Iowa Medicaid Enterprise

Managed Care
Annual Performance Report

(July 2018 – June 2019)

Published December 2019

CONTENTS

Executive Summary 2
Plan Enrollment By Age 4
Plan Enrollment by MCO 5
Plan Disenrollment by MCO 5
All MCO Long Term Services and Supports (LTSS) Enrollment 6
All MCO Home and Community-Based Service Waiver Enrollment 6
Care Coordination and Case Management 7
Iowa Participant Experience Survey Reporting 11
Consumer Protections and Supports 13
MCO Program Management 16
MCO Financials 46
Program Integrity 49
Health Care Outcomes 51
Oversight Entities Executive Summaries 63
Appendix: Glossary 178

Executive Summary

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

- Consumer Protection
- Outcome Achievement
- Program Integrity

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

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

This report includes the information for the two Iowa Medicaid Managed Care Organizations (MCO):

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

Notes about the reported data:
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS®[1] and CAHPS[2].
- 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.

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

- 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.

Highlights:

- Timely Helpline Services: When members have questions they can contact the health plans' member helplines. In all quarters for SFY19, both health plans exceeded the timeliness requirements required by their contract. The state conducts "secret shopper calls" to ensure quality of helpline services.

- Claims Requirements: Both MCOs exceeded the contractual expectation that ninety percent (90%) of clean medical payment claims be paid within 30 days for all four quarters of SFY19.

- Value Based Purchasing Enrollment: Both MCOs were expected to have 40% of their population covered by a value based purchasing agreement by the end of CY2018. As of December 2018, Amerigroup had reached 45% and UnitedHealthcare had reached 62%. As of June 2019, both MCOs have maintained that goal, as Amerigroup is at 47% and UnitedHealthcare is at 54%.

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.

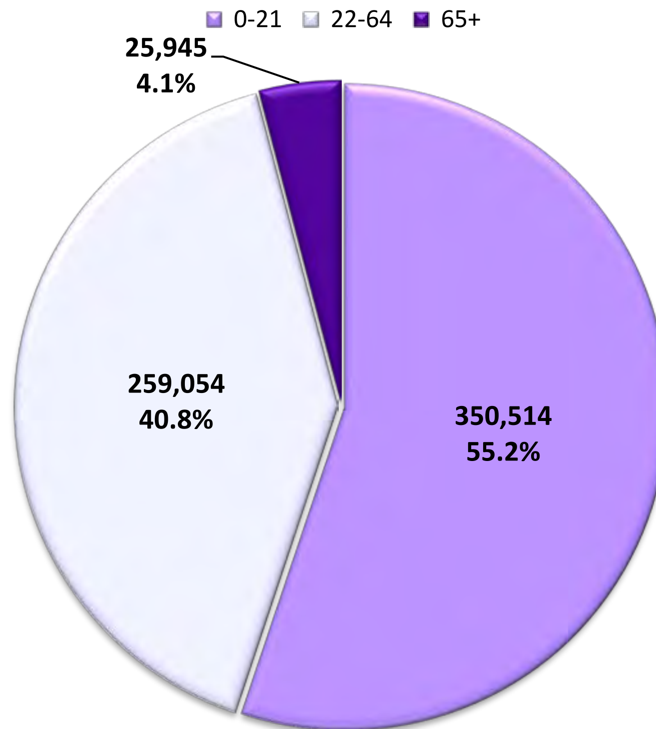
- The Council on Human Services
- The Medical Assistance Advisory Council
- The Hawki Board
- The Mental Health and Disability Services Commission
- The Office of the Long Term Care Ombudsman (data is not verified by the department)

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

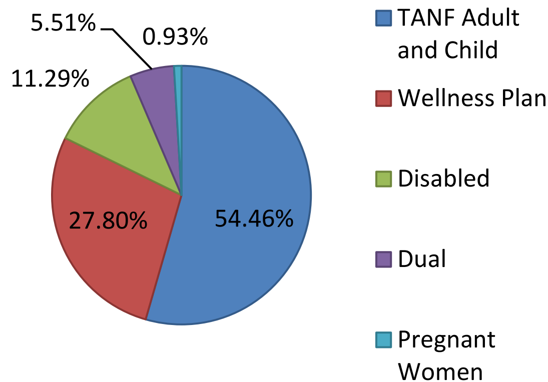
More information on the move to managed care is available at
http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

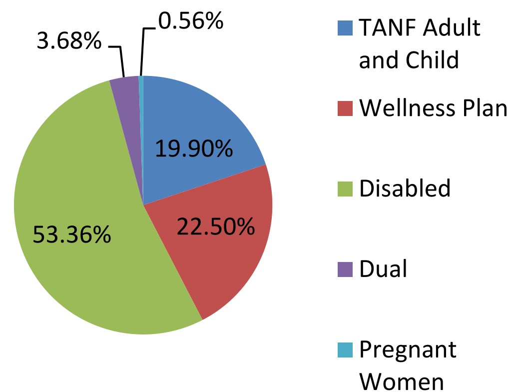
Providers and members can find more information on the IA Health Link program at
http://dhs.iowa.gov/iahealthlink

Plan Enrollment By Age

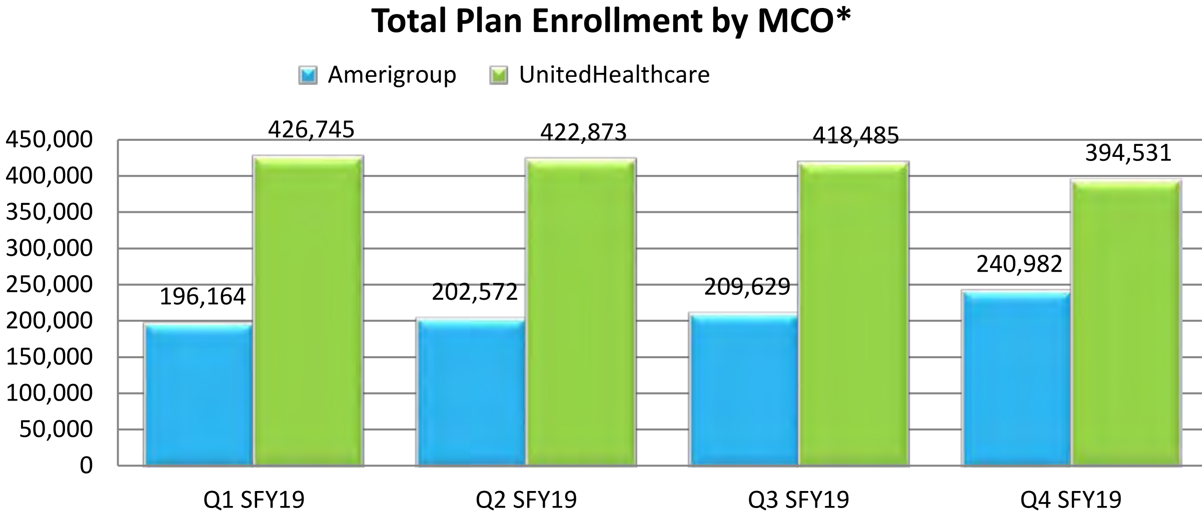


*June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes Hawki enrollees. 56,074 members remain in Fee-for-



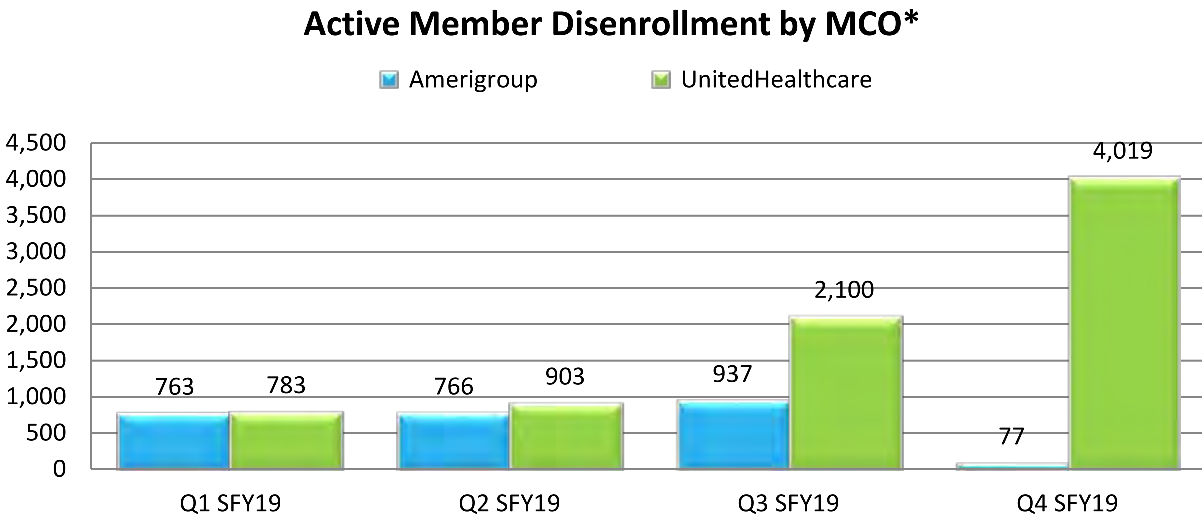


Plan Enrollment by MCO



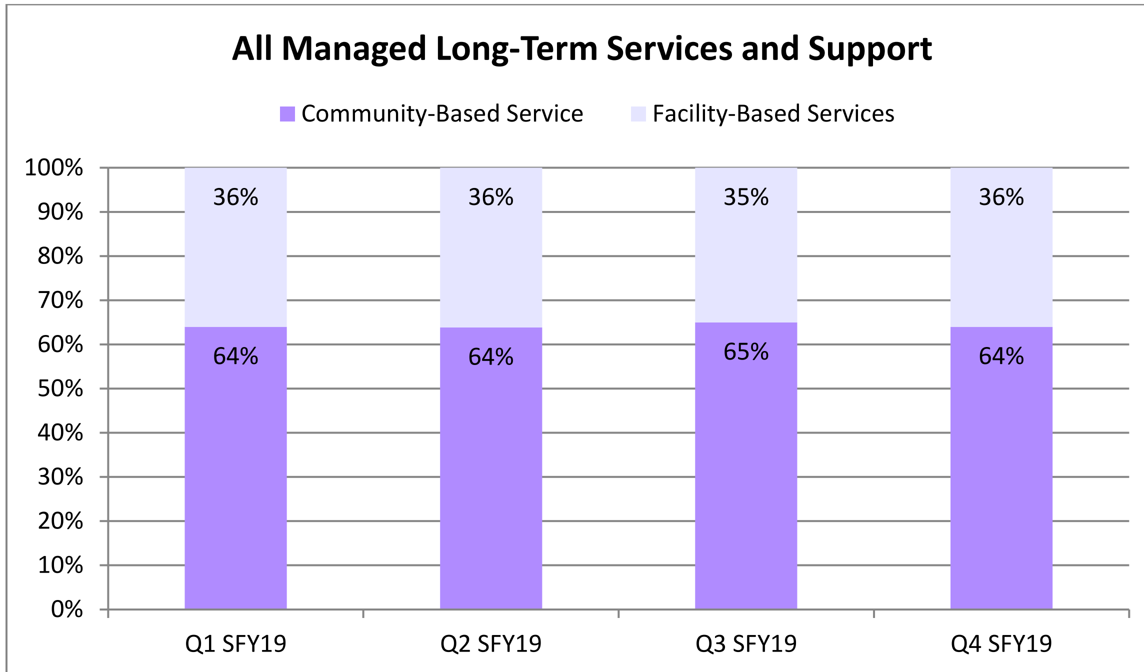
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Plan Disenrollment by MCO



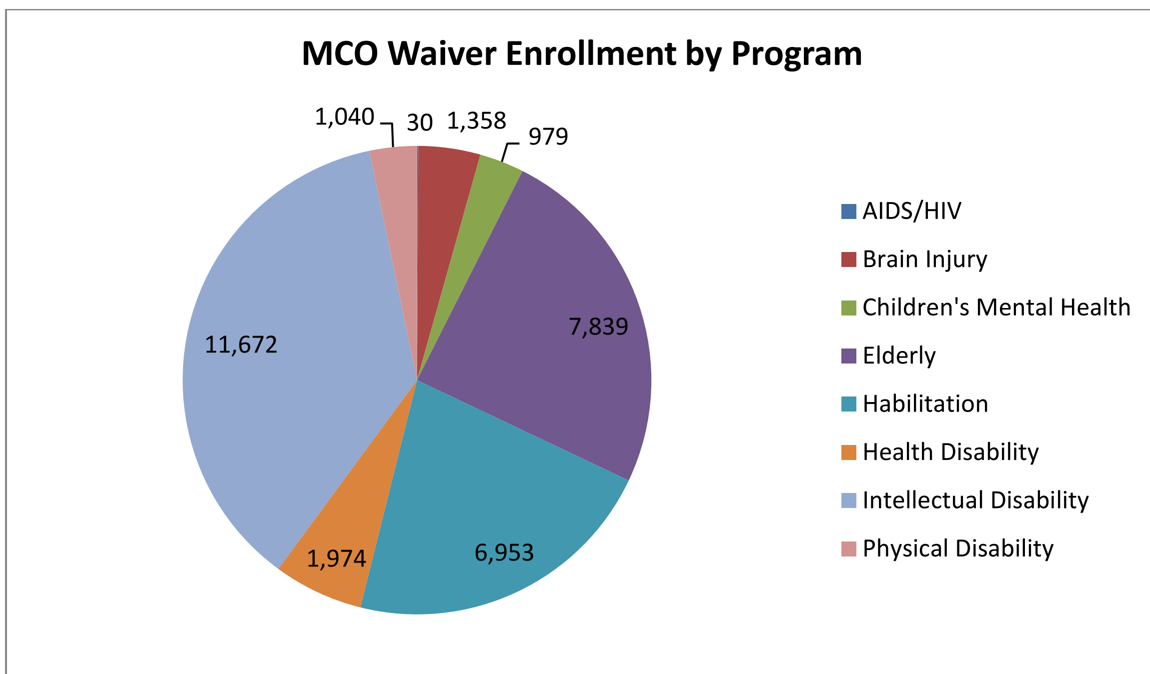
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



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

ALL MCO HOME AND COMMUNITY-BASED SERVICE WAIVER ENROLLMENT



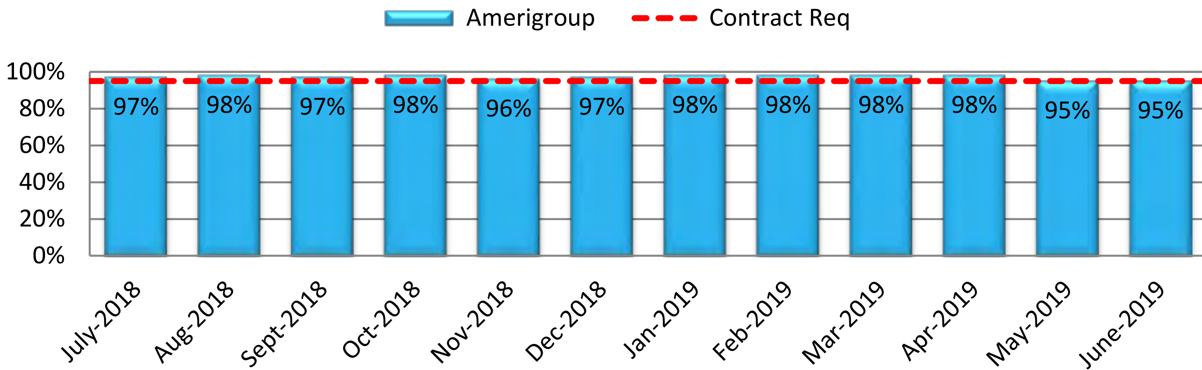
Care Coordination and Case Management

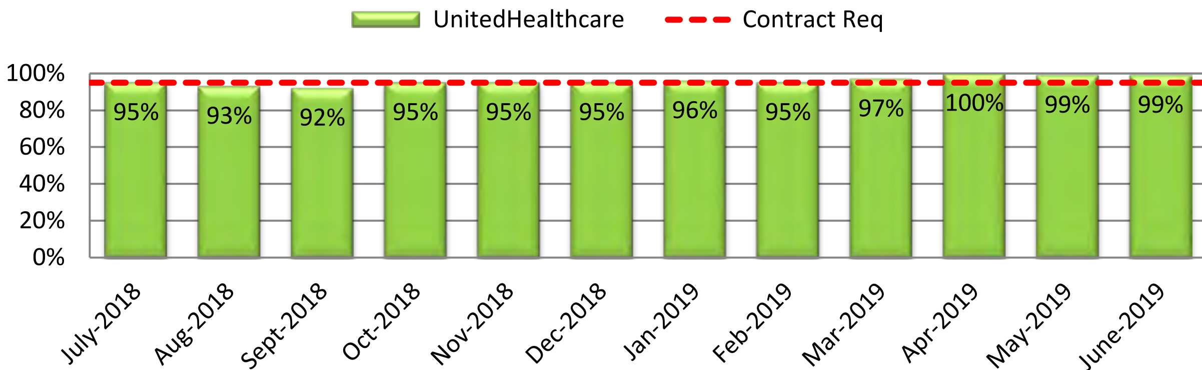
Average Number of Contacts		
Data Reported as of June 30, 2019	**Amerigroup**	**UnitedHealthcare**
Average Number of Care Coordinator Contacts per Member per Month	2.1	0.4
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.1

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

Level of Care

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



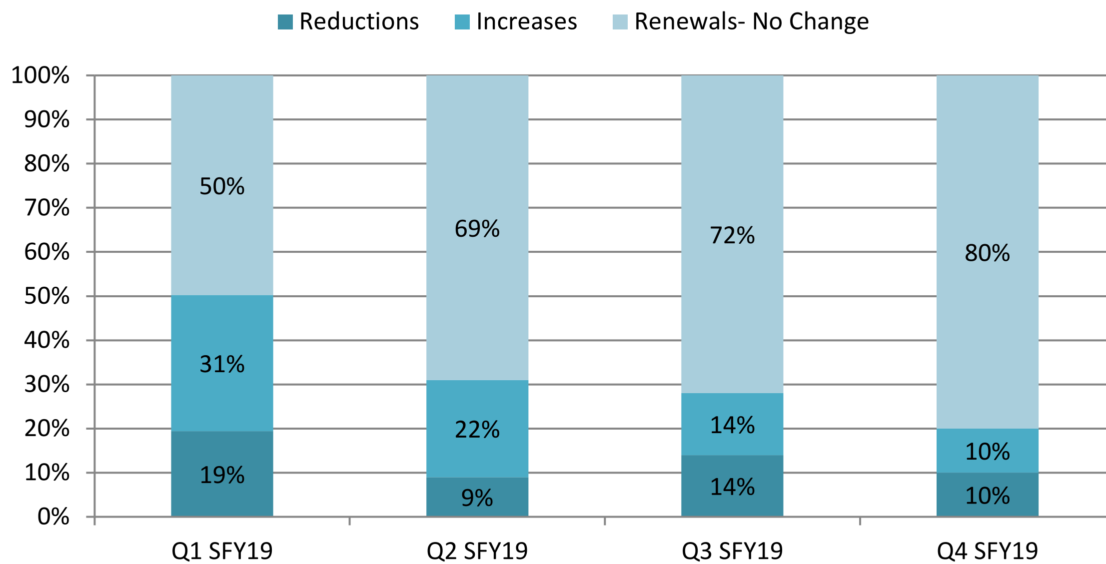


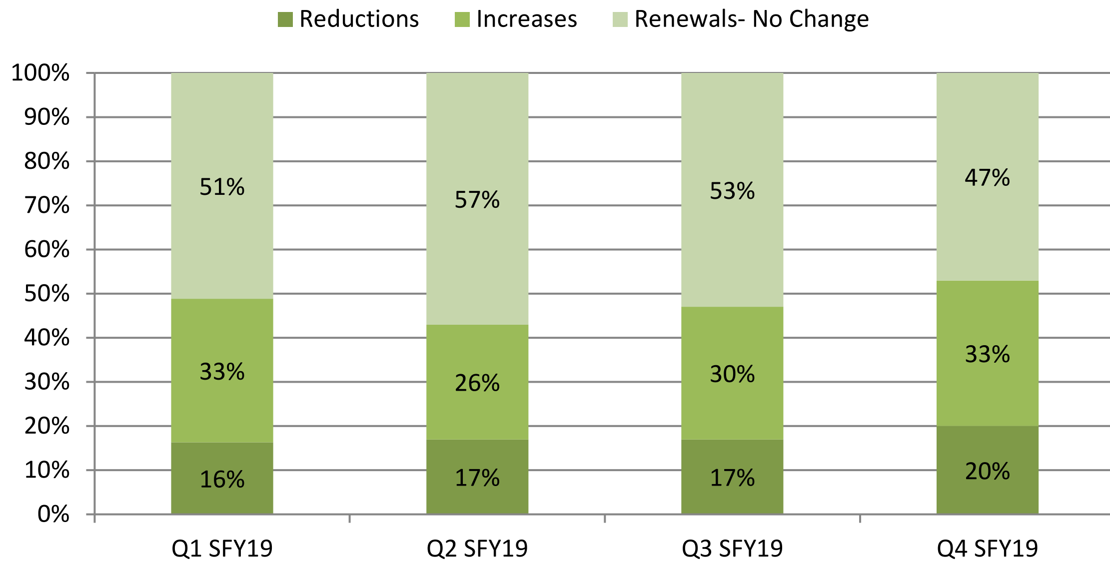
Ninety-five percent (95%) of needs assessments must be completed annually or as a member's needs change. There may be legitimate reasons for MCO failure to complete LOC Reassessments timely, such as member hospitalization or other extenuating member circumstances. The department requests MCO exception 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.

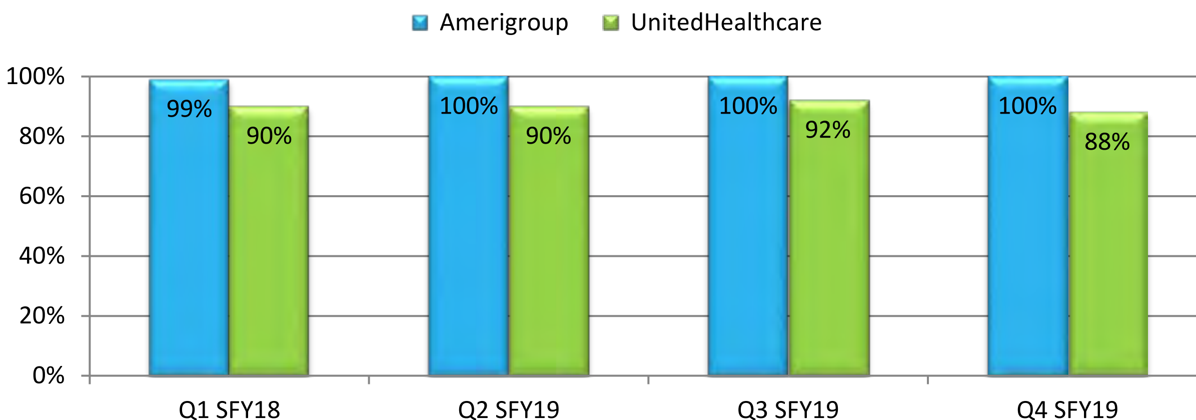
Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving home- and community-based services. These are new measures for SFY 2019.

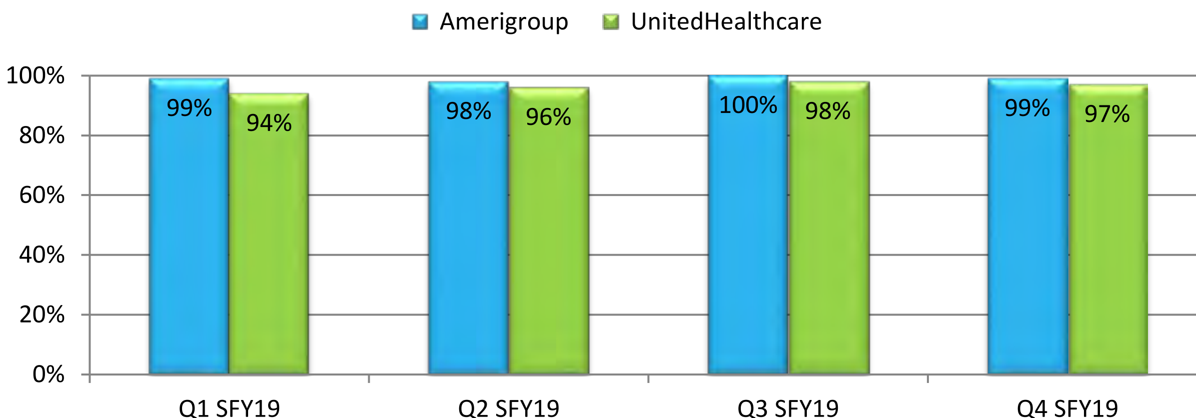


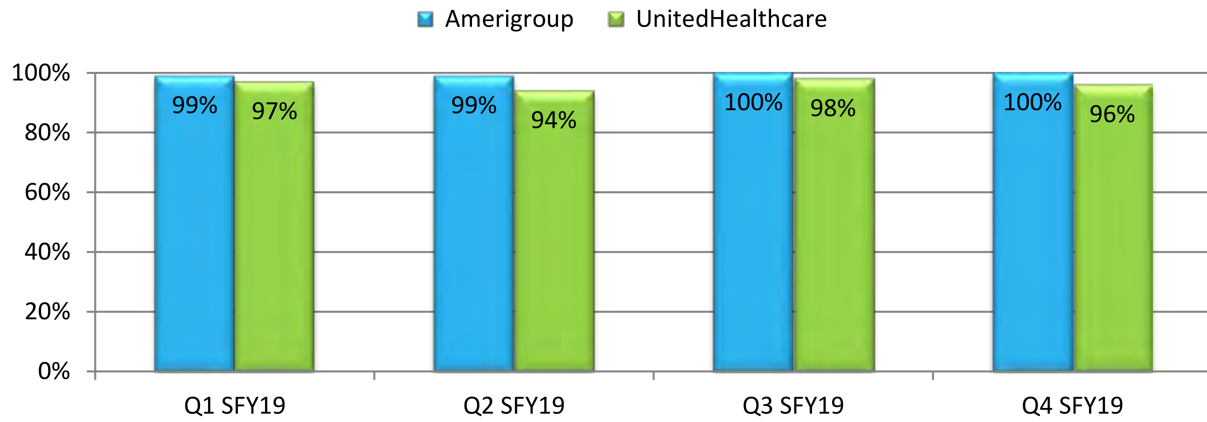

UnitedHealthcare Service Plan Revision Outcomes
Reductions
Increases
Renewals- No Change
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
51%
33%
16%
57%
26%
17%
53%
30%
17%
47%
33%
20%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

Iowa Participant Experience Survey Reporting

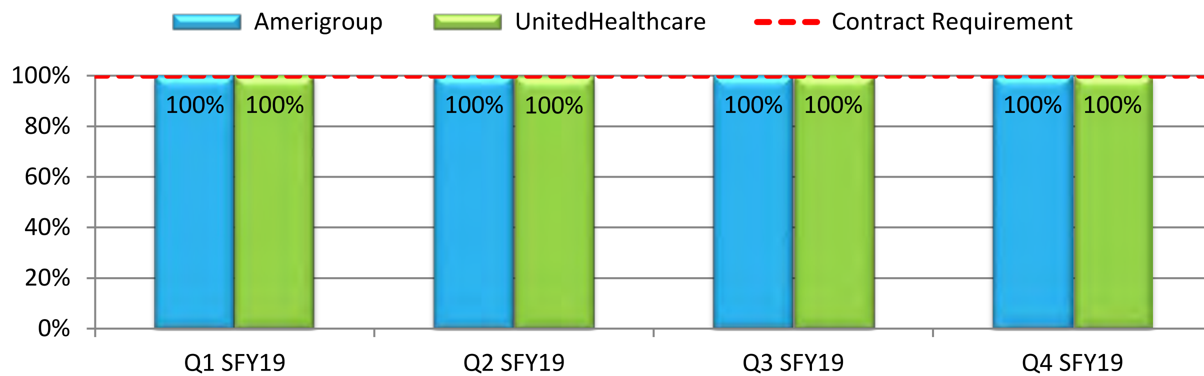
The data below reflect the results of Iowa Participant Experience Survey (IPES) activities and results. IPES results are one component of the Iowa Department of Human Services Home- and Community-Based Services quality strategy. Surveys are conducted to achieve a statistically significant representative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



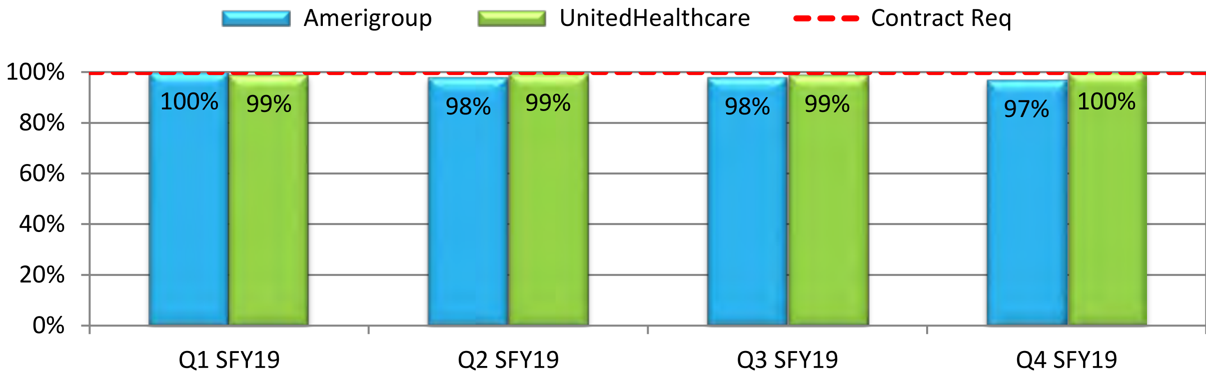



Members Reporting Their Services Make Their Lives Better
Amerigroup
UnitedHealthcare
100%
80%
60%
40%
20%
0%
99%
97%
99%
94%
100%
98%
100%
96%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

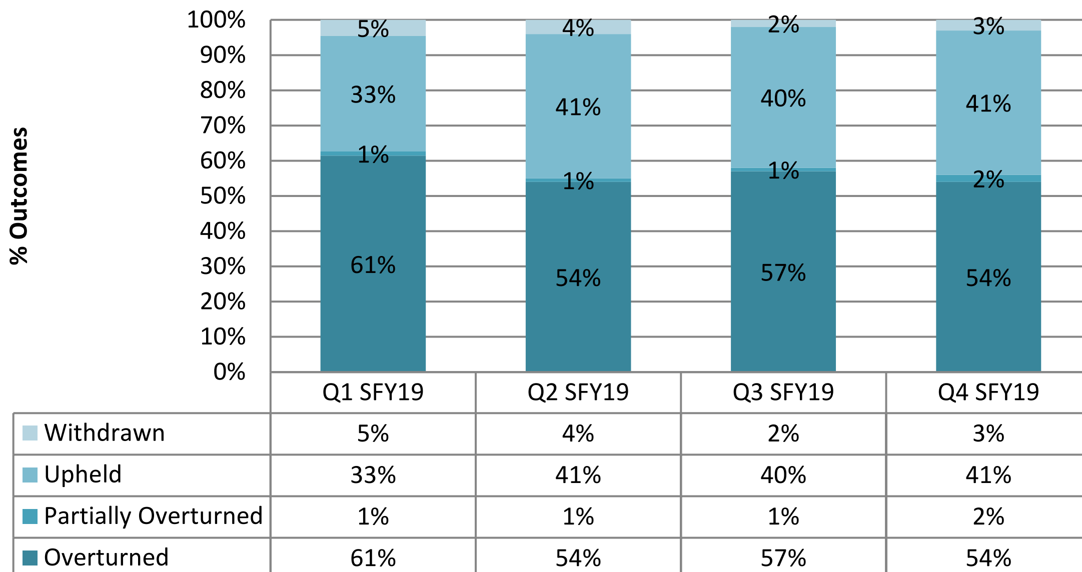
MCO Member Grievances and Appeals
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization. *Grievance:* A written or verbal expression of dissatisfaction. *Appeal:* A request for a review of an MCO's denial, reduction, suspension, termination or delay of services. *Resolved:* The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.



