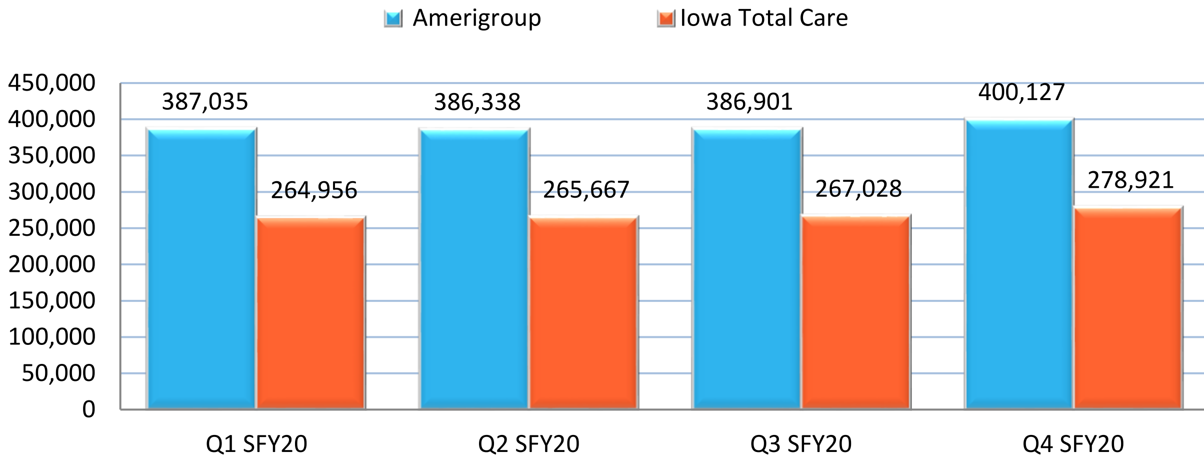
*June 2020 enrollment data as of July 30, 2020. Enrollment data captures Hawki enrollees; however, excludes the 38,979 Fee-for-Service (FFS) members.

Plan Enrollment By Capitation



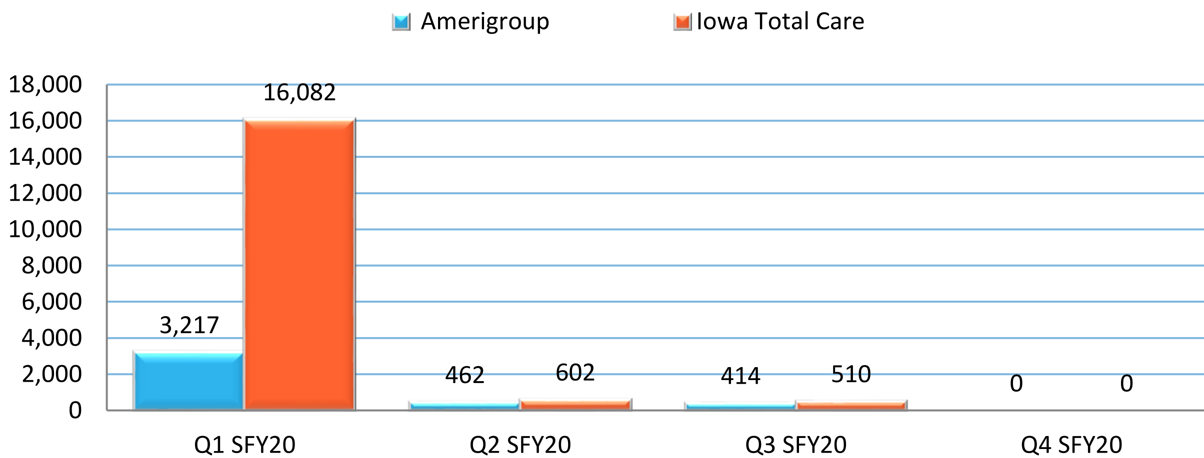


PLAN ENROLLMENT BY MCO



* June 2020 enrollment data as of July 30, 2020. Due to the effects of COVID-19 in Iowa, disenrollment from Medicaid was suspended in Iowa starting in March 2020. As a result, the total number of members enrolled increased in the second half of SFY2020.

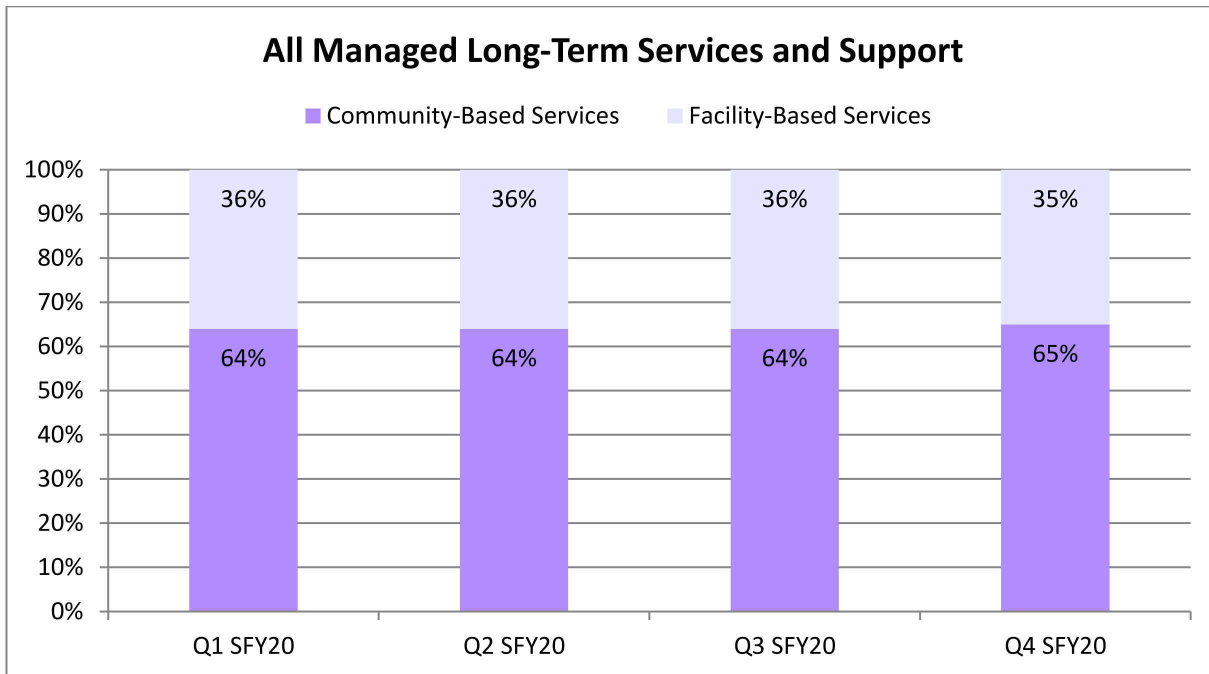
PLAN DISENROLLMENT BY MCO



* June 2020 enrollment data as of July 30, 2020. ITC started serving Medicaid beneficiaries on July 1, 2019. The Department assigned all members to an MCO prior to

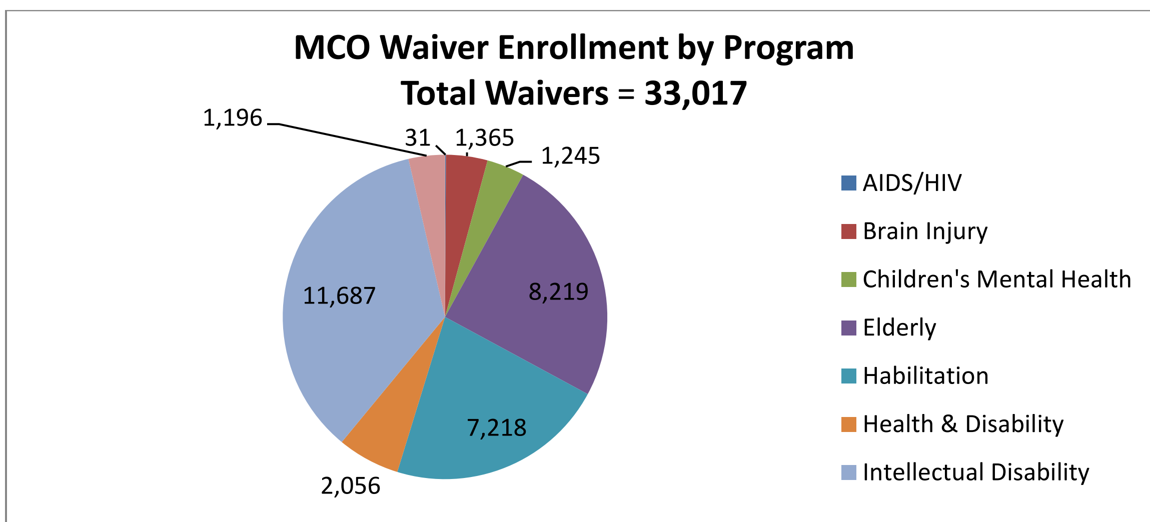
this date, but members had the opportunity to switch to the other MCO within 90 days after the change in MCOs. Due to the effects of COVID-19 in Iowa, disenrollment from Medicaid was suspended in Iowa starting in March 2020.

All MCO Long Term Services and Supports (LTSS) Enrollment



This chart depicts those members currently receiving community based or facility based services for each identified quarter. The data indicates a strong focus on maintaining members in community based services when possible. 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 (HCBS) Waiver Enrollment



This chart reflects the HCBS populations as of the end of SFY2020.

Care Coordination and Case Management

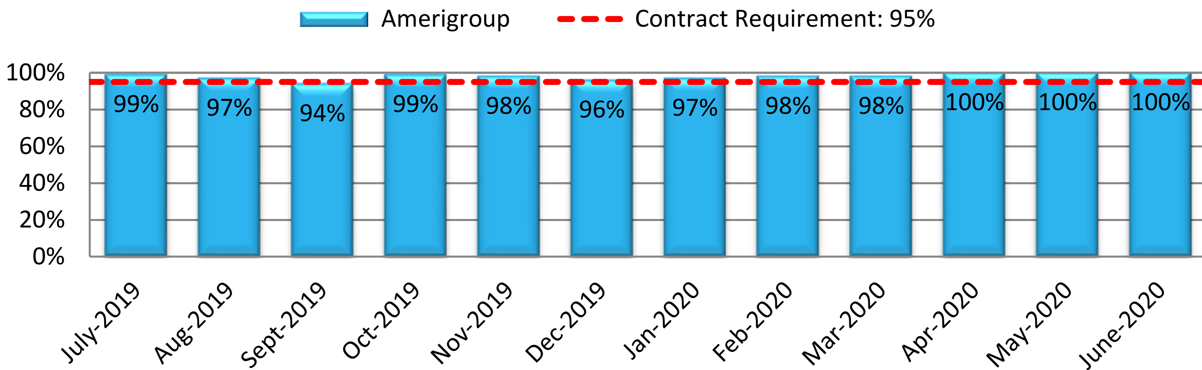
Average Number of Contacts		
Data Reported as of June 30, 2020	Amerigroup	Iowa Total Care
Average Number of Care Coordinator Contacts per Member per Month	0.9	0.8
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.0

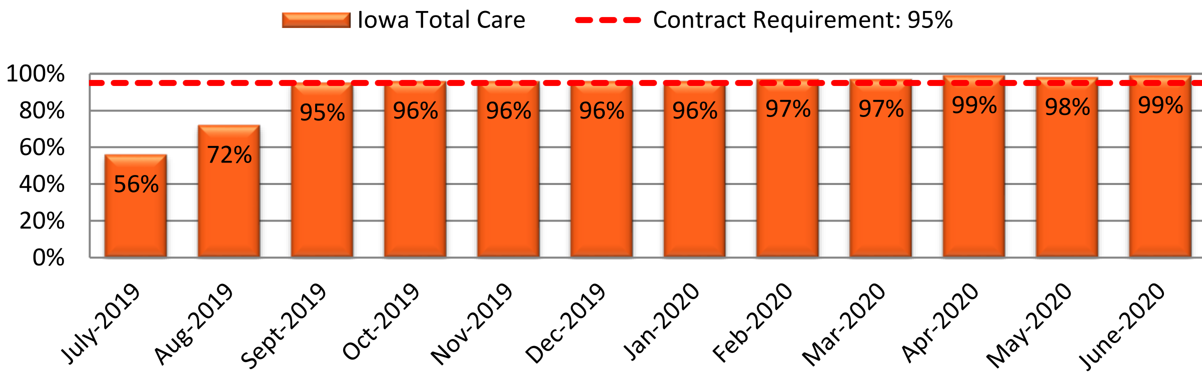
Member to Coordinator Ratios		
Data Reported as of June 30, 2020	Amerigroup	Iowa Total Care
Ratio of Members to Care Coordinators	14	75
Ratio of HCBS Members to Community-Based Case Managers	65	38

There are no current MCO contract standards for ratios of members to care coordinators or community based case managers. The current MCO contract does state that members are to be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least 60 days between visits. It also states that community based case managers shall contact HCBS waiver members either at least monthly in person or by telephone with an interval of at least 14 calendar days between contacts.

Level of Care

Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change. LOC assessments are conducted using tools designated by the Department. These assessments identify the level and type of needs a member has and the level of services for which that member would be eligible.



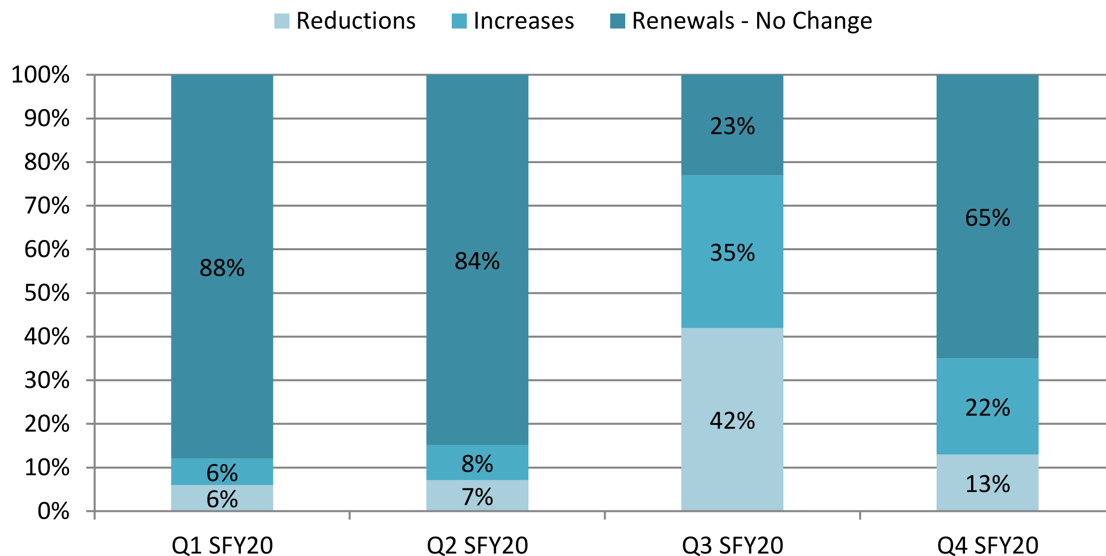


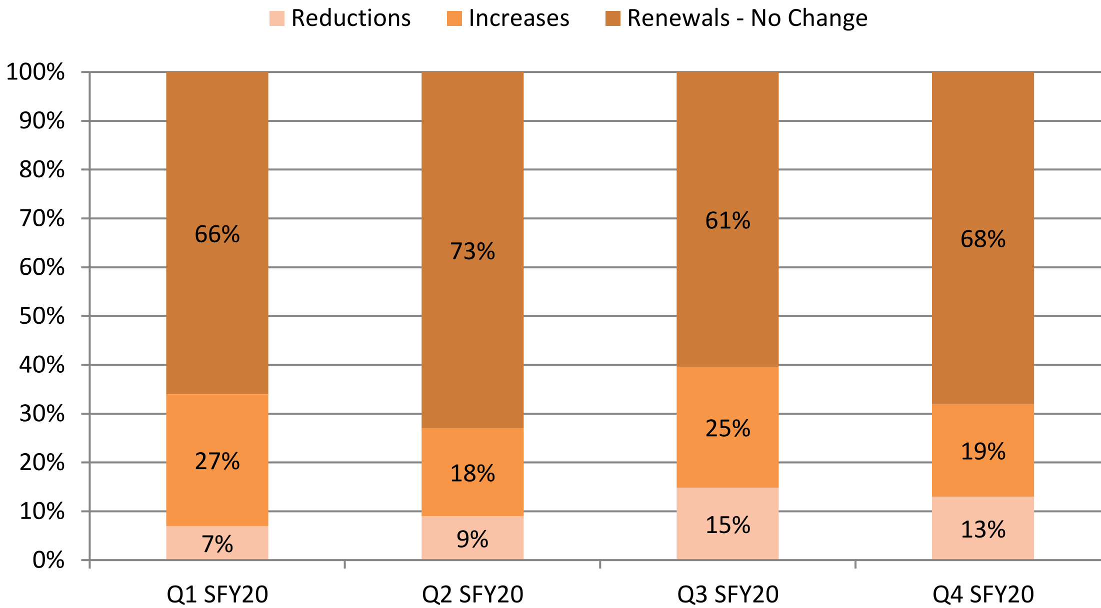
Ninety-five percent (95%) of needs assessments must be completed annually or as a member's needs change. There may be legitimate reasons for MCO failure to complete LOC Reassessments timely, such as member hospitalization or other extenuating member circumstances. The Department requests MCO exception details for members that did not have LOC Reassessments completed timely. Exceptions are granted for one month only, with the requirement that MCOs complete the assessment in the following month, or request a new exception.

The Department closely monitors these details in conjunction with corrective actions to ensure that LOC assessments are completed in a timely manner for all Medicaid members. This includes staffing contingencies implemented to ensure that adequate resources are available to perform level of care assessments for both new members as well as members that are due for their annual reassessment.

Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

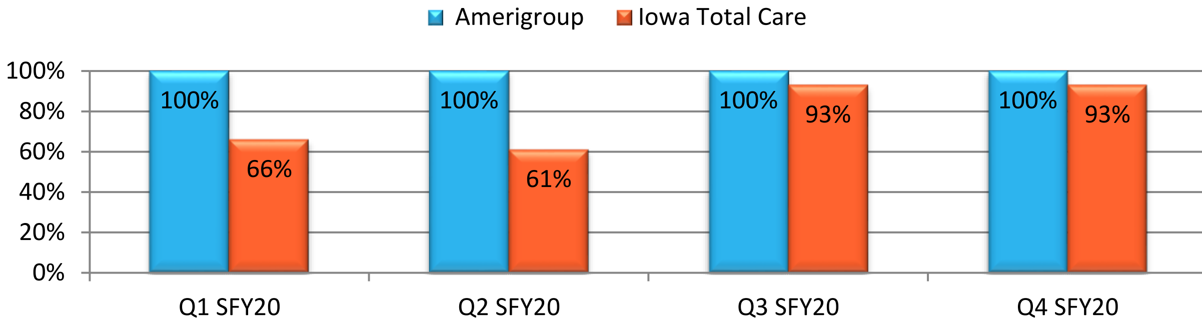
Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving home- and community-based services.

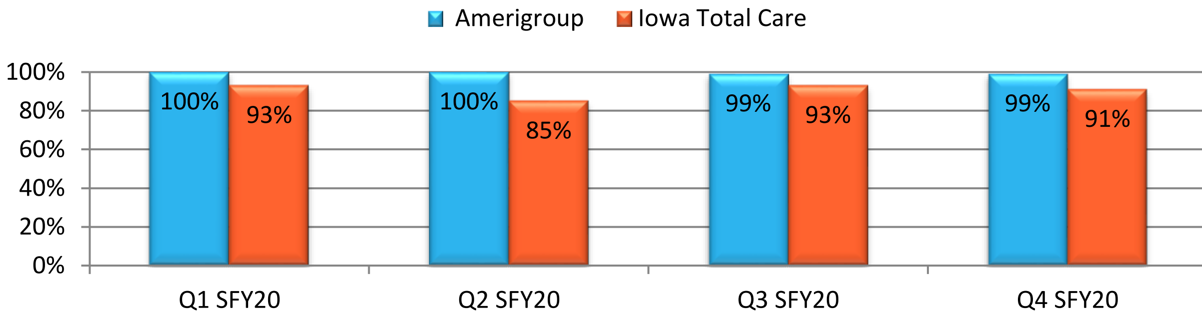


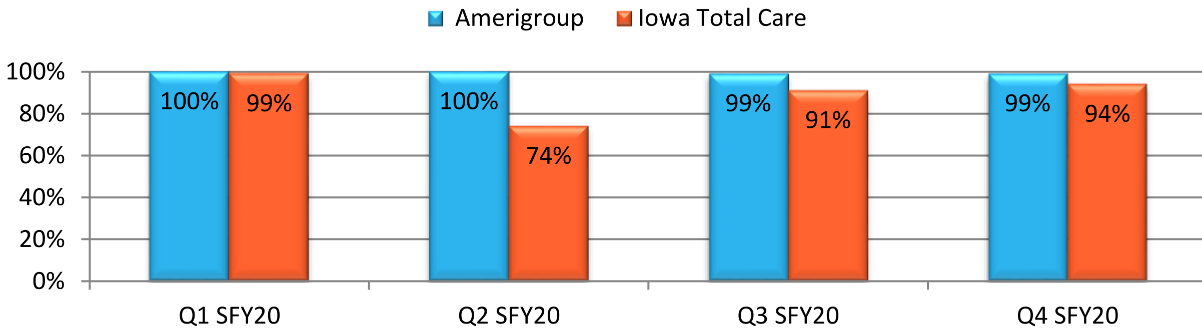


Iowa Participant Experience Survey Reporting

Iowa Participant Experience Survey Reporting
The following data reflects the results of Iowa Participant Experience Survey (IPES) activities. IPES results are one component of the Department's Home- and Community-Based Services (HCBS) 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." The three IPES questions below give indications of important member outcomes: safety, quality of life, and member input into service planning.

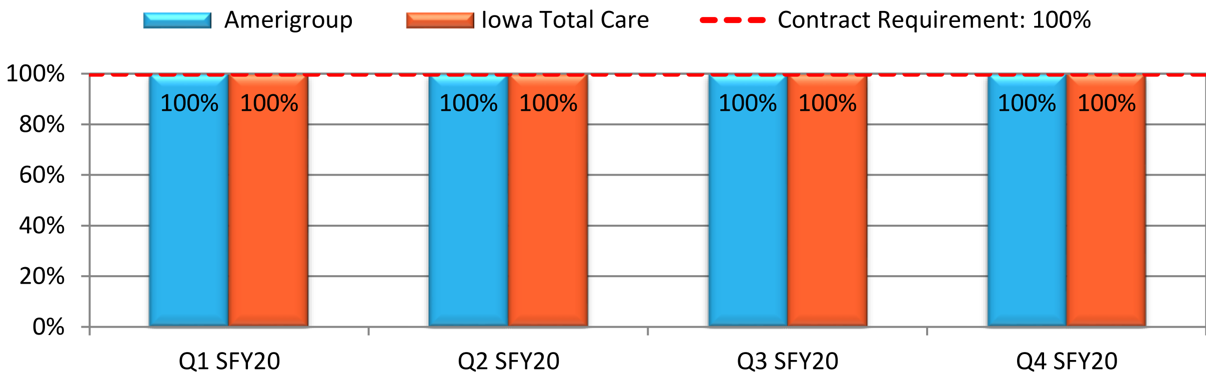

Members Reporting: They Were Part of Service Planning
Amerigroup
Iowa Total Care
100%
80%
60%
40%
20%
0%
100%
66%
100%
61%
100%
93%
100%
93%
Q1 SFY20
Q2 SFY20
Q3 SFY20
Q4 SFY20


Members Reporting: They Feel Safe Where They Live
Amerigroup
Iowa Total Care
100%
80%
60%
40%
20%
0%
100%
93%
100%
85%
99%
93%
99%
91%
Q1 SFY20
Q2 SFY20
Q3 SFY20
Q4 SFY20


Members Reporting: Their Services Make Their Lives Better
Amerigroup
Iowa Total Care
100%
80%
60%
40%
20%
0%
100%
99%
100%
74%
99%
91%
99%
94%
Q1 SFY20
Q2 SFY20
Q3 SFY20
Q4 SFY20

MCO Member Grievances

The grievances resolved data below demonstrates the level to which the member is receiving timely and adequate levels of service. A grievance is an expression of dissatisfaction about any matter other than an action the MCO has taken. A grievance is considered resolved once it has been through the process and a disposition has been communicated to the member and member representative by the MCO or IME.



Grievances Received

	Amerigroup		Iowa Total Care	
Quarter	Count	% Pop	Count	% Pop
Q1 SFY20	286	0.07%	155	0.05%
Q2 SFY20	784	0.19%	282	0.10%
Q3 SFY20	706	0.19%	230	0.08%
Q4 SFY20	322	0.09%	100	0.03%

Top 10 Reasons for Grievances

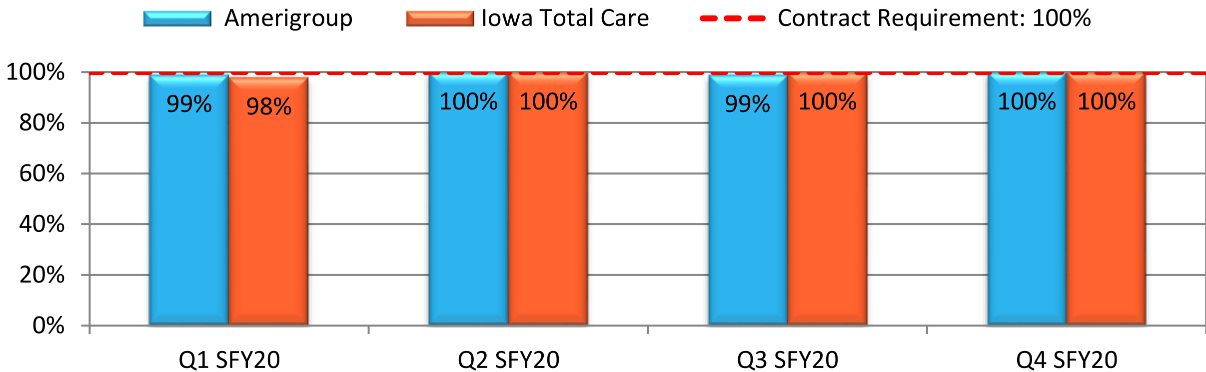
**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
1.	Voluntary Disenrollment	28%	Access to Care - Network Availability	42%
2.	Provider Balance Billed	14%	Unhappy with Benefits	19%
3.	Provider Attitude/Rudeness	8%	Transportation - General Complaint Vendor	8%
4.	Adequacy of treatment record keeping	6%	Claim Dispute	3%
5.	Transportation – Driver No-Show	6%	Lack of Caring/Concern	3%
6.	Transportation – Driver Delay	5%	Provider - Interpersonal	3%
7.	Termination of Eligibility	5%	Transportation – Missed Appointment	2%
8.	Availability of appointments	4%	Transportation – General Complaint Vendor/CSR	2%
9.	Effective Dates of Coverage	2%	Customer Service – Health Plan Staff	2%
10.	Treatment Dissatisfaction	2%	Inappropriate Behavior – Office Staff - Interpersonal	1%

MCO Member Appeals

The appeals resolved data below demonstrates the level to which the member is receiving adequate and timely and levels of service. An appeal is a request for a review of an adverse benefit determination. An appeal is considered resolved once it has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



Appeals Received Supporting Data

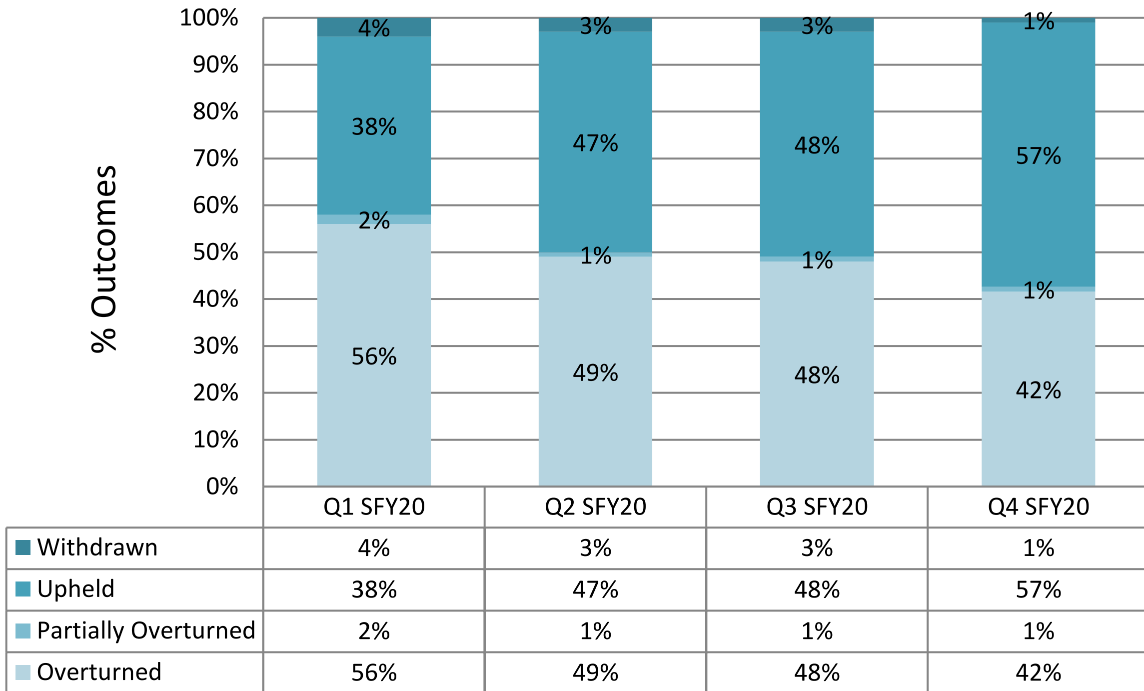
	Amerigroup		Iowa Total Care	
Quarter	Count	% Claims	Count	% Claims
Q1 SFY20	244	0.01%	89	0.01%
Q2 SFY20	355	0.01%	199	0.01%
Q3 SFY20	433	0.01%	179	< 0.01%
Q4 SFY20	372	0.01%	205	< 0.01%

Top 10 Reasons for Appeals

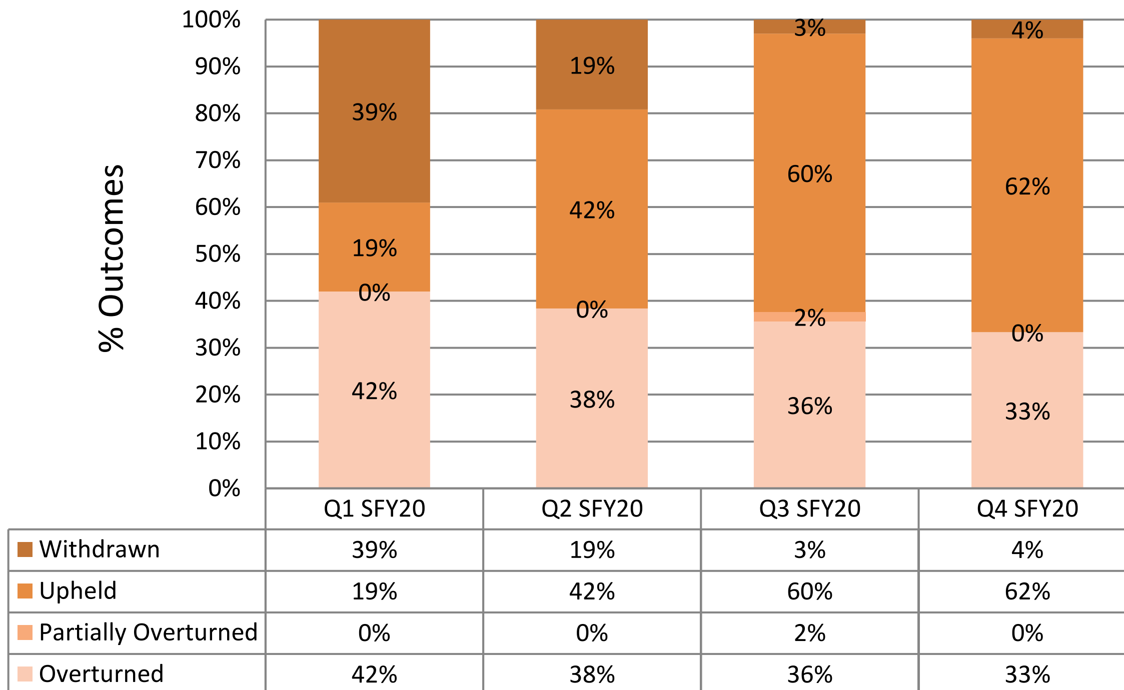
**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
1.	Durable Medical Equipment	27%	Other – Mental Health Service	36%
2.	Pharmacy – Non-Injectable	22%	Pharmacy– Does Not Meet Prior Authorization Guidelines	15%
3.	Behavioral Health– Op Service	9%	Durable Medical Equipment - Other	8%
4.	Personal Care Services Self Directed	8%	Durable Medical Equipment - Wheelchair	6%

Top 10 Reasons for Appeals **As of the end of the reporting period				
#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
5.	Pharmacy - Injectable	7%	Durable Medical Equipment – Orthopedic Devices	3%
6.	Radiology	6%	Durable Medical Equipment– Pneumatic Compressor/Appliance	3%
7.	Surgery	5%	Durable Medical Equipment – Blood Glucose Monitor	2%
8.	Behavioral Health - Inpatient	5%	Durable Medical Equipment – Motorized Wheelchair	2%
9.	Other	5%	Durable Medical Equipment – Wheelchair Accessories	2%
10.	Pain Management.	4%	Injections – Epidural Injections	2%

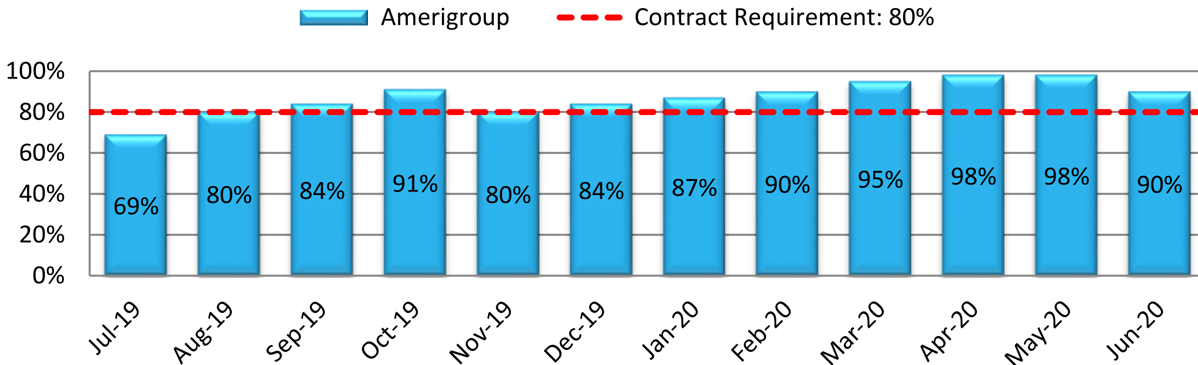


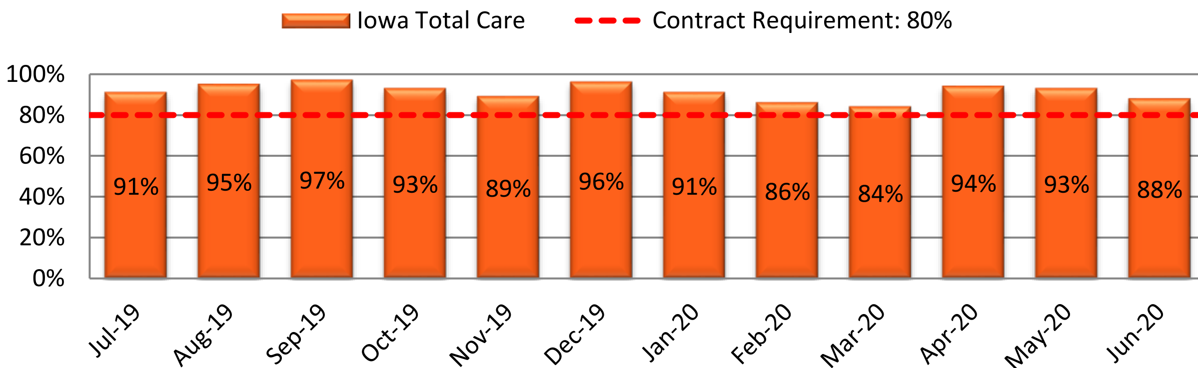
	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Withdrawn	4%	3%	3%	1%
Upheld	38%	47%	48%	57%
Partially Overturned	2%	1%	1%	1%
Overturned	56%	49%	48%	42%



	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Withdrawn	39%	19%	3%	4%
Upheld	19%	42%	60%	62%
Partially Overturned	0%	0%	2%	0%
Overturned	42%	38%	36%	33%

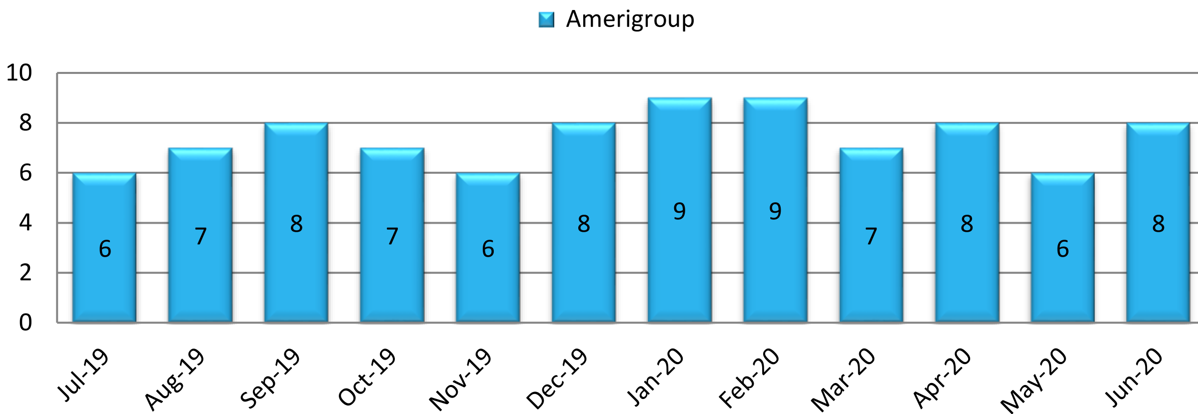
Member Helpline





This performance target measures the timeliness of answering the helpline calls. A call answered "timely" is defined as having been answered by an individual within 30 seconds after entering a waiting queue. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the Department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines. The CAHPs surveys conducted annually also measure member satisfaction with their health plan.

Secret Shopper: Member Helpline Average Monthly Score



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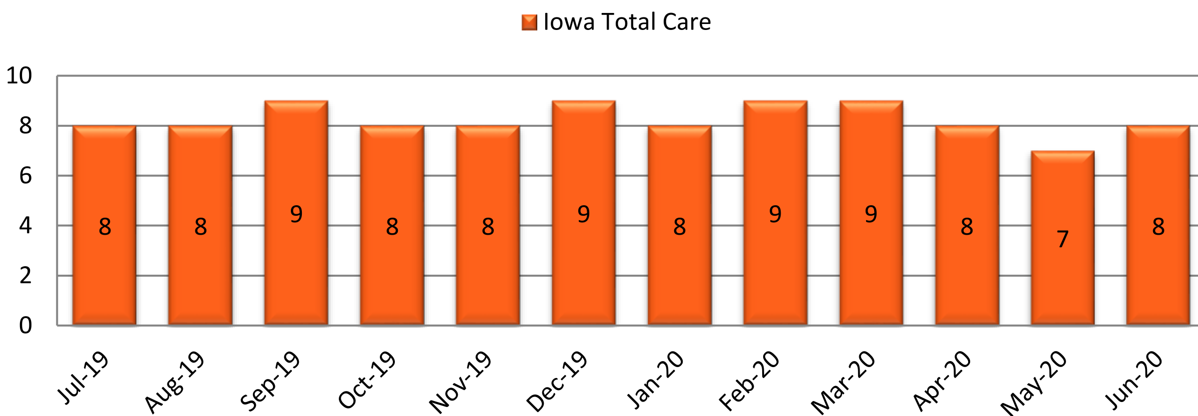


Secret shopper calls are conducted by the Iowa Medicaid Enterprise (IME) at least weekly and assess MCO customer service representative soft skills and policy knowledge. For each day that call monitoring occurs, five questions are asked of Member helpline representatives to be monitored and scored.

Each question can receive a maximum of 2 points, where 2 points indicate a full and complete answer free of errors was provided. Scores are aggregated for each day to achieve a daily score with a maximum of ten points. Results shown above are the average of all calls completed in the reporting month, rounded to the nearest whole number. All results are provided to MCOs so they can address any training needs.

The focus of these activities is continuous quality improvement, with topics changing based on current issues. During SFY20, the member helpline secret shopper topics focused on:

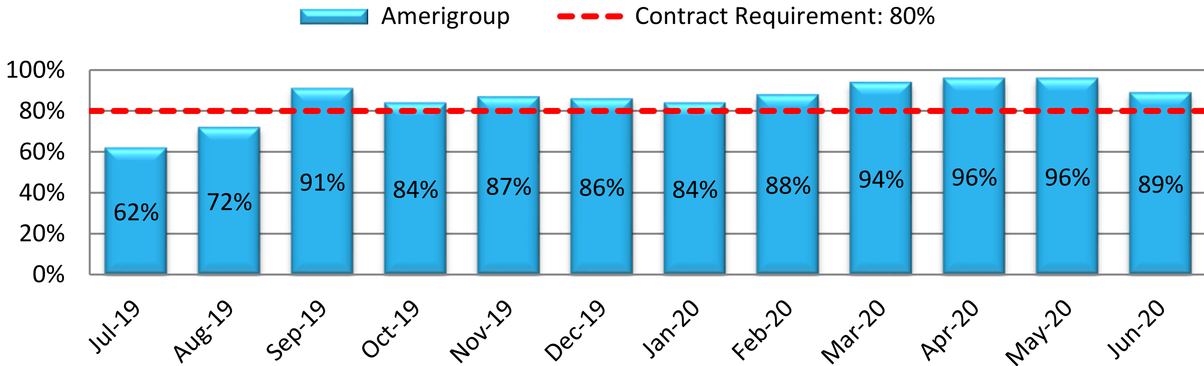
Q1 SFY20 – Enrollment, MCO changes, dental service availability, assessments, transportation limits and scheduling, Hawki

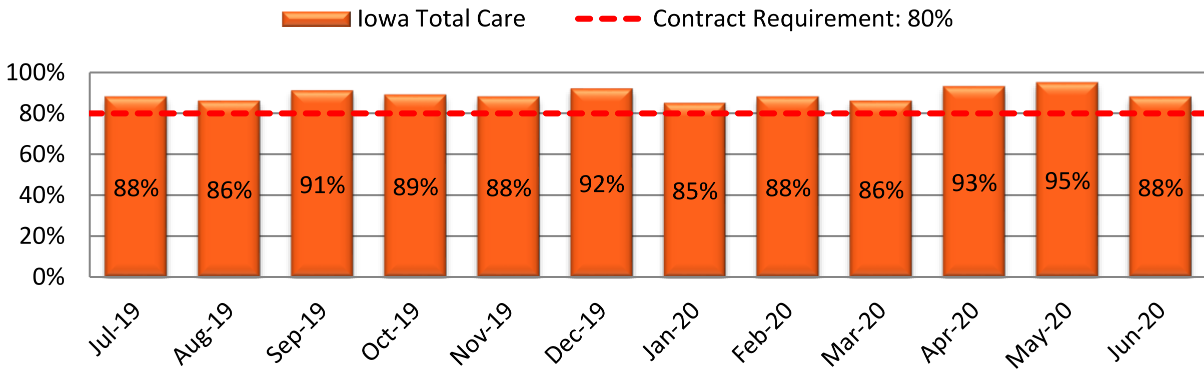
Q2 SFY20 – Transportation, ID Card, Assessments, Hawki Open choice period, continued services, flu shots, CCO program, Benefits, appeals

Q3 SFY20 – Billing and Newborn Enrollment, Healthy Behaviors and Iowa Health and Wellness Plan

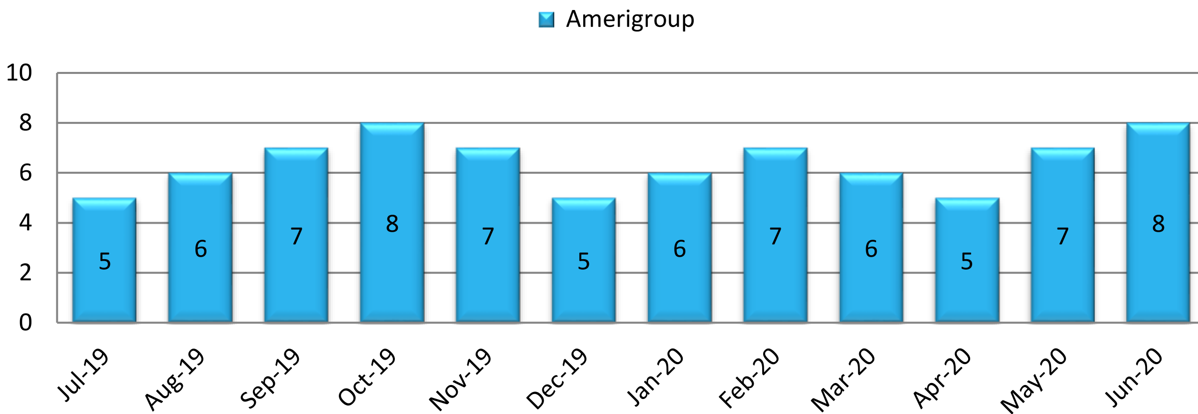
Q4 SFY20 – Healthy Behaviors and Iowa Health and Wellness Plan, Copays and Services during pandemic

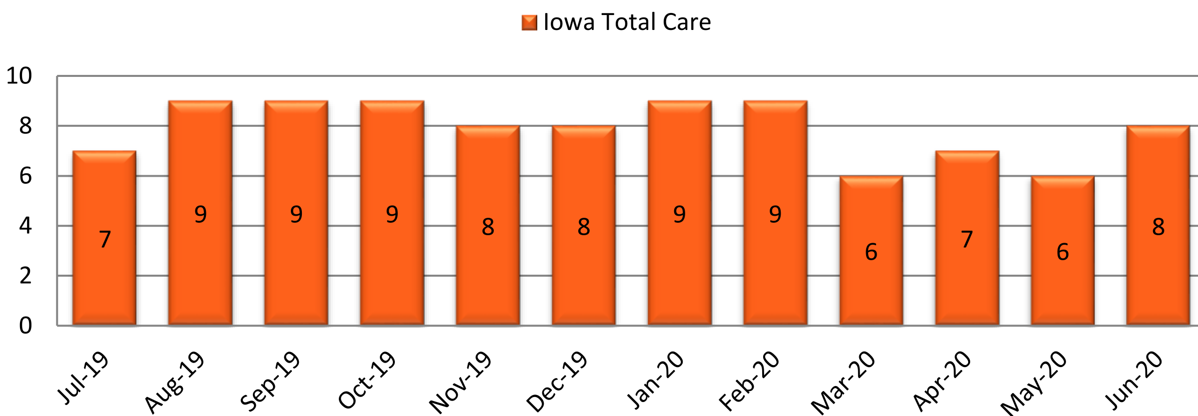
Provider Helpline





This performance target measures the timeliness of answering the helpline calls. The Department defines “timely” answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the Department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines.





