Iowa Medicaid Enterprise

Managed Care
Annual Performance Report
(July 2017 – June 2018)

Published January 7, 2019

Department of
HUMAN SERVICES

CONTENTS

EXECUTIVE SUMMARY

Legislative Requirements:

The Managed Care Annual Performance Report is based on requirements of 2016 Iowa Acts Section 1139.93. The Legislature grouped these reports into three main categories:

- Consumer Protection
- Outcome Achievement
- Program Integrity

The Department presents managed care organization (MCO) performance data in this publication as closely as possible to the categories in House File 2460. This information is presented in the following way:

- Eligibility and demographic information of members assigned to the IA Health Link Program
- Consumer protections and support
- Health plan operations
- Network access and continuity of providers
- Financial reporting
- Program integrity actions and recoveries
- Health care outcomes
- Appendices with supporting information

This report includes information for the three MCOs participating in the IA Health Link Program:

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

AmeriHealth Caritas Iowa, Inc. withdrew from the IA Health Link managed care program effective November 30, 2017. Measures that represent contractual standards still in effect for AmeriHealth, including but not limited to helpline performance and grievance processing, are included in the report. Measures that reflect contract standards no longer in effect for AmeriHealth do not include AmeriHealth data. Data from previous quarters is available at the dedicated Medicaid Managed Care Quarterly Reports webpage: https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports.

Understanding the Performance Data:

- This annual report is focused on key descriptors and measures that provide information about managed care operations.

- While this report does contain operational data that can be an indicator of positive member outcomes, the Department believes that movement towards standardized health outcome measures is a more meaningful measurement of the delivery system.

- The reported information is 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 due to Medicaid providers have 180 days from service to file their claims. Based on our knowledge of claims data, the report accounts for a majority, or about eighty-five percent (85%) or more of the total claim volume, for the reporting period.

- The Department validates the data by examining historical baselines from the previous fee-for-service program, available encounter data, and by reviewing the source data provided by the MCOs.

Highlights:

- Health Risk Assessments: Over 53,000 member health risk assessments (HRAs) were conducted by the health plans during SFY18. HRAs were not a previous requirement. These assessments help identify risk factors to provide better treatment.

- Value-Added Services: Over 86,000 value-added services in the past four quarters were utilized. The health plans offer numerous value-added services that go above and beyond what traditional Medicaid benefits offer. These value-added services are intended for the right patient to improve their health and well-being including health incentives and wellness programs.

- Timely Helpline Services: When members have questions they can contact the health plans' member helplines. In all quarters for SFY18, all three health plans exceeded the timeliness requirements required by their contract. The state conducts "secret shopper calls" to ensure the quality of helpline services.

- Claims Requirements: All MCOs exceeded the contractual expectation that ninety percent (90%) of clean medical payment claims be paid within 30 days for all four quarters of SFY18.

- Member and Provider Escalated Issues: Escalated member issues decreased by 50% since SFY17 and escalated provider issues decreased by 81% since SFY17.

- Health Outcomes: There has been positive movement on the health outcomes reported when compared to SFY17. For example, non-emergent emergency Department use per 1,000 emergency Department visits have decreased and increases are seen in HEDIS measured outcomes.

Member and Provider Engagement:

The Department works to ensure that member and provider issues are addressed and resolved in a timely manner. To assist with the implementation of managed care, the Department designated two full-time staff members to triage and follow up on member and provider escalated issues that come to the Department through a "no wrong door" approach. The following is a summary of these activities as of the date of this report.

Member Escalated Issue Tracking						
	Amerigroup		AmeriHealth		UnitedHealthcare	
	SFY17	SFY18	SFY17	SFY18	SFY17	SFY18
Number of Member Escalated Issues Reported to the Department	662	296	676	262	849	537
Number of Escalated Member Issues Considered Closed*	623	292	650	258	849	534
Percentage of Escalated Member Issues Considered Closed*	94%	99%	96%	98%	100%	99%

**Issues still open reflect the status of issues in the Iowa Medicaid Enterprise escalated issue tracker that is managed by the Department. The Department is responsible for working with MCOs to close issues.*

**Escalated member issues decreased by 50% between SFY17 and SFY18.

Provider Escalated Issue Tracking						
	Amerigroup		AmeriHealth		UnitedHealthcare	
	SFY17	SFY18	SFY17	SFY18	SFY17	SFY18
Number of Provider Escalated Issues Reported to the Department	772	157	781	103	638	159
Number of Escalated Provider Issues Considered Closed*	771	157	779	103	637	159
Percentage of Escalated Provider Issues Considered Closed*	100%	100%	100%	100%	100%	100%

**Issues still open reflect the status of issues in the Iowa Medicaid Enterprise escalated issue tracker that is managed by the Department. The Department is responsible for working with MCOs to close issues.*

**Escalated provider issues decreased by 81% between SFY17 and SFY18.

Managed Care Related Projects:

- Tiered Rates Stakeholders Workgroup: The Department engaged stakeholders in a review of the tiered rates system of provider reimbursement and discussed a potential for redistribution of tiered rate reimbursement in the future.

- Managed Care Reporting: The Department has updated the reporting requirements for the MCOs as part of the ongoing oversight of the program. Those updates have been applied to the reporting manual as well as published performance reports.

- Process Improvement Working Group: The Department, along with the MCOs, met monthly with about three dozen providers from across the state to discuss issues with the current Medicaid processes and then worked together on improvements. The Department posted the issues and solutions on its website.

- Electronic Visit Verification (EVV): During SFY18, the Department met with stakeholders multiple times to provide opportunities for them to give feedback on EVV implementation. Discussions were also held with the MCOs and Veridian on how to include CCO services in the proposed EVV program. Planning continues into SFY19.

- Health Homes Stakeholders Workgroup: The Department held meetings with stakeholders of the Health Homes program to review the program, including the State Plan amendments, and discuss the future.

Compliance:

The Department continues to closely monitor each MCO's compliance with reporting benchmarks and contractual requirements. An aggregated summary of remedies is found below.

Tracked Remedies			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Number of Remedies for Failure to Meet Contractual Performance Standard	13	6	14
Number of Remedies for Incomplete/ Untimely Reporting	24	12	9
Total Remedies Imposed State Fiscal Year 2018	37	18	23

**Some issues still open may have been recently received. All open issues are being actively monitored.*

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 ***hawk-i*** 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."

Additional Information:

The Department continues to regularly publish information related to the managed care program on the Department's website. Noteworthy links are included below.

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

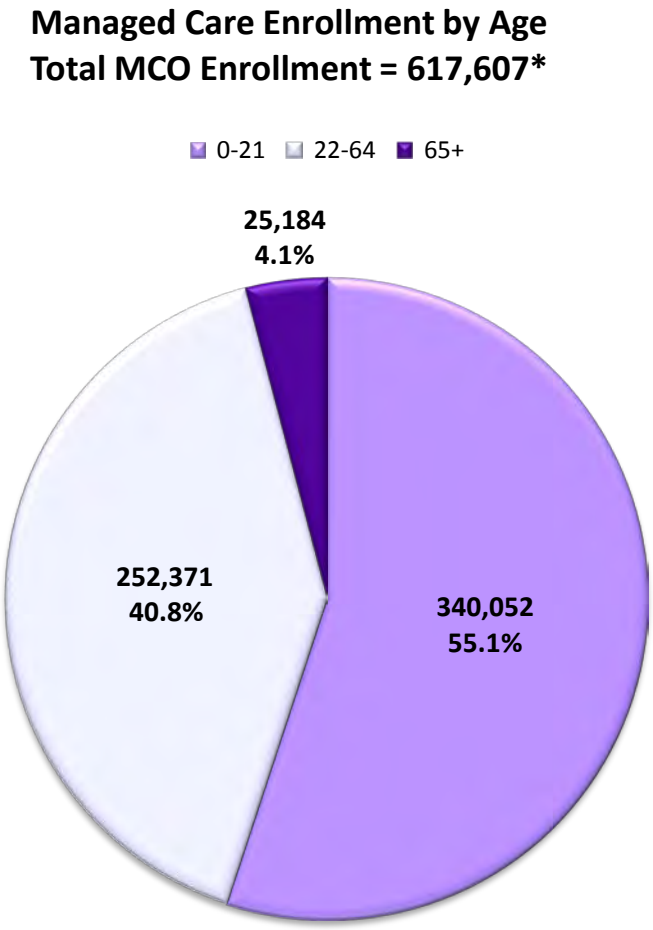
Providers and members can find more information on the IA Health Link program at
http://dhs.iowa.gov/iahealthlink

Informational Letters related to managed care can be found at
http://dhs.iowa.gov/ime/providers/rulesandpolicies/bulletins/MC-infoletters

Monthly Managed Care Performance Reports can be found at
https://dhs.iowa.gov/ime/about/performance-data/MC-monthly-reports

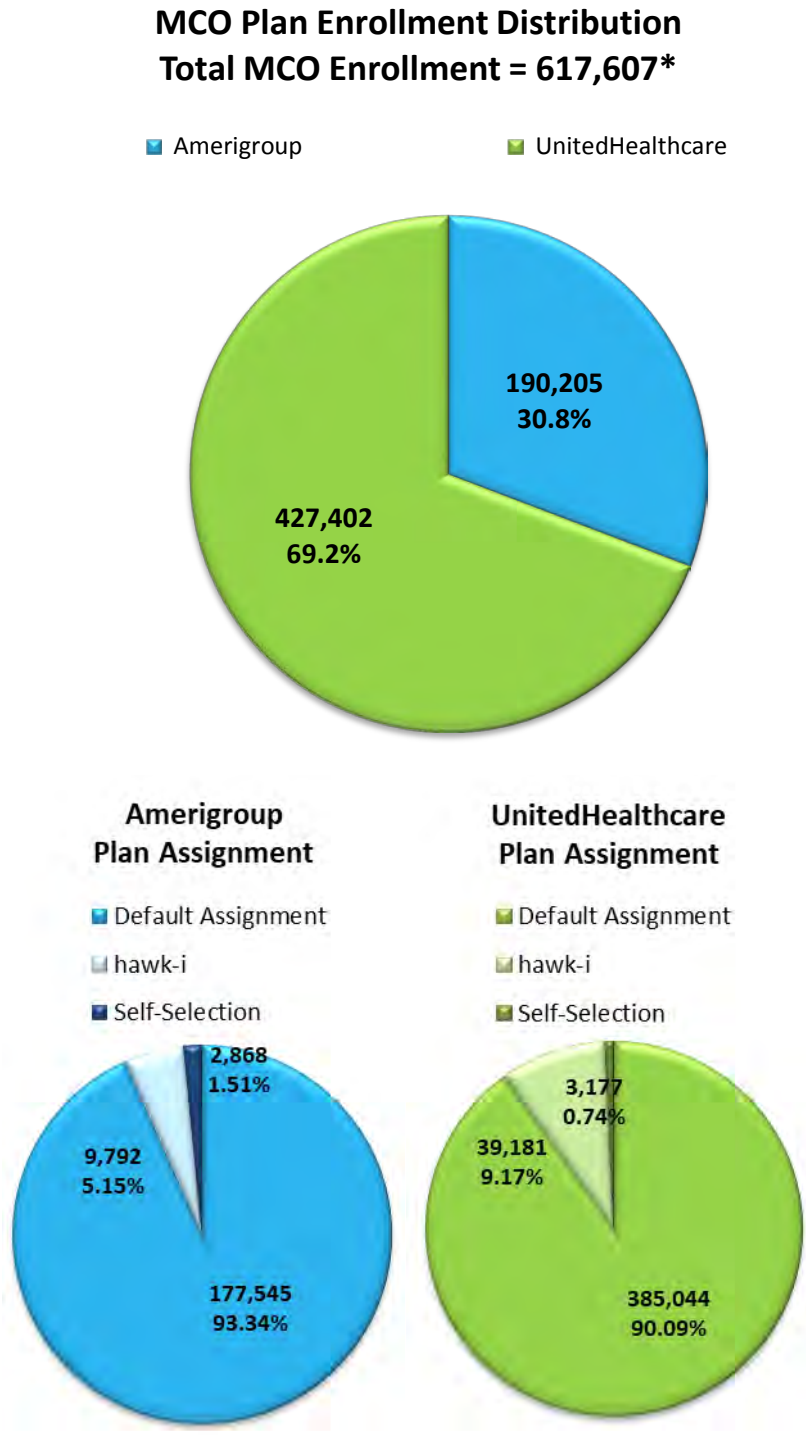
Quarterly Managed Care Performance Reports can be found at
https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports

PLAN ENROLLMENT BY AGE

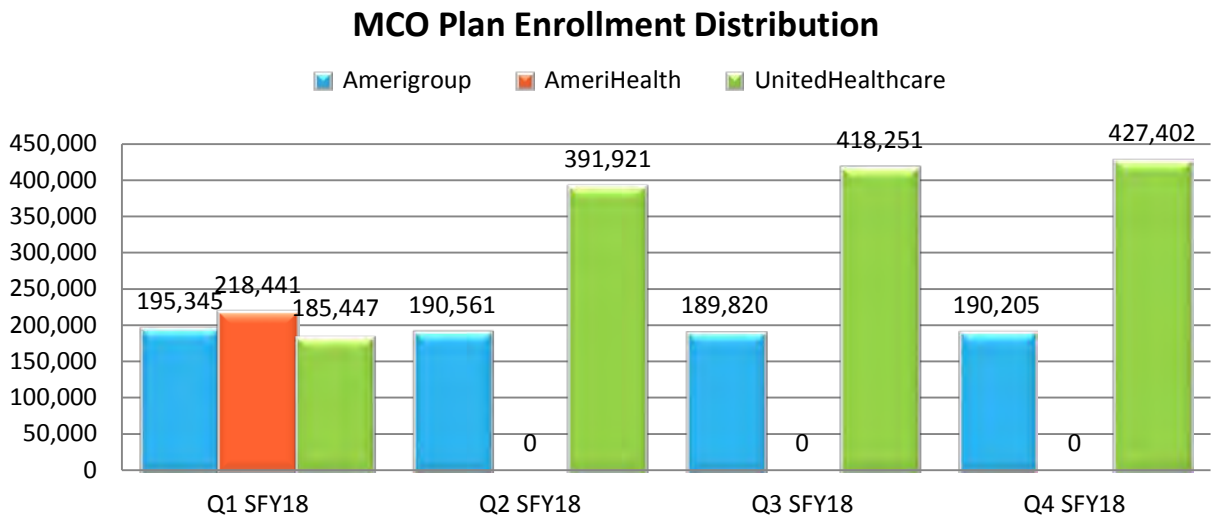


*June 2018 enrollment data as of July 10, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes **hawk-i** enrollees. 58,126 members are in the Fee-for-Service (FFS) program.

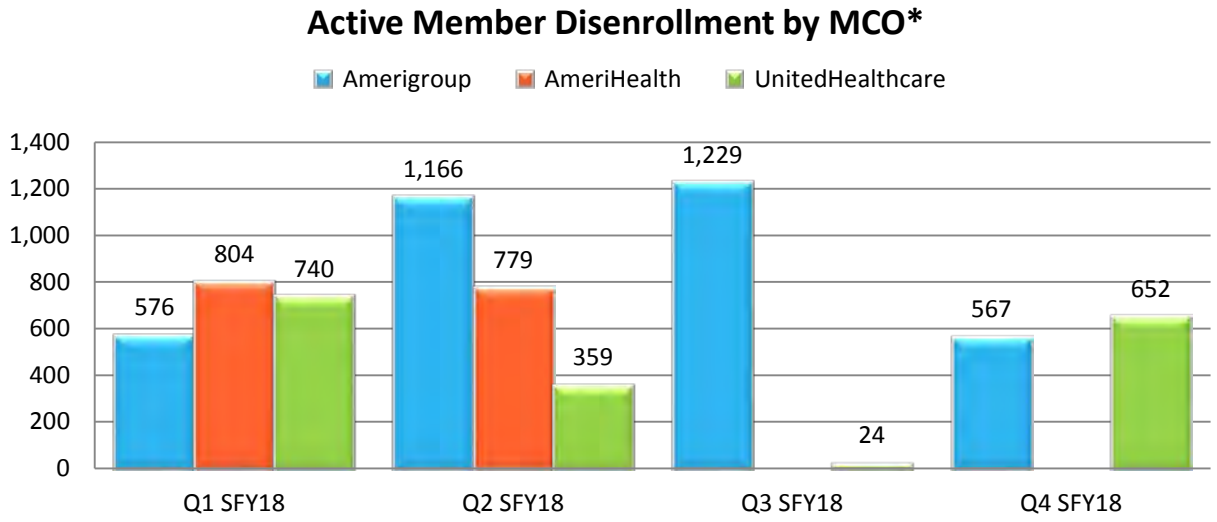
PLAN ENROLLMENT BY MCO



*June 2018 enrollment data as of July 10, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This differentiates ***hawk-i*** enrollees due to differences in ***hawk-i*** enrollment procedures. In most cases, ***hawk-i*** members select an MCO prior to beginning benefits whereas other programs have default assignment with self-selection occurring after default assignment. 58,126 members are in the Fee-for-Service (FFS) program.



PLAN DISENROLLMENT BY MCO



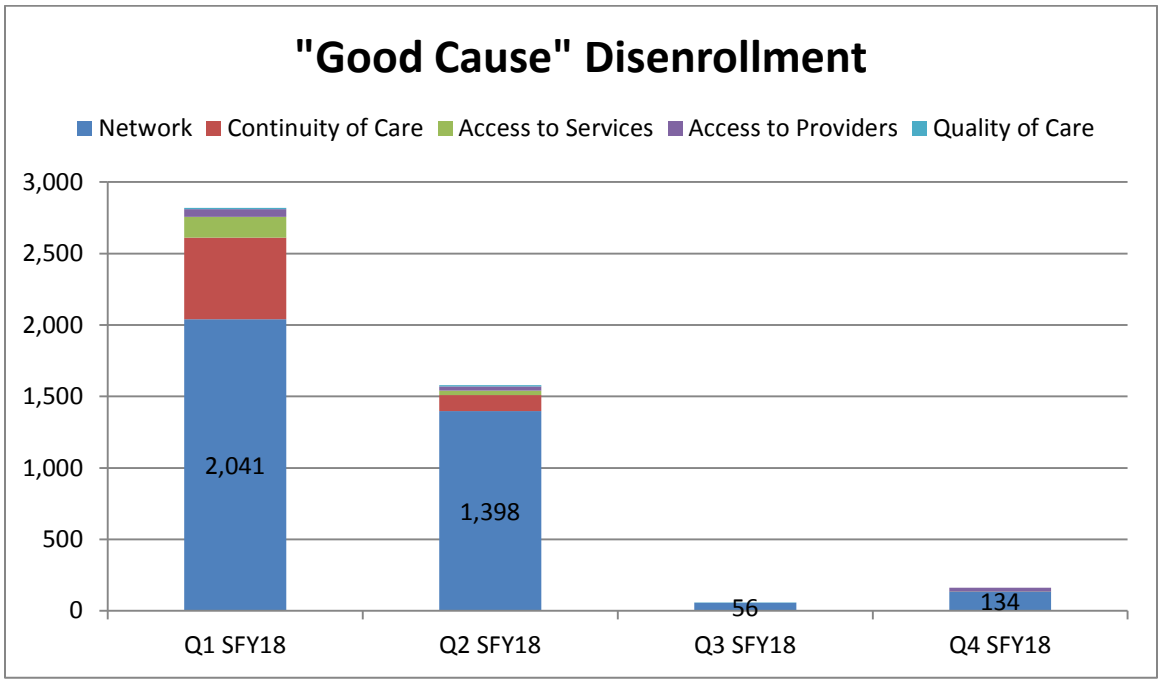
*Q4 SFY18 enrollment data as of June 30, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. Disenrollment does not include members in the ***hawk-i*** program.

Disenrollment refers to members who have chosen to change their enrollment with one MCO to an alternate MCO. The chart above indicates the number of members disenrolling from the MCO to another MCO. This includes members changing MCOs within the 90 day "choice period" that they can change for any reason as well as "good cause" disenrollments after the 90 day choice period. Members leaving AmeriHealth in November and December are not being counted because there was not member choice.

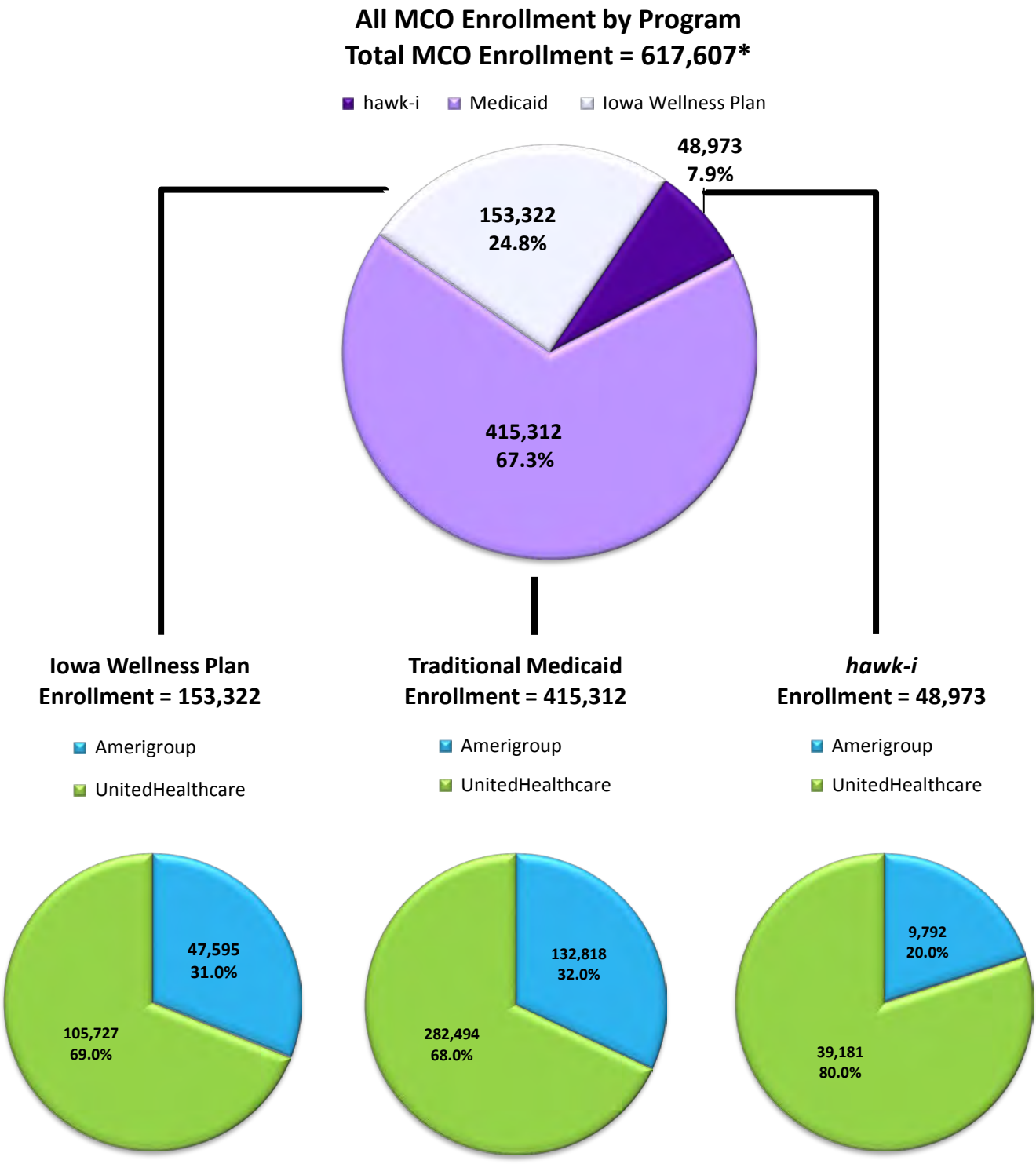
Reasons for "Good Cause" Disenrollment for SFY18

Members can disenroll for good cause any time during the year after their 90 day choice period if certain criteria are met such as:

- The member needs related services to be performed at the same time; not all related services are available within the network, and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- Other reasons, including but not limited to: poor quality of care, lack access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (i.e. PACE).
- MCO does not, because of moral or religious objections, cover the service the member seeks.