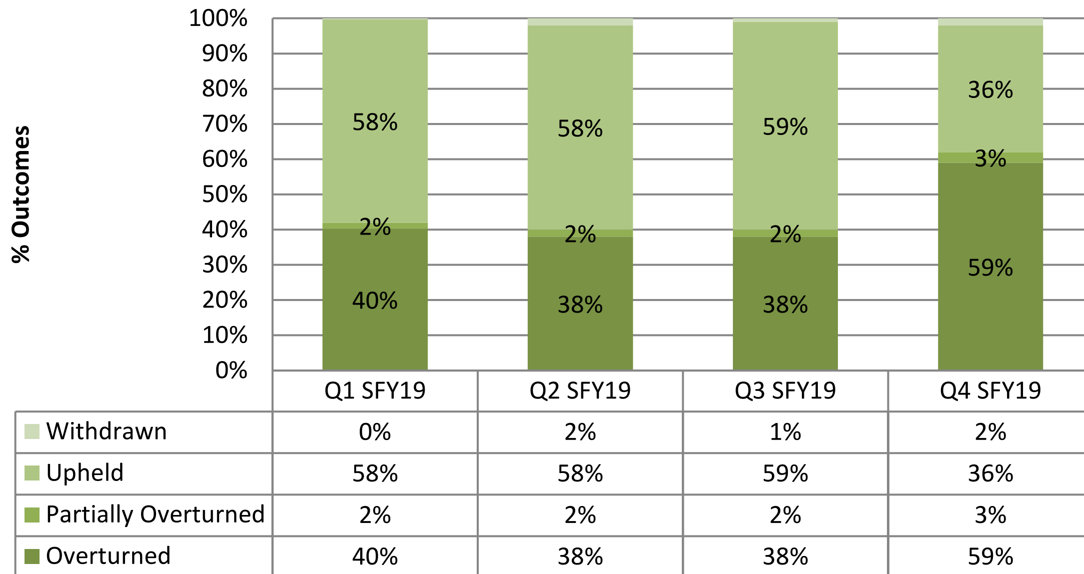
Supporting Data				
	Amerigroup		UnitedHealthcare	
Metric	**Count**	**% Pop**	**Count**	**% Pop**
Grievances Received in Q1 SFY19	228	0.10%	471	0.10%
Grievances Received in Q2 SFY19	280	0.13%	474	0.10%
Grievances Received in Q3 SFY19	314	0.14%	307	0.07%
Grievances Received in Q4 SFY19	248	0.09%	205	0.05%



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

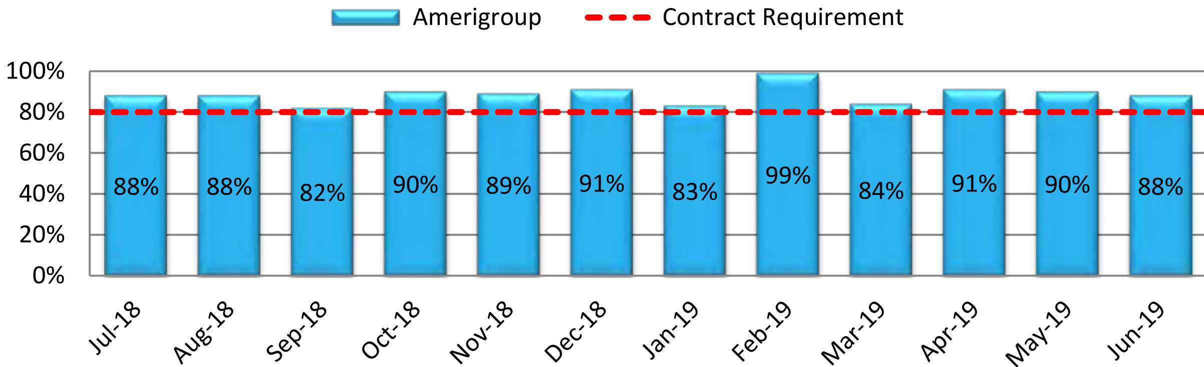


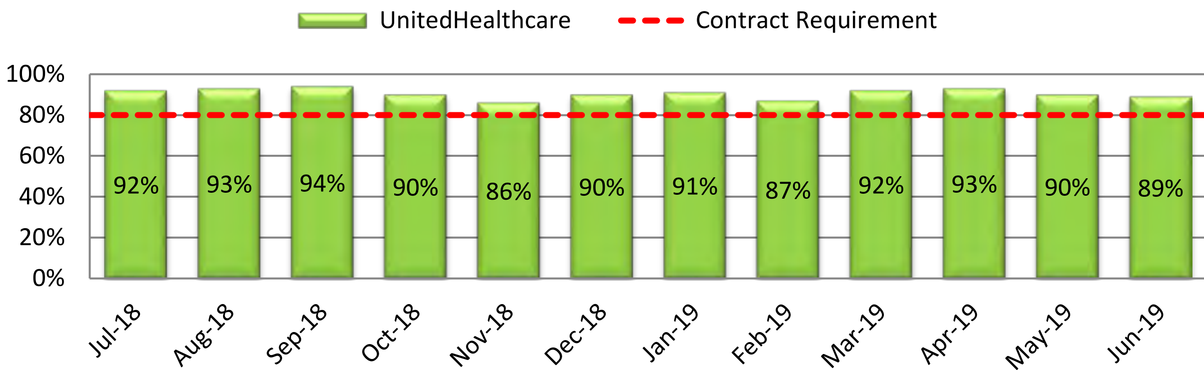
	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	5%	4%	2%	3%
Upheld	33%	41%	40%	41%
Partially Overturned	1%	1%	1%	2%
Overturned	61%	54%	57%	54%



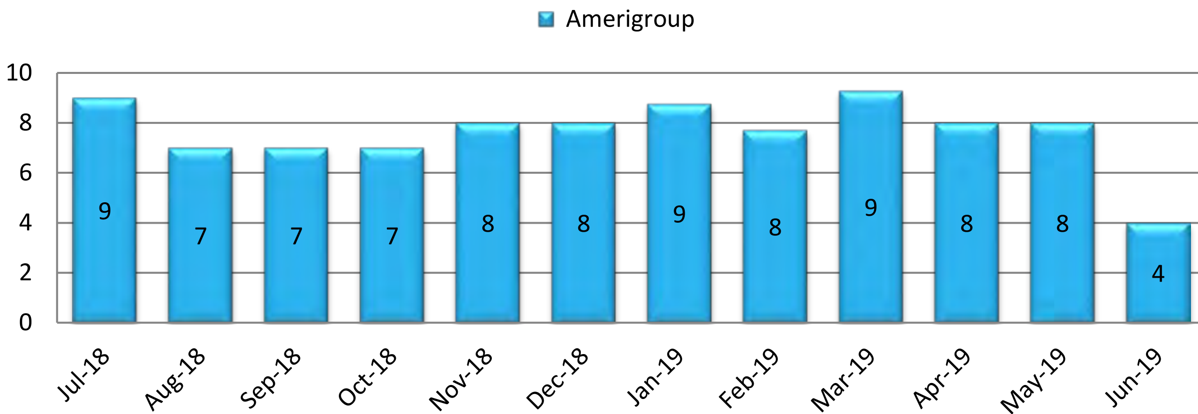
	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	0%	2%	1%	2%
Upheld	58%	58%	59%	36%
Partially Overturned	2%	2%	2%	3%
Overturned	40%	38%	38%	59%

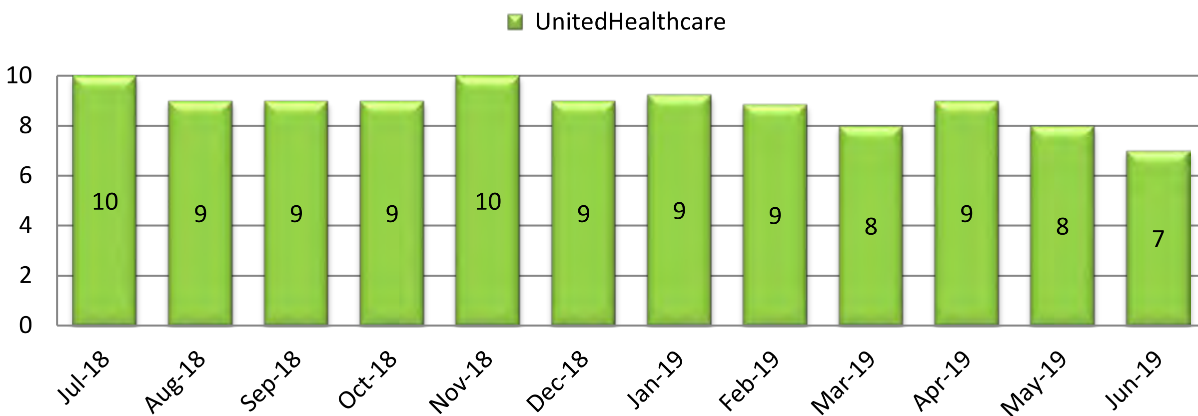
Member Helpline





This performance target measures the timeliness of answering the helpline calls. 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 calls are conducted by the Iowa Medicaid Enterprise 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 SFY19, the member helpline secret shopper topics focused on:

Q1 SFY19 - Annual benefit maximum (dental services), non-emergency medical transportation (NEMT) problem reporting, health risk assessments, case manager complaints, primary care physician (PCP) assignment, out of state coverage, out of pocket costs, pregnancy tests, service reduction recourse, appeals, emergency room coverage, community-based care manager (CBCM) contacts, service plan updates, urgent care co-pays, and value-added services .

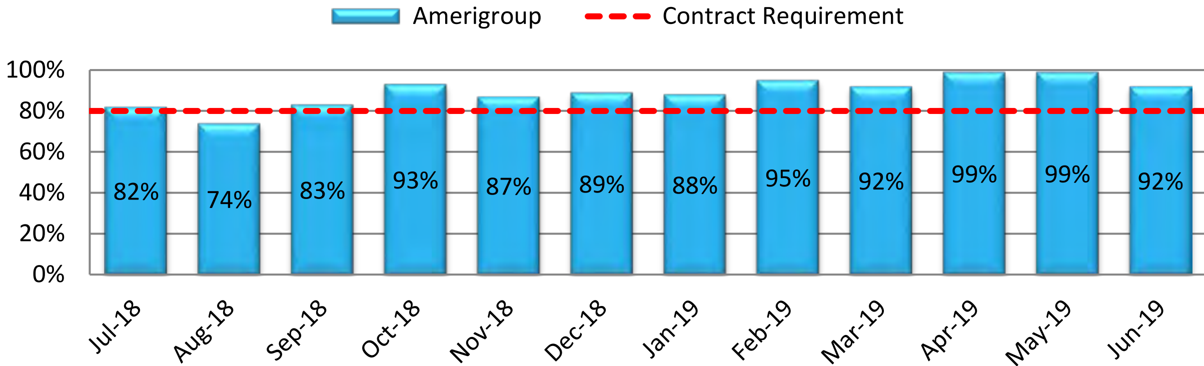
Q2 SFY19 - Member appeals, Healthy Behaviors within the dental program, changing MCOs, ER prior authorizations, out of network coverage for ER/hospitals, dual eligibility for Medicare/Medicaid, ID cards, filling prescriptions out of state, disputed charges, coverage for newborns, Iowa Plan copays, ER coverage, and income requirements.

Q3 SFY19 – Iowa Health and Wellness Plan (IHAWP) contributions, newborn coverage, Medicaid application process, changing MCOs, eye exam and hospital coverage, Healthy Behaviors, switching MCOs/Open Choice, and NEMT.

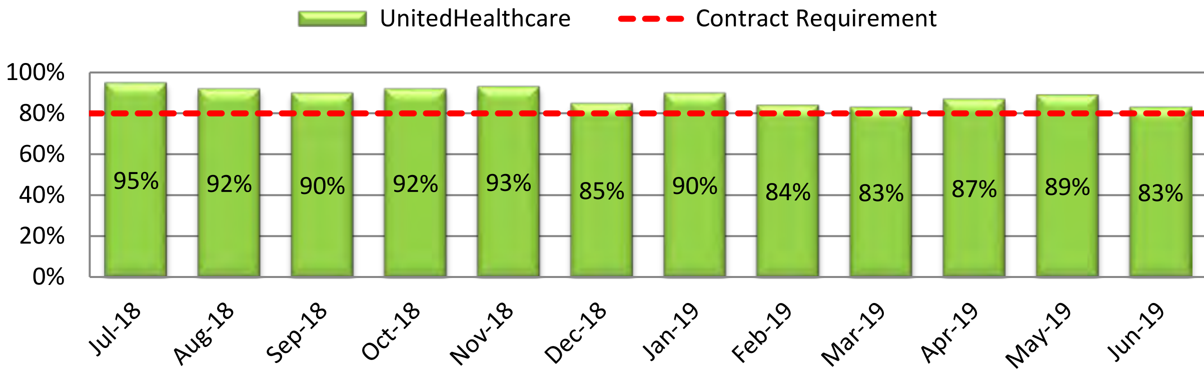
Q4 SFY19 - Switching MCOs/ transitioning and reenrolling with a new MCO, keeping a prior case manager, and maintaining prior authorizations.

Provider Helpline

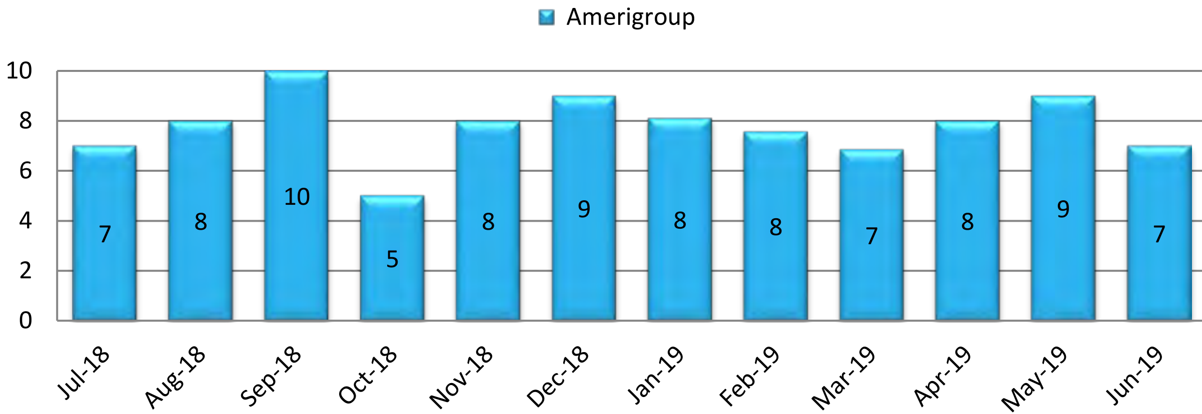
Service Level: Percentage of Provider Helpline Calls Answered Timely

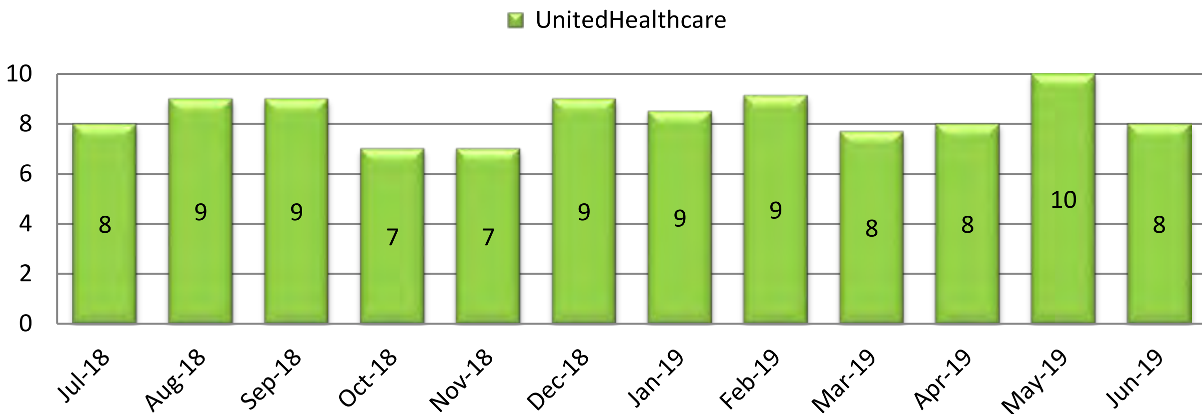


Service Level: Percentage of Provider Helpline Calls Answered Timely



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 SFY19, the provider helpline secret shopper topics focused on:

Q1 SFY19 - Prior authorizations, preferred drug list recommendations, Iowa Family Planning Program, provider enrollment, recoupments, clean claims, claim adjustment reason code (CARC) definition, claim submission timeframes, resubmission timeframes, credentialing, prior authorizations with changes in MCO, Hepatitis C treatment, prior authorization response timeframes (both standard and expedited), pharmacy and prior authorization denial next steps .

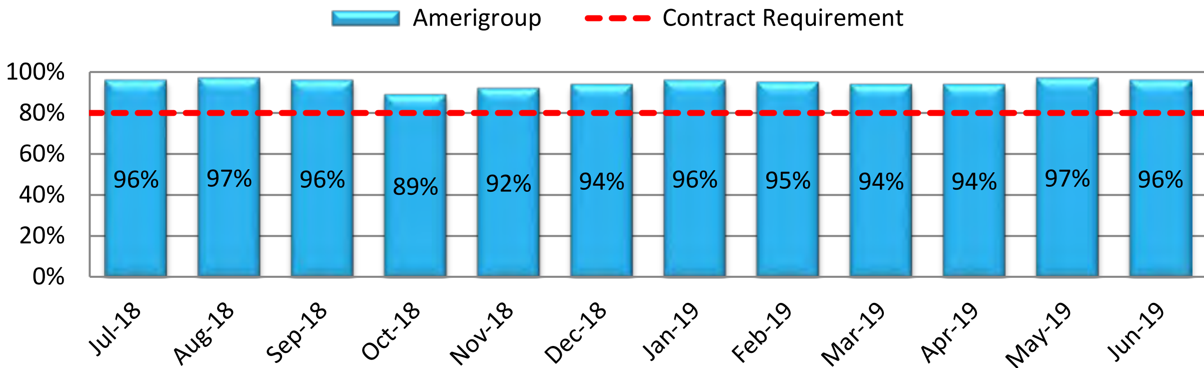
Q2 SFY19 - Prior authorizations, retroactive coverage for nursing homes, Medicare/Medicaid enrollment, prior authorizations, level of care assessments, denied claims, additional insurance, client participation, vaccinations on Hawki, and using existing pharmacy stock.

Q3 SFY19 - Denied claims, Medical Claim forms, third party liability (TPL) Claims, out of network providers, claim reconsiderations, Health/Disability Waiver, tiered rates, and Healthy Behaviors.

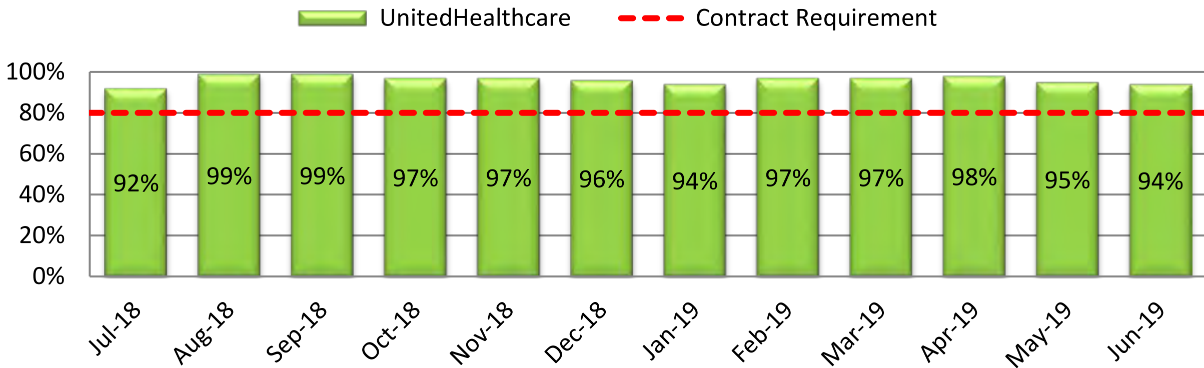
Q4 SFY19 - Supported community living (SCL) tiered rates, MCO enrollment during open choice period, UHC leaving the Iowa market, and processes while transitioning from UHC to a new MCO.

Pharmacy Services Helpline

Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely



Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely



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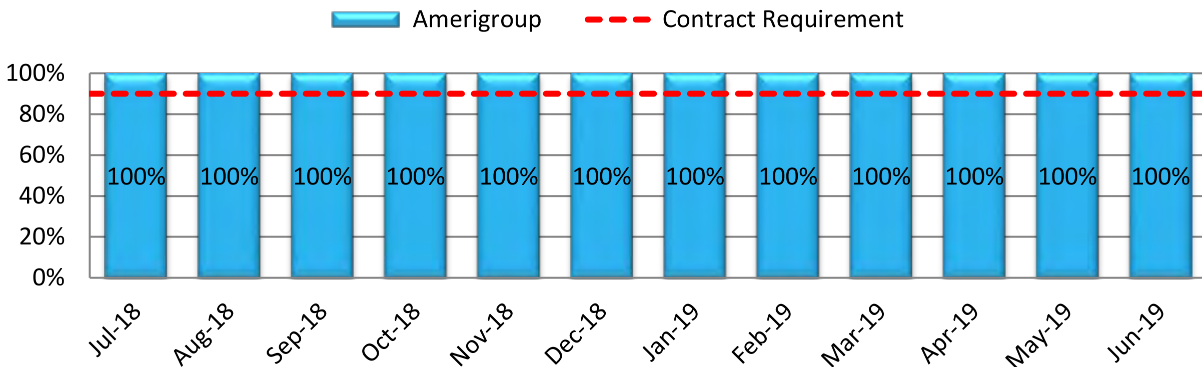
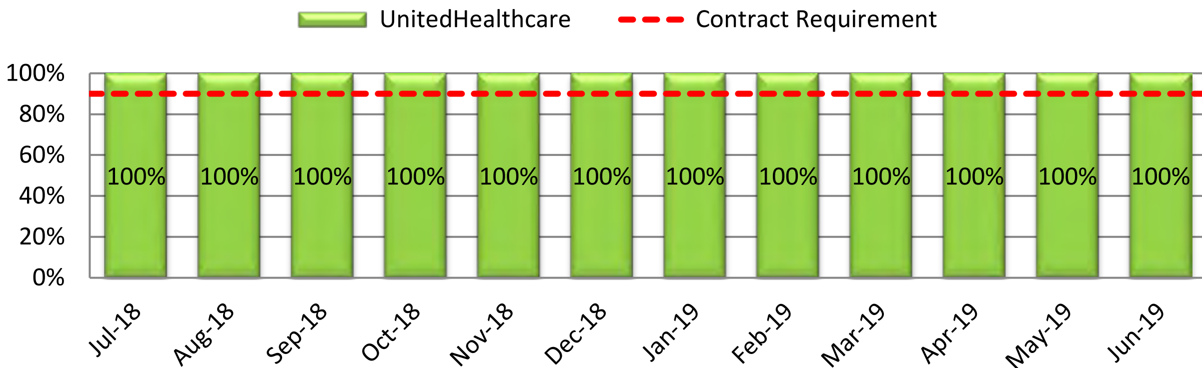
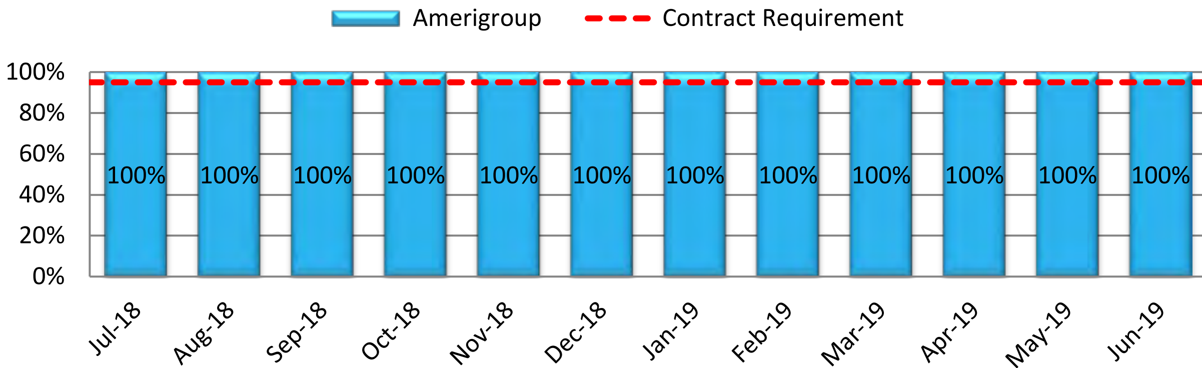
Non-Pharmacy Claims Payment

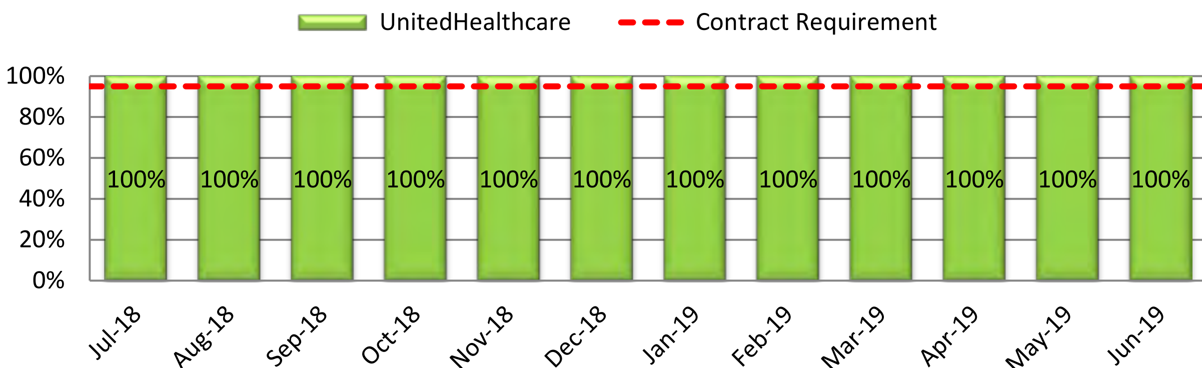
Non-pharmacy claims processing data is for the entire quarter.





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.





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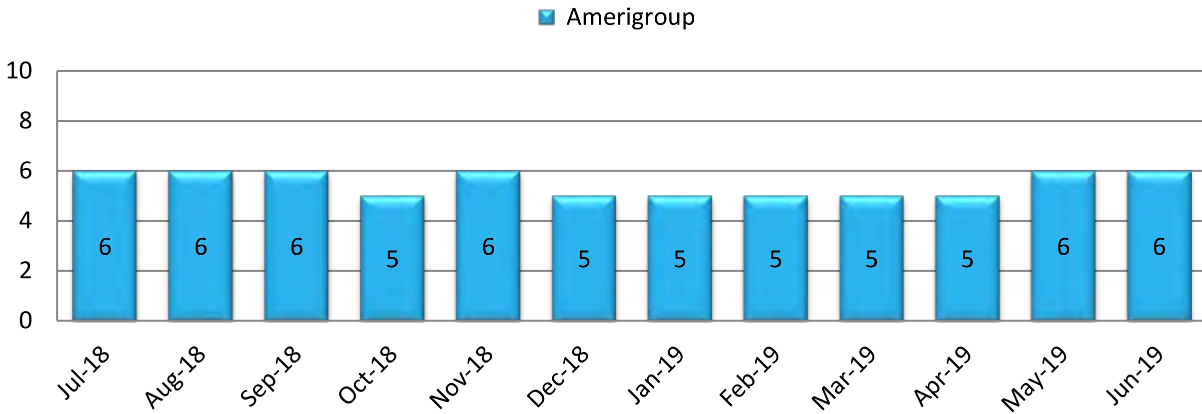
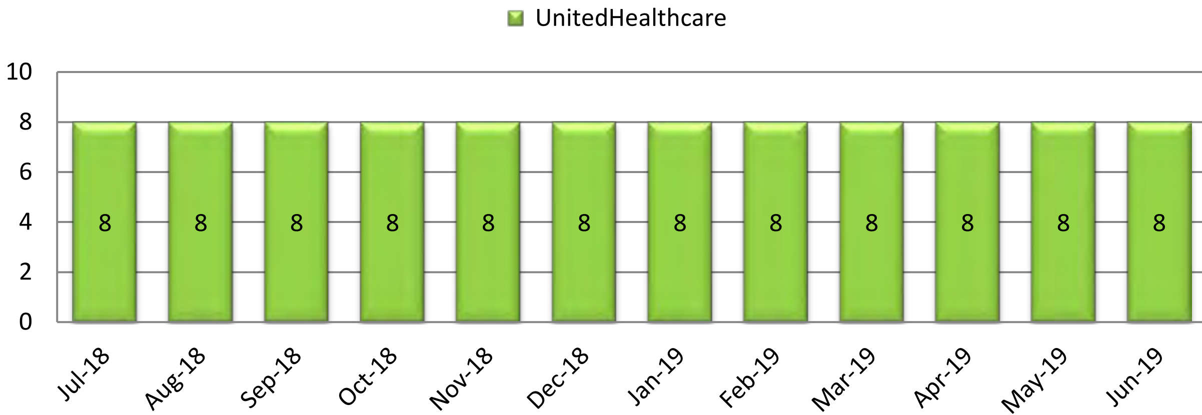
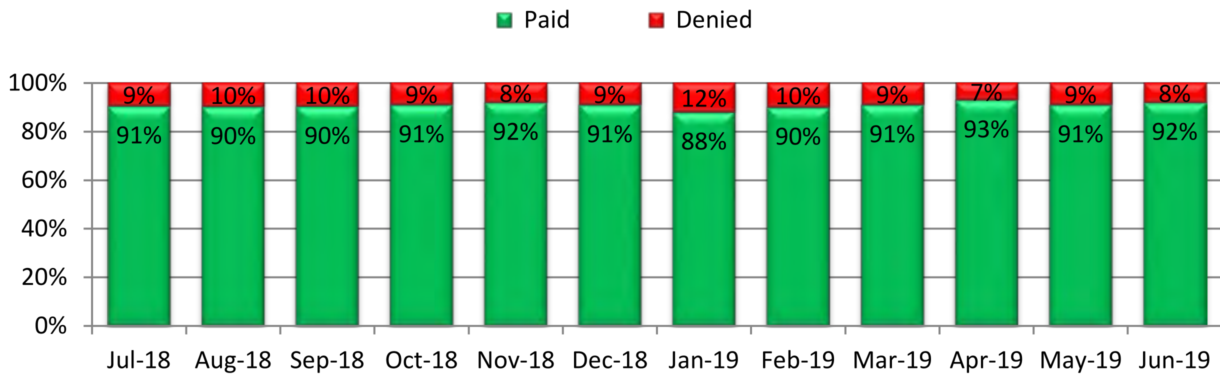
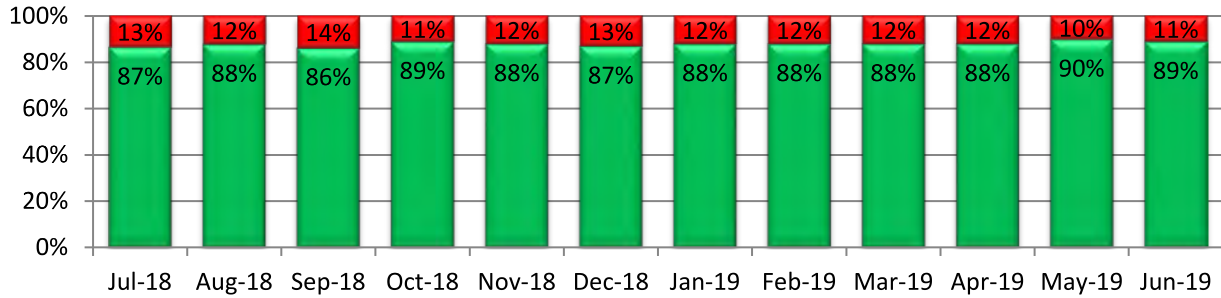
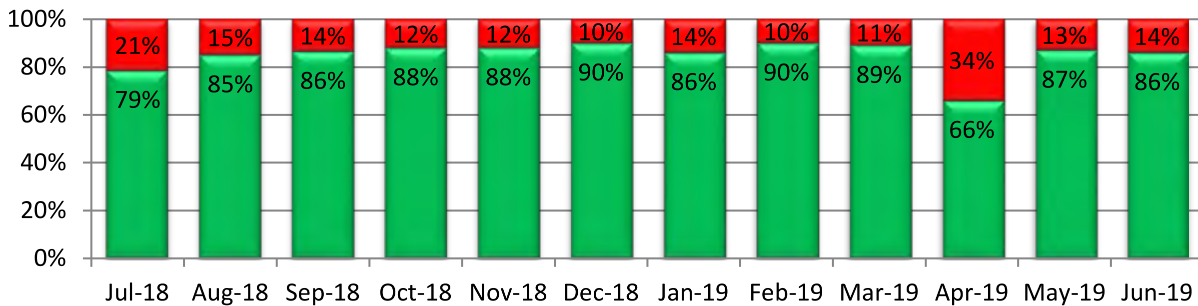
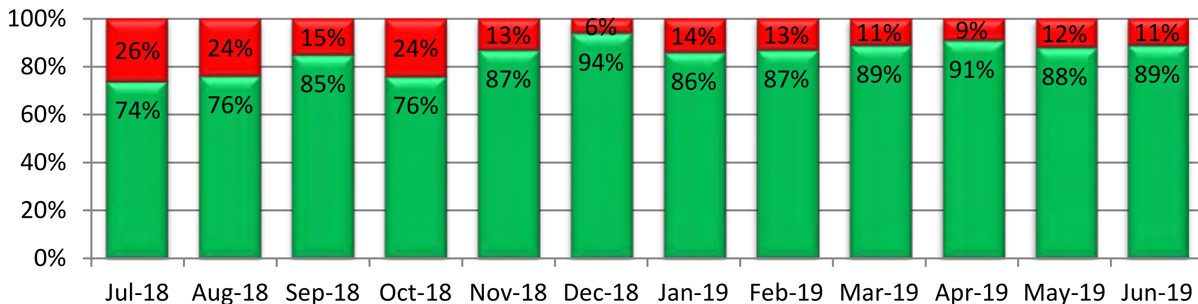