Secret shopper calls are conducted by the IME at least weekly and assess MCO customer service representative soft skills and policy knowledge. For each day that call monitoring occurs, five questions are asked of provider helpline representatives to be monitored and scored.

Each question can receive a maximum of 2 points, where 2 points indicate a full and complete answer free of errors was provided. Scores are aggregated for each day to achieve a daily score with a maximum of ten points. Results shown above are the average of all calls completed in the reporting month, rounded to the nearest whole number. All results are provided to MCOs so they can address any training needs.

The focus of these activities is continuous quality improvement, with topics changing based on current issues. During SFY20, the provider helpline secret shopper topics focused on:

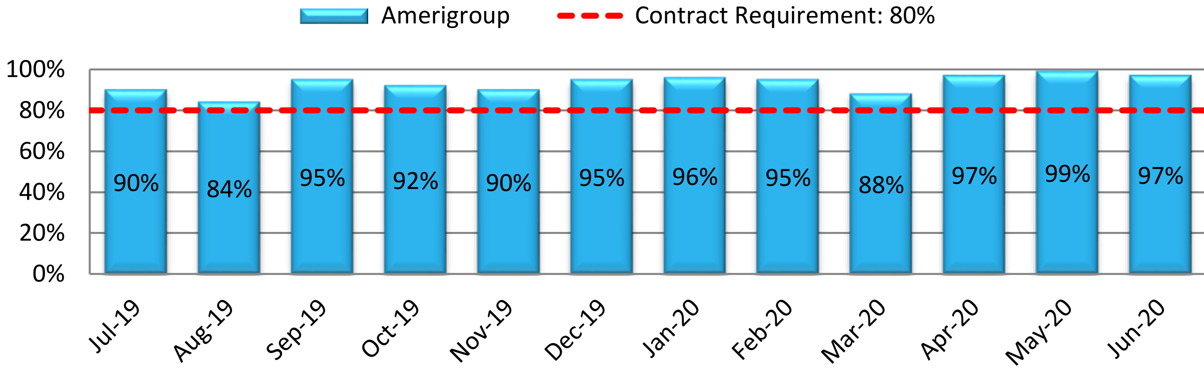
Q1 SFY20 – Billing with MCO change, contracting/credentialing new providers, tiered waiver rates, waiver budgeting, paper claims, electronic billing, timely filing

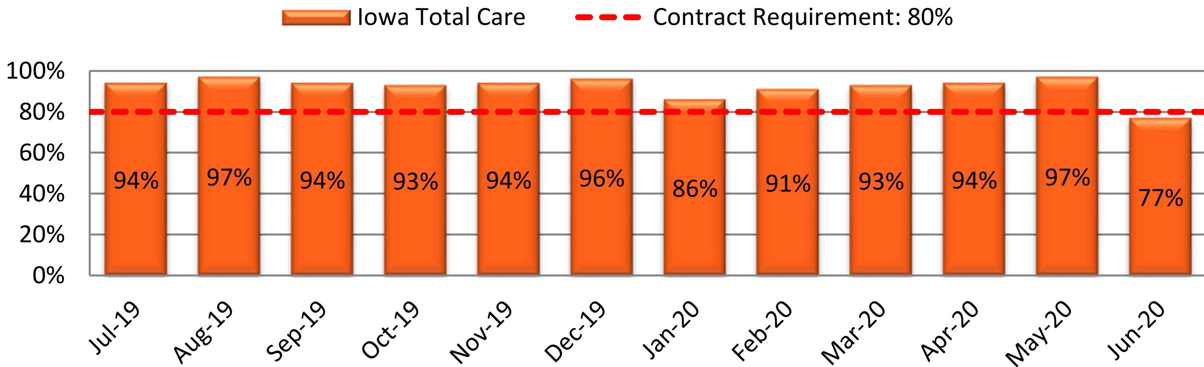
Q2 SFY20 – Waiver program, electronic billing, timely filing, Consumer-Directed Attendant Care (CDAC) providers, continuity of care, prior authorizations, vaccine program, claims, assessments

Q3 SFY20 – Prior Authorization and payments, coverage and denials, transportation billing, Iowa Medicaid Portal Access (IMPA) System

Q4 SFY20 – Transportation and Supported Community Living (SCL), Telehealth/billing and claims

Pharmacy Services Helpline





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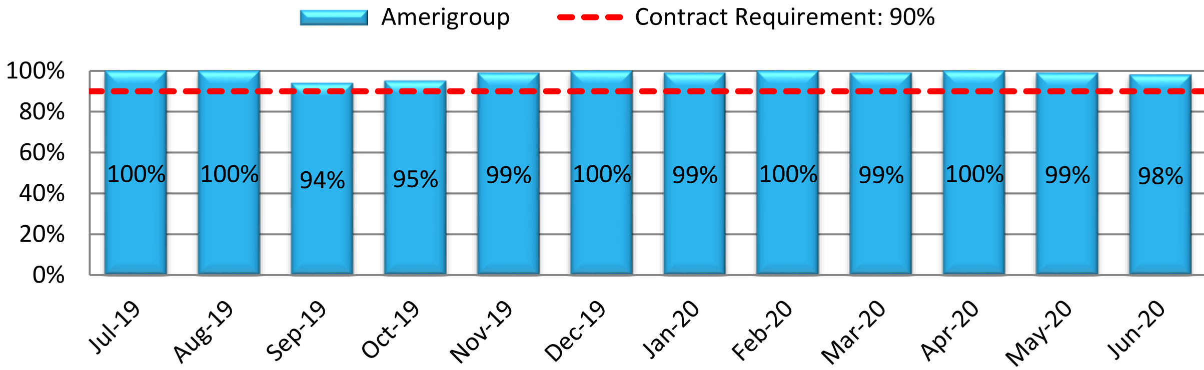
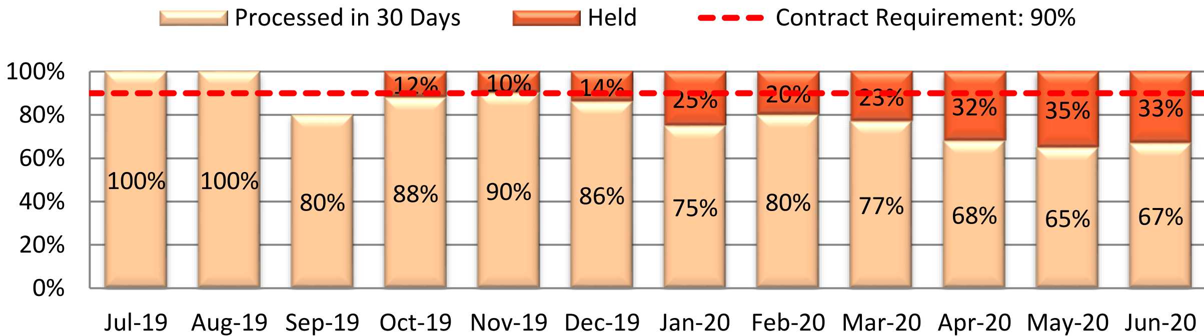
Non-Pharmacy Claims Payments

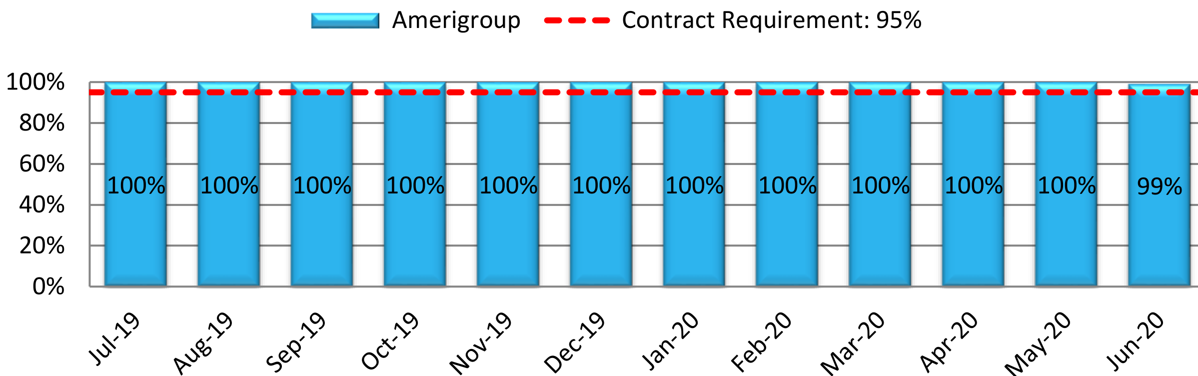




This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The Department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the Department is made aware of provider reimbursement concerns.

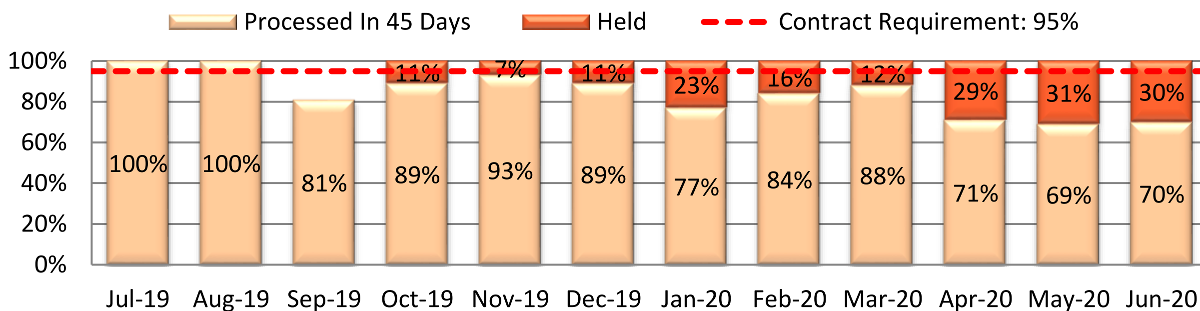
This measure is being reported separately for ITC at this time due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as those processed within 30 calendar days. There is potential for some clean claims withheld by ITC due to payment system configuration issues to have been processed within 30 or 45 days. The Department will continue to monitor this issue.

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



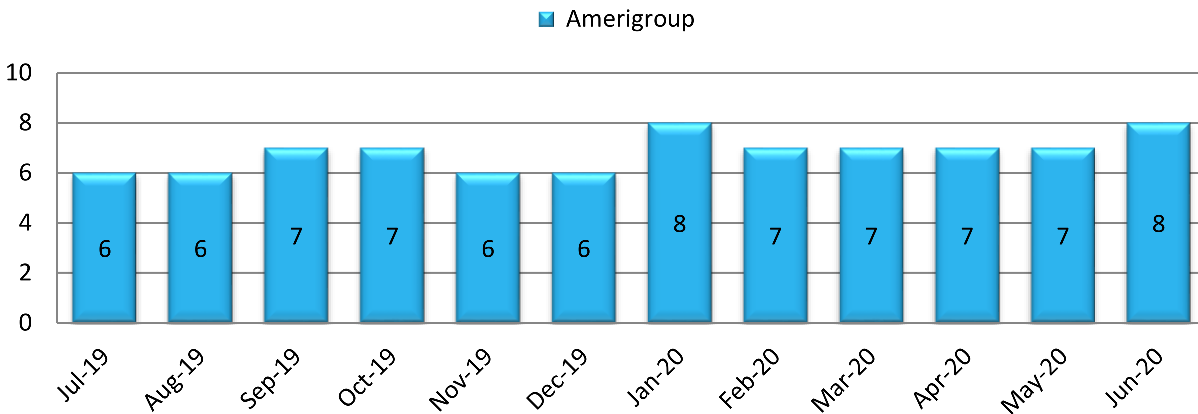
Iowa Total Care

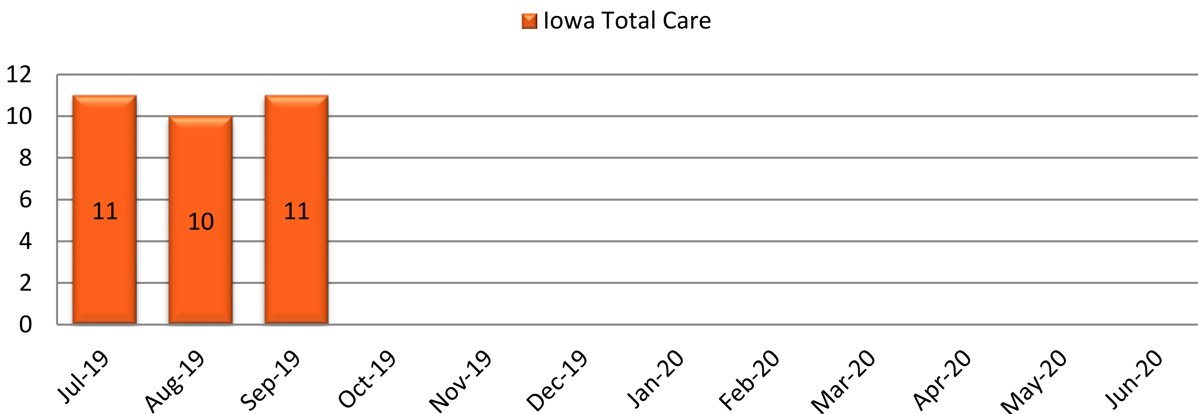
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 45 Calendar Days



This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The Department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the Department is made aware of provider reimbursement concerns.

This measure is being reported separately for ITC at this time due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as those processed within 45 calendar days. There is potential for some clean claims withheld by ITC due to payment system configuration issues to have been processed within 30 or 45 days. The Department will continue to monitor this issue



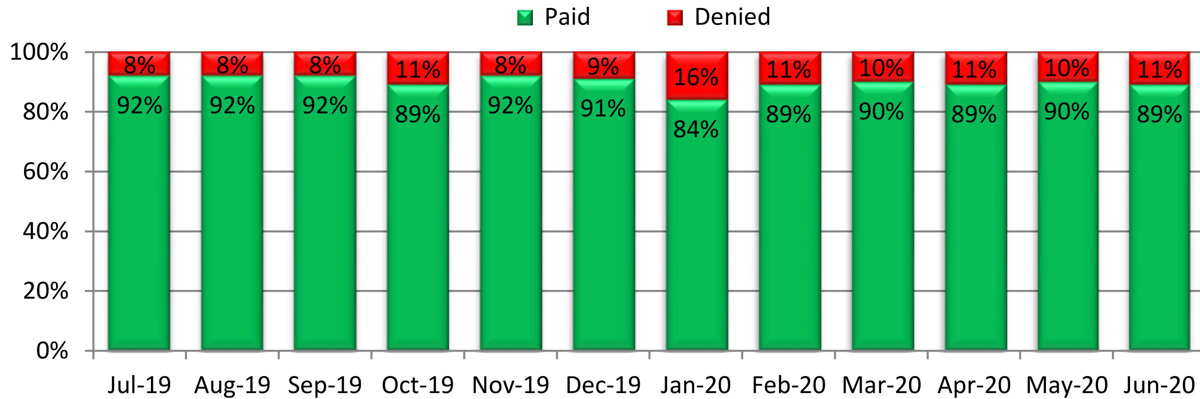


Due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues, it is not possible to accurately reflect this measure for ITC for the final three quarters of this fiscal year.

Amerigroup

Non-Pharmacy Claims Status

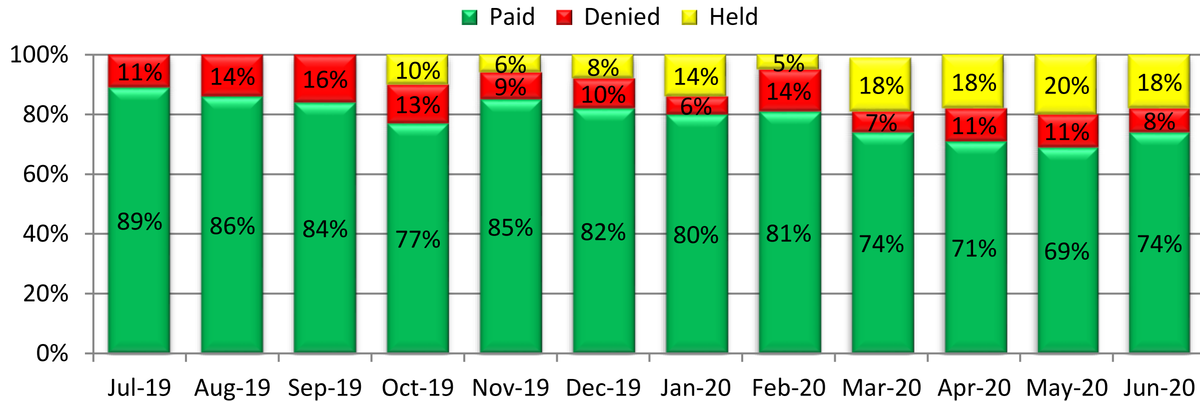
**As of the end of the reporting period



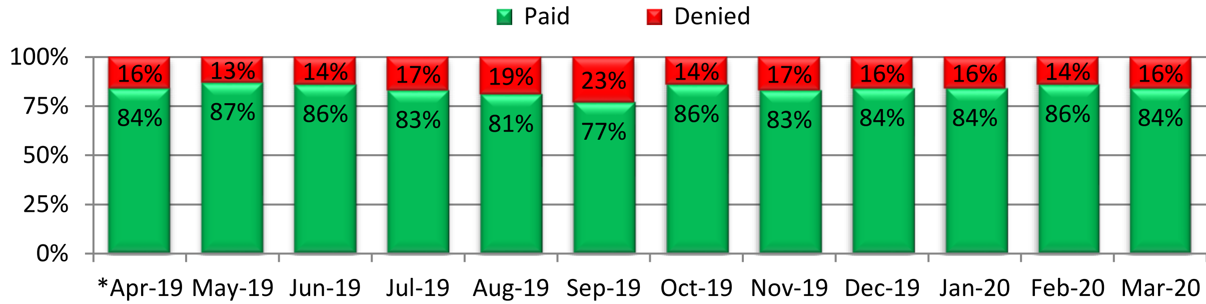
Iowa Total Care

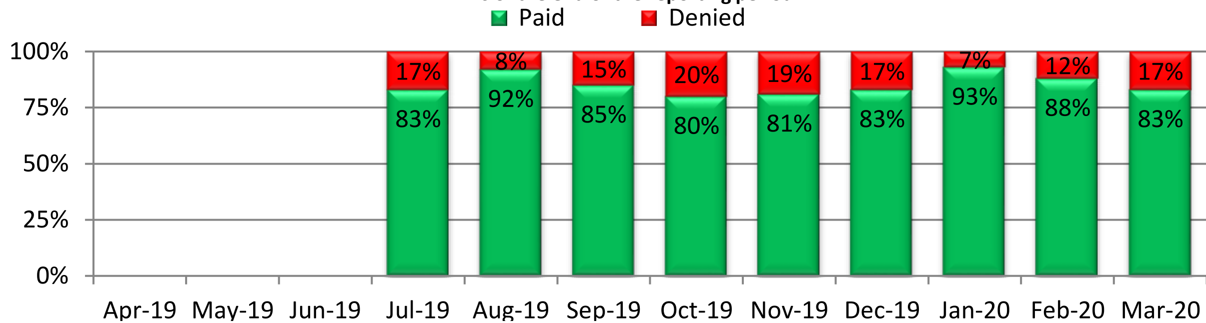
Non-Pharmacy Claims Status

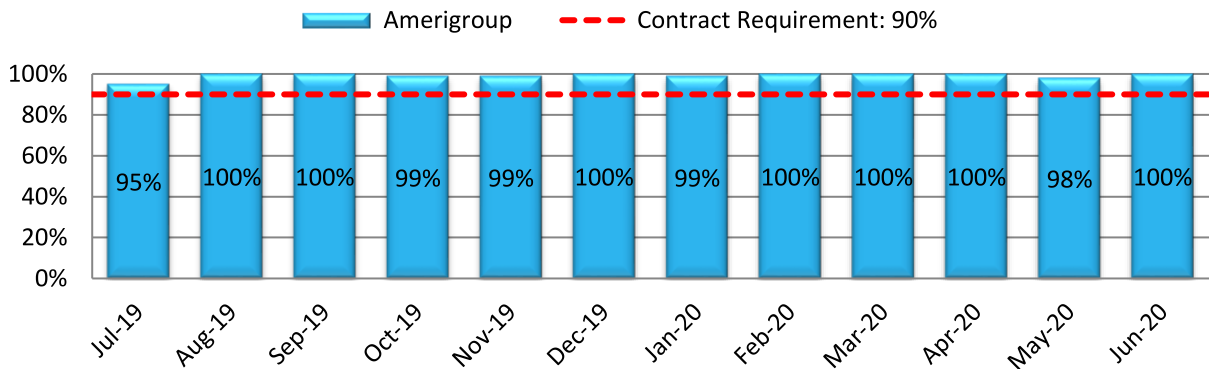
**As of the end of the reporting period

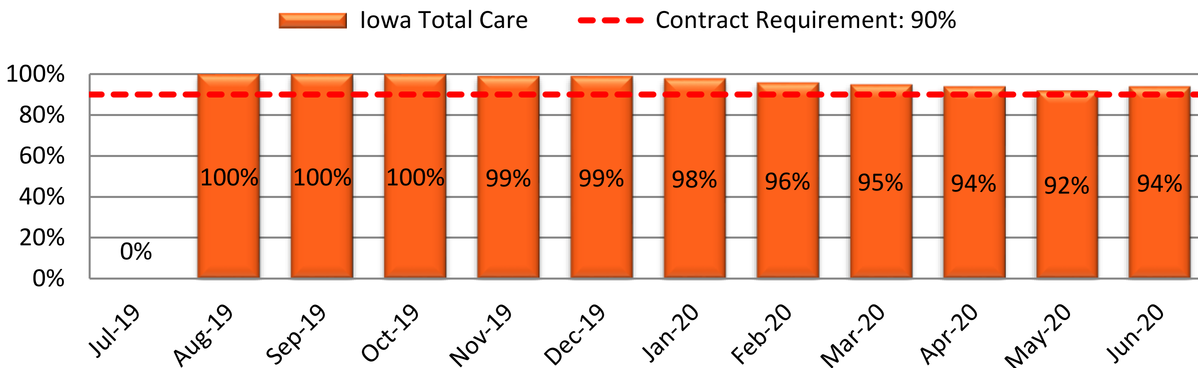


This measure is being reported differently for ITC at this time due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as all claims paid and denied.


Amerigroup
Suspended Non-Pharmacy Claims Payment Rates (90-day lag)
**As of the end of the reporting period
Paid
Denied
100%
75%
50%
25%
0%
16% 13% 14% 17% 19% 23% 14% 17% 16% 16% 14% 16%
84% 87% 86% 83% 81% 77% 86% 83% 84% 84% 86% 84%
*Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20


Iowa Total Care
Suspended Non-Pharmacy Claims Payment Rates (90-day lag)
**As of the end of the reporting period
Paid
Denied
100%
75%
50%
25%
0%
17% 8% 15% 20% 19% 17% 7% 12% 17%
83% 92% 85% 80% 81% 83% 93% 88% 83%
Apr-19 May-19 Jun-19 Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20


Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification
Amerigroup
Contract Requirement: 90%
100%
80%
60%
40%
20%
0%
95% 100% 100% 99% 99% 100% 99% 100% 100% 100% 98% 100%
Jul-19 Aug-19 Sep-19 Oct-19 Nov-19 Dec-19 Jan-20 Feb-20 Mar-20 Apr-20 May-20 Jun-20



Plans have 30 days from the date of identification of an error or a clean provider adjustment request to reprocess 90% of the claims identified. Claims reprocessing projects may be processed on a different timeline with Agency approval.

Top 10 Reasons for Non-Pharmacy Claims Denial

**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service	30%	18: DENY: DUPLICATE CLAIM SERVICE	27%
2.	27-Expenses incurred after coverage terminated	9%	18: DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS	5%
3.	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	8%	A1: ADVANCED CLAIM EDITS CLAIM LEVEL RETURN TO PROVIDER (REVIEW CLAIM REMARKS)	5%

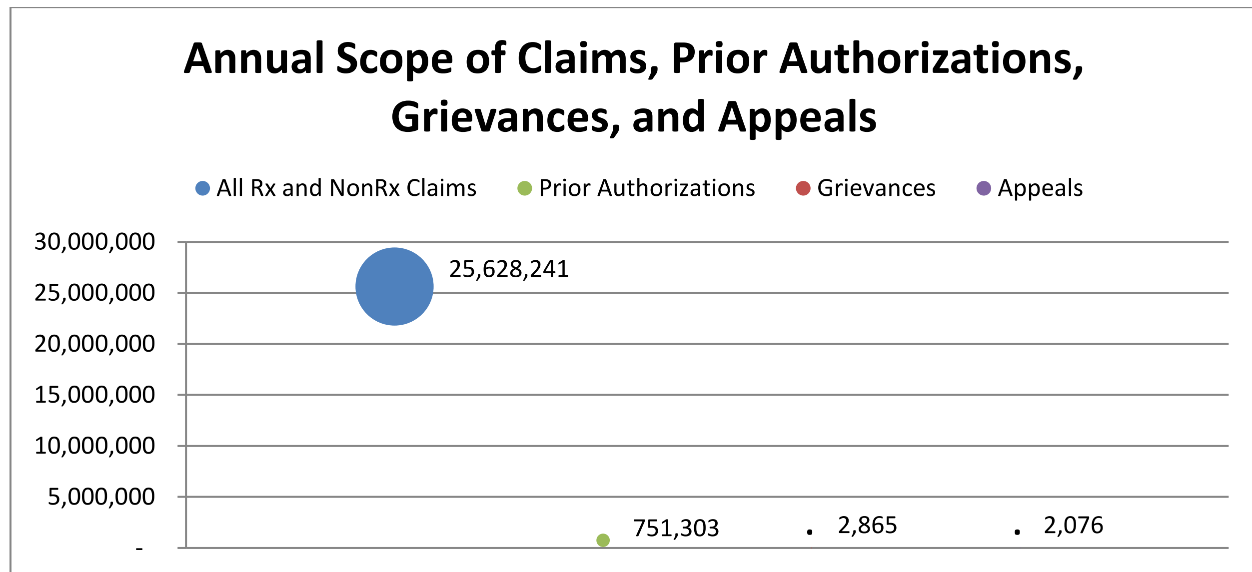
Top 10 Reasons for Non-Pharmacy Claims Denial

**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
	restrictions/billing/payment information related to these charges			
4.	16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	8%	A1: ADVANCED CLAIM EDITS LINE ITEM DENIAL	5%
5.	256-Service not payable per managed care contract	7%	23: ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM	5%
6.	29-The time limit for filing has expired	6%	A1: DENY : PROCEDURE COVERAGE NOT DEFINED BY MEDICAID – PROVIDER TO RESUBMIT	4%
7.	197-Precertification/authorization/ notification absent	5%	236: DENY: CMS MEDICAID NATIONAL CORRECT CODING INITIATIVE UNBUNDLING	3%
8.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	4%	A1: PROVIDER MEDICAID ID REQUIRED FROM MEMBER STATE; OBTAIN ID & RESUBMIT	3%
9.	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 National Council for Prescription Drug Program 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)	4%	A1: DENY: NATIONAL DRUG CODE MISSING/INVALID OR NOT APPROPRIATE FOR PROCEDURE	3%
10	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%	96: DENY SERVICE REVIEWED AND IS NOT COVERED BY IOWA MEDICAID	3%

Claim Adjustment Rea son 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/

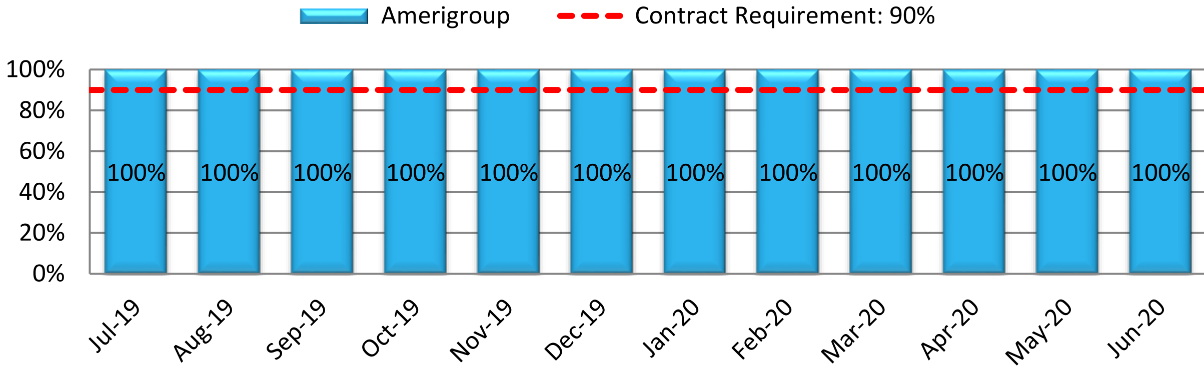
Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

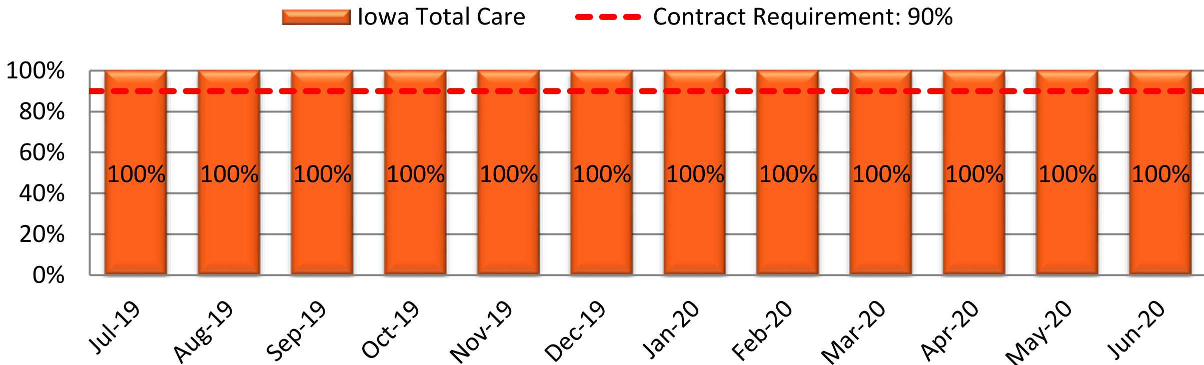


Annual volume of all Claims (Paid & Denied), Prior Authorizations, Grievances, and Appeals depict at scale the universe of actions that may be associated with paid or denied claims. Some claims require prior authorizations for services while other claims may be reprocessed due to provider requests or 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.

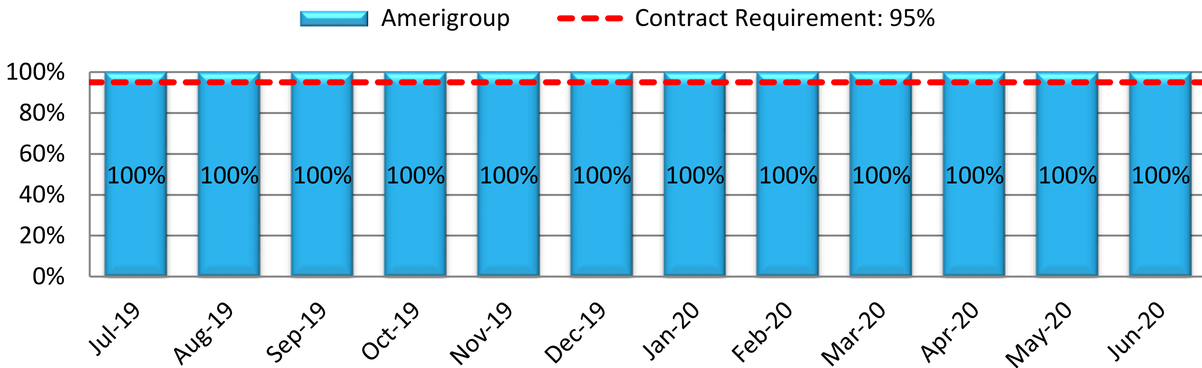
Supporting Data		
All Rx and NonRx Claims	**25,628,241**	**% of Claims Universe**
Prior Authorizations	751,303	2.93%
Grievances	2,865	0.01%
Appeals	2,076	0.01%

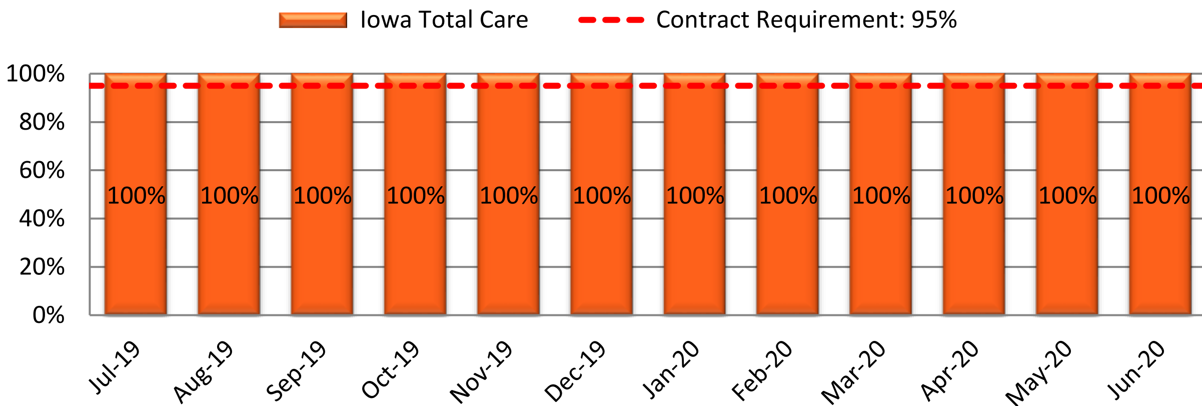
Pharmacy Claims Payment



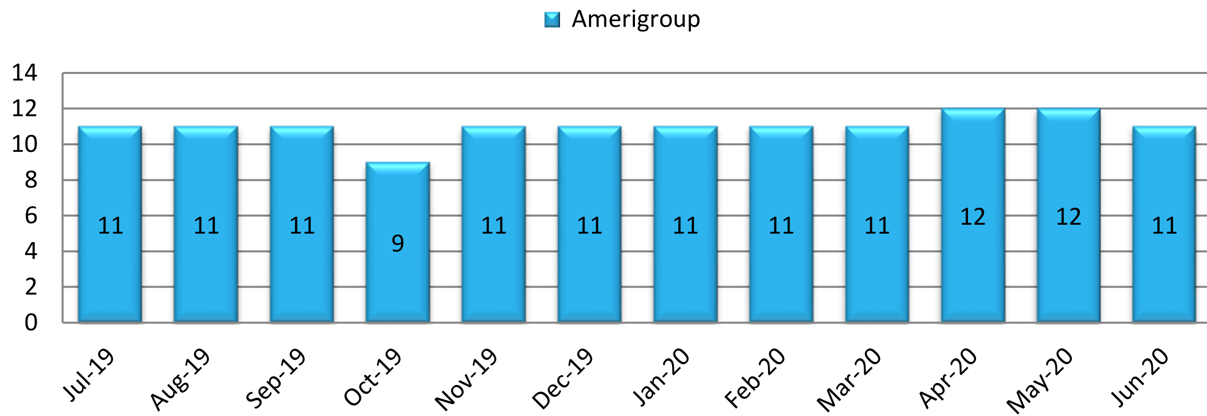


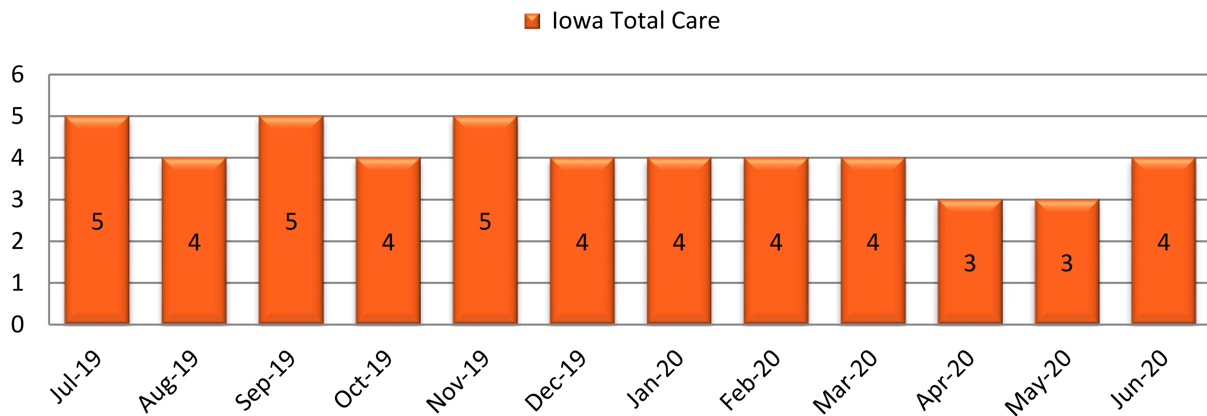
This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The Department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the Department is made aware of provider reimbursement concerns.

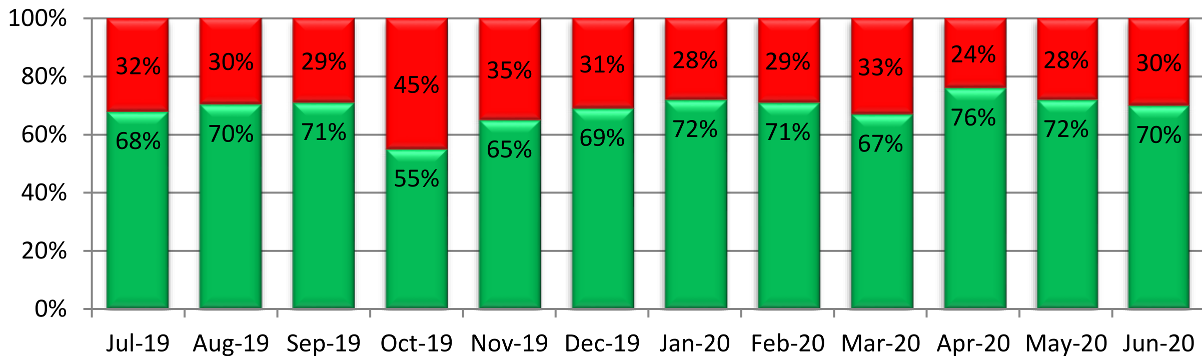


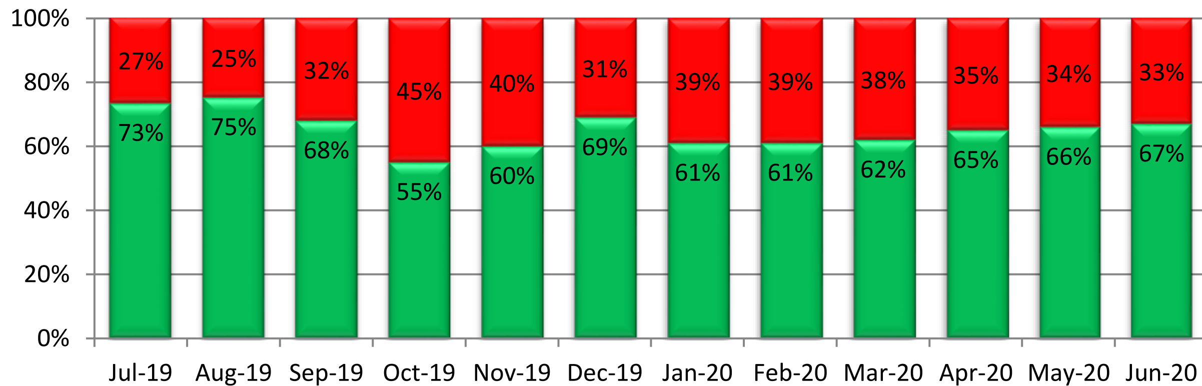


This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The Department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the Department is made aware of provider reimbursement concerns.


Average Days for Pharmacy Claims Payment
Amerigroup
14
12
10
8
6
4
2
0
11
11
11
9
11
11
11
11
11
12
12
11
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20


Average Days for Pharmacy Claims Payment
Iowa Total Care
6
5
4
3
2
1
0
5
4
5
4
5
4
4
4
4
3
3
4
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20





Top 10 Reasons for Pharmacy Claims Denial

**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
1.	79 - REFILL TOO SOON	46%	79 - REFILL TOO SOON	30%
2.	41 – SUBMIT BILL TO OTHER PROCESSOR	15%	75 - PRIOR AUTHORIZATION REQUIRED	10%

Top 10 Reasons for Pharmacy Claims Denial **As of the end of the reporting period				
#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
3.	75 – PRIOR AUTHORIZATION REQUIRED	12%	AG - Days' Supply Limitation For Product/Service	5%
4.	70 – NATIONAL DRUG CODE NOT COVERED	9%	85 – CLAIM NOT PROCESSED	3%
5.	76 – PLAN LIMITATIONS EXCEEDED	5%	MR – Product Not On Formulary	3%
6.	69 – FILLED AFTER COVERAGE TERM	2%	9G – Quantity Dispensed Exceeds Maximum Allowed	3%
7.	6E – MISSING/INVALID OTHER PAYER REJECT CODE	2%	41 - SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR	2%
8.	56 – NON-MATCHED PRESCRIBER ID	2%	88 – DRUG UTILIZATION REVIEW REJECT ERROR	2%
9.	7M – DISCREPANCY BETWEENOTHER COVERAGE CODE&OTHER PAYER PATIENT RESPONSIBILITY	1%	68 – FILLED AFTER COVERAGE EXPIRED	2%
10.	77 – DISCONTINUED NATIONAL DRUG CODE NUMBER	1%	70 – NATIONAL DRUG CODE NOT COVERED	2%

Utilization of Value Added Services Reported Count of Members

Value Added Services (**VAS**): Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf?121420201719

- **Taking Care of Baby and Me®** (**AGP**): It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

- **My Health Pays** (**ITC**): This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

Q1 SFY20 Data	Iowa Total Care
My Health Pays Program	52,446
The Flu Program	779
Start Smart for Your Baby	1,035
Member Connections Program	63
Q2 SFY20 Data	Iowa Total Care
My Health Pays Program	36,278
The Flu Program	16,562
Start Smart for Your Baby	1,581
Member Connections Program	547
Q3 SFY20 Data	Iowa Total Care
My Health Pays Program	14,835
The Flu Program	6,537
Start Smart for Your Baby	1,212
Member Connections Program	317
Mobile App	598
Q4 SFY20 Data	Iowa Total Care
My Health Pays Program	13,421
The Flu Program	1,517
Start Smart for Your Baby	1,417
Member Connections Program	110
Mobile App	349
Tobacco Cessation	90

Q1 SFY20 Data	Amerigroup
Weight Watchers	474
Exercise Kit	129
Dental Hygiene Kit	164
Personal Bag for Belongings with Comfort Item	24
SafeLink Mobile Phone	2,247
Healthy Families Program	20
Community Resource Link	406
Live Health Online	47
Healthy Rewards	2,951
Taking Care of Baby and Me	4,951
Boys & Girls Club	51
Personal Care Attendant	3
Home Delivered Meals	8
Assistive Devices	3
Community Reintegration	4
Q2 SFY20 Data	**Amerigroup**
Weight Watchers	229
Exercise Kit	62
Dental Hygiene Kit	78
Personal Bag for Belongings with Comfort Item	20
SafeLink Mobile Phone	4
Healthy Families Program	12
Community Resource Link	555
Live Health Online	77
Healthy Rewards	2,944
Taking Care of Baby and Me	3,918
Boys & Girls Club	16
Personal Care Attendant	1
Home Delivered Meals	10
Community Reintegration	3
HiSET	1
Q3 SFY20 Data	**Amerigroup**
Weight Watchers	209
Exercise Kit	57

Dental Hygiene Kit	76
Personal Bag for Belongings with Comfort Item	4
SafeLink Mobile Phone	619
Healthy Families Program	30
Community Resource Link	763
Live Health Online	115
Healthy Rewards	1,620
Taking Care of Baby and Me	2,895
Boys & Girls Club	289
Home Delivered Meals	20
Community Reintegration	5
HiSET	3
Q4 SFY20 Data	**Amerigroup**
Weight Watchers	853
Exercise Kit	79
Dental Hygiene Kit	80
Comfort Item	3
SafeLink Mobile Phone	652
Healthy Families Program	14
Community Resource Link	715
Live Health Online	135
Healthy Rewards	1,765
Taking Care of Baby and Me	2,754
Personal Care Attendant	1
Home Delivered Meals	50

Provider Network Access

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

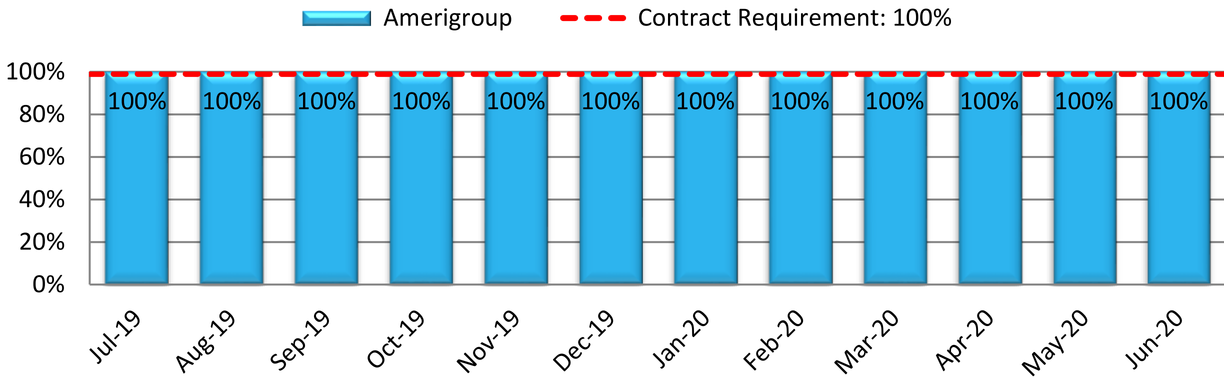
- Member and provider ratios by provider type and by region(East, West, and Central Iowa)
- Geographic access by time and distance

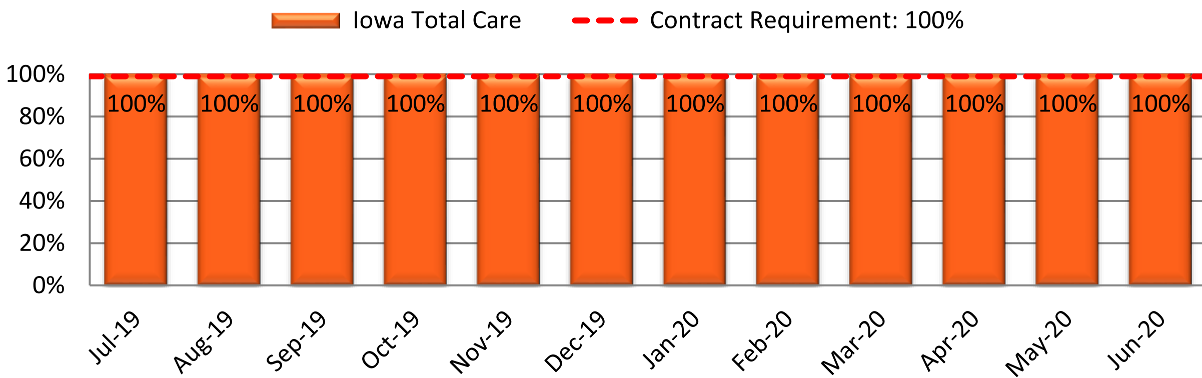
As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the Department when the MCO clearly demonstrates that:

- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area. An area is defined as either a county in the case of HCBS providers, or within a certain time/distance requirement (e.g., within 60 minutes/miles) for non-HCBS providers.