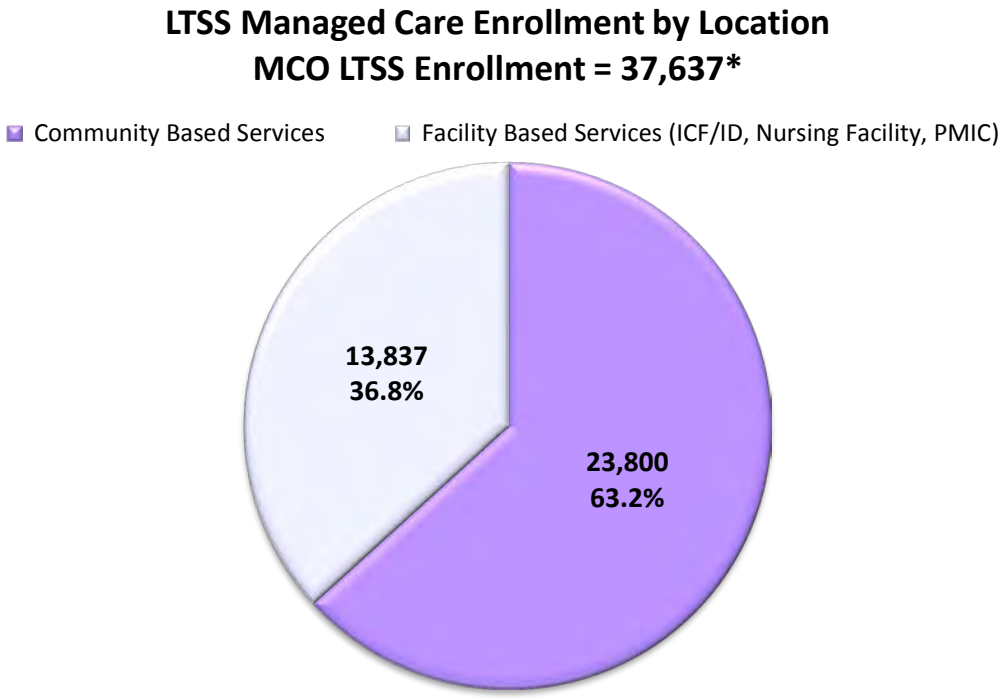


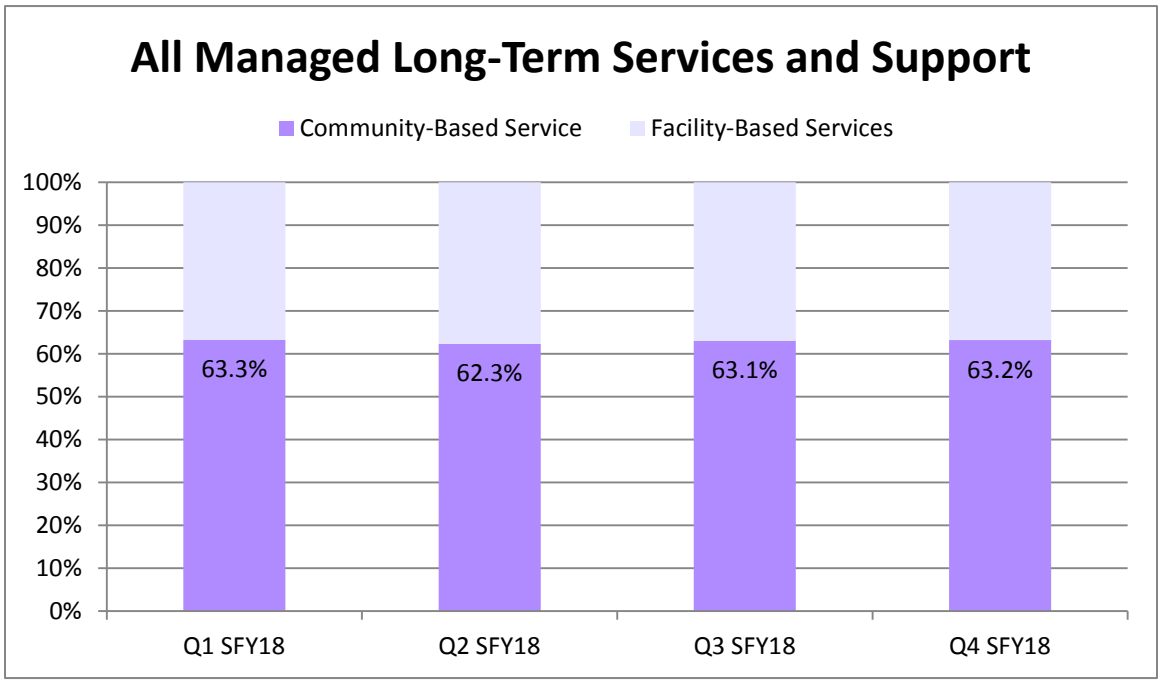
PLAN ENROLLMENT BY PROGRAM



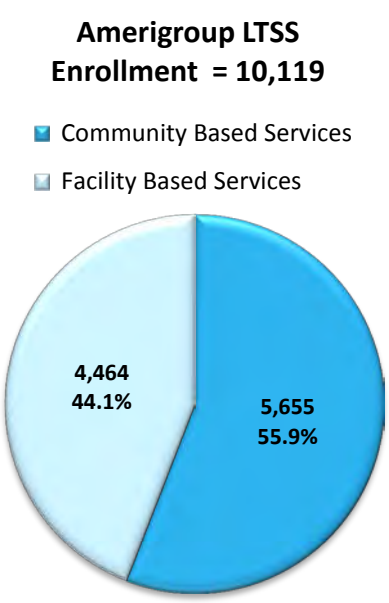
*June 2018 enrollment data as of July 10, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. 58,128 members are in the Fee-for-Service (FFS) program.

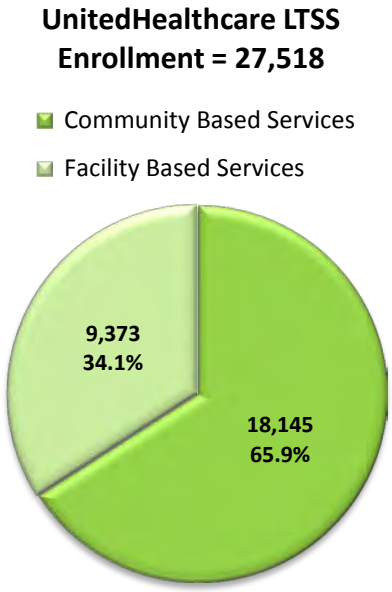
ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



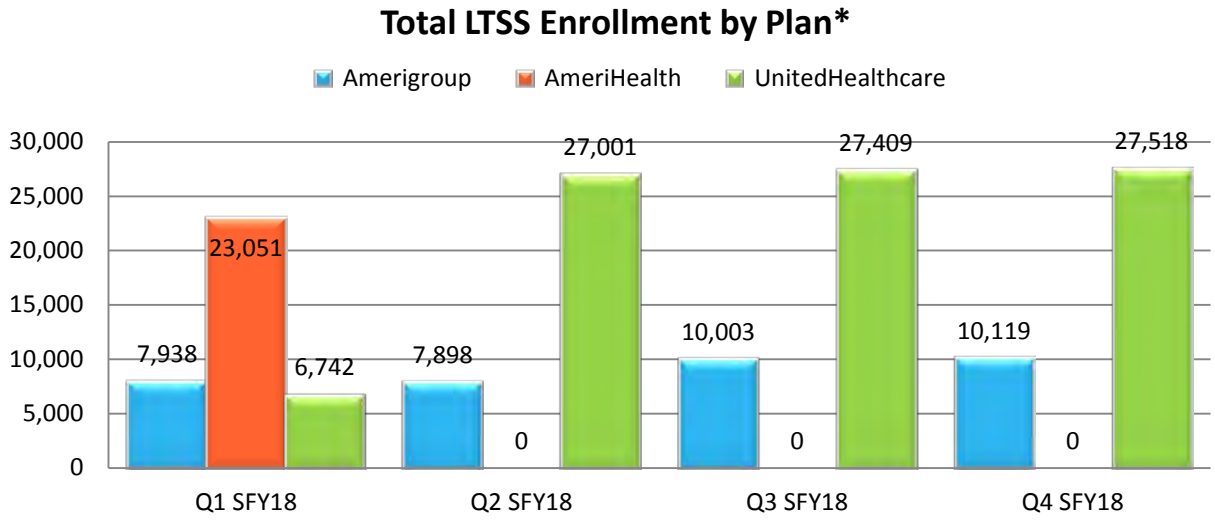


TOTAL MCO LTSS ENROLLMENT BY PLAN





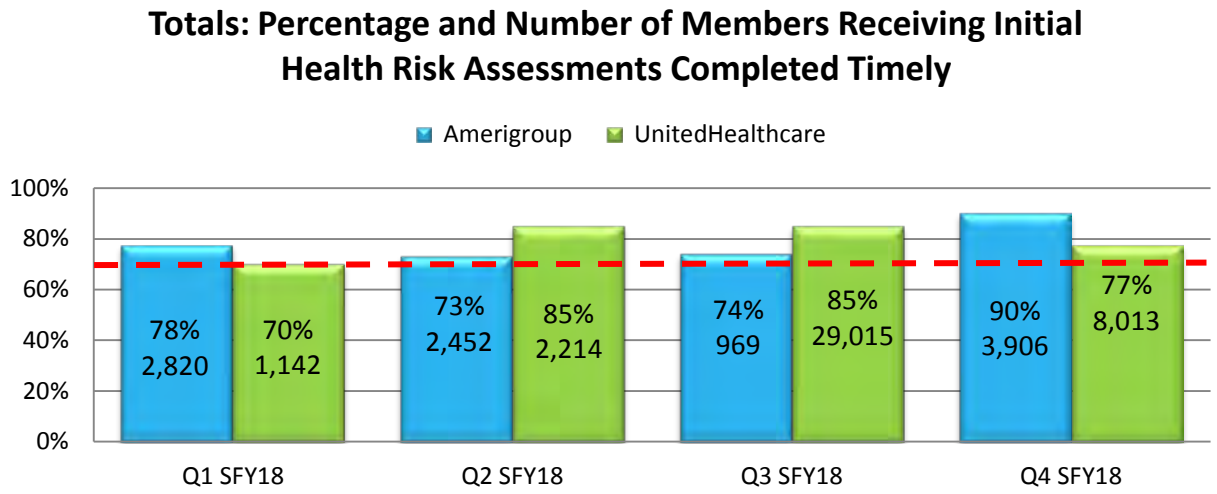
*June 2018 enrollment data as of July 30, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.



*Based on data reported in each of the quarterly reports.

Care Coordination Reporting

Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. Special health care needs may be identified through the initial health risk assessment, standard industry predictive modeling, claims review, or physician referral. Care coordination can also occur at the request of the member or caregiver. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service.



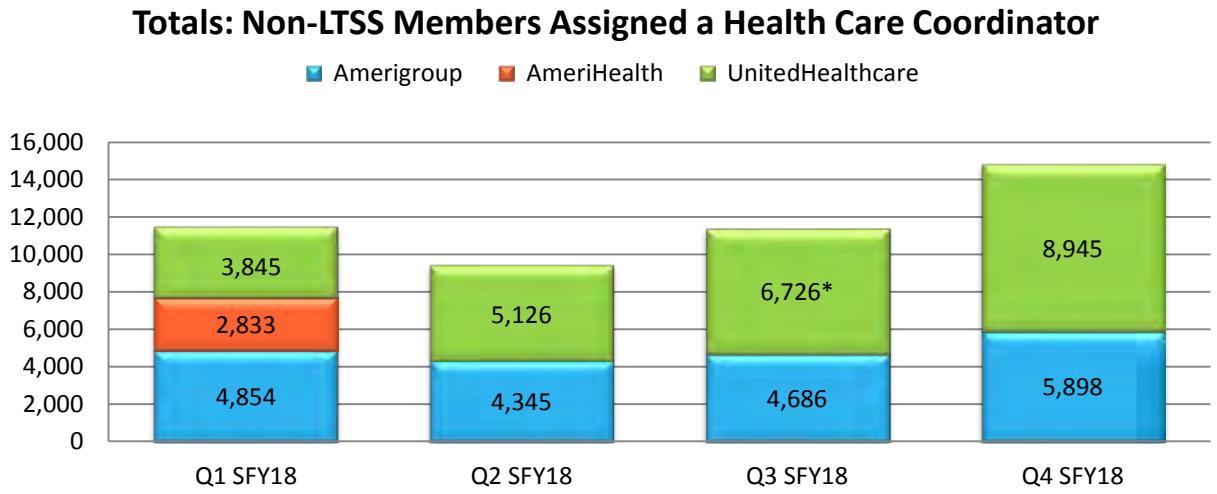
Population-Specific Supporting Data for SFY18				
Data are cumulative for the quarter	**Amerigroup**		**UnitedHealthcare**	
	Count	%	Count	%
Initial HRAs Completed Timely for Seniors (Ages 65& Up) – Q1 SFY18	312	94%	271	99%
Initial HRAs Completed Timely for Seniors (Ages 65& Up) – Q2 SFY18	276	90%	333	89%
Initial HRAs Completed Timely for Seniors (Ages 65& Up) – Q3 SFY18	95	96%	7,853	83%
Initial HRAs Completed Timely for Seniors (Ages 65& Up) – Q4 SFY18	591	84%	1,223	89%
Initial HRAs Completed Timely for Adults(Ages 18-64) – Q1 SFY18	1,247	88%	528	82%
Initial HRAs Completed Timely for Adults(Ages 18-64) – Q2 SFY18	1,057	86%	1,071	94%
Initial HRAs Completed Timely for Adults(Ages 18-64) – Q3 SFY18	461	91%	15,184	93%
Initial HRAs Completed Timely for Seniors (Ages 65& Up) – Q3 SFY18	95	96%	7,853	83%
Initial HRAs Completed Timely for Adults(Ages 18-64) – Q4 SFY18	2,213	91%	4,078	94%
Initial HRAs Completed Timely for Children (Under Age 18) – Q1 SFY18	1,261	66%	343	48%
Initial HRAs Completed Timely for Children (Under Age 18) – Q2 SFY18	1,119	61%	810	74%
Initial HRAs Completed Timely for Children (Under Age 18) – Q3 SFY18	413	59%	5,978	72%

At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days and the MCO has been able to reach within three attempts, must receive an initial health risk assessment. This data includes all MCO

populations. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed.

Members identified as having a special health care need through the initial health risk assessment or other means may be assigned a care coordinator with an MCO Care Coordination Program, a Chronic Condition Health Home, or an Integrated Health Home. This data element does not have a direct benchmark to compare to historical fee-for-service data.



*UnitedHealthcare data has been restated to align with reporting requirements outlined for this fiscal year.

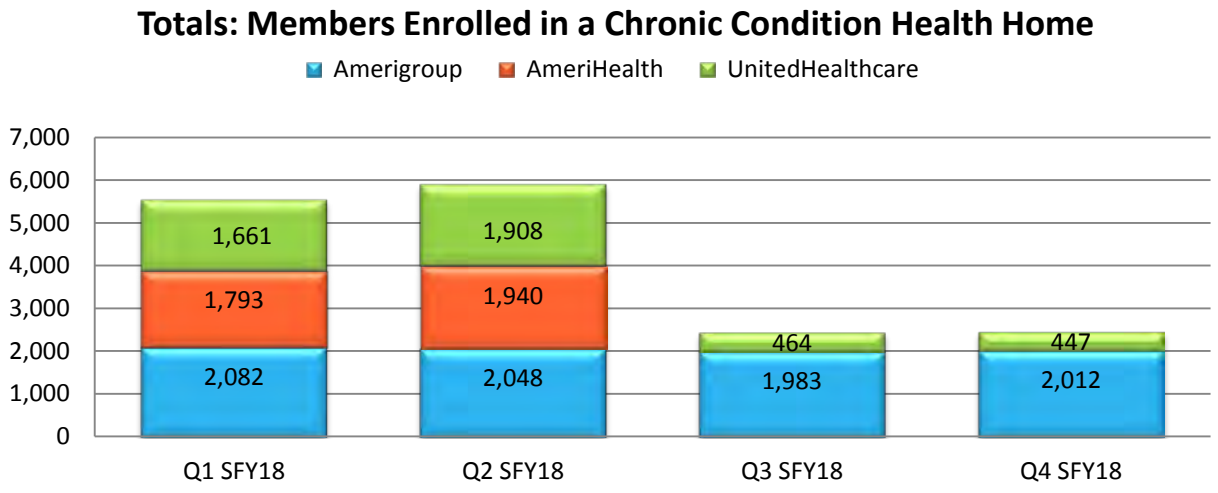
Data is as of June 2018.

Population-Specific Supporting Data for SFY18		
Data Reported	**Amerigroup**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator – Q1 SFY18	292	96
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator – Q2 SFY18	197	140
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator – Q3 SFY18	175	5
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator – Q4 SFY18	202	198
Count of Non-LTSS Adults (Ages 18-64) Assigned a Health Care Coordinator – Q1 SFY18	3,134	2,702
Count of Non-LTSS Adults (Ages	2,945	3,167

18-64) Assigned a Health Care Coordinator – Q2 SFY18		
Count of Non-LTSS Adults (Ages 18-64) Assigned a Health Care Coordinator – Q3 SFY18	3,466	1,312
Count of Non-LTSS Adults (Ages 18-64) Assigned a Health Care Coordinator – Q4 SFY18	4,669	6,370
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator – Q1 SFY18	1,428	1,047
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator – Q2 SFY18	1,203	1,819
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator – Q3 SFY18	1,045	190
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator – Q4 SFY18	1,027	2,377

Chronic Condition Health Home Assignment

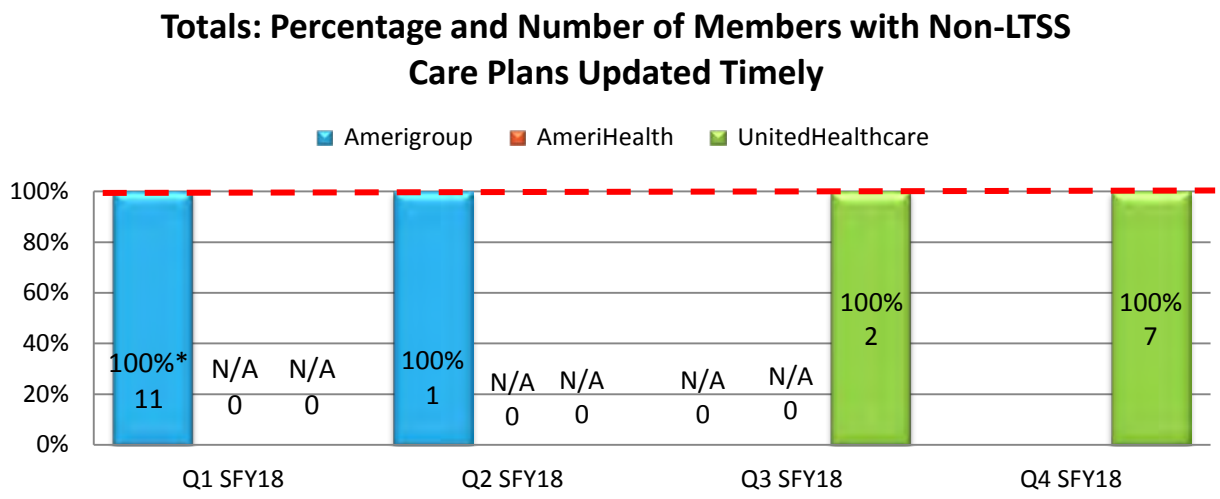
Alternatives to MCO Health Care Coordinators are Chronic Condition Health Home care coordination and Integrated Health Home care coordination. This section focuses on Chronic Condition Health Homes. Chronic Condition Health Homes are medical offices that provide care coordination services on behalf of the Managed Care Organization. During the course of SFY18, UnitedHealthcare worked with Chronic Condition Health Homes and Accountable Care Organizations to identify members that may be receiving duplicative care coordination services which is seen in the decreased enrollment beginning in Q3SFY18.



Population-Specific Supporting Data for SFY18		
Data Reported	**Amerigroup**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home – Q1 SFY18	210	127
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home – Q2 SFY18	205	143
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home – Q3 SFY18	194	37
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home – Q4 SFY18	197	36
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home – Q1 SFY18	1,425	1,112
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home – Q2 SFY18	1,427	1,270
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home – Q3 SFY18	1,392	363
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home – Q4 SFY18	1,427	357
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home – Q1 SFY18	447	422
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home – Q2 SFY18	416	495
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home – Q3 SFY18	397	64
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home – Q4 SFY18	388	54

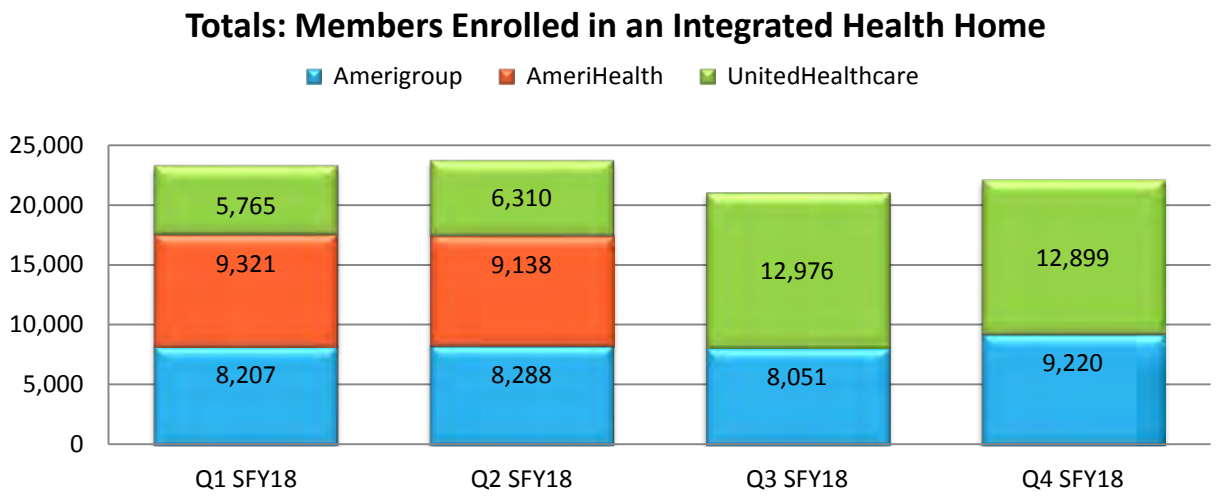
Non-LTSS Update of Care Plans

Non-LTSS Members identified as having special health care needs and requiring ongoing care coordination have care plans developed and managed by the MCO. Federal regulations require that revisions to care plans for these members occur at least annually. This measure does not have a fee for service benchmark. All plans have indicated that their care coordination works to provide health care coordination such that members are prepared to discharge within twelve months, which is why the data reported indicates that few or zero care plans have been updated.



Behavioral Health: Integrated Health Home Enrollment

Integrated Health Homes specialize in the coordinated care of members with serious and persistent mental illness and serious emotional disturbances. Members receiving Habilitation program services and Children's Mental Health Waiver services may receive care coordination through the Integrated Health Home instead of from MCO care coordinators or community-based case managers.

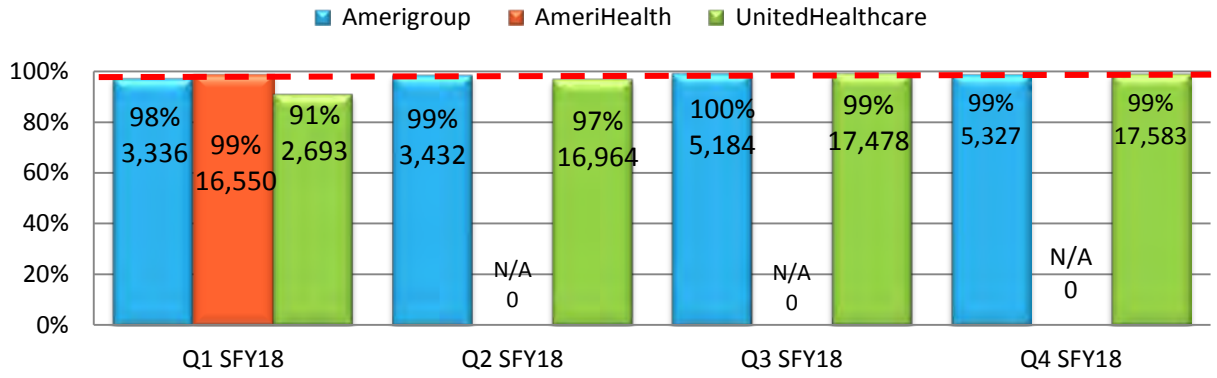


Population-Specific Supporting Data for SFY18		
Data Reported as of June 15, 2018	**Amerigroup**	**UnitedHealthcare**
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home – Q1 SFY18	131	74
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home – Q2 SFY18	124	89
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home – Q3 SFY18	127	145
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home – Q4 SFY18	148	152
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home – Q1 SFY18	4,822	3,398
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home – Q2 SFY18	4,898	3,756
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home – Q3 SFY18	5,038	7,713
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home – Q4 SFY18	5,588	7,641
Count of Children (Under Age 18) Enrolled in an Integrated Health Home – Q1 SFY18	3,254	2,293
Count of Children (Under Age 18) Enrolled in an Integrated Health Home – Q2 SFY18	3,266	2,465
Count of Children (Under Age 18) Enrolled in an Integrated Health Home – Q3 SFY18	2,886	5,118
Count of Children (Under Age 18) Enrolled in an Integrated Health Home – Q4 SFY18	3,484	5,106

SPECIAL NEEDS: LTSS HOME AND COMMUNITY-BASED CARE COORDINATION

Community-based case management is a service that is specifically-designed to manage members receiving long term services and supports (LTSS). This is a new and more comprehensive case management strategy than was available in fee-for-service. Key components of community-based case management include person-centered care planning, addressing member's care and treatment needs, providing assurances for health and safety, and addressing potential risks related to members' desire to live as independently as possible. The count of Members Assigned a Community-Based Case Manager represents an unduplicated count of members assigned a community-based case manager (CBCM) on the last day of the quarter. 100% of members receiving Home- and Community-Based Services (HCBS) should be assigned a community-based case manager. Data timing issues such as member movement between programs or settings may affect member assignment rates.