Average Days for Non-Pharmacy Claims Payment
Amerigroup
10
8
6
4
2
0
6
6
6
5
6
5
5
5
5
5
6
6
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Average Days for Non-Pharmacy Claims Payment
UnitedHealthcare
10
8
6
4
2
0
8
8
8
8
8
8
8
8
8
8
8
8
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Amerigroup Non-Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
9%
10%
10%
9%
8%
9%
12%
10%
9%
7%
9%
8%
91%
90%
90%
91%
92%
91%
88%
90%
91%
93%
91%
92%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


UnitedHealthcare Non-Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
13% 12% 14% 11% 12% 13% 12% 12% 12% 12% 10% 11%
87% 88% 86% 89% 88% 87% 88% 88% 88% 88% 90% 89%
Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19


Amerigroup Suspended Non-Pharmacy Claims Payment Rates
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
21% 15% 14% 12% 12% 10% 14% 10% 11% 34% 13% 14%
79% 85% 86% 88% 88% 90% 86% 90% 89% 66% 87% 86%
Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19

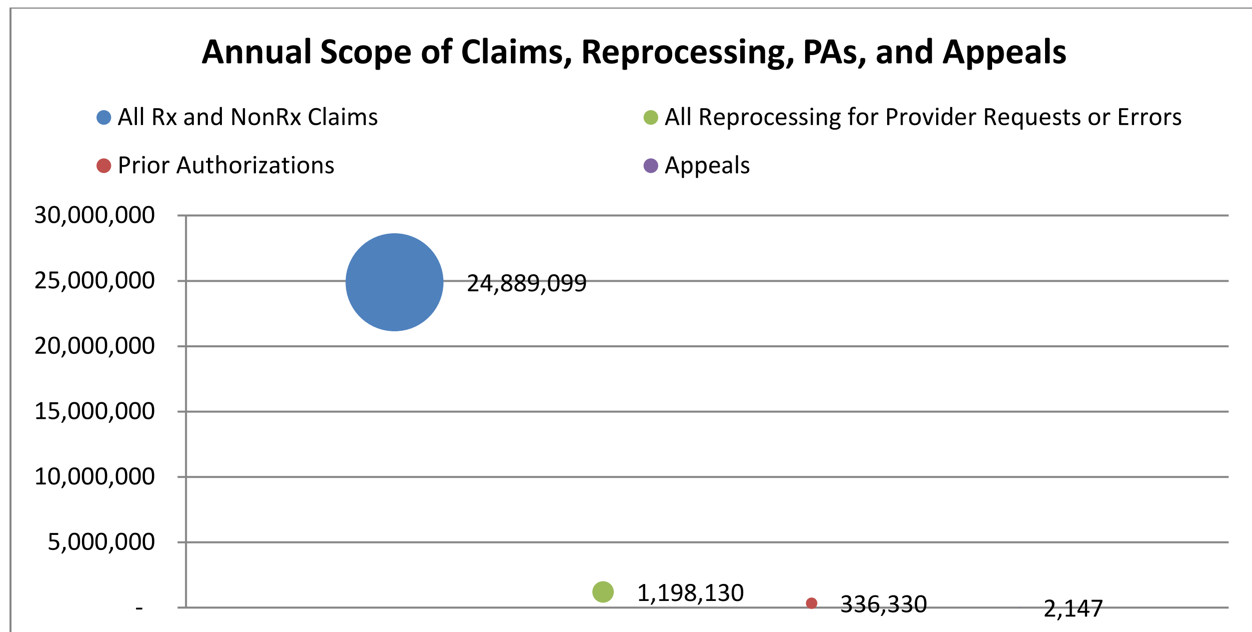

UnitedHealthcare Suspended Non-Pharmacy Claims Payment Rates
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
26% 24% 15% 24% 13% 6% 14% 13% 11% 9% 12% 11%
74% 76% 85% 76% 87% 94% 86% 87% 89% 91% 88% 89%
Jul-18 Aug-18 Sep-18 Oct-18 Nov-18 Dec-18 Jan-19 Feb-19 Mar-19 Apr-19 May-19 Jun-19

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	**%**	**Reason**	**%**
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	30%	CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim	15%
2.	27-Expenses incurred after coverage terminated	15%	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.	13%
3.	252-An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) N479-Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)	9%	CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.	12%
4.	256-Service not payable per managed care contract	6%	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service	11%
5.	45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges	6%	CARC-29 The time limit for filing has expired.	6%
6.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	5%	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.	6%
7.	29-The time limit for filing has expired	5%	CARC-256 Service not payable per managed care contract. RARC-N448	4%

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	**Amerigroup**		**UnitedHealthcare**	
	Reason	**%**	**Reason**	**%**
			This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	
8.	197-Precertification/authorization/notification absent	5%	CARC-97 The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	3%
9.	97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present N432-Alert: Adjustment based on a Recovery Audit	3%	CARC-23 The impact of prior payer(s) adjudication including payments and/or adjustments.	2%
10.	16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present MA130-Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information	1%	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.	2%

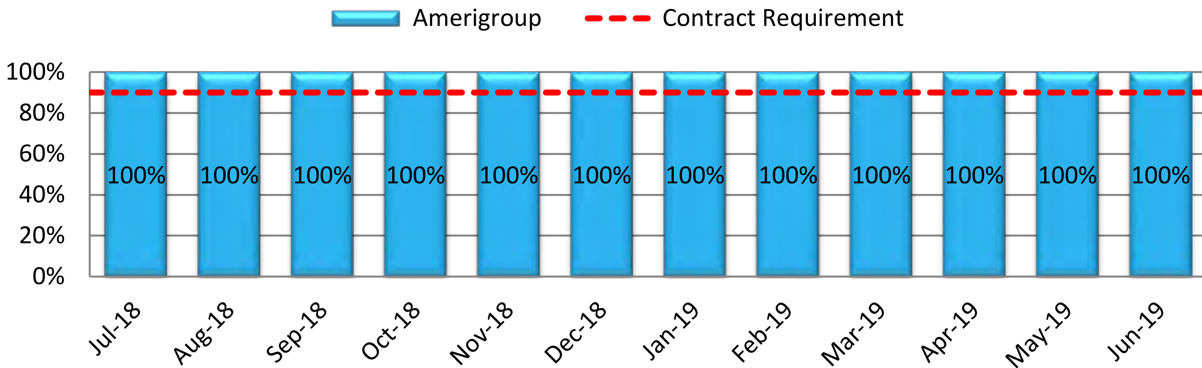
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

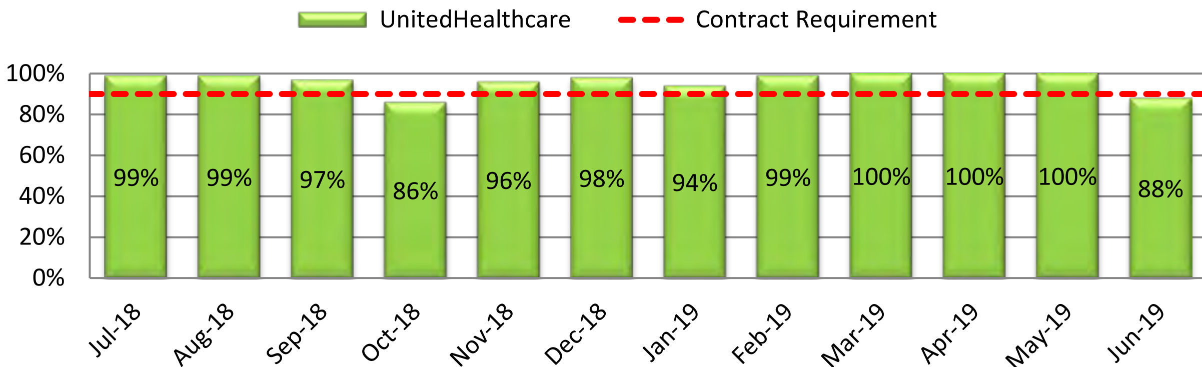
Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/



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

Supporting Data		
All Rx and NonRx Claims	24,889,099	**% of Claims Universe**
All Rx and NonRx Reprocessing for Provider Requests or Errors	1,198,130	4.81%
All Rx and NonRx Prior Authorizations	336,330	1.35%
Appeals	2,147	0.01%

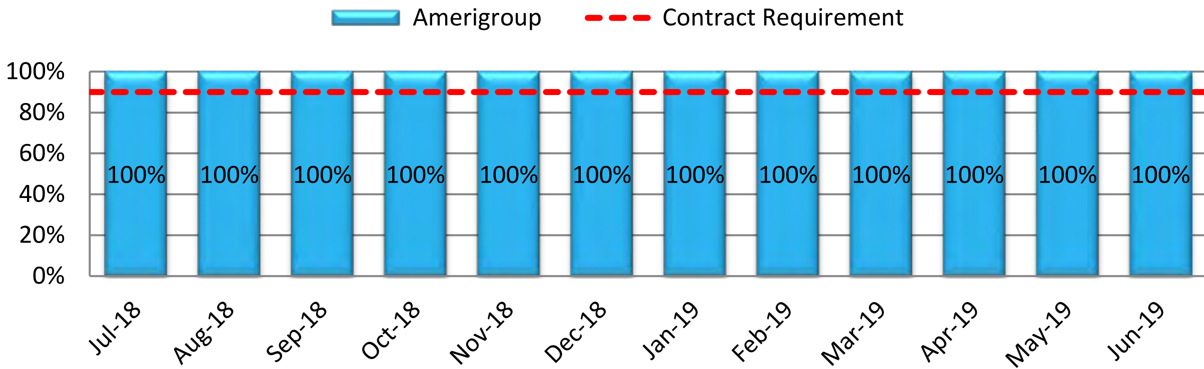


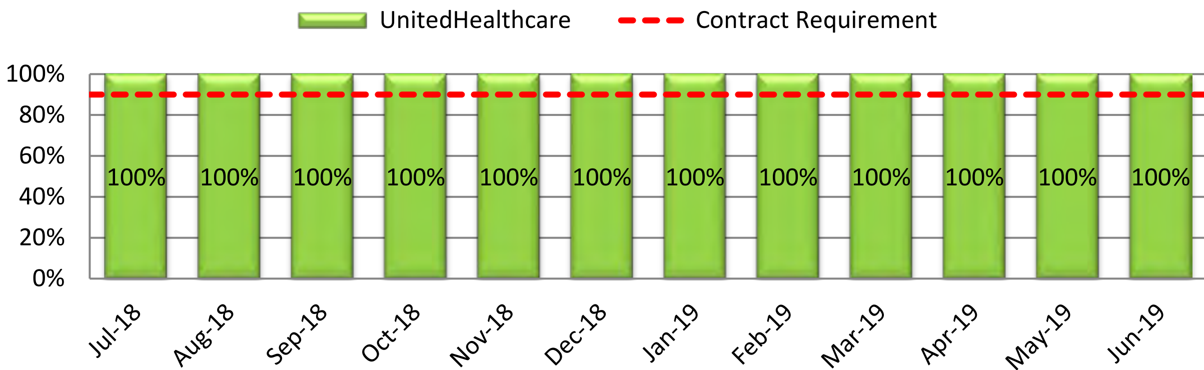


Plans have 30 days from the date of identification of an error or a clean provider adjustment request to reprocess 90% of the claims identified. Claims reprocessing projects may be processed on a different timeline with Agency approval.

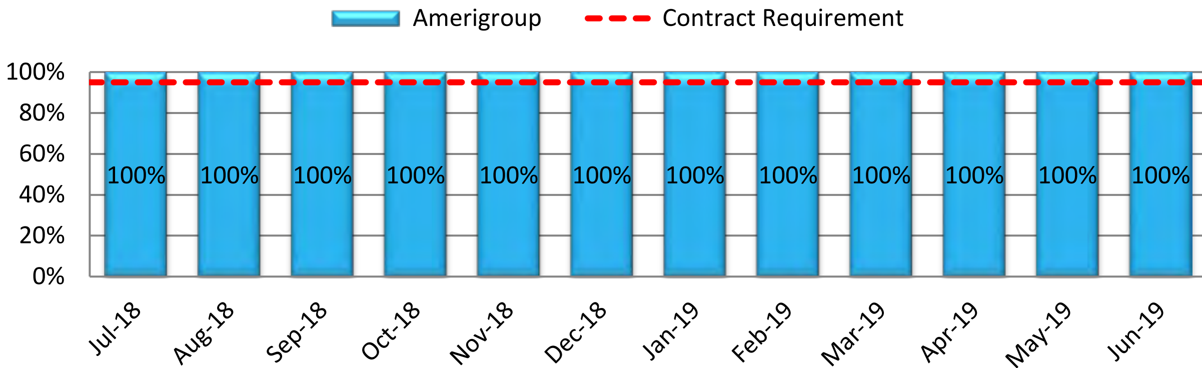
Pharmacy Claims Payment

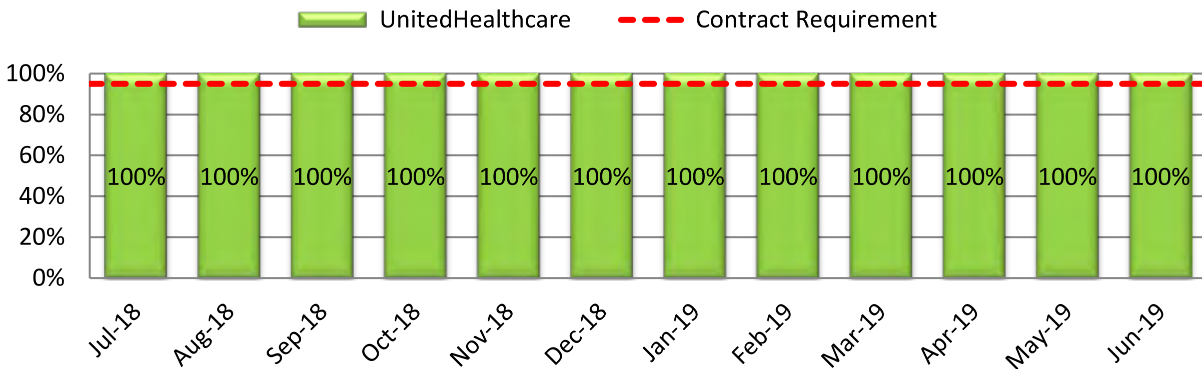
Pharmacy claims processing data is for the entire quarter.



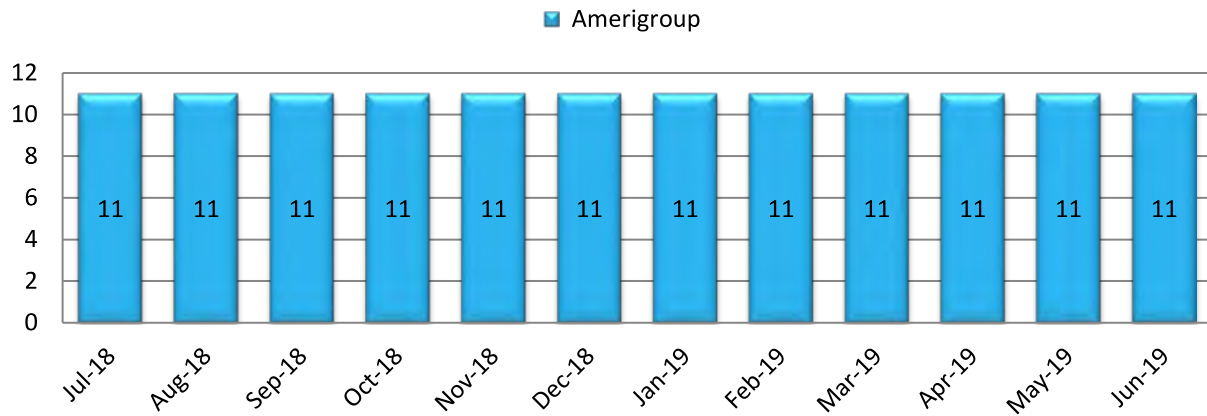


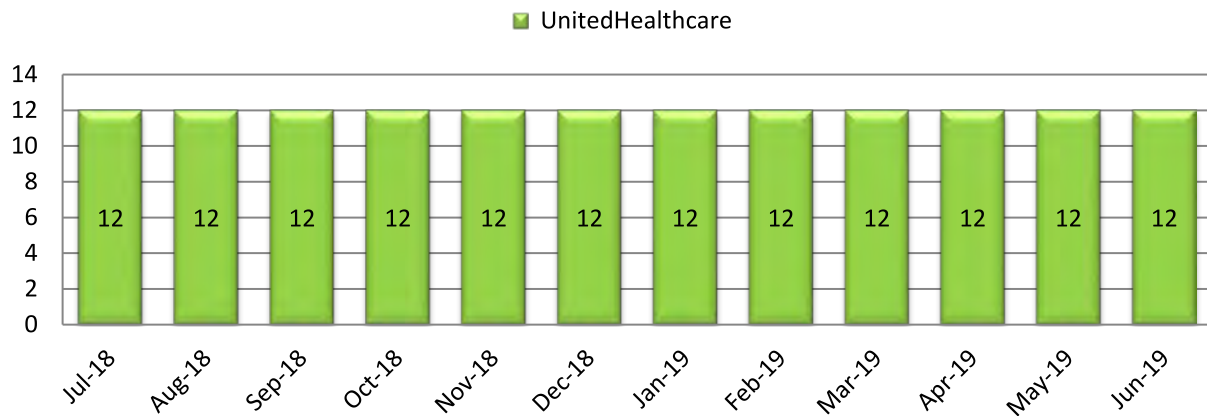
This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department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

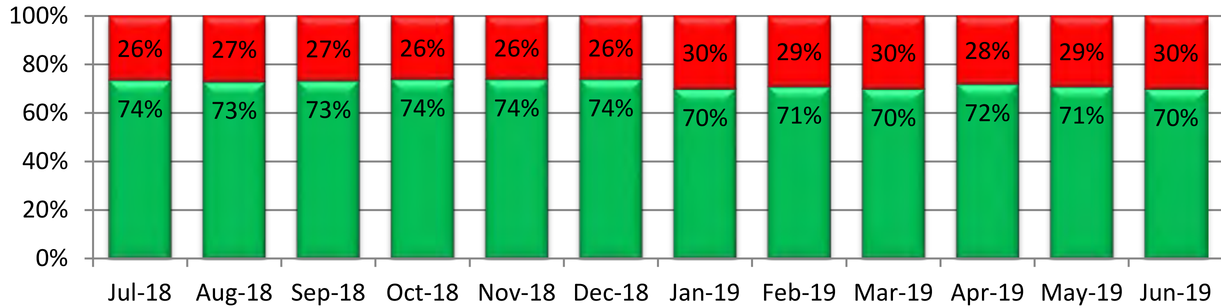


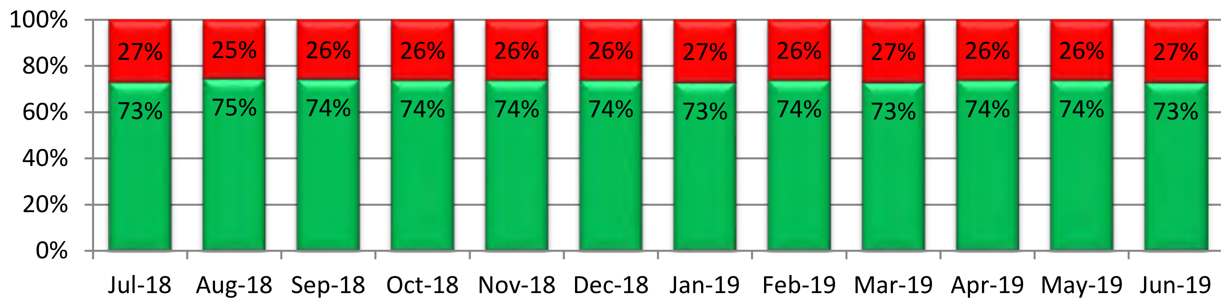


This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department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


Average Days for Pharmacy Claims Payment
Amerigroup
12
10
8
6
4
2
0
11
11
11
11
11
11
11
11
11
11
11
11
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


Average Days for Pharmacy Claims Payment
UnitedHealthcare
14
12
10
8
6
4
2
0
12
12
12
12
12
12
12
12
12
12
12
12
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19





Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period

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

Utilization of Value Added Services Reported Count of Members	
Managed care organizations may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.	
Q1 SFY19 Data	**UnitedHealthcare**
Baby Blocks	2,398
School/Camp/Sports Physicals	124
Non Emergent Transportation	959
Weight Watchers	149
Q2 SFY19 Data	**UnitedHealthcare**
Baby Blocks	2,883
School/Camp/Sports Physicals	77
Non Emergent Transportation	980
Weight Watchers	123
Q3 SFY19 Data	**UnitedHealthcare**
Baby Blocks	3,046
School/Camp/Sports Physicals	55
Non Emergent Transportation	1,033
Weight Watchers	124
Q4 SFY19 Data	**UnitedHealthcare**
Baby Blocks	2,985
School/Camp/Sports Physicals	48
Non Emergent Transportation	932
Weight Watchers	105

Utilization of Value Added Services Reported
Count of Members

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

Q1 SFY19 Data	Amerigroup
Weight Watchers	91
Exercise Kit	35
Dental Hygiene Kit	68
Personal Bag for Belongings with Comfort Item	10
SafeLink Mobile Phone	50
Healthy Families Program	18
Community Resource Link	261
Live Health Online	23
Healthy Rewards	1,745
Taking Care of Baby and Me	2,427
Boys & Girls Club	107
Personal Care Attendant	0
Home Delivered Meals	16
Community Reintegration Benefit	0
Post-Discharge Stabilization Kit	0
Q2 SFY19 Data	**Amerigroup**
Weight Watchers	72
Exercise Kit	0
Dental Hygiene Kit	39
Personal Bag for Belongings with Comfort Item	25
SafeLink Mobile Phone	83
Healthy Families Program	25
Community Resource Link	117
Live Health Online	14
Healthy Rewards	1,823
Taking Care of Baby and Me	4,045
Boys & Girls Club	12
Personal Care Attendant	0
Home Delivered Meals	0

Community Reintegration Benefit	8
Post-Discharge Stabilization Kit	0
Q3 SFY19 Data	**Amerigroup**
Weight Watchers	139
Exercise Kit	36
Dental Hygiene Kit	53
Personal Bag for Belongings with Comfort Item	9
SafeLink Mobile Phone	65
Healthy Families Program	40
Community Resource Link	204
Live Health Online	20
Healthy Rewards	13,348
Taking Care of Baby and Me	2,345
Boys & Girls Club	193
Personal Care Attendant	1
Home Delivered Meals	0
Community Reintegration Benefit	4
Post-Discharge Stabilization Kit	0
Q4 SFY19 Data	**Amerigroup**
Weight Watchers	169
Exercise Kit	45
Dental Hygiene Kit	35
Personal Bag for Belongings with Comfort Item	9
SafeLink Mobile Phone	83
Healthy Families Program	25
Community Resource Link	625
Live Health Online	25
Healthy Rewards	2,394
Taking Care of Baby and Me	4,671
Boys & Girls Club	67
Personal Care Attendant	7
Home Delivered Meals	10
Community Reintegration Benefit	0
Post-Discharge Stabilization Kit	1

Provider Network Access

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

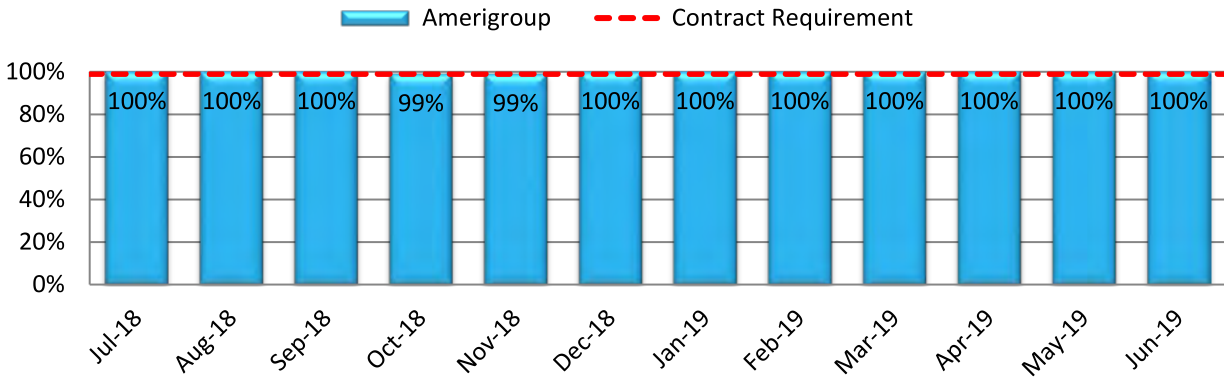
- Member and provider ratios by provider type and by region
- Geographic access by time and distance

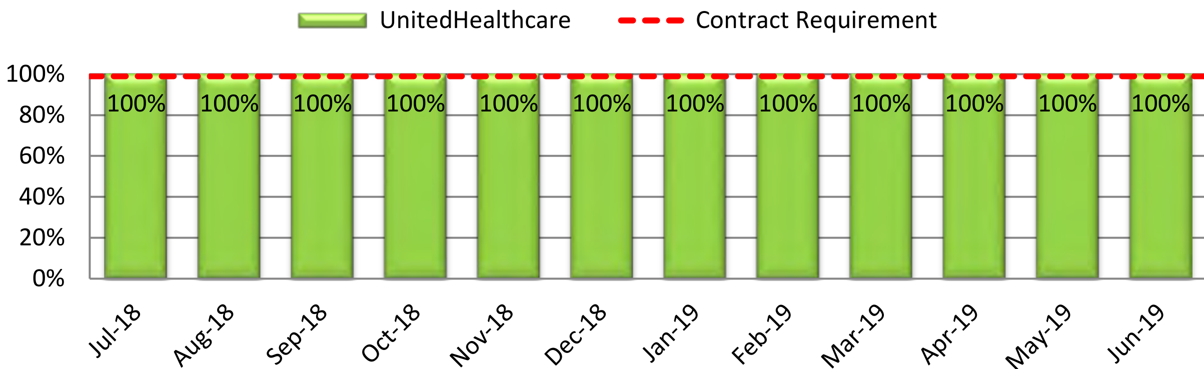
As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the department when the MCO clearly demonstrates that:

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

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

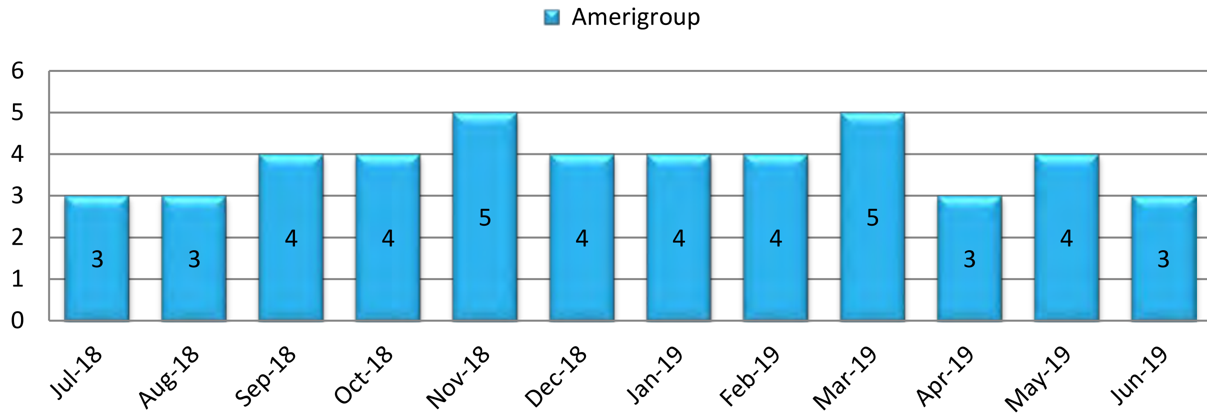
Non-Pharmacy Prior Authorization



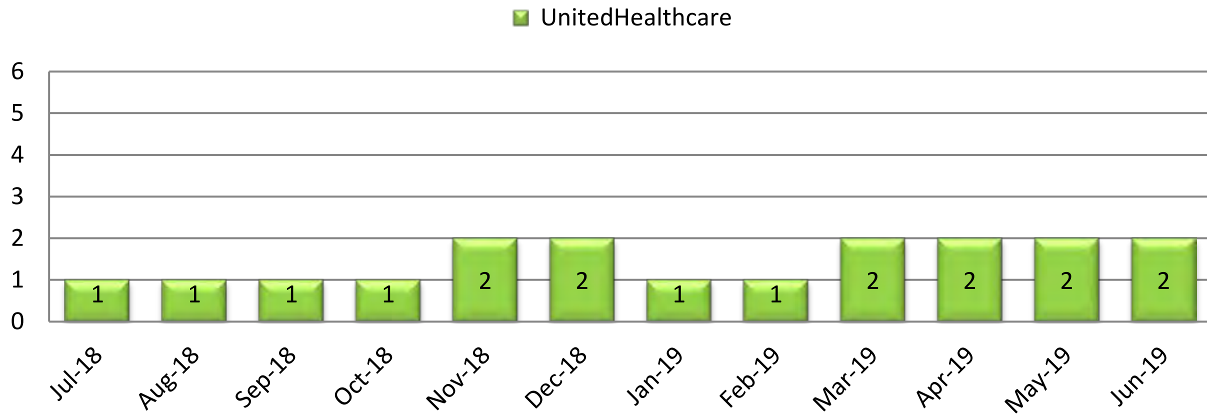


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of regular prior authorizations (PAs) must be completed within 14 calendar days of request to meet performance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

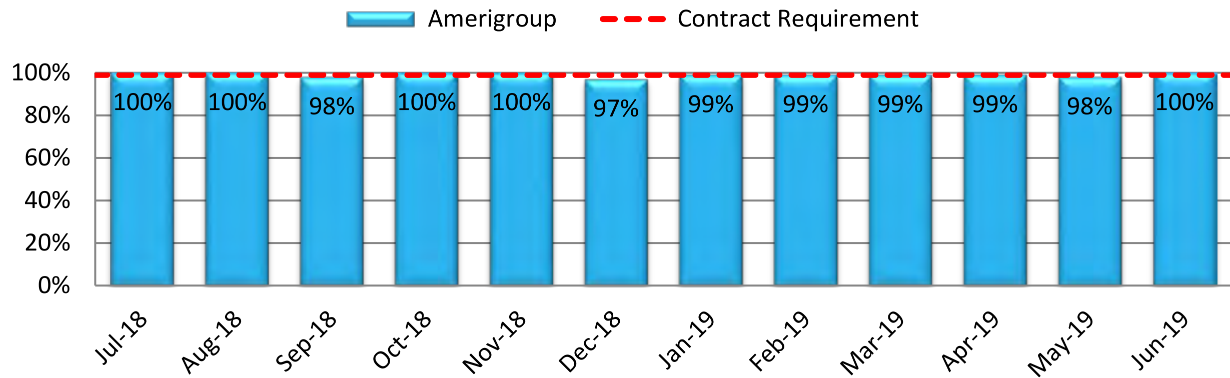
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.