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

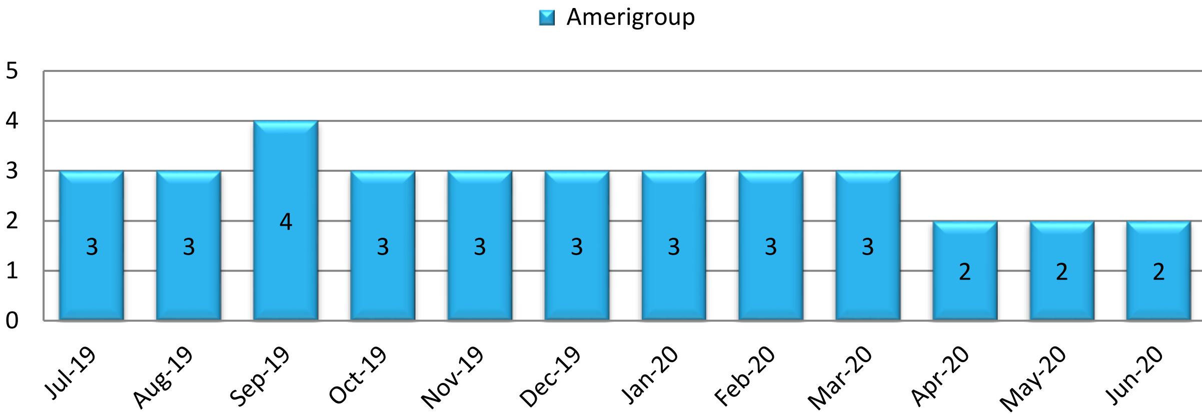
Non-Pharmacy Prior Authorizations (PAs)

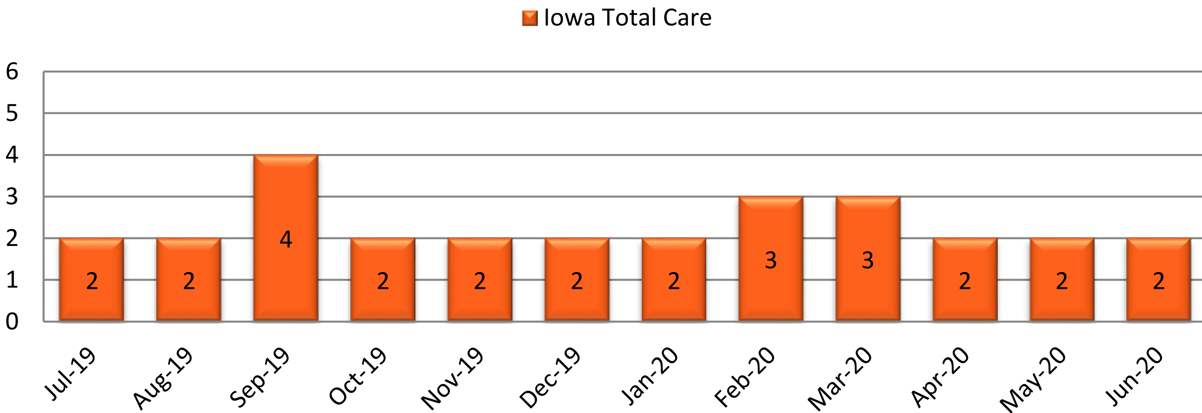


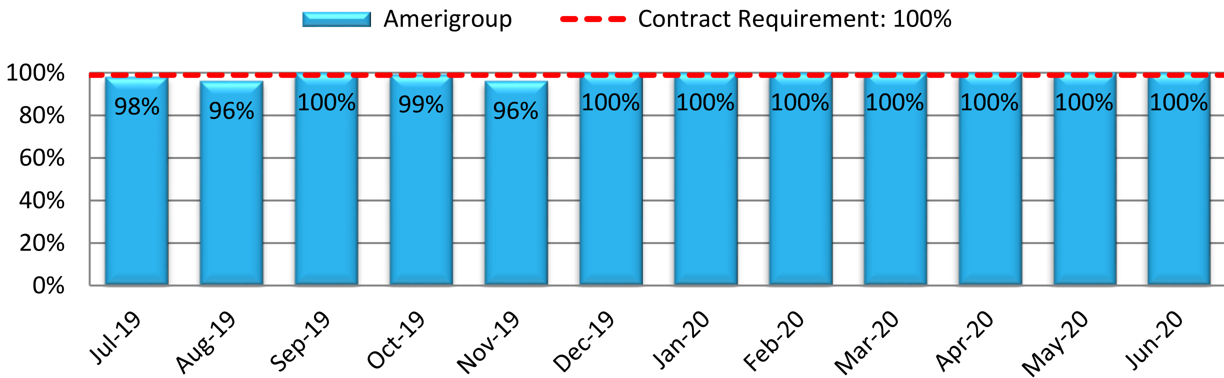


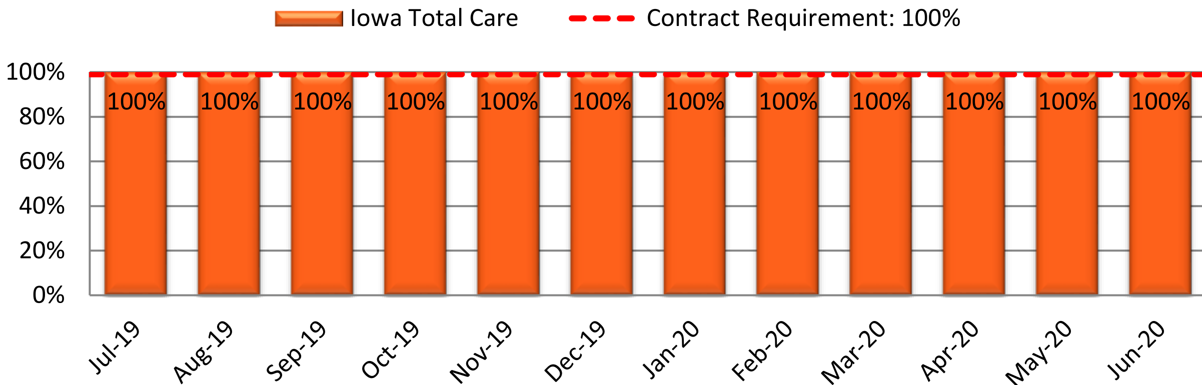
This data element does not have a direct benchmark to compare to historical FFS data as the managed care and FFS prior authorization (PA) process and volume may differ. 99% of regular PAs must be completed within 14 calendar days of request to meet performance guarantees.

The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.


Average Days for Regular PA Processing
Amerigroup
5
4
3
2
1
0
3
3
4
3
3
3
3
3
3
2
2
2
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

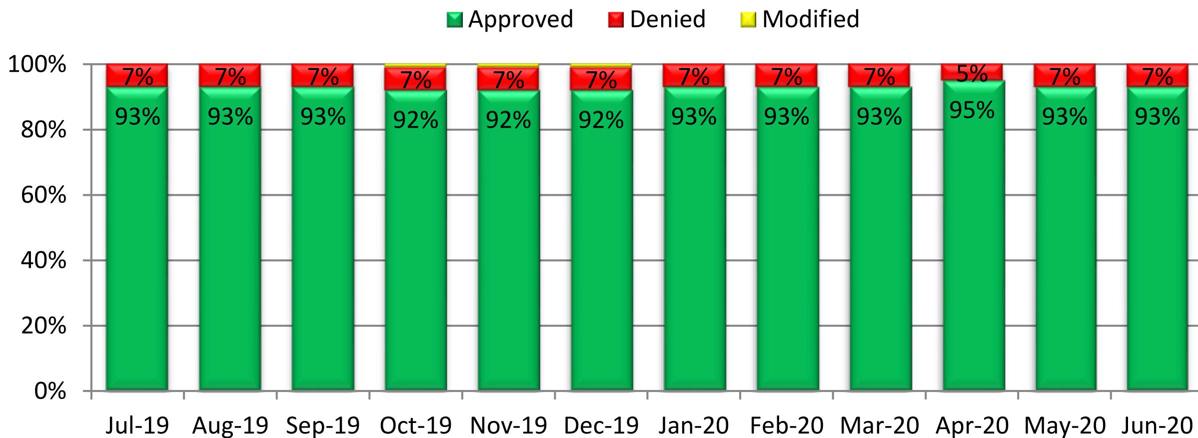

Average Days for Regular PA Processing
Iowa Total Care
6
5
4
3
2
1
0
2
2
4
2
2
2
2
3
3
2
2
2
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

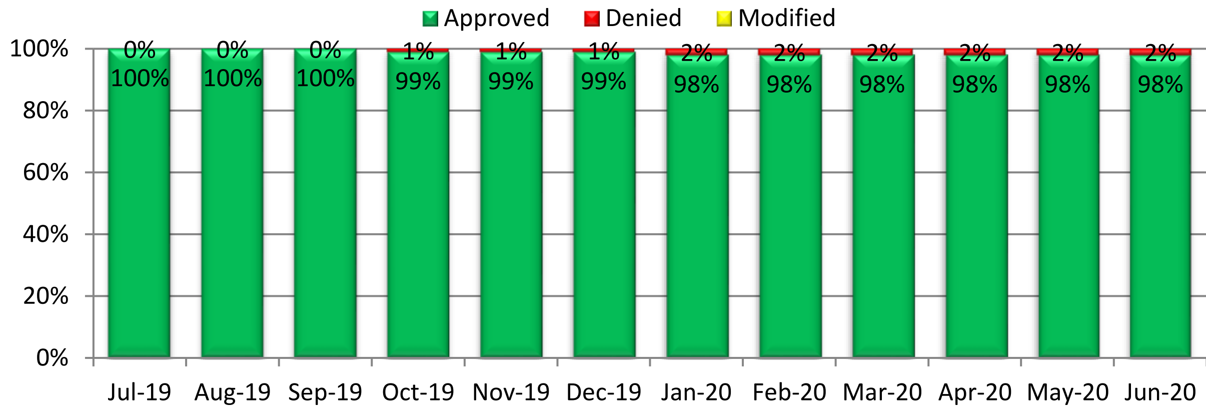

Percentage of PAs for Expedited Services Completed
Within 72 Hours of Request
Amerigroup
Contract Requirement: 100%
100%
80%
60%
40%
20%
0%
98%
96%
100%
99%
96%
100%
100%
100%
100%
100%
100%
100%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20



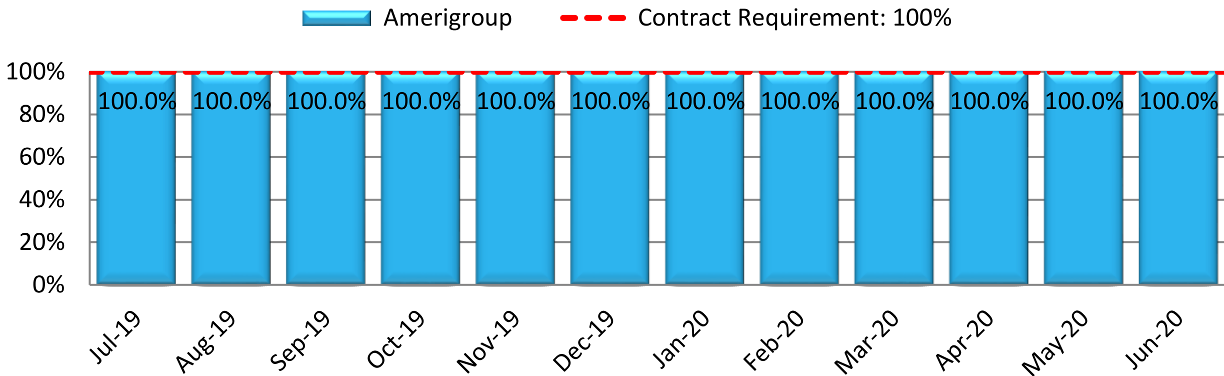
This data element does not have a direct benchmark to compare to historical FFS data as the managed care and FFS PA process and volume may differ. 99% of PAs for expedited services must be authorized within 72 hours of request to meet performance guarantees.

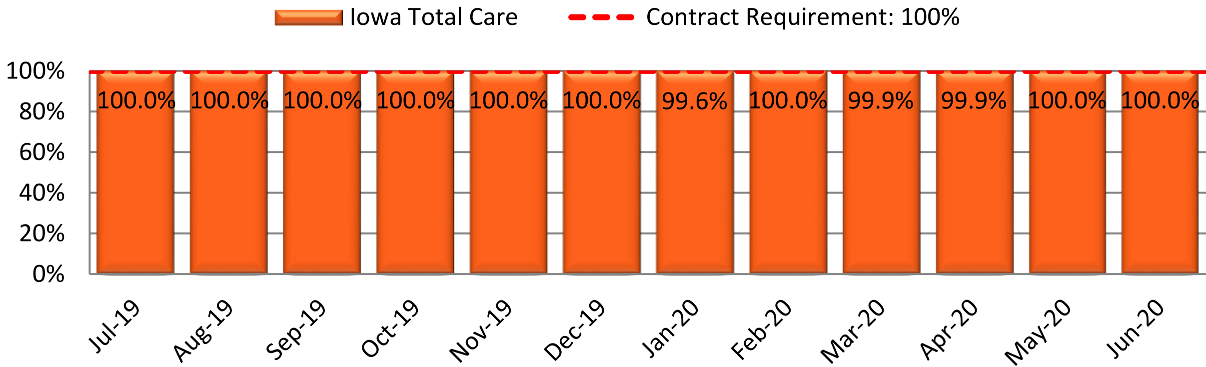
The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.




Iowa Total Care
Non-Pharmacy PAs Status
**As of the end of the reporting period
Approved
Denied
Modified
100%
80%
60%
40%
20%
0%
0%
100%
0%
100%
0%
100%
1%
99%
1%
99%
1%
99%
2%
98%
2%
98%
2%
98%
2%
98%
2%
98%
2%
98%
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20
Apr-20
May-20
Jun-20

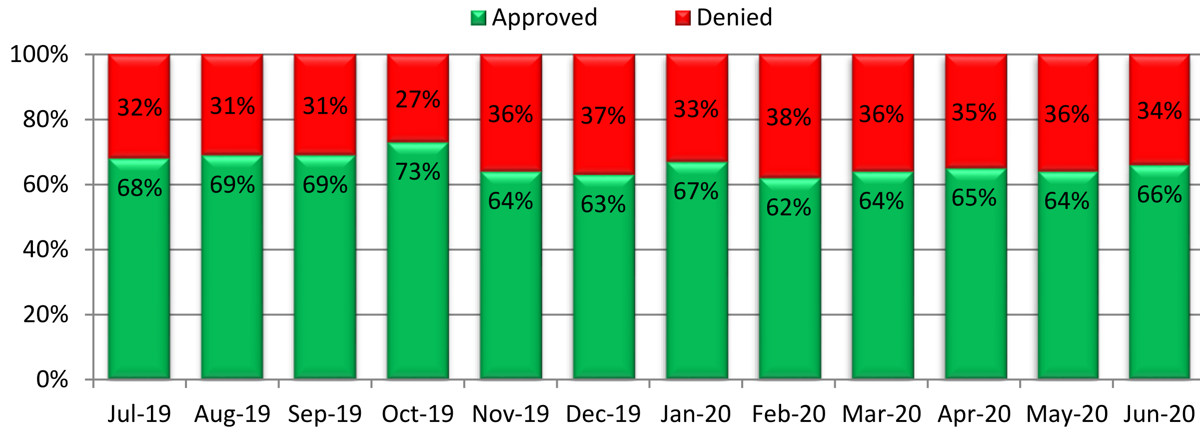
Prior Authorization (PA) - Pharmacy

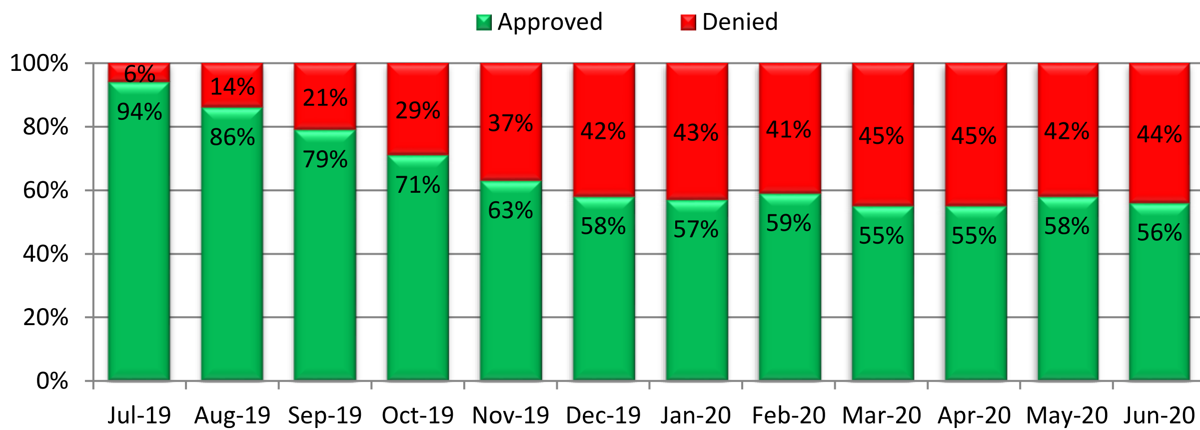




This data element does not have a direct benchmark to compare to historical FFS data as the managed care and FFS PA process and volume may differ. 100% of regular PAs must be completed within 24 hours of request to meet performance guarantees.

The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.





Prior Authorizations for pharmaceuticals are becoming more complex and may require more specific data for approval.

Encounter Data Reported

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											
Encounter Data Submitted Timely By 20th of the Month	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y
Performance Measure	**Iowa Total Care**											
Encounter Data Submitted Timely By 20th of the Month	July	Aug	Sep	Oct	Nov	Dec	Jan	Feb	Mar	Apr	May	Jun
	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y	Y

Value Based Purchasing Enrollment

Value Based Purchasing agreements link provider payments to improved performance by health care providers. They hold health care providers accountable for both the cost and quality of care they provide. MCOs are expected to have 40% of their population covered by a value based purchasing agreement.

Data	Amerigroup	Iowa Total Care
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards for Q1 SFY20	52%	0%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q2 SFY20	56%	23%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q3 SFY20	60%	30%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q4 SFY20	63%	32%

Medical Loss Ratio (MLR)/Administrative Loss Ratio (ALR)/Underwriting

MCOs are required to meet a minimum medical loss ratio (MLR) of 88% per the contract between the Department and the MCOs. This requirement is calculated as an average across the year in question. This average is only finalized after 6 months of claims runout following the end of the year in question.

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

Q1 SFY20 Data	Amerigroup	Iowa Total Care
MLR	94.6%	91.6%
ALR	5.2%	7.0%
Underwriting	0.2%	1.4%
Q2 SFY20 Data	**Amerigroup**	**Iowa Total Care**
MLR	83.3%	92.4%
ALR	4.7%	5.5%
Underwriting	12.1%	2.2%
Q3 SFY20 Data	**Amerigroup**	**Iowa Total Care**
MLR	89.2%	93.2%
ALR	9.9%	7.4%
Underwriting	0.9%	-0.6%
Q4 SFY20 Data	**Amerigroup**	**Iowa Total Care**
MLR	80.5%	90.8%
ALR	5.7%	5.0%
Underwriting	13.8%	4.2%

These measurements may be subject to change after the end of the reporting quarter due to out of period adjustments made by the MCOs. All amounts listed are unaudited. The MCOs are required to submit data as prescribed within 30 days following the six (6) months claims run-out period for final determination of SFY MLR.

Capitation Payments

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.

Amerigroup	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Total	**$776,896,261**	**$770,541,008**	**$780,177,202**	**$801,008,868**
Adjustments	$6,430,230	($318,472)	($561,917)	(-$709,161)
Current	$746,007,181	$741,757,464	$737,725,943	$765,456,683
Member Reinstatements and Retroactive Eligibility	$24,458,850	$29,102,016	$43,013,176	$36,261,345
Iowa Total Care	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Total	**$490,980,587**	**$515,932,803**	**$517,576,251**	**$533,865,563**
Adjustments	($2,210,078)	($738,123)	($269,855)	(-$985,520)
Current	$472,574,570	$477,277,865	$482,489,315	$505,021,654
Member Reinstatements and Retroactive Eligibility	$20,616,095	$39,393,061	$35,356,790	$29,829,430

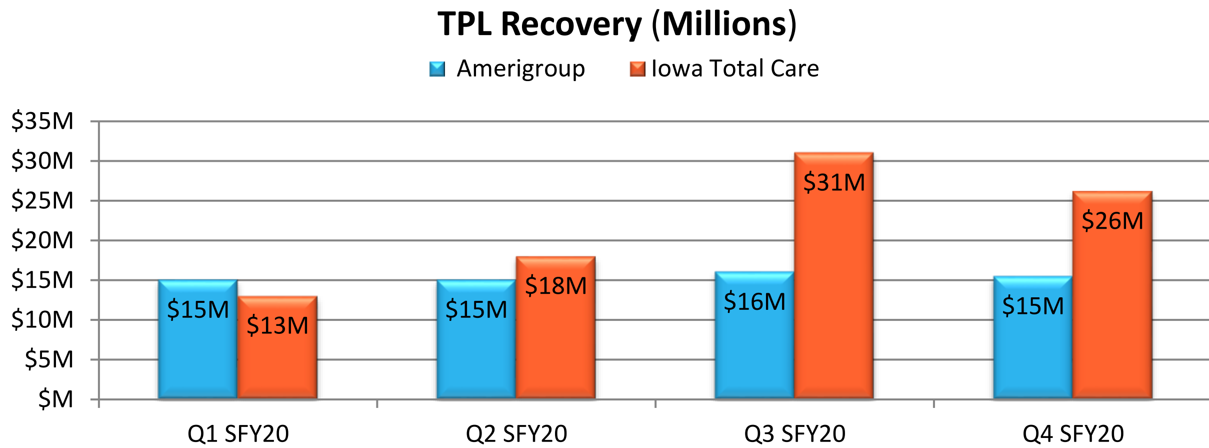
Starting in March2020, there were no members disenrolled from Medicaid due to COVID-19, which resulted in an increase in capitation payment for the last two quarters of the fiscal year. Also in Q3SFY2020, the Department withheld $44M from Iowa Total Care due to internal claims payments issues. As of June 30, 2020, this withhold has not been released to Iowa Total Care.

MCO Reported Reserves

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

Reported Reserves refer to an MCO's ability to pay their bills and the amount of cash they have on hand to do so.

Third Party Liability (TPL)



Third Party Liability refers to payments from additional insurers (Medicare, supplemental insurance, etc.) that can help offset Medicaid costs.

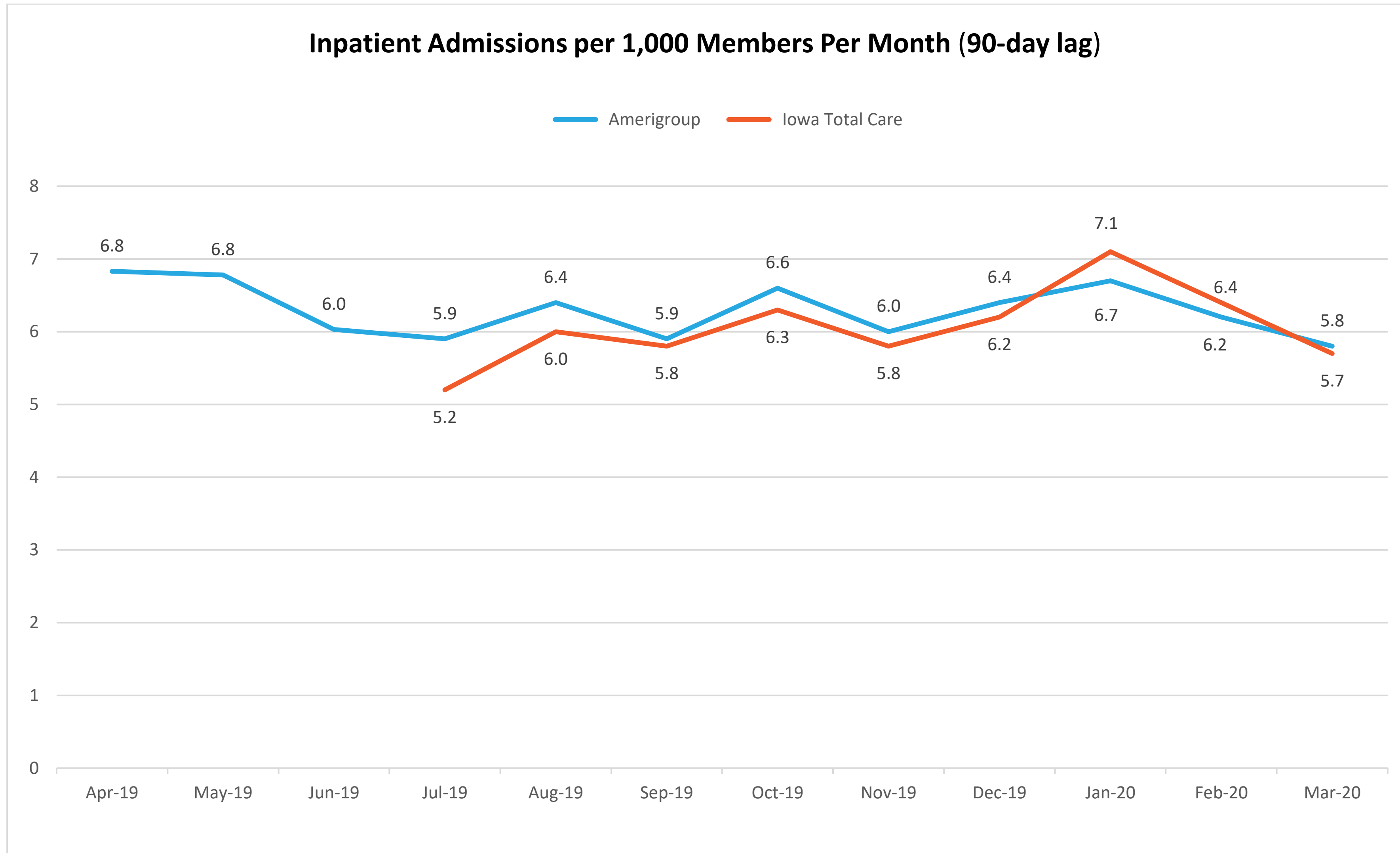
Program Integrity

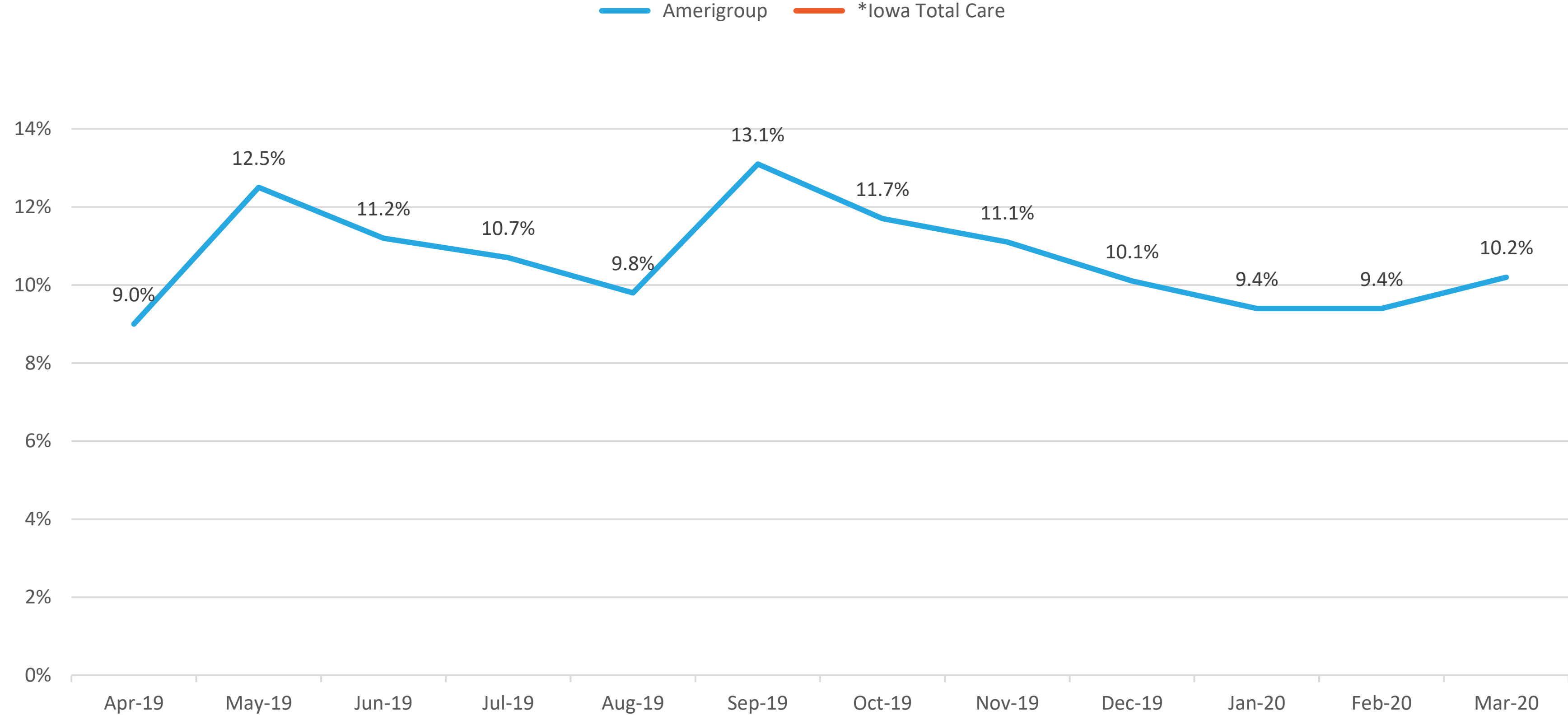
Program Integrity
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done 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		
PI activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.		
Q1 SFY20 Data	**Amerigroup**	**Iowa Total Care**
Investigations Opened During the Quarter	23	1
Overpayments Identified During the Quarter	6	0
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	6	0
Member Concerns Referred to IME	5	2
Q2 SFY20 Data	**Amerigroup**	**Iowa Total Care**
Investigations Opened During the Quarter	26	18
Overpayments Identified During the Quarter	4	0
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	3	0
Member Concerns Referred to IME	5	6
Q3 SFY20 Data	**Amerigroup**	**Iowa Total Care**
Investigations Opened During the Quarter	42	50
Overpayments Identified During the Quarter	0	0
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	4	0

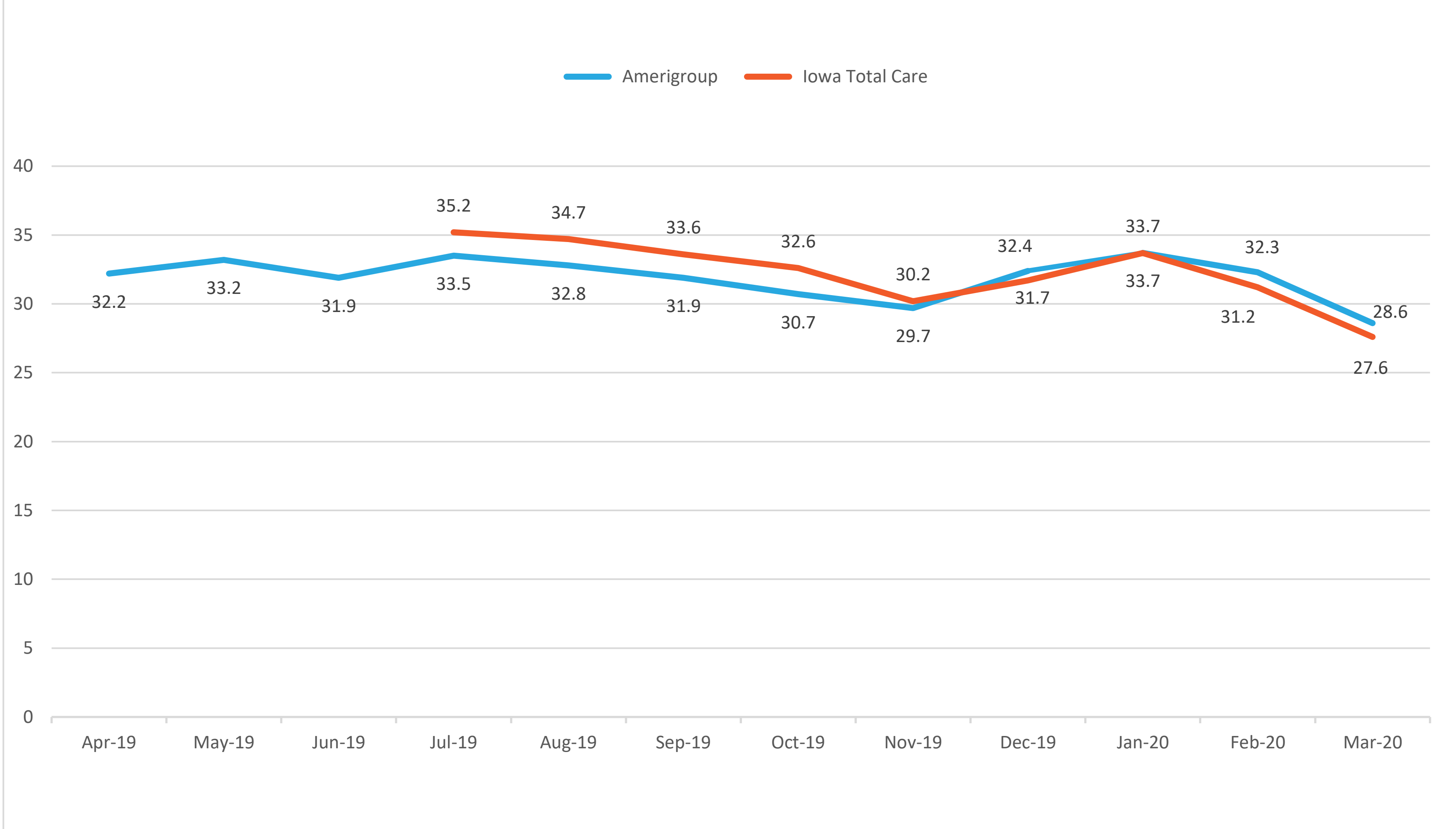
Member Concerns Referred to IME	6	3
Q4 SFY20 Data	**Amerigroup**	**Iowa Total Care**
Investigations Opened During the Quarter	72	6
Overpayments Identified During the Quarter	14	2
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	4	3
Member Concerns Referred to IME	5	4

In SFY20, the plans initiated 238 investigations and have referred a total of 20 cases to the Medicaid Fraud Control Unit (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 listed in this chart would be considered pending until final determinations are made.


Inpatient Admissions per 1,000 Members Per Month (90-day lag)
Amerigroup
Iowa Total Care
8
7
6
5
4
3
2
1
0
6.8
6.8
6.0
5.9
6.4
5.9
6.6
6.0
6.4
6.7
6.2
5.8
5.2
6.0
5.8
6.3
5.8
6.2
7.1
6.4
5.7
Apr-19
May-19
Jun-19
Jul-19
Aug-19
Sep-19
Oct-19
Nov-19
Dec-19
Jan-20
Feb-20
Mar-20



**This measure requires 12 months of continuous enrollment with the MCO. Since ITC does not have members with 12 months of continuous enrollment, and since this measure is reported using a 90 day lag, there will not be results for ITC for this measure until Q2 SFY2021.*

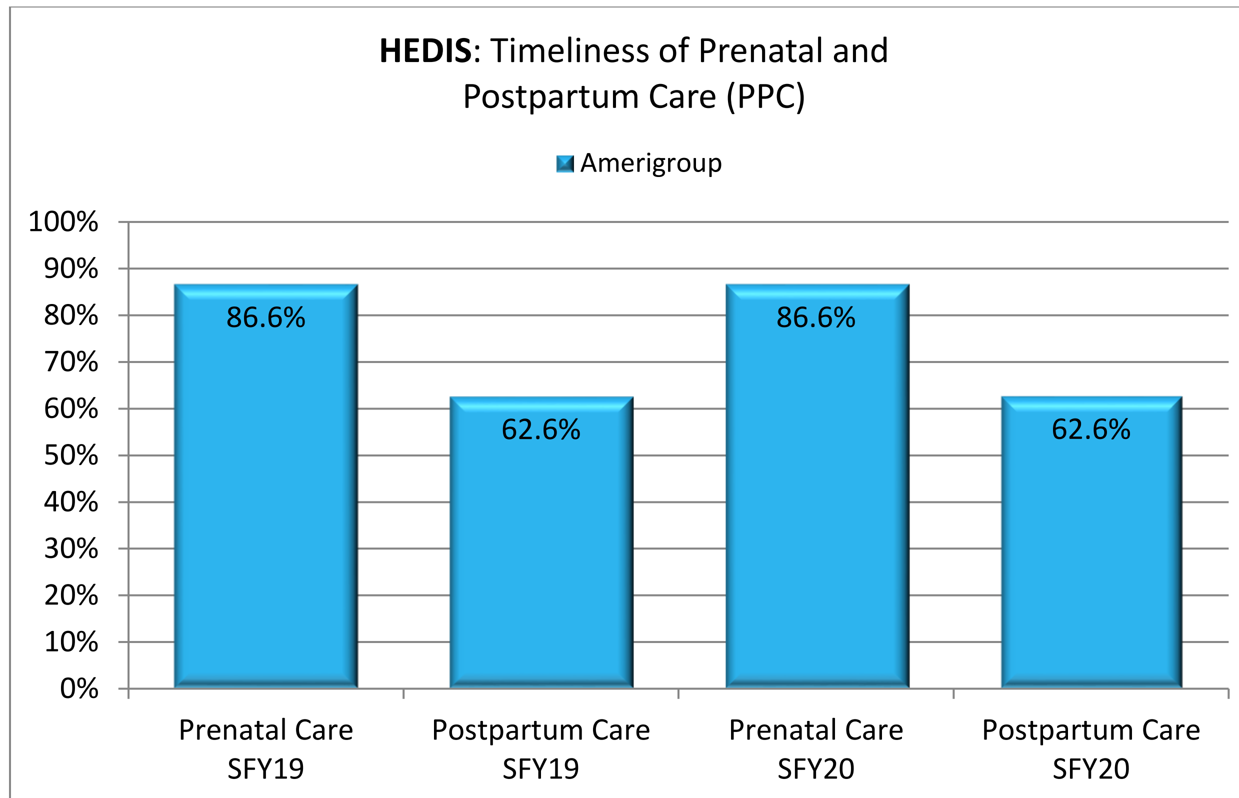


Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.

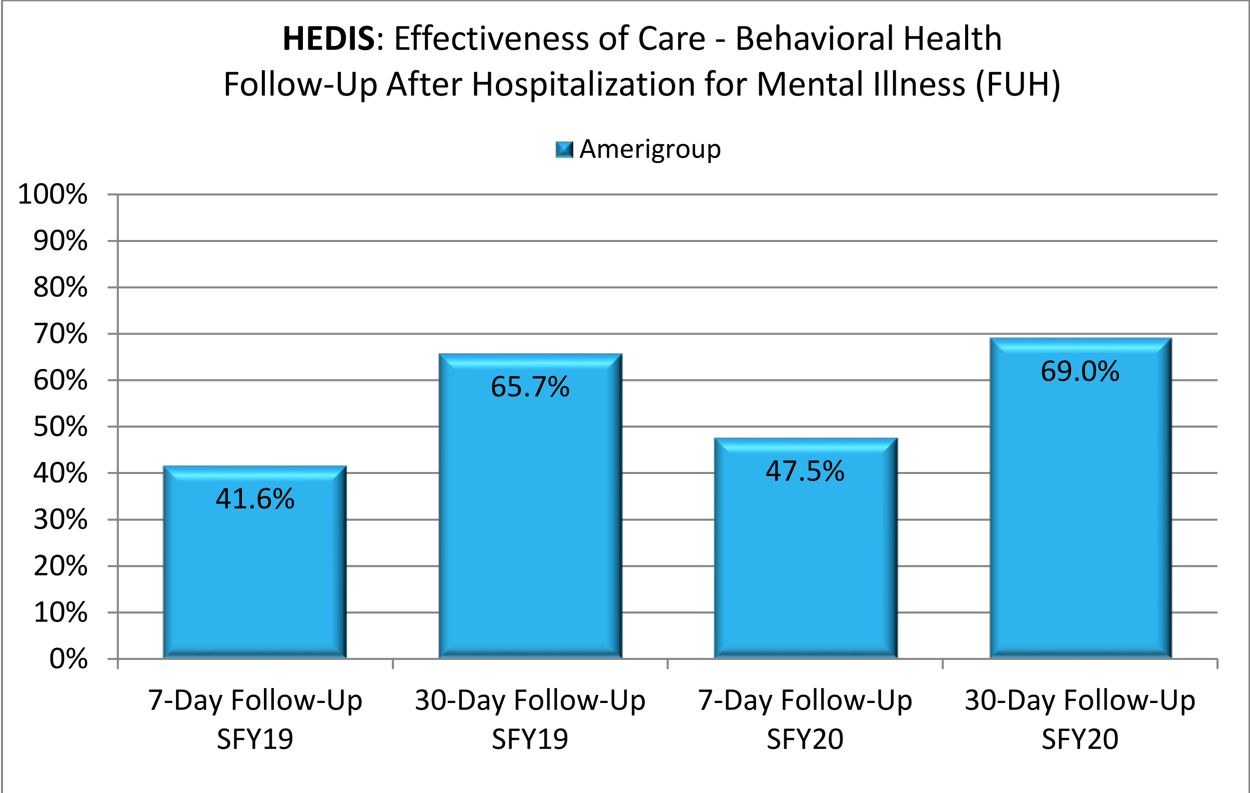
Health Effectiveness Data and Information Set (HEDIS)

A goal of managed care is to improve health outcomes. The Health Effectiveness Data and Information Set (HEDIS) uses evidence-based measurement and specifications to benchmark health plan performance. The data published in this report include measures that were reportable and focus on the following domains of health: prenatal care, behavioral health, children's health, and adult health.