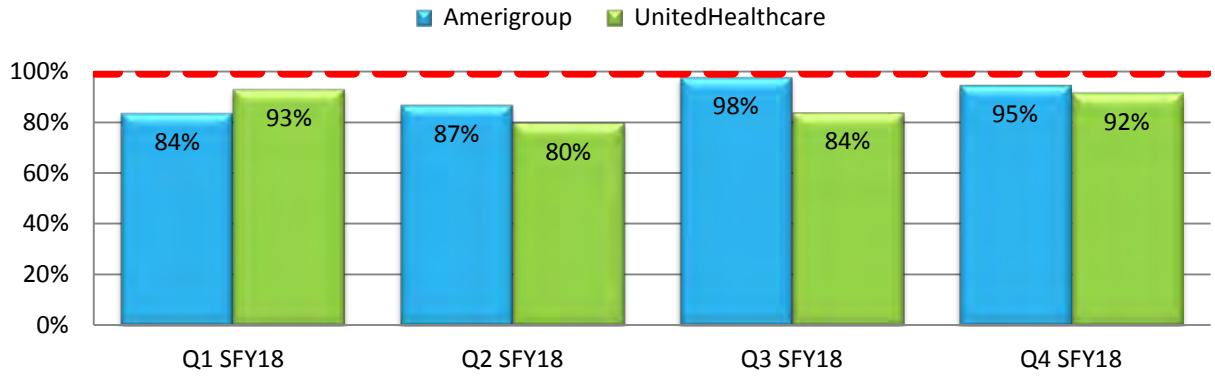
Totals: Percentage and Number of HCBS Members Assigned a Community-Based Case Manager



HCBS Waiver-Specific Supporting Data for SFY18		
Data Reported	**Amerigroup**	**UnitedHealthcare**
Brain Injury Members Assigned a CBCM – Q1SFY18	205	154
Brain Injury Members Assigned a CBCM – Q2SFY18	202	947
Brain Injury Members Assigned a CBCM – Q3SFY18	292	980
Brain Injury Members Assigned a CBCM – Q4SFY18	306	977
Elderly Members Assigned a CBCM – Q1SFY18	1,248	1,043
Elderly Members Assigned a	1,322	5,816

CBCM – Q2SFY18		
Elderly Members Assigned a CBCM – Q3SFY18	1,702	5,927
Elderly Members Assigned a CBCM – Q4SFY18	1,728	5,910
Health and Disability Members Assigned a CBCM –Q1SFY18	538	450
Health and Disability Members Assigned a CBCM –Q2SFY18	542	1,046
Health and Disability Members Assigned a CBCM – Q3SFY18	665	1,114
Health and Disability Members Assigned a CBCM – Q4SFY18	679	1,162
HIV/ AIDS Members Assigned a CBCM – Q1SFY18	14	9
HIV/ AIDS Members Assigned a CBCM –Q2SFY18	13	18
HIV/ AIDS Members Assigned a CBCM – Q3SFY18	15	19
HIV/ AIDS Members Assigned a CBCM – Q4SFY18	15	19
Intellectual Disability Members Assigned a CBCM – Q1SFY18	1,015	783
Intellectual Disability Members Assigned a CBCM – Q2SFY18	1,043	8,562
Intellectual Disability Members Assigned a CBCM – Q3SFY18	2,184	8,851
Intellectual Disability Members Assigned a CBCM – Q4SFY18	2,223	8,920
Physical Disability Members Assigned a CBCM – Q1SFY18	316	254
Physical Disability Members Assigned a CBCM – Q2SFY18	310	575
Physical Disability Members Assigned a CBCM – Q3SFY18	326	587
Physical Disability Members Assigned a CBCM – Q4SFY18	376	595

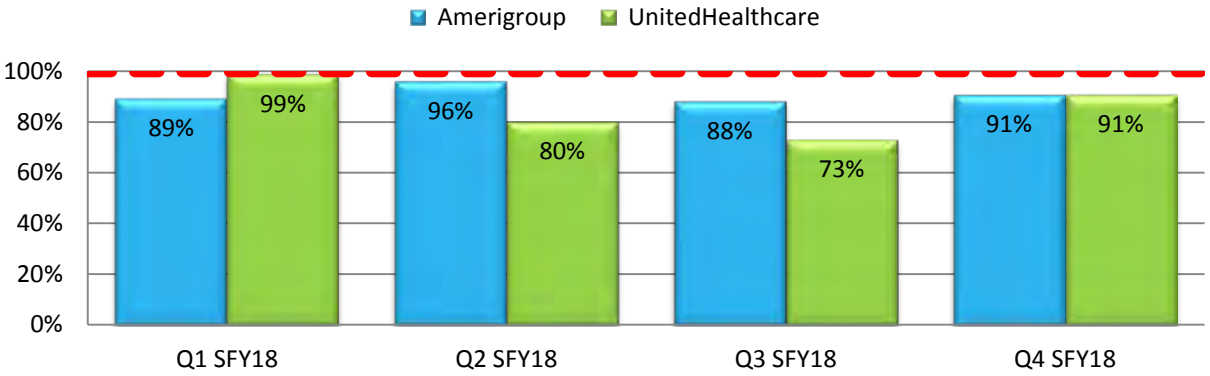
Percentage of HCBS Members Receiving Minimum Monthly Contact Timely



At a minimum, community-based case managers must contact 1915(c) HCBS waiver members at least monthly in person or by phone with an interval of at least 14 calendar days between contacts. The Percentage of HCBS Members Receiving Monthly Contact Timely monitors the proportion of required contacts that were made timely during the quarter. There may be legitimate reasons a member cannot be contacted that are outside MCO control; however, the data published does not include exceptions to timely contact requirements. The Department monitors the volume and reasons for missed contacts.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members in December and this impacted the UnitedHealthcare results for December and Q3 SFY18. AmeriHealth Caritas members that transitioned to FFS in December, were transitioned to Amerigroup on March 1, 2018, and this impacted Amerigroup results for Quarter 3.

Percentage of HCBS Members Receiving Minimum Quarterly Face-to-Face Contact Timely



At a minimum, community-based case managers must visit members in their residence face-to-face quarterly with an interval of at least 60 calendar days between visits. The Percentage of HCBS Members Receiving Quarterly Face-to-Face Contact Timely monitors the proportion of required face-to-face contacts that were made timely during the quarter. There may be

legitimate reasons a member cannot be contacted that are outside MCO control; however, the data published does not include exceptions to timely contact requirements. The Department monitors the volume and reasons for missed contacts.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members in December and this impacted the UnitedHealthcare results for Quarters 2 and 3. AmeriHealth Caritas members that transitioned to FFS in December, were transitioned to Amerigroup on March 1, 2018. This transition impacted Amerigroup's results for Q3 SFY18.

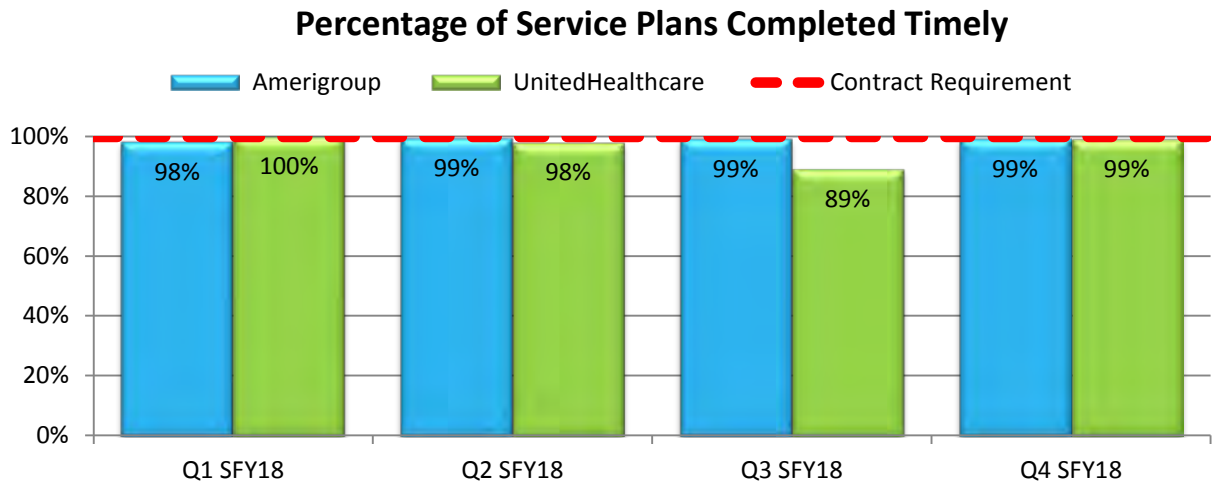
Community-Based Case Management Ratios

The ratios below reflect combined adult and child populations for these settings where applicable.

Data Reported as of June 30, 2018	Amerigroup	UnitedHealthcare
Members in Facility per Community-Based Case Manager	33	59
Members in Community per Community-Based Case Manager	44	42
Unduplicated LTSS Members per Community-Based Case Manager	66	62

Service Plans

Waiver service plans must be updated annually or as the member's needs change.

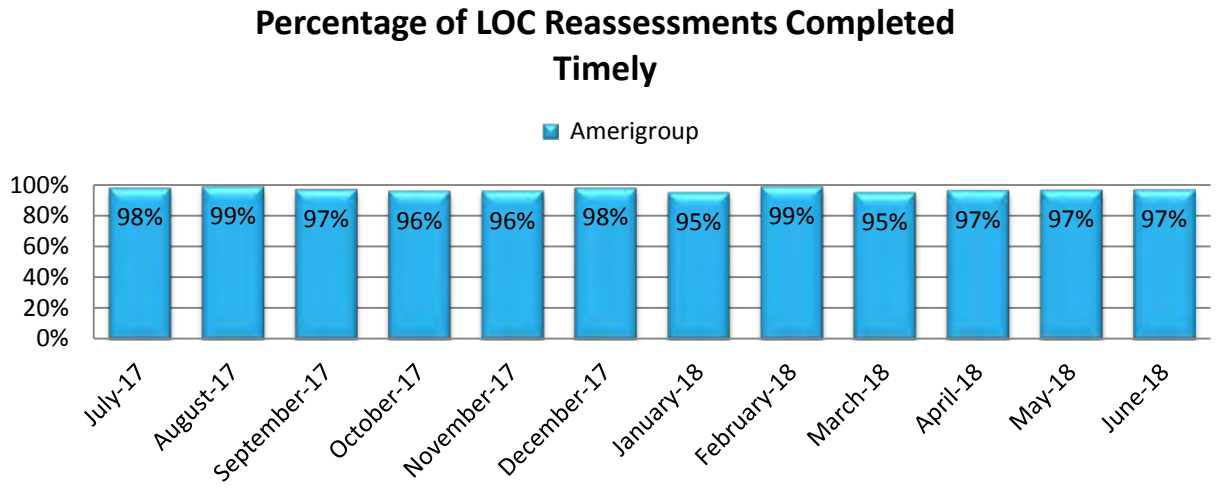


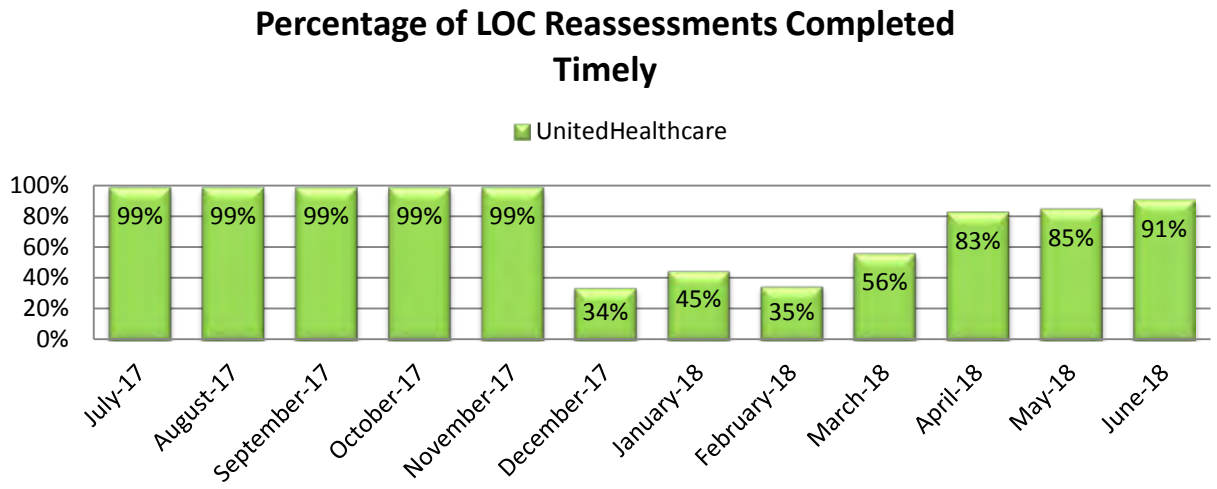
Members will continue to receive the same level of services regardless of whether the service plan has been updated timely.

The Department will be closely monitoring corrective actions to ensure that service plans are completed in a timely manner for all Medicaid members.

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.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members and this impacted the UnitedHealthcare results for December 2017, as well as January, February and March 2018.

Critical Incidents

Home- and Community-Based Services (HCBS) Waiver and Habilitation providers and case managers/care coordinators are required to report critical incidents to the MCOs. These critical incidents are to be reported if the reporting entity witnesses the incident or is made aware of the incident. Critical incidents are events that may affect a member's health or welfare, such incidents involving:

- Physical injury;
- Emergency mental health treatment;
- Death;
- Law enforcement intervention;
- Medication error resulting in one of the above;
- Member elopement; or,
- Reported child or dependent abuse.

Resolution indicates that the MCO has reviewed the incident and is working with the member or provider to mitigate the risk of events in the future.

Data Reported	Amerigroup		UnitedHealthcare	
HCBS and Habilitation Members as of June 2018	5,655		18,145	
Critical Incident SFY18 Resolution				
Program	Received	Resolved	Received	Resolved
Aids/HIV Waiver Critical Incidents Received in SFY18	0	N/A	3	100%
Brain Injury Critical Incidents Received in SFY18	56	100%	292	99%
Children's Mental Health Critical Incidents Received in SFY18	84	100%	201	100%
Elderly Critical Incidents Received in SFY18	128	100%	483	100%
Habilitation Critical Incidents Received in SFY18	1,358	100%	2,029	100%
Health Disability Critical Incidents Received in SFY18	136	100%	72	100%
Intellectual Disability Critical Incidents Received in SFY18	425	100%	2,116	100%
Money Follows the Person Critical Incidents Received in SFY18	18	100%	19	100%
Physical Disability Critical Incidents Received in SFY18	13	100%	44	100%

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.		
Data Reported	**Amerigroup**	**UnitedHealthcare**
Iowa Participant Experience Survey Count of Members Surveyed SFY18		
Aids/HIV	3	4
Brain Injury	16	55
Children's Mental Health	15	25
Elderly	104	116
Habilitation	50	82
Health Disability	25	82
Intellectual Disability	32	78
Money Follows the Person	0	0
Physical Disability	14	77
Iowa Participant Experience Survey Aggregated Responses SFY18		
Members Reporting They Feel They Have Been a Part of Planning Their Waiver Services	97%	88%
Members Reporting Talking About Health Issues When Their Plan Was Being Developed	95%	89%
Members Reporting Services Include All the Things They Told Their Team They Needed and Wanted	89%	86%
Members Reporting They Feel Safe Where They Live	98%	98%
Members Reporting it was Easy to Make Contact with Service Staff	91%	88%
Members Reporting Their Services and Providers Make Their Life Better	98%	95%
Members Receiving Employment Services that Report They Like Their Job (Only Applicable to Members Receiving Employment Services)	100%	100%

Percentages reflect the number of survey responses from all applicable waivers indicating "yes". Other valid survey responses include "no," "I don't know," "I don't remember," and "No/Unclear response."

BIANNUAL WAIVER EMPLOYMENT SERVICES REPORTING

Biannual Waiver Employment Services Outcomes

Supported employment services are provided to members on home and community based service waivers for Brain Injury, Habilitation, and Intellectual Disability. As stated in the Iowa Department of Human Services Employment Outcomes Vision, "Employment in the general workforce is the first priority and the expected and preferred outcome in the provision of publically funded services for all working age Iowan's with disabilities."

In alignment with this vision, utilization and wage data for members receiving employment services is requested by case managers twice annually in April and October with a 90 day reporting lag.

Supported Employment Data

The Department collects labor and wage information for members in eligible waiver programs receiving supported employment services.

Data Reported as of October 31, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Individual Jobs Services Outcomes			
Brain Injury Waiver Members Served	9	56	5
Habilitation Members Served	156	302	79
Intellectual Disability Waiver Members Served	93	1,480	80
Small Group Employment Services Outcomes			
Brain Injury Waiver Members Served	0	15	2
Habilitation Members Served	53	92	25
Intellectual Disability Waiver Members Served	32	479	39
Facility-Based Services Outcomes			
Brain Injury Waiver Members Served	2	27	2
Habilitation Members Served	70	172	34
Intellectual Disability Waiver Members Served	23	807	51

MCO Member Grievances and Appeals

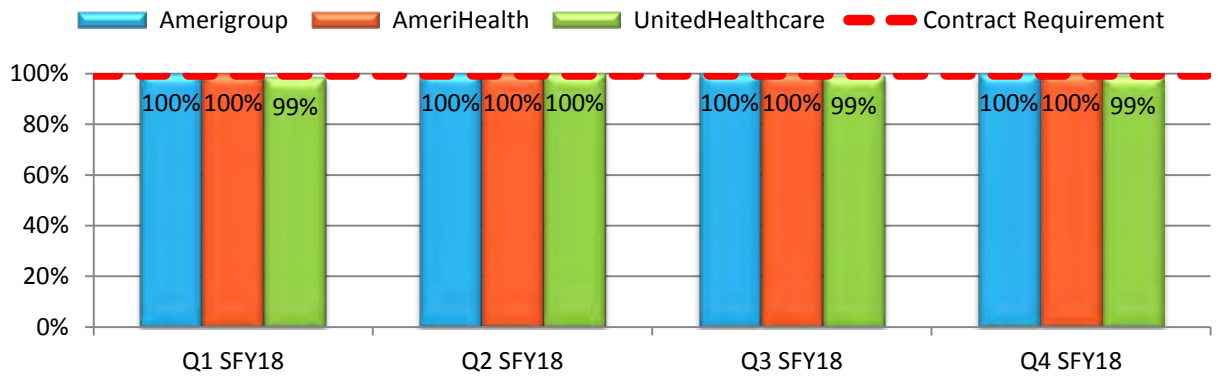
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization.

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.

Percentage of Grievances Resolved within 30 Calendar Days of Receipt



This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. If a member is not satisfied with the MCO's resolution to their grievance, the member may contact the Iowa Medicaid Enrollment Broker to disenroll if "good cause" criteria are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Grievances Received in Q1 SFY18	260	638	104
Grievances Received in Q2 SFY18	244	63	247
Grievances Received in Q3 SFY18	276	3	471
Grievances Received in Q4 SFY18	297	4	745

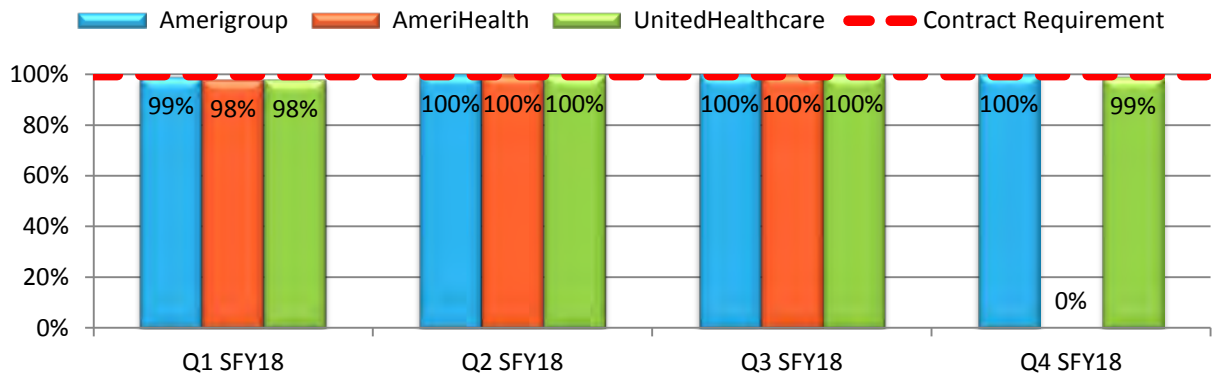
MCOs have different criteria for bucketing so the above numbers may represent each reason filed for the grievance with AmeriHealth and Amerigroup while representing unduplicated member grievances for UnitedHealthcare.

Top Five Reasons for Grievances for Q4 SFY18

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Out of Network	182	Provider - Member Received Bill	3	Administration – Enrollment/Member Material – Request to enroll/change benefit plan did not occur within open enrollment period	348
2	Transportation Delay	87	Hospital – Harm or Danger to Member	1	Benefit – Other – Ambulance/Transportation – Dispute regarding non-ambulance methods of transportation	160
3	Provider Balance Billed	61	Hospital – Member Alleges Practitioner Failed to Treat Member's Condition	1	Enrollee Access/Availability – Provider Network Adequacy	83
4	Termination of Eligibility	42	Hospital – Member Threatens Lawsuit	1	Administration – Transition of Care	54
5	Provider attitude/rudeness	32	N/A	N.A	Benefit – Other – Balance Billing	52

Members may file a grievance with the MCOs for any dissatisfaction that is not related to a clinical decision.

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



This measure represents appeals resolved within 30 calendar days of receipt. In state fiscal year 2017, appeals required resolution within 45 days of receipt. The first quarter may include appeals resolved in the quarter that were received prior to the 30 day requirement and may have met the previous timeliness standard of 45 calendar days. If a member is not satisfied with the appeal decision, they may file a state fair hearing request with the state.

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Appeals Received in Q1 SFY18	521	430	127
Appeals Received in Q2 SFY18	499	244	154
Appeals Received in Q3 SFY18	325	17	260
Appeals Received in Q4 SFY18	309	0	320

This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care appeal process does differ from the administrative appeal process.

Top Five Reasons for Appeals for Q4 SFY18

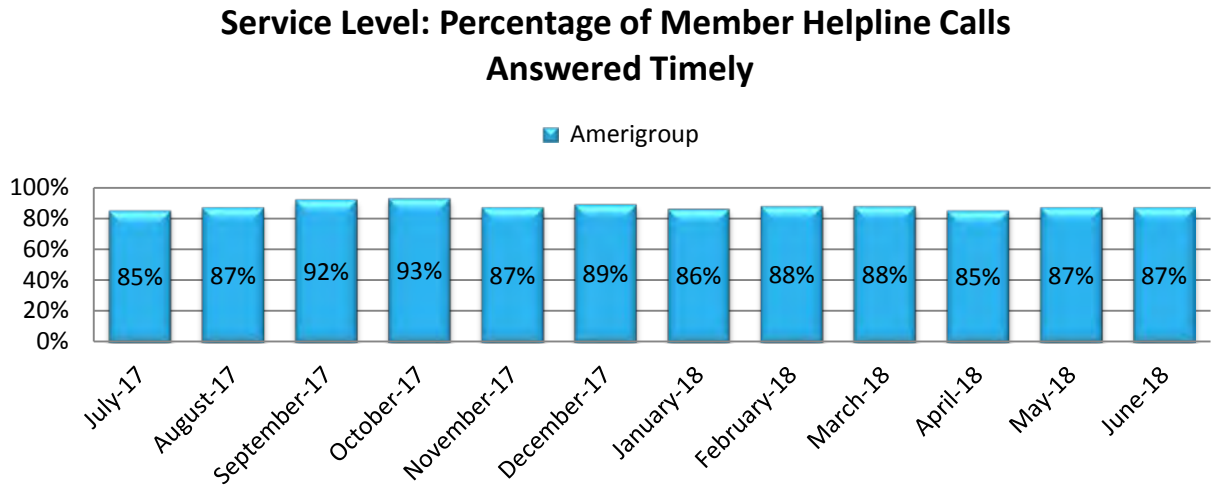
	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
#	**Appeals**	**Count**	**Appeals**	**Count**	**Appeals**	**Count**
1	Pharmacy - Non Injectable	121	N/A	0	Benefit – Other – Pharmacy – Dispute of coverage of non-preferred drugs	166
2	Radiology	31	N/A	0	Benefit – Other – Pharmacy – Dispute of drugs that require clinical coverage review	83
3	BH – Op Service	26	N/A	0	Benefit – Clinical – Utilization Review Determination – Dispute over the medical necessity of a service or treatment	53
4	Pharmacy – Injectable	21	N/A	0	Benefit – Other – Notification/Authorization – Dispute involving authorization requirement	30
5	DME	20	N/A	0	Benefit – Clinical – Durable Medical Equipment	24

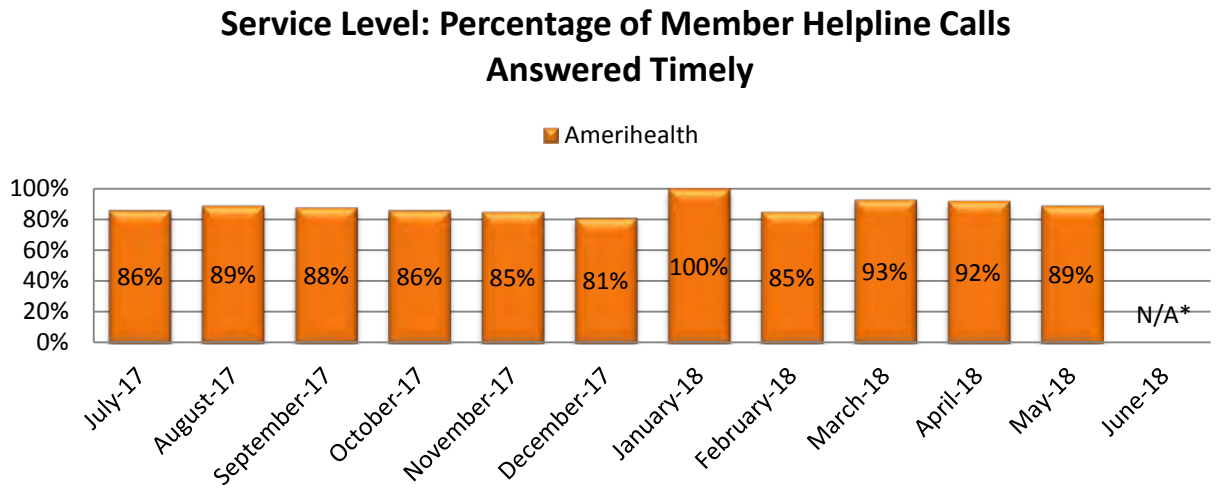
State Fair Hearing Summary for Members in Managed Care SFY18

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Level of Care	0	0	0
Medical Service Denial/Reduction	160	148	66
Pharmacy Denial/Reduction	73	5	9
Durable Medical Equipment Denial/Reduction	7	6	31

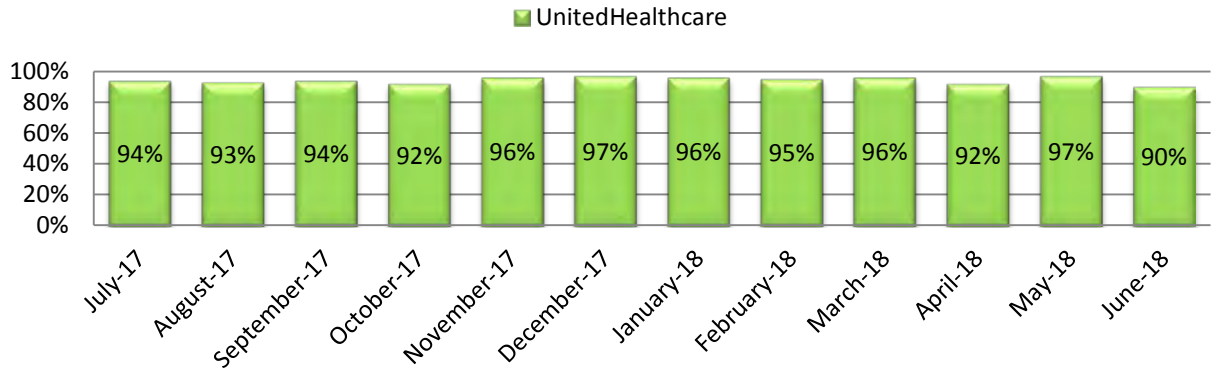
This data reflects the type of state fair hearing requests and does not reflect the disposition of the appeal. Most of the appeal requests received are dismissed or withdrawn due to resolution of the issue prior to hearing.