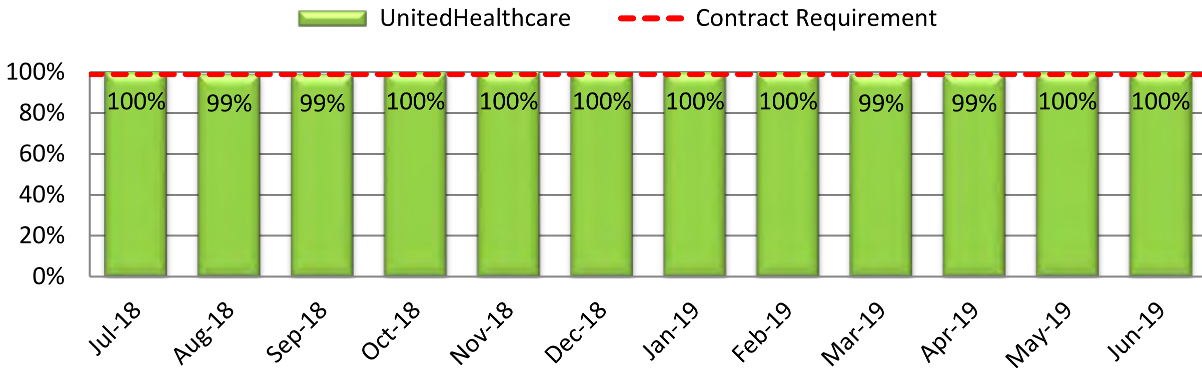
Average Days for Regular PA Processing
Amerigroup
6
5
4
3
2
1
0
3
3
4
4
5
4
4
4
5
3
4
3
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19



Average Days for Regular PA Processing
UnitedHealthcare
6
5
4
3
2
1
0
1
1
1
1
2
2
1
1
2
2
2
2
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

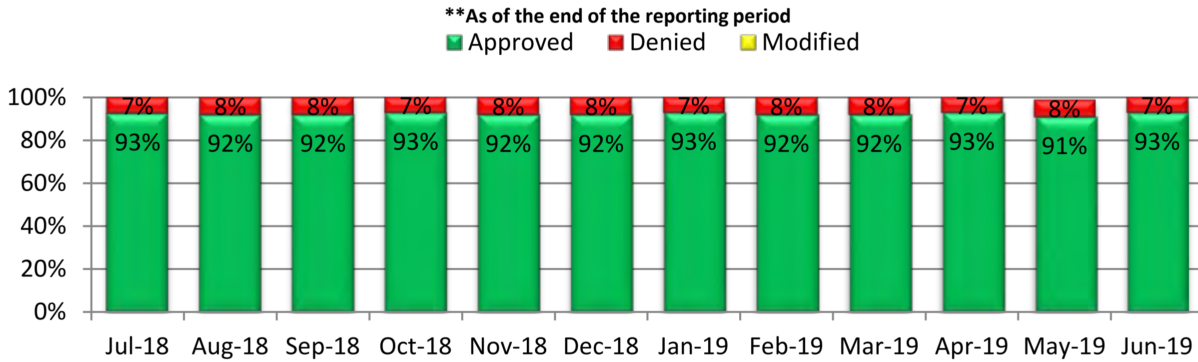


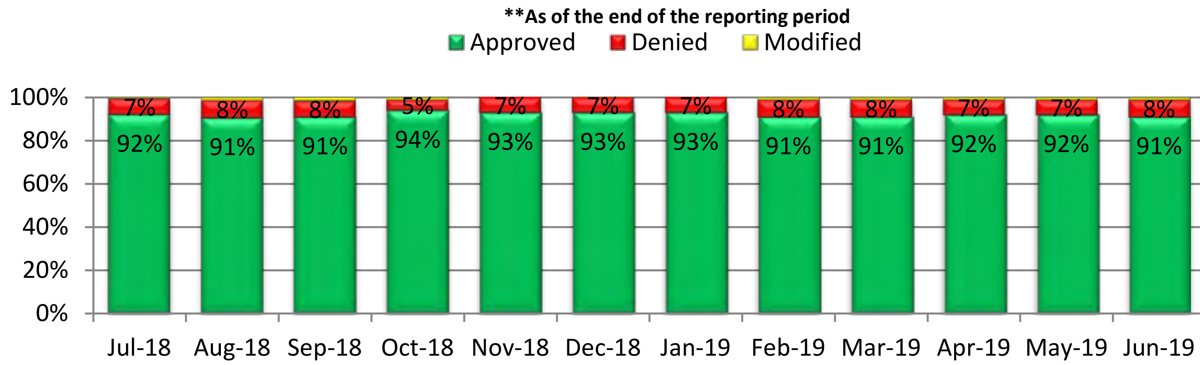
Percentage of PAs for Expedited Services Completed Within 72 Hours of Request
Amerigroup
Contract Requirement
100%
80%
60%
40%
20%
0%
100%
100%
98%
100%
100%
97%
99%
99%
99%
99%
98%
100%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19



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

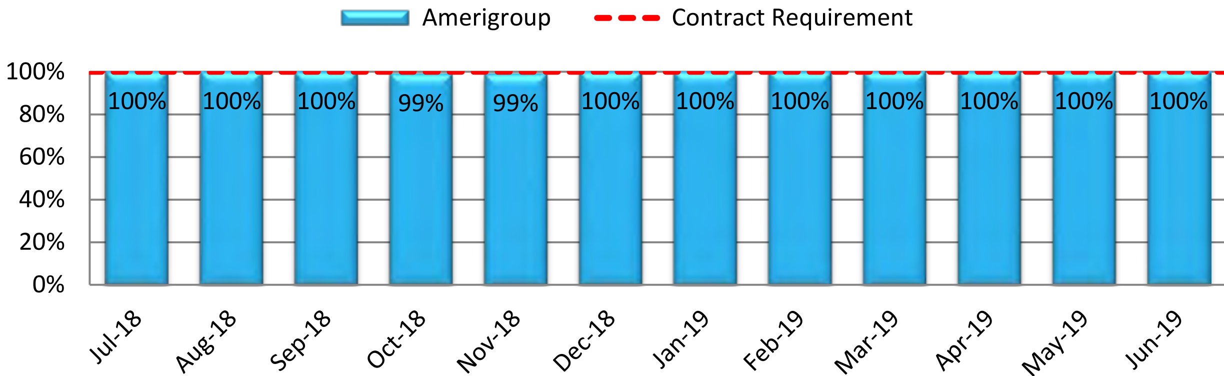
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.

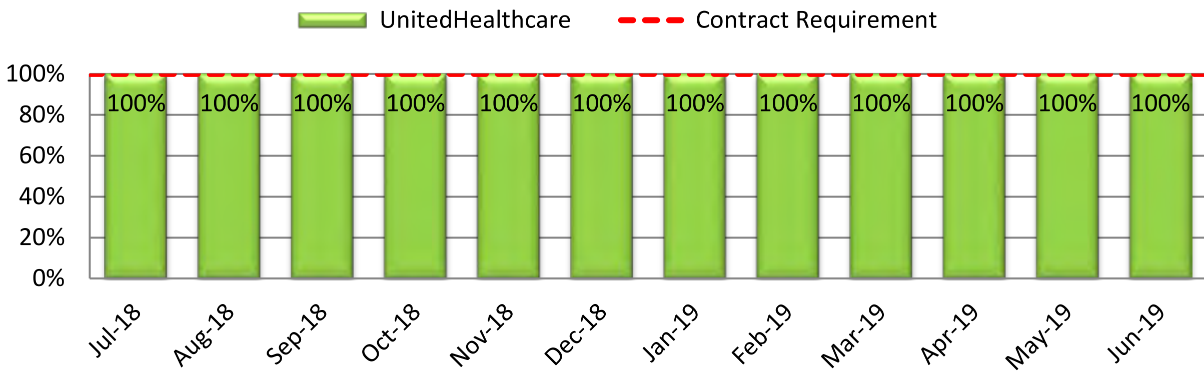




The Department has found and corrected an error in reporting percentages for Non-Pharmacy PA Status from October 2018 – March 2019. The graphs above contain the correct percentages.

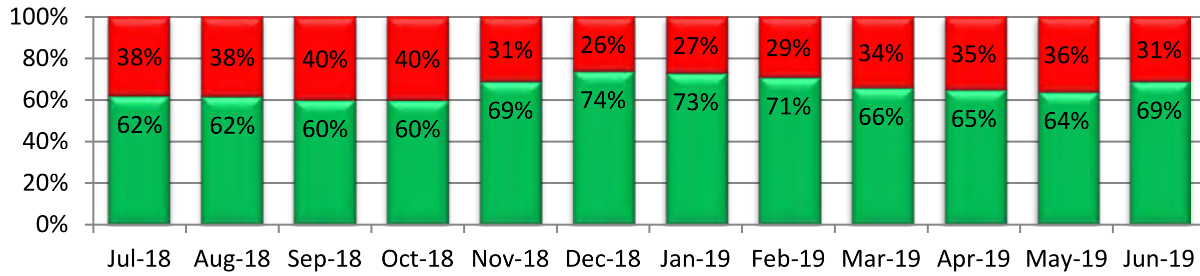
Prior Authorization - Pharmacy

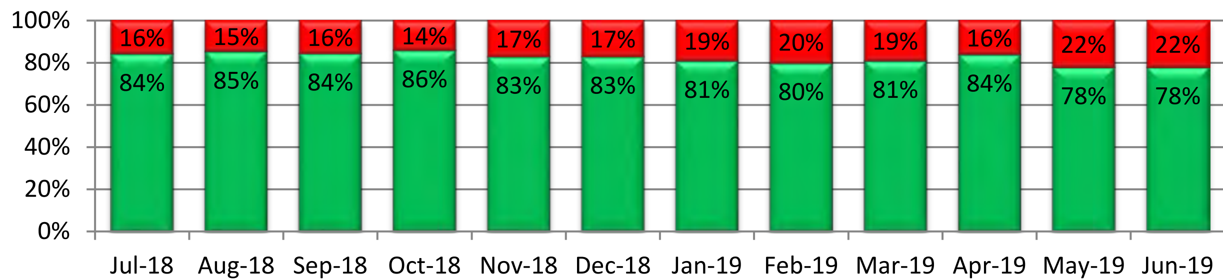




This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ. 100% of regular PAs must be completed within 24 hours of request to meet performance guarantees.

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


Amerigroup Pharmacy PAs Submitted Status
**As of the end of the reporting period
Approved
Denied
100%
80%
60%
40%
20%
0%
38%
38%
40%
40%
31%
26%
27%
29%
34%
35%
36%
31%
62%
62%
60%
60%
69%
74%
73%
71%
66%
65%
64%
69%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19


UnitedHealthcare Pharmacy PAs Submitted Status
**As of the end of the reporting period
Approved
Denied
100%
80%
60%
40%
20%
0%
16%
15%
16%
14%
17%
17%
19%
20%
19%
16%
22%
22%
84%
85%
84%
86%
83%
83%
81%
80%
81%
84%
78%
78%
Jul-18
Aug-18
Sep-18
Oct-18
Nov-18
Dec-18
Jan-19
Feb-19
Mar-19
Apr-19
May-19
Jun-19

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	**UnitedHealthcare**											
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

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

Data	Amerigroup	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards for Q1 SFY19	32%	46%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q2 SFY19	45%	62%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q3 SFY19	49%	55%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q4 SFY19	47%	54%

MCO FINANCIALS

MLR/ALR/Underwriting

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the department and the managed care organizations.

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

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

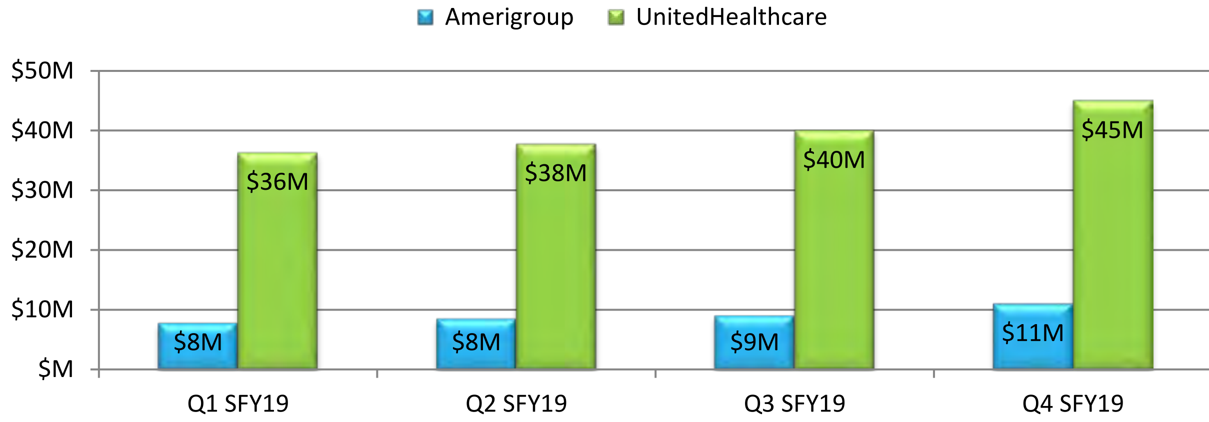
Q1 SFY19 Data	Amerigroup	UnitedHealthcare
MLR	91.0%	91.6%
ALR	6.0%	7.9%
Underwriting	3.0%	0.5%
Q2 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
MLR	89.5%	94.0%
ALR	5.5%	12.1%
Underwriting	5.0%	-6.1%
Q3 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
MLR	91.6%	97.1%
ALR	6.2%	9.2%
Underwriting	2.2%	-6.4%
Q4 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
MLR	98.1%	92.2%
ALR	6.2%	9.1%
Underwriting	-4.3%	-1.3%

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

Capitation Payments Made to the MCOs				
Capitation payments include payments made for the reported quarter's enrollment, adjustments, and member reinstatements and retroactive eligibility. Quarterly Performance Reports in previous fiscal years only included payments for the current quarter's enrollment, which is why previous quarters are not provided.				
MCO	**Q1 SFY19**	**Q2 SFY19**	**Q3 SFY19**	**Q4 SFY19**
Amerigroup Total	**$417,598,591**	**$429,046,037**	**$376,525,389**	**$402,424,413**
Adjustments	$97,848,029	$72,262,766	($509,327)	($313,567)
Current	$312,420,560	$347,223,304	$365,336,282	$391,378,265
Member Reinstatements and Retroactive Eligibility	$7,330,002	$9,559,966	$11,698,434	$11,359,715
UnitedHealthcare Total	**$768,872,756**	**$865,012,150**	**$763,249,472**	**$497,225,366**
Adjustments	$78,327,083	$121,133,543	$673,460	($604,321)
Current	$671,528,707	$722,723,962	$738,949,197	$483,286,115
Member Reinstatements and Retroactive Eligibility	$19,016,967	$21,154,644	$23,626,815	$14,543,572

For Q4 SFY19, the capitation payment for UHC was withheld for the month of June.

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


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

PROGRAM INTEGRITY

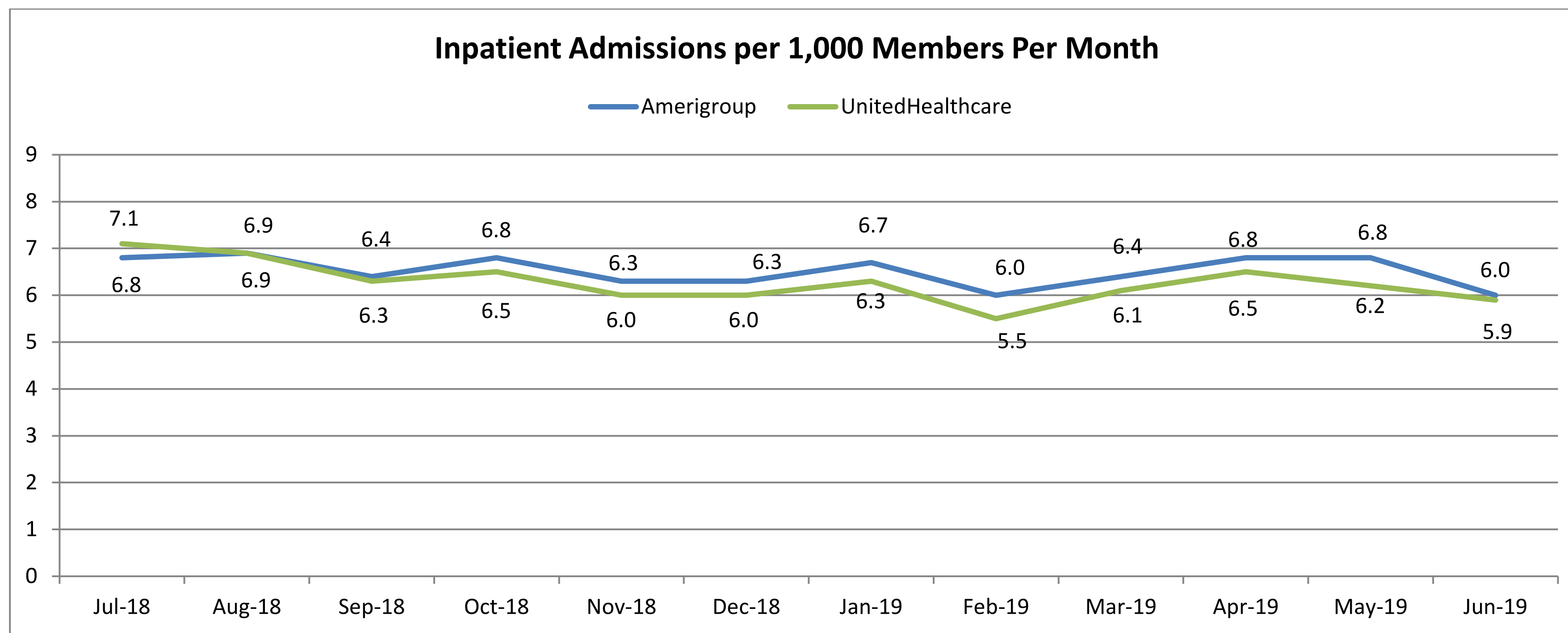
Program Integrity
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done 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		
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.		
Q1 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
Investigations Opened During the Quarter	15	151
Overpayments Identified During the Quarter	11	15
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	8	14
Member Concerns Referred to IME	0	11
Q2 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
Investigations Opened During the Quarter	27	19
Overpayments Identified During the Quarter	24	19
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	4	2
Member Concerns Referred to IME	7	10
Q3 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
Investigations Opened During the Quarter	27	4
Overpayments Identified During the Quarter	26	4
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	9	13

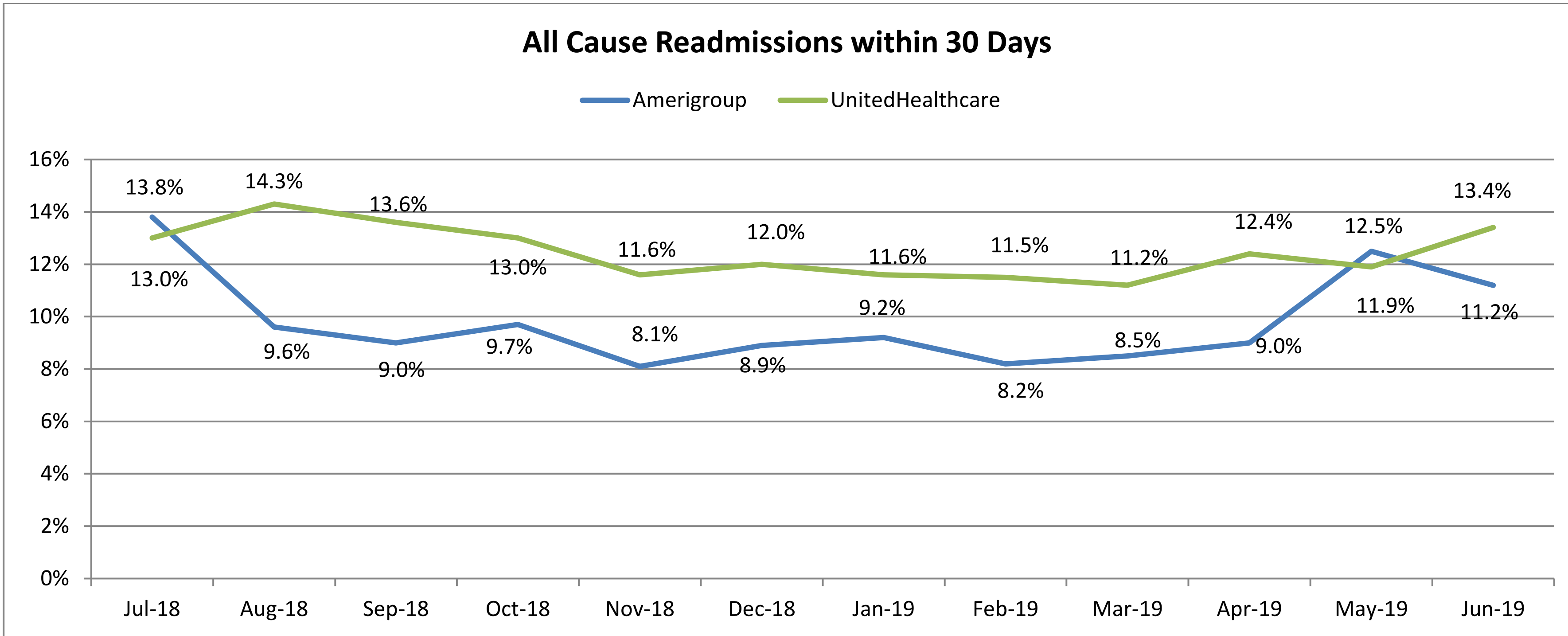
Member Concerns Referred to IME	7	14
Q4 SFY19 Data	**Amerigroup**	**UnitedHealthcare**
Investigations Opened During the Quarter	30	12
Overpayments Identified During the Quarter	14	10
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	14	16
Member Concerns Referred to IME	8	12

In SFY19, the plans initiated 285 investigations and have referred a total of 81 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 would not occur until there is sufficient evidence to implement.

For Q4 SFY19, one of Amerigroup's referrals was made twice to the Medicaid Fraud Control Unit, but was only accepted once. This was originally counted as 2 referrals, but should have been counted as 1. The reduction from 15 to 14 referrals for Amerigroup for Q4 has been noted in the table above.



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



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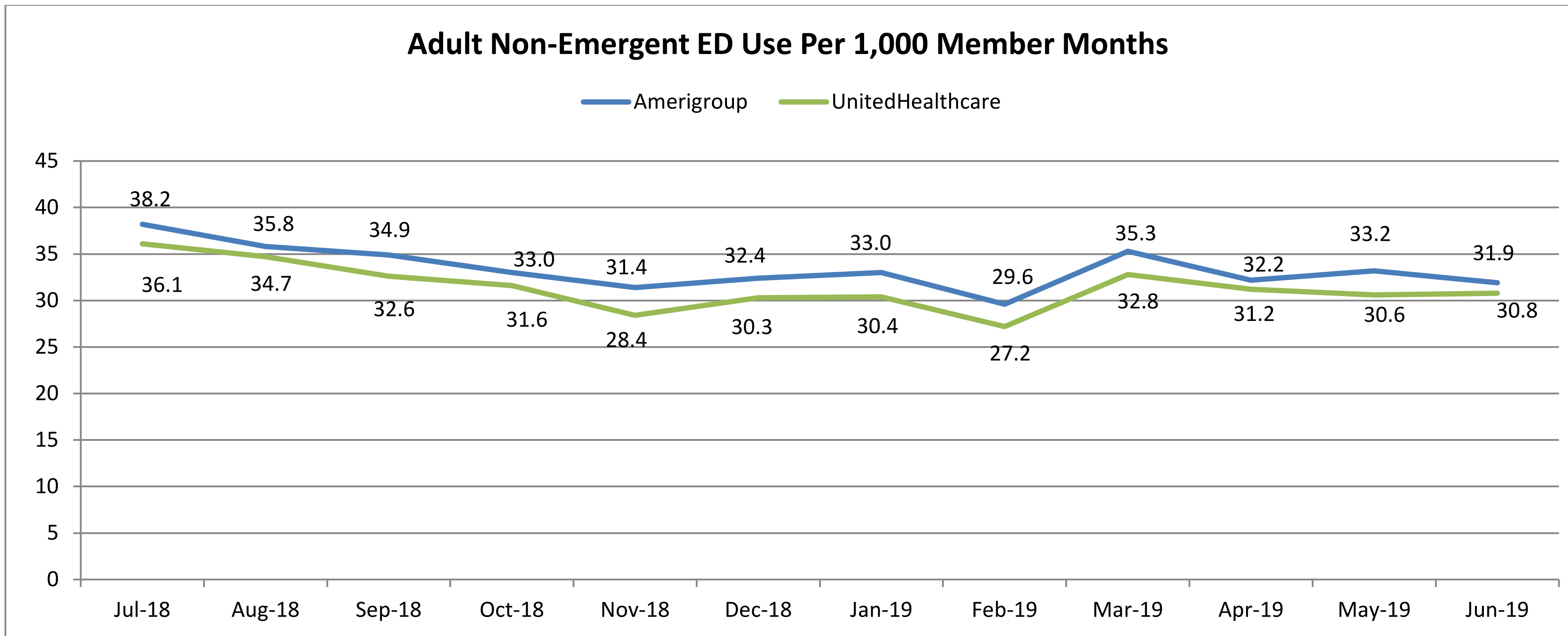

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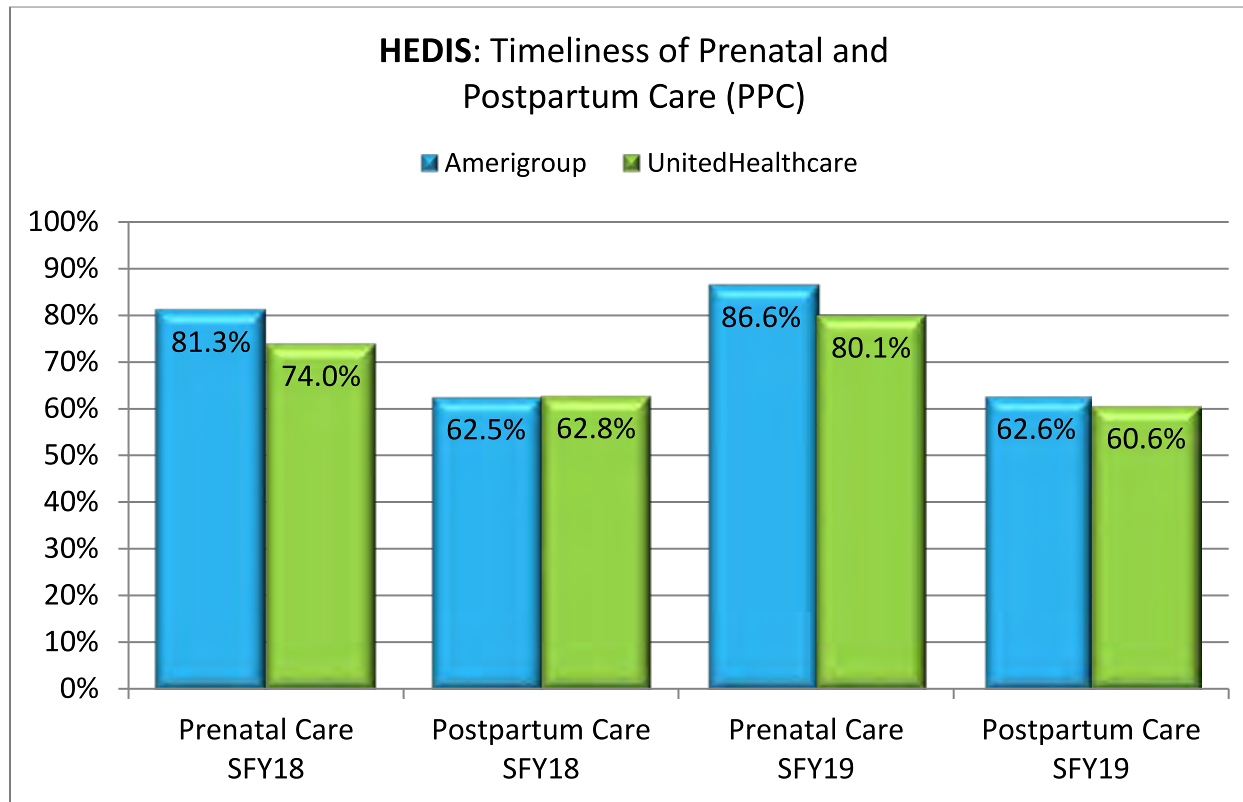
As of July 1, 2018, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase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

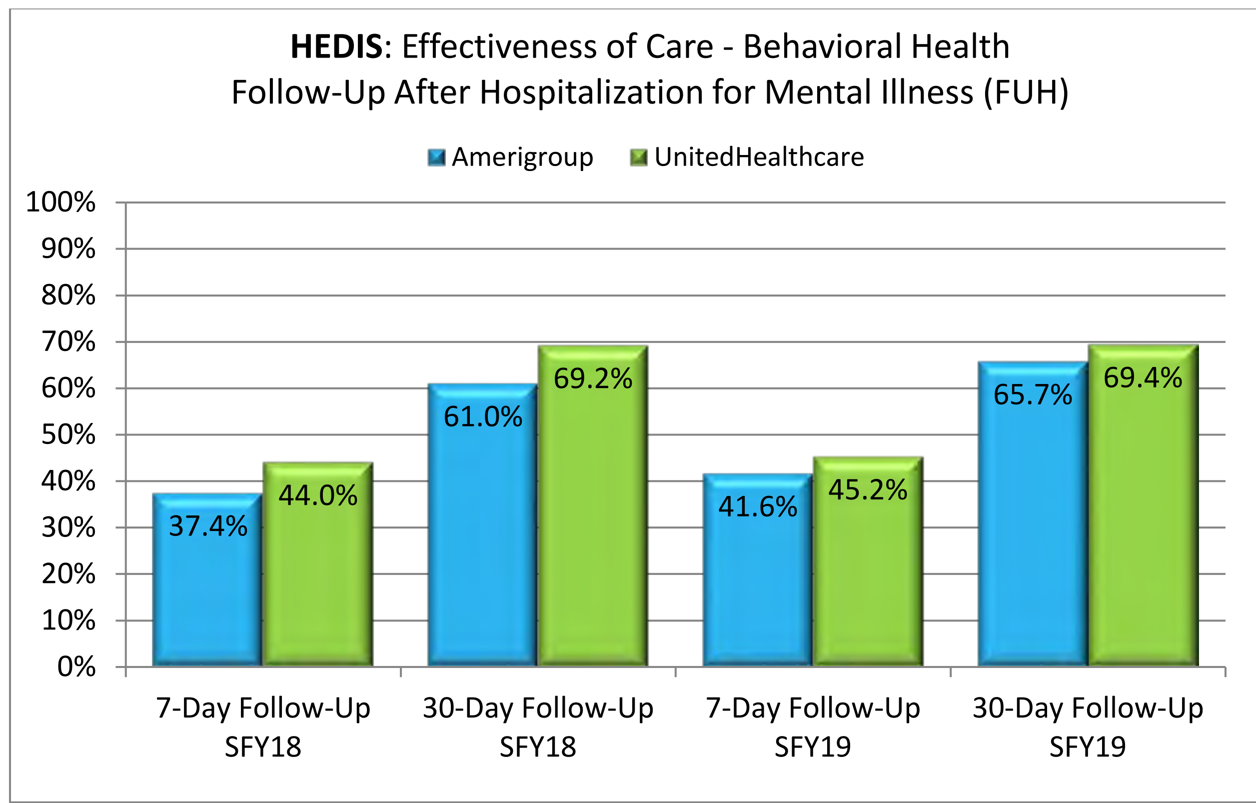
As of January 1, 2019, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number of ED visits considered non-emergent would increase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