Due to ITC entering the Iowa market in July 2019, the first HEDIS and CAHPS measures to be reported for ITC (for calendar year 2020) will be in July 2021 and included in the December 2021 annual report.

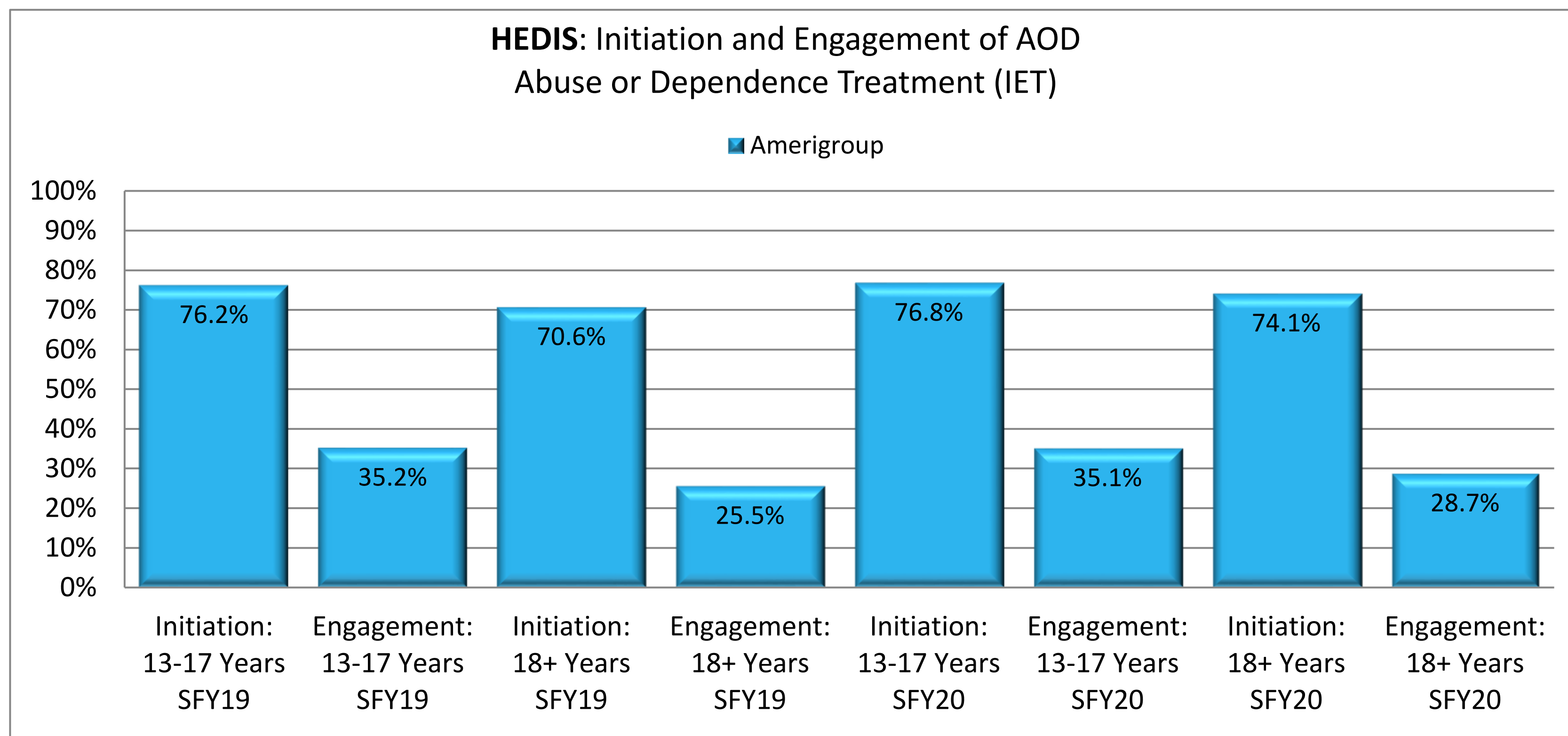


Timeliness of prenatal and postpartum care measures assess the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization. Timeliness of Postpartum Care: The percentage of deliveries that had a postpartum visit on or between 21 and 56 days after delivery. In 2020, Amerigroup and Iowa Total Care have started working on Performance Improvement Projects (PIPs) within the External Quality Review Process in an effort to improve their percentages for the Postpartum Care measure.



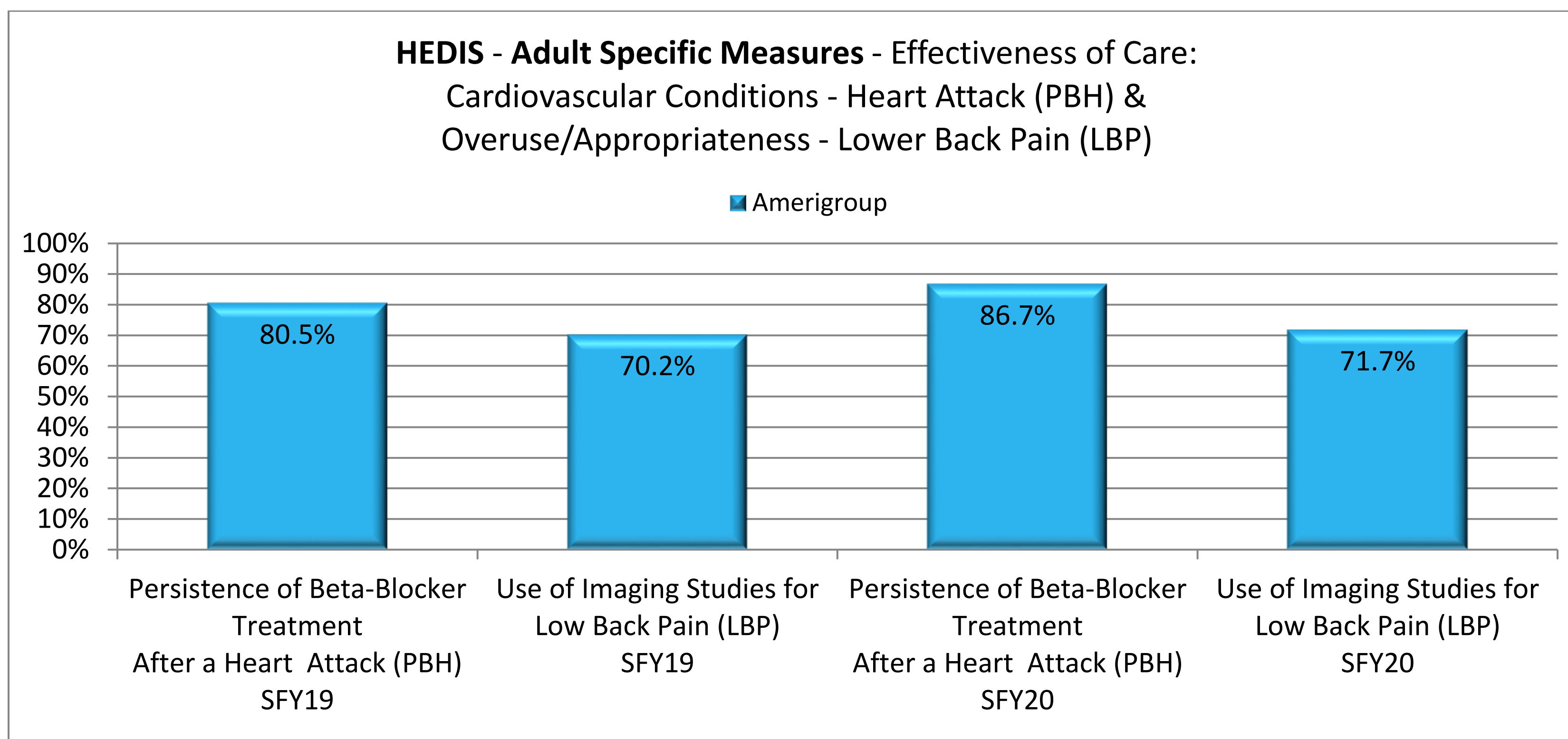
The follow-up after Hospitalization measure (shown in the table above) assesses adults and children 6 years of age and older who were hospitalized for treatment of selected mental health disorders and had an outpatient visit, an intensive outpatient encounter or a partial hospitalization with a mental health practitioner. The measure identifies the percentage of members who received follow-up within 7 days of discharge and within 30 days of discharge. Patients hospitalized for mental health issues are vulnerable after their discharge and follow-up care by trained mental health clinicians is critical for their health and well-

being. Amerigroup's percentages for these measures are above the national average reported by NCQA (State of Health Care Quality Report – 2018)



The Alcohol or Drug Dependence Initiation and Engagement of Treatment measure (shown in the table above) assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care. Initiation of AOD Treatment: Adolescents and adults who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis. Engagement of AOD Treatment: Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. AOD dependence is common across many age groups and a cause of morbidity,

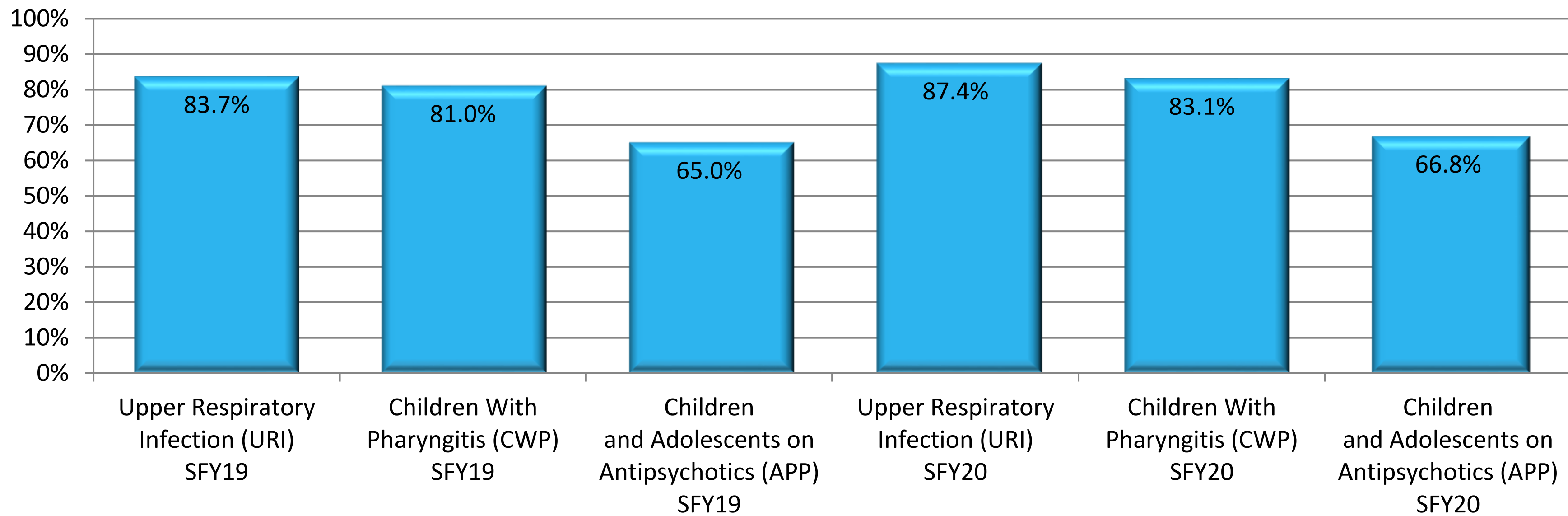
mortality and decreased productivity. There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs. Amerigroup's percentages for these measures are above the national average reported by NCQA (State of Health Care Quality Report – 2018)



The Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) measure (shown in the table above) assesses adults 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge. Beta-blockers work by

lowering the heart rate, which reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.

The Use of Imaging Studies for Low Back Pain (LBP) measure (shown in the table above) assesses adults 18 to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance). Evidence shows that many patients diagnosed with low back pain receive excessive imaging which can lead to unnecessary worry and unneeded surgery. For the great majority of individuals who experience severe low back pain, pain improves within the first two weeks of onset. Avoiding imaging (i.e., X-ray, MRI, CT scans) for patients when there is no clinical necessity, can prevent unnecessary harm, unintended consequences to patients and reduce health care costs.



The Appropriate Treatment for Children with Upper Respiratory Infection (URI) measure (shown in the table above) assesses children 3 months‒18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed). Most URIs, also known as the common cold, are caused by viruses that require no antibiotic treatment. Too often, antibiotics

are prescribed inappropriately, which can lead to antibiotic resistance (when antibiotics can no longer cure bacterial infections). Antibiotic resistance is a major health concern in the United States and around the world.

Recent efforts to decrease unnecessary prescribing have resulted in fewer children receiving antibiotics in recent years, but inappropriate use remains a problem. Increased education and awareness of appropriate treatment for URIs can reduce the danger of antibiotic-resistant bacteria.

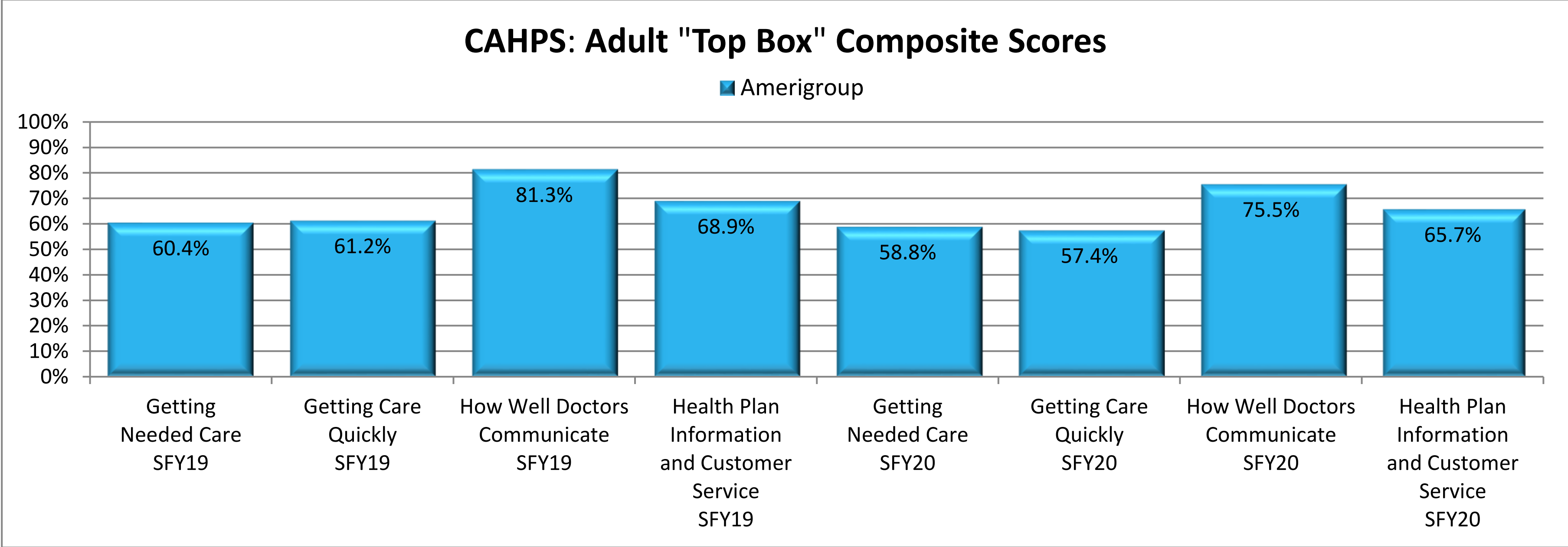
The Appropriate Testing for Children with Pharyngitis measure (shown on the previous page) assesses children 2- to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a "Group A" streptococcus test for the episode. A higher rate represents better performance (i.e., appropriate testing).

Pharyngitis, or sore throat, is a leading cause of pediatric ambulatory care visits and can be caused by a virus or by bacteria. Viral pharyngitis does not require antibiotic treatment, but antibiotics continue to be inappropriately prescribed. Proper testing and treatment of pharyngitis would prevent the spread of sickness, while reducing the unnecessary use of antibiotics. Inappropriate treatments with antibiotics can lead to antibiotic resistance (when antibiotics can no longer cure bacterial infections), which makes it essential that children with pharyngitis have appropriate testing, diagnosis and treatment.

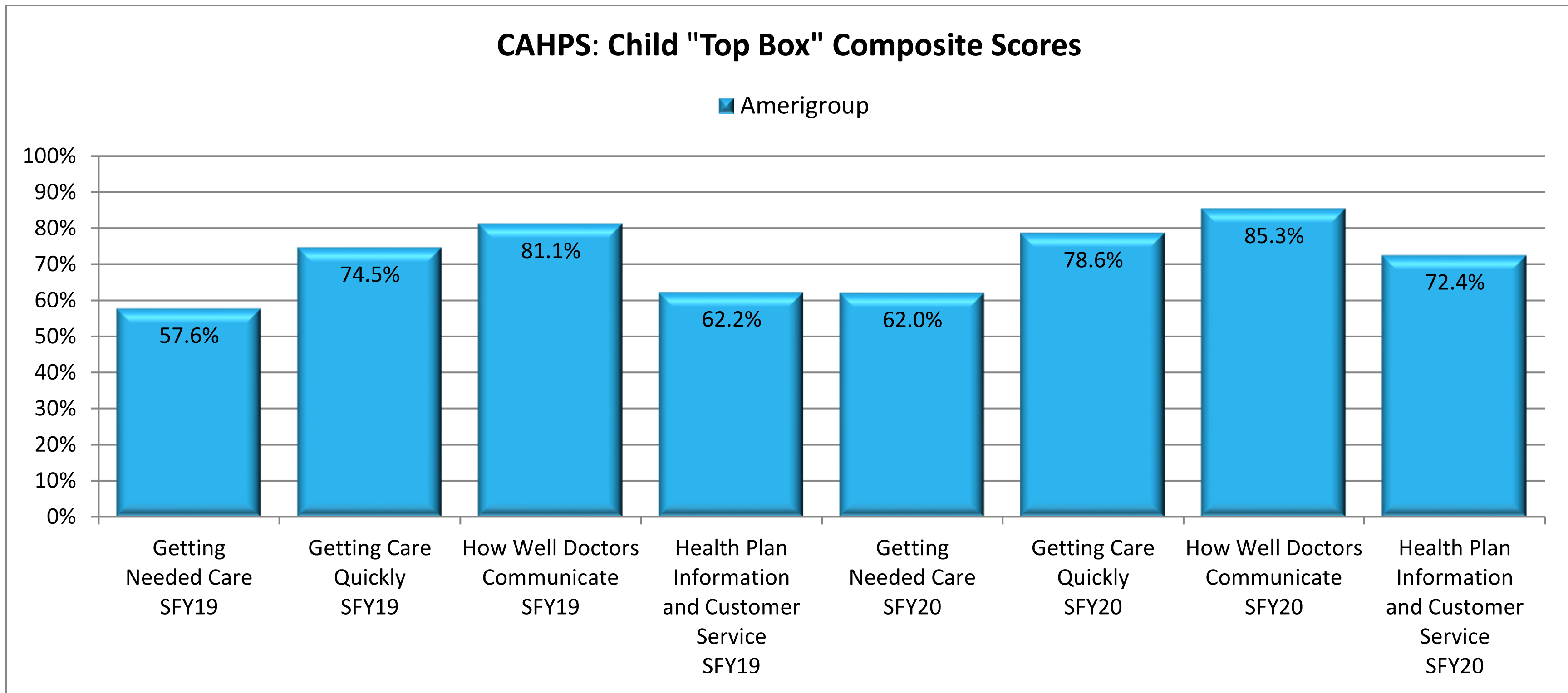
The Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics measure (shown on the previous page) assesses whether children and adolescents without an indication for antipsychotic medication use had documentation of psychosocial care as first-line treatment before being prescribed an antipsychotic medication. Although antipsychotic medications may serve as effective treatment for a narrowly defined set of psychiatric disorders in children and adolescents, they are often prescribed for nonpsychotic conditions for which psychosocial interventions are considered first-line treatment. Safer, first-line psychosocial interventions may be underutilized, and children and adolescents may unnecessarily incur the risks associated with antipsychotic medications.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

A goal of managed care is to improve the patient experience of care. The Consumer Assessment of Healthcare Providers and Systems (CAHPS) uses evidence-based measurement and survey delivery specifications to benchmark health plan performance in this area. The data published in this report include composite scores of the following domains: getting needed care, getting care quickly, how well doctors communicate, and customer service.



The composites above reflect the number of responses to domain questions where members indicated plan performance was always satisfactory. National and regional Top Box benchmarks are published at the Agency for Healthcare Research and Quality website.



The composites above reflect the number of responses to domain questions where members indicated plan performance was always satisfactory. National and regional Top Box benchmarks are published at the Agency for Healthcare Research and Quality website.

OVERSIGHT ENTITIES EXECUTIVE SUMMARIES

Gerd W. Clabaugh, Interim Director — **Council on Human Services**

Meeting Minutes
July 10, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Gerd W. Clabaugh – **present**
Kimberly Kudej – **present**	Mikki Stier - **present**
Carol Forristall – **present**	Nancy Freudenberg **- present**
Rebecca Peterson – **present**	Mike Randol – **present**
Skylar Mayberry-Mayes – **present**	Anthony Lyman - **present**
Sam Wallace – **present via phone**	Jean Slaybaugh - **present**
	Vern Armstrong - **present**
	Jana Rhoads - **present**
	Rick Shults - **present**
	Nancy Freudenberg **- present**
	Matt Highland - **present**
	Carrie Malone - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Timi Brown-Powers – **absent**
Senator Amanda Ragan – **absent**
Senator Marianne Miller-Meeks – **absent**

Guests

Tony Leys – Des Moines Register
Patty Funaro – LSA
Shelly Chandler – IACP
Kim Scorza – Seasons Center
Steve Kremer – JCS
Sandi Hurtado-Peters – IDOM
Tim Ross- JCS
Terry Bailey – YSS-AMP
Erika Eckley – IHA
Lauren Linnenbrink – Iowa AEYC
Erin Drinnin – United Way
Jess Benson – LSA
Craig Schoenfeld - Iowa Total Care
Kris Bell – SDC
Stacey Walter – Iowa ELC
John Bellini – Hillcrest Family Services
Dave Stone – United Way
Chad Jensen – JCS
Kristie Oliver – Coalition for Family & Childrens Services
Kayla Eckerman – Youth Policy Institute for Iowa
Carol Behrer – Youth Policy Institute for Iowa
Jennifer Harbiso- UI Health Care

1 August 7, 2019

Call to Order

Chairman Mark Anderson called the Council meeting to order at 10:01 a.m. in Conference Room 1 at the Polk County River Place Building.

Roll Call

All Council members were present.
All Ex-officio legislative members were absent.

Chairman Anderson stated, "Council this is a public hearing and an opportunity to hear from the public in preparation for our budget planning. Each group that has signed up to speak will be given 10 minutes. We would like groups to please keep the topic of the budget in mind. Please do not use individuals names as that is a HIPPA violation, also there will not be any discussion or debate at this hearing as that would be ruled out of order. The council is allowed to ask questions. The council is very happy you have all joined us today and we look forward to hearing from all of you."

The following groups presented comments to the council:

Erika Eckley	Iowa Hospital Association
Shelly Chandler	Iowa Association of Community Providers
Carol Beher/Kayla Eckerman	Youth Policy Institute of Iowa
Dave Stone	United Way of Central Iowa
John Bellini	Hillcrest Family Services
Liz Cox	Polk County Mental Health Region
Tim Ross/Chad Jensen	4th and 5th Juvenile Court Districts
Kristie Oliver	Coalition for Family & Child Services
Terry Bailey/Kelly Noveshen	Youth and Shelter Services
Youth Impact Statements	Youth and Shelter Services
Jodi Tomlonovic	Family Planning Council of Iowa
Shanell Wagler	Iowa Department of Management-Early Childhood Iowa

Rules

Nancy Freudenberg presented the following rules for adoption:

R-1. Amendments to Chapter 40, Application for Aid and Chapter 65, "Food Assistance Program Administration". Remove obsolete form references from the Family Investment Program (FIP) rules and also removes outdated and unnecessary rules related to Electronic Benefit Transfer (EBT) for Food Assistance.

Motion was made by Kudej to approve and seconded by Wallace. **MOTION CARRIED UNANIMOUSLY.**

R-2. Amendments to Chapter75, "Conditions of Eligibility". Adjusts the federal poverty level (FPL) increments used to assess premiums for applicants and

recipients for the Medicaid for Employed People with Disabilities (MEPD) program with income over 150% of the FPL.

Motion was made by Wallace to approve and seconded by Mayberry-Mayes. **MOTION CARRIED UNANIMOUSLY.**

R-3. Amendments to Chapter 75, "Conditions of Eligibility". Removes specific amounts listed for the statewide average charges for nursing facility services for private-pay residents, average pay charges for nursing facilities and psychiatric medical institutions for children, and the maximum Medicaid rate for intermediate care facilities for person with an intellectual disability. The annually revised amounts for these charges will now be published on the Department's website.

Motion was made by Wallace to approve and seconded by Kudej. **MOTION CARRIED UNANIMOUSLY.**

R-4. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services". Provide a definition of a customized wheelchair for all Medicaid members and providers. Aligns Iowa's Medicaid definition of a customized wheelchair with the definition for the Medicare program provided by the Centers for Medicare and Medicaid Services (CMS).

Motion was made by Forristall to approve and seconded by Peterson. **MOTION CARRIED UNANIMOUSLY.**

R-5. Amendments to Chapter 97, "Collection Services Center", Chapter 98, "Support Enforcement Services" and Chapter 99, "Support Establishment and Adjustment Services". Remove references to obsolete form numbers and names.

Motion was made by Peterson to approve and seconded by Forristall. **MOTION CARRIED UNANIMOUSLY.**

There are no noticed rules for your review this month.

Approval of Minutes

A motion was made by Kudej and seconded by Mayberry-Mayes to approve the minutes of the June 12, 2019 meeting.
MOTION UNANIMOUSLY CARRIED.

Election of Officers

Wallace nominated Mark Anderson as Chair of the Council on Human Services. Kudej seconded the nomination. There were no other nominations. **The Council voted unanimously to elect Mark Anderson as Chair.**

Anderson nominated Kim Kudej as Co-Chair of the Council on Human Services. Mayberry-Mayes seconded the nomination. There were no other nominations. **The Council voted unanimously to elect Kim Kudej as Co-Chair.**

Managed Care Update
Mike Randol, Director of Iowa Medicaid, gave an overview of the MCO report for the second quarter of SFY 2019. Director Randol highlighted the following items in the report.

- Overall improvement in the level of care received.
- Member helpline scores were higher.
- Out of 6 million claims processed, only 82,000 prior authorizations were recorded and only 556 appeals.

Council Update
Anderson – Nothing to report.

Kudej – Made a motion that the council receive quarterly reports on family planning. Chairman Anderson repeated the motion is to direct DHS to give the council quarterly reports on accessibility to family planning. The motion was seconded by Forristall.
MOTION PASSED UNAMIMOUSLY.
Kudej also asked that the council plan a site visit to Independence and get a report from ACFS regarding the foster care after care program. Jana Rhoads, DA of ACFS will plan on giving an update to the council at the September meeting on that program.

Wallace – Asked Interim Director to give a short update on the Medical residency program in Iowa. ID Clabaugh gave a brief overview of the program put in place by then Governor Branstad. That the program has been successful since being established 4 years ago.
Foristall: Requested a site visit for the council.
Peterson: Nothing to report
Mayberry-Mayes: Nothing to report

Director's Report
Director Clabaugh expressed his appreciation to the council for allowing him to be part of the meeting. He stated that his current role is to prepare the department for a new director. He has worked closely with all the DHS management team and appreciates their time and guidance to inform him of the day to day operations of DHS.

Next Meeting
The next meeting of the Council on Human Services is Wednesday, August 14, 2019 at the Independence Mental Health Institute. More details to follow.

Adjournment
Anderson adjourned the meeting at 1:16 p.m.

Respectfully submitted by,
Julie Dougherty
Council Secretary
Jk

Department of HUMAN SERVICES

Gerd W. Clabaugh, Interim Director | **Council on Human Services**

Meeting Minutes
August 14, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Gerd Clabaugh – **present**
Kimberly Kudej – **present**	Mikki Stier - **present**
Sam Wallace – **absent**	Rick Schults - **present**
Carol Forristall – **absent**	Dr. Bhaskar Dave - **present**
Rebecca Peterson – **present**	Carrie Malone - **present**
Skylar Mayberry-Mayes - **present**	Matt Highland - **present**
	Julie Dougherty - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Timi Brown-Powers - **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests

Sherry Streif – IMHI
Debra Fenner – IMHI
Kevin Jimmerson – IMHI
Mike Cook – IMHI
Charles McCardle - IMHI
Sandy Hurtado-Peters - IDOM
Natalie Ginty – Caucus Staff
Denise Rathman - NASW

Call to Order

Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the auditorium of the Independence Mental Health Institute.

Roll Call

Four council members were present.
All Ex-officio legislative members were absent.

Approval of Minutes

A motion was made by Mayberry-Mayes and seconded by Kudej to approve the minutes of the July 10, 2019 meeting.
MOTION UNANIMOUSLY CARRIED

Director's Report

- Director Clabaugh thanked Dr. Dave for hosting our council meeting at the Independence facility. He recognized Dr. Dave for receiving recognition from the American Psychiatric Association for outstanding contributions to the profession. This is a lifetime honor and the State of Iowa and DHS are very fortunate to have Dr. Dave as a leader in our division.
- Our next meeting will be potentially held over two days on September 10th and 11th at the Hoover State Office Building. These will be our budget meetings. More details will be coming, please try to plan accordingly.
- Director Clabaugh addressed the press coverage of the SNAP program error rate. He informed the council that the department is reviewing its options and will be submitting a plan to USDA.
- Medicaid Director Mike Randol has informed Director Clabaugh that the transition to Iowa Total Care is going very smoothly and so far he is very pleased with the implementation.
- The first meeting for the Children's Behavioral Health Board will take place on August 27, 2019.
- Chair Mark Anderson asked the Director to have a better description of the IV-E funds for the council during next month's budget meeting. Jana Rhoads will provide more information to the council.

Presentations

- MHDS Division Administrator Rick Shults gave a presentation on Mental Illness and Iowa Mental Health Services to the council.
- Dr. Bhaskar Dave, Superintendent of the Independence Mental Health Institute, gave an overview of the facility and its functions to the council.

Next Meeting

The next meeting of the Council on Human Services will be September 11 and 12, 2019 at the Hoover State Office Building.

Adjournment

Chair Mark Anderson adjourned the meeting at 11:38 a.m.

Submitted by,
Julie Dougherty
Council Secretary
JD

2

Department of HUMAN SERVICES

Gerd W. Clabaugh, Interim Director | **Council on Human Services**

Meeting Minutes
September 10 - 11, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Gerd Clabaugh – **present**
Kimberly Kudej – **present**	Mikki Stier - **present**
Sam Wallace – **present**	Jean Slaybaugh - **present**
Carol Forristall – **present**	Rick Schults - **present**
Rebecca Peterson – **absent**	Vern Armstrong - **present**
Skylar Mayberry-Mayes - **present**	Jana Rhoads - **present**
	Mike Randol - **present**
	Anthony Lyman - **present**
	Joe Havig - **present**
	Jody Lane-Molnari - **present**
	Karalyn Kuhns - **present**
	Bob Krebs - **present**
	Carrie Malone - **present**
	Kevin Kirkpatrick - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **present**
Representative Timi Brown-Powers - **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests

Rod Borhart– CR Gazette
Jess Benson – LSA
Flora Schmidt – IBHA
Adrienne Seusy – LSA
Patty Funaro – LSA
Maddie Wilcox – Advocacy Strategies
Kris Bell – SDC
Kent Ohms – LSA
Sandy Hurtado-Peters - IDOM
Natalie Ginty – Caucus Staff
Stacie Maass - ITC
Craig Schoenfeld - ITC
Sara Allen
Kelsey Thien - HDC
Peggy Huppert – NAMI Iowa
Kristie Oliver -

Call to Order
Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the first floor conference room at the Hoover State Office Building in Des Moines, IA.

Roll Call
All council members were present with the exception of Peterson.
All Ex-officio legislative members were absent with the exception of Representative Joel Fry.

Director's Comments

Director Clabaugh provided the following updates to the council:

- Governor Reynolds appointed Kelly Garcia the new director of DHS on September 5th. Kelly is currently the Executive Commissioner of the Texas Health and Human services commission. We're looking forward to her starting on November 1st.

- Director Clabaugh thanked the Council for their visit to the Independence Mental Health facility in August. The staff at the facililty were all very appreciative for the council's time.

- The first meeting of the Children's Behavioral Health board took place on August 27th. Director Clabaugh co-chaired that board. He's very pleased with the work that the board is wanting to accomplish.

Director Clabaugh thanked the Division of Fiscal Management staff for their hard work in putting the budget book together. He then gave an executive summary of pages 2-5 in the SFY 2020 Budget Book.

Budget Overview
Jean Slaybaugh, Chief Financial Officer of DHS, gave an overview of the SFY 2020 Budget Book highlighting DHS clients served, overall budget totals, and comparisons to STY 2019 budget.

SFY 2021 Budget Presentations:

IMPROVE IOWANS' HEALTH STATUS
Division of Adult, Children & Family Services (ACFS) and Iowa Medicaid Enterprise (IME)
-Medical Assistance (Mike Randol)
-Iowa Health and Wellness Plan (Mike Randol)
-Children's Health Insurance Program (Mike Randol)
-Medical Contracts (Mike Randol)
-State Supplementary Assistance (Mike Randol)

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PROMOTE IOWANS' BEHAVIORAL & DISABILITIES HEALTH STATUS

Division of Mental Health and Disability Services

-Cherokee Mental Health Institution (Rick Shults)
-Independence Mental Health Institution (Rick Shults)
-Glenwood Resource Center (Rick Shults)
-Woodward Resource Center (Rick Shults)
-Conner Training (Rick Shults)
-Civil Commitment Unit for Sexual Offenders (Rick Shults)
-State Payment Program (Rick Shults)
-MHDS Regional Funding (Rick Shults)

Recess

The council recessed 4:35 pm

Wednesday September 11, 2019

Call to Order

Mark Anderson, Chair, reconvened the Council meeting at 9:00 a.m. on September 11, 2019.

Rules

Nancy Freudenberg presented the following Notices of Intended Action

N-1. Amendments to Chapter 13, "Program Evaluation". These proposed amendments clarify the programs that are reviewed by the Department of Human Services Quality Control Bureau. These amendments also update forms that are required in that process and remove obsolete forms.

N-2. Amendments to Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services, "and Chapter 83, "Medicaid Waiver Services". The Department is clarifying the Brain Injury (BI) Waiver provider qualifications to align with the services and supports that are rendered by qualified brain injury professionals and accredited brain injury rehabilitation programs.

N-3. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 80, "Procedure and Method of Payment," and Chapter 81," "Nursing Facilities." These proposed amendments provide updated form names, numbers and terminology and remove references to form names and numbers that are no longer in use.

N-4. Amendments to Chapter 86, "Healthy and Well Kids in Iowa (HAWK-I) Program". The proposed amendments add language to reflect the Department's implementation of a passive managed care enrollment. HAWK-I- eligible individuals will be passively enrolled with a managed care plan; however, the effective date will remain consistent with current practices. The propose amendments also add necessary definitions, revise the time frame for a decision on eligibility, clarify policy on when a waiting period does not apply, revise premium payment language,

eliminate the lock-out period for premium nonpayment, make technical changes and remove outdated program language.

N-5. Amendments to Chapter 105, "Juvenile Detention and Shelter Care Homes", Chapter 112, "Licensing and Regulation of Child Foster Care Facilities," and Chapter 114, "Licensing and Regulation of All Group Foster Care Facilities for Children," Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability." These proposed amendments remove obsolete elements within the administrative rules, bring better alignment to current practice and implement changes required within federal law.

N-6. Amendments to Chapter 109, "Child Care Centers." These proposed amendments document the expectation of a pre-inspection visit prior to granting a new child care center permission to open. Pre-inspection visits occur in practice already. These amendments clarify the expectation around Department receipt of the regulatory fee during application and when and where the fee is submitted. These proposed amendments better align rules to current practice.

N-7. Amendments to Chapter 109, "Child Care Centers," Chapter 110, "Child Development Homes," and Chapter 120, "Child Care Homes." These proposed amendments change child abuse mandatory reporter training requirements for child care providers from once every five years to once every three years with modified expectations. These proposed amendments remove the five-year requirement and state that certification must be maintained. Additionally, the proposed amendments require all child care providers to participate in minimum health and safety training as a preservice or orientation requirement.
The requirement for child care providers to take preservice training every five years without training credit is removed. Child care providers would be able to continue their professional development requirements without repeating the same training and may also receive credit for the training taken.

A motion was made by Wallace and seconded by Kudej to approve the notice rules.
MOTION UNANIMOUSLY CARRIED.

SFY 2021 Budget Presentations Continue

IMPROVE SAFETY, WELL-BEING & PERMANENCY FOR IOWA'S CHILDREN

Divisions of ACFS and MHDS

-Child Abuse Prevention (Jana Rhoads)
-Adoption Subsidy (Jana Rhoads)
-Child and Family Services (Jana Rhoads)
-Eldora Training School (Rick Shults)
-Comprehensive Family Support Programs (Jana Rhoads)

IMPROVE IOWANS' EMPLOYMENT & ECONOMIC SECURITY

Divisions of ACFS, MHDS and Field Operations

-Family Investment Program (Jana Rhoads)
-Food Assistance (Jana Rhoads)
-Child Care Assistance (Jana Rhoads)
-Child Support Recovery (Vern Armstrong)

EFFECTIVELY MANAGE RESOURCES

Divisions of Field Operations and Fiscal Management

-Field Operations (Vern Armstrong)
-General Administration (Jean Slaybaugh)
-Volunteers (Vern Armstrong)

ALLOCATION OF SPECIFIC FEDERAL AND STATE FUNDS

-TANF & Block Grants (Jean Slaybaugh)

Jean will give a follow up presentation on TANF to the council at the November council meeting to provide more details and clarification.

TECHNOLOGY REQUESTS

- IT Transformation and Modernization (Anthony Lyman)
- Major Technology Projects (Anthony Lyman)

General Budget Discussions

Director Clabaugh thanked Jean and her staff again for putting together the budget book. He reviewed the Executive Summary document and reminded the council of the number of Iowans served by DHS and how many agencies DHS collaborates with to improve the lives of Iowans. Director Clabaugh also thanked all the DA's for their time and presentations given to the council. A short discussion was held, council members each thanked the DA's and Jean Slaybaugh for their hard work in preparing the SFY 2020 budget.

- Skylar Mayberry-Mayes asked about cost of living increases for Iowans being served by DHS. Jean Slaybaugh informed him that cost of living increases are not required to be part of the budget, it is managed by other state entities.
- Kim Kudaj asked how the Iowa Total Care transition has been going. Medicaid Director Randol believes it has been going very well. He and his team continue to meet with the executives at Iowa Total Care weekly. His team is working hard on taking care of any issues promptly.
- Sam Wallace asked if the current Medicaid program is working effectively for the State of Iowa, compared to other states. Director Randol said our program is very effective and efficient. He advised the council to go online to look at the MCO quarterly report where you can see the positive results of surveys that have been conducted.

SFY 2021 Budget Decisions

A motion was made by Wallace to approve the proposed state fiscal year status quo budget request, with the identified changes for Medicaid, CHIP, Eldora and Adoption. This includes state general funding, related federal funding and other funding including TANF, SSBG, the Health Care Trust Fund and all other sources of funding as associated with the DHS budget request document.
The motion was seconded by Mayberry-Mayes.
MOTION UNANIMOUSLY CARRIED.

A motion was made by Wallace to allow the Department to make adjustments, including federal match rates changes necessary to the Council's state fiscal year 2021 budget recommendations. The motion was seconded by Forristall.
MOTION UNANIMOUSLY CARRIED.

Approval of Minutes

A motion was made by Kudej and seconded by Forristall to approve the minutes of the August 14, 2019 meeting. **MOTION UNANIMOUSLY CARRIED.**

Council Update

Wallace thanked Director Clabaugh for serving as Interim Director of DHS. His hard work and dedication to DHS during this time is very appreciated. All the council members thanked all the DHS staff in attendance for their hard work in preparing the Budget book and facilitating the meeting.

Next Meeting

The next meeting of the Council on Human Services will be October 9, 2019 at the Woodward Resource Center, Woodward, IA.

Adjournment

Wallace made a motion to adjourn the meeting, motion was seconded by Mayberry-Mayes. **MOTION UNANIMOUSLY CARRIED.**

Chair Mark Anderson adjourned the meeting at 11:25 a.m.

Submitted by,
Julie Dougherty
Council Secretary

Department of HUMAN SERVICES

Gerd W. Clabaugh, Interim Director | **Council on Human Services**

Meeting Minutes
October 9, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Gerd Clabaugh – **present**
Kimberly Kudej – **absent**	Mikki Stier - **present**
Sam Wallace – **present**	Rick Schults - **present**
Carol Forristall – **present**	Mike Randol - **present**
Rebecca Peterson – **present**	Carrie Malone - **present**
Skylar Mayberry-Mayes - **present**	Matt Highland - **present**
	Julie Dougherty - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Timi Brown-Powers - **absent**
Senator Amanda Ragan – **absent**
Senator Mariannette Miller-Meeks – **absent**

Guests
Clint Reynolds – WRC
Dawn Stevenson – WRC
Phillip Werger – WRC
Val Kilmer – WRC
Diane Stout – WRC
Jennifer Wyant – WRC
Susan Smith - WRC
Kelsey Thien – Caucus Staff

Call to Order
Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the conference room at the Woodward Resource Center in Woodward, Iowa.

Roll Call
Five council members were present.
All Ex-officio legislative members were absent.

Approval of Minutes

A motion was made by Wallace and seconded by Forristall to approve the minutes of the September 10-11, 2019 meeting.
MOTION UNANIMOUSLY CARRIED

Representative Mark Smith

Representative Smith requested that the DHS Council review the LMSW laws and rules to ensure that what DHS has stated aligns with IDPH licensing requirements. Medicaid Director Mike Randol will provide an update at the November council meeting and a discussion will be held.

Rules

Mikki Stier presented the following rules for adoption:

R-1. Amendments to Chapter 13, "Program Evaluation." These amendments clarify the programs that are reviewed by the Department of Human Services Quality Control Bureau. These amendments also update forms that are required in that process and remove obsolete forms.

A motion was made by Forristall to approve and seconded by Wallace.
MOTION UNANIMOUSLY CARRIED.

R-2. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 80, "Procedure and Method of Payment," and Chapter 81," "Nursing Facilities." These amendments provide updated form names, numbers and terminology and remove references to form names and numbers that are no longer in use.

A motion was made by Wallace to approve and seconded by Forristall.
MOTION UNANIMOUSLY CARRIED.

R-3. Amendments to Chapter 109, "Child Care Centers". These amendments document the expectation of a pre-inspection visit prior to granting a new child care center permission to open. Pre-inspection visits occur in practice already. These amendments clarify the expectation around Department receipt of the regulatory fee during application and when and where the fee is submitted. These amendments better align rules to current practice.

A motion was made by Mayberry-Mayes to approve and seconded by Wallace.
MOTION UNANIMOUSLY CARRIED.

R-4. Amendments to Chapter 109, "Child Care Centers," Chapter 110, "Child Development Homes," and Chapter 120, "Child Care Homes." These amendments change child abuse mandatory reporter training requirements for child care providers from once every five years to once every three years with modified expectations. These amendments remove the five-year requirement and state that certification must be maintained. Child care providers would be able to continue their professional development requirements without repeating the same training and may also receive credit for the training taken.

A motion was made by Wallace to approve and seconded by Mayberry-Mayes.
MOTION UNANIMOUSLY CARRIED.

The following amendments to the administrative rules are presented as **Notice of Intended Action** for review by the Council.

N-1. Amendments to Chapter 77, "Appeals and Hearings." In an ongoing effort to streamline the Department's processes and provide accessibility to consumers. The Department has revised its appeal rules with the following goals in mind:

- Simplification
- Uniformity
- Clarification of scope
- Clearly defining appeal rights
- Protecting self-represented litigants

In this effort the Department has sought to eliminate redundancies, streamline processes across programs where permissible under state and federal law, clarify circumstances in which appeal hearings are granted and ensure conformity among appeal processes.

N-2. Implements a new Chapter 16, "Notices". Amendments to Chapter 14, "Offset of County Debts Owed Department"; Chapter 40, "Application for Aid," Chapter 41, "Granting Assistance," Chapter 46, "Overpayment Recovery," Chapter 74, "Iowa Health and Wellness Plan," Chapter 75, "Conditions of Eligibility," Chapter 76, "Enrollment and Reenrollment," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 82, "Intermediate Care Facilities for Persons with an Intellectual Disability," Chapter 83, "Medicaid Waiver Services," Chapter 86, "Healthy and Well Kids in Iowa (HAWK-I) Program," Chapter 90, "Targeted Case Management," Chapter 91, "Medicare Drug Subsidy," Chapter 93, "PROMISE JOBS Program," Chapter 95, "Collections," Chapter 106, "Certification Standards for Children's Residential Facilities," Chapter 109, "Child Care Centers," Chapter 153, "Funding for Local Services," Chapter 170, "Child Care Services," and Chapter 187, "Aftercare Services Program," Iowa Administrative Code.

These amendments propose to adopt a new Chapter 16, "Notices" to centralize administrative rules regarding timely and adequate notices. In addition, these amendments update cross-references in other chapters regarding timely and adequate notices based on changes in Chapter 7 cross references that are being updated. The Department is still required to provide timely and adequate notice. The rules are simply being moved from one chapter into a centrally located chapter and rules updated accordingly.