Member Helpline





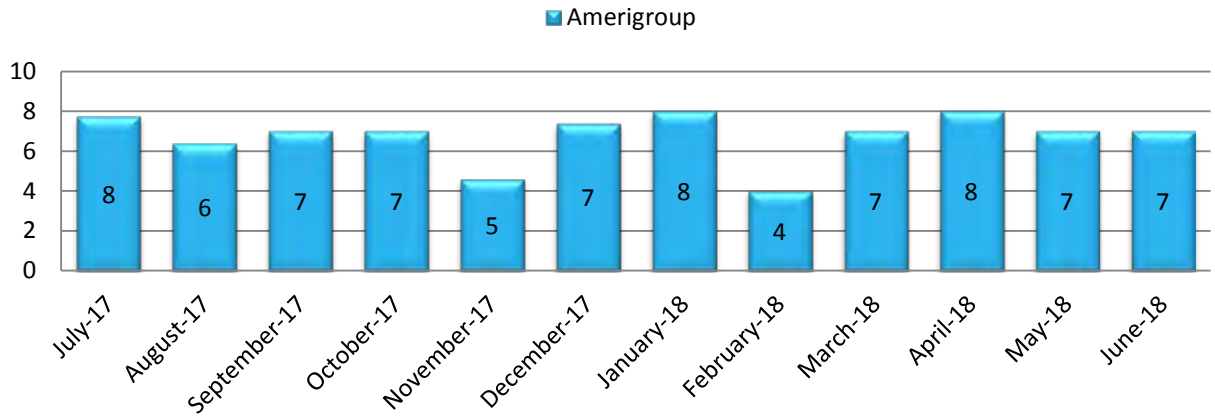
Service Level: Percentage of Member Helpline Calls Answered Timely

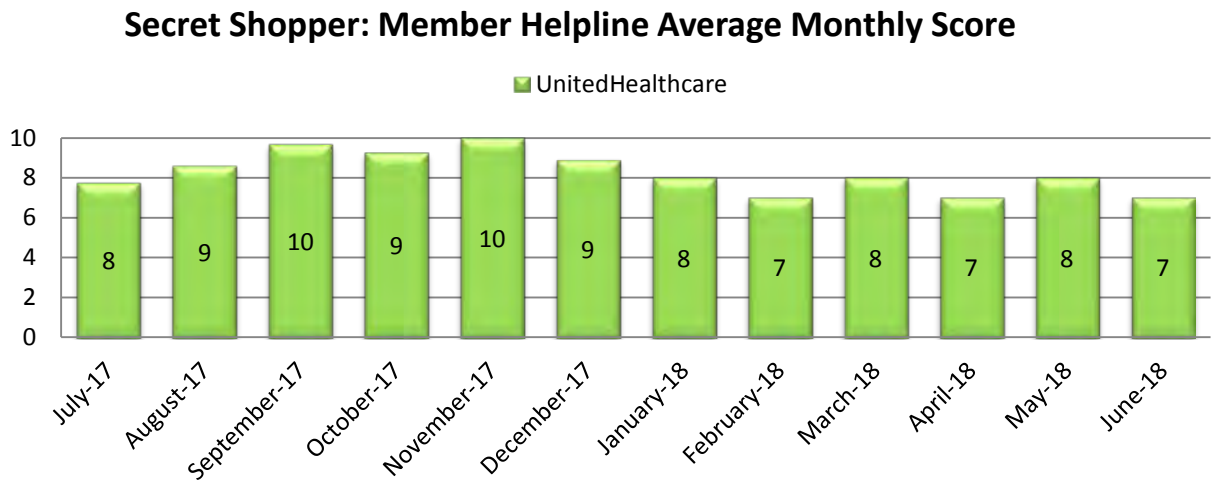


*AmeriHealth received zero member calls in June.

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: Member Helpline Average Monthly Score





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. In the first quarter of SFY18, member helpline secret shopper topics focused on Iowa Health and Wellness Plan Ombudsman referrals, member grievance processes, translation services, ombudsman referrals, grievance processes, translation services, guardianship, case manager processes for guardianship, HIPAA compliance, member fraud, pharmacy benefits, transportation services, and durable medical equipment. In the second quarter, member helpline secret shopper topics included getting authorized to receive information regarding an adult child, receiving information regarding the appeals process, and receiving information regarding MCO choice options. In the third quarter, member helpline secret shopper topics focused on Integrated Health Home eligibility, covered services, value-added services, when coverage begins, retroactive eligibility, member Iowa Wellness Plan copays, residential substance abuse program eligibility, emergency room coverage, walk in clinics, member choice, dissatisfaction with medical providers, grievance processes, and good cause disenrollment. In quarter four, member helpline secret shopper topics dealt with open enrollment, changing MCOs, family members on Medicaid, getting information on family members on Medicaid, using family members as service providers, getting information on friends on Medicaid, case management, paying for prescriptions, and online availability of health risk assessments.

Top Five Reasons for Members Contacting Helplines for SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
Jul-17						
1	Transportation Questions	8,138	Member Inquiries-Plan Policy/Procedure Education	6,471	PCP Inquiry	4,422
2	Benefit Inquiry/Issue	1,657	Member Changes-Demographic Changes	5,605	Eligibility Inquiry	3,689
3	Enrollment Inquiry/Issue	1,004	Eligibility/Enrollment-Member Eligibility	2,232	COB Information	1,775
4	Provider Find/Change/Verify PCP	675	Member Inquiries-General Benefit	1,646	General Inquiry	777
5	Pharmacy Inquiry	566	Other Programs & Services	3,986	COB Information	1,144
Aug-17						
1	Transportation Questions	9,270	Member Inquiries-Plan Policy/Procedure Education	7,164	PCP Inquiry	4,857
2	Benefit Inquiry/ Issue	953	Member Changes-Demographic Changes	6,320	Benefits	3,963
3	Provider Find/Change/Verify PCP	947	Member Request- ID Card Request	3,170	Eligibility Inquiry	3,017
4	Benefit Inquiry	921	Eligibility/Enrollment-Member Eligibility	2,378	COB Information	1,429
5	Pharmacy Inquiry/Issue	892	Member Changes-PCP Change	1,683	Claims Inquiry	813
Sep-17						
1	Transportation Questions	9,561	Member Inquiries-Plan Policy/ Procedure Education	6,700	PCP Inquiry	4,355

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Benefit Inquiry	845	Member Changes-Demographic Changes	5,520	Benefits	3,168
3	Provider Find/Change/Verify PCP	780	Member Request- ID Card Request	2,599	Eligibility Inquiry	2,453
4	Pharmacy Inquiry/Issue	778	Eligibility/Enrollment-Member Eligibility	2,116	COB Information	1,451
5	Benefit Inquiry/ Issue	696	Member Changes-PCP Change	1,522	Claims Inquiry	769
Oct-17						
1	Transportation Questions	9,844	Member Inquiries-Plan Policy/ Procedure Education	7,270	PCP Inquiry	4,635
2	Benefit Inquiry	1,119	Member Changes-Demographic Changes	6,265	Benefits	3,550
3	Pharmacy Inquiry/ Issue	854	Eligibility/Enrollment-Member Eligibility	2,309	Eligibility Inquiry	2,541
4	Provider Find/Change/Verify PCP	810	Member Request- ID Card Request	2,282	COB Information	1,778
5	Benefit Inquiry/ Issue	802	Member Changes-PCP Changes	1,690	Claims Inquiry	788
Nov-17						
1	Transportation Questions	9,185	Member Inquiries – Plan Policy/Procedure Education	6,087	PCP Inquiry	5,188
2	Benefit Inquiry	1,187	Member Changes-Demographic Changes	4,889	Benefits	3,991

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
3	Enrollment Information	771	Eligibility/Enrollment-Member Eligibility	1,785	Membership Record	2,595
4	Eligibility Inquiry	720	Member Inquiries-General Benefit	1,132	COB Information	1,167
5	Find/Change PCP	573	Member Request – ID Card Request	735	General Inquiry	884
Dec-17						
1	Transportation Questions	8,354	Member Inquiries-Plan Policy/Procedure Education	1,539	PCP Inquiry	19,714
2	Benefit Inquiry	1,187	Eligibility/Enrollment-Member Eligibility	824	Benefits	9,959
3	Enrollment Information	771	Member Billing Inquiries- Par Billing Issue	210	Eligibility Inquiry	4,804
4	Eligibility Inquiry	720	Member Inquiries-General Benefit	206	Change Address/Phone #	3,801
5	Find/Change PCP	573	Member Changes-Demographic Changes	181	General Inquiry	2,690
Jan-18						
1	Transportation Questions	11,024	Member Inquiries-Plan Policy/Procedure Education	824	PCP Inquiry	14,063
2	Benefit Inquiry	1,172	Eligibility/Enrollment-Member Eligibility	546	Benefits	10,844
3	Enrollment Information	651	Other Programs & Services- Par Billing Issue	252	Eligibility Inquiry	4,700

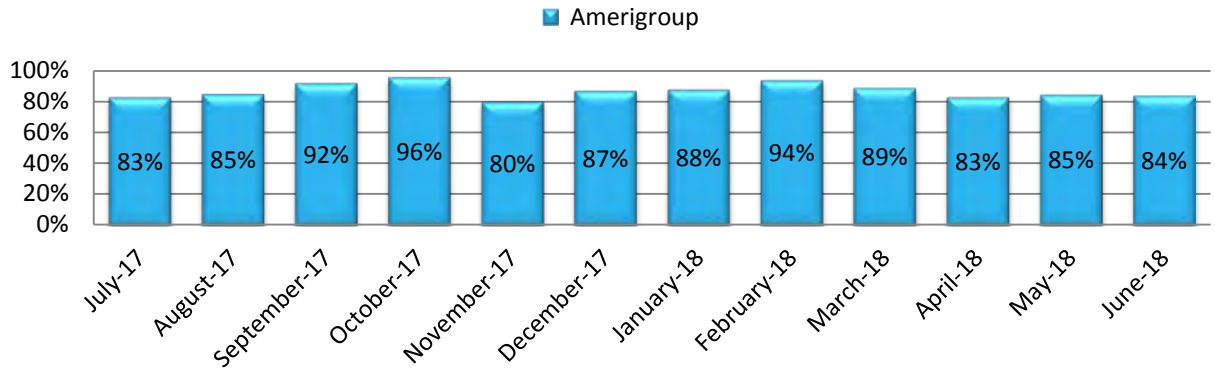
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
4	Eligibility Inquiry	627	Member Changes- Demographic Changes	201	COB Information	3,536
5	ID Card Request/Inquiry	519	Member Billing Inquiries- Claims Status Investigation	86	Change Address/ Phone #	3,292
Feb-18						
1	Transportation Questions	9,813	Member Inquiries- Plan Policy/Procedure Education	632	PCP Inquiry	8,873
2	Benefit Inquiry	918	Eligibility/Enrollment- Member Eligibility	402	Benefits	8,330
3	Enrollment Information	534	Member Changes- Demographic Changes	208	Eligibility Inquiry	3,858
4	Eligibility Inquiry	484	Member Billing Inquiries- Claims Status/Investigation	80	Change Address/Phone #	2,154
5	ID Card Request/ Inquiry	388	Member Billing Inquiries- Claims Status/Investigation	80	Change Address/Phone #	2,154
Mar-18						
1	Transportation Questions	9.596	Member Inquiries- Plan Policy/ Procedure Education	458	Benefits	9,814
2	Benefit Inquiry	1,459	Eligibility/Enrollment- Member Eligibility	280	PCP Inquiry	9,099
3	Find/Change PCP	560	Other Programs & Services- Par Billing	128	Eligibility Inquiry	3,217
4	Eligibility Inquiry	516	Member Changes- Demographic Changes	115	Change Address/Phone #	2,760

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Enrollment Information	482	Member Billing Inquiries- Claims Status/ Investigation	76	COB Information	2,446
Apr-18						
1	Transportation Questions	10,610	Member Inquiries- Plan Policy/Procedure Education	488	Benefits	10,030
2	Benefit Inquiry	1,287	Eligibility/Enrollment- Member Eligibility	370	PCP Inquiry	9,006
3	Claim/Billing Issue	554	Member Changes- Demographic Changes	156	Change Address/Phone #	3,007
4	Eligibility Inquiry	512	Other Program & Services – Par Billing Issue	148	Eligibility Inquiry	2,828
5	Enrollment Information	475	Member Billing Inquiries- Claims Status/Investigation	92	General Inquiry	2,551
May-18						
1	Transportation Questions	10,610	Member Inquiries- Plan Policy/Procedure Education	348	Benefits	9,108
2	Benefit Inquiry	1,514	Eligibility/Enrollment- Member Eligibility	226	PCP Inquiry	6,117
3	Eligibility Inquiry	487	Other Programs & Services – Par Billing Issue	65	Eligibility Inquiry	2,467
4	Claim/Billing Issue	483	Member Billing Inquiries- Claims Status/Investigation	56	General Inquiry	2,277
5	Provider- Find/Change/Verify PCP	462	Member Changes- Demographic Changes	50	COB Information	2,202
Jun-18						
1	Transportation Questions	10,408	N/A	0	Benefits	9,033

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Benefit Inquiry	1,302	N/A	0	PCP Inquiry	5,202
3	Claim/Billing Issue	495	N/A	0	COB Information	2,385
4	Eligibility Inquiry	441	N/A	0	Eligibility Inquiry	2,287
5	Enrollment Information	416	N/A	0	General Inquiry	2,264

Provider Helpline

Service Level: Percentage of Provider Helpline Calls Answered Timely



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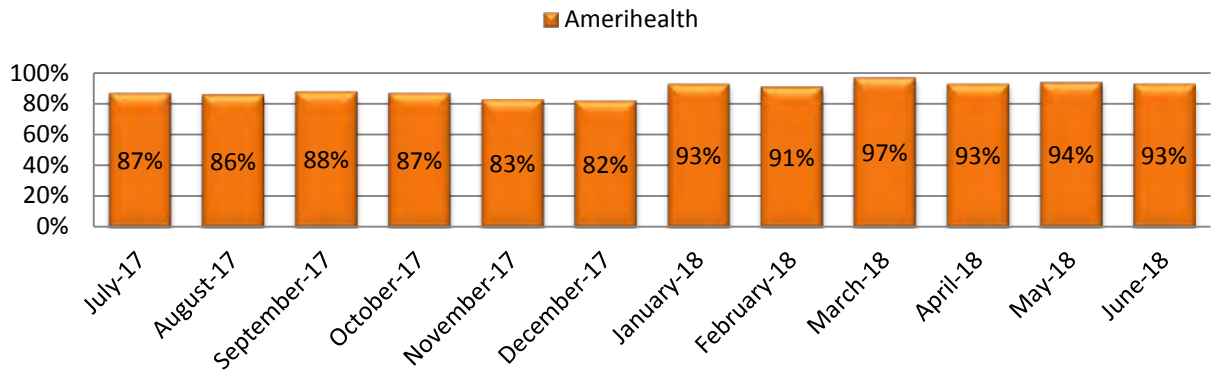

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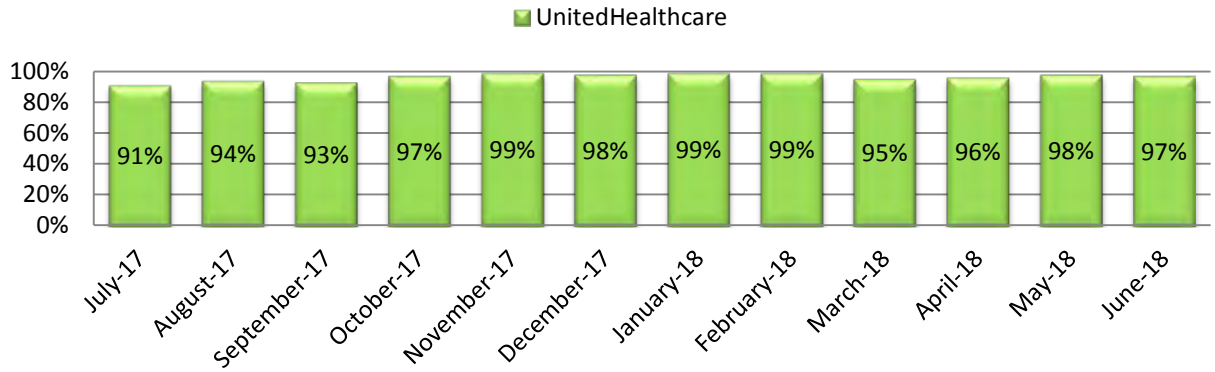
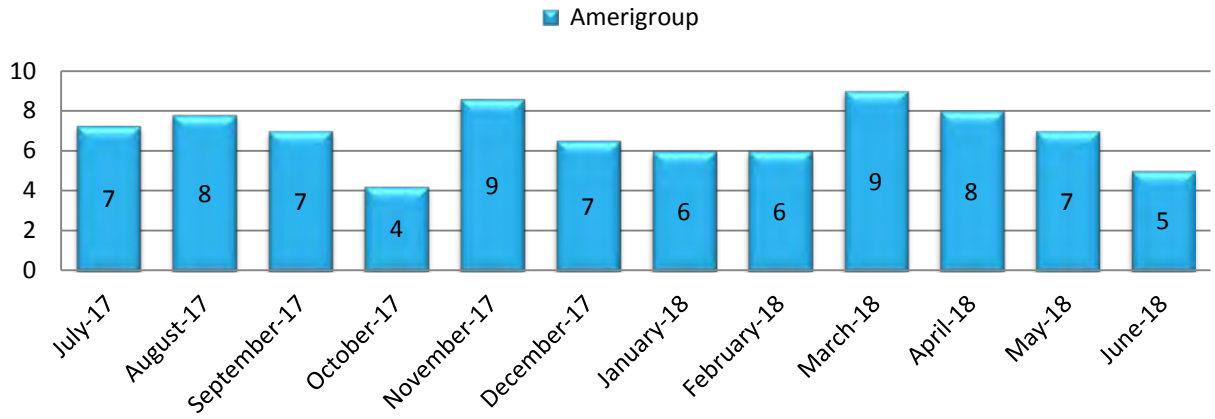
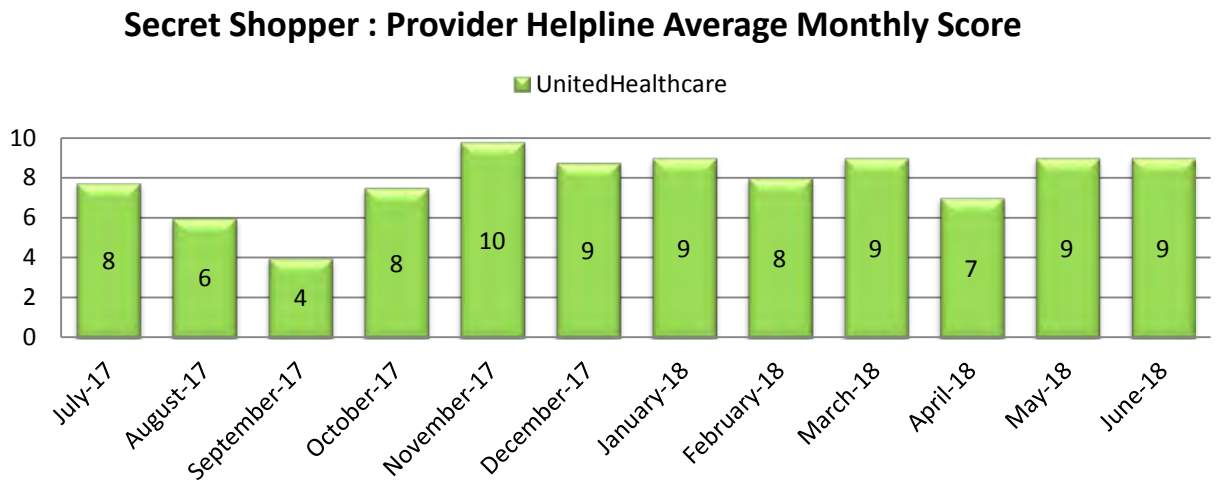


This performance target measures the timeliness of answering the helpline calls. The Department defines "timely" answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the Department conducts secret shopper calls to measure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

Secret Shopper : Provider Helpline Average Monthly Score





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 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. In the first quarter of SFY18, provider helpline secret shopper topics focused on family planning services, prior authorizations, claim denial processes, vaccines for children, retroactive eligibility, hearing aids for durable medical equipment, retroactive eligibility, and vaccines for children. In the second quarter, member helpline secret shopper topics included getting authorized to receive information regarding an adult child, receiving information regarding the appeals process, and receiving information regarding MCO choice options. In the third quarter, topics focused on finding prior authorization criteria and claim forms, retroactive eligibility, client participation, provider renewal, appeals and overpayments. In quarter four, provider helpline secret shopper topics dealt with timely filing of claims, disagreements regarding claims, prior authorizations, denied claims notifications, pharmacy lock-in programs, enrollment in IHH programs, overpayments, the Preferred Drug List, new providers submitting claims, and checking claims status.

Top Five Reasons for Providers Contacting Helplines for SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
Jul-17						
1	Claim Status Inquiry	3,015	Claims- Claim Status	13,574	Claims Inquiry	13,664
2	Claim Rejected	1,635	Provider Requests-Check Remittance Advice	7,180	Benefits	4,280
3	Claims Inquiry	1,366	Provider Inquiries-Plan Policy/Procedure Education	5,652	COB Information	1,693
4	Claim Denial Inquiry	981	Eligibility/Enrollment-Member Eligibility	2,344	Authorization Related	953
5	Benefits Inquiry	862	Claims- Claim Issues	1,823	Membership Record	665
Aug-17						
1	Claim Status Inquiry	3,113	Claims – Claim Status	16,335	Claims Inquiry	11,063
2	Claims Inquiry	1,496	Provider Requests-Check Remittance Advice	6,750	Benefits	3,709
3	Claim rejected	1,492	Provider Inquiries-Plan/Policy/Procedure Education	5,352	COB Information	981
4	Claim Denial Inquiry	1,240	Eligibility/Enrollment-Member Eligibility	2,665	Authorization Related	824
5	Benefits Inquiry	1,084	Claims- Claim Issues	2,324	Membership Record	667
Sep-17						
1	Claim Status Inquiry	2,962	Claims- Claim Status	14,239	Claims Inquiry	15,536
2	Claim Rejected	1,336	Provider Requests-Check Remittance	7,550	Benefits	4,577

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			Advice			
3	Claims Inquiry	1,313	Provider Inquiries-Plan/Policy Procedure Education	5,248	COB Information	1,211
4	Claims Denial Inquiry	1,013	Eligibility/Enrollment-Member Eligibility	2,407	Membership Record	912
5	Benefits Inquiry	876	Claims- Claim Issues	1,975	Authorization Related	1,180
Oct-17						
1	Claim Status Inquiry	3,229	Claims-Claim Status	15,141	Claims Inquiry	13,172
2	Claims Inquiry	1,455	Provider Requests-Check Remittance Advice	7,994	Benefits	3,671
3	Claim Denial Inquiry	1,065	Provider Inquiries-Plan Policy/Procedure Education	5,761	Authorization Related	1,093
4	Benefits Inquiry	998	Eligibility/Enrollment-Member Eligibility	2,540	COB Information	1,032
5	Transportation Questions	930	Claims- Claim Issues	2,159	Membership Record	573
Nov-17						
1	Claim Status Inquiry	2,676	Claims-Claim Status	14,807	Claims Inquiry	10,461
2	Claims Inquiry	1,253	Provider Requests-Check Remittance Advice	7,250	Benefits	2,772

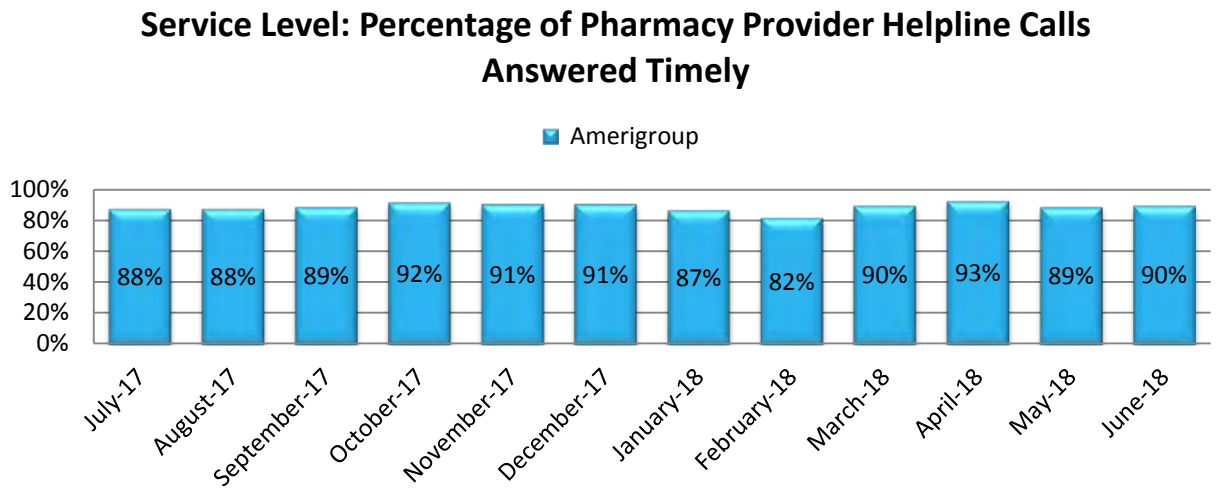
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
3	Claim Denial Inquiry	906	Provider Inquiries-Plan Policy/Procedure Education	5,302	Authorization Related	1,019
4	Transportation Questions	897	Claims-Claim Issues	2,204	COB Information	763
5	Benefits Inquiry	862	Eligibility/Enrollment-Member Eligibility	2,106	Membership Record	511
Dec-17						
1	Claim Status Inquiry	2,326	Claims Status	12,975	Claims Inquiry	13,060
2	Claims Inquiry	1,247	Provider Check Remittance Advice	6,514	Benefits	8,603
3	Claim Denial Inquiry	804	Provider Inquiries-Plan Policy/ Procedure Education	3,669	Authorization Related	2,884
4	Transportation Questions	787	Claim – Claims Issues	1,722	COB Information	1,574
5	Benefits Inquiry	756	Eligibility/Enrollment – Member Eligibility	1,391	Membership Record	1,400
Jan-18						
1	Claim Status Inquiry	2,528	Claim Status	11,488	Claims Inquiry	16,235