Health Effectiveness Data and Information Set (HEDIS)

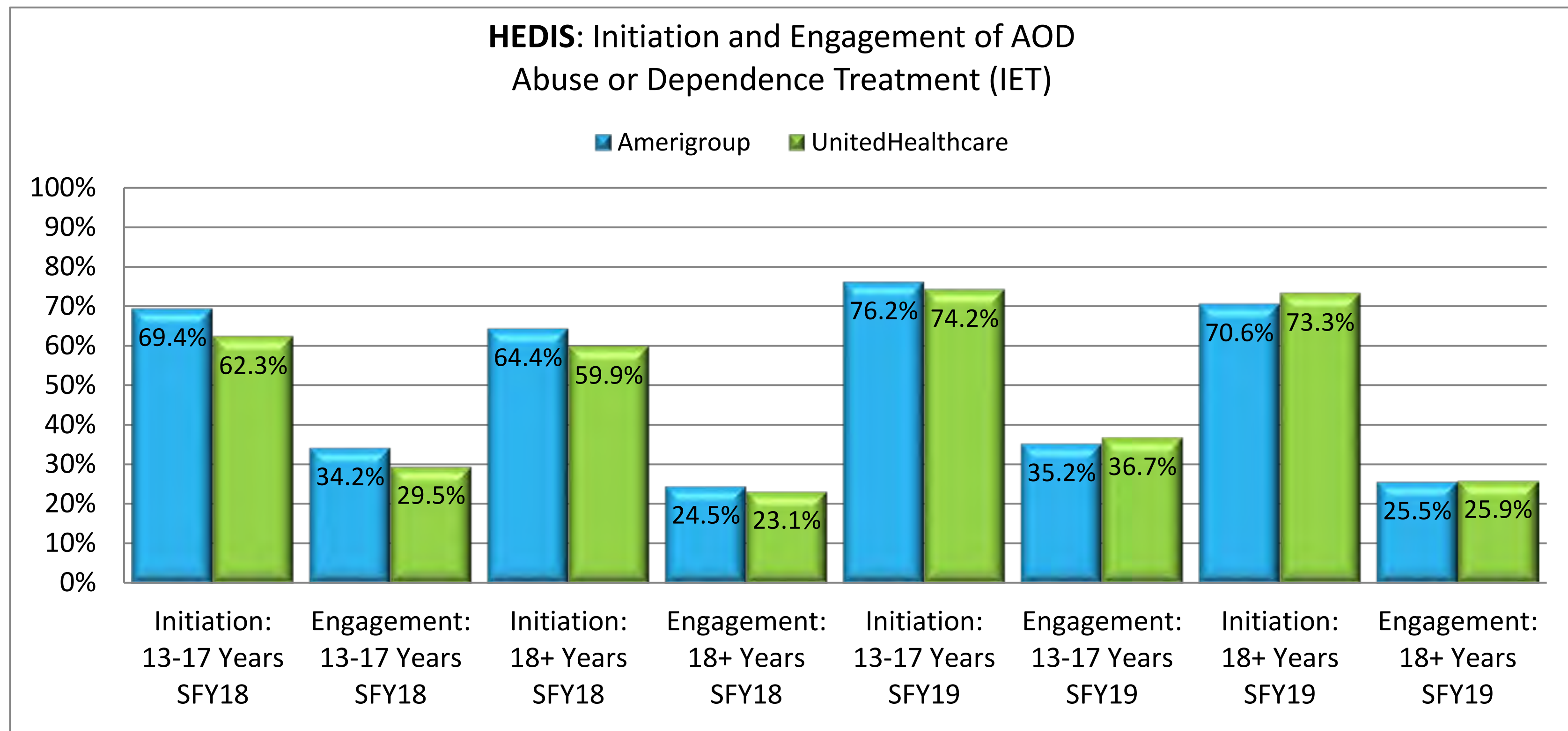
A goal of managed care is to improve health outcomes. The Health Effectiveness Data and Information Set (HEDIS) uses evidence-based measurement and specifications to benchmark health plan performance. The data published in this report include measures that were reportable and focus on the following domains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



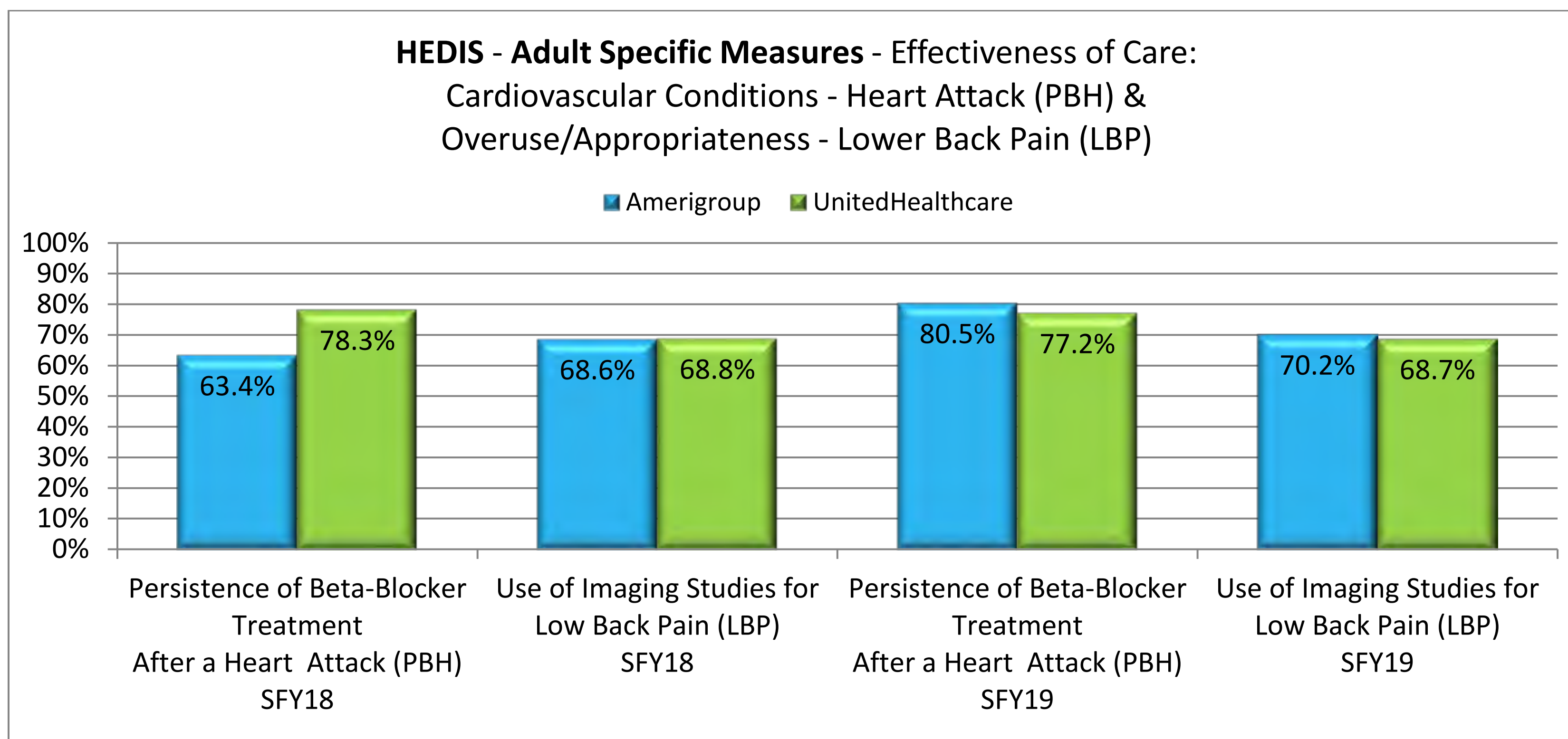
Timeliness of prenatal and postpartum care measures assess the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal and postpartum care. Timeliness 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.



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.

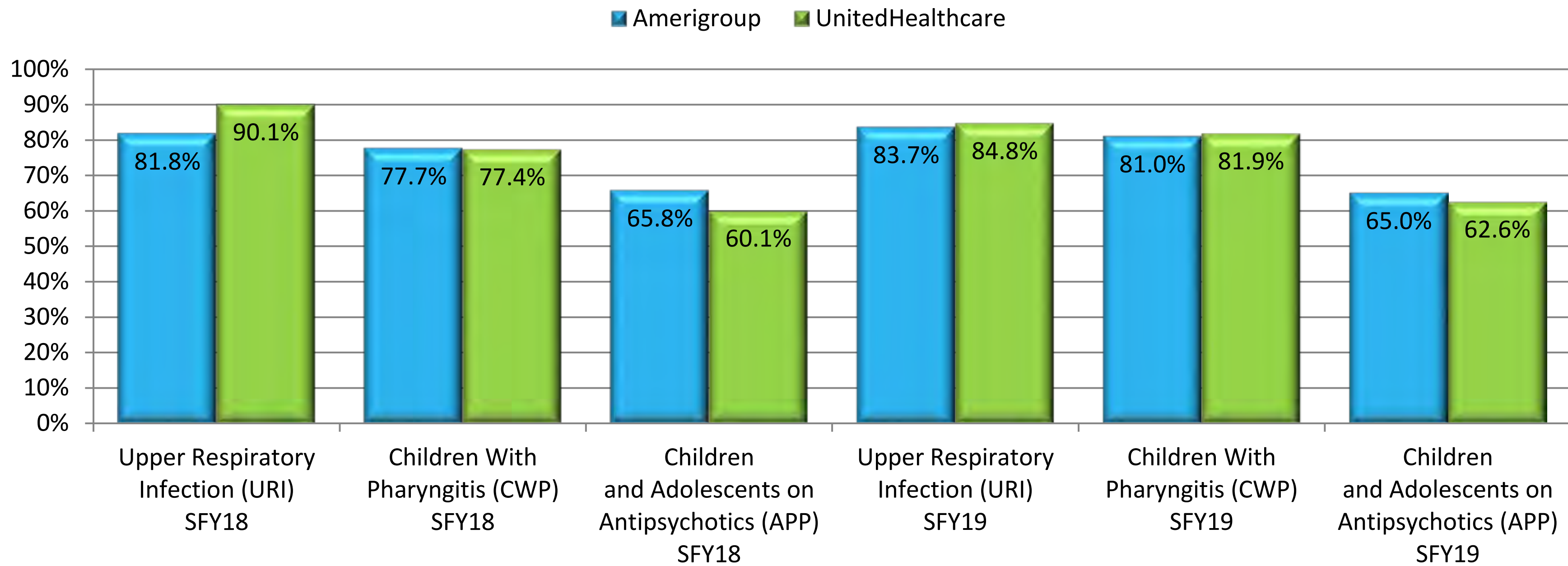


The Alcohol or Drug Dependence Initiation and Engagement of Treatment measure (shown in the table above) assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care. Initiation of AOD Treatment: Adolescents and adults 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.



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.

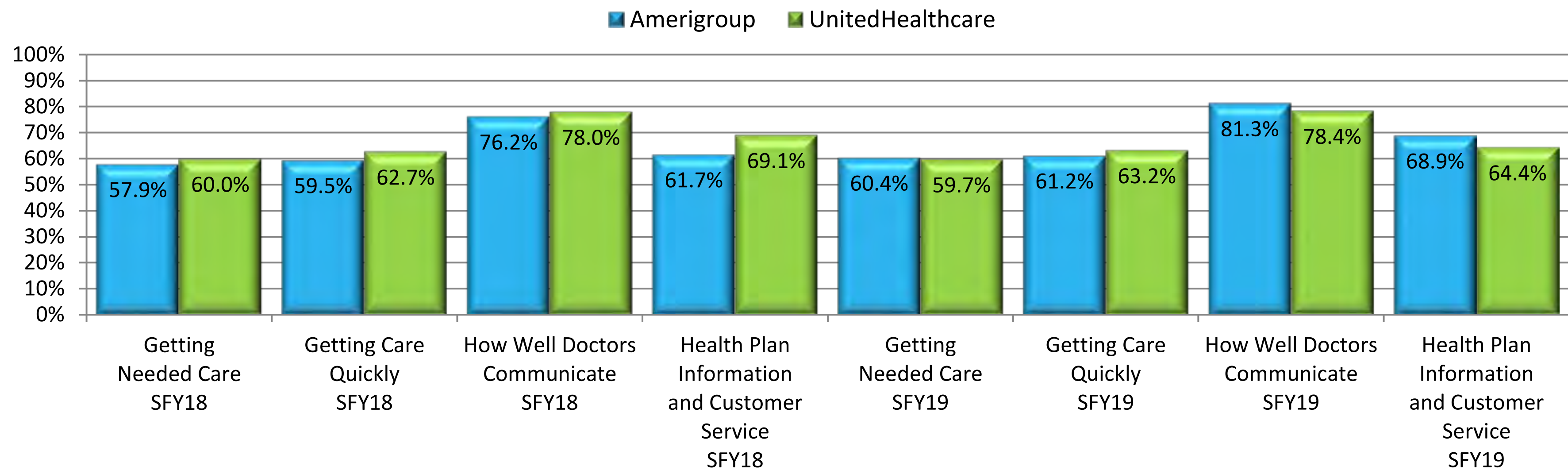
The Appropriate Testing for Children with Pharyngitis measure (shown on the previous page) assesses children 2- to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic, and received a "Group A" streptococcus test for the episode. A higher rate represents better performance (i.e.,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

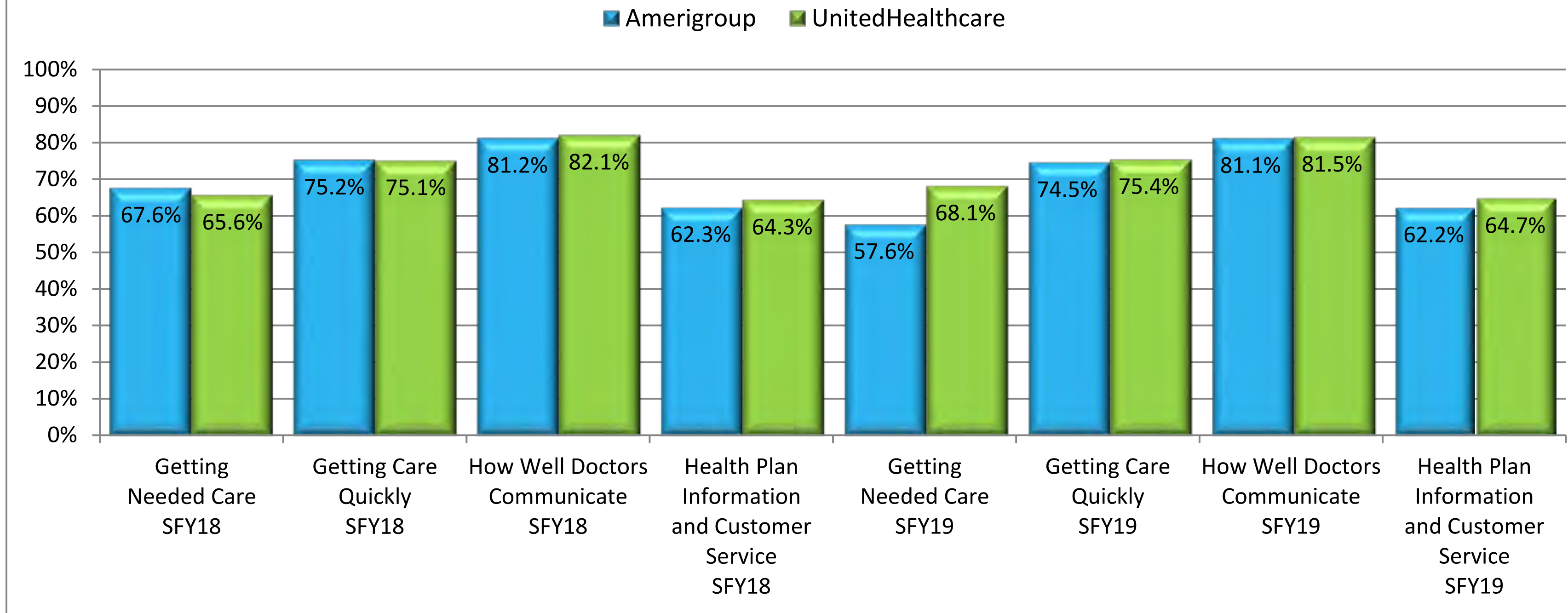
The Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics measure (shown on the previous page) assesses whether children and adolescents without an indication for antipsychotic medication use had documentation of psychosocial care as first-line treatment before being prescribed 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.

Jerry Foxhoven, Director — **Council on Human Services**

Meeting Minutes
January 9, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present via phone**	Jerry Foxhoven – **present via phone**
Alexa Heffernan – **present via phone**	Harry Rossander - **present**
Kimberly Kudej – **present via phone**	Nancy Freudenberg - **present**
Kim Spading – **absent**	Mike Randol – **present via phone**
Sam Wallace – **present via phone**	Mikki Stier – **present via phone**
	Lisa Cook – **present via phone**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **present via phone**
Representative Lisa Heddens – **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests
Erin Cubit, Iowa Hospital Association
Tony Leys, Des Moines Register
Tony Reed, Central Iowa Detention

Call to Order
Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m. via conference call on Wednesday, January 9, 2019. Anderson stated:

"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."

1 February 14, 2019

Roll Call
All Council members were present with the exception of Spading.
Ex-officio legislative member Representative Fry was present via phone. All of the other ex-officio legislative members were absent.

Rules
Nancy Freudenberg presented the following rule for adoption:

R-1 Amendments to Chapter 167, Child Welfare. Adds clarity to 441—Chapter 167 by defining who must complete the required financial and statistical report for Juvenile Detention Reimbursement.

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

Approval of Minutes
A motion was made by Wallace and seconded by Heffernan to approve the minutes of December 12, 2018 meeting. MOTION UNANIMOUSLY CARRIED.

Oversight of Managed Care
Mike Randol, Medicaid Director, Iowa Medicaid Enterprise (IME) introduced Lisa Cook (IME) to provide a brief overview of the first quarter SFY 2019 Medicaid Managed Care performance report. Lisa Cook provided the following update:

The quarterly performance report is for the first quarter of State Fiscal Year 2019, July 2018 through September 2018. The IME has made some key changes in the performance reporting and she highlighted those changes by going through specific changes presented in the report by page and topic. Cook noted that the IME has taken a lot of input from stakeholders and worked with MCOs and internally within DHS to make the content of the reports more meaningful and easier to consume visually. The performance report is available on the IME webpage.

Lisa Cook reviewed the report and highlighted changes and results. Council member questions during that discussion were as follows:

Page 26 – One chart shows top ten reasons for pharmacy claims denials. A second chart on that page shows Utilization of Value Added Services Reported Count of Members.

Heffernan questioned that so few members are utilizing services.

Randol responded that it is already an opportunity to review the services being provided to members. IME will continue to monitor the utilization of these services.

Anderson asked why is there such a difference between the two companies?

Randol responded that we allow the MCOs to determine what value-added benefits with state approval that they offer. Trying to determine better ways to present the utilization of the services.

Kudej noted on Page 36 that there seem to be a high number of Fraud, Waste, and Abuse investigations for UnitedHealthCare as compared to Amerigroup.

Cook explained that UnitedHealthCare has a higher number of members in managed care than Amerigroup.

Heffernan referring back to Page 31 of the report asked why Amerigroup has a high percentage of denials for prior authorization (40% vs 16%)

Randol stated that IME will research that question and report back to the Council on the results.

Anderson noted that the new tables provided helpful information.

Council Update
Heffernan – Nothing to report
Kudej – Nothing to report
Wallace – Would like to update the Council on information regarding the Medical Residency Program.
Anderson – Nothing to report

Director's Report
Jerry Foxhoven, Director, reported

- DHS continues to prepare for the upcoming legislative session and budget discussions.
- Children's Mental Health provisions will continue to move forward.
- Finalizing the Medicaid Program Annual Report. Noted that many of the problems from prior years are being resolved and doing much better of taking care of members and providers.
- The Governor's office recently appointed a new person to manage candidates for appointments to Boards and Commissions. The Council is near the top of the list to receive two additional appointees once identified.

Legislator's Report
Representative Fry reported

- Echoed Director Foxhoven's statement about the legislative session will gavel in at 10:00 a.m. on Monday, January 14, 2019.

3

- He will be chairing the Health and Human Services Budget Committee this year.
- He anticipates that funding for Adult and Children's Mental Health will move forward.

Next Meeting

The next meeting of the Council on Human Services is Wednesday, February 13, 2019 at the Hoover Building.

Adjournment

Anderson adjourned the meeting at 10:39 a.m.

Submitted by,
Harry Rossander
Interim Recording Secretary
hr

IOWA Department of HUMAN SERVICES

Jerry Foxhoven, Director | **Council on Human Services**

Meeting Minutes
February 13, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present via phone**	Jerry Foxhoven – **present via phone**
Alexa Heffernan – **absent**	Harry Rossander - **present**
Kimberly Kudej – **present via phone**	Nancy Freudenberg - **present**
Kim Spading – **present via phone**	Carrie Malone – **present via phone**
Sam Wallace – **present via phone**	Jana Rhoads – **present**
	Matt Highland – **present via phone**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Lisa Heddens – **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests
Tony Leys, Des Moines Register
Sandi Hurtado-Peters, IDOM
Craig Schoenfeld, Iowa Total Care

Call to Order
Mark Anderson, Chair, called the Council meeting to order at 10:01 a.m. via conference call on Wednesday, February 13, 2019. Anderson stated:

"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
All Council members were present with the exception of Heffernan.
All ex-officio legislative members were absent.

Rules
Nancy Freudenberg presented the following rule for adoption:

R-1 Amendments to Chapters 51 and 52, State Supplementary Assistance. These amendments implement the January 1, 2019, cost of living adjustments (COLA) to income limits and benefit amounts for several State Supplementary Assistance categories. These amendments also implement the changed personal needs allowance for the Residential Care Facility (RCF) assistance Family-Life Home (FLH) assistance.

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

Nancy Freudenberg presented the following rules for Notice:

N-1 Amendments to Chapter 73, Medicaid. Allows advanced registered nurse practioners (ARNPs) and physician assistants (PAs) to be primary care providers with a managed care organization (MCO).

N-2 Amendments to Chapter 176, Dependent Adult Abuse. Streamlines required maintenance of administrative rules for dependent adult abuse by removing form numbers from administrative rules.

A motion was made by Wallace to accept the Notices of Intended Action and seconded by Kudej. MOTION UNANIMOUSLY CARRIED.

Legislative Update
Carrie Malone presented a legislative update in which she discussed:

- There has been much conversation regarding telehealth and how telehealth can be a solution either within or outside of Medicaid but how it could be a source of cost savings.
- Presentations on Children's Board at the HHS Budget sub-committee. Legislators were excited about moving forward on this topic. MHDS gave presentation to the House Human Resources Committee on the Complex Needs Bill that passed last year and what next steps could be.
- Gov's office approved 5 DHS bills:
  - Child support fees
  - Community self resource allowance
  - Medicaid Member Appeals
  - Family First Legislation
  - Hawk-I and ELIAS system

2

- Two of the five bills have already passed through committee and will pass through the first funnel.
- DHS is also working with legislators to push forward a bill on the subject of Divestiture.
- As a result of discussion after the formal bill process, this bill concept was proposed. The federal government requires that the state follow up with someone on Medicaid who has assets that used Medicaid to recover costs. Iowa is the only state in the country that follows our current process. The concept discussed would instead place a lien on assets that would allow heirs to determine the best way to pay for the lien. The current process has been in place for more than 20 years and allows the State to seize assets from members to pay for Medicaid services rendered. The new proposal would install a lien on those assets that would allow heirs to determine method of payment for the incurred debt.

Approval of Minutes
A motion was made by Wallace and seconded by Kudej to approve the minutes of the January 9, 2019 meeting. MOTION UNANIMOUSLY CARRIED.

Council Update
Anderson – Nothing to report
Wallace – Nothing to report
Spading – Will soon begin working with the Iowa Department of Public Health and others in the TelePrEP program. This program is intended to deliver HIV pre-exposure prophylaxis (PrEP) and comprehensive sexually transmitted infection (STI) prevention services in rural areas.
Kudej – Nothing to report

Director's Report
Jerry Foxhoven, Director, reported

- The Department is very busy with many different presentations on our programs and proposed legislation.
- The Department is out promoting the Governor's decision to add additional funding within her proposed budget. These monies will improve technologies available to workers in the field and add up to 84 social workers to the staff and will help ease work loads. This is the first time in many years where the Department is not trying to determine how to deal with budget cuts.

Matt Highland, Chief Information Officer, reported on the status of the new MCO choice roll out.

New MCO Choice Roll Out Overview
- In your materials are some information on the addition of the new MCO we prepared for legislators and wanted to share with you.
- As you know, Iowa Total Care (ITC) coverage begins July 1, 2019. Some members (about 140,000) will not be included in the redistribution to minimize disruption for these members with critical health care needs, but they will still have the opportunity to switch MCOs if they wish to:

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- Pregnant women
- Members with severe illnesses such as cancer
- Members who have recently transitioned from a long-term care facility back to the community

New MCO Communications

- Mailings will begin March 4, and will be staggered until March 22.
- For those who are not being redistributed, they still have a choice, and packets will be mailed to them the week of March 25 to 29.
- All of these members have until June 18, to make a choice which will be effective July 1, 2019
- In addition—members will have until September 30, to make a change for any reason.
- Members can email their choice, return the form in their packet or simply call member services.
- We will also be publishing an Informational Letter, as we know doctors are often key to getting information to our members
- We are also setting up a New MCO Choice webpage, which will link to sample mailings, have frequently asked questions and will be putting a variety of notices and information on our website.
  - We will also be using our e-news and social media posts to get information out.
  - Included in the packet, is a timeline and legislative, member and provider resources to assist if with constituent questions.

Kudej asked if all providers would need to re-enroll with the new provider. Highland explained that all providers would need to be enrolled with the Iowa Medicaid Enterprise and also with each MCO. Highland also noted that ITC has been in the process of enrolling providers for some time.

Anderson asked when the information in the packet supplied to Council would be shared with the press. Highland explained that the information is already available on the DHS website.

Next Meeting

The next meeting of the Council on Human Services is Wednesday, March 13, 2019 at the Hoover Building.

Adjournment

Anderson adjourned the meeting at 10:28 a.m.

Submitted by,
Harry Rossander
Interim Recording Secretary
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IOWA Department of HUMAN SERVICES

Jerry Foxhoven, Director — Council on Human Services

Meeting Minutes
March 13, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present via phone**	Jerry Foxhoven – **present via phone**
Alexa Heffernan – **present via phone**	Harry Rossander - **present**
Kimberly Kudej – **present**	Nancy Freudenberg - **present**
Kim Spading – **present via phone**	Mikki Stier – **present via phone**
Sam Wallace – **present via phone**	Mike Randol – **present via phone**
	Marissa Eyanson – **present via phone**

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Lisa Heddens – **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests

Craig Schoenfeld, Iowa Total Care
Stacie Maass, Iowa Total Care
Abdullah Amehee, Iowa Total Care

Call to Order

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m. via conference call on Wednesday, March 13, 2019. Anderson stated:

"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
All Council members were present.
All ex-officio legislative members were absent.

Rules
Nancy Freudenberg presented the following rule for adoption.

R-1. Amendments to Chapter 73, Medicaid. Allows advanced registered nurse practitioners (ARNPs) and physician assistants (PAs) to be primary care providers with a managed care organization (MCO).

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

R-2. Amendments to Chapter 176, Dependent Adult Abuse. Streamlines required maintenance of administrative rules for dependent adult abuse by removing form numbers from administrative rules.

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

Nancy Freudenberg presented the following rules for Notice:

N-1. Amendments to Chapters 36 and 81, Medicaid. Changes the assessment levels for nursing facilities effective July 1, 2019. The Human Services Department in collaboration with stakeholders developed new assessment levels and requested an effective date of July 1, 2019.

Anderson asked for clarification on the effects of this proposed rulemaking. Randol and Eyanson discussed the effects of this rule making and that the Iowa Medicaid Enterprise worked with the two nursing facility associations to craft the administrative rule.

Heffernan asked if this rule making was designed to provide a net increase to nursing facilities. Eyanson assured Heffernan that she was correct in her statement about the net increase.

Spading asked if this rule making would have a greater impact on smaller facilities. Randol and Eyanson explained that the number of residents in any given facility does not specifically impact the increase found in this rule making.

N-2. Amendments to Chapter 73, Medicaid. Revises language to reflect the Department's implementation of a passive managed care enrollment process.

Spading asked if this rule making will affect the current on-going efforts to "on-board" the new managed care organization (MCO). Randol reiterated how the process to "on-board" the new MCO was being accomplished. He stated that IME had created an algorithm to re-allocate Medicaid members between the three MCO providers. He noted that there are a number of members who, due to their medical condition, would not be moved as part of the algorithm.

N-3. Amendments to Chapters 78 and 79, Medicaid. Changes the Consumer Choices Option (CCO) program available within the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. Consolidates the CCO service description rules into one administrative sub rule, 441--78.34(13). Changes the monthly budget billing methodology for the Financial Management Services (FMS) provider from a prepay method to a post pay method. Also clarifies who may self-direct services and the budget and employer authority responsibilities. Defines how the monthly CCO budget may be used by a member self-directing services. Removes the reference to the DHS service workers who are no longer involved in the CCO program. Finally, adds new member and employee responsibilities to assure proper payment for CCO services are made.

A motion was made by Wallace to accept the Notices of Intended Action and seconded by Spading.
MOTION UNANIMOUSLY CARRIED.

Approval of Minutes
A motion was made by Spading and seconded by Kudej to approve the minutes of the February 13, 2019 meeting.
MOTION UNANIMOUSLY CARRIED.

Council Update
Anderson – Consulted with community leaders impacted by these specific administrative rules to gain a better understanding of impacts.
Wallace – Nothing to report.
Spading – Nothing to report.
Kudej – Nothing to report.

Director's Report
Jerry Foxhoven, Director, reported

- The Department continues to send out letters to Medicaid recipients regarding the new MCO provider and the realignment of recipients to MCOs. Approximately 20,000 to 21,000 letters are being sent out daily. The Director noted that even though the letters designate a specific MCO for recipients, the recipients will have a specified time to choose from which MCO they wish to receive services.
- The Governor recognizes that the work load for case workers has grown to be too high. As the result of working with the Department, the Governor has

3

currently allocated monies in her budget submission that would increase the number of case workers by 83.

Anderson noted that the Council will have three new members at the next Council meeting. Director Foxhoven stated that he and staff will be working with the new members to prepare them for their new duties on the Council.

Next Meeting
The next meeting of the Council on Human Services is Wednesday, April 10, 2019 at the Hoover Building.