N-3. Amendments to Chapter 73, "Managed Care." 2019 Iowa Acts, House File 766, section 63, requires the Department to adopt rules to require that both managed care and fee-for-service payment and delivery systems utilize a uniform process, including but not limited to uniform forms, information requirements, and time frames, to request medical prior authorizations under the Medicaid program.

A motion was made by Wallace and seconded by Mayberry-Mayes to approve the noticed rules. **MOTION UNANIMOUSLY CARRIED.**

Managed Care Update
Medicaid Director Mike Randol gave an update on the third quarter Managed Care Report.

Council Update
Council member Carol Forristall gave a brief update on the flooding in her area of Iowa.

Director's Report
Director Clabaugh thanked the staff of Woodward Resource Center for hosting the Council. He also thanked the council for their support during his time as Interim Director of DHS.

Presentations
MHDS Division Administrator Rick Shults and Public Service Manager of Woodward Resource Center Clint Reynolds gave a presentation on the history of the facility and services for individuals with developmental disabilities provided at Woodward Resource Center.

Next Meeting
The next meeting of the Council on Human Services will be November 13, 2019 at the Hoover State Office Building. The following items will be added to the agenda:

- Update on Children's Mental Health Board
- Family Planning Report
- 4th quarter Managed Care Report
- Follow up on Representative Smith's request

Adjournment
Chair Mark Anderson adjourned the meeting at 11:25 a.m.

Respectfully Submitted by,
Julie Dougherty
Council Secretary
JD

Department of HUMAN SERVICES

Kelly Garcia, Director — Council on Human Services

Meeting Minutes
November 13, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Kelly Garcia – **present**
Kimberly Kudej – **absent**	Mikki Stier - **present**
Sam Wallace – **present**	Rick Schults - **present**
Carol Forristall – **present**	Julie Lovelady - **present**
Rebecca Peterson – **present**	Carrie Malone - **present**
Skylar Mayberry-Mayes - **present**	Matt Highland - **present**
	Julie Dougherty - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Timi Brown-Powers - **absent**
Senator Amanda Ragan – **absent**
Senator Mariannette Miller-Meeks – **absent**

Guests

Patty Funaro – LSA
Stacie Maass – Iowa Total Care
Denise Rathman – NASW
Harleigh Boldridge – ICCI
Kris Bell – SDC
Natalie Ginty – House GOP
Flora A. Schmidt - IBHA
Lisa Whelan – Iowa CCI

Call to Order

Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the first floor conference room at the Hoover State Office Building in Des Moines, IA.

Roll Call

Five council members were present.
All Ex-officio legislative members were absent.

Approval of Minutes

A motion was made by Wallace and seconded by Forristall to approve the minutes of the October 9, 2019 meeting.
MOTION UNANIMOUSLY CARRIED

Rules

The following amendments to the administrative rules are presented for adoption at the November 13, 2019, meeting of the Council on Human Services:

R-1. Amendments to Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 83, "Medicaid Waiver Services"'. The Department is clarifying the brain injury (BI) waiver provider qualifications to align with the services and supports that are rendered by qualified brain injury professional and accredited brain injury rehabilitation programs. These amendments also adopt the use of the most current version of the Mayo-Portland Adaptability Inventory Scale for both the brain injury waiver and the community-based neurobehavioral rehabilitation service as a valid and appropriate assessment tool for service planning.

A motion was made by Wallace to approve and seconded by Kudej.
MOTION UNANIMOUSLY CARRIED.

R-2. Amendments to Chapter 105, "Juvenile Detention and Shelter Care Homes," Chapter 112, "Licensing and Regulation of Child Foster Care Facilities," Chapter 114, "Licensing and Regulation of All Group Living Foster Care Facilities for Children," Chapter 115, "Licensing and Regulation of Comprehensive Residential Facilities for Children," and Chapter 116, "Licensing and Regulation of Residential Facilities for Children with an Intellectual Disability. These amendments remove obsolete elements within the administrative rules, bring better alignment to current practice and implement changes required by federal law.

A motion was made by Kudej to approve and seconded by Wallace.
MOTION UNANIMOUSLY CARRIED.

The following amendments to the administrative rules are presented as Notice of Intended Action for review by the Council.

N-1. Amendments to Chapter 75, "Conditions of Eligibility." This rule will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed Residential Care Facility (RCF) based on the Consumer Price Index (CPI) for urban consumers. This annual change continues to be a benefit to Medically Needy members who reside in a licensed RCF because it allows the personal care needs to be applied to the spenddown obligation.

N-2. Amendments to Chapter 81, "Nursing Facilities." The department has promulgated rules in order to provide clarification on the treatment of depreciation when a change of nursing facility ownership occurs. Rules are also promulgated to clarify leasing arrangements. The department has updated the Iowa Medicaid Enterprise (IME) mailing address and made changes to reflect current operations of the IME.

N-3. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 83, "Medicaid Waiver Services," and rescinds and adopts new Chapter 90, "Case Management Services". Clarifies the case management service activities that are received by various populations in the Medicaid program. Revises rules to include definition and references to Core Standardized Assessments (CSA) as required under the Balancing Incentive Program (BIPP). The BIPP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142 (20). Adds a section to outline and require billable activities for fee for service members. Adds a requirement for provider reporting of minor incidents. Adds the person-centered service planning definition and service requirements. Updates case management cross references in other chapters that are affected by this rule package.

A motion was made by Wallace and seconded by Forristall to approve the noticed rules. **MOTION UNANIMOUSLY CARRIED**.

Children's Mental Health Board Update

MHDS Division Administrator Rick Shults provided an update on the work of the newly formed Children's Mental Health Board. The board will be meeting quarterly in a different region of the state. He shared that the board is made up a diverse group of professionals from DHS, Public Health, MHDS commission, workforce development, child welfare, AEA, school administrators, law enforcement, and children's health care providers.
He stated that rules are in the process of being finalized so the regions can begin assisting citizens throughout the state at that level. The board is also working on creating a comprehensive centralized call line. Council members requested a MHDS Regions map. This will be included with their December meeting materials.

Family Planning Update

Julie Lovelady, Deputy Director of Medicaid, gave a brief update on the Family Planning report. The final report will be presented to the council at the December meeting.

Managed Care 4th Quarter Report

Julie Lovelady, Deputy Director of Medicaid, provided an overview on the fourth quarter Managed Care Report.

Follow up on LMSW laws

Julie Lovelady, Deputy Director of Medicaid, addressed the concern regarding the LMSW laws brought to the attention of the board by Representative Mark Smith at the October meeting. She informed the board this isn't something DHS can change, it is Iowa Code and has to be changed by the legislature. See the attached follow up document from the MHDS commission.

Council Update

Mark Anderson shared his concern with the number of farmer suicides in the state and inquired about any specific services that were being offered to support farmers in crisis. Rick stated that currently there is nothing specific at the state level but that we should be referring families to their local extension offices for a list of resources. Rick also mentioned that Senator Grassley is working on this issue at the federal level.

Kim Kudej inquired about a news article about Independence Mental Health Facility being fined by OSHA for safety violations. Rick Shults informed the council that DHS is contesting all

the citations through a formal appeal. He also shared what happens when a "code green" is issued at the facility and added that additional staff have been hired at IMH.
Director Garcia asked Rick to elaborate on what we are doing to improve safety across all our facilities. Rick explained management of assaultive behavior in all of our facilities.

Rebecca Peterson stated she is still hearing from providers about delays in payments and issues with prior authorizations with Medicaid. Providers stated not seeing progress in that area. Providers are excited about the Children's Mental Health Board.

Carol Forristall brought up the issue of lack of good and affordable child care in the state, especially in rural Iowa. Senator Grassley is working on this issue at the federal level.

Director's Report

Director Garcia introduced herself to the board and highlighted her experience at the Texas Health and Human Services Commission. She also shared her vision and goals for DHS here and how she is spending her first few months as our new director.

The next meeting of the Council on Human Services will be December 11, 2019 at the Hoover State Office Building.

Adjournment

Chair Mark Anderson adjourned the meeting at 11:53 a.m.

Respectfully Submitted by,
Julie Dougherty
Council Secretary
JD

Department of HUMAN SERVICES

Kelly Garcia, Director | Council on Human Services

Meeting Minutes
December 11, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Kelly Garcia – **present**
Kimberly Kudej – **present**	Mikki Stier - **present**
Sam Wallace – **present**	Rick Schults - **present**
Carol Forristall – **present**	Julie Lovelady - **present**
Rebecca Peterson – **present**	Carrie Malone - **present**
Skylar Mayberry-Mayes - **present**	Matt Highland - **present**
	Julie Dougherty - **present**
	Nancy Freudenberg - **present**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Timi Brown-Powers - **absent**
Senator Amanda Ragan – **present**
Senator Mariannette Miller-Meeks – **absent**

Guests
Adrienne Erazo – DHS
Erin Davison-Rippey – PPNCS
Sheena Dooley – PPNCS
Stacie Maas – ITC
Jane Hudson - DRI
Flora Schmidt – IBHA
Natalie Krebs - IPR
Kris Bell – SDC
Sandi Hurtado-Peters – IDOM

Call to Order
Chair Mark Anderson called the Council meeting to order at 10:00 a.m. in the first floor conference room at the Hoover State Office Building in Des Moines, IA.

Roll Call
Five council members were present.
One Ex-officio legislative member was present, three were absent.

Approval of Minutes

A motion was made by Wallace and seconded by Forristall to approve the minutes of the November 13, 2019 meeting.
MOTION UNANIMOUSLY CARRIED

Rules

The following amendment to the administrative rules is presented for adoption at the December 11, 2019, meeting of the Council on Human Services: Due to the comment period just ending on November 26, 2019, rules there was not sufficient time to gather the comments and propose changes for your review for the other noticed rules that were under review. Those rules will be presented at the January meeting.

R-1. Amendments to Chapter 73, "Managed Care'". 2019 Iowa Acts, House file 766, Section 63, requires the Department to adopt rules to require that both managed care and fee for service payment and delivery systems utilize a uniform process, including but not limited to uniform forms, information requirements, and time frames, to request medical prior authorizations under the Medicaid program.

A motion was made by Wallace to approve and seconded by Forristall.
MOTION UNANIMOUSLY CARRIED.

The following amendments to the administrative rules are presented as Notice of Intended Action for review by the Council.

N-1. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care." This rule implements HF 766, which updates the Medical Assistance Advisory Council (MAAC) and Executive Committee meeting rules regarding membership, voting, and duties. This amendment also removes the Executive committee and its responsibilities. .

N-2. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 83, "Medicaid Waiver Services". This rule implements HF 760 which directs the department to eliminate the monthly budget maximum or cap for individuals eligible for the Medicaid home and community–based brain injury waiver. This rule also implements HF 766 which appropriates additional funds to adjust the per diem rates for assertive community treatment (ACT) services.

N-3. Amendments to Chapter 95, "Collections." This rule eliminates references to the application fee paid by non-assistance customers when requesting services from the Child Support Recovering Unit (CSU). Recent legislative changes to Iowa Code Chapter 252B.4 under eliminated he customer paid fee. SF 605 also increased the annual fee for non-assistance child support cases.

A motion was made by Wallace and seconded by Forristall to approve the noticed rules. **MOTION UNANIMOUSLY CARRIED**.

Family Planning Update
Julie Lovelady, Deputy Director of Medicaid, gave an overview of the Family Planning Update.

Update on Park and Institutional Roads Program
MHDS DA Rick Shults provided the council with a review of roads program.

Director's Report
Director Garcia spoke to the council about the recent investigation by the Department of Justice at Glenwood and Woodward Resource Centers. She provided the council with a brief update regarding Glenwood and how DHS is fully cooperating with the investigation. Director Garcia mentioned that she met with a team of Doctors from the University of Iowa hospitals and clinics that were brought in to make ensure the patients there are ok and are being well taken care of. She informed the council she will keep them updated on any additional information related to the investigation.

The next meeting of the Council on Human Services will be a conference call on January 8, 2020 in the Cabinet room at the Hoover State Office Building.

Adjournment
Chair Mark Anderson adjourned the meeting at 10:58 a.m.

Respectfully Submitted by,
Julie Dougherty
Council Secretary
JD

KELLY GARCIA, DIRECTOR | COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: JANUARY 8TH 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – absent
Kimberly Kudej – present via phone	Mikki Stier – present
Sam Wallace – present via phone	Matt Highland – present
Carol Forristall – present via phone	Nancy Freudenberg – present
Rebecca Peterson – present via phone	Annie Lukens – present
Skylar Mayberry-Mayes – present	

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – present via phone
Representative Timi Brown-Powers – absent
GUESTS
Jane Hudson – Director of Disability Rights of Iowa – present

CALL TO ORDER

Mark Anderson, Council Chair, called the Council meeting to order at 10:01 a.m. via conference call on Wednesday, January 8th, 2020.

Annie Lukens, Executive Office with the Department of Human Resources read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

ROLL CALL

Annie Lukens, held roll call of the Council of Human Services. Attendance details listed above.

APPROVAL OF MINUTES

A motion was made to approve the minutes of the December 11, 2019 meeting minutes.
VOTE: MOTION UNANIMOUSLY CARRIED.

COUNCIL ACTION
Matt Highland, Public Information Officer (PIO) and Bureau Chief of Communications with Department of Human Services brought a council action to vote to create two Division Administrator positions to oversee MHDS; one for Community and the other for Facilities. This had previously been one position. Council discussed whether there would be additional cost (the current budget affords these positions).
VOTE: MOTION UNANIMOUSLY CARRIED.

RULES
Nancy Freudenberg, Bureau Chief of Policy Coordination with Department of Human Services presents the following amendments to the administrative rules for adoption:

R-1. Amendments to Chapter 75, "Conditions of Eligibility." This rule will continue to allow an annual change in the statewide monthly standard deduction for personal care services provided in a licensed Residential Care Facility (RCF) based on the Consumer Price Index (CPI) for urban consumers. This annual change continues to be a benefit to Medically Needy members who reside in a licensed RCF because it allows the personal care needs to be applied to the spenddown obligation.
VOTE: MOTION UNANIMOUSLY CARRIED.

R-2. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care." This rulemaking updates and clarifies language to reflect existing prescribed outpatient drug policies for qualified prescribers, reasons for nonpayment of drugs, covered nonprescription drugs, quantity prescribed, drug reimbursement methodology and credits for returned unit dose drugs not consumed.
VOTE: MOTION UNANIMOUSLY CARRIED.

R-3. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 83, "Medicaid Waiver Services," and rescinds and adopts new Chapter 90, "Case Management Services". Clarifies the case management service activities that are received by various populations in the Medicaid program. Revises rules to include definition and references to Core Standardized Assessments (CSA) as required under the Balancing Incentive Program (BIPP). The BIPP was created as part of the federal Patient Protection and Affordable Care Act. Participation by Iowa is required by 2012 Iowa Acts, chapter 1133, section 14, and 2013 Iowa Senate File 446, section 142 (20). Adds a section to outline and require billable activities for fee for service members. Adds a requirement for provider reporting of minor incidents. Adds the person-centered service planning definition and service requirements. Updates case management cross references in other chapters that are affected by this rule package.
VOTE: MOTION UNANIMOUSLY CARRIED.

R-4. Amendments to Chapter 81, "Nursing Facilities." The department has promulgated rules in order to provide clarification on the treatment of depreciation when a change of nursing facility ownership occurs. Rules are also promulgated to clarify leasing arrangements. The department has updated the Iowa Medicaid Enterprise (IME) mailing address and made changes to reflect current operations of the IME.
Will be filed this year – cost rates – will not effect until next years rates.
VOTE: MOTION UNANIMOUSLY CARRIED.

R-5. Amendments to Chapter 95, "Collections." This rule eliminates references to the application fee paid by non-assistance customers when requesting services from the Child Support Recovery Unit (CSU). Recent legislative changes to Iowa Code Chapter 252B.4 eliminated the customer paid fee. SF 605 also increased the annual fee for non-assistance child support cases.
VOTE: MOTION UNANIMOUSLY CARRIED.

COUNCIL UPDATE

No updates

DIRECTORS REPORT

Matt Highland presented the Directors report on Director Garcia's behalf.

Glenwood Resource Center

- Director Garcia wanted to inform you that effective December 30, Jerry Rea is no longer employed with DHS.
- We are working quickly to hire a new superintendent; Marsha Edgington will remain the interim superintendent of Glenwood Resource Center.
- The DOJ has submitted another round of questions and request for information.
  - We continue to cooperate and assist in any way we can and they have been extremely complimentary of our font line workers and of Marsha as we've worked with them throughout this investigation.
- We continue our fact finding efforts, and our partnership with the University of Iowa, which has been incredibly helpful.
- We are finalizing an agreement to bring in technical assistance to help look at our policies and procedures so that don't have to wait for the DOJ conclusions to make any changes that may be needed.
- Again, our efforts are not to get in the way of the DOJ investigation, but to ensure we're doing everything we can to support the individuals we serve and our staff.
- Does anyone have any questions on that?

Mark Anderson states that there will come a time when the counsel will want to know what happened and how it was possible that it happened.

Matt Highland responded that all information will be provided when the department has finished the investigation and legally are able to.

Staffing Update

- Director Garcia also wanted me to provide you an update as it relates to staffing at DHS.
- You may have noticed, since we last met we've posted a few key positions at DHS, including:
  - Division Administrator for Adult, Children and Family Services (ACFS)
    - You may recall, Jana has accepted the position of Des Moines Service Area Manager
  - A Division Administrator position for community mental health and a Division Administrator position dedicated to our facilities.
  - You also are aware that Julie, who previously assisted with Council, has accepted a position, which is a great opportunity for her.
- Which leads to a larger challenge we're facing at the agency, staff recruitment and retention.
  - A low unemployment rate is great for the state, but challenging for employers with lots of jobs to fill.
  - With 4,000+ employees, we are a huge employer and many of our jobs are in rural areas.
  - I want to share with you that I am very focused on finding creative ways to attract new workers, which includes developing partnerships with community colleges and universities.
    - Residencies at our facilities
    - Creating pipelines from community colleges and even high school.
      - Example of GRC 19 year old, who is a great tool for recruitment.
  - We also need to look at the changing nature of the workforce. We know that millennials are very different than generations before. They value flexibility, more frequently change jobs, or want different hours. So, we're exploring ways we can accommodate that and attract the workforce of the future.

- We also are looking at more innovative ways to promote and campaign for the workforce we need.
  - A lot of our jobs are good paying jobs and provide deeply rewarding work, so we need do a better job of promoting that and are looking at opportunities there as well.

Mark Anderson expresses the urgent need in both governmental and non-governmental centers. He advises increasing pay to retain front line workers in this market.

Managed Care Withhold

- Oversight of the Medicaid managed care program is critical to its overall success—and DHS is exercising its authority to hold Iowa Total Care accountable.
- We intend to use our contractual remedies to ensure proper administration of the program.
- Provider payment issues exist, specifically with Iowa Total Care, and in particular for behavioral health, consumer directed attendant care (CDAC) and other limited long-term services and supports (LTSS) providers and today DHS is exercising its authority to hold Iowa Total Care accountable.
- The Department is withholding nearly $44M from Iowa Total Care's January capitation payment. Since coming online in July, DHS has worked closely with Iowa Total Care to assess readiness and ensure adequate process times.
  - Despite many attempts to correct deficiencies in the claims payment system, Iowa Total Care has not met the terms of its corrective action plan. Once Iowa Total Care resolves the issues identified, the withhold will be released. However, additional remedies may be sought.

OCIO Assistance

- It's not news to you that we have a lot of very important and large IT initiatives underway.
- This work is critical to our agency and the people we serve and our staff is doing amazing work on really challenging projects.
- As I continue to look at our overall agency needs, we'll be doing a complete assessment of all IT projects and efforts.
- I have asked for assistance from the Office of the Chief Information Officer (OCIO) to assist with an external assessment. Our team has great expertise in DHS programs while OCIO brings a statewide perspective, and together I think we will do incredible things.

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, February, 11th 2020 and will be a teleconference.

ADJOURN

Council on Human Services teleconference meeting help on January 8th, 2020 adjourned at 10:54am CST.

KELLY GARCIA, DIRECTOR	COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: FEBRUARY 12th 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – present
Kimberly Kudej – present via phone	Mikki Stier – present
Sam Wallace – present via phone	Matt Highland – present
Carol Forristall – present via phone	Nancy Freudenberg – present
Rebecca Peterson – present via phone	Annie Lukens – present
Skylar Mayberry-Mayes – present via phone	

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – absent
Representative Timi Brown-Powers – absent
GUESTS
N/A

CALL TO ORDER
Mark Anderson, Council Chair, called the Council meeting to order at 10:01 a.m. via conference call on Wednesday, February 12, 2020.

Mark Anderson read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

ROLL CALL
Annie Lukens, held roll call of the Council of Human Services. Attendance details listed above.

APPROVAL OF MINUTES
A motion was made to approve the minutes of the January 8th, 2020 meeting minutes.
VOTE: MOTION UNANIMOUSLY CARRIED.

RULES

Nancy Freudenberg, Bureau Chief of Policy Coordination with Department of Human Services presents the following amendments to the administrative rules for adoption:

R-1. Amendments to Chapter 7, "Appeals and Hearings." In an ongoing effort to streamline the Department's processes and provide accessibility to consumers. The Department has revised its appeal rules with the following goals in mind:

- Simplification
- Uniformity
- Clarification of scope
- Clearly defining appeal rights
- Protecting self-represented litigants

The Department has sought to eliminate redundancies, streamline processes across programs where permissible under state and federal law, clarify circumstances in which appeal hearings are granted and ensure conformity among appeal processes.

VOTE: MOTION UNANIMOUSLY CARRIED.

R-2. Adopts a new Chapter 16, "Notices". Amendments to Chapter 14, "Offset of County Debts Owed Department"; Chapter 40, "Application for Aid," Chapter 41, "Granting Assistance," Chapter 46, "Overpayment Recovery," Chapter 74, "Iowa Health and Wellness Plan," Chapter 75, "Conditions of Eligibility," Chapter 76, "Enrollment and Reenrollment," Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Chapter 82, "Intermediate Care Facilities for Persons with an Intellectual Disability," Chapter 83, "Medicaid Waiver Services," Chapter 86, "Healthy and Well Kids in Iowa (Hawk-I) Program," Chapter 90, "Targeted Case Management," Chapter 91, "Medicare Drug Subsidy," Chapter 93, "PROMISE JOBS Program," Chapter 95, "Collections," Chapter 106, "Certification Standards for Children's Residential Facilities," Chapter 109, "Child Care Centers," Chapter 153, "Funding for Local Services," Chapter 170, "Child Care Services," and Chapter 187, "Aftercare Services Program," Iowa Administrative Code.

These amendments adopt a new Chapter 16, "Notices" to centralize administrative rules regarding timely and adequate notices. In addition, these amendments update cross-references in other chapters regarding timely and adequate notices based on changes in Chapter 7 cross references that are being updated. The Department is still required to provide timely and adequate notice. The rules are simply being moved from one chapter into a centrally located chapter and rules are updated accordingly.

VOTE: MOTION UNANIMOUSLY CARRIED.

R-3. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care." This rule updates Medical Assistance Advisory Council (MAAC) and Executive meeting rules regarding MAAC membership, voting and duties and removal of the executive committee and responsibilities based on legislative changes from the 2019 session.

VOTE: MOTION UNANIMOUSLY CARRIED.

R-4. Amendments to Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," and Chapter 83, "Medicaid Waiver Services." Legislation from the 2019 session directed the Department to eliminate the monthly budget maximum or cap for individuals eligible for the Medicaid home and community based services (HCBS) brain injury waiver. Legislation also appropriated additional funds to adjust the per diem rates for assertive rates for assertive community treatment (ACT) Services.

VOTE: MOTION UNANIMOUSLY CARRIED.

The following amendments to the administrative rules are presented as Noticed rules this month.

N-1. Amendments to Chapter 86, "Healthy and Well Kids in Iowa (HAWK-I) Program." Legislation from the 2019 session removes the references to the third party administrator for the Healthy and Well Kids in Iowa (Hawk-I) program. These rules also update incorrect references in the rules.

VOTE: MOTION UNANIMOUSLY CARRIED.

N-2. Amendments to Chapter 176, "Dependent Adult Abuse." Two pieces of legislation recently passed in the 2019 session which resulted in proposed rule changes. HF 569 added personal degradation as a category for dependent adult abuse. HF 323 changed the definition of personal degradation for dependent adult abuse. These proposed rules define dependent adult abuse and the criteria for outcome determinations for dependent adult abuse evaluations conducted by the Department for personal degradation.

VOTE: MOTION UNANIMOUSLY CARRIED.

N-3. Amendments to Chapter 176, "Dependent Adult Abuse," and Chapter 177, "In-Home Health Related Care." These proposed amendments add provisions for coordination of services to avoid duplication. The rules also add clarification when reviews need to be completed and when services may be terminated. The amendments remove form names and numbers.

VOTE: MOTION UNANIMOUSLY CARRIED.

N-4. Amendments to Chapter 187, "Aftercare Services and Support." Aftercare rules were recently changed by the Department. There was an oversight when changes were made and an incorrect dollar amount was cited in the amount of services some participants may receive for financial support for aftercare programs. This proposed amendment corrects the rule clarifying that youth may receive up to $300 per quarter, which was the original intent of the rule.

VOTE: MOTION UNANIMOUSLY CARRIED.

MANAGED CARE UPDATE

Mike Randol and Mary Stewart presented update:

- 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 CAHPS2, 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, 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.

COUNCIL UPDATE

Mark Anderson discusses being approached by a citizen regarding a juvenile with multiple mental illnesses but has not committed a crime so does not fit the requirement to be admitted. This information has been taken to the director to look into.

No other reports

DIRECTORS REPORT

Organization Updates

- An updated table of organization
- I want to share with you that Mikki Stier expressed her intent to resign. Her last day in the office will be April 17, 2020.
- I thank Ms. Stier for her years of service to the State of Iowa. I look forward to building a team that yields strong oversight and operational efficiencies to ensure that Iowans receive the highest quality services.
- The Department will post two new positions in the immediate future, Deputy of Client Services (DCS) and Chief Operating Officer (COO).
    - The DCS will oversee work to connect all client services—mental health, medical, developmental and other services to better meet the needs of the whole person. This deputy will also be charged with ensuring connections exist to other agencies which provide client services.
    - The COO will focus on connection points between the agency's significant administrative services (IT, fiscal, and procurement) and will ensure these structures work together to support the client service functions.

Glenwood Update

- The Department is not going to comment on pending litigation, but DHS is committed to ensuring the safety and well-being of those we serve, and our employees. We continue to take all necessary action to address all allegations.
- We held both staff and family town halls
    - The family town hall we held the Saturday before last.
        - There were tough conversations, which is to be expected.
        - They were concerned about their loved ones, they wanted accountability and to know who knew what when.
        - And, they wanted us to know that Glenwood has provided the best to care to their loved ones and they want the facility to stay open.
    - The staff town halls we held on last Thursday, February 6.
        - 21 hours of discussion
        - 102, or about a third of direct care staff
        - 13 pages of notes
        - 4 consistent themes: Communication, trust, scheduling and training.
- There is a lot of work to do to build trust and improve communication from the leadership team and supervisors to direct care staff.
- This Friday I will return to Glenwood to hear from the leadership team.
- DOJ is on-site this week, and I will meet with them on Friday.
- They too will be having office hours to hear directly from staff.

Tours of Facilities and Providers around the State

- Last week I toured Woodward Resource center.
- I have now visited all DHS facilities within my first 100 days.
    - It's clear at Woodward they have a strong leadership team with a great sense of trust among their staff.
    - Certainly some best practices and approaches to share with Glenwood.
    - As we move forward, it will be important for the new DA of facilities to encourage information and practice sharing among facilities.

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- I continue to get out and meet not just our staff but a variety of stakeholders and providers throughout the state.
- A couple of weeks ago, I joined Rebecca at the House of Mercy recently, which was a really special tour.
    - Some of our social workers from the Des Moines Service Area joined us and we talked about some of the interesting work their doing, some of the areas they're expanding, and talked about some potential pilot projects in the future.
    - I've asked Rebecca to present at a future council meeting to highlight the unique work they do and look forward to her presentation.
- And, I also recently went to Iowa City to meet with Senator Bolkcom and several providers in the area.
    - We had productive discussions around their region's mental health progress and I also met with providers who work closely with individuals with intellectual disabilities.
    - We toured one provider's facility, where they should us some pretty incredible programming for those they serve.
    - And we'll also be exploring partnerships showcasing some of their creative arts programs. So lots of fun things in the works.

Meeting with Legislators and Confirmation

- I've spent a lot of time in the past several weeks meeting with legislators to provide them updates, mostly on GRC and Medicaid, but also to see what they're hearing from constituents.
- I was introduced to the Senate on Monday, as part of the confirmation process and later today I will go before the Human Resources committee in preparation for a vote.
    - It's been an honor to serve Iowans in this crucial role at this critical time and I am hopeful I'll be able to continue to help to improve the lives of Iowa's families who rely on us.

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, March, 11th 2020 and will be a teleconference.

ADJOURN

Council on Human Services teleconference meeting held on February 12th, 2020 adjourned at 11:04am CST.

KELLY GARCIA, DIRECTOR	COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: MARCH 11, 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – present
Kimberly Kudej – present via phone	Mikki Stier – present
Sam Wallace – present via phone	Matt Highland – present
Carol Forristall – present via phone	Nancy Freudenberg – present
Rebecca Peterson – present via phone	Annie Lukens – absent
Skylar Mayberry-Mayes – absent	

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – absent
Representative Timi Brown-Powers – absent
GUESTS

CALL TO ORDER
Mark Anderson, Council Chair, called the Council meeting to order at 10:00 a.m. via conference call on Wednesday, March 11th, 2020.

Mark Anderson, Council Chair, read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

ROLL CALL
Courtney Bushell, held roll call of the Council of Human Services. Attendance details listed above.

APPROVAL OF MINUTES
A motion was made to approve the minutes of the February 12th, 2010 meeting minutes.
VOTE: MOTION UNANIMOUSLY CARRIED.

COUNCIL ACTION
A motion was made to amend Council agenda to move the Director's Report to the beginning of the teleconference.
VOTE: MOTION UNANIMOUSLY CARRIED.

RULES
Nancy Freudenberg, Bureau Chief of Policy Coordination with Department of Human Services presents the following amendments to the administrative rules for adoption:

R-1. Amendments to Chapter 176 "Dependent Adult Abuse," and Chapter 177, "In-Home Health related Care," Iowa Administrative Code. These amendments add provisions for coordination of services to avoid duplication. The rules also add clarification when reviews need to be completed and when services may be terminated. The amendments remove form names and numbers.
VOTE: MOTION UNANIMOUSLY CARRIED.

R-2. Amendments to Chapter 187, "Aftercare Services and Support," Iowa Administrative Code. Aftercare rules were recently changed by the Department. There was an oversight when changes were made and an incorrect dollar amount was cited in the amount of services some participants may receive for financial support for aftercare programs. this amendment corrects toe rule clarifying that youth may receive up to $300 per quarter, which was the original intent of the rule.
VOTE: MOTION UNANIMOUSLY CARRIED.

N-1. Amendments to Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code. The Iowa Board of Pharmacy, in collaboration with the Iowa Department of Public Health, developed statewide protocols for pharmacists ordering and dispensing of naloxone and nicotine replacement therapy (NRT) tobacco cessation products, as well as pharmacists ordering and administering vaccines. In order to allow these expanded pharmacist practice protocols under Medicaid the following changes are proposed: Add "Pharmacist" as a provider type eligible to enroll in the Medicaid program. Clarifies qualified prescriber and prescription requirements based on the pharmacist expanded practice standard. Amends the section related to pharmacies administering influenza vaccine to children to include all Medicaid covered vaccines for children and adds the administration of adult vaccines, pursuant to 657 IAC 39 and the statewide protocols. Also adds Medicaid verification and reporting requirements. The changes enable pharmacists to take advantage of the expanded practice standards while clarifying the Medicaid verification and reporting requirements for vaccines. Amends the section related to basis of reimbursement for vaccines related to pharmacies. All billing and reimbursement of vaccines, regardless of provider type, will be through the healthcare common procedure coding system (HCPCS) to ensure consistency among providers as well as a coordinated Medicaid immunization record for the member.
VOTE: MOTION UNANIMOUSLY CARRIED.

N-2. Amendments to Chapter 170, "Child Care Services," Iowa Administrative Code. The current Child Care Assistance (CCA) Plus program is based on an income limit of 85 percent of the state median income and is limited to 12 months. The time limit is in conflict with federal regulations. effective July 1, 2020, the time limit will be eliminated and the income eligibility criteria will be reduced to 225 percent of the federal poverty level. The change recommended by the Governor to the infant and toddler definition is also incorporated in this estimate.
VOTE: MOTION UNANIMOUSLY CARRIED

COUNCIL UPDATE
No Updates

DIRECTORS REPORT

Glenwood Resource Center

- Director Garcia will be presenting to House Government Oversight Committee today.
- DOJ will be onsite March 30 through April 3rd for interviews.
- Ensure our stakeholders have a clear, identified understanding of facilities - who we serve and who we don't serve.
- Redefining the role - a higher level of care.
- Broader goal - understand each individuals needs.
- Ensure people understand with ease our commitment to those we serve.
- Does anyone have any questions on tha?

Staffing Update

- Director Garcia also provided and update on staffing at DHS.
- You may have noticed, since we last met we've posted a few key positions at DHS, including:
    - Division Administrator for Adult, Children and Family Services (ACFS)
        - Interviews have been conducted and a decision will be announced soon.
    - A Division Administrator position for community mental health and a Division Administrator position dedicated to our facilities.
    - Interviews have been conducted and a decision will be announced soon.

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Managed Care Withhold

- Iowa Total Care is reprocessing claims.
- We will be reaching out to provider groups soon.
    -

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, April 8th, 2020 and will be a teleconference.

ADJOURN

Council on Human Services teleconference meeting on March 11th, 2020 adjourned at 10:55am CST.

KELLY GARCIA, DIRECTOR	COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: APRIL 8th 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – absent
Kimberly Kudej – present via phone	Faith Sandberg – present via phone
Sam Wallace – present via phone	Matt Highland – present via phone
Carol Forristall – present via phone	Annie Lukens – present via phone
Rebecca Peterson – present via phone	
Skylar Mayberry-Mayes – present via phone	

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – present via phone
Representative Timi Brown-Powers – absent

CALL TO ORDER

Mark Anderson, Council Chair, called the Council meeting to order at 10:01 a.m. via conference call on Wednesday, April 8th, 2020.

ROLL CALL

Annie Lukens, held roll call of the Council of Human Services. Attendance details listed above.

Mark Anderson read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

RULES

Presented by Nancy Freudenberg

R-1. Amendments to Chapter 170, "Child Care Services," Iowa Administrative Code. The current Child Care Assistance (CCA) Plus program is based on an income limit of 85 percent of the state median income and is limited to 12 months. The 12 month time limit is in conflict with federal regulations. The time limit will be eliminated and the income eligibility criteria will be reduced to 225 percent of the federal poverty level. The change recommended by the Governor to increase the age of the infant and toddler definition up to three years of age is also incorporated in this rule filing. The Department is continuing this rulemaking as we are under a federal corrective action plan under the Office of Child Care and the rules need to be in place effective July 1, 2020 so there is not a fiscal penalty.

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The following amendments to the administrative rules are presented as Noticed rules.

N-1. The President signed the Bipartisan Budget Act of 2018, Public Law (P.L.) 115-123 into law on February 9, 2018. P.L. 115-123 includes the Families First Prevention Services Act (FFPSA) in Division E, Title VII. Section 50731 of the FFPSA directs the federal Department of Health and Human Services (HHS) to "identify reputable model licensing standards with respect to the licensing of foster family homes" (as defined in section 472(c)(1) of the Social Security Act). In response to this directive, the Children's Bureau of HHS issued the National Model Foster Family Home Licensing Standards.

The proposed amendments pertain to the licensing and regulation of foster family homes and are required to align with the federal model licensing standards. The Model Licensing Standards were to be in effect April 1, 2019. The Department requested additional time from the federal Department of Health and Human Services (HHS) to implement the standards through administrative rules. Additional time was approved by HHS. We are moving forward with this rulemaking as Iowa is out of compliance in several areas. Failure to meet the Model Family Home Foster Licensing Standards could result in the loss of Iowa's IV-E federal funding.

The following requirements have been added to the administrative rules:

- Applicants must be able to communicate with the licensing agency, health care and other service providers.
- At least one applicant in the home must have functional literacy; a level of reading, writing and calculation skills sufficient to function in the community in which an individual lives. An example for a foster parent would be to have the ability to read labels on medications in order to properly administer the medications to a child.
- Applicants and all household members must disclose any past or current mental health and/or substance abuse issues. The agency may require further documentation and/or evaluation to determine the suitability of the home.
- There must be at least one scheduled in-home, individual interview of each household member to observe family functioning and assess the family's capacity to meet the needs of a child in foster care. The contracted agency will determine whether to interview or just observe each household member based on his or her age and development.
- All household members who are caregivers must have up to date whooping cough vaccines unless contrary to the person's health.
- The contracted agency must obtain at least three references, including at least one from a relative and one from a non-relative.
- The applicant's home must meet the following standards concerning swimming pools, hot tubs and spas:
    - Swimming pools must have a barrier on all sides at least four feet high.
    - Swimming pools must have their methods of access through the barrier equipped with a safety device, such as a bolt lock.
    - Swimming pools must be equipped with a life saving device, such as a ring buoy.
    - If the swimming pool cannot be emptied after each use, the pool must have a working pump and filter system.
    - Hot tubs and spas must have safety covers that are locked when not in use.
- The applicants' home must meet the following standards concerning hazardous materials and first aid supplies:
    - Applicants must prevent the child's access, as appropriate for his or her age and other development, to all medications, poisonous materials, cleaning supplies, other hazardous materials and alcoholic beverages. All medications should be kept in a locked cabinet.
    - Applicants must maintain first aid supplies as recommended by the American Red Cross.

- Assurances from applicants must be agreed upon including:
  - They will not use any corporal or degrading punishment on any child in the home.
  - They will not use any illegal substances, abuse alcohol by consuming it in excess amounts, or abuse legal prescription and nonprescription drugs by consuming them in excess amounts or using them contrary as indicated.

Weapons and ammunition must be separately store, locked, unloaded and inaccessible to children. Previously the rules listed that weapons and firearms shall be maintained in a locked place such as a gun case. Federal requirements now specify the type of place and a listing of weapons and ammunition which must be identified in the rule.
VOTE: MOTION UNANIMOUSLY CARRIED

DIRECTORS REPORT
Matt Highland presented the Directors Report on behalf of Director Kelly Garcia.

Hi Everyone, Director Garcia asked me to apologize on her behalf for not being able to join today's call and has asked me to provide an update.

- We are one of the few agencies that is impacted top to bottom by the COVID-19 pandemic.
- It impacts the way facilities protect the individuals we serve and places a huge strain on our direct care workforce. It impacts the mental health of countless Iowans. It impacts the needs of Medicaid members and Iowans receiving other assistance. And it impacts our IT and Fiscal operations.
- Before any confirmed cases of COVID-19 in the State of Iowa, DHS began analyzing our operations across the agency and conferring with other states. Our leadership team quickly mobilized to assess our emergency response protocols and tailor those plans to this unique pandemic. As you know, things progressed very quickly, as did our response.

FACILITIES

- COVID-19 for DHS, sort of began at Glenwood.
- Before there were any cases in Iowa, there was a case in Omaha.
- We knew we needed to take immediate action, because of the proximity, but also because we know the individuals we serve—not just at Glenwood but at all of our facilities—are extremely vulnerable.
- On March 10, Director Garcia reached out to all DHS staff to provide protocols for potential exposure, to limit all non-essential business travel and to encourage suspension of personal travel, to provide detail on sick leave, to notify them of coming visitor restrictions at our facilities.
- On March 12, we notified guardians and loved ones of visitor restrictions at all DHS facilities.
  - The message indicated all visitors would be screened for illness and risk to previous exposure, including temperature screenings, and those permitted entry would be asked to take further precautionary measures to mitigate risk of potential exposure.
- The next day, on March 13, DHS notified guardians and loved ones that we suspended all in-person visitation, with limited exception, at all DHS facilities.
- We continue to check temperatures at every shift change, and have put in place robust and evolving mitigation strategies at all of our facilities.
- Throughout this period, Director Garcia has had multiple phone calls daily with our facility superintendents to monitor all aspects of their operations. We will continue to adjust our approach to assure the health and safety of those we serve.

SOCIAL WORK / CHILD WELFARE

- COVID-19 impacts the way social workers interact with families.
- We've put out a significant amount of guidance for our team members and our partners.
- We've put policies in place to screen interactions and provide sanitizer and PPE.

- Most recently, this week we've shifted in-person family interactions to video and phone options, with limited exception.
  - This was a very difficult decision; we know family interaction is critical to the wellbeing of children and to the goal of reunification.
- We're also paying very close attention to abuse reports, which have dropped, due to teachers and other mandatory reporters not seeing children. We also know with the added stress of economic hardship and fear that our most vulnerable children are especially at risk.
- We'll really going to try to highlight this through a variety of methods.
  - We're working with the Department of Education on this effort, encouraging comfort calls to check in on their students.
  - We're also putting the call out to communities, neighbors and all Iowans, If you hear something, or see something, say something.
  - We will continue to closely monitor this.

MEDICAID AND FOOD AND ECONOMIC ASSISTANCE

- The Medicaid and ACFS teams kicked into high gear and set in forth waivers that will truly help those most in need; ensuring access to medical care, food and economic assistance. And we have income maintenance workers who stand ready to assist those families who have questions or find themselves now in need.
- We're just beginning to see the signs of an uptick in people applying for assistance, and expect this to really begin to materialize in numbers in the coming month.
- We've removed barriers and expanded home delivered meals, stopped disenrollment and waived all premiums.

DHS OPERATIONS

- We went from an agency with no telecommute policy, to deploying more than 1,700 people to work from home, deploying more than 500 in one day.
- Our IT team stepped in to help disassemble and lift computers for those team members who couldn't.
- Our fiscal team shifted paper approval processes to electronic streamlined processes to assist our new telecommute capabilities.
- Many team members have stepped into roles when asked because an immediate need arose.

FIELD OPERATIONS

- We have equipped most staff to work from home, while maintaining a minimal footprint in offices to assist individuals on a by appointment only basis.
- We've equipped them with sanitizer and PPE, such as gloves and masks.
- We continue to work with our team throughout the state to accommodate their needs.

LEADS TO NEW PARTNERSHIPS

- We have been working closely with Department of Corrections to get hand sanitizer, masks and gloves to our teams at facilities, to our social workers and to our partners including childcare providers and HCBS providers.
- You may have recently seen our press release announcing a unique partnership with Cedar Ridge Distillery, who produced enough sanitizer for all of our frontline staff.
  - Director Garcia spoke with Senator Mathis about our need for sanitizer, she made one phone call
- Director Garcia asked to share that she's been incredibly impressed and humbled with how everyone has come together to help us make every effort we can to protect your loved ones and those who serve them. In this challenging time, it is inspiring and deeply moving.
- Please know, that all of this work will continue and as we closely monitor events and tailor our response to anticipate the future needs of our team and those we serve as this progresses.

OTHER:

- This past Saturday we held a virtual town hall with the families and loved ones of Glenwood.
- Director Garcia gave an update on our COVID efforts, an update on the DOJ investigation and kicked off a conversation on community integration.
- It was a really special event. It was so nice being able to see the faces of families in their homes on video.
- While the conversations where inherently difficult, the families were appreciative of all the efforts we've taken related to COVID-19, of our continued openness and communication with them, and for Director Garcia's directness in answer their questions, acknowledging that sometimes we don't have great answers to give.
- The MCOs joined us as well for the entire town hall and we had a few legislators that joined at the end.
- We committed to doing more of these to keep in touch, and we will expand these to other facilities as well.

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, May, 13th 2020 and will be a teleconference.

ADJOURN

Council on Human Services teleconference meeting held on April 8th, 2020 adjourned at 10:42am CST.

KELLY GARCIA, DIRECTOR | COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: May 13th, 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – present via phone
Kimberly Kudej – present via phone	Faith Sandberg – present via phone
Sam Wallace – present via phone	Matt Highland – present via phone
Carol Forristall – present via phone	Mike Randol – present via phone
Rebecca Peterson – present via phone	Annie Lukens – present via phone
Skylar Mayberry-Mayes – present via phone	Janee Harvey – present via phone
	Cory Turner – present via phone

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – present via phone
Representative Timi Brown-Powers – absent
GUESTS
Iowa Attorney General's Iowa Dental Hygienist's Association Des Moines Register Iowa Office of the Ombudsman Brown Winnick Advocacy Iowa Forrest Ridge Youth Services Iowa Medicaid

CALL TO ORDER

Mark Anderson, Council Chair, called the Council meeting to order at 10:00 a.m. via conference call on Wednesday, May 13th, 2020.

ROLL CALL

Annie Lukens, held roll call of the Council of Human Services. Attendance details listed above.

Mark Anderson read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

ACFS COVID UPDATE

Presented by: Janee Harvey; Division Administrator for Adult Children and Family Services

CHILDCARE SUSTAINABILITY PLAN

The Iowa Department of Human Services (DHS) recognizes the critical role childcare plays in supporting the state's essential workforce and economy as schools remain closed. Childcare providers have demanding jobs supporting families and children in the best of times, and even more so during the global COVID-19 pandemic. To support these providers and Iowa families, we have worked closely with our partners to develop this plan, looking across all potential funding sources, and will continue to do so and adjust as needed. This plan prioritizes funding to help licensed centers and registered homes to remain open or, if temporarily closed, reopen to assist Iowa's essential workforce to remain at work.

COVID-19 IMPACT

As of January 1, 2020, there were 154,095 childcare slots across the state of Iowa between licensed, registered, and non-registered programs.