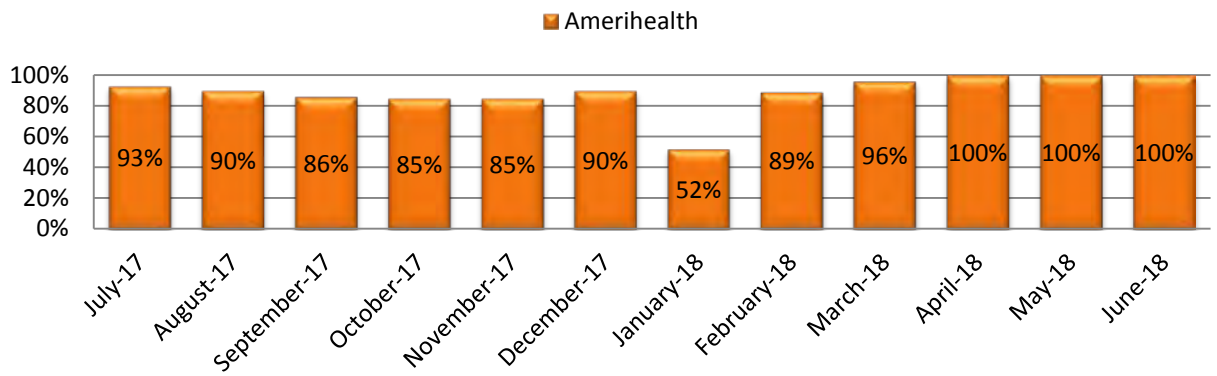
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Claims Inquiry	1,295	Provider Requests-Check Remittance Advice	3,595	Benefits	7,949
3	Benefits Inquiry	1,074	Provider Inquiries-Plan/Policy Procedure Education	1,470	Authorization Related	2,476
4	Claim Denial Inquiry	998	Claims-Claim Issues	1,437	COB Information	2,009
5	Transportation Questions	938	Requests/Inquiries-Plan/Policy Procedure	924	Membership Record	1,598
Feb-18						
1	Claim Status Inquiry	2,287	Claim Status	9,471	Claims Inquiry	19,577
2	Claims Inquiry	1,173	Provider Requests-Check Remittance Advice	2,272	Benefits	7,025
3	Claim Denial Inquiry	898	Provider Inquiries-Plan Policy/Procedure Education	880	COB Information	2,262
4	Benefits Inquiry	860	Claims- Claim Issues	765	Authorization Related	2,218

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Transportation Questions	816	Requests/Inquiries-Plan Policy/Procedure	569	Membership Record	1,483
Mar-18						
1	Claims Status Inquiry	2,329	Claim Status	7,843	Claims Inquiry	24,789
2	Claims Inquiry	1,549	Provider Requests – Check Remittance Advice	1,920	Benefits	8,141
3	Benefits Inquiry	1,179	Claim-Claim Issues	713	COB Information	2,737
4	Claim Denial Inquiry	1,068	Provider Inquiries-Plan Policy/Procedures Education	699	Authorization Related	2,584
5	Transportation Questions	997	Requests/Inquiries-Plan Policy/Procedure	586	Membership Record	2,005
Apr-18						
1	Claim Status Inquiry	2,322	Claim Status	5,963	Claims Inquiry	20,323
2	Claims Inquiry	1,426	Provider Requests-Check Remittance Advice	1,343	Benefits	6,317
3	Claim Denial Inquiry	1,106	Claims – Claim Issues	531	COB Information	2,470
4	Benefits Inquiry	1,090	Requests/Inquiries – Plan Policy/Procedure	495	Authorization Related	2,279

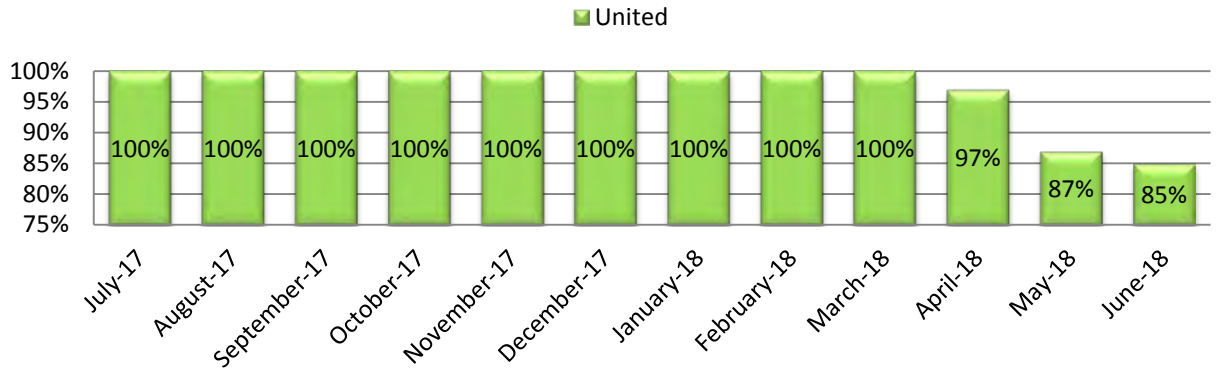
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Transportation Questions	1,033	Provider Inquiries – Plan Policy/Procedure Education	372	Membership Record	1,927
May-18						
1	Claim Status Inquiry	2,387	Claim Status	4,929	Claims Inquiry	21,328
2	Claims Inquiry	1,439	Provider Requests-Check Remittance Advice	1,283	Benefits	6,201
3	Benefits Inquiry	1,113	Provider Inquiries-Plan Policy/Procedure Education	637	COB Information	2,860
4	Claim Denial Inquiry	1,080	Claim-Claims Issues	603	Authorization Related	2,209
5	Transportation Questions	1,050	Eligibility/Enrollment – Member Eligibility	580	Membership Record	1,973
Jun-18						
1	Claims Status Inquiry	2,321	Claim Status	3,338	Claims Inquiry	20,721
2	Claim Inquiry	1,134	Requests/Inquiries-Plan Policy/Procedure	265	Benefits	5,316
3	Benefits Inquiry	1,019	Claims-Claim Issues	250	COB Information	2,345
4	Transportation Questions	974	Appeal –Appeal Status	138	Authorization Related	2,733
5	Claim Denial Inquiry	967	Provider Inquiries – Plan Policy/Procedure	111	Membership Record	2,191

Pharmacy Services Helpline





Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely

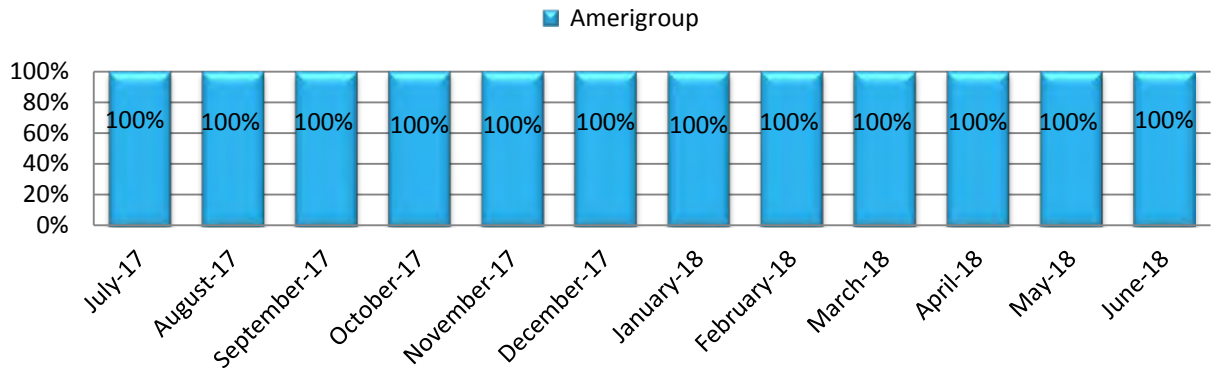


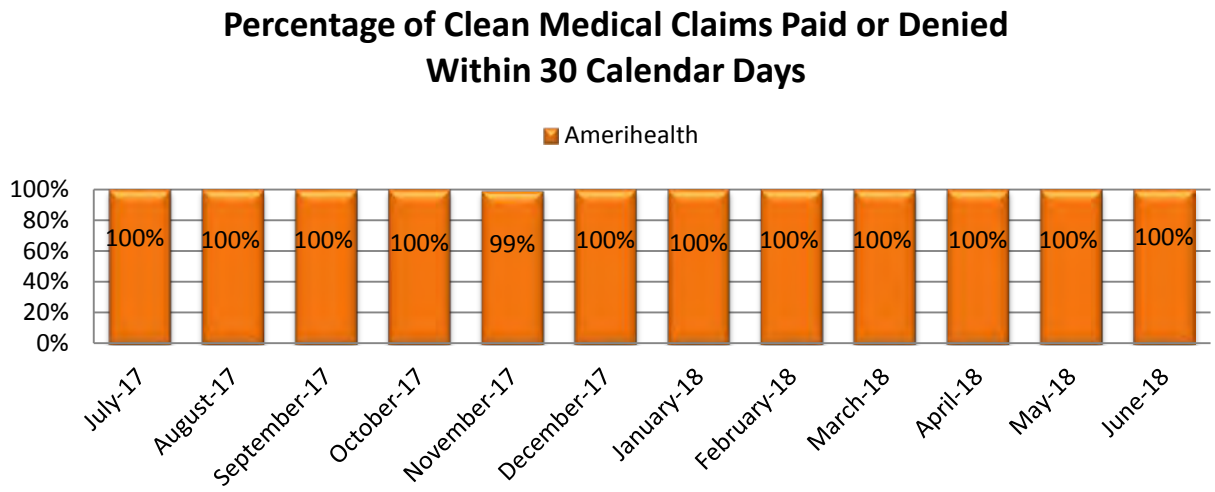
This performance target measures the timeliness of answering the helpline calls. The Department defines "timely" answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the Department conducts secret shopper calls to measure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

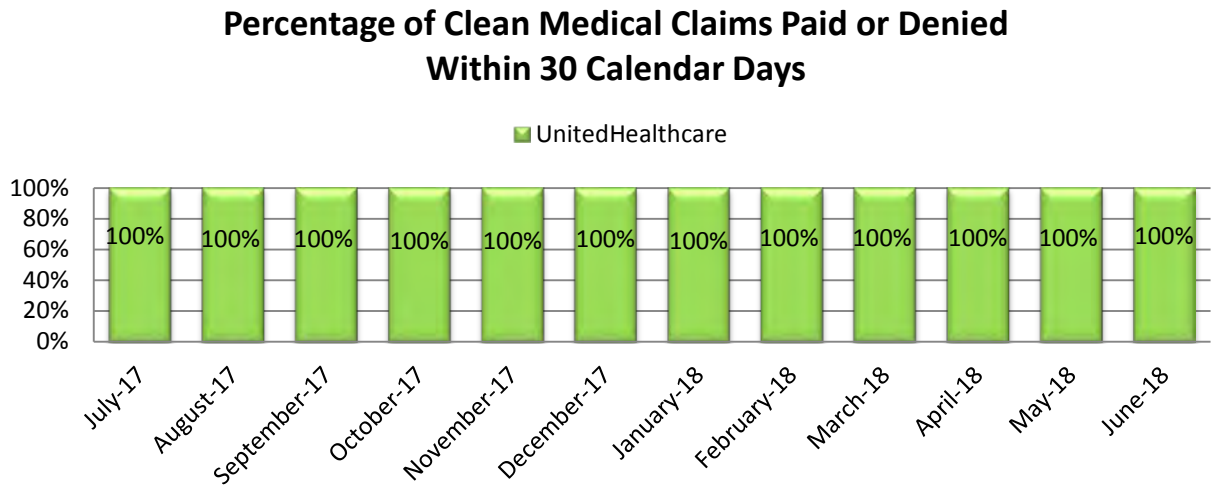
Medical Claims Payment

Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

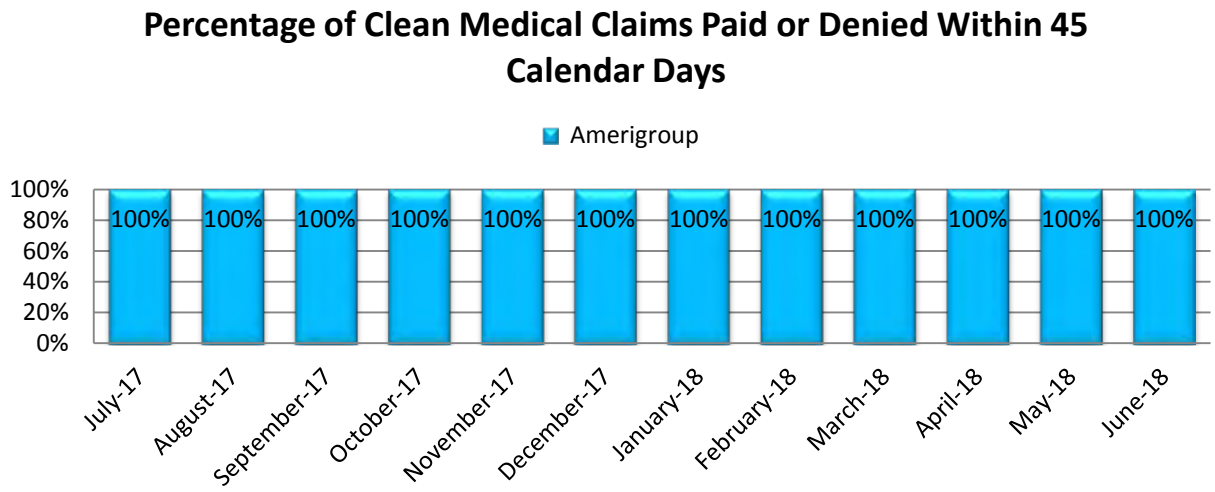
Percentage of Clean Medical Claims Paid or Denied Within 30 Calendar Days

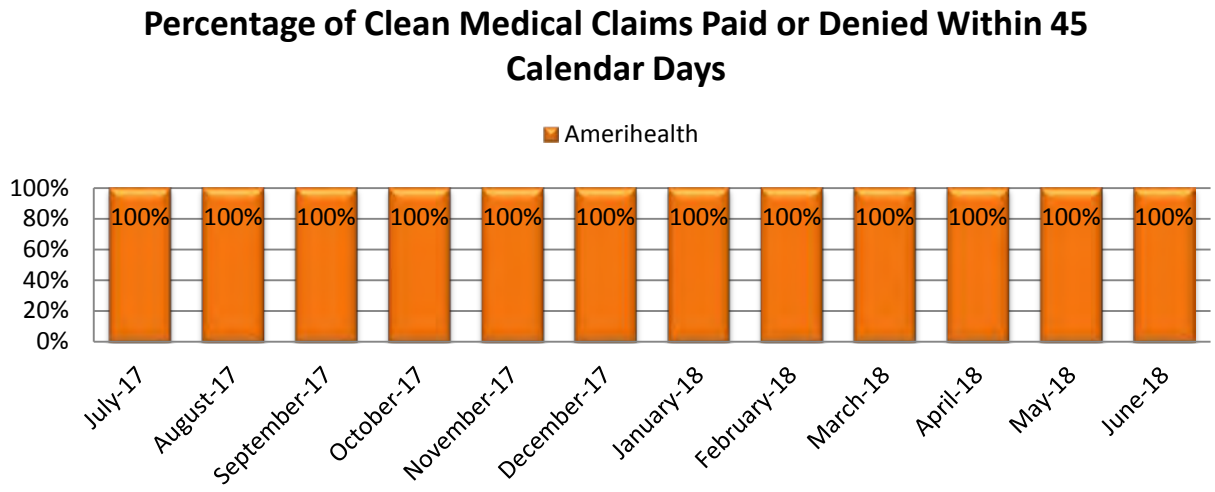


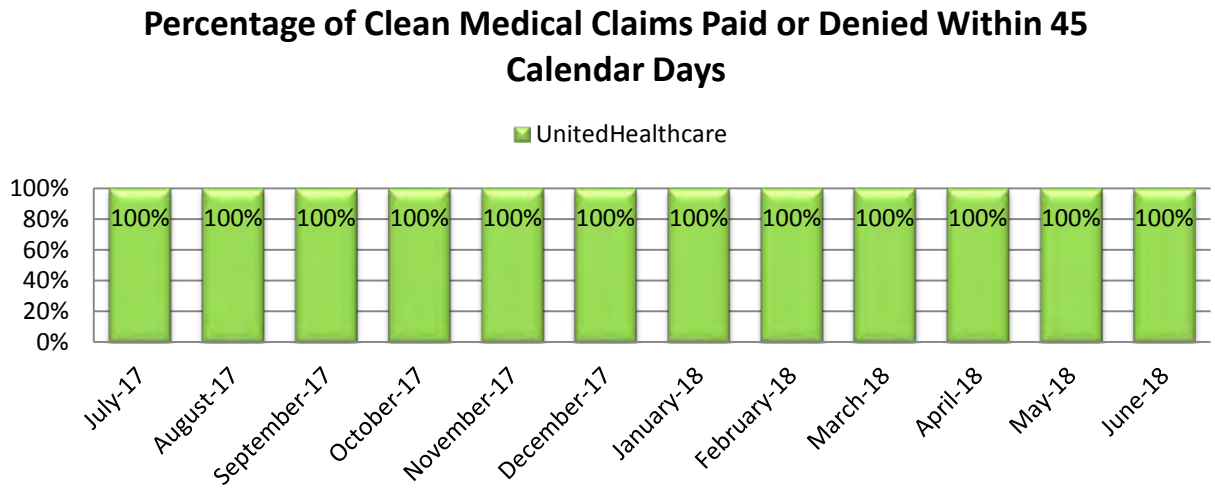




This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The Department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the Department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







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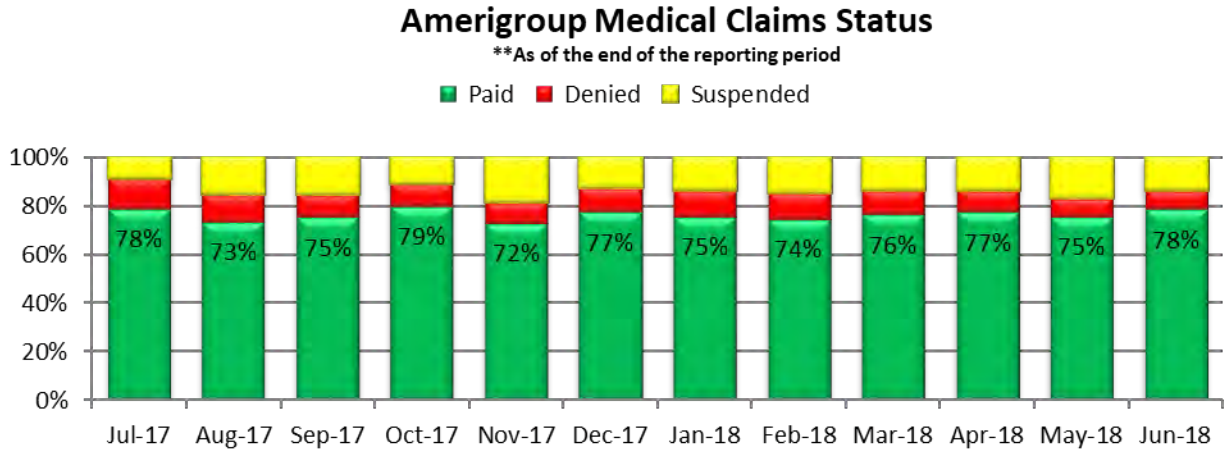
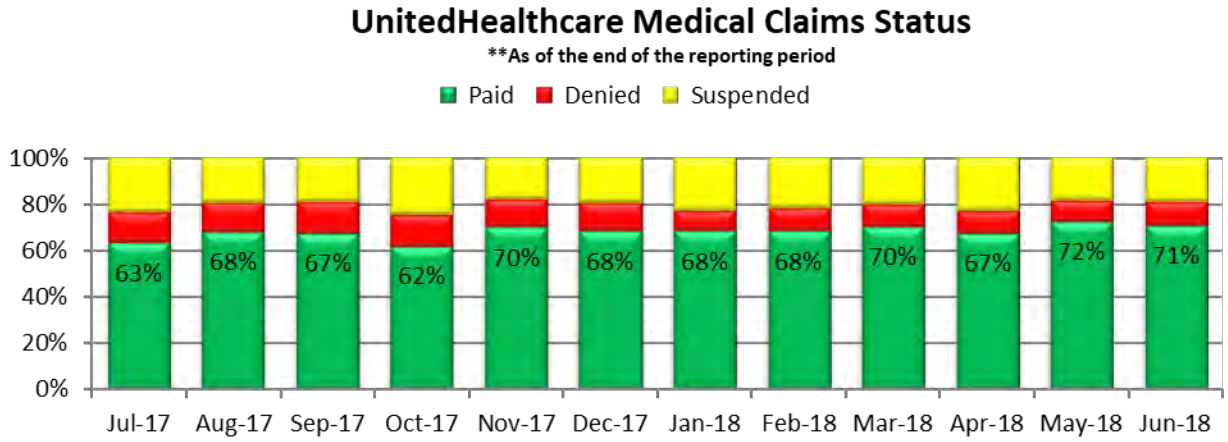




Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
#	**Amerigroup**	**UnitedHealthcare**
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim
2.	27-Expenses incurred after coverage terminated	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered

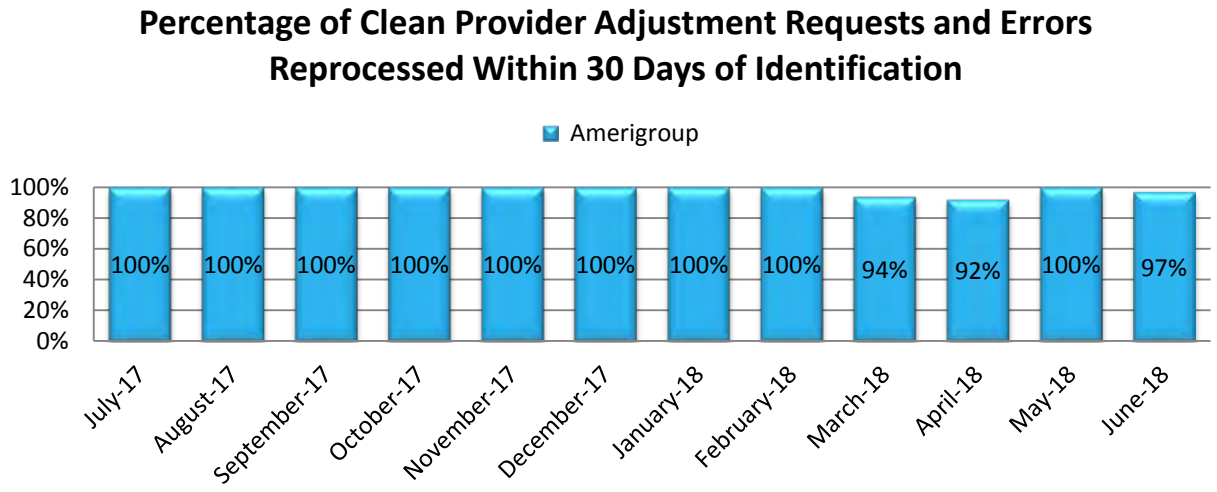
Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
#	**Amerigroup**	**UnitedHealthcare**
		without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
3.	252- An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark code that is not an ALERT) N479- Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.
4.	256-Service not payable per managed care contract	CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.
5.	29 – The time limit for filing has expired	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service
6.	197- Precertification/authorization/notification absent	CARC-256 Service not payable per managed care contract. RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
7.	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	CARC-29 The time limit for filing has expired.
8.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	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

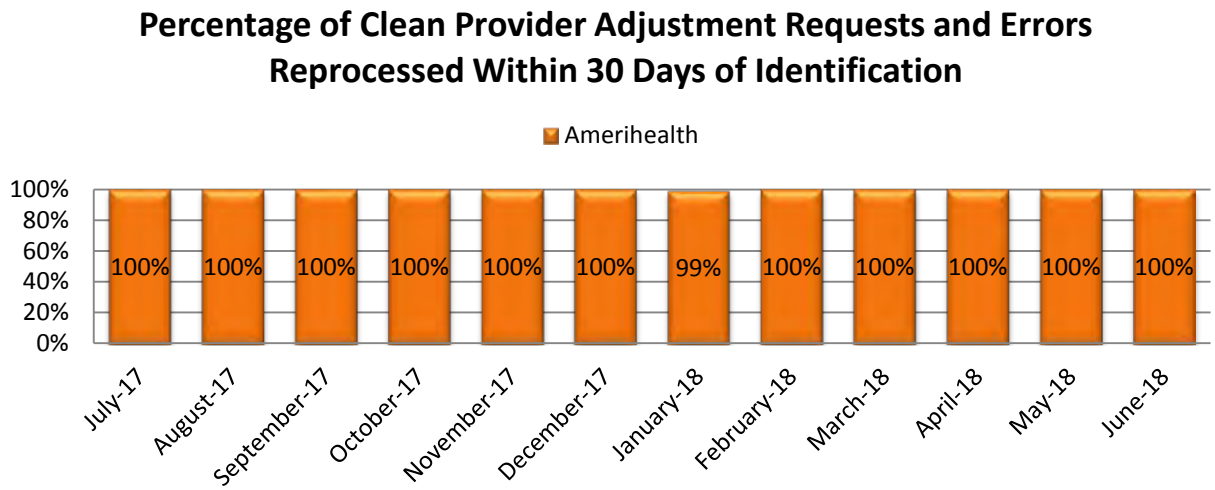
Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
#	**Amerigroup**	**UnitedHealthcare**
		components of the same procedure. Separate payment is not allowed.
9.	16-Claim/service lacks information or has submission/billing error(s) which is 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	CARC-23 – The impact of prior payer(s) adjudication including payments and/or adjustments.
10.	97 – The benefit for this service is included in the payment /allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present N432: Adjustment based on a Recovery Audit	CARC-11 The diagnosis is inconsistent with the patient's gender. N657 this should be billed with the appropriate code for these services.