Adjournment
Anderson adjourned the meeting at 10:35 a.m.

Submitted by,
Harry Rossander
Interim Recording Secretary
hr

Department of
HUMAN SERVICES

Jerry Foxhoven, Director | **Council on Human Services**

Meeting Minutes
April 10, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present**	Jerry Foxhoven – **present**
Alexa Heffernan – **present**	Mikki Stier - **present**
Kimberly Kudej – **present**	Nancy Freudenberg - **present**
Kim Spading – **present via phone**	Mike Randol – **present**
Sam Wallace – **present via phone**	Carrie Malone - **present**
Matt Highland-**present**	Julie Dougherty - **present**
Liz Matney - **present**	

EX-OFFICIO LEGISLATIVE MEMBERS
Representative Joel Fry – **absent**
Representative Lisa Heddens – **absent**
Senator Amanda Ragan – **absent**
Senator Mark Segebart – **absent**

Guests
Carol Forristall – New Council Member
Rebecca Peterson – New Council Member
Rick Sanders – New Council Member
Tony Leys – Des Moines Register
Stacie Maass – Iowa Total Care
Erin Cubit – Iowa Hospital Association
Paige Petitt – United Healthcare
Flora Schmidt – IBHA

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

Roll Call
All Council members were present.
All ex-officio legislative members were absent.

Rules
Nancy Freudenberg presented the following rule for adoption:

R-1. Amendments to Chapters 36 and 81, Medicaid. Changes the assessment levels for nursing facilities effective July 1, 2019. The Human Services Department in collaboration with stakeholders developed new assessment levels and requested an effective date of July 1, 2019.

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

R-2. Amendments to Chapter 73, Medicaid. Revises language to reflect the Department's implementation of a passive managed care enrollment process.

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

R-3. Amendments to Chapters 78 and 79, Medicaid. Changes the Consumer Choices Option (CCO) program available within the AIDS/HIV, Brain Injury, Elderly, Health and Disability, Intellectual Disability, and Physical Disability Waivers. Consolidates the CCO service description rules into one administrative sub rule, 441--78.34(13). Changes the monthly budget billing methodology for the Financial Management Services (FMS) provider from a prepay method to a post pay method. Also clarifies who may self-direct services and the budget and employer authority responsibilities. CCO defines how the monthly budget may be used by a member self-directing services. Removes the reference to the DHS service workers who are no longer involved in the CCO program. Finally, adds new member and employee responsibilities to assure proper payment for CCO services are made.

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

The following amendments to administrative rules is presented as a **Notices of Intended Action** for review by the Council.

N-1. Amendments to Chapter 75, Medicaid. Changes the start date for HIPP approval for fee-for-service and premium assistance. Also changes the estimated savings to the Department from $60 annually to $1200 annually, eliminates the second cost-effective test, and provides technical changes to policy and definitions.

2

N-2. Amendments to Chapter 170, Child care. Revises the child care assistance program fees that are based on federal poverty level, household size, and family gross monthly income. Also provides clarification regarding change reporting requirements.

N-3. Amendments to Chapter 187, Child welfare. Complete revision to Chapter 187 regarding aftercare services. Merges aftercare and PAL rules into one division for clarity. Extends program eligibility to a maximum participant age of 23 and a number of other changes.

A motion was made by Heffernan to and seconded by Spading to approve the noticed rules. MOTION UNANIMOUSLY CARRIED.

Approval of Minutes

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

Legislative Update

Carrie Malone, Legislative Liaison, updated the council reporting that the Health and Human Services budget has been delayed until Thursday, April 11, 2019. There are 23 amendments in the bill that are being worked through at present. Five policy bills we introduced made it through the funnel deadline. Chair Mark Anderson asked if the Children's mental health bill would be passed. Malone stated that it would be passed this session. Council member Heffernan asked if the Governor had increased funding for Child Care Assistance. After the meeting Carrie checked into this and found there is no budget proposals that are public that deal with an increased appropriation for CCA.

Managed Care Update

Mike Randol, Director of Iowa Medicaid reported that the entire IME department is 100% focused and committed to a smooth transition for our Medicaid members after UnitedHealthcare announced that they are exiting the market on June 30, 2019. His team is working closely with Iowa Total Care (ITC) to ready themselves for the additional members that they will be onboarding. ITC is actively adding staff on a weekly basis and will be ready for the transition. Randol stated continuity of care is our highest priority.

Council Update

Anderson – Nothing to report.
Wallace – Expressed his appreciation to council member Heffernan for her service.
Spading – Nothing to report.
Kudej – Nothing to report.
Heffernan – Expressed her gratitude to everyone that she served on the council with and the hard work done by DHS.

Director's Report

Jerry Foxhoven, Director, reported

- Director Foxhoven reassured the group that the department is in a much better place with this MCO transition than a few years ago. We have more time and experience this time around. He mentioned for our members sake, let's all stay optimistic. The department is working very hard for a smooth transition.
- He reported that one of his main goals has been to decrease the case loads of our social workers by adding more positions. He shared that 79 new social workers are in the hiring process right now. The Governor, House and Senate have all been very supportive of this. We are working diligently to lower caseloads for all of our social workers.
- Some of the technology is very old in our department. Child welfare is trying to manage with technology that is 24 years old. The Governor and Legislators are giving us financial support to move forward with updating our technology. We are making great progress in the field, and moving in the right direction.

Next Meeting

The next meeting of the Council on Human Services is Wednesday, May 8, 2019 at the Hoover Building.

Adjournment

Anderson adjourned the meeting at 11:16 a.m.

Submitted by,
Julie Dougherty
Council Secretary
jk

Department of HUMAN SERVICES

Jerry Foxhoven, Director

Council on Human Services

Meeting Minutes
May 8, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **not present**	Jerry Foxhoven – **present**
Kimberly Kudej – **not present**	Mikki Stier - **present**
Sam Wallace - present	Nancy Freudenberg - **present**
Carol Forristall - present	Mike Randol – **present**
Rebecca Peterson - present	Carrie Malone - **present**
	Julie Dougherty - **present**
	Matt Highland-**present**
	Liz Matney-**present**

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

Guests
Tony Leys – Des Moines Register
Stacie Maass – Iowa Total Care
Erin Cubit – Iowa Hospital Association
Paige Petitt – United Healthcare
Flora Schmidt – IBHA
Patty Funaro – LSA
Sandy Hurtado-Peters - IDOM

Call to Order
Sam Wallace called the Council meeting to order at 10:00 a.m. in the first floor conference room of the Hoover State Office Building.

Roll Call
Three council members were present. All legislative ex-offico members were absent. **Therefore, we did not have a quorum for voting. The council scheduled a conference call on Monday, May 13, 2019 to vote on rules and**

approve the April meeting minutes. See attached minutes for that conference call.

Managed Care Quarterly Report – October-December 2018

Liz Matney updated the council on the latest quarterly report. Some of the items in the report that were highlighted were:

- Long Term Services Enrollment and Programs
- Level of Care and Service plan outcomes for both Amerigroup and United Healthcare.
- Iowa participant Experience Survey Reporting
- MCO Member Grievances and Appeals
- Service center helpline metrics for members and providers
- Quarterly scope of claims, reprocessing, PA's and Appeals.

Presentation of new DHS Website

Matt Highland introduced the new DHS website to the council. It features our new branding and he described how it offers a much more positive and uplifting tone for our users. He stated it is much more mobile friendly and adaptable depending on which device is being used to access it. Matt stated that there is more to come and as new DHS programs are added, this new technology will help us tremendously in serving our members.

Budget Overview

Jean Slaybaugh gave an overview of the budget bill that was just signed by the Governor as it relates to DHS services. Some items she highlighted were:

- Field Operations– Jean stated there is a significant increase of about 6 million dollars which reflects the support we have from the Governor and Legislature to increase staffing and reduce caseloads for social workers. This has been an important focus of Director Foxhoven.
- Child Support and Facilities - both have received increased funding due to the increase in cost of services. This is a result of inflation of operating expenses with the exception of Woodward and Glenwood.
- Mental Health – Jean reminded the council that last year the council recommended an increase at CCUSO and Eldora due to an increase in cost of services and a need for more staffing. Jean stated both of those requests were funded this year.

Legislative Update

Carrie Malone, Legislative Liaison, gave the council a brief report on the Legislative session that ended on April 27th. DHS had a very successful year in the legislature. Four DHS bills were passed including the Children's Mental Health Bill.

Director's Report

- Director Foxhoven updated the council on his continuing efforts to reduce caseloads for social workers and other DHS departments. The Governor and Legislature are committed to that goal as well. He has been meeting with social workers in the field in Des Moines, Cedar Rapids and will be traveling to Iowa City next week.

Council Update

Wallace: Updated the council on his work with medical residency awareness and programs and in Iowa.
Peterson: Nothing to share
Forristall: Nothing to share

Next Meeting

The next meeting of the Council on Human Services is June 12, 2019 at the Hoover Building.

Adjournment

Sam Wallace adjourned the meeting at 11:08 a.m.

Submitted by,
Julie Dougherty
Council Secretary
Jk

3

Department of HUMAN SERVICES

Jerry Foxhoven, Director | Council on Human Services

Meeting Minutes

May 13, 2019
Conference Call

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – called in	Jerry Foxhoven – **present**
Kimberly Kudej – **absent**	Mikki Stier - **present**
Sam Wallace – called in	Nancy Freudenberg - **present**
Carol Forristall – called in	Julie Dougherty - **present**
Rebecca Peterson – called in	

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

Call to Order

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m. via conference call on Monday, May 13, 2019. Anderson stated:

"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

All Council members were present with the exception of Kudej.
All Ex-Officio legislative members were absent.

Rules

Nancy Freudenberg presented the following rules for adoption:

R-1. Amendments to Chapter 170, Child care. Revises the child care assistance program fees that are based on federal poverty level, household size, and family gross monthly income. Also provides clarification regarding change reporting requirements.

A motion was made by Wallace for approval, seconded by Forristall. MOTION UNAMIMOUSLY CARRIED.

R-2. Amendments to Chapter 187, Child welfare. Complete revision to Chapter 187 regarding aftercare services. Merges aftercare and PAL rules into one division for clarity. Extends program eligibility to a maximum participant age of 23 and a number of other changes.

A motion was made by Wallace for approval, seconded by Peterson. MOTION UNAMIMOUSLY CARRIED.

Approval of Minutes
A motion was made by Wallace and seconded by Forristall to approve the minutes of the April 10, 2019 meeting. **MOTION UNAMIMOUSLY CARRIED.**

Adjournment
Anderson adjourned the meeting at 10:10 a.m.

This meeting is accessible to persons with disabilities. (If you have special needs, please contact the Department of Human Services (515) 281-5455 two days prior to the meeting.) Note: Times listed on agenda for specific items are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

Department of HUMAN SERVICES

Jerry Foxhoven, Director

Council on Human Services

Meeting Minutes
June 12, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Mark Anderson – **present via phone**	Jerry Foxhoven – **present via phone**
Kimberly Kudej – **present via phone**	Mikki Stier – **present via phone**
Rebecca Peterson – **present**	Nancy Freudenberg - **present**
Carol Forristall – **present via phone**	Carrie Malone – **present**
Skylar Mayberry-Mayes – **present**	Jana Rhoads – **present**
Sam Wallace – **absent**	Mike Randol – **present via phone**
	Kevin Kirkpatrick- **present**
	Julie Dougherty - **present**
	Marissa Eyanson- **present via phone**
	Julie Lovelady- **present via phone**
	Elizabeth Matney- **present via phone**

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

Guests

Sandy Hurtado-Peters- IDOM
Flora Schmidt – IBHA
Stacie Maass-Iowa Total Care
Paige Pettit-United Healthcare
WHO-TV 5 representative

Call to Order

Mark Anderson, Chair, called the Council meeting to order at 10:04 a.m. via conference call on Wednesday, June 12, 2019. Anderson stated:

"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 Fifth 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
All Council members were present except Sam Wallace.
All ex-officio legislative members were absent.

Rules
Nancy Freudenberg presented the following rules for Notice:

N-1. Amendments to Chapter 40, Application for Aid and Chapter 65, "Food Assistance Program Administration". These proposed amendments remove obsolete form references from the Family Investment Program (FIP) rules. These proposed amendments also remove outdated and unnecessary rules related to Electronic Benefit Transfer (EBT) for Food Assistance.
N-2. Amendments to Chapter75, "Conditions of Eligibility". This proposed amendment 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.
N-3. Amendments to Chapter 75, "Conditions of Eligibility". These amendments propose to remove 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.
N-4. Amendments to Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services". These proposed amendments provide a definition of a customized wheelchair for all Medicaid members and providers. These amendments also align 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).
N-5. Amendments to Chapter 97, "Collection Services Center", Chapter 98, "Support Enforcement Services" and Chapter 99, "Support Establishment and Adjustment Services". These amendments remove references to obsolete form numbers and names.

There were no adopted and filed rules for your review this month.

There was one terminated rule that we have enclosed for your information. This rule does not require any further action on the council's part.

Notice of Termination – Chapter 75, Conditions of Eligibility. Previously this proposed amendment changed the start date for the Health Insurance Premium Program (HIPP) approval to the first day of the month following the month of application. The proposed amendments also changed the estimated savings required from $60 annually to $1200 annually per policy and eliminated the second test to determine cost effectiveness.

The Department of Human Services is terminating the HIPP rulemaking commenced in ARC 4368C at this time in order to further research technical aspects of the proposed rule-making.

A motion was made by Kudej to accept the Notices of Intended Action and seconded by Forristall.
MOTION UNANIMOUSLY CARRIED.

Approval of Minutes

A motion was made by Forristall and seconded by Peterson to approve the minutes of the May 8, 2019 meeting.
MOTION UNANIMOUSLY CARRIED.

Council Update

No updates were given by any council members.

Director's Report

Director Foxhoven reported to the council that Rick Shults, current Division Administrator of Mental Health and Disability Services at DHS, has announced his retirement. The director stated it will be a big loss for DHS but noted the positive impact Rick has had on mental health programs throughout our state for years to come. We wish him all the best in his retirement and will be sending out an announcement regarding his retirement celebration soon.

Director Foxhoven stated he would like to schedule a tour of a couple of our facilities for the council members. Chair Mark Anderson and Director Foxhoven will work together on this and share an agenda at a later date.

Next Meeting

The next meeting of the Council on Human Services will be our public hearing which is scheduled for Wednesday, July 10, 2019 at River Place, 2309 Euclid Ave, Des Moines, IA. Conference room 1.

Adjournment

Anderson adjourned the meeting at 10:26 a.m.

Submitted by,
Julie Dougherty
Council Secretary

IOWA Department of HUMAN SERVICES

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

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

2

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

IOWA 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

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)

2

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)

4

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

IOWA 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

Iowa Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
January 8, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund –	Michael Randol – **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present**	Liz Matney -
Shelly Chandler –	Kevin Kirkpatrick – **present**
Cindy Baddeloo –	Lindsay Paulson – **present**
Casey Ficek –	Sean Bagniewski – **present**
Lori Allen –	Luisito Cabrera - **present**
Marsha Fisher –	Alisha Timmerman - **present**
Thomas Broeker –	Marissa Eyanson - **present**
Marcie Strouse –	

Call to Order and Roll Call

Jason called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above; quorum was not met.

Approval of the Executive Committee Meeting Minutes of December 18, 2018

Quorum was not met. The December 18, 2018, meeting minutes could not be approved.

DHS Branding

Kevin Kirkpatrick discussed the new Department of Human Services branding and how this change will impact forms, documents, and websites.

Rate Setting

Mike reviewed the PowerPoint document made available in the materials packet. The Centers for Medicare & Medicaid Services (CMS) must approve rates before a Medicaid program can move forward with a contract between the state and an MCO. The Office of the Actuary within CMS evaluates rates to ensure that rates comply with all federal and state laws. Iowa's rates are generally evaluated on an annual basis; however, events such as the inclusion of Iowa Total Care can result in a review by CMS. To be approved, rates must be considered actuarially sound.

Quarterly Performance Report

Lisa Cook presented the Quarterly Performance Report for Quarter 1 SFY 2019 made available in the materials packet. Topics discussed included Plan Enrollment, the Appeals process, Program Management Reporting, Provider Helpline Metrics, Utilization of Value-Added Services, Capitation Payments Made to MCO's, Third Party Liability (TPL) Recovery, Fraud Waste and Abuse in regard to Program Integrity, and Health Care Outcomes.

Contract Update On New MCO

Mike provided an update on the status of adding Iowa Total Care to the program and the plan to redistribute members across the three MCOs based on an algorithm. Mike advised that some populations would not be included in the resdistribution such as pregnant women and members who are seriously ill. Once a member is assigned to a new MCO, members will have a 60 day choice period to change their MCO for any reason prior to implementation and an additional 90 days following implementation.

Open Discussion

There were no comments made during the open discussion period.

Adjournment

Meeting adjourned at 4:13 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Full Council
Summary of Meeting Minutes
February 5, 2019

Call to Order and Roll Call

Gerd called the roll call at 1:02 P.M. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met. It was noted that this was the fifth Full Council meeting in a row where quorum was not met. Members stated that the continued failure to meet quorum should be addressed in some fashion.

Approval of Previous Full Council Minutes

A vote to approve the meeting minutes of *February 19, 2018*, *May 3, 2018*, *August 9, 2018, and November 8, 2018* could not be taken because quorum was not met.

New DHS Branding

Matt Highland discussed the new Department of Human Services (DHS) branding and how this change will impact forms, documents, and websites. In addition to the new color palette there will be significant improvements in navigation and website design on all DHS websites.

Data Recommendations Subcommittee Update

The 2018 Legislature directed the MAAC Executive Committee to review the code required reporting that is laid out in Iowa law and reported quarterly. The final report was submitted back to the legislature in time for the December 31, 2018 deadline. Gerd recognized the hard work that the subcommittee of the Executive Committee put into the report. It was noted that the document included in the materials was a draft copy from December 1, 2018. A final version of the document will be sent out to all council members.

Long-Term Care (LTC) Ombudsman Update

Cynthia Pederson gave an update on the LTC Ombudsman Year 3 Quarter 3 report including service reductions, advocacy, health and disability and intellectual disability waivers, issues affecting members in CDAC and CCO, Level of Care assessments, case management issues, Notice of Decision issues with MCOs, and network adequacy.

Medicaid Director's Update

Process Improvement Working Group

February of 2018 a work group of providers and parents was formed to discuss issues and challenges and opportunities within the Managed Care program. In the first meeting roughly one hundred and fifty issues were gathered, these issues were organized into themes. Subgroups were organized to work around specific themes. The overall group has identified three high-level themes: a.) providing annual and quarterly training, b.) streamlining of processes and c.) improving communications. The group has worked with the MCO's to eliminate unnecessary prior authorizations; thus far they have removed 200. A list of the removed prior authorizations will be published on the Iowa Medicaid Enterprise website. The

removal of these prior authorizations will be consistent across all three MCO's and across Medicaid as a whole.

MCO Contracts
CMS has approved Amendment 7; Amendment 8 is still being negotiated with the MCO's. Two weeks ago Mike implemented a weekly project meeting with the plan president of Iowa Total Care so that decisions and progress can be made at least every Wednesday. Iowa Total Care is continuing to build their provider network. Provider contracts are due back to Iowa Total Care by February 15, 2019. Mike provided an update on the status of adding Iowa Total Care to the program and the plan to redistribute members across the three MCOs based on an algorithm. Mike advised that some populations would not be included in the redistribution such as pregnant women and members who are seriously ill. Once a member is assigned to a new MCO members will have a 60 day choice period to change their MCO for any reason prior to implementation and an additional 90 days following implementation.

Rate Setting
Mike reviewed the PowerPoint document made available in the materials packet. The Centers for Medicare & Medicaid Services (CMS) must approve rates before a Medicaid program can move forward with a contract between the state and an MCO. The Office of the Actuary within CMS evaluates rates to ensure that rates comply with all federal and state laws. Iowa's rates are generally evaluated on an annual basis; however, events such as the inclusion of Iowa Total Care can result in a review by CMS. To be approved, rates must be considered actuarially sound.

2019 Annual Provider Training
Annual provider training will take place in 9 cities across Iowa starting May 13, 2019.The full schedule will be distributed to MAAC council members. Director Randol will attend three sessions.

Quarterly Managed Care Report
Liz Matney presented the Quarterly Performance Report for Quarter 1 SFY 2019 made available in the materials packet. Topics discussed included Plan Enrollment, the Appeals process, Program Management Reporting, Provider Helpline Metrics, Utilization of Value-Added Services, Capitation Payments Made to MCO's, Third Party Liability (TPL) Recovery, Fraud Waste and Abuse in regard to Program Integrity, and Health Care Outcomes.

Value Added Services Follow Up From November 20, 2019 Executive Committee Meeting

It was noted that Value Added services have been a regular topic of discussion, and Mike requested specific questions about this topic. Gerd stated that the table displayed in the quarterly report has been changed and there is some confusion around this data. Mike replied that the next edition will show a much larger list of value added services as the current one rolls up services into categories, and that seems to be where a lot of the confusion is coming from. Lori Allen asked how MCO's are paid for value added services, are they based on a person's diagnosis, or is there a fee that is set for that person per month. Mike stated that MCO's are paid on a per-member-per-month capitated payment. They are required to pay for all services for that member. The rate is based on 56 different rate cells, or cohorts, so each member could fall into one of 56 categories. The MCO's

receive a payment that totals each member in each of these categories each month. Value added services are not included in the capitated rate, and are services that the state does not require. Lori then asked who is monitoring what the rate is per person, does the state of Iowa determine what those rates are for those individuals. Mike stated that the State, specifically Mike personally, and the actuary monitor these rates and payments closely.

Updates from MCOs

Amerigroup Iowa, Inc.

John McCauly provided operational updates for Amerigroup. Amerigroup has implemented program changes that resulted from the last legislative session, including new program rules and cost initiatives. AmeriGroup has expanded mental health core services following last year's important mental health reform bill, including new services such as assertive community treatment. The IME Process Improvement Work Group has been a big focus for AmeriGroup, yielding results in the areas of provider reimbursement, clinical processes, and identification of opportunities for administrative simplification. AmeriGroup has successfully gone through provider re-contracting and renewal, incorporating a switch to value based contracting. John also provided a report on the activities of the Anthem foundation.

UnitedHealthcare Plan of the River Valley, Inc.

Paige Pettit gave an update on UnitedHealthcare. UHC has named former CFO Alissa Weber, as their new CEO. UHC continues to search for a new CFO to replace Alissa. UHC is preparing for the 2019 Annual Provider Training, and has updated several materials and forms on their website: CDAC form, Care Coordination Quick Reference Guide.

Iowa Total Care

Chris Priest (interim CEO of Iowa Total Care) introduced the Managed Care Organization, noting that it is a subsidiary of Centene Corporation which is one of the largest Managed Care providers in the country. Chris highlighted Centene's experience in standing up new MCO operations, as well as their commitment to keeping their operations local.

Secret Shopper Data

Gerd asked Paige Pettit to discuss how MCO's use the secret shopper data provided by the quarterly report. Paige stated that UHC receiveS a report from the IME, and then a quality team discusses the data: they identify opportunities and issues presented by the data. They then take these issues and opportunities to their frontline staff. Liz Matney stated that IME provides fairly granular data to the MCO, including date and time and identity of the call center representative. The IME and the MCO then have a discussion about the call. John McCauly stated that AmeriGroup's process is very similar to UHC. Each MCO call center is called a certain number of times with the same questions.

Comments For MCO's

Amy Shriver, public member and pediatrician, praised John McCauly's update on AmeriGroup, she also called for more of a distinction in these reports between child and adult lives, especially when it comes to mental health initiatives.

David Beeman was curious as to why he's seen some members have been directed to apply for disability by their MCO. Liz Matney responded stating this is a result of enhanced

care coordination. Care coordinators have been coached to advise the members they work with to apply for as much assistance as possible to ensure that the members needs are met. David then went on to request that the MCO's develop a closer relationship with the case workers who work in the Child Abuse division of DHS. John McCauly and Liz Matney responded asking for the information of the social workers in question so they could develop those connections.

Sue Whitty made a comment calling for more surveying of specific populations within Medicaid that have been affected by recent policy and spending changes, specifically youth with high needs. She commented that she appreciated the new formatting of the quarterly report. Liz stated that some of this work is being done already, and that some of these results are available in the quarterly report.

Open Discussion

Gerd recognized David Beeman who had submitted a question for discussion by email. David was concerned about the process by which CPT codes are changed. He stated that CMS has issued new CPT codes, specifically for psychology billing, on January 1, 2019. He contacted the MCO's about these new codes but they stated that they have not yet been implemented because the new codes must come through IME first. His concern is that the delay in implementing these codes will cause issues for members, as it is unclear to him whether or not a provider can bill for a service under the old codes while the new codes are being processed by IME. The uncertainty of whether or not codes can be billed to MCO's affects providers' ability to provide services. Director Randol clarified that there is a process, and that the IME has to change and update thousands of CPT codes quarterly and annually. The codes in question were just recently approved and will be communicated to MCO's and providers in the next several weeks. Furthermore, these codes and billing rates will be consistent across all MCO's. Director Randol stated that during the code change process a provider can continue to bill in the same manner. A member stated that she was concerned that Program Integrity might consider billing using the old codes as an example of fraud, and requested that there be some sort of paper trail that providers can use to mitigate this risk.

Steve Bowen made a comment regarding Iowa Telehealth, stating that providers should be reimbursed the same whether they provide services in person or via telehealth.

Barb Nebel asked about the progress of a State Plan Amendment regarding Multiple Procedure Payment Reduction (MPPR) for Speech, Occupational, and Physical Therapists, specifically if the open comment period was over. Director Randol stated that this period ended roughly one week ago, and the department is in the process of summarizing these comments and will be submitting the State Plan Amendment to CMS before the end of February. Steve Bowen asked for clarification of whether most of the comments received during the open comment period were for or against MPPR. Director Randol stated that they were against, but that MPPR would be implemented, and that this is not a new practice in the state of Iowa. Barb Nebel asked a follow up question, about whether the actual comments received during the open comment period would be directly forwarded on to

CMS. Director Randol stated that a summary would be forwarded and not the actual comments.

David Beeman returned to his question asking for clarification on the rate setting process in regards to these specific codes. Director Randol stated that he would send David a response outlining the process at a high level.

Barb Nebel asked a question regarding the Medicaid Reimbursement Comparison Report, specifically about where the rates were in the report for speech pathologists. Director Randol clarified that in order for the report to be comprehensible comparisons had to be rolled up into larger groups, but that individual comparisons could be found online. In a follow-up question Barb asked about the benchmark by which IME sets the rates, assuming that all of the reimbursement rates are below Medicare levels. Director Randol stated that it is inaccurate to assume all reimbursement rates are below Medicare levels, they may be above, at, or below Medicare.

Adjournment
Meeting adjourned at 4:03 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
February 19, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund – **present**	Michael Randol – **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Kevin Kirkpatrick – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Casey Ficek –present	Sean Bagniewski –
Lori Allen –	Michael Kitzman - **present**
Marsha Fisher – **present**	Alisha Timmerman - **present**
Thomas Broeker –	Marissa Eyanson -
Marcie Strouse – **present**	

Call to Order and Roll Call

Gerd called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of January 8, 2019 and December 18, 2018

A vote was taken to approve the December 18, 2018, and January 8, 2019, meeting minutes and the meeting minutes were approved.

New MCO Choice

Mike reviewed the onboarding of Iowa Total Care and onsite reviews of Iowa Total Care facilities will begin in April 2019. Most IA Health Link members will be redistributed across the Managed Care Organizations (MCOs) with the utilization of an algorithm although some populations will not be redistributed in an effort to minimize the disruption of their services. Populations excluded from redistribution are pregnant women, members who are seriously ill, hemophiliacs, cancer patients, and other high risk members. Redistributed IA Health Link members will be given an open choice period where they may change their MCO for any reason prior to June 18, 2019, for a start date of July 1, 2019, as well as an opportunity to change their MCO for any reason prior to September 30, 2019. Letters announcing this change will be mailed to members from March 4, 2019, March 22, 2019.

Hawki eligibility system will transition from Maximus to the MMIS system. Rather than risk any sort of eligibility issues with this population due to the system conversion these members will be redistributed across the MCOs after this system conversion has taken

place. The open choice period for Hawki members will be from July 1, 2019, through September 30, 2019, with coverage becoming effective the month after this choice is made; letters announcing this change will be sent June 18, 2019. **Medicaid Director's Update**

Administrator for Mental Health and Disability Services for the Department of Human Services, Rick Shults, gave a presentation about the status of Adult and Children's Mental Health systems in the state of Iowa and provided a handout to the Committee. He outlined several initiatives recently approved by the state legislature focusing mainly on increasing access to critical services such as Assertive Community Treatment (ACT), Comprehensive Crisis Services, Subacute Services, and intensive residential and access centers House File 2456 will establish a Children's Behavioral Health System State Board to ensure that a system is implemented in Iowa. Rick stated that such a system would empower families to identify mental health issues and obtain assistance while keeping children at home in a family environment.

Liz Matney gave a presentation regarding Network Adequacy and provided a handout to the Committee. Network Adequacy can be measured in a number of ways such as proximity of service which reviews a given service and asks if members have access to this service geographically. Liz advised that the MCOs have contracted with enough providers to keep within the 30 minute/30 mile time and distance standard. Two member satisfaction surveys had been utilized, the Consumer Assessment of Healthcare Providers and Systems (CAHPS), and the Iowa Participant Experience Survey (IPES).

Full Council Quorum

MAAC quorum was discussed. Minutes cannot be published without approval, and therefore the lack of quorum does not allow the general public to read approved minutes. The Executive Committee raised possible solutions to the lack of quorum including: asking the state legislature to reduce quorum requirements; asking the state legislature to provide a mechanism to hold members accountable for their attendance. It was noted that 14 organizations had not sent a representative to attend the Full Council meetings for the last year. The Iowa Medicaid Enterprise contacts organizations that have not attended three meetings in a row, sending emails and making phone calls to appointed representatives. Gerd and Jason stated that as co-chairs of the council, they will make attempts to contact organizations that have had poor attendance.

Open Discussion

Marcie Strouse stated that she had assisted someone in enrolling in Medicaid and found the process to be pleasant and expedient.

Director Randol and Liz Matney had shadowed a Community Based Care Manager (CBCM) for a home visit to an Intellectual Disability (ID) waiver member. Director Randol relayed that the member was very happy to be able to live at home with their family.

Adjournment

Meeting adjourned at 4:30 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

IOWA Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
March 5, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund – **present**	Michael Randol – **present**
Dennis Tibben –	Julie Lovelady -
Dan Royer –	Liz Matney - **present**
Shelly Chandler – **present**	Kevin Kirkpatrick – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Casey Ficek –	Sean Bagniewski –
Lori Allen – **present**	Michael Kitzman - **present**
Marsha Fisher –	Alisha Timmerman - **present**
Thomas Broeker –	Marissa Eyanson -
Marcie Strouse –	Adrian Olivares - **present**

Call to Order and Roll Call

Gerd called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above and quorum was not met. Members had difficulty dialing into the meeting as the regular conference line was not functioning. Attempts were made at communicating the back-up conference call number, but quorum was still not achieved as of 3:30 PM. It was decided that without quorum the meeting should be adjourned and all agenda items be carried forward to the April 9, 2019 Executive Committee meeting.

Adjournment

Meeting adjourned at 3:36 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
April 9, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund – **present**	Michael Randol – **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present* Erin Cubit**	Liz Matney - **present**
Shelly Chandler – **present**	Kevin Kirkpatrick – **present**
Cindy Baddeloo – **present**	Lindsay Paulson –
Casey Ficek –	Sean Bagniewski –
Lori Allen – **present**	Michael Kitzman - **present**
Marsha Fisher – **present**	Adrian Olivares - **present**
Thomas Broeker – **present**	Marissa Eyanson -
Marcie Strouse – **present**	

Call to Order and Roll Call

Gerd called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of February 19, 2019 and March 5, 2019

A vote was taken to approve the February 19, 2019, and March 5, 2019, meeting minutes and the meeting minutes were approved.