Non-registered programs are typically in-home providers serving five or less children. However, if these programs wish to be eligible for Childcare Assistance (CCA) payments, they must sign an agreement with DHS. Slot counts for this provider type represent those programs with an active agreement. This number grew to 159,204 by March 1, 2020. However, as of March 31, 2020, 793 licensed centers and 28 licensed childcare development homes had reported temporary closure to DHS as a result of COVID-19, representing a loss of 49,750 slots. As of April 21, 2020, 829 centers and 171 homes had reported temporary closure. While this loss of slots has not caused immediate strain on the childcare system given that many parents or guardians are able to stay home with their children, downstream impacts are expected. Because these providers are closed and not receiving revenue through tuition payment at this time, their ability to come back online during or after the COVID-19 pandemic is negatively impacted.

To address this hurdle, some providers could raise tuition payments and effectively price families out of affordable childcare. In the future, as the economy begins to recover from the impact of COVID-19, increased costs and reduced availability of affordable childcare will likely present a significant barrier to Iowans reentering the job market.

FUNDING

- The CARES Act provides an additional $3.5 billion in discretionary funding for the Child Care and Development Block Grant, also known as the Childcare Development Fund (CCDF).
- On April 14, 2020, Iowa received its supplemental allocation of $31,899,093.This funding is intended to serve two key purposes.
- Support members of the essential workforce, irrespective of income, through CCA.
- Assist childcare providers to remain open or reopen, whether these providers serve CCA families or not.
- Per the CARES Act, the supplemental funds must be obligated by the end of federal fiscal year
- 2022 and liquidated by the end of federal fiscal year 2023.

SUSTAINABILITY PLAN

- Unless noted otherwise, providers are eligible for a strategy if they meet the following qualifications.
- Currently open and agree to remain open or temporarily closed but reopen.
- In the event that the center does not feel they can remain open safely, they will work with
- DHS and health officials to try to take needed steps to remain open.

- Prioritize serving families with essential services workers.
- Comply with current CDC, IDPH, and DHS guidance.
- Strategies and associated details are laid out in Table 1, below.
- DHS will monitor expenditures under this plan and may shift allocated amounts to best meet identified needs.

CHILD WELFARE SUPPORT PLAN

Due to school closures, foster group care and shelter care providers have incurred additional costs associated with caring for youth when they would normally be at school or on home visits. Foster parents with children who test positive for COVID-19 incur additional costs to provide appropriate care for the children in their homes. The Department of Human Services (DHS) is committed to assisting with the increased costs associated with the public health emergency. The federal Coronavirus Aid, Relief, and Economic Security (CARES) Act provided additional funds to the State of Iowa to prevent, prepare for and respond to the pandemic. DHS has developed a thoughtful plan to support group and shelter care providers, as well as foster parents.

COVID-19 IMPACT

- As of March 2020, there were 5,791 children and youth in foster care.
- DHS provided guidance to minimize the number of in-person contacts between caseworkers and the families they serve. This guidance impacts the ability of many parents to have in-person family interactions with their children.
- The majority of biological parents whose children are in foster care are participating in community based mental health and/or substance use treatment. Many of these services have also shifted to virtual platforms in order to maintain social distancing guidelines.
- Group care and shelter providers are required to maintain specific staff-to-youth ratios. Because youth are no longer leaving campus to physically attend school and because youth cannot go on home visits, these residential providers have been required to increase the number of staff hours needed to maintain licensing ratios.
- During this same time period, there were 1,700 children placed in foster homes.
- Children who are positive for COVID-19 will have increased supervision and support needs, transportation costs for testing or medical appointments, and deep cleaning of the home following the exposure.

FUNDING

- The CARES Act provided Iowa with an allocation $476,722 in discretionary funding for child welfare services.
- These funds must be used to prevent, prepare for and respond to coronavirus, consistent with the regulatory requirements under Title IV-B, Subpart 1 of the federal Social Security Act.
- Federal guidance provided in the award notice gives flexibility to ensure the funds are used to support the well-being, permanency and stability of children who are in, or at risk of entering, foster care.
- Per the CARES Act, the supplemental funds must be obligated by the end of federal fiscal year 2021 and liquidated by December 31, 2021.

CONSIDERATIONS

- In developing this plan, DHS used information from internal data systems and research from other states, and also engaged in conversations with the child welfare provider community.
- DHS tailored this plan to address immediate financial concerns associated with the provision of residential services and address the impact of reducing in-person contacts with parents and children.

FOOD ASSISTANCE

- DHS will increase April and May Food Assistance benefits to the maximum allowable amount per household.
- If a household is not already receiving the maximum amount for April and May, those additional benefits will be added to their EBT card with their normal monthly benefits.
- Currently evaluating if we will do the same for June
- Food Assistance households who would normally have a recertification due in March, April, or May, have had their cases recertified for six months. A Notice of Decision will not be sent to households regarding this extension.
- Amazon and Walmart now offer online options for Iowans using their Food Assistance EBT card to purchase food. This service is available statewide. Amazon will deliver to all Iowa ZIP codes. Walmart provides this service for all store locations that offer online grocery. DHS is exploring additional opportunities to expand this program to include other retailers.
- Iowans who are in need of emergency assistance due to an income change are now eligible for TEFAP.

P-EBT Specific:

- Continue to work with Department of Education (DOE) for the data match
    - Updated date to receive information from DOE is May 25, 2020
- Anticipate a call with DOE to finalize timeline tomorrow – will update you once completed
- Expected issuance: June 2020

MEDICAID COVID UPDATE

Presented by: Mike Randol; Division Administrator for Iowa Medicaid Enterprise and Mary Stewart; Bureau Chief for Iowa Medicaid Enterprise

NO DISENROLLMENTS/PREMIUMS

- No one is being disenrolled or having their services reduced due to an inability to pay a premium, incomplete Healthy Behaviors, or other means throughout the duration of the COVID-19 pandemic.
- All co-pays, contributions and premiums have been waived through at least June. Members who already paid their co-pay, premium, or contribution for a waived month will receive a credit on their account when billing resumes.
    - We've disabled the online payment option temporarily so that members can't make a payment.

WAIVERS

- We've received approval from CMS for several different waivers to ensure continuous and expanded services for Medicaid members during this pandemic.
- There's a comprehensive matrix posted on the DHS website that lists all the flexibilities we've requested, along with the implementation date or status of each request.

FAQS/TOOLKIT

- Also on the DHS website is a comprehensive list of the questions we've received related to COVID-19, and our answers.
- I'd encourage everyone to go to the website and look through those FAQs. New ones are posted regularly.
- We've answered a lot of questions around telehealth and Home- and Community-Based services, as well as other program and general Medicaid operations questions. If you don't see an answer to your question on the website, you can email us at IMECOVID19@dhs.state.ia.us and we'll get

INFORMATIONAL LETTERS

- In addition to the FAQs, we've published several ILs that offer guidance for services and billing during the pandemic:
  - Telehealth services and billing
  - Teledentistry
  - Pharmacy
  - Expanded home delivered meals, homemaker and companion services
- Those ILs are all posted on the website

TIMELY FILLING EXTENDED

- The MCOs are extending the timely filling deadline by 90 days due to COVID-19.
- Effective with dates of service beginning April 1, 2020, providers will have 270 calendar says from the date of service to submit first time claims and encounters.
- Fee-for-Service and dental timely filing is at 360 days and remains unchanged right now.
- After this interim period, we'll return to normal billing guidelines.

PRIOR AUTHORIZATIONS (PAS)

- At this time, we're not waiving all PAs for Medicaid members during the pandemic.
- We're also NOT extending all PAs for continuity of care.
- What we are doing is extending PAs that were approved by the MCOs, dental plans and IME, for Fee-for-Service, for elective procedures that were delayed or cancelled due to the pandemic, that expire in March, April or May. We're extending those PAs an additional 90 days from the date of expiration. And, they'll be extended in 90-day increments through the end of the emergency period.
- We're monitoring PAs daily, including the time period for approval, and we'll use this data to make changes, if necessary.

STAKEHOLDER CALLS

- I've been holding a weekly call with providers on Fridays to talk about Medicaid updates related to COVID-19 and answer questions.
- I'm going to continue these calls as providers find them very helpful to get the latest updates.

CIVIL MONEY PENALTIES FUNDING DURING COVID-19

- We released an Informational Letter last week with details about how nursing facilities can apply for civil money penalties funding to purchase communicative technology during the COVID-19 public health emergency.
- The grants will be used to purchase communicative technology devices like iPads, tablets or webcams for residents to use.
- Instructions on how to apply for a grant are listed in the Informational Letter and are posted on our website on the COVID-19 Provider webpage.

RETAINER PAYMENTS

- We have requested authority through CMS to make retainer payments to HCBS and habilitation providers.
- We're still working with CMS on how this will work.

CARES ACT PROVIDER RELIEF FUND

- CMS requested a data file from us that contained all of the funding provided to every Medicaid provider for state fiscal years 2018 and 2019.
- We submitted this file to CMS last week.
- The data included both Fee-for-Service as well as managed care data and dental.
- CMS intends to use this data to determine payments to Medicaid specific providers.

- We are not aware at this point, of what calculation CMS will be using to determine the payment amount for providers.

OTHER MEDICAID UPDATES – NOT RELATED TO COVID-19

THIRD PARTY LIABILITY VERIFICATION CHANGE

- Our eligibility system no longer provides third-party liability verification for members assigned to an MCO.
- The MCOs will provide TPL verification for their members.
- TPL changes for members in managed care should now be reported to the member's MCO.

ELECTRONIC VISIT VERIFICATION

- We've determined that the service codes that will require EVV starting January 1, 2021. We issued an Informational Letter about that in March.
- We're going to reconvene the EVV Stakeholder work group to provide an update on EVV implementation and answer questions.
- We're looking at holding the workgroup meeting on June 4. Look for an IL with details soon.
    - If you're unable participate in the conference call, you'll be able to send in questions beforehand that we can answer, as well.

MANAGED CARE UPDATE

Presented by: Mary Stewart; Bureau Chief for Iowa Medicaid Enterprise

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 and CAHPS2 . • 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, 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.

DIRECTORS REPORT

TOWN HALLS

- Conducted our 2nd virtual town hall with Glenwood families and loved ones
- These continue to be a great way to have ongoing dialog with the loved ones and families of our Glenwood residents.
    - We plan to do the same with our other facilities in the coming weeks.
- At the town hall we provided information on our COVID-19 Response, and update on the DOJ investigation, and we've begun our discussion on our community integration plan.

GLENWOOD UPDATE

- The DOJ continues their work remotely.
    - They conducted interviews with past and present leadership of the past two weeks.
- You likely saw in the news Dr. Rehman is no longer with the agency.
    - He resigned in lieu of termination.
- Continue HR on campus presence

COMMUNITY INTEGRATION

- DOJ has two parts to their investigation, and one is focused on how we serve individuals in the community.
- We've put together a plan, which we discussed at the town hall, and we've also been talking to legislators about the framework.
- This will be a person-centered approach.
  - No set target numbers
  - Creating individual plans for each of the people who currently reside at both Resource Centers
- When DOJ was at GRC, they visited residents and a dozen self-identified that they wanted to live in the community.
- We have some work to do to build out capacity in the community.
- We also need to work on our pipeline.
- This is a state-led effort. I want to make sure everyone is engaged and feels like a partner in this effort.
- Not focused on closure. Not DOJ's goal either. Right sizing of facilities
- We know these are tough conversations with families and loved ones, but so far they have gone really well.

COVID-19

- Last month Matt provided an update on our response to the pandemic so far, this really effects every part of our work at the agency.
- Today we had Director Randol and Janee Harvey, the new DA for ACFS, provide you an update on their respective division's efforts around COVID-19.
  - Moving forward we're going to have two DAs come to provide an update on their division's response each month.
- We continue to update our timeline on our website for the overall agency response, and we're also providing regular updates on our facilities.

WOODWARD RESOURCE CENTER

- You've likely seen that unfortunately we have had 10 residents test positive at WRC.
- This is the only facility with positive residents to date.
- Our thoughts go out to our team members at WRC.
- We are doing everything we can to protect those in our care and equipping our team with the tools, resources and sick policy they need to ensure their safety as well.
- With the nature of the virus we knew it was a matter of when, not if, we would have positive cases, and we continue to take strong swift action.
- U of I consult on our mitigation measures-confirmed we're using best practices.
- We put in place policies very early on, which I believe have really helped keep it out of most of our facilities, and to limit the spread at WRC.
- Each facility has staffing contingency plan to ensure proper levels of care

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, June, 10th 2020 and will be a teleconference.

ADJOURN

Council on Human Services teleconference meeting held on May 13th, 2020 adjourned at 11:02am CST.

Department of HUMAN SERVICES

KELLY GARCIA, DIRECTOR | COUNCIL ON HUMAN SERVICES

TELECONFERENCE MINUTES: COUNCIL ON HUMAN SERVICES: June 10th, 2020

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson, Chair – present via phone	Director Kelly Garcia – absent
Kimberly Kudej – present via phone	Faith Sandberg – present via phone
Sam Wallace – present via phone	Matt Highland – present via phone
Carol Forristall – present via phone	Mike Randol – present via phone
Rebecca Peterson – absent	Annie Lukens – present via phone
Skylar Mayberry-Mayes – present via phone	Janee Harvey – present via phone
	Cory Turner – present via phone

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – absent
Senator Mariannette Miller-Meeks – absent
Senator Amanda Ragan – absent
Representative Timi Brown-Powers – absent
GUESTS
Des Moines Register Iowa Total Care

CALL TO ORDER

Mark Anderson, Council Chair, called the Council meeting to order at 10:00 a.m. via conference call on Wednesday, June 10th, 2020.

ROLL CALL

Annie Lukens, held roll call of the Council of Human Services. Attendance details listed above.

Mark Anderson read aloud: "This meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled, "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the First Floor Conference Room of the Hoover State Office Building. An agenda was sent to interested groups as well as the press advising that the meeting will be held via conference call. Minutes will be kept of the meeting."

APPROVAL OF MINUTES

Approval of Minutes for Council meetings held on 4/8/2020 & 5/13/2020

MOTION TO VOTE: SAM WALLACE AND SKYLAR MAYBERRY-MAYES

VOTE CARRIED UNANIMOUSLY CARRIED

1

RULES

Presented by Nancy Freudenberg; Bureau Chief Policy Coordination

The following amendments to the administrative rules are presented for adoption at the June10, 2020, Council on Human Services meeting.

R-1. Amendments to Chapter 113, "Family Foster Homes". The President signed the Bipartisan Budget Act of 2018, Public Law (P.L.) 115-123 into law on February 9, 2018. P.L. 115-123 includes the Families First Prevention Services Act (FFPSA) in Division E, Title VII. Section 50731 of the FFPSA directs the federal Department of Health and Human Services (HHS) to "identify reputable model licensing standards with respect to the licensing of foster family homes" (as defined in section 472(c)(1) of the Social Security Act). In response to this directive, the Children's Bureau of HHS issued the National Model Foster Family Home Licensing Standards.

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- Applicants and all household members must disclose any past or current mental health and/or substance abuse issues. The agency may require further documentation and/or evaluation to determine the suitability of the home.
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- All household members who are caregivers must have up to date whooping cough vaccines unless contrary to the person's health.
- The contracted agency must obtain at least three references, including at least one from a relative and one from a non-relative.
- The applicant's home must meet the following standards concerning swimming pools, hot tubs and spas:
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    - Swimming pools must have their methods of access through the barrier equipped with a safety device, such as a bolt lock.
    - Swimming pools must be equipped with a life saving device, such as a ring buoy.
    - If the swimming pool cannot be emptied after each use, the pool must have a working pump and filter system.
    - Hot tubs and spas must have safety covers that are locked when not in use.
- The applicants' home must meet the following standards concerning hazardous materials and first aid supplies:
    - Applicants must prevent the child's access, as appropriate for his or her age and other development, to all medications, poisonous materials, cleaning supplies, other

hazardous materials and alcoholic beverages. All medications should be kept in a locked cabinet.
    - Applicants must maintain first aid supplies as recommended by the American Red Cross.
- Assurances from applicants must be agreed upon including:
    - They will not use any corporal or degrading punishment on any child in the home.
    - They will not use any illegal substances, abuse alcohol by consuming it in excess amounts, or abuse legal prescription and nonprescription drugs by consuming them in excess amounts or using them contrary as indicated.

Weapons and ammunition must be separately store, locked, unloaded and inaccessible to children. Previously the rules listed that weapons and firearms shall be maintained in a locked place such as a gun case. Federal requirements now specify the type of place and a listing of weapons and ammunition which must be identified in the rule.
MOTION TO VOTE: CAROL FORRISTALL AND KIM KUDEJ
VOTE CARRIED UNANIMOUSLY CARRIED

N-1. Amendments to Chapter 75, "Conditions of Eligibility. The proposed rule is amended to adjust the federal poverty levels increments used to assess premiums for applicants and recipients with income over 150% of the federal poverty level under the Medicaid for Employed People with Disabilities (MEPD) program.

NO PUBLIC COMMENTS
MOTION TO VOTE: CAROL FORRISTALL AND SAM WALLACE
VOTE CARRIED UNANIMOUSLY CARRIED

FACILITIES COVID UPDATE
Presented by: Cory Turner; Division Administrator for Adult Children and Family Services

COVID-19 EFFORTS
- Policy development at all facilities
- PPE review, monitor, and now daily counts
- Limited then ceased visitation
- Added technology (e.g. Skype) for visitation options
- Began daily screening (including temps) of patients
- Stopped out of state travel (including contractors in/out)
- Began daily task force(s) at each facility
- Began twice daily leadership calls on issues/efforts
- Developed COVID-19 sick wards/cottages, as well as, suspected and step-down options to mitigate risk
- Began testing all residents and staff (WRC & GRC complete). Working on long term strategy

QUESTIONS:
What are the cost differences between having people in the institution vs community?
Response from Cory Turner: Will need to get the numbers and get back to the Council.

FISCAL COVID UPDATE
Presented by: Jean Slaughbaugh; Division Administrator for Division of Fiscal Management

FEDERAL FUNDING SOURCES:
- Normal: Federal funding allowed under normal program expenditures
- New: New federal funding (for example, enhanced FMAP, additional CCDBG funding)
- FEMA: FEMA Public Assistance Program
- Last resort source

- Appears to be broad in terms of coverage

PURPOSE:

- Some clearly defined purposes (TEFAP; commodities)
- Some broader purposes (for example, enhanced FMAP, additional CCDBG funding)

TRACKING EXPENSES:

- Have established centers to track COVID expenditures
- All affected programs/appropriations
- May need multiple cost centers
- Expenditures are covered by different funding sources (i.e., Normal, New, FEMA)
- Tracking various types of expenditures

TO DATE:

- 14 revenue streams; $220M
- 6.2% FMAP, e.g., $66M/Qtr

SORTING THROUGH IT ALL:

- For each New funding source (by program):
  - Consistent template:
    - Brief description of New funding source
    - Anticipated amount
    - Allowable uses
    - Method for claiming
    - Definition of cost tracking Reporting requirements
  - Working to maximize our ability to use new resources
  - Working to ensure clear audit trail for future

BUDGET / SESSION UPDATE

- Omnibus bill
  - Largely status quo

QUESTIONS:

"Do you anticipate and issues with the Budget Bill passing?"
Response from Jean Slaybaugh: "I do not think that there will be any issues."

DIRECTORS REPORT

Presented by Matt Highland on behalf of Kelly Garcia

TOWN HALLS

- We continue to conduct virtual town halls with the Glenwood and Woodward families and loved ones
- These continue to be a great way to have ongoing dialog.
  - Beginning in June we'll join the Glenwood and Woodward families together.
- This is a key part of our communications effort related to our community integration plan.

COMMUNITY INTEGRATION

- You'll recall at our last meeting we discussed our Community Integration Plan approach at a high level.
- Last week we published that plan to our website, put out a press release and now the real work begins.
- So, I encourage you to take a look at that and feel free to ask any questions.
  - If you already have and have questions I'm happy to answer, or if you want to look after this meeting, we can do that at our next council meeting.

COVID-19

- Recently we also issued our plan to ease restrictions at the facilities, which includes the criteria for that.
- It relies on three phases, with very clear guidelines.
- This is also posted to our website.
- As for reporting positive cases at our facilities, we have updated the way we publish that information to include the numbers of recovered and more granular detail.

- Woodward is still the only facility with resident or client positives.
    - 11 have recovered and 2 currently are positive for COVID.

AGENCY DASHBOARDS AND KEY METRICS

- One of my goals when I first started was to identify key priorities and to track them by looking closely at data and measuring our progress.
- Right now each DA is working to identify what they think some of those areas of focus should be, and we'll begin meeting with stakeholders to get their input.
- Which leads me to the current larger discussion in our society around race and systemic inequity.
- As families continue to be torn apart by social injustice, like the death of George Floyd, my heart breaks.
    - Governor Reynolds shared in her press conference last week, the need to implement systemic change.
    - So, I am challenging Team DHS to think about our role in this process and platform for change.
- Since I began as DHS director, a primary focus of mine has been setting goals and measurements of key areas within our agency.
- This plan always included a focus on the racial disparities in our own system.
    - This includes the disproportionate removals of indigenous youth and children of color, the disproportionate number of youth of color at our Boys State Training School and significant disparities in access to healthcare and maternal health outcomes.
    - To tackle these inequities, we must name them, measure them, highlight them and make meaningful improvements.
    - We owe it to the people of Iowa, and most especially to those who experience these inequities.
- Along with all of the other challenges we face as an agency, this is one we must address.
- And, if the last 7 months at DHS has taught me anything, our team is up to the challenge.
- So expect to hear more about this as we move forward.

LEGISLATIVE SESSION

- As you're aware, the legislature is currently in session, which is expected to be brief, although I'm not sure anyone knows entirely what to expect.
- It appears there is a bill moving with a status quo budget, which includes some increases for our facilities.
- Carrie, our legislative liaison is tracking on everything very closely, though this session is new terrain for us all, so we're trying to be responsive and prepared.
- We had done a lot of work building relationships with members and getting information gathered, which I think has served us well.

BRIGHT SPOT

- I've really been trying to work on cross connections between agencies and other partners in the state because our work intersects so much with the work of others.
- One relationship that I'm proud to highlight is a new partnership we're forging with Broadlawns.
- We are finalizing an agreement to have a residency rotation at Woodward Resource Center, which provides Broadlawns residents with a great opportunity to work with individuals with complex needs and provides the individuals we serve at Woodward additional medical staff.
- This will be a mutually beneficial relationship and is the kind of thing we need to be doing more of to help build out the pipeline of healthcare professionals and bring new talent into our workforce at DHS.
- I'm very excited about this opportunity and will be happy to provide updates as we progress.
- Their first rotation will begin this summer.

NEXT MEETING
The next meeting of the Council on Human Services is Wednesday, July, 8th 2020 and will be a teleconference.

ADJOURN
Council on Human Services teleconference meeting held on June 10th, 2020 adjourned at 10:42am CST.

Submitted by: Annie Lukens

Iowa Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
August 6, 2019

Call to Order and Roll Call

Council Co-Chair Sarah Reisetter, Iowa Department of Public Health, called the roll call at 1:02 P.M. Attendance is as reflected in the separate roll call sheet. A quorum was met.

Approval of Previous Full Council and Executive Committee Minutes

Sarah called for a motion to approve minutes from the May 7, 2019 Full Council meeting and the June 11, 2019 Executive Committee meeting.

Anthony Carroll, AARP, called for a point of order stating that he believed the roll had only been called for the Executive Committee. Several representatives of participating Professional and Business Entities echoed Anthony's concerns, generally stating confusion over which organizations would be considered members of the MAAC, and which organizations would have their attendance reflected in roll calls. Director Randol stated that IME staff would send out more information regarding membership of the MAAC. Sarah then again called for a motion to approve the minutes of May 7, 2019 and June 11, 2019. The motion carried and the minutes were approved.

Election of the Public Co-Chair

Sarah called for any interest in serving as co-chair, Jason Haglund expressed interest. Tom Broeker made a motion to nominate Jason as co-chair, Marcie Strouse seconded. The motion carried; Jason Haglund will continue serving as Co-Chair of the council.

Determining Staggered Terms for Business and Professional Members

Three of the five professional and business entities need to be identified as serving three-year terms, and two need to be identified as serving two year terms. The Council determined the terms by votes received in the recent election: of the five professional and business entities receiving the most votes, the top three vote getters would serve three-year terms, and the remaining two organizations would serve two-year terms. The Iowa Medical Society and the Iowa Pharmacy Association received the same amount of votes; a coin toss determined that the Iowa Pharmacy Association will serve a three-year term. The Iowa Hospital Association will serve a three-year term. The Iowa Health Care Association will serve a three-year term. The Iowa Medical Society will serve a two-year term. The Iowa Association of Community Providers will serve a two-year term.

Review and Approval Draft Administrative Rules

Sarah read through the Draft Administrative Rules developed by the Executive Committee. Once the MAAC approves the Draft Administrative Rules, the rules will be passed on to the Council on Human Services to formally adopt. Sen. Joe Bolkcom commented that the legislative membership of the roll call was not up to date, and raised the issue of who would be able to speak during the open comment period of the agenda. The Council further discussed who is considered a member of the council per the draft Administrative Rules and Iowa Administrative Code. The Council decided to table the adoption of the Draft Administrative Rules until clarification of membership and the open comment period was sent out by IME staff. The Council will examine this issue again in the November meeting.

Medicaid Director's Update

Director Randol stated the transition of members from UnitedHealthcare to Iowa Total Care and Amerigroup Iowa, Inc. has gone well. There have not been any widespread issues or concerns, small issues have been identified and are resolved as quickly as possible. Iowa Total Care has already successfully paid claims. Amerigroup has hired staff to take on the addition of new members. Member choice continues through September 30, 2019. The IME is monitoring member choice to maintain the equitable distribution of members between the two MCOs.

The IME has received signed contracts from Amerigroup and Iowa Total Care for SFY 2020. There have been some program changes: members are now allowed to have whomever they wish present at their Long Term Services & Supports (LTSS) assessment. MCOs are required to notify members of their LTSS assessment 14 days in advance. MCOs are required to provide the results of the LTSS assessment to the member within three business days. The IME is funding greater access to Hepatitis C treatment, by reducing the fibrosis score required for Medicaid members to access treatment, the fibrosis score will likely be lowered again in January 2020. Provider rates were rebased for Federally Qualified Health Centers, Rural Health Clinics, and Intermediate Care Facilities for the Intellectually Disabled. MCOs are required to load their provider rates within 30 days or face liquidated damages if they fail to comply. The MCOs must complete provider credentialing and accurately load provider rosters; the IME may assess liquidated damages if the MCOs do not comply.

The IME is increasing total funding in several key areas: nursing homes by almost $60 million; additional $12.8 million for mental health; and an increase in $3.8 million for critical access hospitals. The IME is developing a critical access hospital factor that will be added on to the fee. The factor will be based on utilization and costs that are reported from those entities. Another funding increase is an additional $2.6 million for the Intellectual Disability Waiver Tiered Rate Fee Schedule effective for July 1, 2019.

Concurrent with the MCO transition, the IME had to transition its eligibility system for Hawki. This has been completed with no major impact on member eligibility.

On August 1, 2019, the IME implemented a mandatory electronic billing requirement for all providers, this includes Fee-for-Service claims as well as Managed Care claims. Individual CDAC providers are excluded, and dental providers will not be required to comply until February 2020.

At Rep. Heather Matson's request, the Director stated IME staff would send a written version of his talking points out to Council members.

Sen. Bolkcom asked the Director where the money reflected in the rate increase for State Fiscal Year 2020 would go. The Director replied that, given an understanding of capitated rates, more than 92% of the funding will go to providers. The Director stated that he would have the actuary develop a document that will explain how the funding and is distributed through capitated rates. This document will be shared with the Council.

Cindy Baddeloo asked the Director to provide an update on Electronic Visit Verification. The Director replied that the Centers for Medicare and Medicaid Services allowed the IME to submit a good faith letter, which will make the effective date for personal care services January 1, 2021. In-home health care will need to comply by January 1, 2023.

Updates from MCOs

Amerigroup Iowa, Inc.
John McCauly provided operational updates for Amerigroup Iowa, Inc. Amerigroup now has more than 380,000 members across all populations. Amerigroup has 593 employees in Iowa, in all 99 counties, with roughly 39% of employees in the Des Moines area. Amerigroup Community-Based Case Managers continue to assist members affected by the Spring 2019 flooding across the state. Amerigroup completed over 15,000 LTSS assessments in the month of July.

Anthony Carroll, AARP, asked what challenges Amerigroup has experienced as the remaining original MCO. John answered that in the most recent transition, Individual CDAC providers did not automatically contract with Amerigroup as the providers members moved to Amerigroup from UnitedHealthcare. John noted that the Medicaid program has made progress in rebalancing long-term care.

Sen. Bolkcom noted that there is a crisis in rural pre-natal care across the state, noting that rural hospitals lose money on every birth they perform. He asked John if there was any way he could increase the rate at which these providers are reimbursed. John stated that Amerigroup reimburses at the rate levels set by the state.

Iowa Total Care
Mitch Wasden, CEO of Iowa Total Care, gave an update on Iowa Total Care's first month in the managed care program. Iowa Total Care has hired 96% of their 820 Iowa based employees. Iowa Total Care has performed 14,000 health risk screenings. Iowa Total Care had 812 employees ready for July 1, 2019. Iowa Total Care has about 15,000 LTSS members. Iowa Total Care has completed over 811 LTSS assessments that were either due before July 1, or within July, and will have all assessments completed by mid-August. Iowa Total Care has just started receiving and paying claims, roughly 120,000 claims were received to date. Iowa Total Care has an active partnership with the Boys and Girls Club of Iowa, as well as the Urban League. Iowa Total Care is looking forward to moving many of their contracts into value based purchasing contracts.

Dennis Tibben, Iowa Medical Society, asked about an issue that some providers had signed contracts but did not see themselves reflected on Iowa Total Care's roster. Mitch and the Director assured Dennis that providers with this issue would be treated as in-network while Iowa Total Care is manually updating their roster.

Sen. Bolkcom asked how many employees Iowa Total Care has, and what the biggest issues have been in the transition. Mitch said their biggest concerns were managing the transition of LTSS members, and that Iowa Total Care's largest unforeseen issue was the tight labor market in Des Moines, specifically finding data analytic talent.

Open Discussion

Shelly Chandler, Iowa Association of Community Providers, asked about an issue she and her providers have seen with the Mandatory Reporter training discussed at the last MAAC Executive Committee Meeting. Director Randol stated that the IME would distribute an update on this issue to the members of the council before the next MAAC meeting.

Dave Carlyle, Iowa Academy of Family Physicians, raised concerns that the Administrative Rules and Iowa Code do not comply with federal regulations, specifically that committee membership requirements are being met given the reduced size of the council. Director Randol stated that he believed the draft administrative rules and Iowa Code complied with federal regulations, but that the draft rules will be reviewed again to ensure compliance.

Adjournment
Meeting adjourned at 2:52 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
November 7, 2019

Call to Order and Roll Call

Council Co-Chair Sarah Reisetter, Iowa Department of Public Health, called the roll call at 1:00 P.M. Attendance is as reflected in the separate roll call sheet. A quorum was met.

Sarah asked voting members to introduce themselves, and then the new Department of Human Services (DHS) Director, Kelly Garcia, briefly introduced herself and her immediate plans for the Department.

Approval of Previous Meeting Minutes

Sarah called for a motion to approve minutes from the August 6, 2019 meeting. The minutes were approved.

Review and Approval of Draft Administrative Rules

At the August 6, 2019 meeting, Draft Administrative Rules were tabled due to concerns about election language and MAAC membership. Language in section 79.7(2) a. (1) was changed to clarify the differences between the initial election and all subsequent elections of voting members from professional and business entities. Additionally, the Department issued a memo clarifying membership of the council. Sarah called for a motion to approve the rules. The rules were approved by the council. The rules will now go before the DHS Rules Council for their review, approval, and adoption.

Medicaid Director's Update

Director Mike Randol introduced Mary Stewart, the new Managed Care Bureau Chief. Director Randol then began his update with a review of the transition of members from UnitedHealthcare to Iowa Total Care and Amerigroup Iowa, Inc. As of November 1, 2019, membership was split between the two Managed Care Organizations (MCOs) as follows: roughly 58% with Amerigroup and roughly 42% with Iowa Total Care. IME staff are monitoring distribution of members between the MCOs by each capitated rate cell..

Iowa Total Care has been operating in the Iowa Medicaid program for four months. IME staff continues to have two weekly meetings with Iowa Total Care leadership to monitor and correct any issues.

The IME has required the MCOs to create a claims issues log, which lists claims issues and has a timeline for resolution and claims reprocessing. This log will be updated weekly, and is posted on the MCO's websites.

An update was requested on the status of Ground Emergency Medical Transportation (GEMT): Director Randol noted that the Centers for Medicare and Medicaid Services (CMS)

recently approved of a plan for the IME to provide prospective payments to reimburse GEMT providers for their average uncompensated care cost (UCC). This program will be effective July 1, 2019.

The IME activated a new online payment system, Click Pay, for the Hawki program. On the new system, reoccurring payments can only be set up for 12 months at a time. State Representative Heather Matson asked if the new online system was voluntary. Director Randol stated that the IME cannot mandate a single form of payment out of concern for equal access to all members.

Managed Care Quarterly Report: State Fiscal Year (SFY) 2019 Quarter 4

Director Randol reviewed the Managed Care Quarterly Report for SFY 19 Quarter 4. Director Randol highlighted several sections of the report including: enrollment numbers, claims payments, prior authorizations, the balance of Long Term Service and Supports (LTSS) members living in institutions vs. LTSS members living in community-based care situations, service plan changes (increases, reductions and renewals), and value added services.

Cindy Baddeloo, of the Iowa Health Care Association, asked if the IME tracked claims paid by provider type. Director Randol replied that the IME does and if the MAAC thought this information was valuable it can be included in future quarterly reports, with the caveat that reliable claims information has to be at least six months old due to claims runout.

Director Randol noted that over 300 prior authorizations had been removed from the Medicaid program. Rep. Matson asked when these were removed. Director Randol stated that they were removed throughout the year in 2018.

Updates from the MCOs

Amerigroup Iowa, Inc.

John McCalley, of Amerigroup Iowa (Amerigroup), presented an update to the council. McCalley stated that Amerigroup increased its membership by roughly 61% due to the transition of members from UnitedHealthcare. McCalley highlighted the growth in LTSS membership: prior to the transition Amerigroup had 12,252 LTSS members, which increased to over 24,000 LTSS members following the transition. McCalley discussed Amerigroup's projects concerning social determinants of health. McCalley stated that Amerigroup has transitioned to a new Pharmacy Benefit Manager (PBM): Ingenio Rx.

Iowa Total Care

Mitch Wasden, Plan President of Iowa Total Care, gave an update on Iowa Total Care's first four months in the managed care program. Iowa Total Care has hired around 800 Iowa based employees. Mitch highlighted Iowa Total Care's relatively low employee turnover rate. Iowa Total Care completed 1,055 level of care (LOC) assessments in the month of October. Iowa Total Care anticipates that they will need three or four more months before they can

begin making value-based purchasing decisions, which will be important in adding value to the program.

Open Discussion

Marcie Strouse asked if claims payment timeliness was an issue monitored by the IME and if a working group could be formed to monitor it. Marcie cited concerns brought to her by several of her clients. Director Randol stated that claims payments are monitored, and asked that Marcie forward her clients concerns directly to him.

Anthony Carroll, of the American Association of Retired Persons (AARP), stated he thought it would be helpful to include reasons for grievances and appeals in the Managed Care Quarterly Report. Director Randol stated that the IME has a mandate to develop semi-annual stand-alone reports on appeals. Marcie asked if the appeals reports include information on grievances, Director Randol advised that the MCOs track grievances and that the IME's legislative mandate does not include grievances.

Denise Rathman, National Association of Social Workers, asked John McCalley about a notification Amerigroup sent out to mental health providers, limiting members to 24 sessions with mental health providers before a prior authorization is required. This limitation excludes psychiatrists and psychologists. John stated that Amerigroup will release a communication which explains the clinical rationale for this limit, pending approval of the communication by the IME. Director Randol clarified that the IME is approving the communication only, and cannot comment on the prior authorization, as in managed care MCOs are free to set their own prior authorization requirements.

Adjournment

Meeting adjourned at 2:15 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of
HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
February 11, 2020

Call to Order and Roll Call

Council Co-Chair Sarah Reisetter, Iowa Department of Public Health, called roll call at 1:00 P.M. Attendance is reflected in the separate roll call sheet. Sarah announced a quorum.

Approval of Previous Meeting Minutes

Sarah called for a motion to approve minutes from the November 7, 2019 meeting. The minutes were approved.

Medicaid Director's Update

Julie Lovelady, Deputy Medicaid Director, gave updates on Iowa Medicaid. The IME asked Amerigroup and Iowa Total Care to set up websites to show any systemic issues delaying payments to providers. The sites will be updated weekly with expected completion and reprocessing dates for the affected payments.

The IME is beginning Quarterly Provider Training; each quarter will focus on specific provider types. The first session focused on Community Based Case Management. Next session will focus on Home- and Community Based- Services (HCBS) Waivers and Consumer Directed Attendant Care (CDAC) training. An Informational Letter (IL) soliciting input from providers regarding training topics is forthcoming. Annual Provider Training will be in May or June, and the 3rd quarter training will cover Durable Medical Equipment. Specific dates, times, and locations will be announced via IL. Locations will cycle through regions. All trainings will be accessible online.

Mandatory Electronic Billing requirements are now in place for dental providers, joining other providers' August 2019 start date. Claims should process more quickly through this method.

Uniform Prior Authorizations workgroup produced a uniform request form for both Managed Care and Fee-for-Service (FFS). The Managed Care Organizations (MCOs) are testing the new form, and an IL will announce start date before July 1, 2020.

Managed Care Quarterly Report: State Fiscal Year (SFY) 2019 Quarter 4

Mary Stewart, Bureau Chief, Managed Care and Julie reviewed the report. This is the first report that includes Iowa Total Care's entry to the market. Topics highlighted included MCO enrollment numbers and open choice period, Level of Care reassessments, results of the Iowa Participant Experience Survey and Secret Shopper calls, Pharmacy and Non-Pharmacy Claim payments and prior authorizations, quarterly volume of claims, and Value Based Purchasing (VBP) enrollments. ITC has not completed their VBP but is committed to meeting standard by December 31, 2020.

Co-Chair Jason Haglund commented on the pattern of grievances focused on Amerigroup's transportation, and asked how recurring trends were being addressed within the system and structure. Julie answered they ask the client, vendor, and MCOs to troubleshoot, which sometimes results in corrective action plans to ensure they meet contractual requirements. Jason highlighted the challenge of identifying data trends as MCOs enter and leave the market. Mary suggested presenting the information in year-over-year format or on a quarterly basis. Jason said a long-term look would be helpful.

Updates from the MCOs

Amerigroup Iowa, Inc.
John McCalley, of Amerigroup Iowa, Inc. (Amerigroup), presented Amerigroup's update. The UnitedHealthcare transition is complete. Amerigroup experienced enormous growth, as they were the only MCO taking new members from April 1, 2019, to June 30, 2019. Amerigroup gained roughly 10,000 members per month during this period. Amerigroup's Long Term Services and Supports (LTSS) membership more than doubled between April 1, 2019, and July 31, 2019, to 23,707. Amerigroup hired 400 new positions, including 177 new LTSS staff. HCBS has shifted to 66 percent of recipients, up from a 50 percent split with institutions from the last quarter.

Speaking to Governor Reynolds' Condition of the State, Amerigroup will continue focusing on maternal screenings, vocational rehabilitation, and mental health services. Amerigroup currently has about 52 percent of providers in some sort of VBP.

Shelly Chandler, of the Iowa Association of Community Providers, asked a question clarifying John's numbers, especially moving from 50 percent to 66 percent HCBS. John credits transitions out of nursing homes and Residential Care Facilities (RCFs), and provider efforts to close RCFs and open waiver homes. Shelly expressed support for this trend. Senator Mark Costello asked John to clarify the timeframe for this trend; John replied from beginning of calendar year (CY) 2019 to the end of CY2019.

Susan Horras, of the Iowa Hospital Association and Casey Ficek, of the Iowa Pharmacy Association, asked about the growth of VBP, and John replied he expects both their performance and the IME standards to grow.

Brandon Hagen, of the Iowa Health Care Association, asked about the appropriateness of denials. Anthem reviews prior authorizations, and Amerigroup has their own process. For claims, John handed out a document outlining the process, and referred to Amerigroup's website for transparency. The IME identifies threshold for what makes it to the report, and Julie said patterns are discussed with individual providers.

Amy Shriver complimented two generation solution and addressing unmet needs on social determinants of health, highlighting long-term cost savings with focus on children's mental health programs.

Kady Reese, of the Iowa Medical Society, asked about provider practices with opioid risk predictor metrics. Providers are being contacted to make sure practices align, and

collaborate with Integrated Health Home (IHH) providers when possible. John would like to discuss in detail and will return to this subject next meeting.

Iowa Total Care

Mitch Wasden, Plan President of Iowa Total Care (ITC) presented ITC's update. With seven months operating in Iowa, ITC has 265,000 members and 820 employees. Mitch addressed claim suspension and ITC's plan to resolve startup claims issues. ITC worked with the IME to complete remediation work by January 20, 2020, and resolution included $50 million in advances to providers. Sixteen consecutive clean check runs since, and ITC is tracking to complete claim reprocessing by February 29, 2020.

ITC's next focus is improving health outcomes for Iowa. ITC's My Health Pays incentive program has launched, with over a million dollars to support expenses related to social determinants of health. ITC completed 180,000 member contact calls and 40,000 health risk assessments in its first seven months. To address hospital readmission, ITC contacted 97 percent of members within 10 days of hospital release. ITC's readmission rate went from 11 percent to 8.3 percent from July 2019 to February 2020.

More than 1,000 new mothers enrolled in ITC's Smart Start for your Baby program. The program's goal is to reduce early labor and receive notices of pregnancy. ITC is launching a program to send short message service (SMS) texts to people who may have a gap in care. ITC's Member Connections program has success stories in locating members without phone or address: after an ER visit, a rep visited a member at home. ITC representatives gave members a Safelink phone programmed with numbers to their doctor, case manager, and providers, and follow-up revealed the member making appointments.

ITC is drafting program for Value Based Care (VBC) to align with IME and DHS Healthcare Effectiveness Data and Information Set (HEDIS) measures. ITC is aiming for 80-90 percent of members engaged with VBC providers. ITC is researching the development of a telehealth app for membership. Centene has a provider that serves over 10,000 members in a month, but ITC would like the program to be much larger.

Sen. Costello asked about the issue tracker Iowa Total Care is using. Mitch says they use an internal research log and maintain communication with IME, and the biggest issues go on the IME issue tracker. Kady asked about Iowa or national infrastructure for telehealth. Mitch explained their invitation process among anybody who is licensed in Iowa. Brandon asked what providers should do if their claims are still denied or pending after February 29, 2020, and Mitch said the provider should contact their ITC provider relations representative to work through the claim. Shelly gave ITC credit for consistent communication.

Open Discussion

Dave Beeman asked questions relating to rules changes for the MAAC and expressed frustration with how public input is received. Julie explained the rules will be effective April 2020. Director Mike Randol explained changes at last meeting and meeting materials were sent through usual channels. Dave asked for a two-way conversation between IME and providers.

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Shelly asked about Electronic Visit Verification (EVV), specifically what services would be included. Julie said the IME will work on getting that IL out. Brandon asked if the EVV task force will reconvene, and Julie responded that feedback had been received and the IME worked with MCOs on pilot projects. Brandon asked Julie to relay decisions to the group.

Amy asked for more reports and data on how Medicaid serves children.

Adjournment
Meeting adjourned at 2:28 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
May 20, 2020

Call to Order and Roll Call

Gerd Clabaugh, Iowa Department of Public Health, called roll call at 1:02 P.M. Attendance is reflected in the separate roll call sheet. Gerd announced a quorum.

Approval of Previous Meeting Minutes

Gerd called for a motion to approve minutes from the February 11, 2019 meeting. The minutes were approved.

Medicaid Director's Update

Mike Randol, Medicaid Director, gave updates on Iowa Medicaid. During the COVID-19 Public Health Emergency, the IME will not disenroll any member due to non-payment of monthly premiums. All copays, contributions, and premiums have been waived by the IME through at least June 2020. The IME has put together a comprehensive list of questions and answers regarding COVID-19; this has been posted to the DHS website. If a question is not addressed, the public is encouraged to email their question to IMECovid19@dhs.state.ia.us. The IME has expanded home delivered meal services to all waiver members, as well as homebound members. The claims timely filing deadline for providers has been extended due to COVID-19, as of April 1, 2020, providers have 270 days to file claims for services provided. Prior authorizations (PAs) are still in effect. The IME and the Managed Care Organizations (MCOs) will extend PAs for services canceled due to COVID-19, in 90-day increments throughout the crisis. Mike is holding a weekly conference call with stakeholders every Friday.

Managed Care Quarterly Report: State Fiscal Year (SFY) 2020 Quarter 2

Mary Stewart, Bureau Chief, Managed Care reviewed the report. This is the first period in two years that enrollment could be considered "flat". On the Iowa Participant Experience Survey (IPES), Iowa Total Care (ITC) reported decreases in several categories. ITC has determined these decreases are a result of members answering, "I don't know" or "I don't remember" on several questions asked by their third party survey company. Going forward, ITC will have an internal team conduct surveys to ensure data is more complete. Mary reviewed the top reasons for grievances, appeals data, non-pharmacy claims data and prior authorization (PA) data.

Updates from the MCOs

Amerigroup Iowa, Inc.
John McCalley, of Amerigroup Iowa, Inc. (Amerigroup), presented Amerigroup's update. Amerigroup has made several adjustments in response to COVID-19. Amerigroup staff is working from home; a small skeleton crew is processing mail and other physical duties at the office. Amerigroup is engaged in daily outreach to nursing facilities in the Long-Term Services and Supports (LTSS) program. Amerigroup is procuring and distributing Personal Protective Equipment (PPE) to Home- and Community-Based Service (HCBS) providers. Amerigroup is maintaining pre-COVID-19 service levels for PAs. Face-to-face services have been suspended, this suspension will be monitored and evaluated as the Coronavirus Emergency unfolds. Telehealth solutions are being implemented where they can to replace face-to-face services.