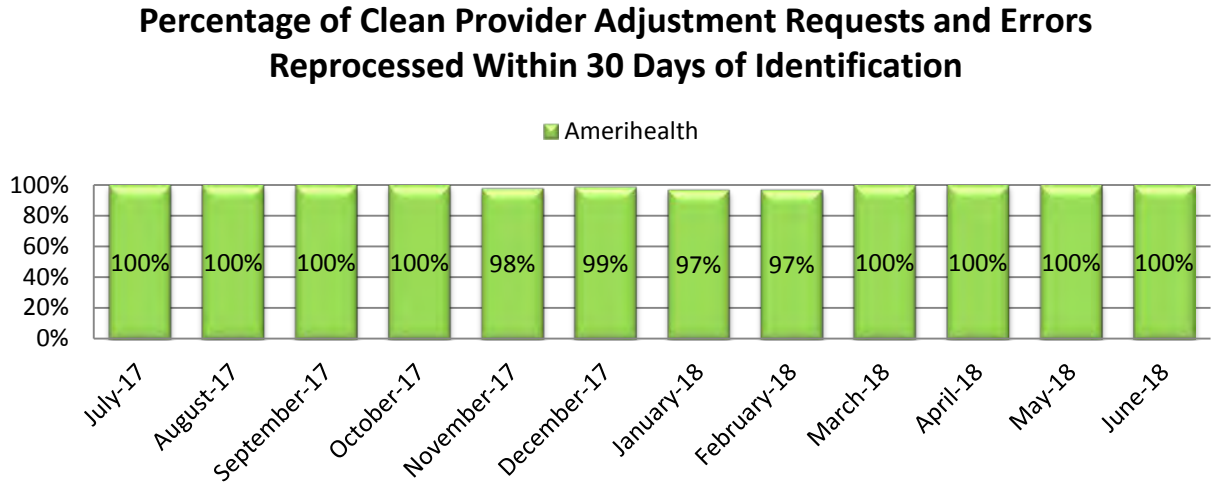
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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/

Claims Reprocessing and Adjustments			
The table below reflects the total count of claims processed including Rx and non-Rx claims, and the count of claims reprocessed or adjusted. Reprocessed or adjusted claims include clean provider adjustment requests, claims processing errors identified, and claims reprocessing projects.			
Period	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Total Claims Processed SFY 2018	8,164,710	4,709,107	11,659,447
Claims Reprocessed or Adjusted SFY 2018	425,733	746,925	366,971



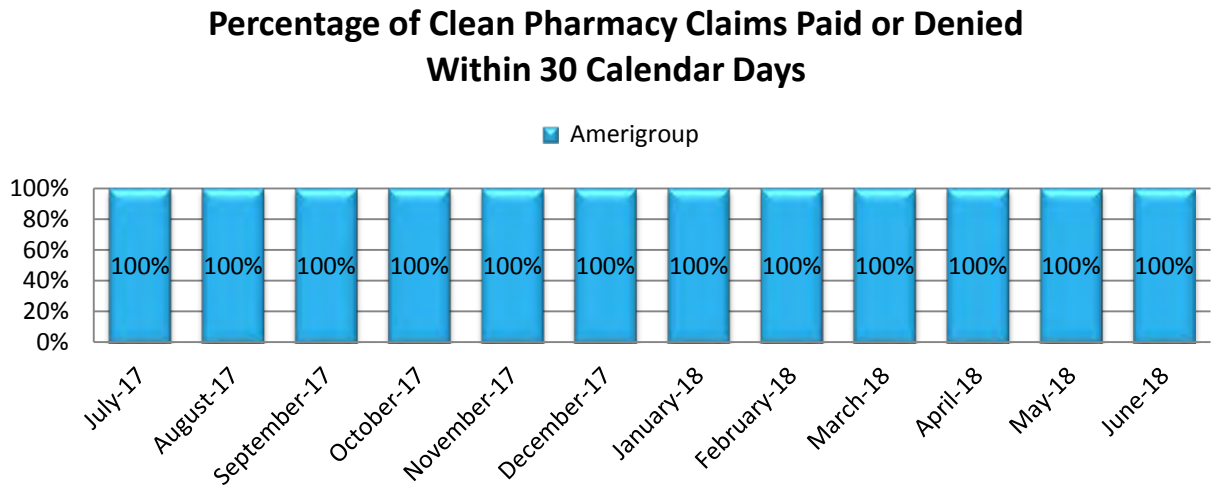


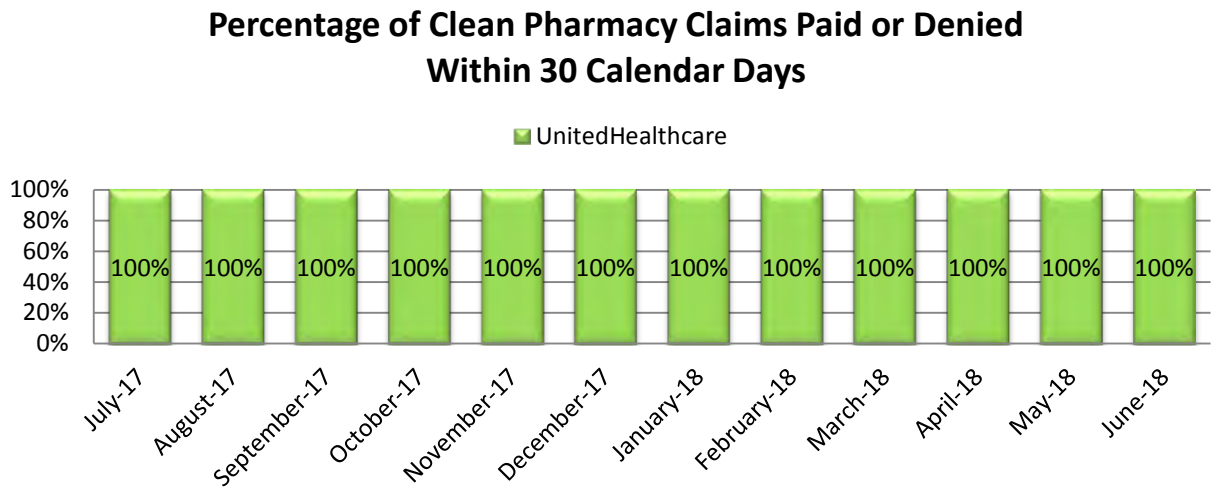


Plans have 30 days from the date of identification of an error or a clean provider adjustment request to reprocess 90% of the claims identified. Claims reprocessing projects may be processed on a different timeline with Agency approval.

Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.





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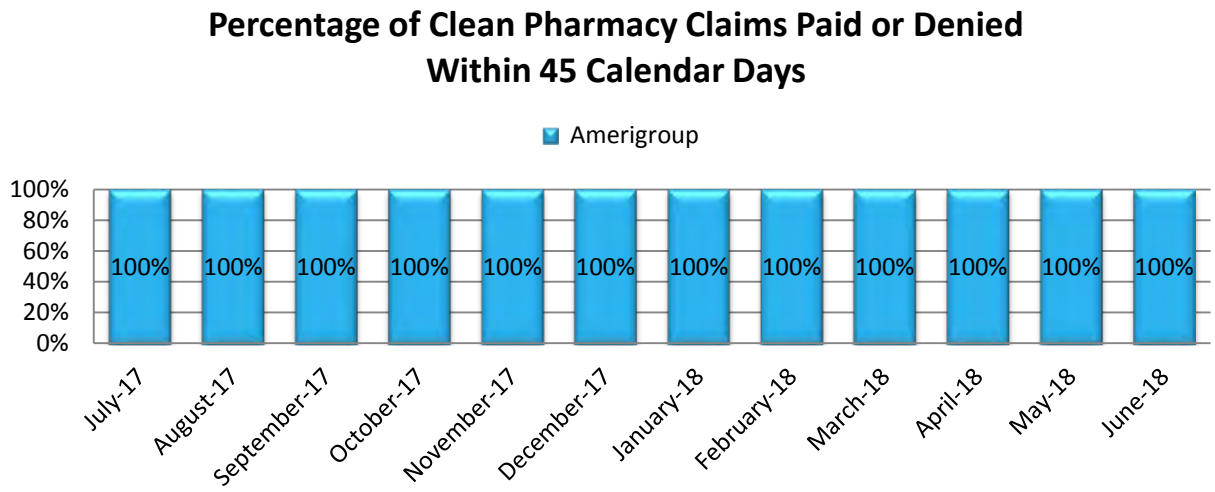

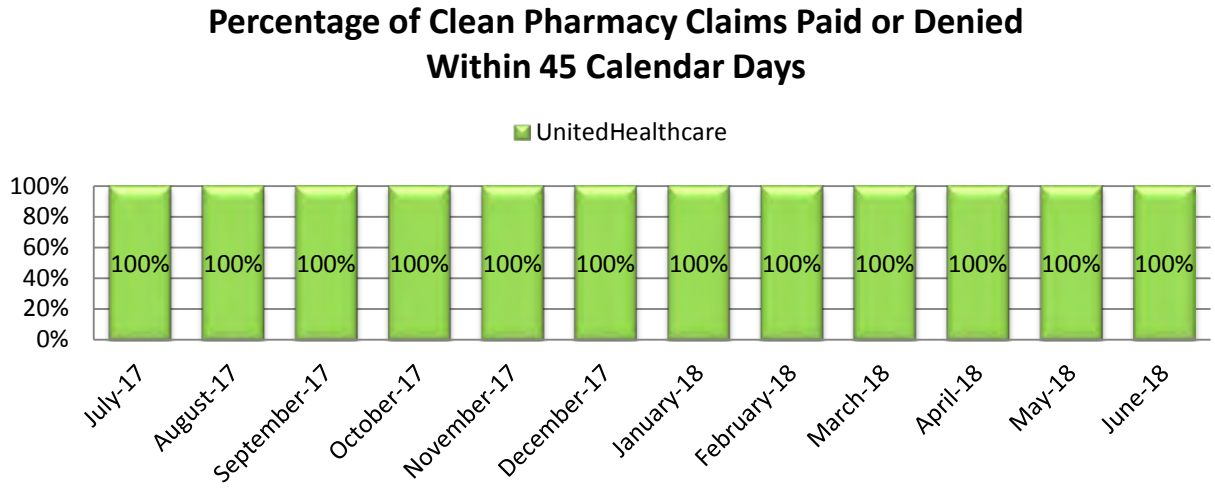

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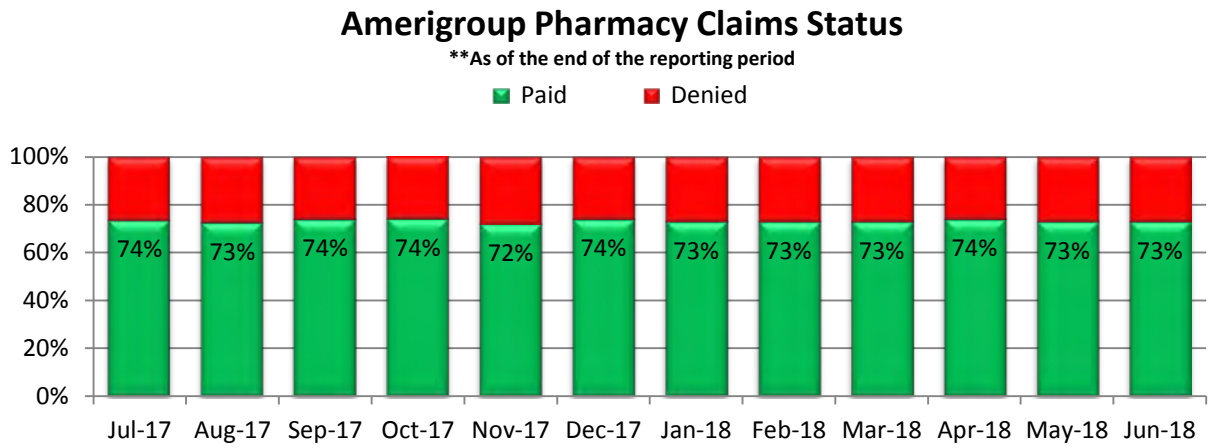
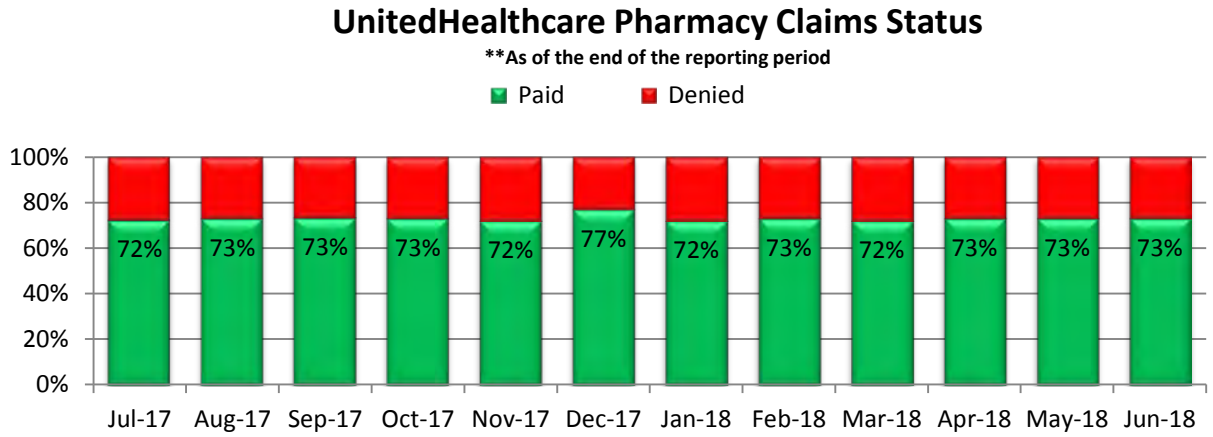




Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period		
#	**Amerigroup**	**UnitedHealthcare**
1.	Refill Too Soon	Refill Too Soon
2.	Product Not On Formulary	Prior Authorization Reqrd
3.	Days Supply Exceeds Plan Limitation	Prod/Service Not Covered
4.	Product/Service Not Covered – Plan/Benefit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

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 SFY18 Data	Amerigroup	UnitedHealthcare	Total
Additional Benefits	1,730	347	2,077
Family Planning and Resources	0	1,057	1,057
Health and Wellness	54	135	189
Healthy Incentives	6,310	1,809	8,119
Q2 SFY18 Data	**Amerigroup**	**UnitedHealthcare**	**Total**
Additional Benefits	924	485	1,409
Family Planning and Resources	0	772	772
Health and Wellness	67	118	185
Healthy Incentives	6,120	1,818	7,938
Q3 SFY18 Data	**Amerigroup**	**UnitedHealthcare**	**Total**
Additional Benefits	741	844	1,585
Family Planning and Resources	0	1,075	1,075
Health and Wellness	69	195	264
Healthy Incentives	4,676	0	4,676
Q4 SFY18 Data	**Amerigroup**	**UnitedHealthcare**	**Total**
Additional Benefits	417	929	1,348
Family Planning and Resources	0	1,770	1,770
Health and Wellness	42	215	257
Healthy Incentives	4,525	0	4,525

Additional services that could be considered as a value add for managed care may not be reflected in this table such as enhanced care coordination, 24/7 nurse call lines, and increased access to health care information.

To view a list of value added services by plan, visit: https://dhs.iowa.gov/sites/default/files/ValueAddedServicesComparisonChart_2015_1202.pdf.

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.

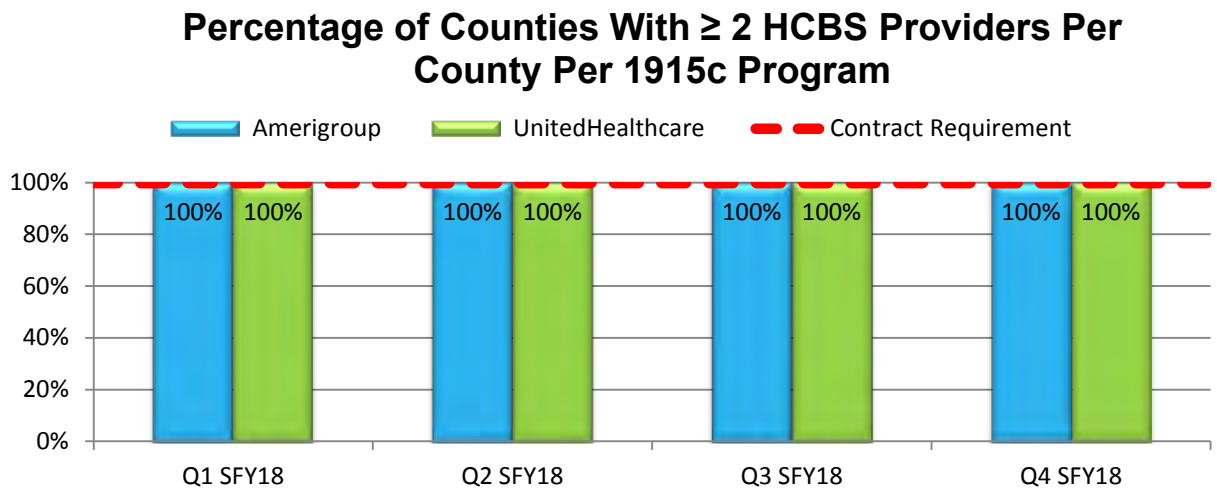
Links to time and distance reports for the last state fiscal year 2018 reporting period can be found at:

- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-AGP-06012018.pdf
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-forExhibit-B-Worksheet-UHC-06012018.pdf

GeoAccess maps reflect traditional time and distance standards. As of the date of this publication, all MCOs have submitted exception reports to the Department but not all MCO submitted exceptions have been approved.

The following table of Percentage of Members with Coverage in Time and Distance Standards provides a snapshot of available non-specialty measures (i.e., providers) for non-HCBS services across the respective regions.

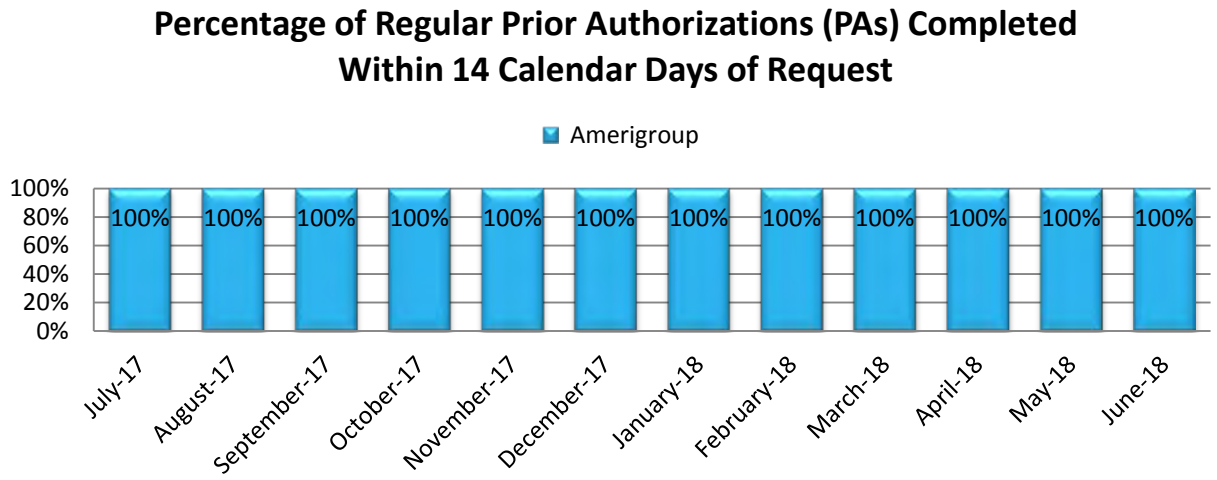
Percentage of Members with Coverage in Time and Distance Standards						
MCO	**Amerigroup**			**UnitedHealthcare**		
Measure	**30 Min/ 30 Mile**			**30 Min/ 30 Mile**		
Primary Care - Adult	100%			100%		
Primary Care – Child	100%			100%		
Hospital	100%			100%		
Behavioral Health – Outpatient	100%			100%		
General Optometry	100%			100%		
Lab and X-ray Services	100%			100%		
Pharmacy	100%			100%		
MCO	**Amerigroup**			**UnitedHealthcare**		
Measure	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**
ICF/SNF	100%	100%		100%	100%	
ICF/ID	100%	100%		90%	100%	
Behavioral Health – Inpatient		98%	100%		98%	100%

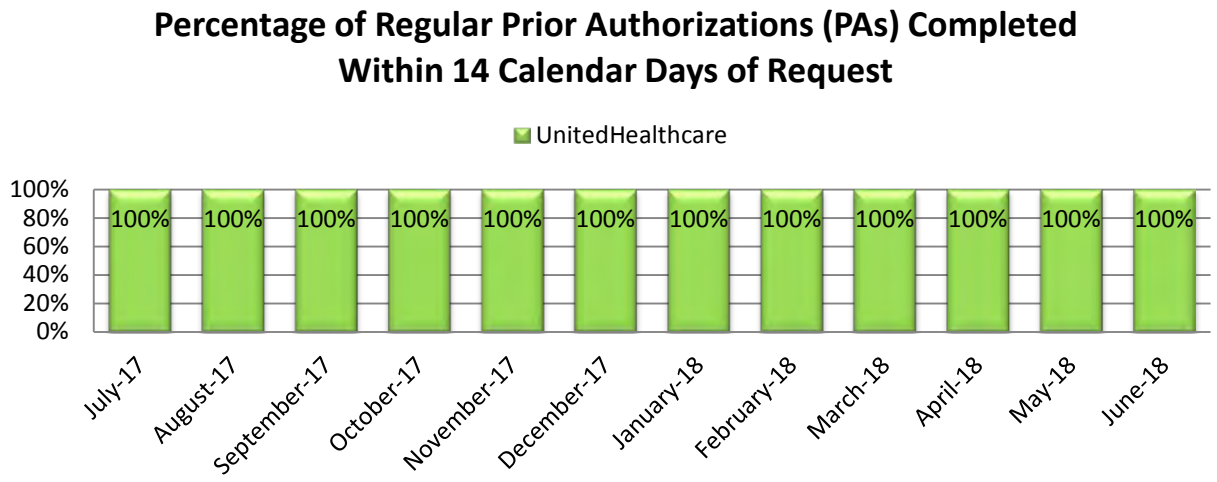


All MCOs have approved exception requests for the network standards in Exhibit B of the contract for HCBS services.

The Department continues to monitor network adequacy to ensure that these contract standards are met and will take additional steps towards progressive remedies if necessary.

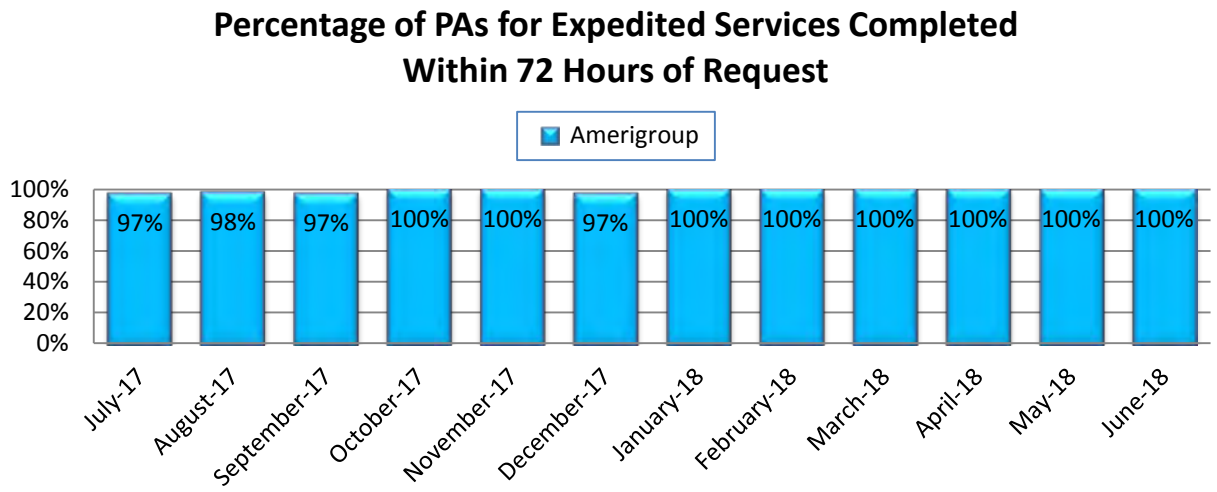
Prior Authorization - Medical

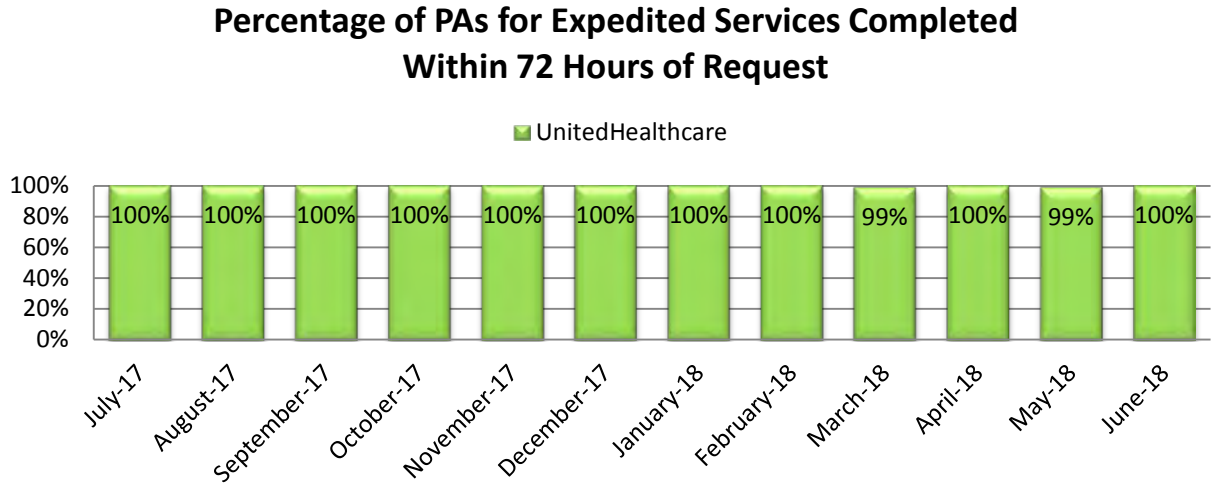




This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of regular prior authorizations (PAs) must be completed within 14 calendar days of request to meet performance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

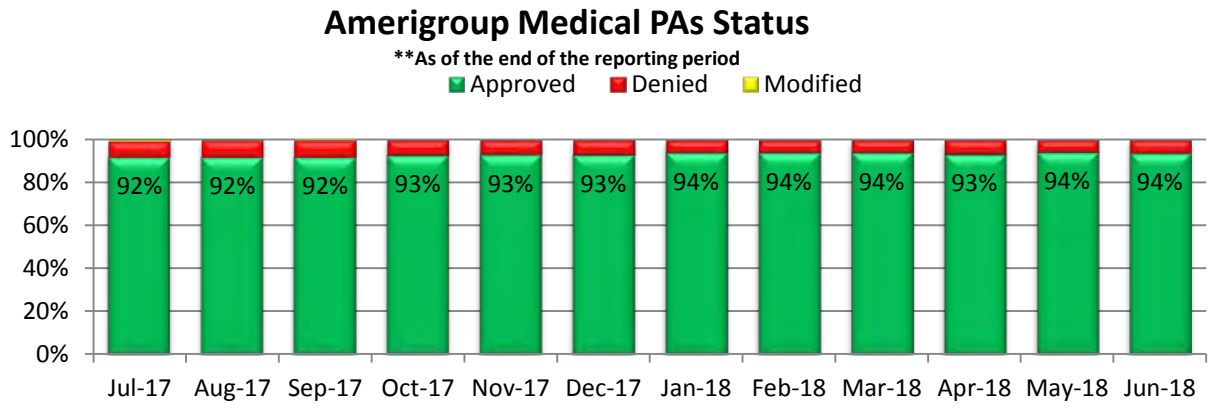
The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.