Dental Quality Strategy and IA Health Link Quality Strategy

Liz Matney introduced two reports relating to Quality Assurance: the Iowa Medicaid Enterprise (IME) Bureau of Managed Care Quality Plan 2019, and the IME Dental Pre-Ambulatory Health plan Quality Assurance System 2019. Liz asked that Executive Committee members provide any edits or comments they may have on these reports ahead of the next Full Council meeting on May 7, 2019. It was determined that Executive Committee members would provide comments no later than April 30, 2019.

Full Council Attendance

Gerd discussed the actions that he and Jason Haglund have taken to address the attendance of Full Council meetings. They have identified 30 organizations that have attended three or fewer meetings in the last two years. Of these 30 organizations, one, Iowa Adult Day Services Association, has ceased to exist. Gerd also noted that the organization ARC of Iowa had been included in this list, but they had been sending Paula Connoly as a representative. In the last two years Paula's attendance had been noted only once, even though it is generally agreed that she has been regularly attending the Full Council meetings. Gerd stated that going forward he will change how he calls the roll: he will call the roll by organization name. Gerd and Jason sent letters to the remaining 28 organizations notifying them of their lack of attendance.

Medicaid Director's Update

Mike began his update by focusing on the progress Iowa Total Care has made in their onboarding process. Iowa Total Care has several job fairs in coming weeks and are actively hiring staff. IME staff and Iowa Total Care staff meet daily, and IME leadership meets weekly with Iowa Total Care leadership. Iowa Total Care is actively reaching out to providers to add to their network, and is updating their provider list on their website daily. Mike stated that he believes Iowa Total Care is on track to be ready for the July 1, 2019 opening date.

Mike then addressed UnitedHealthcare's recently announced plan to withdraw from the Iowa Medicaid managed care program. The IME's first concern is the transition of especially vulnerable Medicaid members to a new Managed Care Organization (MCO) without interruption of services. The IME is working out details of the transition with the three MCO's. Mike has proposed a transition plan for Case Managers. Should a Case Manager currently working for UnitedHealthcare be hired at another MCO; they will continue to work at UnitedHealthcare until the exit date, but will be given time to train and onboard at their new MCO. This way Case Managers will be able to start operations immediately upon the exit of UnitedHealthcare and the transition of their members to a new MCO. The IME has the goal of having Case Manager information available to its call center representatives so that members and providers calling in will know where their Case Manager will be working.

Mike discussed the current plan for transitioning members away from UnitedHealthcare. Medicaid was already in the process of redistributing membership equitably between the three MCOs some members were already moving away from UnitedHealthcare. If a member was reassigned away from Amerigroup that member will remain with Amerigroup, unless they chose to move to Iowa Total Care. Members that were assigned to UnitedHealthcare as part of the original redistribution will be randomly, and equitably, assigned to Amerigroup and Iowa Total Care. Tests of the system indicate this will be accomplished equitably. IME is planning on sending out letters regarding the transition of membership away from UnitedHealthcare the first week of May. UnitedHealthcare has stated publically that their exit date will be no later than September 30, 2019. Mike stated that the Medicaid program has a goal of having UnitedHealthcare exit no later than June 30, 2019.

Open Discussion

Gerd began the open discussion by asking Mike about any bills currently before the legislature which may have some impact on Medicaid. There is some language reflecting recently proposed work requirements for Medicaid, and some language relative to the exit of UnitedHealthcare from Medicaid, centering on payment of provider claims. There is also a bill removing the prior authorizations for Smoking Cessation. Mike stated there is some language around increasing the number of Nursing Homes in the state. Mike also noted the recent Supreme Court ruling allowing Medicaid funds to be used for gender reassignment surgery: he stated the number of individuals awaiting this reassignment surgery at the University of Iowa hospital is in the hundreds.

Lori Allen then asked for clarification about how the UnitedHealthcare exit would affect members. As Medicaid was already in the process of redistributing membership, some members were already going to the right places. The only members that will be affected are those that were assigned to UnitedHealthcare. These members were either assigned as a part of the redistribution or chose to stay with UnitedHealthcare. They will be split randomly, and equitably, by the redistribution algorithm. Additionally, any members moved away from Amerigroup will remain with Amerigroup.

Adjournment

Meeting adjourned at 3:55 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

Department of
HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Full Council
Summary of Meeting Minutes
May 7, 2019

Call to Order and Roll Call

Gerd called the roll call at 1:02 P.M. Full Council attendance is as reflected in the separate roll call sheet. A quorum was achieved.

Approval of Previous Full Council Minutes

Gerd called for the council to read through the meeting minutes of *February 19, 2018*, *May 3, 2018*, *August 9, 2018, November 8, 2018, and February 5, 2019*. Gerd stated he would accept any suggested changes and entertain the motion to approve the minutes as a block of five. Steve Bowen moved to approve the minutes, Dave Beaman seconded the motion. The motion carried and the minutes were approved.

MAAC Full Council Attendance

Gerd discussed the attendance for the Full Council. In the past two years 31 organizations had attended three or fewer meetings. Letters were sent to 29 of these organizations alerting them to this fact. Gerd stated that the feedback he and Jason received from the letters were that in many cases an organization had supplied a representative, but that representative was not the one whose name was called for the roll. Going forward the procedure will be to call the name of the organization rather than the name of the listed representative.

Public Forum on Iowa Health and Wellness Plan and Dental Wellness Plan

Kevin Kirkpatrick gave an overview of the Iowa Health and Wellness Plan and the Dental Wellness Plan and alerted the Full Council to the public forums where public feedback regarding these plans will be gathered. The forums will be held on May 21, 2019 at the Hoover State Offices building and on May 22, 2019 at the Coralville Public Library.

Medicaid Director's Update

MCO Transition

Iowa Total Care onboarding continues. Readiness reviews were completed at the beginning of May. Areas reviewed included: Information Technology; claims; provider relations; and member relations. IME leadership and staff were onsite at Iowa Total Care's facilities for the readiness review. Director Randol stated Iowa Total Care continues to be on track for July 1, 2019. Iowa Total Care will be participating in the Annual Provider Training later this month, and will have staff available to answer questions from providers.

When UnitedHealthcare leaves the market Iowa Total Care will receive roughly half the Medicaid population. IME is trying to accomplish equitable distribution of members between Iowa Total Care and Amerigroup, there may be some slight difference due to member

choice. Director Randol stressed that no members will be losing any benefits as a result of UnitedHealthcare leaving the market. IME determines Medicaid benefits, not the MCO's. UnitedHealthcare members can continue to see their providers through June 30. Director Randol stated the most important aspect of UnitedHealthcare's exit is that members receive continuity of care. To that end the IME is tracking case managers as they move from UnitedHealthcare to either Iowa Total Care or Amerigroup in order to facilitate choice for any members who wish to follow their case manager from one MCO to another. Members will have until September 30, 2019 to make their choice.

2019 Annual Provider Training and Town Hall Meetings

Starting May 8, Iowa Medicaid will be conducting town hall meetings across the state. IME leadership will be present at all town hall meetings. The first will be held at Polk County River place in Des Moines. Meetings will also be held in Waterloo, Sioux City, Council Bluffs, Cedar Rapids, and Davenport. The town halls will each have two sessions, a provider specific session and a member specific session. Director Randol stated he thought it important that the IME have interaction with the public to answer any questions providers and members have.

Medicaid Quarterly Report

Liz Matney presented the Quarterly Performance Report for Quarter 2 SFY 2019 made available in the materials packet. One issue of note is the increasing levels of enrollment in the Iowa Health and Wellness Plan which is occurring at historically low levels of unemployment. Other topics discussed include: Level of Care Assessments completion metrics; Service Plan update metrics; Service Level information for Medicaid call centers; and claim payment timeliness.

Iowa Medicaid Managed Care Quality Assurance System and Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System

Liz presented the Iowa Medicaid Managed Care Quality Assurance System and Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System reports to the council. These reports will eventually be sent to the Centers for Medicare and Medicaid after receiving comments from the Medical Assistance Advisory Council and from the public. Liz asked that members submit their comments back to IME staff by Friday May 31, 2019.

Updates from MCOs

Iowa Total Care

Mitch Wasden, CEO and plan president for Iowa Total Care, gave an update on Iowa Total Care's onboarding progress. Iowa Total Care is actively building their presence in the market, with 30 contractors working to contract with providers. Iowa Total Care has 812 employees ready for July 1, 2019. Iowa Total Care feels that it's readiness audits went very well over the past months, and is working with a third party group to perform auxiliary readiness audits including claims testing and payment systems testing. Iowa Total Care is working very closely with Amerigroup and UnitedHealthcare to achieve a smooth transition.

Amerigroup Iowa, Inc.
John McCauly provided operational updates for Amerigroup. John spoke briefly on flood disaster response recovery, member retention and choice period, operational excellence, and work Amerigroup is doing in building capacity in social determinants of health. Case managers are working closely with members in communities that have been affected by flooding, Amerigroup has briefly lifted pharmacy refill restrictions to allow members to refill prescriptions that may have been lost in the flood. John stated that having gone through a member transition period previously, Amerigroup is confident in their ability to ensure a smooth transition of care for members. Amerigroup recently rolled out a new program designed to improve quality of care for pregnant members and members with newborn children. Amerigroup is committed to social determinants of health work, sponsoring several programs around the state that support nutrition and shelter for citizens of Iowa.

UnitedHealthcare Plan of the River Valley, Inc.
Paige Pettit gave an update on UnitedHealthcare. Paige stated that there is a difference between the exit of Amerihealth Caritas from the Iowa Medicaid program and the exit of UnitedHealthcare from the Iowa Medicaid program. Specifically, UnitedHealthcare is maintaining a presence in the state of Iowa in parallel markets to the Medicaid program. UnitedHealthcare expects to maintain relationships with providers and members and leave the Medicaid program in a responsible manner. UnitedHealthcare will be present at the townhalls and provider trainings scheduled for later in the month of May. Paige thanked the council for the privilege of being a participant for the past several years.

Open Discussion

Senator Bolkcom stated that a legislative colleague of his was concerned about whether or not a Pharmaceutical Benefit Management raised a question of whether the state of Iowa was being over-charged for pharmaceutical billing, and whether or not an audit should be initiated looking into this issue. Director Randol stated that the state cannot be over-charged in this manner due to the structure of capitated rates.

Amy Shriver stated that only one metric in the Quarterly Report separates out children from adults and that this makes it harder to understand what opportunities there are to improve services for children. Director Randol stated that the operational metrics, such as claims paid, may not be relevant, but that he would look at including data from the child core data set.

Steve Bowen urged the council to consider how professional and business entities will maintain a voice in the council, as the voting membership will be reduced to five. Director Randol stated that he appreciated that point, and that meetings will remain public.

Dave Beaman asked the Director when he thought another MCO would enter the program. Director Randol stated that would likely not happen for another year as the program needs stability and he didn't want to disrupt vulnerable populations.

Adjournment
Meeting adjourned at 3:16 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
May 21, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund – **present**	Michael Randol –
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present* Erin Cubit**	Liz Matney - **present**
Shelly Chandler – **present**	Kevin Kirkpatrick – **present**
Cindy Baddeloo – **present* Maria Bench**	Lindsay Paulson –
Casey Ficek – **present**	Sean Bagniewski –
Lori Allen – **present**	Michael Kitzman - **present**
Marsha Fisher – **present**	Adrian Olivares - **present**
Thomas Broeker –	Marissa Eyanson -
Marcie Strouse – **present**	

Call to Order and Roll Call

Jason called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of April 9, 2019

A vote was taken to approve the April 9, 2019 meeting minutes: the minutes were approved.

Medicaid Director's Update

Liz Matney provided the Medicaid Director's Update. Mike, Liz, and Kevin have been travelling around the state speaking at Provider and Member town halls. Liz stated that they had received many comments driven by the anxiety of the coming transition. One of the top concerns is Iowa Total Care's network adequacy. Liz stated that Iowa Total Care continues to send out contractors and continues to update its network of providers every week on its website. IME Member Services has the Iowa Total Care provider directory available, so members can call into the IME and ask if their provider is currently in Iowa Total Care's network. One of the top concerns from providers is how smooth the transition will be from UnitedHealthcare to Iowa Total Care, specifically whether or not the IME is doing claims testing with Iowa Total Care. The IME is performing claims testing, which has not been a part of previous Managed Care Organization onboarding. IME staff have been logging questions from these town halls and will be compiling them into an FAQ which will be posted on the IME website.

Liz stated that members affected by UnitedHealthcare's exit from the Medicaid market were sent letters starting May 10. These letters identified a tentative assignment for the member,

and stated the member is in an open choice period for 90 days. The letters also state that for the member's choice to be effective July 1, 2019, they must make their choice known by June 18, 2019.

Liz went on to address the consolidation of the Hawki program into the IME's internal systems. Previously the Hawki program had its systems provided by a third party. Additionally, Hawki members will be redistributed similar to Medicaid members with letters going out later this month.

Liz stated that a common concern members have raised regarding UnitedHealthcare's exit from the Medicaid market is where their case manager will be going. The IME is developing a roster of case managers hired by Iowa Total Care and Amerigroup from UnitedHealthcare. This roster will be available to IME Member Services. If a member wishes to choose their new Managed Care Organization based on where their case manager has gone, they will be able to get that information and make that choice in the same phone call to IME Member Services. Kevin Kirkpatrick added that the roster will include the area the case manager typically works in, so that they may be searched by more than just a name.

MAAC Restructuring

Gerd began discussion of the recently passed House File 766, which includes language that restructures the Medical Assistance Advisory Council. Gerd stated that as he read the law it would essentially turn the current executive committee into the full council, and the larger group would be eliminated. Under the new structure there will be five business and professional voting members and five voting public members. Gerd stated that the five public members would be appointed by the Governor, but the mechanism for electing the five business and professional voting members was unclear. The five would be elected from the 41 business and professional organizations numerated in the law, but how that would be accomplished has not been determined. Shelly Chandler raised the issue of how long terms for voting members would be. Gerd stated that for business and professional voting members the current administrative rules reflect a two year term limit. Shelly proposed that terms be staggered, in order to provide continuity. Specifically, Shelly proposed terms of three years for two of the voting members, and terms of two years for three of the voting members.

Gerd stated that on July 1, 2019 the new committee should be in place, but that the administrative rules could not be determined until later, this means that the Medical Assistance Advisory Council will have to run on its own internal policies until the administrative rules and any necessary amendments can be officially adopted. Gerd proposed that the council adopt the current calendar for the Full Council. Shelly requested that going forward the calendar aligns with the quarterly reports generated by the IME.

Discussion then turned to whether or not the administrative rules should include requirements that the five business and professional voting members be representative of specific groups. Gerd stated that creating an extra requirement for representation like this

would be extra-legal, that if the legislature had wanted this structure they could have created it.

Gerd proposed that a draft of administrative rules be written for the next meeting of the Executive Committee in June. This would allow time for feedback and edits to be made to the rules before the first meeting of the new council structure in August. The new council structure would then be able to approve the rules and send them on up to the DHS council.

Open Discussion

Lori Allen asked what the committee is doing about comments on the quality reports previously distributed to the executive committee and the full council. Liz responded that she is compiling these comments and that they will eventually be submitted to CMS. Gerd stated that comments from the Full Council are not due until the end of the month.

Adjournment

Meeting adjourned at 4:05 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Michael Randol, Medicaid Director | Medical Assistance Advisory Council (MAAC)

Executive Committee
Summary of Meeting Minutes
June 11, 2019

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
Jason Haglund – **present**	Michael Randol – **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present**	Liz Matney -
Shelly Chandler – **present**	Kevin Kirkpatrick – **present**
Cindy Baddeloo – **present**	Lindsay Paulson –
Casey Ficek – **present**	Sean Bagniewski –
Lori Allen –	Michael Kitzman - **present**
Marsha Fisher – **present**	Adrian Olivares – **present**
Thomas Broeker – **present**	Marissa Eyanson -
Marcie Strouse –	

Call to Order and Roll Call

Gerd called the roll call at 3:00 P.M. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of April 9, 2019

A vote was taken to approve the May 21, 2019 meeting minutes: the minutes were approved.

Mandatory Reporter Training Changes

Janee Harvey reviewed changes to Mandatory Reporter Child Abuse and Dependent Adult Abuse Reporting requirements as a result of House File 731. Iowa Department of Public Health is no longer responsible to review and approve mandatory reporter trainings and accompanying curricula in Iowa. Iowa Department of Human Services (DHS) must now create, produce, and publically host a child abuse and dependent adult abuse mandatory reporter training online. The house file also permits employers to provide supplemental training, but not replace the core training that is created, produced, and publically hosted by DHS. Additionally, the house file separates out the Child Abuse and Dependent Adult Abuse Mandatory Reporter training into two curriculum that are each two hours long. Prior to House File 731 Mandatory Reporters were expected to take these trainings every five years, this has been reduced to every three years. After the initial core training, a Mandatory Reporter is only required to take a one hour refresher course, as long as the refresher

course is taken within the three year time period. All Mandatory Reporters who take their training before June 30, 2019 will considered to be in good standing for the next five years. The training will be hosted on the DHS website, allowing 24 hours- 7 days a week- access.

MAAC Restructuring

Gerd followed up on the discussion from the last executive committee meeting regarding recently passed House File 766, which changes the structure of the MAAC beginning July 1, 2019. A draft set of administrative rules was submitted to committee members for their review. Gerd called for questions and comments on the draft set of administrative rules. The committee discussed how to stagger terms of Professional and Business Entities representatives so that an election would occur every year. Director Randol suggested a simple coin flip between elected representatives to determine which entity would have an initial three year term versus a two year term. All terms would be for a period of two years after the initial term. These staggered terms would allow for an election from among the Business and Professional entities every year.

Concerns were raised about implementing these revised rules, specifically provisions for elections, ahead of their official adoption by the Council on Human Services. Official adoption of rules can take as long as six months, which would mean that were the MAAC to wait for rules to be officially adopted before meeting, the MAAC would not be able to meet until February 2020. It was therefore determined that the MAAC should adopt a set of revised administrative rules ahead of the official adoption by the Council on Human Services.

Gerd proposed that Department staff circulate a ballot to Professional and Business entities in time for an election to occur ahead of the August 6, 2019 MAAC meeting. Staff would contact elected members to confirm they wish to serve and communicate the results of the election to the council at large. The election of the public co-chair will occur at the August 6 meeting if all five public members have been appointed by the Governor's office at that time.

Gerd proposed that Department staff communicate Professional and Business Entity representative attendance to each organization once a year at the start of the new fiscal year. It was suggested that this be communicated to the full council as well as the Governor.

Medicaid Director's Update

Director Randol stated the focus of the IME over the past several months has been on the exit of UnitedHealthcare and the onboarding of Iowa Total Care. Member redistribution notices have been sent to all Iowa Health Link members regarding the July transition. The Member Open Choice period that begins July 1, 2019 will end September 30, 2019. Notices regarding the Open Choice period for Hawki members will be going out later this week. IME staff are maintaining a roster of the case managers that work for Iowa Total Care and for

Amerigroup Iowa, Inc. Members who wish to follow their case managers may contact IME Member Services to see which MCO their case manager has gone to. Passive enrollment will go to into effect July 1, 2019, which will greatly benefit Long Term Service and Supports members as they will no longer have a waiting period before being assigned to an MCO, which means they can begin their service plan evaluations immediately. The IME continues to onboard Iowa Total Care. IME staff meets with Iowa Total Care staff daily. Director Randol meets with Iowa Total Care senior leadership every Wednesday for two hours. Iowa Total Care has formally submitted their readiness review results. Director Randol noted there were some opportunities for improvements, particularly in operational areas of the readiness review, but that Iowa Total Care has submitted a plan of action to correct for these opportunities. Director Randol is confident Iowa Total Care will be ready to go live on July 1, 2019.

Shelly Chandler noted that she was extremely impressed with the responsiveness from Iowa Total Care staff. Her one area of concern was that provider's contracts are coming back, but that the Iowa Total Care website notes that the credentialing process is ongoing for these providers. Director Randol is aware of this issue, and has had confirmed that Iowa Total Care will make sure these providers are treated as in-network.

Open Discussion

The issue of multiple procedure payment reduction (MPPR) was raised, specifically if services are provided by three different disciplines in a day whether each subsequent service is reduced by 10% for each discipline or if services are reduced by 10% for each code subsequent code by discipline. Director Randol clarified that the intent is to reduce by discipline, for example if a member sees a speech therapist and then an occupational therapist the speech therapist would bill at 100% and the occupational therapist would bill at 90%.

Adjournment

Meeting adjourned at 4:01 P.M.

Submitted by,
Mike Kitzman
Recording Secretary
mk

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.

3

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

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

Hawki Board Meeting
February 18, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston - **present**	Mike Randol, Medicaid Director
Dr. Jonathan Crosbie - **present**	Liz Matney
Jim Donoghue - **present**	Anna Ruggle
Eric Kohlsdorf, Chair - **present**	Kevin Kirkpatrick
Dr. Bob Russell - **present**	
Dr. Kaaren Vargas - **present**	**Guests**
Senator Nate Boulton - **present**	Jean Johnson, IA Department of Public Health
Senator Dennis Guth	Mary Nelle Trefz, Child and Family Policy Ctr.
Representative John Forbes	Michelle Canfield, HACAP
Representative Shannon Lundgren	Amanda Josvanger, Dubuque VNA
	Joe Estes, MAXIMUS

Call to Order and Roll Call
Eric Kohlsdorf called the meeting to order at 12:31 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes of December 5, 2018
A vote was taken to approve the December 5, 2018, meeting minutes, as corrected, and the meeting minutes were approved.

Director's Report
Mike Randol, Medicaid Director, introduced a new format of the Hawki enrollment reports. The reports show the monthly program numbers and also provide historical enrollment of the Hawki program. Randol introduced Liz Matney to provide a brief overview of the first quarter SFY 2019 Medicaid Managed Care Performance Report. She pointed out highlights of the report, and noted a decrease in emergency room visits and more member visits to Primary Care Providers.

Hawki System integration
Randol reported that the MAXIMUS member system will be integrated into the Medicaid Management Information System (MMIS) by June 30, 2019. The change over to MMIS will occur the week of May 20, 2019. He reported that there has been significant planning that has paved the way for the data migration. This change will eventually cancel the Hawki contract with MAXIMUS.

Hawki Administrative Rules 441 IAC 86
Anna Ruggle, Iowa Medicaid, reported that the final approvals for the Hawki Administrative Rules had been delayed and were not available for the Board to review. She stated that there will need to be an ad-hoc meeting of the Board to approve the rules. The date of the meeting will be arranged with the Board as soon as all sign-offs on the rules have occurred.

New Hawki Logo and Branding
Kevin Kirkpatrick discussed the new logo and name branding of Hawki. The logo has been updated using

a hawk-type figure in colors associated with the IA Health Link program. Going forward Hawki will be written as one word, traditionally capitalized, without a hyphen and in plain text.

New MCO Choice
Randol reported that Iowa Total Care (ITC), a Centene company, is on schedule to become the third Iowa Medicaid Managed Care Organization (MCO) on July 1, 2019. He gave an overview of the timelines for IA Health Link and Hawki member choice of ITC, including auto-reassignment. IA Health Link member mailings regarding the new MCO choice will start March 4, 2019, and Hawki member mailings will start in June 2019.

Outreach Update
Jean Johnson, Hawki Outreach Coordinator, reported that she will be attending health fairs, community events, local health clinics and provider offices through the spring. She also shared examples of the materials she gives out at events and recognized Dr. Bob Russell and the I-Smile program for continued success in serving Iowans.

Hawki Anniversary
Ruggle recognized that the Hawki program celebrated its 20th year anniversary on January 1, 2019.

New Business
Kohlsdorf reminded the Board that two public Board appointments are expiring on April 30, 2019, and they will need to elect a Chair and Vice-Chair at that time. Jim Donoghue and Angela Burke Boston were asked to be the nominating committee for Hawki officers and present a report at the April meeting.

Next Meeting
The next meeting will be April 15, 2019.

Meeting adjourned at 1:33 PM.

Submitted by,

Nick Peters
Recorder of Minutes

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

Hawki Board Meeting
March 1, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston - **present**	Julie Lovelady
Dr. Jonathan Crosbie - **present**	Marissa Eyanson
Jim Donoghue - **present**	Anna Ruggle
Eric Kohlsdorf, Chair - **present**	Kevin Kirkpatrick
Dr. Bob Russell - **present**	
Dr. Kaaren Vargas	**Guests**
Senator Nate Boulton -	Mike Jenkins, Brown Winnick Law firm
Senator Dennis Guth	Nancy Lind, UnitedHealthcare of the River Valley
Representative John Forbes	Sabrina Johnson, MCNA
Representative Shannon Lundgren	Gretchen Hageman, Delta Dental
	John Hitchcock, Amerigroup
	Dr. Jeff Chapman, Delta Dental

Call to Order and Roll Call

Eric Kohlsdorf, Board Chair, called the meeting to order at 11:31 A.M. A roll call was conducted and attendance is as reflected above. A quorum was present. Kohlsdorf read the following statement:

> ***"This meeting of the Hawki Board 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 Conference Room 129 of the Iowa Medicaid Enterprise Office Building. An agenda was sent to interested groups as well as the press advising them the meeting will be held via conference call. Minutes will be kept of the meeting."***

Hawki Administrative Rules 441 IAC 86

Anna Ruggle, DHS, presented Notice of Intended Action for the Iowa Department of Human Services to amend Chapter 86, the "Healthy and Well Kids in Iowa (Hawki) Program." The board reviewed the proposed changes and the Board Chair entertained a motion to approve the changes. A motion to approve the rules was made by Jim Donoghue and seconded by Jonathan Crosbie. Discussion centered on the language in subrule 86.3(8) regarding the time periods to determine eligibility and clarifications on waiting periods. Kohlsdorf asked if Donoghue and Crosbie would accept a friendly amendment to change the 90-day choice period to begin from the date of decision. The friendly amendment was accepted.

A voice vote was taken followed by the call for a roll call vote. The results of the roll call were:

Eric Kohlsdorf – Aye
Jonathan Crosbie – Aye
Dr. Bob Russell – Aye

Angela Burke Boston – Nay
Jim Donoghue – Aye

The motion passed 4-1 on the roll call vote.

Meeting adjourned at 12:12 P.M.

Submitted by,

Nick Peters
Recorder of Minutes

Next meeting: April 15, 2019
12:30 P.M.
Iowa Historical Building
600 East Locust
Des Moines, IA 50309

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

Hawki Board Meeting
April 15, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston - **present**	Mike Randol
Jim Donoghue - **present**	Marissa Eyanson
Eric Kohlsdorf, Chair - **present**	Anna Ruggle
Ronda Eick, - present	Kevin Kirkpatrick
Dr. Kaaren Vargas - **present**	Dr. C. David Smith
Senator Nate Boulton - present	
Senator Dennis Guth	**Guests**
Representative John Forbes	Joe Estes, Maximus
Representative Shannon Lundgren	Sandi Hurtado-Peters, DOM
	Page Petit, UnitedHealthcare of the River Valley
	Jean Johnson, IDPH
	Gretchen Hageman, Delta Dental

Call to Order and Roll Call
Eric Kohlsdorf called the meeting to order at 12:32 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes9
Motion to approve the meeting minutes February 18, 2019 and March 1, 2019 made Angela Burke Boston and second by Jim Donoghue. Motion passes.

Director's Report
Mike Randol, Medicaid Director, reviewed the enrollment numbers and finances. He has asked staff to provide reports in a different format than they are now. They will be presented at the next Board meeting. Liz Matney reviewed the MCO Q1 Report.

Randol also reported that the Hawki system integration from the Maximus system to MMIS. The change-over is scheduled for May 18, 2019.

Hawki Administrative Rules 441 IAC 86
The Hawki Rules Package was reintroduced to the Board. Marissa Eyanson, Bureau Chief, asked the Board for approval. Motion by Vargas, second by Donoghue to approve rules. Motion does not pass, there was not a quorum present for the vote.

Communication Update
Kevin Kirkpatrick reported that there are mailings that will be sent to members about the new MCO. Members will be assigned an MCO and will also be made aware of the cut-off date to have any changes made.

Outreach Update
Jean Johnson reported on her past and future marketing and outreach plans for Hawki.

Medical Directors Report
Dr. Smith reported that the Hawki Clinical Advisory Committee has not met since the fall and even then attendance was minimal. There was no meeting in January

New Business
Kohlsdorf asked for a report from the nominating committee. The committee has asked Eric Kohlsdorf to continue as chair and Dr. Kaaren Vargas to serve and Vice-Chair for the upcoming year.

Next Meeting
An ad hoc meeting will need to be arranged to approve the Hawki Administrative rules. It will be a telephone conference call.

Next meeting will be June 17, 2019.

Meeting adjourned at 1:505 PM.

Submitted by,

Nick Peters
Recorder of Minutes

Next meeting: June 17, 2019
12:30 P.M.
Iowa Historical Building
600 East Locust
Des Moines, IA 50309

2

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

Hawki Board Meeting
April 23, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston - **present**	Mike Randol
Jim Donoghue - **present**	Marissa Eyanson
Eric Kohlsdorf, Chair - **present**	Anna Ruggle
Dr. Bob Russell - **present**	Kevin Kirkpatrick
Dr. Kaaren Vargas - **present**	Dr. C. David Smith
Senator Nate Boulton - present	
Senator Dennis Guth	**Guests**
Representative John Forbes	
Representative Shannon Lundgren	

Call to Order and Roll Call

Eric Kohlsdorf called the meeting to order at 12:32 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

After roll call is taken – the Chair of the Board reads the following statement:

"This meeting of the Hawki Board 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 Conference Room 129 of the Iowa Medicaid Enterprise Office Building. An agenda was sent to interested groups as well as the press advising them the meeting will be held via conference call. Minutes will be kept of the meeting."

Kohlsdorf announces that this meeting was called to approve the Hawki Administrative Rules 441 IAC 86 that had previously been presented and discussed by the Board. The rules had been approved at an earlier meeting, but because of a parliamentary mistake, the Board vote to approve needed to be taken again.

Kohlsdorf asked for a motion to approve. Vargas moved to approve the rules, Donoghue second. Motion approved unanimously.

Meeting adjourned at 12:56 p.m.

Nick Peters
Recorder of Minutes

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

Hawki Board Meeting
June 17, 2019

Hawki Board Members	Department of Human Services
Angela Burke Boston - **present**	Mike Randol
Jim Donoghue - **present**	Marissa Eyanson
Eric Kohlsdorf, Chair - **present**	Anna Ruggle
Dr. Bob Russell - **present**	Kevin Kirkpatrick
Dr. Kaaren Vargas - **present**	Dr. C. David Smith
Senator Nate Boulton - present	
Senator Dennis Guth	**Guests**
Representative John Forbes	Amanda Josvanger, VNA of Dubuque
Representative Shannon Lundgren	Sandi Hurtado-Peters
	Page Petit, UnitedHealthcare of the River Valley
	John Hedgecoat, ITC
	Alannah Larson North Iowa Comm. Action Org.
	John Hitchcock, Amerigroup

Call to Order and Roll Call
Eric Kohlsdorf called the meeting to order at 12:32 PM. A roll call was conducted and attendance is as reflected above. A quorum was present.

Approval of the Hawki Board Meeting Minutes of April 15, 2019 and April 23, 2019
Board Chair Eric Kohlsdorf postponed vote on the meeting until the August Board meeting.

Director's Report
Mike Randol, Medicaid Director, reviewed the enrollment numbers and finances. He said that he was still working on the format needs to more clearly reflect the information on the reports at a glance.

Hawki System integration
Randol reported that the MAXIMUS member system integration has been completed into the Medicaid Management Information System (MMIS).

Communication Update
Kevin Kirkpatrick reported that there have been two mailings that have gone to members successfully. Printed information coming from the MCOs will be updated as current stock is depleted.

New Business

Next Meeting
The next meeting will be June 17, 2019.

Meeting adjourned at 1:05 PM.