Barb Niebel, of the Iowa Speech and Hearing Association, asked John about Amerigroup's banning of specific Current Procedural Terminology (CPT) codes used by occupational therapists, speech therapists, and physical therapists. John stated that he would follow up with Barb regarding this request.

Senator Joe Bolkcom asked if Amerigroup was tracking positive COVID-19 test results among its members. John answered that Amerigroup is tracking this closely and to the best of their ability, as the usual tracking metrics (such as a PAs) do not yet exist for COVID-19. Senator Bolkcom asked if Medicaid was tracking COVID-19 test results. Mike stated that the IME is tracking, using data from MCOs and other sources. Senator Bolkcom asked if Mike could share how many Iowa Medicaid members had tested positive for COVID-19. Mike replied that he would provide this information to Senator Bolkcom.

Senator Bolkcom asked if providers running nursing homes felt they had the tools needed to prevent the spread of COVID-19. Mike answered that he thought they did. Gerd noted that the IME and the Iowa Department of Public Health (IDPH) are working closely with several organizations to provide support and outreach to providers, supporting testing of employees and residents in care facilities. Gerd stated that they have been in touch with every single nursing home since the start of the crisis.

Iowa Total Care

Stacie Maase, Vice President of Legislation and Government Affairs Iowa Total Care (ITC), presented ITC's update. Stacie stated she would focus her remarks on how ITC is navigating the Coronavirus Emergency. ITC has been meeting with the IME and other stakeholders on a regular basis to make sure ITC members and others in the Medicaid community continue to have their needs met. ITC transitioned the vast majority of its employees in Iowa to working from home, a small skeleton crew makes sure operations

continue to run smoothly at ITC's offices. ITC has implemented telehealth solutions to help mitigate the impact of the emergency, for example ITC has begun using video calls to ensure assessments are completed for LTSS members. ITC has worked very closely with meal providers to provide meals for members newly eligible under the IME's recent home delivered meal benefit expansion. ITC is facilitating the distribution of PPE to providers and members.

Open Discussion

Senator Bolkcom thanked Mike and the IME for their excellent work. Amy Shriver stated that she was grateful for telehealth solutions, Barb Niebel seconded this. Barb went on to ask how the IME was implementing guidance the Centers for Medicare and Medicaid Services (CMS) issued regarding CPT codes for telehealth services. Mike stated that he would examine the issue and respond to Barb, but that in general the IME attempts to follow CMS guidance as close as possible. Mike thanked the team at IME for their hard work during the Coronavirus Emergency.

Adjournment

Meeting adjourned at 2:24 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Michael Randol, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Hawki Board Meeting
August 19, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston – call in	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie -	Marissa Eyanson
Jim Donoghue – call in	Anna Ruggle
Eric Kohlsdorf, Chair - present	Kevin Kirkpatrick
Dr. Bob Russell – present	
Dr. Kaaren Vargas – present	**Guests**
Senator Nate Boulton – call in	Jean Johnson, IA Department of Public Health
Senator Dennis Guth -	Joe Estes, MAXIMUS
Representative John Forbes – present	
Representative Shannon Lundgren -	

Call to Order and Roll Call
Board Chair Eric Kohlsdorf called the meeting to order at 12:33 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes
Kohlsdorf called for the board to review the minutes from the following meetings: December 5, 2018, April 15, 2019 April 23, 2019 and June 17, 2019. Kohlsdorf called for a motion to approve the minutes. Jim Donoghue raised an issue, with approving a recommendation during previous meetings.

A vote was taken to approve the December 5, 2018, meeting minutes, as corrected, and the meeting minutes were approved.

Director's Report
Medicaid Director Mike Randol reviewed highlights of the Hawki Dashboard, specifically enrollment reports. Director Randol noted anomalous data in the chart due to transitioning the enrollment system from MAXIMUS to the Department of Human Services. Director Randol then reviewed the Managed Care Report for State Fiscal Year 2019, Quarter 3 (Q3 SFY19). The Managed Care report link included in the materials was not correct. A corrected link will be sent out by IME staff. Director Randol then discussed the Managed Care Organization (MCO) transition of UnitedHealthcare leaving Iowa Medicaid and Iowa Total Care coming onboard. Director Randol stated that the transition was successfully completed with minimal disruption to members, noting that he continues to meet regularly with Iowa Total Care leadership.

Updates from the MCOs
John Hedgecoth, of Amerigroup Iowa, presented an update to the Board. Hedgecoth stated that Amerigroup has been pleased with the transition. Amerigroup has taken an additional 190,000 -195,000 members in this transition. To accommodate the increase in members, Amerigroup has almost doubled the size of its workforce in Iowa. Sen. Nate Boulton asked for who the best contact would be if a constituent approached him with transition issues. Hedgecoth responded that for legislators the point of contact is Carl Callson; but he, John McCauly, and the Ombudsman's office should all be contacted as well. Hedgecoth announced that early next year Amerigroup will be introducing a new Pharmacy Benefit Manager (PBM) named Ingenio Rx.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update: DDIA has about 56,000 members, with an access rate of about 68 percent. DDIA is working with providers on high-risk assessment.

ClickPay
Anna Ruggle gave a presentation on Iowa Medicaid's ClickPay web application. About 60 percent of Hawki families pay a premium pay online. Hawki families can now pay their premiums through an online payment system called ClickPay, which is operated by DHS. The system is currently used by members of the Iowa Health and Wellness Plan and Dental Wellness Plan to pay monthly contributions. The system is planned to be live by the end of October. Online payments will be processed by US Bank.

Outreach
Jean Johnson gave an update on Hawki Outreach. In July, Hawki Outreach held a conference with over 300 school nurses from the School Nurses Association. There are several conferences scheduled for the fall: an injury prevention conference in September, Hawki's own fall conference in October, and a conference for pediatric nurses in November.

Public Comment
Dr. Kaaren Vargas asked about a large number of denials she has seen for multiple preventive items for at-risk children with special needs. Director Randol stated that Heather Miller will reach out and walk Dr. Vargas through the exception-to-policy (ETP) process.

New Business
Donoghue put forward a motion to have Kohlsdorf and Dr. Vargas continue serving as Chair and Vice-Chair, respectively. The motion passed.

Next Meeting
The next meeting will be October 21, 2019.

Meeting adjourned at 1:36 PM.

Submitted by,

Adrian Olivares
Recording Secretary
ao

Michael Randol, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Hawki Board Meeting
October 21, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie – present	Julie Lovelady, Deputy Medicaid Director
Jim Donoghue – present	Anna Ruggle
Eric Kohlsdorf, Chair – present	Kevin Kirkpatrick
Dr. Bob Russell – present	
Dr. Kaaren Vargas – present	**Guests**
Ronda Eick -	Jean Johnson, IA Department of Public Health
Senator Nate Boulton – call in	Joe Estes, MAXIMUS
Senator Dennis Guth -	Lindsay Paulson, MAXIMUS
Representative John Forbes – present	
Representative Shannon Lundgren -	

Call to Order and Roll Call

Board Chair Eric Kohlsdorf called the meeting to order at 12:30 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Director's Report

Medicaid Director Mike Randol reviewed Hawki enrollment and financials. Director Randol discussed how the transition from UnitedHealthcare, and the open choice period, affected membership distribution between Iowa Total Care and Amerigroup. Kohlsdorf asked how membership will be balanced between the Managed Care Organizations (MCOs) moving forward. Director Randol stated that the algorithm that assigns members to a MCO at the time of enrollment can be adjusted, and that membership is tracked between the MCOs on a month-to-month basis.

Approval of the Hawki Board Meeting Minutes

Kohlsdorf called for the Board to review the minutes from the August 19, 2019 meeting. Kohlsdorf called for a motion to approve the minutes, the motion carried and the minutes were approved.

Approval of Administrative Rules

Anna Ruggle, presented administrative rules for adoption by the Board. The board previously noticed these rules. Kohlsdorf called for a motion to adopt the rules, the motion carried and the rules were adopted.

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Updates from the MCOs
John McCalley, of Amerigroup Iowa (Amerigroup), presented an update to the Board. McCalley stated that Amerigroup increased its membership by roughly 61% due to the transition of members from UnitedHealthcare. McCalley highlighted the growth in Long Term Service and Supports (LTSS) membership: prior to the transition Amerigroup had 12,252 LTSS members, which increased to over 24,000 LTSS members following the transition. McCalley discussed Amerigroup's projects concerning social determinants of health. McCalley stated that Amerigroup will be transitioning to a new Pharmacy Benefit Manager (PBM): Ingenio Rx.

Representative John Forbes noted that his constituents had raised an issue with delays in claims payments from Amerigroup to Nursing Facility providers. McCalley and Director Randol stated that the issue is known and is in the process of being resolved.

Kohlsdorf asked if there were any issues with Amerigroup's new PBM, specifically any issues with the preferred drug list, McCalley stated no issues have been identified.

Kim Flores, of Iowa Total Care (ITC), presented an update. ITC currently has 260,620 members, 22,000 of that being Hawki members. During the open choice period ITC engaged with members to understand where the care gaps are. ITC has been working diligently to improve their network and remove any barriers to care their membership may experience.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update: DDIA has about 60,000 members in the Hawki program. Hageman stated that 67% of DDIA members have had a preventative service in State Fiscal Year (SFY) 2018. DDIA has about 1,600 dentists in their network, 1,300 of which are available to serve Hawki members. Hageman noted there are 71 pediatric dentists in the state of Iowa and 69 of them are in the DDIA network. DDIA's outreach program is targeting children ages one to three, trying to increase visits for this population. DDIA outreach is also targeting adolescent members, as regular dental visits tend to drop off for adolescents.

MCO Quarterly Report
Director Randol gave a brief overview of the MCO Quarterly Report: SFY19 Quarter 4. Director Randol provided information in the following areas: capitated payments as broken down by population, percentage of population in each capitated payment rate cell, secret shopper data, claims denial reasons, and pharmacy claims data. Director Randol introduced the new IME medical director, Dr. William Jagiello.

Communications Update
Kevin Kirkpatrick gave an update on the Hawki online payment system. The new system came online October 21, 2019. The new system will require members to reaffirm their online payment every 12 months; this will eliminate any legacy automated payments that members may have forgotten to cancel.

Outreach
Jean Johnson gave an update on Hawki Outreach and some upcoming conferences.

Public Comment
There were no comments.

New Business
Kohlsdorf inquired about how speech therapy is managed between the two MCOs. Director Randol stated that each MCO has the authority to set their own prior authorization requirements.

Kohlsdorf discussed an email that he and Dr. Vargas received regarding a member who had been denied a flu shot at a pharmacy. Director Randol explained that the issue was likely due to how the pharmacist billed for the shot. Representative Forbes noted that some pharmacists would be hesitant to bill in the manner described, due to the amount of paperwork. Director Randol stated that this issue comes up once a year, and that only a very small number of pharmacies deny this service due to their own internal policies.

Representative Forbes discussed legislation that requires prescribers to e-prescribe all their prescriptions as of January 2020. Representative Forbes noted that the State Board of Pharmacy has around 250 requests for waivers from physicians all over the state. Representative Forbes advised this is an issue this board and Medicaid in general should be tracking.

Next Meeting
The next meeting will be December 16, 2019.

Meeting adjourned at 2:12 PM.

Submitted by,

Michael Kitzman
Recording Secretary
mk

Hawki Board Meeting
December 16, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie – present	Marissa Eyanson, IME Bureau Chief
Jim Donoghue – present	Kevin Kirkpatrick
Eric Kohlsdorf, Chair – present	
Dr. Bob Russell – present	
Dr. Kaaren Vargas – present	**Guests**
Ronda Eick -	Jean Johnson, IA Department of Public Health
Senator Nate Boulton – call in	Lindsay Paulson, MAXIMUS
Senator Dennis Guth -	
Representative John Forbes – present	
Representative Shannon Lundgren -	

Call to Order and Roll Call
Board Chair Eric Kohlsdorf called the meeting to order at 12:30 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes
Kohlsdorf called for the Board to review the minutes from the October 21, 2019 meeting. Kohlsdorf called for a motion to approve the minutes, the motion carried and the minutes were approved.

Hawki Annual Report
Marissa Eyanson, Iowa Medicaid Enterprise (IME) Bureau Chief, reviewed the annual report. Marissa highlighted annual Hawki membership statistics, the rebranding of the Hawki program, the budget for State Fiscal Year (SFY) 2019, Hawki population breakdowns, projected populations for SFY 2020, care quality metrics, provider network adequacy, the Hawki Outreach Program, presumptive eligibility, the Hawki Dental Plan, and membership of the board. Angela Burke Boston asked if print resources are translated into other languages aside from Spanish. Marissa stated that print resources are available only in Spanish and English, but translation services are available to members via telephone. Eric called for a motion to approve the report, the motion carried and the report was approved.

Director's Report

Medicaid Director Mike Randol reviewed Hawki enrollment and financials. Mike stated that in SFY 20 Hawki would request $19.3 million in state funding. The federal share for the Hawki program will be about $171 million. Starting in 2020 the IME will begin offering quarterly provider trainings, as opposed to annual provider trainings. The first quarterly provider training will be held on January 13 in Dubuque. Quarterly provider training sessions will be regionally focused, and focused on topics requested by providers. The IME is developing a Uniform Prior Authorization form to be used by both Managed Care Organizations (MCOs) and the IME. Marissa and her team are developing this and hope to implement in early 2020. Dr. Jonathan Crosbie asked for more information regarding the Uniform Prior Authorization form. Mike stated that the form was mandated by the legislature in the 2019 session, and that it will be a standard form for prior authorizations between the MCOs and Fee-for-Service, all services requiring a prior authorization within the Medicaid program will use the same form.

Rep. John Forbes raised an issue that his constituents had recently contacted him about, regarding a letter they received from Amerigroup noting that rates for Durable Medical Equipment (DME) would be reduced. Rep. Forbes stated that these rates were at or below cost for the products, and that these products included things like diapers and glucose strips. John Hedgecoth of Amerigroup Iowa, Inc. (Amerigroup) stated that he had some information, but would not be able to respond in full at this meeting.

Updates from the MCOs

Hedgecoth presented an update to the Board. Hedgecoth noted that currently Amerigroup has roughly 380,000 Iowa Medicaid members. Since the transition in July Amerigroup has brought on 206 new employees, 130 of which are new community based case managers. Amerigroup is still looking to fill more case manager positions. Amerigroup continues to focus on assessments and follow-ups for members, especially long term service and supports (LTSS) members. Amerigroup continues to monitor its community-based placement vs its institutional placement of members, continuing their mandate to move members from institutional placements to community-based placements.

Rep. Forbes noted that his constituents forwarded him a letter they received from Amerigroup announcing a reduction in rates for DME. Rep. Forbes noted his constituents received this letter on December 13, 2019, announcing the rate reduction would go into effect on December 15, 2019. Mike asked Hedgecoth to provide him with a report on this rate reduction. Hedgecoth stated he would follow up with Mike regarding this issue.

Kim Flores, of Iowa Total Care (ITC), presented an update. ITC went live in the Medicaid program on July 1, 2019, spending their first several months in the market overcoming the operational challenges involved in standing up a health plan. ITC is now focusing on increasing outreach to their members and providing value-added benefits. One such benefit is the My Health Pays program, an incentive given to members when they complete a healthy activity. The My Health Pays program rewards members with a pre-paid, reloadable, Visa gift card. Additionally, these gift cards can be used to pay for utilities, transportation, childcare, rent, telecommunications, and education as long as the vendors are coded appropriately; the cards cannot be used to purchase alcohol, tobacco, or firearms.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update: DDIA has about 60,000 members in the Hawki program. Hageman stated that 40% of Hawki DDIA members have had a preventative service in SFY 2020. DDIA has a network of 1,300 dentists available to serve Hawki members. DDIA's outreach program is continuing targeting children ages one to three, trying to increase visits for this population.

Communications Update
Kevin Kirkpatrick gave an update on the Hawki online payment system. Since implementation on October 21, 2019, 2,600 users have signed up for the service. The system has gone through one payment cycle. The new system will require members to reaffirm their online payment every 12 months; this will eliminate any legacy-automated payments that members may have forgotten to cancel.

Outreach
Jean Johnson gave an update on Hawki outreach and shared some local outreach success stories.

Public Comment
There were no comments.

New Business
Rep. Forbes discussed the electronic prescription mandate recently passed by the Iowa Legislature. As of January 1, 2020, pharmacies will continue to fill prescriptions received in a non-electronic format. Pharmacies will then notify the Iowa Board of Pharmacy when they receive non-electronic prescriptions. The Iowa Board of Pharmacy will then notify the board that governs the prescriber, and this board will discipline the prescriber.

Next Meeting
The next meeting will be February 17, 2020.

Meeting adjourned at 2:12 PM.

Submitted by,

Michael Kitzman
Recording Secretary
mk

Michael Randol, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Hawki Board Meeting
February 17, 2020

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie – present	Mary Stewart, IME Bureau Chief
Jim Donoghue – present	Marissa Eyanson, IME Bureau Chief
Eric Kohlsdorf, Chair – present	Kevin Kirkpatrick
Dr. Bob Russell – present	Anna Ruggle
Dr. Kaaren Vargas – present	**Guests**
Ronda Eick -	Jean Johnson, IA Department of Public Health
Senator Nate Boulton –	Lindsay Paulson, MAXIMUS
Senator Dennis Guth -	Joe Estes, MAXIMUS
Representative John Forbes –	
Representative Shannon Lundgren -	

Call to Order and Roll Call

Board Chair Eric Kohlsdorf called the meeting to order at 12:30 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes

Kohlsdorf called for the Board to review the minutes from the December 16, 2019 meeting. Kohlsdorf called for a motion to approve the minutes, the motion carried and the minutes were approved.

Director's Report

Medicaid Director Mike Randol gave updates on the Hawki program and Medicaid overall. In an effort toward transparency, the Managed Care Organizations (MCOs) have posted on their websites spreadsheets that show systemic issues, such as claims payments issues. These spreadsheets will be updated weekly, and will allow providers to track progress toward issue resolution.

The first Quarterly Provider Training session was held in Dubuque, focusing on Home- and Community-Based Services (HCBS). The next session is scheduled to be held in March in Mason City.

As of February 1, 2020, Dental providers are required to submit claims electronically. Legislation passed last year, mandated the creation of a uniform prior authorization form. A form has been created, and the Department hopes to implement this form by early spring.

The Department has withheld a portion of Iowa Total Care's (ITC's) monthly payment for January 2020, $44 million, due to a lack of timely claims payments. Iowa Total Care has until February 29, 2020 to process 75% of delayed claims, or they will not receive these funds. Randol stated that he anticipates ITC meeting the deadline. Randol then reviewed Hawki enrollment and financial data.

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Managed Care Quarterly Report

Mary Stewart, Managed Care Bureau Chief, presented the Managed Care Quarterly Report for State Fiscal Year (SFY) 2020 Quarter 1. Topics covered included: Discussion about Open Choice Period, Service Level Assessments, Secret Shopper data, Non-Pharmacy Claim Payments, and Prior Authorizations. During the discussion of Prior Authorizations, it was noted that the IME recently approved payment of $1.78 million for a single dose of Zolgensma®, a drug for spinal muscular atrophy. Dr. John Crosbie remarked that the drug uses a virus to inject genetic material into cellular structures that are not functioning, stating, "That's dope!" he then requested these remarks be included in the minutes. Angela Burke Boston requested information regarding spending for hemophilia drugs.

Updates from the MCOs

John Hedgecoth, of Amerigroup Iowa, Inc., presented an update to the Board. Hedgecoth stated that for 2020 Amerigroup will focus on innovations in Maternal Child Health, Social Determinants of Health, Value Based Purchasing, and developing their integrated case management team. Hedgecoth noted that Amerigroup missed target on assessment completions by a small margin. At the last Hawki Board meeting Rep. John Forbes raised an issue that Amerigroup had sent a notice that they would be reducing rates for Durable Medical Equipment providers, and that the notice was received on December 13, 2019, with an effective date of December 15, 2019. Hedgecoth addressed this notice, stating that the notice was sent with the incorrect effective date, it was supposed to say January 15, 2020, and that no providers had left the network due to these rates.

Kim Flores, of ITC, presented an update. Currently, ITC has roughly 255,000 Iowa Medicaid members. ITC went live in the Medicaid program on July 1, 2019, spending their first several months in the market overcoming the operational challenges involved in standing up a health plan. ITC is now focusing on increasing outreach to their members and providing value-added benefits. ITC launched a new Notification of Pregnancy program on January 1, 2020, partnering with providers specializing in maternity care, with a focus on reducing Neonatal Intensive Care Unit (NICU) admissions.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update: DDIA has about 60,000 members in the Hawki program. Hageman stated that 50% of Hawki DDIA members have had a preventative service in the first quarter of 2020. DDIA is forecasting an average of 68-70% members will have a preventative service by the end of the year. DDIA is funding the installation of water bottle refilling stations, primarily targeting high risk school districts. In addition to building the water bottle refilling station, DDIA gives everyone at the school a water bottle. DDIA is moving this program out into community settings as well, installing water bottle filling stations in airports and along trails.

Communications Update

Kevin Kirkpatrick stated that the IME Communications team is gearing up for the annual Open Choice period for Hawki in May and June of 2020. The onboarding of ITC and redistribution of members in 2019 reset a large population of members' annual Open Choice period to the same dates.

Outreach

Jean Johnson gave an update on Hawki outreach. Hawki outreach is developing a new brochure, and has on-boarded some new outreach coordinators.

Public Comment

There were no comments.

New Business

No new business was proposed.

Next Meeting
The next meeting will be April 20, 2020.

Meeting adjourned at 1:42 PM.

Submitted by,

Michael Kitzman
Recording Secretary
mk

Michael Randol, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Hawki Board Meeting
April 20, 2020

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie	Mary Stewart, IME Bureau Chief
Jim Donoghue – present	Marissa Eyanson, IME Bureau Chief
Eric Kohlsdorf, Chair – present	Kevin Kirkpatrick, IME
Dr. Bob Russell – present	Anna Ruggle, IME
Dr. Kaaren Vargas – present	Julie Lovelady, IME Deputy Director
Ronda Eick –	**Guests**
Senator Nate Boulton – present	Jean Johnson, IA Department of Public Health
Senator Dennis Guth –	Lindsay Paulson, MAXIMUS
Representative John Forbes – present	Joe Estes, MAXIMUS
Representative Shannon Lundgren -	Michelle Canfield, HACAP
	Jess Benson, Legislative Services Agency
	Heather Miller, IME
	Brenda Settelmeyer, MATURA
	Sandi Hurtado-Peters, IA Dept of Management
	Kim Flores, Iowa Total Care
	John Hedgecoth, Amerigroup Iowa, Inc.
	Mary Nelle Trefz, Child and Family Policy Center

Call to Order and Roll Call

Board Chair Eric Kohlsdorf called the meeting to order at 12:30 PM by phone. A roll call was conducted, and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes

Kohlsdorf called for the Board to review the minutes from the February 17, 2020 meeting. Kohlsdorf asked for a motion to approve the minutes, and the motion carried.

Director's Report

Medicaid Director Mike Randol gave updates on the Hawki program and Medicaid overall. Director Randol referred to written materials for finance reports and focused today's update on the Department's response to COVID-19. The Department's priority is preventing members from losing coverage from March 13, 2020 through the pandemic. There will be no disenrollment or reductions due to incomplete healthy behaviors or unpaid premiums. Members notified of disenrollment prior to March 13, 2020 have had their coverage reinstated. Copays, contributions, and premiums are waived through at least June, and the online payment system is temporarily disabled. Members who already paid will receive a credit when billing resumes. Due to COVID-19, nearly all services are open for telehealth, and usage increased significantly. All waiver members will be eligible for meals, as well as homebound non-waiver

members.

A matrix of the program changes, toolkit, and frequently asked questions (FAQs) are posted to the Department's website, and several Informational Letters (ILs) have been published. Timely filing deadlines for providers are extended by 90 days, effective April 1, 2020. Providers will need to submit claims within 270 calendar days from date of service. Prior authorizations (PA) are not waived during pandemic, and continuity of care is not automatically extended. PAs for elective surgeries are extended for 90 days.

In response to Kohlsdorf's question, Director Randol clarified that premiums are canceled and waived, not postponed or billed retroactively.

Updates from the Managed Care Organization (MCOs)
John Hedgecoth, of Amerigroup Iowa, Inc., presented an update to the Board. Amerigroup is working with the Iowa Medicaid Enterprise (IME) to set new processes for telehealth, employee and member safety. Policy updates are on the IME webpage, as well as an Amerigroup FAQ and toolkit. Focus is on homemaker and companion services, and access to meals. Amerigroup is working with the Iowa Association of Community Providers (IACP) to distribute personal protective equipment (PPE) to providers. Amerigroup is projecting an increase in the number of people on Medicaid due to the freeze on disenrollment and as unemployment increases new Medicaid applications. Amerigroup is maintaining normal operations, claims, and communication channels to support individual provider issues and its provider network.

Kim Flores, of Iowa Total Care (ITC), presented an update. ITC is maintaining operations. ITC staff has send out daily resources email to member-facing staff with statewide and local resources in each county. Case managers are providing education on housing, utilities, language services, and answering questions for members. There has been good feedback from members on telehealth options. Live events are migrating to virtual events.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update. The governor's mandate has closed dental offices except for emergent care, causing a 70% drop in dental usage. Federally qualified health centers are providing the majority of services, but some private dentists are operating. Medicaid opened telehealth codes to dentists, which allows dental providers to triage members before they visit an open dentist. Dentists are reporting supply problems with PPE.

Communications Update
Kevin Kirkpatrick provided an IME Communications update. The IME mailed letters to all Hawki families that the IME is not collecting premiums through at least June. In response to Kohlsdorf's questions, Kirkpatrick and Director Randol clarified that the annual open enrollment period for members has been postponed from now until September at the earliest. Members may still switch their MCO for reasons of Good Cause.

Outreach
Jean Johnson, of IDPH, gave an update on Hawki outreach. Hawki brochures are out to print. There will be additional messaging on health insurance opportunities and local resources coming out through social media. Visibility activities are canceled due to pandemic.

Public Comment
Mary Nelle Trefz asked about waiving the waiting period for Children's Health Insurance Program (CHIP), and how Medicaid is performing disenrollment, reenrollment, and eligibility verifications. Director Randol said his team is revisiting waiting periods, as they want to give access as soon as possible. All enrollment activities are still happening for statistical reasons; dis-enrollments are not being submitted at the

conclusion of the verification process.

New Business
New appointees to the Board have been received from the Governor, but they have not been approved by the Senate. Confirmations are tabled to next meeting.

Rep. John Forbes expressed concern that children not in school and not interacting with mandatory reporters are at higher risk of unreported abuse. Director Randol deferred to last week's press conference from Iowa Department of Human Services (DHS) Director Kelly Garcia about communication and coordination with DHS.

Next Meeting
The next meeting will be June 15, 2020.

Meeting adjourned at 1:21 PM.

Submitted by,

Jordan Murphy
Recording Secretary
jm

Michael Randol, Medicaid Director | **Healthy and Well Kids in Iowa (Hawki) Board**

Hawki Board Meeting
June 15, 2020

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Mike Randol, Medicaid Director
Mary Nelle Trefz – present	Kevin Kirkpatrick, IME
Jim Donoghue – present	Anna Ruggle, IME
Eric Kohlsdorf, Chair – present	Heather Miller, IME
Dr. Bob Russell – present	
Dr. Kaaren Vargas – present	**Guests**
Shawn Garrington – present	Jean Johnson, IA Department of Public Health
Senator Nate Boulton – present	Lindsay Paulson, MAXIMUS
Senator Dennis Guth – present	Joe Estes, MAXIMUS
Representative John Forbes –	Gretchen Hageman, Delta Dental Iowa
Representative Shannon Lundgren -	John Hedgecoth, Amerigroup Iowa, Inc.
	Gabe Medley, Iowa Total Care

Call to Order and Roll Call
Board Chair Eric Kohlsdorf called the meeting to order at 12:30 PM by phone. Chair Kohlsdorf conducted a roll call, and attendance is as reflected above. Chair Kohlsdorf established a quorum.

Approval of the Hawki Board Meeting Minutes
Chair Kohlsdorf called for the Board to review the minutes from the April 20, 2020 meeting. Chair Kohlsdorf asked for a motion to approve the minutes, and the motion carried.

Welcoming of New Committee Members
Chair Kohsldorf recognized Mary Nelle Trefz and Shawn Garrington as new members of the board and allowed them time to introduce themselves. Mary Nelle introduced herself, stating she works at the Child and Family Policy Center, focusing on health policy issues, working to ensure children have access to healthcare. Shawn introduced himself, stating he has been involved in foster care and working with at risk youth.

Director's Report
Medicaid Director Mike Randol gave updates on the Hawki program and Medicaid overall. Director Randol referred to written materials for finance reports and focused his remarks on the response to COVID-19. The Department has not seen a significant increase in Medicaid applications, as other states have during the coronavirus emergency. The Department will not disenroll members during the duration of the coronavirus emergency. The Centers for Medicare and Medicaid Services (CMS) has created a new billing group for uninsured testing and diagnosis services, the IME has implemented this program to allow uninsured members to be tested for COVID-19. This billing group does not allow for services beyond testing and diagnosis. During the coronavirus emergency, the IME has been given permission to make retainer payments for specific Home- and Community- Based Services (HCBS) providers who have not been allowed to provide services to members. Additional federal funds have been released for Medicaid and Children's Health Insurance Program (CHIP) providers. Providers may access these funds by submitting an application through the enhanced provider relief fund portal located on the DHS website. Mike continues to hold weekly calls with stakeholders regarding the coronavirus emergency. Mike noted that Angela Burke Boston had requested information regarding spending on hemophilia drugs, this information has been put together and is being peer-reviewed and will be distributed to the board prior to the next meeting.

Mary Nelle thanked Mike for all the flexibility IME has allowed providers to have during the coronavirus emergency, and asked if this will continue moving forward. Mike stated that the IME would continue some of these flexibilities, specifically telehealth services.

Senator Dennis Guth asked if there are Medicaid members who have tested positive for COVID-19. Mike stated that yes there are Medicaid members who have tested positive, and that the Department is closely monitoring this information.

Updates from the MCOs
John Hedgecoth, of Amerigroup Iowa, Inc., presented an update to the Board. Amerigroup continues to work with the IME in response to the coronavirus emergency. Amerigroup has engaged in direct outreach to its members, working on food insecurity connecting members with the Supplemental Nutrition Assistance Program (SNAP) and the Women, Infants, and Children (WIC) program. Amerigroup's foundation has donated to several foodbanks across the state. Amerigroup obtained and distributed 65,000 Personal Protective Equipment (PPE) masks, primarily amongst Medicaid providers.

Gabe Medley, of Iowa Total Care (ITC), presented an update. ITC has been working in partnership with the IME in response to the coronavirus emergency. ITC has been working with staff and providers to make sure members are still able to receive services. ITC has made an effort to communicate to members resources available to them during the coronavirus emergency, such as Test Iowa and COVID Recovery Iowa. ITC recently implemented a texting program, adding an additional channel of communication between ITC and its members. ITC is continuing its outreach campaign to new mothers, in an attempt to avoid or reduce Neonatal Intensive Care Unit (NICU) stays.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update. Due to the shutdown of dental services during the coronavirus emergency, DDIA is tracking large decreases in service utilization by Hawki children. The order eliminating all but emergency dental services expired on May 8, 2020, and DDIA has since seen an increase in services. Traditionally June, July and August are popular months for children to receive preventative dental services. DDIA has heard from some Federally Qualified Health Centers (FQHCs) that some centers are only providing emergency dental services due to a PPE shortage. DDIA has seen an uptick in telehealth services.

Dr. Kaaren Vargas asked if telehealth services were being reimbursed. Mike answered that this was being evaluated.

Eric asked if there were reports of an uptick in telehealth services. Mike answered that they had seen a significant increase, as well as an increase in home-delivered meals. The IME has opened up reimbursement for home-delivered meals to a wider pool of members.

Managed Care Quarterly Report

Mike presented the Managed Care Quarterly Report for State Fiscal Year (SFY) 2020 Quarter 2. Enrollment was relatively flat during this period, Mike noted it this is the first time in a long time that enrollment has been relatively flat. ITC reported several decreases in participant survey data points due to an issue with their survey vendor, a large percentage of members answered questions with "I don't know" or "I do not understand". Moving forward ITC will conduct surveys in-house. Mike covered enrollment figures, secret shopper data, non-pharmacy claims data, prior authorization (PA) data, and pharmacy claims data.

Communications Update

Kevin Kirkpatrick provided a brief IME Communications update, noting there are no major communications issues regarding Hawki. With disenrollments and premiums suspended, there are not many communications going out to members.

Outreach

Jean Johnson, of Iowa Department of Public Health (IDPH), gave an update on Hawki outreach. Jean noted that the big push for outreach during the pandemic was in March and April and that the outreach program has since slowed down. Jean stated that she has been working closely with Mary Nelle. Jean stated there will be a virtual nurse's conference in July.

Public Comment

There were no public comments.

New Business

Eric stated that the board needed to create a committee to nominate the chair and vice chair of the board. Eric asked Jim Donoghue to head the nominating committee as he has worked on it in the past. Shawn volunteered to join the nominating committee.

Mary Nelle requested an update on where Iowa's CHIP program stands in terms of offering behavioral health services.

Next Meeting

The next meeting will be August 17, 2020.

Meeting adjourned at 1:31 PM.

Submitted by,

Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Iowa Mental Health and Disability Services Commission

September 17, 2020

Commissioners

John Parmeter

Russell Wood

Betsy Akin

Cory Turner

Diane Brecht

Janee Harvey

Lorrie Young

Maria Sorensen

Richard Whitaker

Shari O'Bannon

Teresa Daubitz

Timothy Perkins

Ex-Officio

Commissioners

Sen. Jeff Edler

Rep. Joel Fry

Sen. Pam Jochum

Rep. Scott Ourth

EXECUTIVE SUMMARY

Pertinent Information Regarding the Deliberations of the Mental Health and Disability Services Commission Relating to Medicaid Managed Care (MCO)

Mental Health and Disability Services Commission Deliberations Summary:

December 5, 2019 – MHDS Commission Meeting
Marissa Eyanson, Iowa Medicaid Enterprise, discussed concerns regarding Iowa Total Care (ITC) claims, new case management rules and rate setting.

January 16, 2020 – MHDS Commission Meeting
Theresa Armstrong, Bureau Chief Mental Health and Disability Services Community Services, discussed Medicaid looking at habilitation program including detailed assessments and tiered rates.

April 16, 2020 – MHDS Commission Meeting
Theresa Armstrong shared that Medicaid has applied for and been granted several waivers from CMS to support individual's access to services due to the pandemic.

September 17, 2020 – MHDS Commission Meeting
The Commission discussed its executive summary to the Department and the members' thoughts on Medicaid Managed Care over the previous year.

During the course of their deliberations, the Commission has heard of a number of concerns from stakeholders that remain similar to the concerns reported in 2019. The Commission is frustrated that we have not seen significant progress in the following areas and urges the Department of Human Services (Department) and Managed Care Organizations (MCOs) continued efforts to address the following:

- Lack of reimbursement to providers for same day treatment
- Delayed and partial payments to providers
- Delayed and/or reduced authorization for long term supports and services

- Confusion over administrative requirements for Integrated Health Homes
- Peer support and recovery peer support services are underutilized and underrepresented
- Increased administrative burdens and costs for providers particularly for keeping claims alive in order to receive payment
- Understaffed mental health providers and disability services workforce due to low rates for services involving direct support professionals
- Inconsistent communication from the MCOs and the Department and within the MCOs
- Increased oversight during times of transition is needed
- Lack of accessibility to additional 1915(b) (3) services under the Medicaid fee-for-service system
- Increased development of quality services, including evidenced based practices is needed
- Increased community capacity to serve the most vulnerable individuals is needed
- Inadequate service rates
- Delayed eligibility updates for individuals post incarceration on Medicaid's Eligibility and Verification Information System (ELVS) line has resulted in large recoupments for providers due to receiving inaccurate eligibility information
- Lack of a valid level of care assessment that captures the needs of individuals with a brain injury
- Continued development of services for individuals with intellectual disabilities including children is needed
- Behavioral health services have a more difficult time getting reimbursement from the MCOs than physical health services
- Procedural and financial barriers to providing integrated care

MANAGED CARE
OMBUDSMAN PROGRAM

QUARTERLY REPORT

Year 4, Quarter 2
(July 1 - September 30, 2019)

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, or elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs, which include: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

Beginning January 1, 2019 the reporting format for the Managed Care Ombudsman Program monthly reports changed. The Managed Care Ombudsman now only reports cases and complaints from the managed care members this Office serves. This reporting method more accurately reflects members served and those members' issues as opposed to the previous contacts reporting method.

The issuance of this quarterly report was significantly delayed due to a change in the federal reporting system for long-term care ombudsman programs which impacted the Managed Care Ombudsman Program's ability to compile figures and run reports. We apologize for any inconvenience this delay has caused and do not anticipate these types of delays in the future.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with individual member cases 53 in July, 46 in August and 53 in September.

The issues identified for this second quarter are the primary managed care member issues addressed in July, August and September 2019. The Office works with a variety of stakeholders who are necessary to address and resolve issues. The Office does so through a variety of methods, including encouraging use of best practices; facilitating and coordinating communication with necessary parties; and referring to outside agencies as necessary. During Quarter 2-Year 4 of Medicaid managed care, members reported the following primary issues:

1. Members are reporting challenges with their case management. Many members express concerns regarding conflicts of interest with internal case management. Members reported they feel their health needs are not being individually addressed and members are having to wait long periods of time to reach their case manager and to seek resolution.

2. Access to Services/Benefits. Waiver members reported a lack of available providers contracted with their Managed Care Organizations. The lack of providers available to members had a direct impact to the members overall health service benefits. Members were approved for services yet did not receive all services for which they were approved.

3. Members are reporting dissatisfaction with changes affecting their CDAC/CCO services. Changes include service reductions or denials and ability to self direct changes in day to day use of CDAC services. Members reported issues accessing the CDAC provider of their choosing, barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Medicaid members have reported CCO budgets have not been completed on time, effecting the members ability to schedule staff to provide services needed.

The report that follows includes an overview of the second programmatic quarter of Year 4 (July, August and September 2019), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.

MEMBER ASSISTANCE

Members per MCO[1] in process July 2019	Amerigroup Iowa	28
	Iowa Total Care	14
	UnitedHealthcare Plan of the River Valley	15
	Fee for Service	2
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	6
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	2
	Appeals assistance	5
	Fair Hearing assistance	1

Members per MCO[1] in process August 2019	Amerigroup Iowa	35
	Iowa Total Care	7
	UnitedHealthcare Plan of the River Valley	4
	Fee for Service	2
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	-
	Iowa Legal Aid	2
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	3
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	2
	Appeals assistance	2
	Fair Hearing assistance	-

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

MEMBER ASSISTANCE

Members per MCO[1] in process September 2019	Amerigroup Iowa	41
	Iowa Total Care	12
	UnitedHealthcare Plan of the River Valley	2
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	5
	Iowa Compass	1
	Iowa Legal Aid	-
	LifeLong Links	1
	MCO	2
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	5
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	2
	Fair Hearing assistance	1

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

A Intellectual Disability Waiver Member received an Exception to Policy from their MCO . The Managed Care Ombudsman Program worked with the member's MCO, IME and Veridian to resolve the issue quickly. The MCO worked with Veridian on the authorization for the budget to be completed and uploaded. The case manager contacted the member and assisted with the scheduled and authorized CCO services to begin in the home. The staff were able to provide services and upload their documentation on time ensuring the member did not experience a gap in health services.

Complaint(s) Resolution by Program Type

Amerigroup Iowa July, August and September	Resolved to Member's satisfaction			Partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	A	S	J	A	S	J	A	S	J	A	S	J	A	S	
AIDS/HIV Waiver				-	-	-	-	-	-				-	-	-	0
Brain Injury Waiver	2	2		-	-	-	-	-	-	-	-	-	1	-	-	5
Children's Mental Health Waiver				-	-	-	-	-	-	-	-	-	-	-	-	0
Dental				-	-	-	-			-	-	-	-	-	-	0
Duals				-	3	-							-	-	-	3
Elderly Waiver	7	7	14	-	-	-	-	-	-	-	-	-	26	18	20	92
Habilitation				-	-	-	-	-	-	-	-	-	-	-	-	0
Health & Disability Waiver	11	2	7	-	-	-	-	-	-	-	-	-	20	3	-	43
HIPP				-	-	-	-	-	-	-	-	-	-	-	-	0
Institutional Care													-	-	-	0
Iowa Health & Wellness				-	-	-	-	-	-	-	-	-	-	-	-	0
Intellectual Disability Waiver	9	2	14	-	-	-	-	1	-			1	15	13	13	68
Medicare				-	-	-	-	-	-	-	-	-	-	-	-	0
PACE													-	-	-	0
Physical Disability Waiver	5		2	-	-	-	-	-	-	-	-	-	10	--	4	21
QMB or SLMB													-	-	-	0
Traditional Medicaid				-	-	-	-	-	-	-	-	-	-	-	-	0
Other			1										-	-	5	6
N/A													-	-	-	0
Unknown													-	-	-	0
TOTAL:	34	13	38	0	3	0	0	1	0	0	0	1	72	34	42	238

UnitedHealthcare Plan of the River Valley July, August and September	Resolved to Member's satisfaction			Partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	A	S	J	A	S	J	A	S	J	A	S	J	A	S	
AIDS/HIV Waiver				-	-	-	-	-	-			-	-	-		0
Brain Injury Waiver				-	-		-	2	-	-	-	-	-	2		4
Children's Mental Health Waiver				-	-		-	-	-	-	-	-	-	-		0
Dental				-	-		-				-		-	-		0
Duals				1	-		5			-		-	-	-		6
Elderly Waiver	1			-	1	-		2	-	-	-	-	1	-		5
Habilitation				-	-	-	-	-	-	-	-	-	-	-		0
Health & Disability Waiver				-	4	-	-	1	-	-	-	-	-	-		5
HIPP				-	-	-	-	-	-	-	-	-	-	-		0
Institutional Care														-		0
Iowa Health & Wellness				-	-	-	-	-	-		-		-	-		0
Intellectual Disability Waiver	5	2	2	-	-	-	-	3	-	3	-	-	5		4	24
Medicare				-	-	-	-	-	-	-	-	-	-	-		0
PACE													-	-		0
Physical Disability Waiver	3			2	-	-	3	-	-	-	-	-	-	-		8
QMB or SLMB													-	-		0
Traditional Medicaid				-		-	-		-		-	-		-		0
Other					1			3				1	1	-		6
N/A										1			1	-		2
Unknown													-	-		0
TOTAL:	9	2	2	3	6	0	8	11	0	4	0	1	8	2	4	60

Complaint(s) Resolution by Program Type

Fee for Service July, August and September	Resolved to Member's satisfaction			Partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	A	S	J	A	S	J	A	S	J	A	S	J	A	S	
AIDS/HIV Waiver		-	-	-	-	-	-	-	-			-	-	-		0
Brain Injury Waiver		-	-	-	-	-	-	-	-	-	-	-	-	-		0
Children's Mental Health Waiver			-	-	-	-	-	-	-	-	-	-	-	-		0
Dental				-	-	-	-			-	-					0
Duals			-	-	-	-						-	-			0
Elderly Waiver	4	3		-	-	-	-	-	-	-	-		7			14
Habilitation			-	-	-	-	-	-	-	-	-	-		-		0
Health & Disability Waiver		-	-	-	-	-	-	-	-	-	-	-	-			0
HIPP		-	-	-	-	-	-	-	-	-	-	-	-	-		0
Institutional Care		-	-									-	-	-		0
Iowa Health & Wellness		-	-	-	-	-	-	-	-	-	-	-	-	-		0
Intellectual Disability Waiver		-	-	-	-	-	-	-	-	-	-	-				0
Medicare		-	-	-	-	-	-	-	-	-	-	-	-	-		0
PACE		-	-									-	-	-		0
Physical Disability Waiver				-	-	-	-	-	-	-	-					0
QMB or SLMB		-	-									-	-	-		0
Traditional Medicaid		-	-	-		-	-	-	-	-		-	-			0
Other	-				4									7		11
N/A	-	-	-								-	-	-	-	-	0
Unknown	-	-	-							-		-	-	-		0
TOTAL:	4	3	0	0	4	0	0	0	0	0	0	0	7	7	0	25

Iowa Total Care July, August and September	Resolved to Member's satisfaction			Partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	A	S	J	A	S	J	A	S	J	A	S	J	A	S	
AIDS/HIV Waiver		-	-	-	-	-	-	-	-			-		-	-	0
Brain Injury Waiver		-	-	-	-	-	-	-	-	-	-	-		-	-	0
Children's Mental Health Waiver		-	-	-	-	-	-	-	-	-	-	-		-	-	0
Dental				-	-	-	-			-	-					0
Duals		-	-	-	-	-						-		-		0
Elderly Waiver	10			-	-	-	-	-	-	-	-		10		3	23
Habilitation	2	-	-	-	-	-	-	-	-	-	-	-	2	-	-	4
Health & Disability Waiver	4	-	-	-	-	2	-	-	-	-	-	1	4	-	3	14
HIPP		-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Institutional Care		-	-									-	-	-	-	0
Iowa Health & Wellness		-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
Intellectual Disability Waiver	12	-	4	-	-	-	-	-	-	-	-	-	12	3	6	37
Medicare		-	-	-	-	-	-	-	-	-	-	-	-	-	-	0
PACE		-	-									-	-	-	-	0
Physical Disability Waiver				-	-	-	-	-	-	-	-					0
QMB or SLMB		-	-									-	-	-	-	0
Traditional Medicaid			-	-	-	-	-	-	-	-		-	-			0
Other		1												6	10	17
N/A		-	-								-	-	-	-	-	-
Unknown		-	-							-		-	-	-	-	-
TOTAL:	28	1	4	0	0	2	0	0	0	0	0	1	28	9	22	95

COMPLAINTS & CASES

JULY

In July, the Managed Care Ombudsman Program worked on complaints from 53 individual members. Out of the 39 active cases, 15 are newly open. The top complaint from managed care members in July was in regard to Case Management (26 members). Additional complaints include:

All open cases:
Case Management (13 members) Access to Services/Benefits (8 members) Services reduced, denied or terminated (7 members) CCO & CDAC (8 members) Transition services/coverage gap, inadequate or inaccessible (2 members)Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (5 members) Member Rights (5 members) Level of Care (4 members) NOD, Appeals, Fair Hearing (3 members) Complaints against provider (1 member) Eligibility & Enrollment (4 members) Care Planning (7 members) Access to durable medical equipment and medications (6 members) Discharge (2 members) Transportation (3 members)Home and vehicle modifications (1 member) Member Relations & Grievances (3 members) Guardianship (1 member)

Closed cases:
Case Management (13 members) Access to Services/Benefits (6 members) Services reduced, denied or terminated (6 members) CCO & CDAC (11 members) Transition services/coverage gap, inadequate or inaccessible (6 members) Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (7 members) Member Rights (9 members) Level of Care (4 members) NOD, Appeals, Fair Hearing (3 members) Complaints against provider (4 members) Eligibility & Enrollment (5 members) Care Planning (2 members)Access to durable medical equipment and medications (3 members) Discharge (3 members) Transportation (2 members) Home and vehicle modifications (2 members) Member Relations & Grievances (4 members) Guardianship (1 member)

AUGUST

In August, the Managed Care Ombudsman Program worked on complaints from 46 individual members. Out of the 30 active cases, 16 are newly open. The top complaint from managed care members in August was in regard to Case Management (26 members). Additional complaints include:

All open cases:
Case Management (18 members) Access to Services/Benefits (11 members) Services reduced, denied or terminated (8 members) CCO & CDAC (10 members) Transition services/coverage gap, inadequate or inaccessible (2 members) Other/Member charged improper cost sharing or needing an ETP (6 members) Member Rights (5 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (4 member) Eligibility & Enrollment (3 members) Care Planning (10 members) Access to durable medical equipment and medications (6 members) Discharge (3 members) Transportation (3 members) Home and vehicle modifications (0 members) Member Relations & Grievances (2 members) Guardianship (2 members)

COMPLAINTS & CASES

Closed cases:
Case Management (8 members) Access to Services/Benefits (2 members) Services reduced, denied or terminated (5 members) CCO & CDAC (5 members) Transition services/coverage gap, inadequate or inaccessible (2 members) Other/Member charged improper cost sharing or needing an ETP (3 members) Member Rights (0 members) Level of Care (1 member) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (0 members) Eligibility & Enrollment (4 members) Care Planning (2 members) Access to durable medical equipment and medications (2 members) Discharge (0 members) Transportation (2 members) Home and vehicle modifications (2 members) Member Relations & Grievances (1 member) Guardianship (0 members)

SEPTEMBER

In September, the Managed Care Ombudsman Program worked on complaints from 53 individual members. Out of the 30 active cases, 25 are newly open. The top complaint from managed care members in September was in regard to Case Management (24 members). Additional complaints include:

All open cases:
Case Management (15 members) Access to Services/Benefits (16 members) Services reduced, denied or terminated (9 members) CCO & CDAC (8 members) Transition services/coverage gap, inadequate or inaccessible (2 members) Other/Exception to Policy and Prior Authorizations (7 members) Member Rights (6 members) Level of Care (5 members) NOD, Appeals, Fair Hearing (4 members) Complaints against provider (3 member) Eligibility & Enrollment (2 members) Care Planning (7 members) Access to durable medical equipment and medications (6 members) Discharge (3 members) Transportation (5 members) Home and vehicle modifications (0 members) Member Relations & Grievances (3 members) Guardianship (1 member)

Closed cases:
Case Management (9 members) Access to Services/Benefits (6 members) Services reduced, denied or terminated (4 members) CCO & CDAC (6 members) Transition services/coverage gap, inadequate or inaccessible (2 members) Other/Exception to Policy and Prior Authorizations (2 members) Member Rights (1 member) Level of Care (1 member) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (1 member) Eligibility & Enrollment (1 member) Care Planning (1 member) Access to durable medical equipment and medications (5 members) Discharge (1 member) Transportation (3 members) Home and vehicle modifications (0 members) Member Relations & Grievances (2 members) Guardianship (0 members)

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. Effective July 1, 2019 Medicaid members have the option of choosing either Iowa Total Care or Amerigroup.