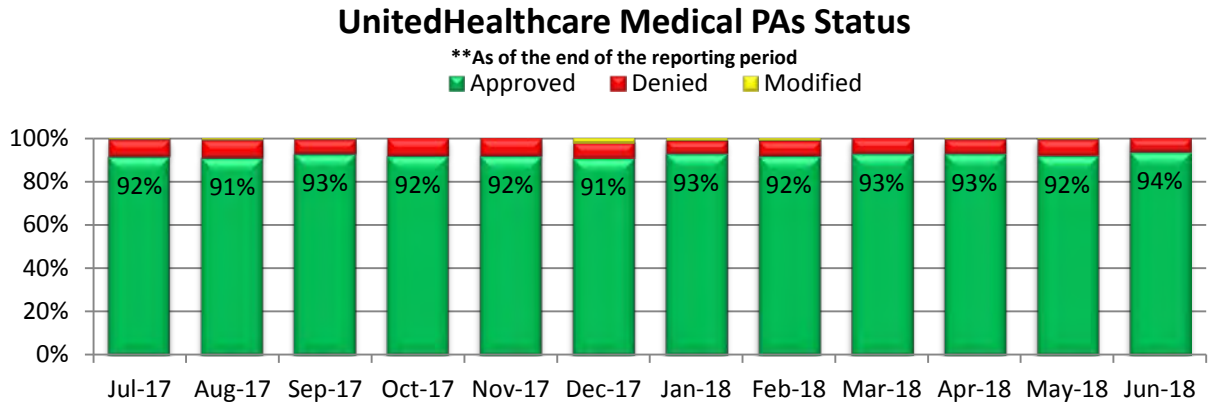


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of PAs for expedited services must be authorized within 72 hours of request to meet performance guarantees.

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

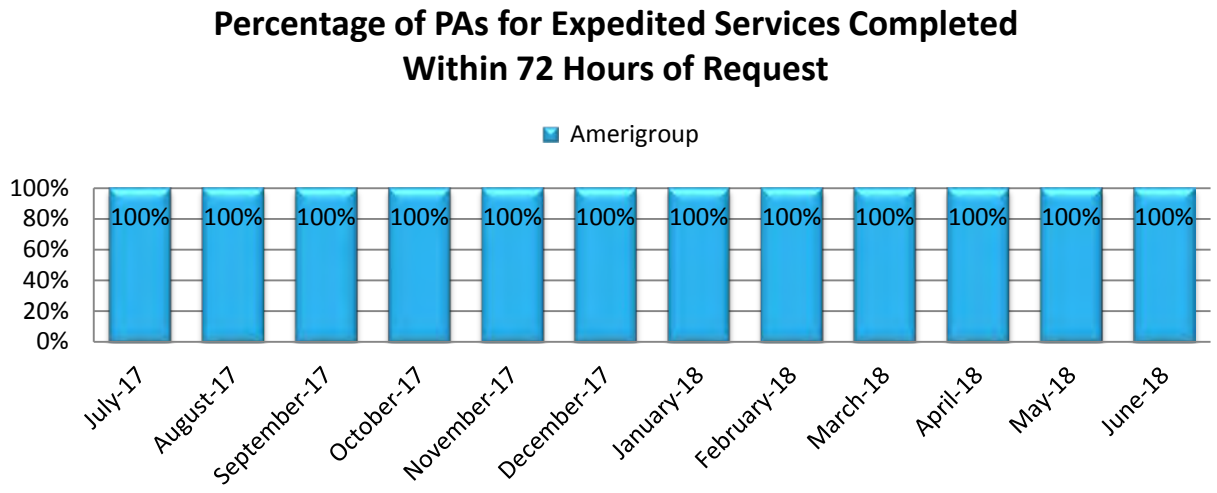


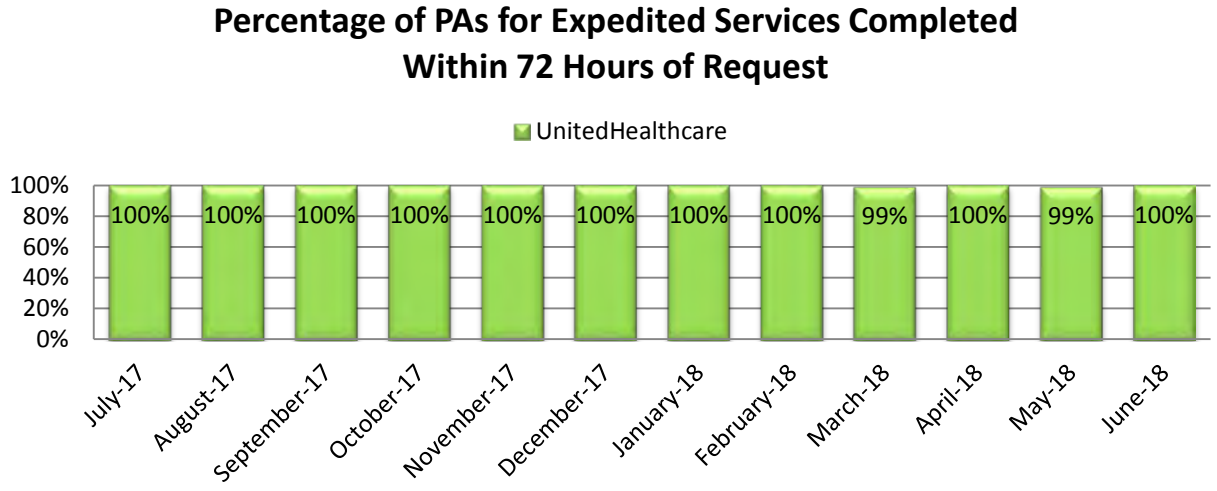
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



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.

Prior Authorization - Pharmacy

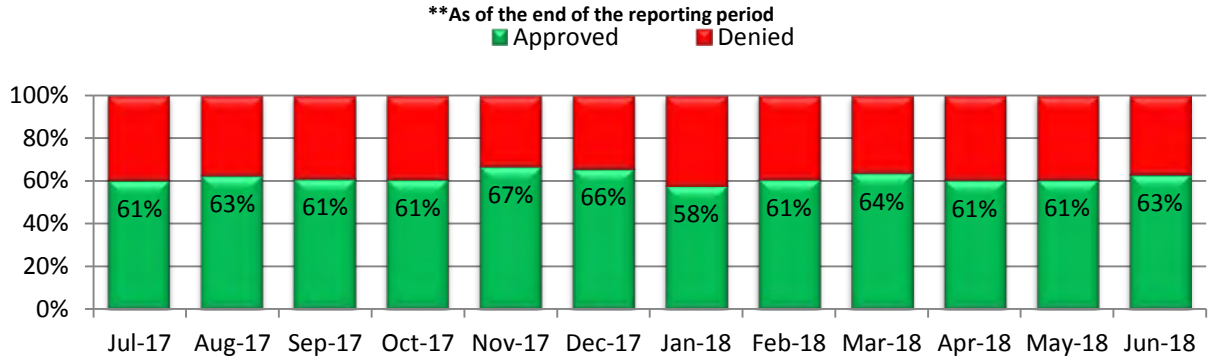




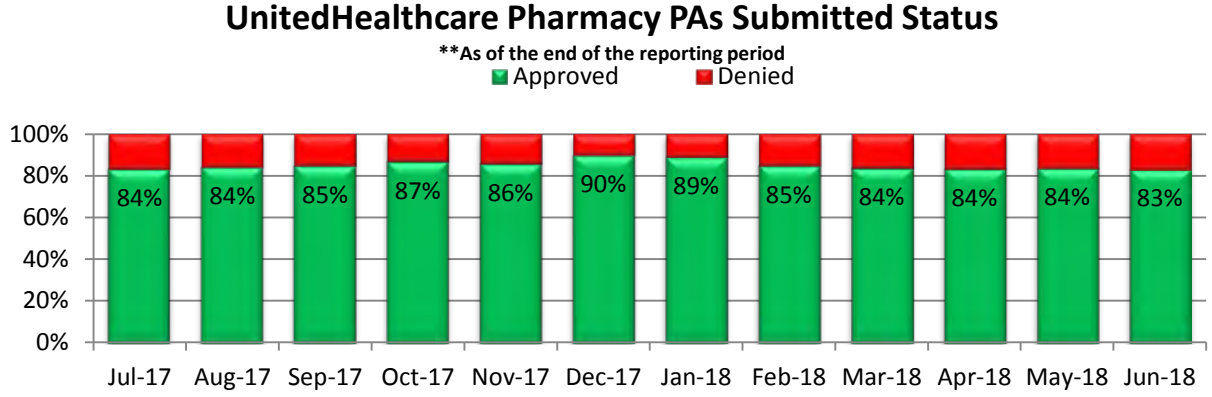
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ. 100% of regular PAs must be completed within 24 hours of request to meet performance guarantees.

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



UnitedHealthcare Pharmacy PAs Submitted Status



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	**AmeriHealth**											
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

Any errors in encounter data are expected to be corrected within contractual timeframes. The Department is engaged in ongoing validation and collaboration associated with the transfer of encounter data as well as continuous evaluation of the quality of data submitted.

Value-Based Purchasing Enrollment

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

Data	Amerigroup	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q1 SFY18	21%	25%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q2 SFY18	20%	39%

Value-Based Purchasing Enrollment		
MCOs are expected to have 40% of their population covered by a value based purchasing agreement by 2018.		
Data	**Amerigroup**	**UnitedHealthcare**
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q3 SFY18	55%	50%
% of Members Covered by a Value Based Purchasing Agreement meeting State Standards for Q4 SFY18	32%	48%

All value based contracts are currently being discussed with MCOs to ensure that all components required are included.

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.

Data for Q1 SFY18 Quarter Only	Amerigroup	UnitedHealthcare
MLR	116.3%	95.5%
ALR	8.6%	11.5%
Underwriting	-24.9%	-7.0%
Data for Q2 SFY18 Quarter Only	**Amerigroup**	**UnitedHealthcare**
MLR	96.0%	95.6%
ALR	7.8%	7.8%
Underwriting	-3.8%	-3.4%
Data for Q3 SFY18 Quarter Only	**Amerigroup**	**UnitedHealthcare**
MLR	104.5%	97.7%
ALR	9.6%	10.9%
Underwriting	-14.1%	-8.6%
Data for Q4 SFY18 Quarter Only	**Amerigroup**	**UnitedHealthcare**
MLR	97.9%	103.8%
ALR	6.4%	8.5%
Underwriting	-4.3%	-12.3%

The Department expects quarter-to-quarter fluctuations in financial metrics while the plans' experience in the Iowa Medicaid market matures. The financial ratios presented above are common financial metrics used to assess MCO financial performance. The Department monitors metrics for the contract to date and the current quarter. The table above shows financial metrics for the quarter only.

Capitation Payments Made to the Managed Care Organizations				
MCO	Q1 SFY18	Q2 SFY18	Q3 SFY18	Q4 SFY18
Amerigroup	$252,059,197	$252,496,960	$300,806,015	$324,632,914
AmeriHealth	$452,572,360	$304,552,047	$4,702,138	$3,254,253
UnitedHealthcare	$213,334,385	$356,479,227	$728,247,202	$702,772,337

Capitation payments reported above do not include credits or adjustments.

Managed Care Organization Reported Reserves			
Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*	Y	Y	Y

Third Party Liability Recovery			
Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Amount of TPL Recovered Q1 SFY18	$10,370,140	$21,561,935	$18,513,369
Amount of TPL Recovered Q2 SFY18	$9,493,182	$17,317,546	$16,846,120
Amount of TPL Recovered Q3 SFY18	$17,067,919	$8,007,960	$28,814,498
Amount of TPL Recovered Q4 SFY18	$7,202,331	$8,049,729	$35,006,202

Historical third party liability recoveries collected by the Iowa Medicaid Enterprise as part of payment for services was included in the capitation rates for the managed care organizations.

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

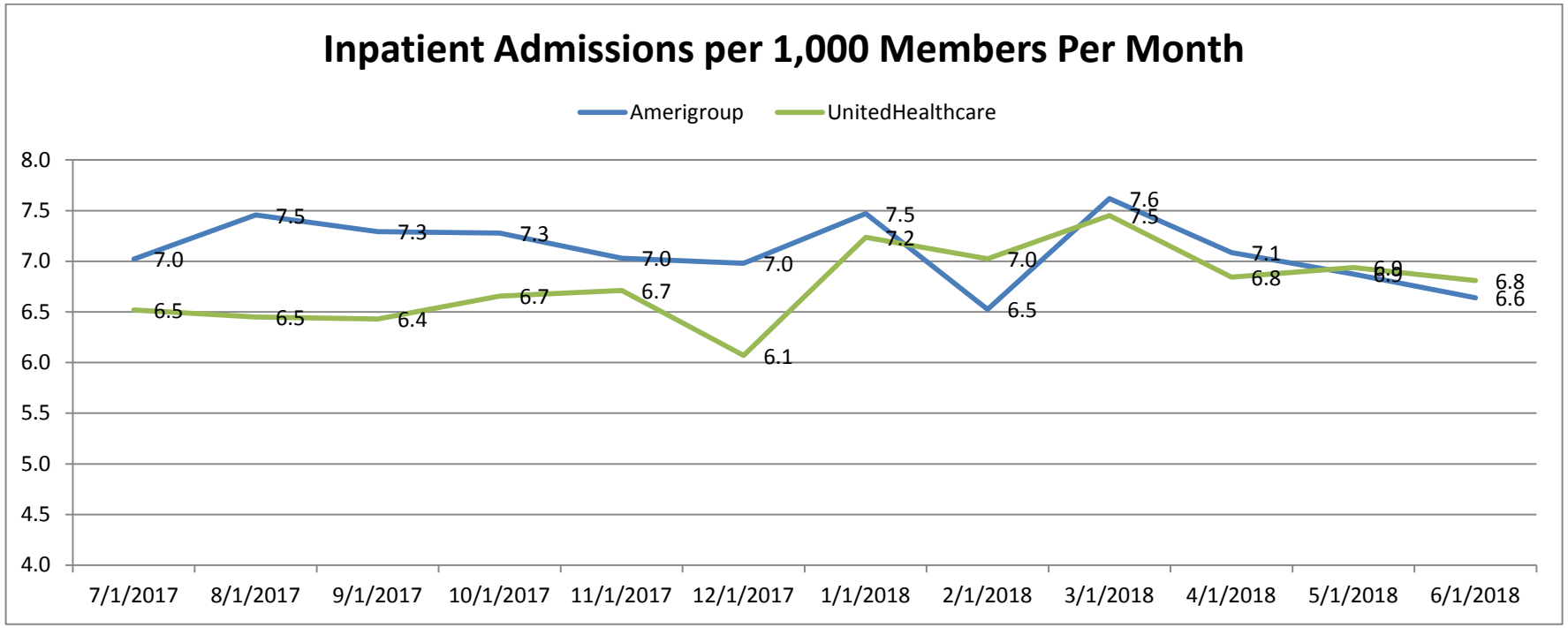
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.

Data for Q1 SFY18	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	123	10	65
Overpayments Identified During the Quarter	6	7	14
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	4	28	5
Member Concerns Referred to IME	0	16	6
Data for Q2 SFY18	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Investigations Opened During the Quarter	4	90	19
Overpayments Identified During the Quarter	0	71	5
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	1	9	2
Member Concerns Referred to IME	3	6	2
Data for Q3 SFY18	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**

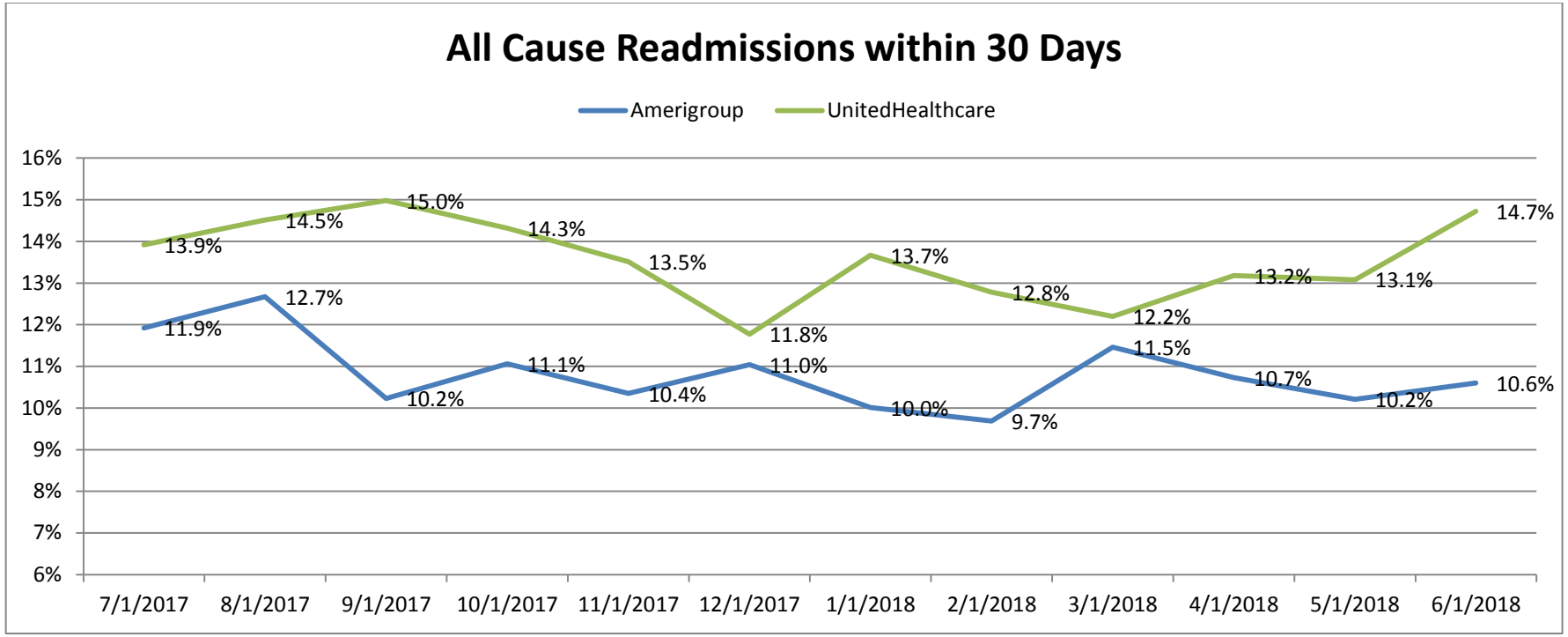
Fraud, Waste and Abuse			
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.			
Investigations Opened During the Quarter	16	16	21
Overpayments Identified During the Quarter	13	16	18
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	10	19	7
Member Concerns Referred to IME	0	0	24
Data for Q4 SFY18	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Investigations Opened During the Quarter	14	8	40
Overpayments Identified During the Quarter	7	7	36
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	9	6	9
Member Concerns Referred to IME	0	0	8

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. It is anticipated that these activities will significantly grow with ongoing claims experience to be used for analytics.

HEALTH CARE OUTCOMES



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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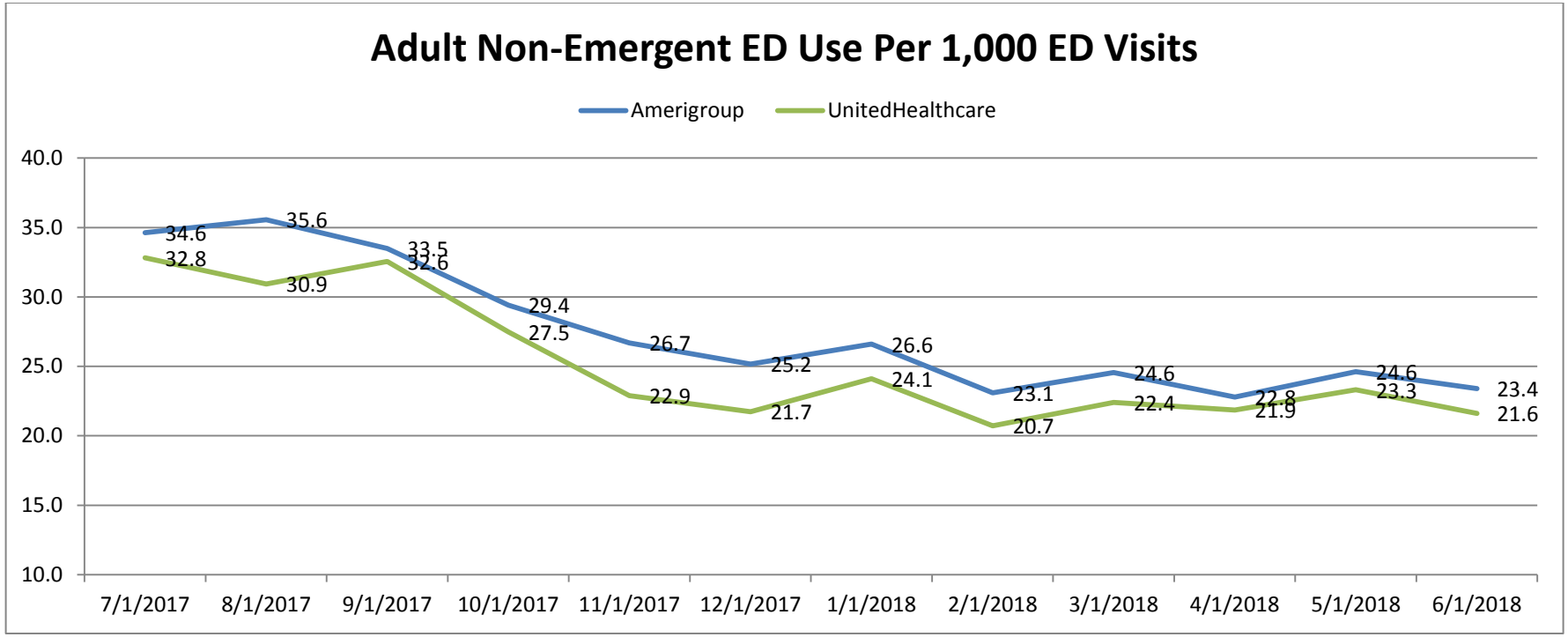

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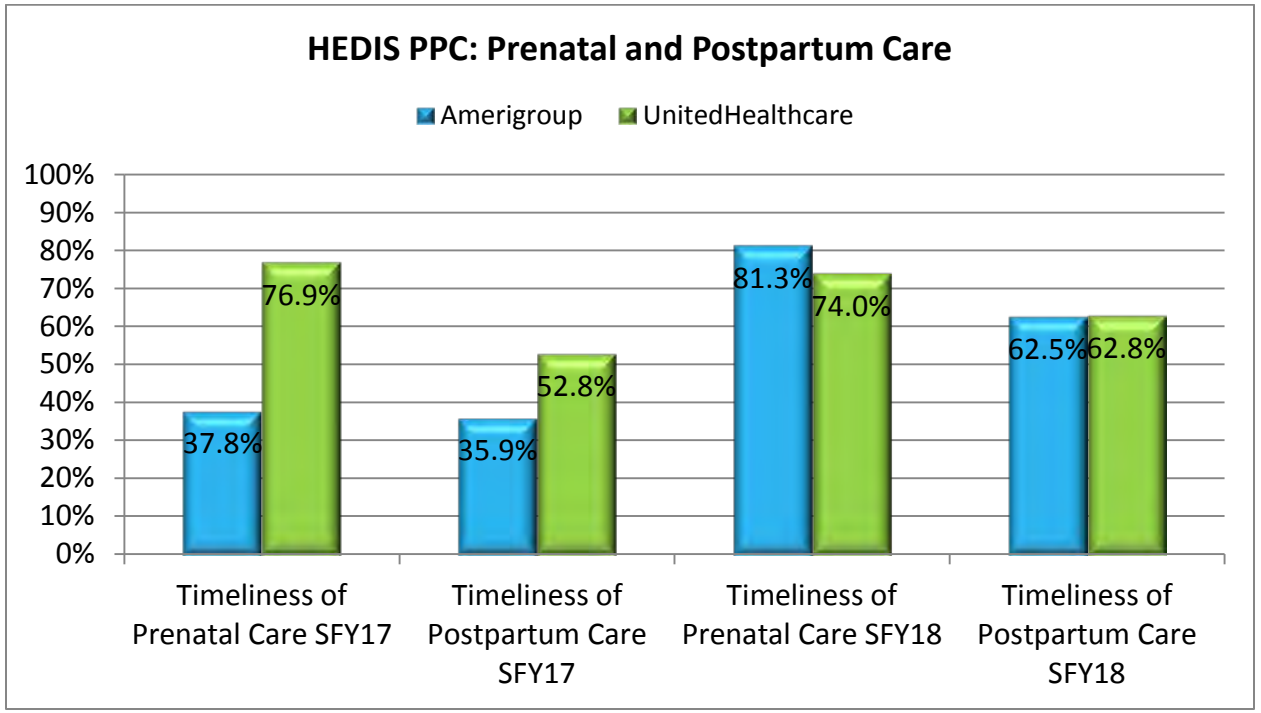
Health Effectiveness Data and Information Set (HEDIS)

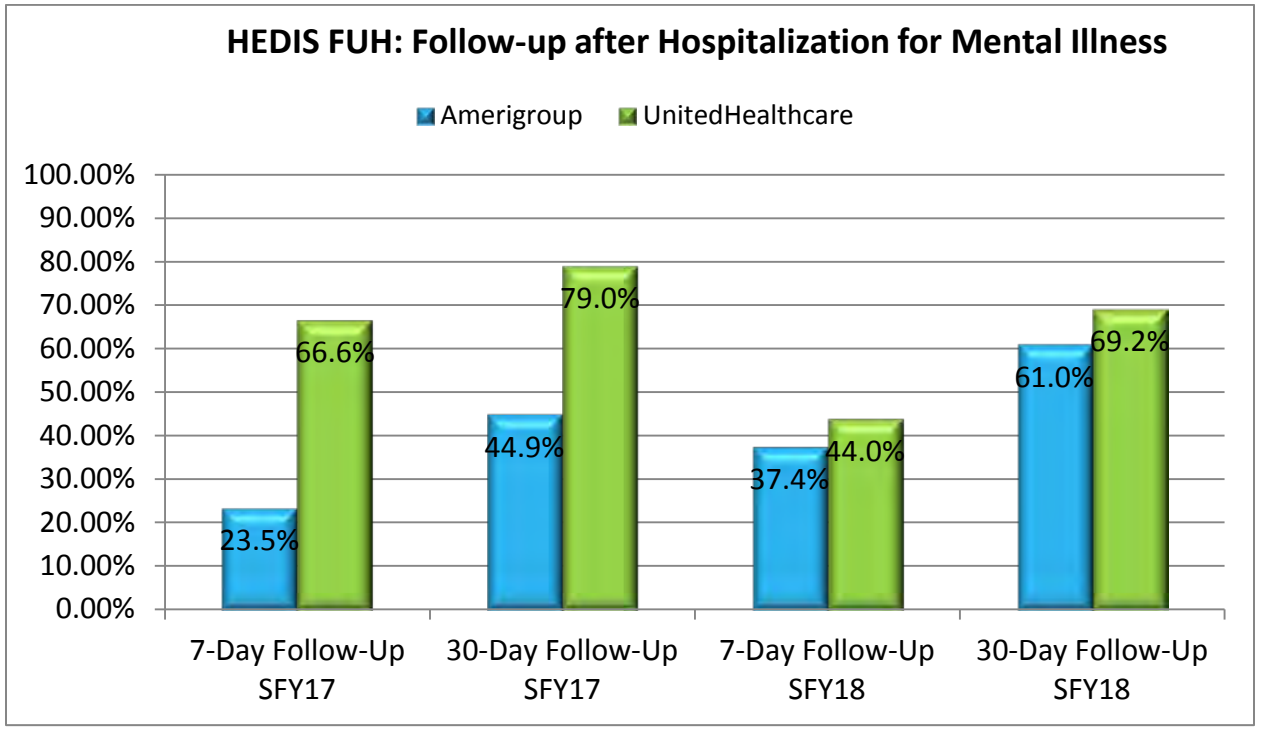
A goal of managed care is to improve health outcomes. The Health Effectiveness Data and Information Set (HEDIS) uses evidence-based measurement and specifications to benchmark health plan performance. SFY17 is based on 9 months of data (April 2016-December 2016) due to April implementation of managed care. 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 (shown in the table above) 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.