Submitted by,

Nick Peters
Recorder of Minutes

Next meeting:	August 19, 2019 12:30 P.M. Iowa Historical Building 600 East Locust Des Moines, IA 50309

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

Department of
HUMAN SERVICES

Iowa Mental Health and Disability Services Commission

September 25, 2019

Commissioners

John Parmeter (Chair)

Kathy A. Johnson (Vice Chair)

Thomas C. Bouska

Thomas Broeker

Dennis Bush

Teresa Daubitz

Jody Eaton

Geoffrey M. Lauer

Shari O'Bannon

Maria Sorensen

Cory Turner

Richard Whitaker

Russell Wood

Lorrie Young

Ex-Officio Commissioners

Senator Jeff Edler

Senator Pam Jochum

Representative Joel Fry

Representative Scott Ourth

EXECUTIVE SUMMARY

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

Mental Health and Disability Services Commission Deliberations Summary:

January 17, 2019 - MHDS Commission Meeting
Rick Shults, Division Administrator of Mental Health and Disability Services, presented to the Commission a review of the Governor's budget that included additional money for Medicaid and reducing the Children's Mental Health Waiver waiting list.

January 17, 2019 - MHDS Commission Meeting
Mike Randol, Director of Iowa Medicaid Enterprise (IME), presented to the Commission on integrated health home review report, Intellectual Disability Waiver SCL tiered rates, process improvement working group, and an update on Iowa Total Care and changes to managed care organization contracts.

March 21, 2019 – MHDS Commission Meeting
Theresa Armstrong, Bureau Chief of Community Services and Planning, in a review of 2019 legislation presented to the Commission on the removal of the Brain Injury Waiver monthly cap.

June 20, 2019 – MHDS Commission Meeting
Marissa Eyanson, Bureau Chief of Medical and Long Term Services and Supports, presented to the Commission on United Healthcare no longer being a managed care organization and Iowa Total Care entering the state as a managed care organization.

September 19, 2019 - 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 2018. The Commission is frustrated that we have not seen significant progress in the following areas and urges the Department of Human Services (Department) and MCOs continued efforts to address the following:

- Delayed and partial payments to providers
- Delayed authorization for long term supports and services
- Delayed credentialing of service providers
- Reduced lengths of stay in residential treatment have been resulting in an increased level of recidivism
- Confusion over administrative requirements for Integrated Health Homes
- Confusion over use of peer support and recovery peer support services
- 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 hiring on behalf of the MCO's to launch their operations
- 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
- Reduced number of out of state placements
- Lack of reimbursement to providers for same day treatment
- 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

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for January 2019

DATE: Tuesday, March 5, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the January 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of January 2019, the Managed Care Ombudsman Program received 32 complaints from the managed care members we serve. The complaints resulted in investigation and advocacy for 15 managed care members. The top three complaints addressed in January 2019 were:

1. Services reduced, denied or terminated
2. Care planning
3. Case management

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Intellectual Disability Waiver, the Elderly Waiver, and the Health & Disability/Physical Disability Waivers.

Additional information can be found in the attached January 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email at mail to: managedcareombudsman@iowa.gov.

Managed Care Ombudsman Program Monthly Report

DATE: 01/2019

Members per MCO[1] in process January 2019	Amerigroup Iowa	11
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	33
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	2
	Disability Rights Iowa	4
	Iowa Compass	4
	Iowa Legal Aid	4
	LifeLong Links	4
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	-
	Senior Health Insurance Information Program	-
	State Ombudsman Office	3
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	4
	Fair Hearing assistance	2

Complaints by Member

The Managed Care Ombudsman Program worked on complaints from 45 individual members. The top complaint received this month was in regard to services reduced, denied or terminated (11 members). Additional complaints included:

Open Cases:
Care Planning (4 members)
Services reduced, denied or terminated (4 members)
Member Rights (2 members)
CCO-CDAC (3 members)
Member Relations & Grievances (3 members)
Case Management (4 members)
Level of Care (0 members)
Access to durable medical equipment & medications (3 members)
Home and vehicle modifications (1 member)
Access to Services/Benefits (2 member)
Discharge (1 member)
Eligibility & Enrollment (2 members)
NOD, Appeals, Fair Hearing (3 members)

Closed Cases:
Care Planning (5 members)
Services reduced, denied or terminated (7 members)
Member Rights (2 members)
CCO-CDAC (0 members)
Member Relations & Grievances (7 members)
Case Management (3 members)
Level of Care (5 members)
Access to durable medical equipment & medications (2 members)
Home and vehicle modifications (0 members)

[1] *Contacts per MCO*: Contacts received regarding the respective MCO.
[2] *Referrals per Entity*: Referrals made to external organizations that provide services beyond the scope of the program.

Complaints by Member

Access to Services/Benefits (1 member)
Discharge (2 members)
Eligibility & Enrollment (1 member)
NOD, Appeals, Fair-Hearing (0 members)
Transition services/coverage gap, inadequate or inaccessible (3 members)

Total Number of Complaints may not equal total number Member contacts due to multiple complaints effecting individual members.

Amerigroup Iowa Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-		-	0
Brain Injury Waiver	-	-	-	-	2	2
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-	-	-	-	-	0
Duals	3	1			4	8
Elderly Waiver	3	-	-	-	3	6
Habilitation	-	-	-	-	-	0
Health & Disability Waiver	-	-	-	-	-	0
HIPP	-	-	-	-	-	0
Institutional Care	-				-	0
Iowa Health & Wellness	-	-	-	-	-	0
Intellectual Disability Waiver	1	-	-	1	5	7
Medicare	-	-	-	-	-	0
PACE	-				-	0
Physical Disability Waiver	-	-	-	-	-	0
QMB or SLMB	-				-	0
Traditional Medicaid	-	-	-	-	-	0
Other	-				-	0
N/A	-				-	0
Unknown	-				-	0
TOTAL:	7	1	0	1	14	23

UnitedHealthcare Plan of the River Valley Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-	1			2	3
Duals	1	-	-	-	-	1
Elderly Waiver	8	1	-	-	2	11
Habilitation	-	-	-	-	-	0
Health & Disability Waiver	-	-	-	-	-	0
HIPP	-	-	-	-	-	0
Institutional Care	1					1
Iowa Health & Wellness	-	-	-		-	0
Intellectual Disability Waiver	12	6	-	1	7	26
Medicare	-	-	-	-	-	1
PACE	-				-	0
Physical Disability Waiver	-	-	-	-	2	2
QMB or SLMB	-				-	0
Traditional Medicaid	-	-	-	-	-	0
Other	-				1	0
N/A	-				-	0
Unknown	-				-	0
TOTAL:	22	8	0	1	14	44

Fee for Service Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
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	-	-	-	2	4	6
Other	-					0
N/A	-				-	0
Unknown	-				-	0
TOTAL:	0	0	0	2	4	6

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for February 2019

DATE: Friday, March 29, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the February 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Beginning with the Managed Care Ombudsman Program report for January 2019, the report is reformatted and contains only information on complaints and cases for which the Managed Care Ombudsman Program undertook advocacy efforts for the LTSS managed care population the program serves.

The report now contains information on LTSS Medicaid member complaints received by the office versus contacts to the office. In order to accurately reflect member issues, the Managed Care Ombudsman Program report captures member issues by waiver program and managed care organization as well as the resolution of those complaints.

Cases and Complaints:
During the month of February 2019, the Managed Care Ombudsman Program received 29 complaints from the managed care members we serve. Out of the 11 open cases 1 case will not be captured in the following grids due to eligibility not determined at that time. The complaints resulted in investigation and advocacy for 11 managed care members. The top three complaints addressed in February 2019 were:

1. Access to Services/Benefits
2. Services reduced, denied or terminated
3. Transition services/coverage gap, inadequate or inaccessible

Medicaid Programs:
Most of the complaints received from the managed care members in February 2019 were related to the Elderly Waiver, the Intellectual Disability Waiver, and the Health & Disability/Physical Disability Waiver.

Additional information can be found in the attached February 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email at mailto: managedcareombudsman@iowa.gov.

Managed Care Ombudsman Program Monthly Report

DATE: 02/2019

Category	Item	Count
Members per MCO[1] in process February 2019	Amerigroup Iowa	6
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	17
	Fee for Service	1
Referrals per Entity[2]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	4
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	1
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	4
	Fair Hearing assistance	1

Complaints by Member

The managed Care Ombudsman Program worked on complaints from 25 individual members. Out of the 11 open cases 1 case will not be captured in the following grids due to eligibility not determined at that time. The top complaint was in regard to access to services and benefits (6 members). Additional complaints include:

Open Cases:
Care Planning (2 members)
Services reduced, denied or terminated (4 members)
Member Rights (1 member)
CCO & CDAC (3 members)
Member Relations & Grievances (1 member)
Case Management (1 member)
Level of Care (2 members)
Access to durable medical equipment (0 members)
Access to Services/Benefits (4 members)
Transportation (0 members)
Guardianship (1 member)
Discharge (3 members)
Eligibility & Enrollment (2 members)
NOD, Appeals, Fair Hearing (0 members)
Transition services/coverage gap, inadequate or inaccessible (4 members)

Closed Cases:
Care Planning (1 member)
Services reduced, denied or terminated (1 member)
Member Rights (1 member)
CCO & CDAC (1 member)
Member Relations & Grievances (1 member)
Case Management (1 member)
Level of Care (0 members)

[1] *Contacts per MCO:* Contacts received regarding the respective MCO.
[2] *Referrals per Entity:* Referrals made to external organizations that provide services beyond the scope of the program.

Complaints by Member

Access to durable medical equipment (3 members)
Access to Services/Benefits (2 members)
Transportation (0 members)
Guardianship (0 members)
Discharge (0 members)
Eligibility & Enrollment (0 members)
NOD, Appeals, Fair Hearing (1 member)
Transition services/coverage gap, inadequate or inaccessible (1 member)

Amerigroup Iowa Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals		-			-	0
Elderly Waiver		2	-	-	5	7
Habilitation		-	-	-	-	0
Health & Disability Waiver		-	1	-	-	1
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver		-	-	-	4	4
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	-	0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other					-	0
N/A					-	0
Unknown					-	0
TOTAL:		2	1	0	9	12

UnitedHealthcare Plan of the River Valley Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	1	-	-	-	-	1
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-	-			-	0
Duals	-	-	-	-	3	3
Elderly Waiver	2	-	-	1	4	7
Habilitation	-	-	-	-	-	0
Health & Disability Waiver	1	-	-	-	1	2
HIPP	-	-	-	-	-	0
Institutional Care	1					1
Iowa Health & Wellness	-	-	-		-	0
Intellectual Disability Waiver	4	-	-	-	1	5
Medicare	-	-	-	-	-	0
PACE	-				-	0
Physical Disability Waiver	3	-	-	-	3	6
QMB or SLMB	-				-	0
Traditional Medicaid	-	-	-	-	-	0
Other	-				4	4
N/A	-				-	0
Unknown	-				-	0
TOTAL:	12	0	0	1	16	29

Fee for Service Complaint(s) Resolution by Program Type	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
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	-	-	-	-	3	3
Other	-					0
N/A	-				-	0
Unknown	-				-	0
TOTAL:	0	0	0	0	3	3

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for March 2019

DATE: Wednesday, April 17, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the March 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of March 2019, the Managed Care Ombudsman Program received 22 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 15 managed care members during the month of March. The top three complaints addressed in March 2019 were:

1. Services reduced, denied or terminated
2. Access to Services/Benefits and Transition services/coverage gap inadequate or inaccessible
3. Access to durable medical equipment and Case Management

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Intellectual Disability Waiver, the Elderly Waiver, and the Physical Disability Waiver.

Additional information can be found in the attached March 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email at mailto: managedcareombudsman@iowa.gov.

Managed Care
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866.236.1430 | ManagedCareOmbudsman@iowa.gov

Managed Care Ombudsman Program Monthly Report

DATE: 03/2019

Members per MCO in process March 2019	Amerigroup Iowa	11
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	26
	Fee for Service	-
Referrals per Entity[1]	Department of Human Services	1
	Department of Inspections and Appeals	1
	Disability Rights Iowa	2
	Iowa Compass	1
	Iowa Legal Aid	1
	LifeLong Links	1
	MCO	1
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	2
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	-
	Appeals assistance	3
	Fair Hearing assistance	2

Complaints by Member

In March, the Managed Care Ombudsman Program worked on complaints from 38 individual members. Out of the 25 active cases, 15 are newly open. 1 case will not be captured in the following grids due to eligibility not determined. The top complaint from manged care members in March was in regard to services reduced, denied or terminated (11 members). Additional complaints include:

All open cases:

Services reduced, denied or terminated (8 members)
CCO & CDAC (6 members)
Member Rights (6 members)
Access to durable medical equipment (5 members)
Access to Services/Benefits (5 members)
Transition services/coverage gap, inadequate or inaccessible (5 members)
Case Management (5 members)
Care Planning (3 members)
Discharge (4 members)
Eligibility & Enrollment (2 members)
NOD, Appeals, Fair Hearing (2 members)
Complaints against provider (2 members)
MCOP-Other/Member charged improper cost sharing (2 members)
Level of Care (2 members)
Guardianship (1 member)
Member Relations & Grievances (1 member)

Closed cases:

Services reduced, denied or terminated (3 members)
CCO & CDAC (0 members)
Member Rights (0 members)
Access to durable medical equipment (2 members)
Access to Services/Benefits (2 members)
Transition services/coverage gap, inadequate or inaccessible (2 members)
Case Management (2 members)
Care Planning (0 members)
Discharge (0 members)
Eligibility & Enrollment (3 members)
NOD, Appeals, Fair Hearing (1 member)
Complaints against provider (0 members)
MCOP-Other (0 members)
Level of Care (0 members)
Guardianship (0 members)
Member Relations & Grievances (1 member)

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

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental	1	-	-	-	-	1
Duals		-			-	0
Elderly Waiver		-	-	-	5	5
Habilitation		1	-	-	1	2
Health & Disability Waiver		1	-	-	-	1
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver		-	-	1	3	4
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	-	0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other					-	0
N/A					-	0
Unknown					-	0
TOTAL:	1	1	0	1	9	12

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental*	0	-			-	0
Duals	-	-	-	-	1	1
Elderly Waiver	1	1	-	-	1	3
Habilitation	-	-	-	-	-	0
Health & Disability Waiver	-	-	-	-	-	0
HIPP	-	-	-	-	-	0
Institutional Care	1					1
Iowa Health & Wellness	-	-	-		-	0
Intellectual Disability Waiver	1	-	-	1	4	6
Medicare	-	-	-	-	-	0
PACE	-				-	0
Physical Disability Waiver	6	-	-	-	3	9
QMB or SLMB	-				-	0
Traditional Medicaid	-	-	-		-	0
Other	2			1	3	6
N/A	-				-	0
Unknown	-				-	0
TOTAL:	11	1	0	2	12	26

**Two complaint resolutions unknown as those complaints are provider issues referred to another agency.*

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
Habilitation	-	-	-	-	-	0
Health & Disability Waiver	-	-	-	-	-	0
HIPP	-	-	-	-	-	0
Institutional Care	-				-	0
Iowa Health & Wellness	-	-	-	-	-	0
Intellectual Disability Waiver	-	-	-	-	-	0
Medicare	1	-	-	-	1	2
PACE	-				-	0
Physical Disability Waiver	-	-	-	-		0
QMB or SLMB	-				-	0
Traditional Medicaid	-	-	-	-	-	0
Other	-					0
N/A	-				-	0
Unknown	-				-	0
TOTAL:	1	0	0	0	1	2

Managed Care Ombudsman Monthly Report | Page 3 of 3

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for April 2019

DATE: Friday, May 17, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the April 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of April 2019, the Managed Care Ombudsman Program received 54 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 29 managed care members during the month of April. The top three complaints addressed in April 2019 were:

1. Services reduced, denied or terminated
2. Access to Services/Benefits and Transition services/coverage gap inadequate or inaccessible
3. CCO & CDAC/ Eligibility and Enrollment

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Elderly Waiver, the Health & Disability Waiver and Intellectual Disability Waiver.

Additional information can be found in the attached April 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email managedcareombudsman@iowa.gov.

Managed Care Ombudsman Program Monthly Report

DATE: 04/2019

Members per MCO in process April 2019	Amerigroup Iowa	23
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	28
	Fee for Service	2
Referrals per Entity[1]	Department of Human Services	2
	Department of Inspections and Appeals	4
	Disability Rights Iowa	3
	Iowa Compass	-
	Iowa Legal Aid	3
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	3
	Senior Health Insurance Information Program	-
	State Ombudsman Office	3
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	3
	Appeals assistance	3
	Fair Hearing assistance	2

Complaints by Member

The Managed Care Ombudsman Program worked on complaints from 56 individual members. The top complaint received this month was in regard to services reduced denied or terminated (13 members). Additional complaints included:

All open cases:

Services reduced, denied or terminated (9 members)
Access to Services/Benefits (7 members)
CCO-CDAC (9 members)
Eligibility & Enrollment (4 members)
Other-Members being billed (5 members)
Case Management (4 members)
Transition services/coverage gap, inadequate or inaccessible (2 members)
Member Rights (4 members)
Access to durable medical equipment & medications (4 members)
Level of Care (3 members)
Transportation (1 member)
Discharge (1 member)
Member Relations & Grievances (4 members)
Complaints against Provider (1 member)
Home and vehicle modification (2 members)
Guardianship (1 member)
NOD, Appeals, Fair-Hearing (1 member)
Care Planning (2 members)

Closed cases:

Services reduced, denied or terminated (4 members)
Access to Services/Benefits (5 members)
CCO-CDAC (1 member)
Eligibility & Enrollment (6 members)
Other-Members being billed (4 members)
Case Management (4 members)
Transition services/coverage gap, inadequate or inaccessible (5 members)
Member Rights (2 members)
Access to durable medical equipment & medications (2 members)
Level of Care (3 members)
Transportation (4 members)
Discharge (4 members)
Member Relations & Grievances (1 member)
Complaints against Provider (3 members)
Home and vehicle modification (1 member)
Guardianship (2 members)
NOD, Appeals, Fair-Hearing (1 member)
Care Planning (0 members)

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

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver	1	-	-		7	8
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals		-			6	6
Elderly Waiver	13	-	-	-	5	18
Habilitation		-	-	-	-	0
Health & Disability Waiver	3	-	-	-	6	9
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver	5	-	-	1	8	14
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	1	1
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other	1				1	2
N/A					-	0
Unknown					-	0
TOTAL:	23	0	0	1	34	58

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	1	-	1
Children's Mental Health Waiver		-	-	-	-	0
Dental		-			-	0
Duals	1	-	-	-	1	2
Elderly Waiver	3	-	-	2	4	9
Habilitation	4	-	-	-	2	6
Health & Disability Waiver	2	-	-	-	5	7
HIPP		-	-	-	-	0
Institutional Care						0
Iowa Health & Wellness		-	-		-	0
Intellectual Disability Waiver		-	-	-	1	1
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver	4	-	-	-	4	8
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other	2				3	5
N/A					-	0
Unknown					-	0
TOTAL:	16	0	0	3	20	39

Complaint(s) Resolution by Program Type

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
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	3	-	-	-	-	3
Other	-					0
N/A	-				-	0
Unknown	-			2	-	2
TOTAL:	3	0	0	0	0	5

Managed Care Ombudsman Monthly Report | Page 3 of 3

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for May 2019

DATE: Friday, June 7, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the May 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of May 2019, the Managed Care Ombudsman Program received 34 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 16 managed care members during the month of May. The top three complaints addressed in May 2019 were:

1. Services reduced, denied or terminated
2. Case Management and Care Planning
3. Access to Services/Benefits

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Intellectual Disability Waiver, Health & Disability Waiver and the Physical Disability and Brian Injury Waivers.

Additional information can be found in the attached May 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email managedcareombudsman@iowa.gov.

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Managed Care Ombudsman Program Monthly Report

DATE: 05/2019

Members per MCO in process May 2019	Amerigroup Iowa	19
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	18
	Fee for Service	-
Referrals per Entity[1]	Department of Human Services	2
	Department of Inspections and Appeals	-
	Disability Rights Iowa	4
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	-
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	1
	Senior Health Insurance Information Program	-
	State Ombudsman Office	4
	Other	-
Grievances/Appeals/Fair Hearings	Grievance assistance	2
	Appeals assistance	1
	Fair Hearing assistance	1

Complaints by Member

In May, the Managed Care Ombudsman Program worked on complaints from 38 individual members. Out of the 38 active cases, 10 are newly open. 1 case will not be captured in the following grids due to eligibility not determined. The top complaint from manged care members in May was in regard to services reduced, denied or terminated (9 members). Additional complaints include:

All open cases:

Services reduced, denied or terminated (7 members)
CCO & CDAC (7 members)
Member Rights (2 members)
Access to durable medical equipment and medications (4 members)
Access to Services/Benefits (7 members)
Transition services/coverage gap, inadequate or inaccessible (1 member)
Case Management (7 members)
Care Planning (4 members)
Discharge (0 members)
Eligibility & Enrollment (1 member)
NOD, Appeals, Fair Hearing (4 members)
Complaints against provider (0 members)
MCOP-Other/Member charged improper cost sharing/Dental (2 members)
Level of Care (2 members)
Guardianship (0 members)
Member Relations & Grievances (3 members)
Home and vehicle modifications (2 members)
Transportation (2 members)

Closed cases:

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

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

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver		-	-		1	1
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals	3	-			-	3
Elderly Waiver	7	-	-	-	-	7
Habilitation		-	-	-	-	0
Health & Disability Waiver		-	-	-	9	9
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver		-	-	-	10	10
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	2	2
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other					2	2
N/A					-	0
Unknown	1				-	1
TOTAL:	11	0	0	0	24	35

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	1	1
Children's Mental Health Waiver		-	-	-	-	0
Dental		-			-	0
Duals		-	-	-	-	0
Elderly Waiver	1	-	-	-	1	2
Habilitation	1	-	-	-	-	1
Health & Disability Waiver	2	-	-	-	-	2
HIPP		-	-	-	-	0
Institutional Care						0
Iowa Health & Wellness		-	-		-	0
Intellectual Disability Waiver	6	-	-	1	4	11
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	-	0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other	3				4	7
N/A					-	0
Unknown					-	0
TOTAL:	13	0	0	1	10	24

Complaint(s) Resolution by Program Type

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
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	-					0
N/A	-			1	-	1
Unknown	-				-	0
TOTAL:	0	0	0	1	0	1

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for June 2019

DATE: Tuesday, July 9, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the June 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of June 2019, the Managed Care Ombudsman Program received 57 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 22 managed care members during the month of June. The top three complaints addressed in June 2019 were:

1. Case management
2. Access to Services/Benefits
3. Services reduced, denied or terminated

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Elderly Waiver, Intellectual Disability Waiver and members under Duals Medicaid Programs.

Additional information can be found in the attached June 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email managedcareombudsman@iowa.gov.

Managed Care Ombudsman Program Monthly Report

DATE: 06/2019

Members per MCO in process June 2019	Amerigroup Iowa	14
	AmeriHealth Caritas	-
	UnitedHealthcare Plan of the River Valley	29
	Fee for Service	-
Referrals per Entity[1]	Department of Human Services	3
	Department of Inspections and Appeals	-
	Disability Rights Iowa	5
	Iowa Compass	-
	Iowa Legal Aid	1
	LifeLong Links	1
	MCO	-
	Medicaid Fraud Control Unit	-
	Provider	2
	Senior Health Insurance Information Program	-
	State Ombudsman Office	4
	Other	1
Grievances/Appeals/Fair Hearings	Grievance assistance	1
	Appeals assistance	4
	Fair Hearing assistance	1

Complaints by Member

In June, the Managed Care Ombudsman Program worked on complaints from 44 individual members. Out of the 17 active cases, 7 are newly open. 1 case will not be captured in the following grids due to eligibility not determined. The top complaint from manged care members in June was in regard to case management (18 members). Additional complaints include:

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

Closed cases:
Case Management (12 members)
Access to Services/Benefits (8 members)
Services reduced, denied or terminated (4 members)
CCO & CDAC (4 members)
Transition services/coverage gap, inadequate or inaccessible (5 members)
MCOP-Other/Member charged improper cost sharing or waiting on CDAC staff to be approved (5 members)
Member Rights (2 members)
Level of Care (4 members)
NOD, Appeals, Fair Hearing (0 members)
Complaints against provider (3 members)
Eligibility & Enrollment (2 members)
Care Planning (2 members)
Access to durable medical equipment and medications (1 member)
Discharge (1 member)
Transportation (1 member)
Home and vehicle modifications (0 members)
Member Relations & Grievances (0 members)

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

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver		-	-		1	1
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals		-			-	0
Elderly Waiver		-	-	-	-	0
Habilitation		-	-	-	-	0
Health & Disability Waiver		-	-	-	4	4
HIPP		-	-	-	-	0
Institutional Care				1	1	2
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver	2	-	-		4	6
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver	2	-	-	-	-	2
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other				2	-	2
N/A					-	0
Unknown					-	0
TOTAL:	4	0	0	3	10	17

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver	2	-	-	1	-	3
Children's Mental Health Waiver		-	-	-	-	0
Dental		-			-	0
Duals	1	-	-	-	6	7
Elderly Waiver	3	1	9	4	15	32
Habilitation	2	-	-	2	2	6
Health & Disability Waiver	8	2	-	-	3	13
HIPP		-	-	-	-	0
Institutional Care						0
Iowa Health & Wellness		-	-		-	0
Intellectual Disability Waiver	6	4	-	4	12	26
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver	5	-	-	-	5	10
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other	2				3	5
N/A				1	-	1
Unknown					-	0
TOTAL:	29	7	9	12	46	103

Complaint(s) Resolution by Program Type

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver	-	-	-	-	-	0
Brain Injury Waiver	-	-	-	-	-	0
Children's Mental Health Waiver	-	-	-	-	-	0
Dental	-					0
Duals	-	-	-	-	-	0
Elderly Waiver	-	-	-	-		0
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	-					0
N/A	-			-	1	1
Unknown	-				-	0
TOTAL:	0	0	0	0	1	1

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for July 2019

DATE: Monday, August 18, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the July 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of July 2019, the Managed Care Ombudsman Program received 115 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 53 managed care members during the month of July. The top three complaints addressed in July 2019 were:

1. Case management
2. CCO/CDAC
3. Access to Services/Benefits and Member Rights

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Elderly Waiver, Intellectual Disability Waiver and Health and Disability Waiver.

Additional information can be found in the attached July 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email managedcareombudsman@iowa.gov.

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Managed Care Ombudsman Program Monthly Report

DATE: 07/2019

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

Complaints by Member

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)

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.

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver	2	-	-		1	3
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals		-			-	0
Elderly Waiver	7	-	-	-	26	33
Habilitation		-	-	-	-	0
Health & Disability Waiver	11	-	-	-	20	31
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver	9	-	-	-	15	24
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver	5	-	-	-	10	15
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other					-	1
N/A					-	0
Unknown					-	0
TOTAL:	34	0	0	0	72	107

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental		-			-	0
Duals		1	5	-	-	6
Elderly Waiver	1	-	-	-	1	2
Habilitation		-	-	-	-	0
Health & Disability Waiver		-	-	-	-	0
HIPP		-	-	-	-	0
Institutional Care						0
Iowa Health & Wellness		-	-		-	0
Intellectual Disability Waiver	5	-	-	3	5	13
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver	3	2	3	-	-	12
QMB or SLMB					-	0
Traditional Medicaid		-	-	-		0
Other					1	1
N/A				1	1	2
Unknown					-	0
TOTAL:	9	3	8	4	8	36

Managed Care Ombudsman Monthly Report | Page 2 of 3

Complaint(s) Resolution by Program Type

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental						0
Duals		-	-	-		0
Elderly Waiver	4	-	-	-	7	11
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		-	-	-	-	3
Other						0
N/A					-	0
Unknown				-	-	0
TOTAL:	4	0	0	0	7	11

Iowa Total Care	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental						0
Duals		-	-	-		0
Elderly Waiver	10	-	-	-	10	20
Habilitation	2	-	-	-	2	4
Health & Disability Waiver	4	-	-	-	4	8
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver	12	-	-	-	12	24
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-		0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other						0
N/A					-	0
Unknown				-	-	0
TOTAL:	28	0	0	0	28	56

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TO: Iowa Department of Human Services

CC: Centers for Medicare and Medicaid Services

FROM: Cynthia Pederson, State Long-Term Care Ombudsman

SUBJECT: Managed Care Ombudsman Program Monthly Report for August 2019

DATE: Tuesday, September 10, 2019

The Office of the State Long-Term Care Ombudsman reports data from the Managed Care Ombudsman Program on a monthly basis. Attached is the August 2019 Report.

The Managed Care Ombudsman Program serves as the independent advocate for Medicaid managed care members receiving care in a health care facility as well as members enrolled in one of the seven home and community-based services (HCBS) waivers.

Cases and Complaints:
During the month of August 2019, the Managed Care Ombudsman Program received 52 new complaints from the managed care members we serve. The complaints resulted in new investigations and advocacy for 21 managed care members during the month of August. The top three complaints addressed in August 2019 were:

1. Case management
2. CCO and CDAC
3. Services reduced, denied or terminated and Access to Services/Benefits

Medicaid Programs:
Most of the complaints received from the managed care members were related to the Elderly Waiver, Intellectual Disability Waiver and Health and Disability Waiver.

Additional information can be found in the attached August 2019 Report. For further information, please contact the Managed Care Ombudsman Program, by phone at 866-236-1430 or email managedcareombudsman@iowa.gov.

Managed Care Ombudsman Program Monthly Report

DATE: 08/2019

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	-

Complaints by Member

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)

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)

1 *Members per MCO:* Due to the 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.

Complaint(s) Resolution by Program Type

Amerigroup Iowa	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-		-	0
Brain Injury Waiver	2	-	-		-	2
Children's Mental Health Waiver		-	-	-	-	0
Dental		-	-	-	-	0
Duals		3			-	3
Elderly Waiver	7	-	-	-	18	25
Habilitation		-	-	-	-	0
Health & Disability Waiver	2	-	-	-	3	5
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver	2	-	1	-	13	16
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	--	0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-	-	0
Other					-	0
N/A					-	0
Unknown					-	0
TOTAL:	13	3	1	0	34	51

UnitedHealthcare Plan of the River Valley	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	2	-	2	4
Children's Mental Health Waiver		-	-	-	-	0
Dental		-			-	0
Duals		-	-	-	-	0
Elderly Waiver		1	2	-	-	3
Habilitation		-	-	-	-	0
Health & Disability Waiver		4	1	-	-	5
HIPP		-	-	-	-	0
Institutional Care						0
Iowa Health & Wellness		-	-		-	0
Intellectual Disability Waiver	2	-	3	-	-	5
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-	-	0
QMB or SLMB					-	0
Traditional Medicaid				-		0
Other		1	3		-	4
N/A				-	-	0
Unknown					-	0
TOTAL:	2	6	11	0	2	21

Complaint(s) Resolution by Program Type

Fee for Service	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental						0
Duals		-	-	-		0
Elderly Waiver	3	-	-	-		3
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:	3	4	0	0	7	14

Iowa Total Care	Resolved to Member's satisfaction	Partially resolved to Member's satisfaction	Not resolved to Member's satisfaction	No action needed or appropriate	Open	Total
AIDS/HIV Waiver		-	-	-	-	0
Brain Injury Waiver		-	-	-	-	0
Children's Mental Health Waiver		-	-	-	-	0
Dental						0
Duals		-	-	-		0
Elderly Waiver		-	-	-	-	0
Habilitation		-	-	-	-	0
Health & Disability Waiver		-	-	-	-	0
HIPP		-	-	-	-	0
Institutional Care					-	0
Iowa Health & Wellness		-	-	-	-	0
Intellectual Disability Waiver		-	-	-	3	3
Medicare		-	-	-	-	0
PACE					-	0
Physical Disability Waiver		-	-	-		0
QMB or SLMB					-	0
Traditional Medicaid		-	-	-		0
Other	1				6	7
N/A					-	0
Unknown				-	-	0
TOTAL:	1	0	0	0	9	10

APPENDIX

APPENDIX: GLOSSARY

MCO Abbreviations:

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

Glossary Terms:

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

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

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

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

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

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

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

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

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

Care Management: Care Management helps members manage their complex health care needs. It may include helping 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.