2. Effective July 1, 2019 Brain Injury Waiver recipients no longer need to request an exception to policy (ETP) to exceed the monthly cap allowed under the Brain Injury Waiver.

3. Case Management. Members reported challenges when trying to reach their case manager and long wait times to hear back from the case manager. Members have been assigned new case managers multiple times at the direction of the MCO. During the transition period members assigned to a new MCO waited months to hear from their new case manager.

4. Lack of Providers. Members have reported a lack of approved providers to choose from in order to receive health services. Reasons shared for lack of providers are that the MCO and/or the provider are not wanting to contract with one another. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers as well as CDAC staff. Some members have lost their providers due to the provider not being paid for services rendered.

5. CDAC and CCO Impacts. Consumer Directed Attendant Care and Consumer Choice Options, are choices available to Medicaid members who are eligible for one of the home and community-based services (HCBS) waiver programs and is a service frequently used by HCBS waiver members. The Managed Care Ombudsman Program continues to receive a high number of complaints from members reporting dissatisfaction with changes affecting their CDAC services. Changes include service reductions or denials, and also changes that impact the day to day use of CDAC services. Members reported issues accessing the CDAC provider of their choosing, barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Medicaid members have reported CCO budgets have not been completed on time, effecting the members ability to schedule staff to provide services needed. Many providers have lost their CDAC staff due to payment issues, lengthy periods of time to become an approved CDAC provider even when already approved through the state and lack of available CDAC providers available to them.

6. Services are being reduced, denied or terminated for members needing long-term services and supports. Members needing long-term services and supports reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often effected CDAC and consumer choice options (CCO) service hours. In response to reductions in services, members are requesting formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

7. Transportation issues created challenges for many members trying to attend regularly scheduled medical appointments or access specialty healthcare. Members reported safety concerns with new transportation individuals who were strangers to the members and who did not understand the individual member needs or did not have vehicles equipped for specific types of medical equipment. Members were not always able to choose their provider of choice.

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

8. Transition services/coverage gap, inadequate or inaccessible. Members and their legal guardians report members are transitioned without a care plan established which fits the needs of the member during the transition. This disruption in the continuity of care of the member creates a gap of services where the member does not receive the care they need placing the member at risk.

A Medicaid member on the Intellectual Disability Waiver program was transitioned to a new MCO beginning July 1, 2019. The member had faced a reduction of CCO hours, denial in medication, and primary care physician of choice. The Managed Care Ombudsman informed the family of the members right to receive a Notice of Decision and Appeal and Grievance rights. The MCO was informed of the issues and approved the CCO hours needed in the home, called the pharmacy to approve the medication and assigned the primary care physician of choice.

COMMUNITY PARTNERSHIPS AND OUTREACH

Advocacy is more than complaint resolution or assistance with filing a grievance, appeal or fair hearing. It includes providing education, information, consultation, technical assistance or making a referral to the appropriate entity to ensure members have the information needed to make informed decisions regarding their care, in addition to partnering with community stakeholders to connect members to resources beyond the Managed Care Ombudsman's scope.

The Managed Care Ombudsman Program networks with other advocacy and provider groups, associations, organizations and agencies to coordinate the provision of assistance to members. The Managed Care Ombudsman Program also participates, when possible, in various forums and work groups on a regular basis to inform and discuss and to address collective concerns expressed.

ADDITIONAL MATERIALS

The Managed Care Ombudsman Program maintains a website with information regarding the program's services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at the Managed Care Ombudsman website. Additionally, How to Be Your Own Best Advocate: A Guide on How to Navigate Managed Care In Iowa is a resource for members.

UPCOMING EVENTS

Assessing the Humanity of Nursing Home Care: A Special Report From the Long Term Care Community Coalition
Jan. 21 (12:00 pm)
More Information | Register

Jessie Parker Building
510 E. 12th Street, Ste. 2
Des Moines, IA 50319
www.iowaaging.gov

866.236.1430
ManagedCareOmbudsman@iowa.gov

MANAGED CARE OMBUDSMAN PROGRAM
QUARTERLY REPORT

Year 4, Quarter 3
(October 1 - December 31, 2019)

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, or elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs, which include: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

Beginning January 1, 2019 the reporting format for the Managed Care Ombudsman Program monthly reports changed. The Managed Care Ombudsman now reports cases and complaints from the managed care members this Office serves. This reporting method more accurately reflects members served and those members' issues as opposed to the previous contacts reporting method.

The issuance of this quarterly report was significantly delayed due to a change in the federal reporting system for long-term care ombudsman programs which impacted the Managed Care Ombudsman Program's ability to compile figures and run reports. We apologize for any inconvenience this delay has caused and do not anticipate these types of delays in the future.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with individual member cases 63 in October, 55 in November and 59 in December.

The issues identified for this third quarter are the primary managed care member issues addressed in October, November and December 2019. The Office works with a variety of stakeholders who are necessary to address and resolve issues. The Office does so through a variety of methods, including encouraging use of best practices; facilitating and coordinating communication with necessary parties; and referring to outside agencies as necessary. During Quarter 3-Year 4 of Medicaid managed care, members reported the following primary issues:

1. Access to Services/Benefits. Waiver members reported a lack of available providers contracted with their Managed Care Organizations as well as a lack of staff available within certain provider agencies. The lack of providers available to members had a direct impact to the members' overall health service benefits. As such members were approved for services yet did not receive all services for which they were approved.

2. Members are reporting issues with their case management. Members continue to experience delayed response time from case managers and a lack of support and understanding of their health needs. At times members were assigned new case managers against the members wishes at times, requiring the member to build new relationships and endure a lack of consistency and understanding of their overall goals and health care needs.

3. Services reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reduction in services, members are filing grievances, formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

The report that follows includes an overview of the third programmatic quarter of Year 4 (October, November and December 2019), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.

MEMBER ASSISTANCE

Category	Item	Count
Members per MCO[1] in process October 2019	Amerigroup Iowa	40
	Iowa Total Care	22
	UnitedHealthcare Plan of the River Valley	4
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	3
	Department of Inspections and Appeals	2
	Disability Rights Iowa	11
	Iowa Compass	1
	Iowa Legal Aid	10
	LifeLong Links	1
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	11
	Other	4
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	2
	Fair Hearing assistance	1

Category	Item	Count
Members per MCO[1] in process November 2019	Amerigroup Iowa	34
	Iowa Total Care	18
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	1
	Department of Inspections and Appeals	-
	Disability Rights Iowa	2
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	1
	Fair Hearing assistance	1

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

MEMBER ASSISTANCE

Category	Item	Count
Members per MCO[1] in process December 2019	Amerigroup Iowa	40
	Iowa Total Care	16
	UnitedHealthcare Plan of the River Valley	2
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	1
	Disability Rights Iowa	3
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	2
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	5
	Other	2
Grievances/Appeals/Fair Hearings	Grievance assistance	-
	Appeals assistance	1
	Fair Hearing assistance	1

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

A Intellectual Disability Waiver Member received a Notice of Decision from their MCO without appeal or grievance information. When the guardian tried to assist the member by calling the MCO, they were told guardianship papers were not found. The Managed Care Ombudsman Program worked with the member's MCO, IME and guardians to ensure a new case manager was assigned as requested and guardianship papers were accessible. Once the proof of guardianship was uploaded, the guardians were able to file a grievance and support the member. A new case manager contacted the family and assisted with the care planning necessary for CDAC, SCL , Day HAB and Respite services to continue ensuring the member did not experience a gap in health services.

Complaint(s) Resolution by Program Type

Amerigroup Iowa October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver	2									2		6	10
Children's Mental Health Waiver												3	3
Dental													
Duals													
Elderly Waiver	3	16	5		1			4		21	2	1	53
Habilitation			2									2	4
Health & Disability Waiver			4							7	4	10	25
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	9	3	13	4						19	5	10	63
Medicare													
PACE													
Physical Disability Waiver			3							2			5
QMB or SLMB													
Traditional Medicaid													
Other	1	1	4							8	1	4	19
N/A													
Unknown													
TOTAL:	15	20	31	4	1	0	0	4	0	59	12	36	182

UnitedHealthcare Plan of the River Valley October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver	1									1			2
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver				4			3			1			8
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other			1								1		2
N/A													
Unknown													
TOTAL:	1	0	1	4	0	0	3	0	0	2	1	0	12

Complaint(s) Resolution by Program Type

Fee for Service October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver			3										3
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other													
N/A													
Unknown													
TOTAL:	0	0	3	0	0	0	0	0	0	0	0	0	3

Iowa Total Care October, November and December	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	O	N	D	O	N	D	O	N	D	O	N	D	
AIDS/HIV Waiver													
Brain Injury Waiver		4								4			8
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver	4	3	7							7		6	27
Habilitation		2								2			4
Health & Disability Waiver			4							10	1	3	18
HIPP													
Institutional Care													
Iowa Health & Wellness		1									1		2
Intellectual Disability Waiver			9			1				3	3		16
Medicare													
PACE													
Physical Disability Waiver										4			4
QMB or SLMB													
Traditional Medicaid													
Other		9								4			13
N/A													
Unknown													
TOTAL:	4	19	20	0	0	1	0	0	0	34	5	9	92

COMPLAINTS & CASES

OCTOBER

In October the Managed Care Ombudsman Program worked on complaints from 63 individual members. Out of the 43 active cases, 23 are newly open. The top complaint from managed care members in October was in regard to Access to Services/Benefits (33 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (22 members) Services reduced, denied or terminated (12 members) CCO & CDAC (7 members) Transition services/coverage gap, inadequate or inaccessible (7 members) Member Rights (15 members) Level of Care (10 members) NOD, Appeals, Fair Hearing (6 members) Complaints against provider (1 member) Eligibility & Enrollment (7 members) Care Planning (12 members) Access to durable medical equipment and medications (6 members) Discharge (2 members) Transportation (9 members) Home and vehicle modifications (2 members) Member Relations & Grievances (5 members) Guardianship (2 member) Network Adequacy (4 members) Exception to Policy (2 members)

Closed cases:
Case Management (7 members) Access to Services/Benefits (11 members) Services reduced, denied or terminated (5 members) CCO & CDAC (5 members) Transition services/coverage gap, inadequate or inaccessible (0 members) Member Rights (2 members) Level of Care (2 members) NOD, Appeals, Fair Hearing (1 member) Complaints against provider (3 members) Eligibility & Enrollment (1 member) Care Planning (1 member) Access to durable medical equipment and medications (4 members) Discharge (2 members) Transportation (7 members) Home and vehicle modifications (0 members) Member Relations & Grievances (4 members) Guardianship (0 members) Network Adequacy (2 members) Exception to Policy (0 members)

NOVEMBER

In November the Managed Care Ombudsman Program worked on complaints from 55 individual members. Out of the 38 active cases, 7 are newly opened. One case was not captured in the previous November grids due to eligibility not determined at that time. The top complaint from managed care members in November was in regard to Access to Services/Benefits (29 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (20 members) Services reduced, denied or terminated (14 members) CCO & CDAC (11 members) Transition services/coverage gap, inadequate or inaccessible (8 members) Member Rights (10 members) Level of Care (8 members) NOD, Appeals, Fair Hearing (5 members) Complaints against provider (3 members) Eligibility & Enrollment (6 members) Care Planning (15 members) Access to durable medical equipment and medications (8 members) Discharge (4 members) Transportation (4 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (0 members) Network adequacy (4 members) Prior Authorization (3 members) Exception to Policy (1 member)

COMPLAINTS & CASES

Closed cases:
Case Management (6 members) Access to Services/Benefits (9 members) Services reduced, denied or terminated (1 member) CCO & CDAC (1 member) Transition services/coverage gap, inadequate or inaccessible (1 member) Member Rights (3 members) Level of Care (4 members) NOD, Appeals, Fair Hearing (0 members) Complaints against provider (0 members) Eligibility & Enrollment (4 members) Care Planning (4 members) Access to durable medical equipment and medications (4 members) Discharge (0 members) Transportation (4 members) Home and vehicle modifications (0 members) Member Relations & Grievances (1 members) Guardianship (1 member) Network adequacy (1 member) Prior Authorization (1member) Exception to Policy (1 member)

DECEMBER

In December the Managed Care Ombudsman Program worked on complaints from 59 individual members. Out of the 38 active cases, 14 are newly opened. The top complaint from managed care members in December was in regard to Access to Services/Benefits (29 members). Additional complaints include:

All open cases:
Case Management (13 members) Access to Services/Benefits (19 members) Services reduced, denied or terminated (13 members) CCO & CDAC (7 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Other/Lack of staff available within an agency (2 members) Member Rights (10 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (3 members) Complaints against provider (6 members) Eligibility & Enrollment (3 members) Care Planning (12 members) Access to durable medical equipment and medications (13 members) Discharge (5 members) Transportation (6 members) Home and vehicle modifications (2 members) Member Relations & Grievances (8 members) Guardianship (2 members) Prior Authorization (6 members) Network Adequacy (3 members) Exception to Policy (2 members)

Closed cases:
Case Management (8 members) Access to Services/Benefits (10 members) Services reduced, denied or terminated (2 members) CCO & CDAC (6 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Other/Lack of staff available within an agency (0 members) Member Rights (5 members) Level of Care (3 members) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (0 members) Eligibility & Enrollment (5 members) Care Planning (5 members) Access to durable medical equipment and medications (2 members) Discharge (6 members) Transportation (1 member) Home and vehicle modifications (0 members) Member Relations & Grievances (0 members) Guardianship (1 member) Prior Authorization (2 members) Network Adequacy (2 members) Exception to Policy (1 member)

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. Lack of Providers. Members have reported a lack of approved CDAC providers as well as an overall lack of providers accessible to the members to provide services. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers as well as CDAC staff. Some members have lost their providers due to the provider not being paid for services rendered.

2. CDAC and CCO Impacts. CDAC and CCO are choices available to managed care members who are eligible for one of the home and community-based services (HCBS) waiver programs and is a service frequently used by HCBS waiver members. The Managed Care Ombudsman Program continues to receive a high number of complaints from members reporting dissatisfaction with changes affecting their CDAC services. Changes include service reductions or denials, and also changes that impact the day to day use of CDAC services. Members reported issues accessing new CDAC providers of their choosing, barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Managed care members have reported CCO budgets have not been completed on time, effecting the members ability to schedule staff to provide services needed.

3. Transportation issues created challenges for many members trying to attend regularly scheduled medical appointments or access specialty healthcare. Members reported safety concerns with new transportation providers who were strangers to the members, who did not understand the individual member needs, or did not have vehicles equipped for specific types of medical equipment. Members were not always able to utilize their provider of choice.

4. Guardianship issues. During the transitions between different MCOs, member information was not transferred over in a timely manner, which impacted the time frame for MCO contact with the member and/or guardian to establish healthcare meetings, assessments and overall services. Members report at times, decisions and changes were made without the guardians involvement and support.

5. Provider and Facility Nonpayment. Providers continue to report nonpayment or receive inadequate payment from the members assigned MCO. Some CDAC providers have had to find other means of employment to make ends meet and at times this has placed the member at risk in their home without staff or services which have been approved to meet the members level of care. Lack of payment and late payments, have had a direct impact on the amount of providers available to provide services necessary to adequately maintain a member's daily health requirements.

6. Denials of durable medical equipment (DME). Medicaid members experienced denials when trying to obtain DME prescribed and recommended by their physician, resulting in members filing appeals and/or fair hearing requests. Members reported the lack of contracted providers willing to work with the MCOs, which created more barriers for members to receive DME.

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

7. Prior authorization. Many prescriptions and medical services were requiring a prior authorization for the first time. The time for prior authorizations to be approved or resubmitted due to initial denials, lengthened wait times for the member to receive prescribed medications and medical care.

A Medicaid member on the Intellectual Disability Waiver program lost eligibility due to a language barrier during the eligibility review process. The Managed Care Ombudsman Program worked with IME and the family to request an exception to policy to assist the member with getting back on the Intellectual Disability Waiver. The MCO has assisted with access to health services needed until the member is approved for the waiver again.

ADDITIONAL MATERIALS

The Managed Care Ombudsman Program maintains a website with information regarding the program's services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at the Managed Care Ombudsman website. Additionally, How to Be Your Own Best Advocate: A Guide on How to Navigate Managed Care In Iowa is a resource for members.

UPCOMING EVENTS

Quarterly Provider Training Sessions 2020
Quarter 2, Home- and Community-Based Services (HCBS) Waivers and Consumer-Directed Attendant Care (CDAC)
March 2020 (final date TBA), 9 am – 12 pm & 1 pm – 4 pm
Location: Mason City

Quarter 3 Annual Provider Training, All Topics
Locations: Cedar Rapids, Davenport, Des Moines, Dubuque, Sioux City, Waterloo
June 2020 (final date TBA), 9 am – 12 pm & 1 pm – 4 pm

Quarter 4 Session, Topic: Durable Medical Equipment (DME)
September 2020 (final date TBA)

Jessie Parker Building
510 E. 12th Street, Ste. 2
Des Moines, IA 50319
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MANAGED CARE
OMBUDSMAN PROGRAM

QUARTERLY REPORT

Year 4, Quarter 4
(January 1 - March 31, 2020)

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs. The waiver programs include: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

The Managed Care Ombudsman Program's monthly and quarterly report reports cases and complaints from the managed care members this Office serves. With the goal of accurately reflecting members served and those members' issues as opposed to the previous contacts reporting method.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with 56 individual member cases in January, 77 individual member cases in February, and 46 individual member cases in March.

The issues identified for this fourth quarter are the primary managed care member issues addressed in January, February and March 2020. The Office works with a variety of stakeholders who are necessary to address and resolve issues. During Quarter 4-Year 4 of Medicaid managed care, the primary issues reported to the Managed Care Ombudsman Program by managed care members continued to be that same as reported last quarter and included:

1. Access to Services/Benefits. Waiver members reported a lack of available providers contracted with their Managed Care Organizations as well as a lack of staff available within certain provider agencies. The lack of providers available to members had a direct impact to the members' overall health service benefits. As such members were approved for services yet did not receive all services for which they were approved.

2. Members are reporting issues with their case management. Members continue to experience delayed response time from case managers and a lack of support and understanding of their health needs. At times members were assigned new case managers against the members wishes at times, requiring the member to build new relationships and endure a lack of consistency and understanding of their overall goals and health care needs.

3. Services reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reduction in services, members are filing grievances, formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

The report that follows includes an overview of the fourth programmatic quarter of Year 4 (January, February and March 2020), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.

MEMBER ASSISTANCE

Members per MCO[1] in process January 2020	Amerigroup Iowa	40
	Iowa Total Care	13
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	2
Referrals per Entity[2]	Department of Human Services	3
	Department of Inspections and Appeals	-
	Disability Rights Iowa	8
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	5
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	5
	Appeals assistance	4
	Fair Hearing assistance	2

Members per MCO[1] in process February 2020	Amerigroup Iowa	65
	Iowa Total Care	10
	UnitedHealthcare Plan of the River Valley	1
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	5
	Iowa Compass	-
	Iowa Legal Aid	-
	LifeLong Links	-
	MCO	7
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	1
	State Ombudsman Office	-
	Other	3
Grievances/Appeals/Fair Hearings	Grievance assistance	5
	Appeals assistance	3
	Fair Hearing assistance	-

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

MEMBER ASSISTANCE

Members per MCO[1] in process March 2020	Amerigroup Iowa	39
	Iowa Total Care	7
	UnitedHealthcare Plan of the River Valley	-
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	8
	Iowa Compass	1
	Iowa Legal Aid	2
	LifeLong Links	1
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	-
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	6
	Fair Hearing assistance	1

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

The Managed Care Ombudsman Program would like to remind manged care members that their managed care organization may have a value add program that could provide the member with a cell phone. Please contact your case manager for additional information.

Due to the COVID-19 pandemic, many states have applied for and been granted waivers from some CMS requirements related to managed care. You can find information regarding these waivers on the DHS website, and Informational Letter 2127-MC-FFS-CVD.

Complaint(s) Resolution by Program Type

Amerigroup Iowa January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver											2		2
Brain Injury Waiver			4							8		3	15
Children's Mental Health Waiver													
Dental													
Duals	1									1			2
Elderly Waiver		43	7							7	10	3	70
Habilitation		1								1	4		6
Health & Disability Waiver	6	12	1							5	3	6	33
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	6	36	12						2	22	14	6	98
Medicare													
PACE													
Physical Disability Waiver	2	3									3	7	15
QMB or SLMB													
Traditional Medicaid													
Other	3	1	10							3	3	5	25
N/A													
Unknown													
TOTAL:	18	96	34	0	0	0	0	0	2	47	39	30	266

UnitedHealthcare Plan of the River Valley January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver													
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other			1								1		2
N/A													
Unknown													
TOTAL:	0	0	1	0	0	0	0	0	0	0	1	0	2

Complaint(s) Resolution by Program Type

Fee for Service January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver			3										3
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other		5			1			1		5			12
N/A													
Unknown													
TOTAL:	0	5	3	0	1	0	0	1	0	5	0	0	15

Iowa Total Care January, February and March	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	J	F	M	J	F	M	J	F	M	J	F	M	
AIDS/HIV Waiver													
Brain Injury Waiver		5											5
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver										2			2
Habilitation													
Health & Disability Waiver	3	3								3	3	2	14
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver													
Medicare													
PACE													
Physical Disability Waiver												3	3
QMB or SLMB													
Traditional Medicaid		1									7		8
Other	2	4							1	2			9
N/A													
Unknown									-				
TOTAL:	5	13	0	0	0	0	0	0	1	7	10	5	41

COMPLAINTS & CASES

JANUARY

In January the Managed Care Ombudsman Program worked on complaints from 56 individual members. Out of the 46 active cases, 15 are newly opened. The top complaint from managed care members in January was in regard to Access to Services/Benefits (22 members). Additional complaints include:

All open cases:
Case Management (11 members) Access to Services/Benefits (18 members) Services reduced, denied or terminated (18 members) CCO & CDAC (14 members) Transition services/coverage gap, inadequate or inaccessible (6 members) Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (2 members) Member Rights (13 members) Level of Care (12 members) NOD, Appeals, Fair Hearing (8 members) Complaints against provider (6 members) Eligibility & Enrollment (9 members) Care Planning (12 members) Access to durable medical equipment and medications (10 members) Discharge (5 members) Transportation (7 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (1 member) Network Adequacy (4 members) Prior Authorization (5 members) Exception to Policy (3 members)

Closed cases:
Case Management (5 members) Access to Services/Benefits (4 members) Services reduced, denied or terminated (1 member) CCO & CDAC (0 members) Transition services/coverage gap, inadequate or inaccessible (0 members) Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (0 members) Member Rights (1 member) Level of Care (1member) NOD, Appeals, Fair Hearing (1 member) Complaints against provider (1 member) Eligibility & Enrollment (1 member) Care Planning (2 members) Access to durable medical equipment and medications (3 members) Discharge (1 member) Transportation (3 members) Home and vehicle modifications (1 member) Member Relations & Grievances (1 member) Guardianship (2 members) Network Adequacy (0 members) Prior Authorization (2 members) Exception to Policy (0 members)

FEBRUARY

In the month of February the Managed Care Ombudsman Program worked on complaints from 77 individual members. Out of the 39 active cases, 15 are newly opened. The top complaint from managed care members in February was in regard to Access to Services/Benefits (32 members). Additional complaints include:

All open cases:
Case Management (16 members) Access to Services/Benefits (15 members) Services reduced, denied or terminated (11 members) CCO & CDAC (12 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Member Rights (6 members) Level of Care (9 members) NOD, Appeals, Fair Hearing (9 members) Complaints against provider (3 members) Eligibility & Enrollment (6 members) Care Planning (13 members) Access to durable medical equipment and medications (7 members) Discharge (5 members) Transportation (5 members) Home and vehicle modifications (1 member) Member Relations & Grievances (6 members) Guardianship (1 member) Exception to policy (4 members) Network Adequacy (3 members) Prior Authorization (1 member)

COMPLAINTS & CASES

Closed cases:
Case Management (14 members) Access to Services/Benefits (17 members) Services reduced, denied or terminated (9 members) CCO & CDAC (6 members) Transition services/coverage gap, inadequate or inaccessible (5 members) Member Rights (8 members) Level of Care (8 members) NOD, Appeals, Fair Hearing (5 members) Complaints against provider (5 members) Eligibility & Enrollment (8 members) Care Planning (8 members) Access to durable medical equipment and medications (6 members) Discharge (1 member) Transportation (8 members) Home and vehicle modifications (1 member) Member Relations & Grievances (4 members) Guardianship (0 members) Exception to policy (2 members) Network Adequacy (0 members) Prior Authorization (0 members)

MARCH

In March the Managed Care Ombudsman Program worked on complaints from 46 individual members. Out of the 31 active cases, 12 are newly opened. The top complaint from managed care members in March was in regard to Access to Services/Benefits (18 members). Additional complaints include:

All open cases:
Case Management (10 members) Access to Services/Benefits (14 members) Services reduced, denied or terminated (10 members) CCO & CDAC (8 members) Transition services/coverage gap, inadequate or inaccessible (3 members) Other/Covid-19 education and information (1 member) Member Rights (5 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (8 members) Complaints against provider (2 members) Eligibility & Enrollment (6 members) Care Planning (10 members) Access to durable medical equipment and medications (6 members) Discharge (4 members) Transportation (2 members) Home and vehicle modifications (1 member) Member Relations & Grievances (7 members) Guardianship (1 member) Exception to Policy (4 members) Prior Authorization (0 members) Network Adequacy (2 members)

Closed cases:
Case Management (5 members) Access to Services/Benefits (4 members) Services reduced, denied or terminated (2 members) CCO & CDAC (2 members) Transition services/coverage gap, inadequate or inaccessible (3 members) Other/Covid-19 education and information (0 members) Member Rights (1 member) Level of Care (1 member) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (2 members) Eligibility & Enrollment (1 member) Care Planning (1 member) Access to durable medical equipment and medications (2 members) Discharge (0 members) Transportation (1 member) Home and vehicle modifications (1 member) Member Relations & Grievances (2 members) Guardianship (1 member) Exception to Policy (4 members) Prior Authorization (1 member) Network Adequacy (0 members)

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. Transportation issues created challenges for many members trying to attend regularly scheduled medical appointments or access specialty healthcare. Members reported safety concerns with new transportation providers showing up to provide transportation for the members, lacking knowledge of the members disabilities and challenges pertaining to mobility. Many providers sent drivers out with ill equipped vehicles which did not meet the members needs or provide a safe transportation ride . Members were not always able to utilize their provider of choice and experienced poor customer service.
2. Lack of Providers. Members have reported a lack of approved CDAC providers as well as an overall lack of providers accessible to the members to provide services. For members living in remote rural areas, this issue was more prevalent. The lack of providers includes medical physicians, skilled care providers, transportation drivers, chore/homemaking providers and home modification providers as well as CDAC staff. Some members have lost their providers due to the provider not being paid for services rendered.
3. Denials of durable medical equipment (DME). Medicaid members experienced denials when trying to obtain DME prescribed and recommended by their physician, resulting in members filing appeals and/or fair hearing requests. Members reported the lack of contracted providers willing to work with the MCOs, which created more barriers for members to receive DME.
4. COVID-19 Planning. Members reported concerns about the virus COVID-19 and the Department of Human Resources began to post resources for the public to access the latest information to help those in need being affected by the COVID-19 Pandemic.
5. Pandemic Waiver response. A COVID-19 Waiver was implemented for Medicaid members to gain access to home delivered meals, services and health care which otherwise might have been denied or limited.
6. Provider and Facility Nonpayment. Providers continue to report nonpayment or receive inadequate payment from the members assigned MCO. Some CDAC providers have had to find other means of employment to make ends meet and at times this has placed the member at risk in their home without staff or services which have been approved to meet the members level of care. Lack of payment and late payments, have had a direct impact on the amount of providers available to provide services necessary to adequately maintain a member's daily health requirements.
7. Prior authorization. The time for prior authorizations to be approved or resubmitted due to initial denials, lengthened wait times for the member to receive prescribed medications and medical care. Often PA's needed to be submitted more than once.
8. Medicaid members are filing more appeals due to denials regarding the need for more service hours to provide necessary support and care in the members home as well as denials pertaining to Durable Medical Equipment (DME).
9. Access to Services/Benefits. Members experienced additional stressful daily living conditions when they did not have any provider to assist and provide approved services such as daily chore services which include lawn care, snow removal and housecleaning. Without these services being completed the members reported they then lacked access to leaver their home and skilled care and direct care were at times blocked from going into the members home. A member received a city fine due to the inability to access lawn care.

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

A managed care ombudsman advocated for a member on the Physical Disability Waiver program in obtaining DME in their home. The member was at risk without a voice activation device, life alert and phone landline. With the aide of the managed care ombudsman and support from the MCO and members physician, the member remained safe in their home with

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ADDITIONAL MATERIALS

The Managed Care Ombudsman Program maintains a website with information regarding the program's services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at the Managed Care Ombudsman website. Additionally, How to Be Your Own Best Advocate: A Guide on How to Navigate Managed Care In Iowa is a resource for members.

UPCOMING EVENTS

Quarter 2 Annual Provider Training, All Topics
Locations: Cedar Rapids, Davenport, Des Moines, Dubuque, Sioux City, Waterloo
June 2020 (final date TBA), 9 am – 12 pm & 1 pm – 4 pm

Quarter 4 Session, Topic: Durable Medical Equipment (DME)
September 2020 (final date TBA)

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MANAGED CARE OMBUDSMAN PROGRAM
QUARTERLY REPORT

Year 5, Quarter 1
(April 1 - June 30, 2020)

EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman's Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs. The waiver programs include: AIDS/HIV Waiver, Brain Injury Waiver, Children's Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

The Managed Care Ombudsman Program's monthly and quarterly report reports cases and complaints from the managed care members this Office serves.

For this reporting quarter, the office experienced a slight fluctuation of cases/complaints per month, with 23 new complaints from 9 individual members in April, 33 new complaints from 15 individual members cases in May, and 29 new complaints from 12 individual members in June.

The issues identified for this first quarter are the primary managed care member issues addressed in April, May and June 2020. The Office works with a variety of stakeholders who are necessary to address and resolve issues. During Quarter 1-Year 5 of Medicaid managed care, the primary issues reported to the Managed Care Ombudsman Program by managed care members included:

1. Access to Services/Benefits. Waiver members reported a lack of available providers contracted with their Managed Care Organizations as well as a lack of staff available within certain provider agencies. The lack of providers available to members had a direct impact to the members' overall health service benefits. As such members were approved for services yet did not receive all services for which they were approved.

2. Members are reporting issues with their case management. Members continue to experience delayed response time from case managers and a lack of support and understanding of their health needs. At times members were assigned new case managers against the members wishes, requiring the member to build new relationships and endure a lack of consistency and understanding of their overall goals and health care needs.

3. Services reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reduction in services, members are filing grievances, formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

The report that follows includes an overview of the first programmatic quarter of Year 5 (April, May, and June 2020), as well as an update on the program.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.

MEMBER ASSISTANCE

Members per MCO[1] in process April 2020	Amerigroup Iowa	41
	Iowa Total Care	12
	UnitedHealthcare Plan of the River Valley	-
	Fee for Service	-
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	4
	Iowa Compass	1
	Iowa Legal Aid	2
	LifeLong Links	1
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	3
Grievances/Appeals/Fair Hearings	Grievance assistance	-
	Appeals assistance	3
	Fair Hearing assistance	2

Members per MCO[1] in process May 2020	Amerigroup Iowa	33
	Iowa Total Care	14
	Fee for Service	3
Referrals per Entity[2]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	6
	Iowa Compass	-
	Iowa Legal Aid	2
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	-
	Other	3
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	4
	Fair Hearing assistance	1

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

MEMBER ASSISTANCE

Members per MCO in process June 2020	Amerigroup Iowa	40
	Iowa Total Care	12
	Fee for Service	1
Referrals per Entity[1]	Department of Human Services	-
	Department of Inspections and Appeals	-
	Disability Rights Iowa	7
	Iowa Compass	-
	Iowa Legal Aid	3
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	5
	Fair Hearing assistance	2

1 *Members per MCO:* Due to the MCO transition some of the managed care members are duplicated.

2 *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

Member needed a communication device which the physician had approved. MCO denied member's application for the device. Managed care ombudsman followed up with the managed care organization for several months and the member was finally able to receive their communication device.

Complaint(s) Resolution by Program Type

Amerigroup Iowa April, May and June	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	A	M	J	A	M	J	A	M	J	A	M	J	
AIDS/HIV Waiver		2											2
Brain Injury Waiver	4	3	5									1	13
Children's Mental Health Waiver			3										
Dental													
Duals													
Elderly Waiver	10							1		3	4	3	21
Habilitation			4					-					4
Health & Disability Waiver	7	2	3					3		5		9	29
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	17	1	20			2	6		1	1	10	4	62
Medicare													
PACE													
Physical Disability Waiver	5	5	4								3		17
QMB or SLMB													
Traditional Medicaid													
Other	5	2								2	2	5	19
N/A													
Unknown													
TOTAL:	48	15	39	0	0	2	6	4	1	11	19	22	167

UnitedHealthcare Plan of the River Valley April, May and June	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	A	M	J	A	M	J	A	M	J	A	M	J	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals													
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver													
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other													
N/A													
Unknown													
TOTAL:	0	0	0	0	0	0	0	0	0	0	0	0	0

Complaint(s) Resolution by Program Type

Fee for Service April, May and June	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	A	M	J	A	M	J	A	M	J	A	M	J	
AIDS/HIV Waiver													
Brain Injury Waiver													
Children's Mental Health Waiver													
Dental													
Duals											1		1
Elderly Waiver													
Habilitation													
Health & Disability Waiver													
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver											2		2
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other		3									3		6
N/A													
Unknown													
TOTAL:	0	3	0	0	0	0	0	0	0	0	6	0	9

Iowa Total Care April, May and June	Fully or partially resolved to Member's satisfaction			Not resolved to Member's satisfaction			No action needed or appropriate			Open			Total
	A	M	J	A	M	J	A	M	J	A	M	J	
AIDS/HIV Waiver													
Brain Injury Waiver										4			4
Children's Mental Health Waiver													
Dental													
Duals										4			4
Elderly Waiver	2											3	5
Habilitation											3		3
Health & Disability Waiver	12									4	2	3	21
HIPP													
Institutional Care													
Iowa Health & Wellness													
Intellectual Disability Waiver	4												4
Medicare													
PACE													
Physical Disability Waiver													
QMB or SLMB													
Traditional Medicaid													
Other	5	5	1								3	1	15
N/A													
Unknown													
TOTAL:	23	5	1	0	0	0	0	0	0	12	8	7	56

COMPLAINTS & CASES

APRIL

In April the Managed Care Ombudsman Program worked on complaints from 53 individual members. Out of the 31 active cases, 9 are newly opened. The top complaint from managed care members in April was in regard to Access to Services/Benefits (24 members). Additional complaints include:

All open cases:
Case Management (10 members) Access to Services/Benefits (20 members) Services reduced, denied or terminated (10 members) CCO & CDAC (8 members) Transition services/coverage gap, inadequate or inaccessible (4 members) Other/Covid-19 planning (0 members) Member Rights (8 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (6 members) Complaints against provider (5 members) Eligibility & Enrollment (3 members) Care Planning (9 members) Access to durable medical equipment and medications (7 members) Discharge (2 members) Transportation (4 members) Home and vehicle modifications (4 members) Member Relations & Grievances (8 members) Guardianship (0 members) Exception to Policy (3 members) Prior Authorization (1 member) Network Adequacy (3 members)

Closed cases:
Case Management (7 members) Access to Services/Benefits (4 members) Services reduced, denied or terminated (9 members) CCO & CDAC (6 members) Transition services/coverage gap, inadequate or inaccessible (4 members) Other/Covid-19 planning (1member) Member Rights (5 members) Level of Care (5 members) NOD, Appeals, Fair Hearing (2 members) Complaints against provider (3 members) Eligibility & Enrollment (4 members) Care Planning (9 members) Access to durable medical equipment and medications (4 members) Discharge (3 members) Transportation (1 member) Home and vehicle modifications (0 members) Member Relations & Grievances (3 members) Guardianship (0 members) Exception to Policy (6 members) Prior Authorization (2 members) Network Adequacy (1 member)

MAY

In May the Managed Care Ombudsman Program worked on complaints from 50 individual members. Out of the 37 active cases, 15 are newly opened. The top complaint from managed care members in May was in regard to Access to Services and Benefits (28 members). Additional complaints include:

All open cases:
Case Management (9 members) Access to Services/Benefits (23 members) Services reduced, denied or terminated (13 members) CCO & CDAC (10 members) Transition services/coverage gap, inadequate or inaccessible (6 members) Other/ (1 member) Member Rights (7 members) Level of Care (5 members) NOD, Appeals, Fair Hearing (8 members) Complaints against provider (7 members) Eligibility & Enrollment (2 members) Care Planning (9 members) Access to durable medical equipment and medications (5 members) Discharge (4 members) Transportation (2 members) Home and vehicle modifications (4 member) Member Relations & Grievances (7 members) Guardianship (0 members) Exception to Policy (5 members) Prior Authorization (2 members) Network Adequacy (5 members)

COMPLAINTS & CASES

Closed cases:
Case Management (2 members) Access to Services/Benefits (5 members) Services reduced, denied or terminated (2 members) CCO & CDAC (3 members) Transition services/coverage gap, inadequate or inaccessible (3 members) Other/ (1 member) Member Rights (2 members) Level of Care (2 members) NOD, Appeals, Fair Hearing (0 members) Complaints against provider (0 members) Eligibility & Enrollment (2 members) Care Planning (3 members) Access to durable medical equipment and medications (2 members) Discharge (1 member) Transportation (1 member) Home and vehicle modifications (1 member) Member Relations & Grievances (0 members) Guardianship (0 members) Exception to Policy (0 members) Prior Authorization (0 members) Network Adequacy (2 members)

JUNE

In June the Managed Care Ombudsman Program worked on complaints from 53 individual members. Out of the 39 active cases, 13 are newly opened. The top complaint from managed care members in June was in regard to Access to Services/Benefits (28 members). Additional complaints include:

All open cases:
Case Management (13 members) Access to Services/Benefits (25 members) Services reduced, denied or terminated (14 members) CCO & CDAC (12 members) Transition services/coverage gap, inadequate or inaccessible (7 members) Other (1 member) Member Rights (9 members) Level of Care (7 members) NOD, Appeals, Fair Hearing (7 members) Complaints against provider (7 members) Eligibility & Enrollment (1 member) Care Planning (14 members) Access to durable medical equipment and medications (6 members) Discharge (4 members) Transportation (5 members) Home and vehicle modifications (5 members) Member Relations & Grievances (9 members) Guardianship (1 member) Exception to Policy (5 members) Prior Authorization (3 members) Network Adequacy (5 members)

Closed cases:
Case Management (3 members) Access to Services/Benefits (3 members) Services reduced, denied or terminated (3 members) CCO & CDAC (4 members) Transition services/coverage gap, inadequate or inaccessible (0 members) Other (0 members) Member Rights (0 members) Level of Care (3 members) NOD, Appeals, Fair Hearing (5 members) Complaints against provider (1 member) Eligibility & Enrollment (2 members) Care Planning (1 member) Access to durable medical equipment and medications (5 members) Discharge (0 members) Transportation (0 members) Home and vehicle modifications (2 members) Member Relations & Grievances (3 members) Guardianship (0 members) Exception to Policy (0 members) Prior Authorization (2 members) Network Adequacy (0 members)

MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. For the second quarterly reporting period in a row, transportation issues created challenges for many members trying to attend regularly scheduled medical appointments or access specialty healthcare. Members reported safety concerns with new transportation providers showing up to provide transportation for the members, lacking knowledge of the members disabilities and challenges pertaining to mobility. Many providers sent drivers out with ill equipped vehicles which did not meet the members needs or provide a safe transportation ride. Members were not always able to utilize their provider of choice and experienced poor customer service.

2. COVID-19 was a trend noted this quarterly reporting period. Concerns reported by members included staffing issues due to providers inability or unwillingness to make in home visits due to COVID-19 concerns.

3 Provider payments continue to be a trend for this quarterly reporting period, placing the member at risk of being in their home without staff or service. Lack of payment and late payments, have had a direct impact on the amount of providers available to provide services necessary to adequately maintain a member's daily health requirements.

4. Access to services/benefits, particularly chore and law services are a trend again this quarterly reporting period. Members report they did not have a provider to assist and provide approved services such as daily chore services which include lawn care, snow removal and housecleaning.

Member's units of CDAC services were reduced even though the member's needs had not changed for years. Member requested a Fair Hearing and while the hearing was pending, the managed care ombudsman was able to assist the member in getting the full amont of CDAC units restored.

ADDITIONAL MATERIALS

The Managed Care Ombudsman Program maintains a website with information regarding the program's services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at the Managed Care Ombudsman website. Additionally, How to Be Your Own Best Advocate: A Guide on How to Navigate Managed Care In Iowa is a resource for members.

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APPENDIX

APPENDIX: GLOSSARY

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.
ITC: Iowa Total Care

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 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 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 home 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 fee-for-service 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 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.