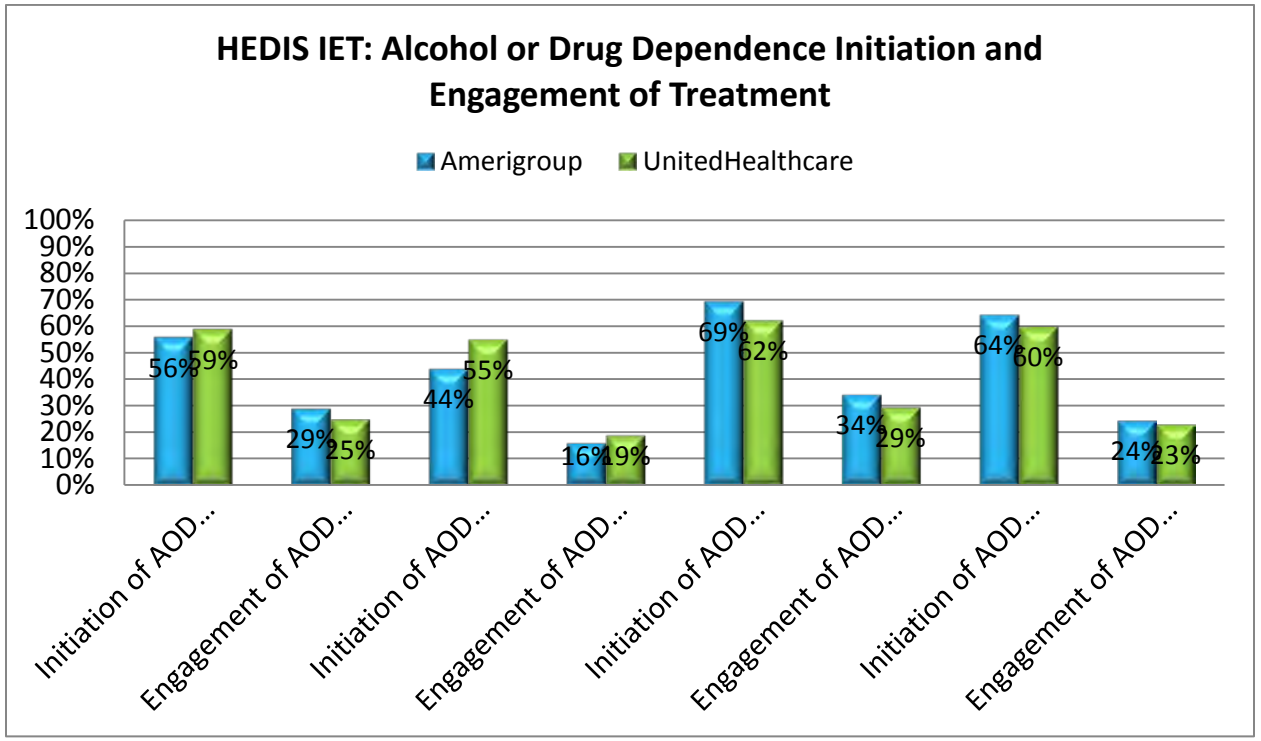
Timeliness of Prenatal Care: The percentage of deliveries that received a prenatal care visit as a member of the organization in the first trimester or within 42 days of enrollment in the organization.

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.



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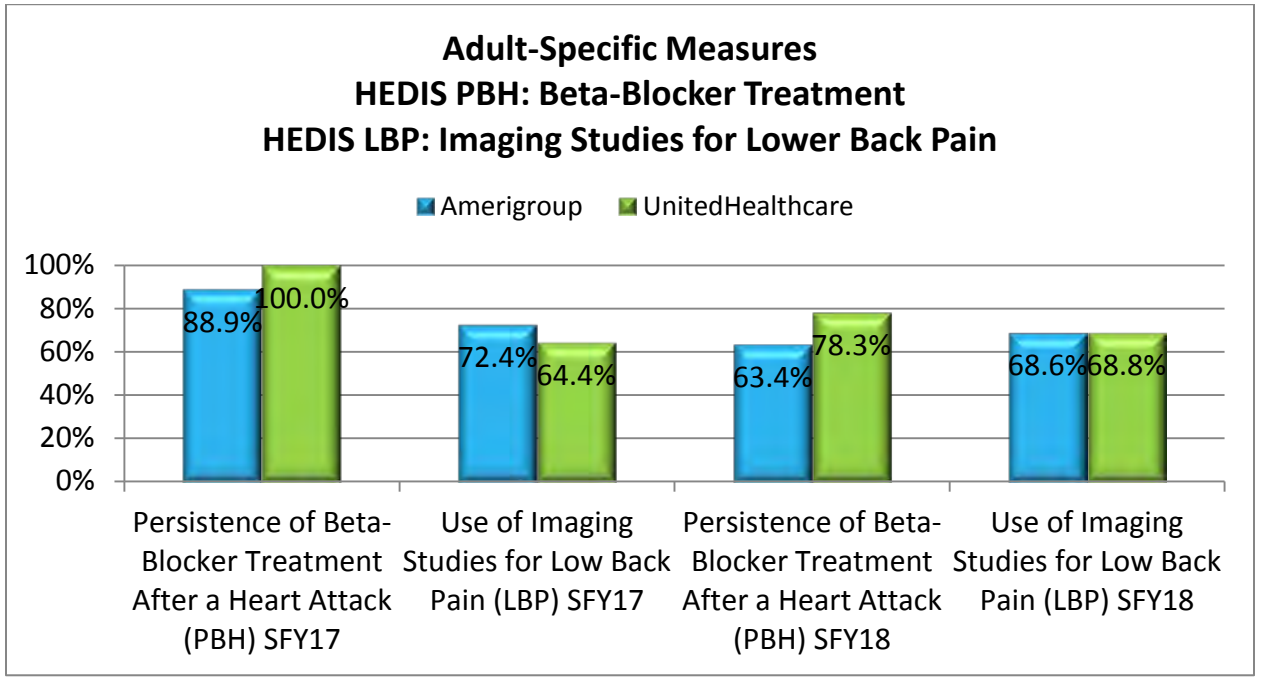
The Alcohol or Drug Dependence Initiation and Engagement of Treatment measure (shown in the table above) assesses the percentage of adolescents and adults with a new episode of alcohol or other drug (AOD) dependence who received the following care.

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.

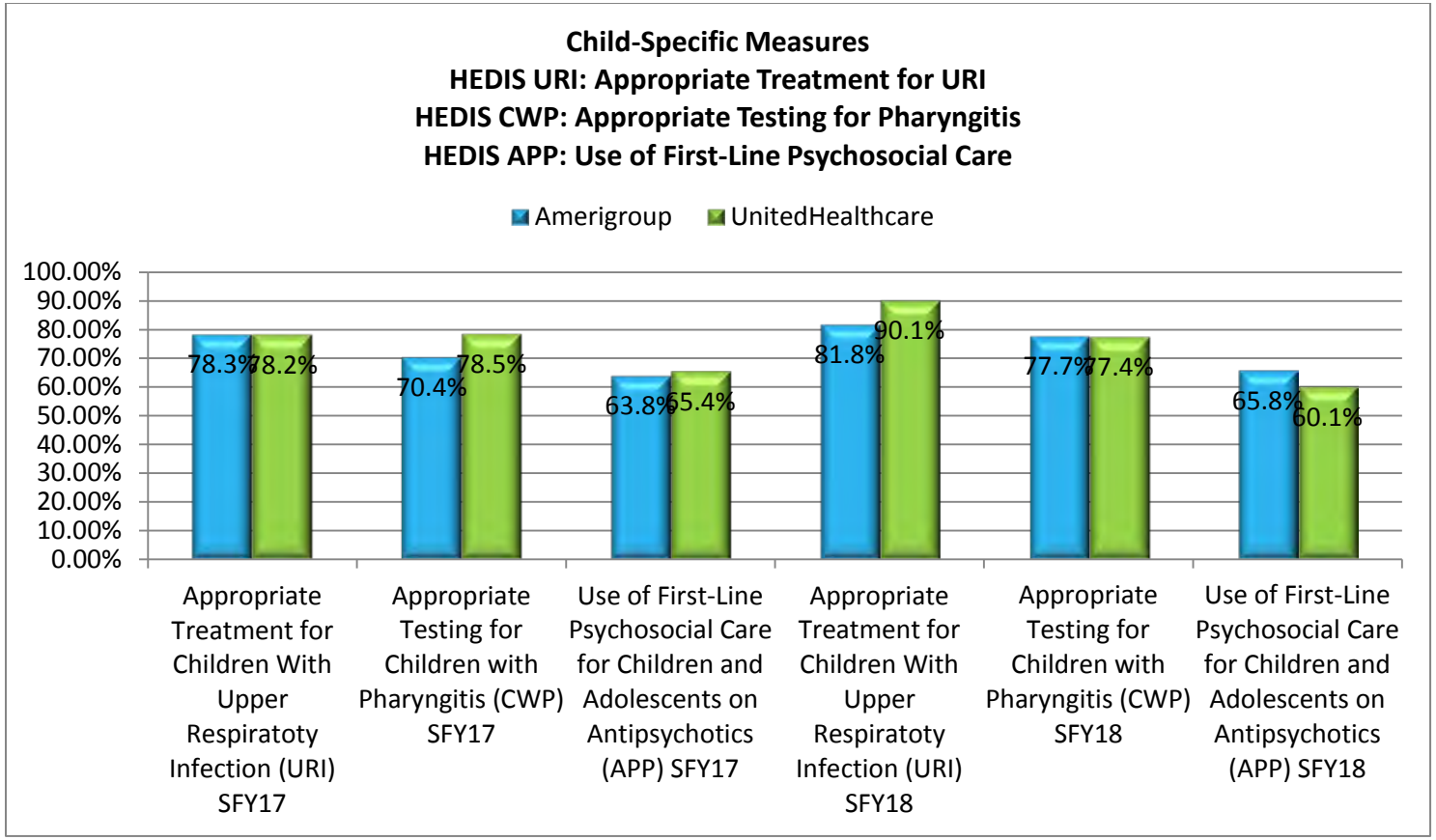


* SFY17 had a very low denominator that could have inflated rates.

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.

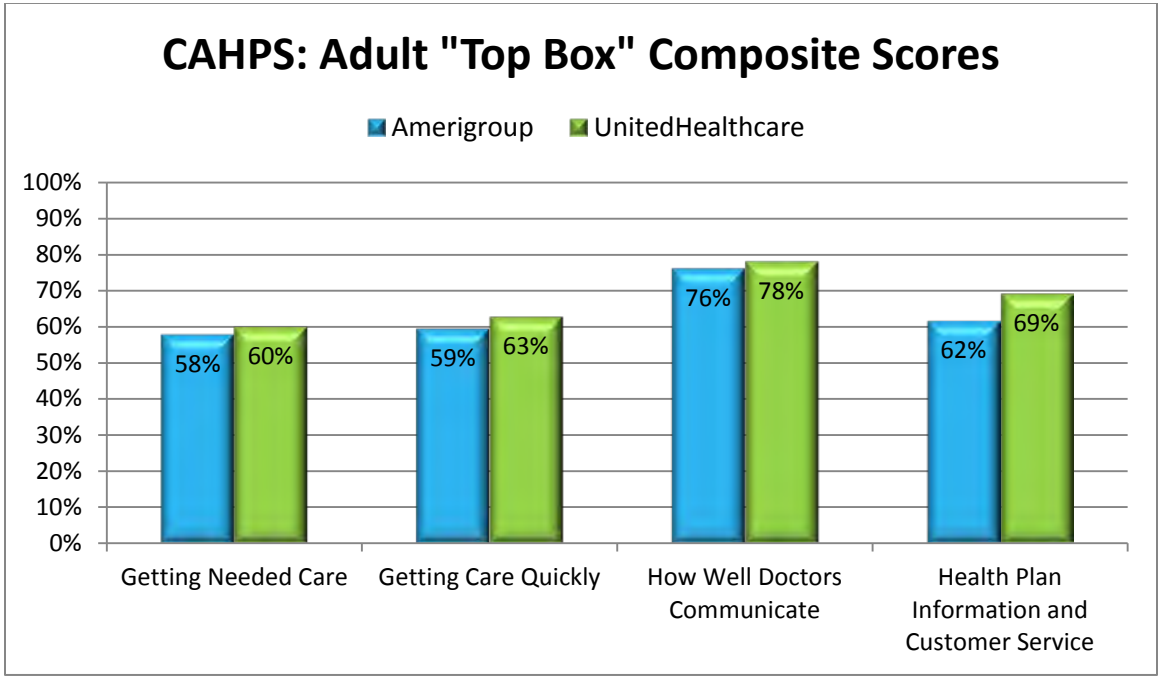
The Appropriate Testing for Children with Pharyngitis measure (shown on the previous page) assesses children 2- to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode. A higher rate represents better performance (i.e.,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

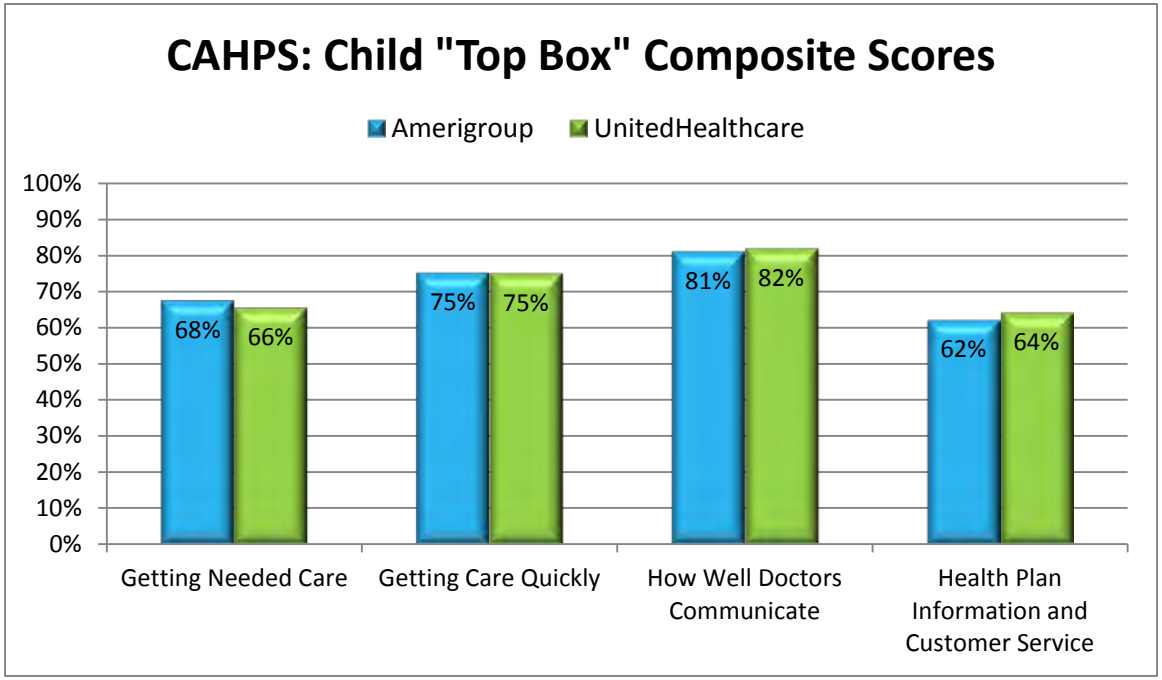
The Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics measure (shown on the previous page) assesses whether children and adolescents without an indication for antipsychotic medication use had documentation of psychosocial care as first-line treatment before being prescribed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

Out-of-State Placement*						
Data for Q1 SFY18	**Amerigroup**			**UnitedHealthcare**		
	July	**August**	**September**	**July**	**August**	**September**
Members in Out-of-State PMIC	10	11	11	3	2	5
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	14	16	16	10	10	9
Members Placed in an Out-of-State ICF/ID	4	4	4	3	3	3
Data for Q2 SFY18	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**
Members in Out-of-State PMIC	5	3	3	4	4	10
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	22	18	17	11	10	57
Members Placed in an Out-of-State ICF/ID	5	4	4	4	3	8
Data for Q3 SFY18	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**
Members in Out-of-State PMIC	4	3	7	5	4	6
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	12	12	14	40	43	45
Members Placed in an Out-of-State ICF/ID	4	4	4	6	6	7
Data for Q4 SFY18	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**
Members in Out-of-State PMIC	7	6	8	5	5	4
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	16	16	17	44	42	43
Members Placed in an Out-of-State ICF/ID	4	4	4	6	7	8

*The data provided is what has been uploaded to the Individualized Service Information System (ISIS) by income maintenance workers based on out of state case activity reports submitted. This process is important in ensuring that member eligibility is up to date and

capitation rates are appropriately paid. The IME is working through encounter data validation processes, and numbers may differ from MCO placement counts. Data is not risk adjusted for differences in MCO populations.

2018 Executive Summary Pertinent Information:

Council Deliberations on Medicaid Managed Care
(October 11, 2017, through October 10, 2018)

HF 2460 Requirements

This executive summary has been prepared to meet the requirements of HF 2460:

> *The Council on Human Services shall regularly review Medicaid Managed Care as it relates to the entity's statutory duties. The Council shall submit an executive summary of pertinent information regarding their deliberations during the prior year relating to Medicaid Managed Care to the Department of Human Services no later than November 15, annually, for inclusion in the annual report submitted as required under this section.*

EXECUTIVE COMMITTEE MEMBERS	EX-OFFICIO LEGISLATIVE MEMBERS
Mark Anderson	Representative Joel Fry
Phyllis Hansell	Representative Lisa Heddens
Alexa Heffernan	Senator Amanda Ragan
Kimberly Kudej	Senator Mark Segebart
Kim Spading	
Sam Wallace	

Safety/Accessibility	
November 8, 2017	
ISSUE	Due to the ending of the AmeriHealth contract there is a short timeline for the transition to a new MCO - creating additional stress on providers and support staff. There is a need for more parity in the assignment of the more challenging populations. *(Spading)*
FOLLOW UP/ RESOLUTION	Much of the situation was impacted due to members' choice of plan. DHS continues to have conversations with CMS regarding the distribution of members among the plans. *(Stier)*
January 10, 2018	
ISSUE	Questions were raised regarding the AmeriHealth withdrawal. *(Spading)*
FOLLOW UP/ RESOLUTION	The Department reported they have a transition plan with AmeriHealth to close out the contract and any activities. AmeriHealth will be responsible for paying claims for a year following their exit and they also have a 'members services helpline' open for six months. Department staff continue to have weekly phone conferences with AmeriHealth representatives. *(Stier/Matney)*
April 11, 2018	
ISSUE	Concern was shared over excessive 'prior authorization' requirements for the opioid addiction treatment clinic at the U of I *(Spading)*
FOLLOW UP/ RESOLUTION	More specific information is required so that DHS staff can follow up.
May 9, 2018	
ISSUE	Did case managers lose their positions when AmeriHealth exited? Could they be re-hired by the current MCOs? *(Heffernan/Kudej)*
FOLLOW UP/ RESOLUTION	Amerigroup and UnitedHealthCare MCOs had their own case management function in-house and hired additional staff. The DHS encouraged a 'warm transfer' if there was a change in a member's case manager. *(Matney)*
ISSUE	Amerigroup temporarily suspended enrollment. *(Randol)*
FOLLOW UP/ RESOLUTION	Amerigroup's capacity has been restored for all managed care members as of May 1st. The 10,000 members on the temporary fee-for-service program have been successfully transitioned to Amerigroup. The Department is working with CMS to finalize the corrective action plan. No new requirements

	were necessary in the plan as the choice has been restored. *(Randol)*

Quality	
October 11, 2017	
ISSUE	Duplication is the leading cause of denials of electronic claims submissions. *(Segebart)*
ACTION ITEM	More time is being spent educating providers on how to follow-up on a claim. *(IME)*
December 13, 2017	
ISSUE	Problems arise when one MCO carries the weight of too many in the disabled population causing an imbalance. *(Spading)*
FOLLOW UP/ RESOLUTION	Much of the situation was impacted due to members' choice of plan. DHS continues to have conversations with CMS regarding the distribution of members among the plans. *(Stier)*

Financial	
November 8, 2017	
ISSUE	How can the department find the resources to fund the 3.3% rate increase to the two remaining MCOs? *(Kudej)*
FOLLOW UP/ RESOLUTION	The Department will request a supplemental appropriation. *(Foxhoven)*
January 10, 2018	
ISSUE	What was the methodology used to initially estimate what the savings would be in moving to managed care and then what the actual savings are. *(Spading)*
FOLLOW UP/ RESOLUTION	See attached "Managed Care Savings Summary" *(Randol)* The report of the State Auditor is expected to be released shortly and, as soon as it is, we will provide copies of the report to all Council members and will adopt whatever methodology is recommended by the State Auditor (*Foxhoven*)

June 13, 2018	
ISSUE	Managed Care cost projections and cost savings analysis *(Randol)*
FOLLOW UP/ RESOLUTION	Costs of the Medicaid program overall was reviewed, with and without managed care. SFY15 was reviewed as the base expenditure period since it was the last complete year under the previous fee-for-service system. These expenditures were trended to SFY18 using a 5% annual trend rate. That trend rate is based on actual Medicaid program trends from SFY11 through SFY15. The Iowa Health and Wellness Plan expenditures were excluded from that trend calculation. Base expenditures represent December 2017 estimate of total SFY18 Medicaid program spending. The state savings were calculated by multiplying total savings on the average state match rate for the applicable years. Projected savings for SFY18 are estimated at $140.9 million. *(Randol)*
ISSUE	How does the data represent provider claims yet to be paid? *(Ragan)*
FOLLOW UP/ RESOLUTION	The DHS has been working closely with all providers who bring payment issues to the Department's attention. The SFY18 projection is from SFY17 data, as the state moves forward in SFY19 and when the DHS has actuals from SFY18, whatever amount is paid for those providers would be incorporated into the SFY18 actual amount. *(Randol)*
ISSUE	How are the MCOs saving the state money? *(Ragan)*
FOLLOW UP/ RESOLUTION	Effective care coordination reduces costs. *(Randol)*
ISSUE	Managed care is a huge investment for the State and Iowans deserve to have all the information so they can make an informed choice. *(Spading)*
FOLLOW UP/ RESOLUTION	The Department has been transparent and that it is important to know what sustainability means. The majority of Medicaid expenditures are for the most vulnerable populations in the state - long term care represents almost 50% of the residents paid for by Medicaid. *(Randol)*

Satisfaction	
October 11, 2017	
ISSUE	What are the most common value added utilized services? *(Ragan)*
FOLLOW UP/ RESOLUTION	The provision of diapers, prenatal activities and gym memberships have all been popular. *(Matney)*
ACTION ITEM	The Department offered to provide a more comprehensive listing. *(Matney)* *(A listing of the value added services is attached to this report)*
November 8, 2017	
ISSUE	Could the Council obtain the monthly Ombudsman's report on managed care? *(Hansell)*
FOLLOW UP/ RESOLUTION	A link to the Department of Aging's website was provided that contain the Ombudsman's reports.
January 10, 2018	
ISSUE	Would it be possible to standardize the different types of grievances available to managed care members? *(Spading)*
ACTION ITEM	That has proved to be very challenging in the past, but IME will re-visit the issue. *(Matney)*
April 11, 2018	
ISSUE	The recent Ombudsman's report regarding managed care refers to 225 complaints. *(Foxhoven)*
ACTION ITEM	The report refers to 225 complaints which represent a very small percentage of the 640,000 Iowans being served by managed care. *(Foxhoven)*
FOLLOW UP/ RESOLUTION	The department takes all complaints seriously and the department has requested information from the Ombudsman's Office to clarify what their numbers mean and the source. *(Foxhoven)* Jennifer Steenblock, DHS Federal Compliance Officer for IME, is working on behalf of the Department with the Ombudsman's Office to revise their report.

May 9, 2018	
ISSUE	The 'Iowa Participant Experience Survey Reporting' has recently been added to the MCO Quarterly Report. *(Matney)*
ACTION ITEM	Aggregate responses indicate that overall members are satisfied with being a part of planning their waiver services and feeling safe where they live. *(Matney)*
FOLLOW UP/ RESOLUTION	A number of the survey questions are 'flagged' if they indicate issues that need follow-up. *(Matney)*
July 11, 2018	
ISSUE	What is being done to ensure that Iowa Total Care will adhere to contracted terms? *(Kudej)*
ACTION ITEM	DHS has been very specific on requirements that are negotiated in the contract and would ensure that terms are adhered to. *(Randol)*
FOLLOW UP/ RESOLUTION	Specific algorithms will be used in the considerations and members have a 90-day period to choose membership. *(Randol)*
ISSUE	Concerns were expressed regarding families experiencing constant changes and disruptions regarding their Medicaid coverage. *(Heddens)*
ACTION ITEM	A communication strategy relative to onboarding the third MCO will be in place to have discussions with family members, groups and associations to walk them through the process and timeline. 'Over-communicating' will be important. *(Randol)*

Executive Committee
Summary of Meeting Minutes
July 11, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben – **present**	Deb Johnson -
Natalie Ginty – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson -
Kate Gainer – **present**	Sean Bagniewski -
Lori Allen – **present**	Amy McCoy -
Richard Crouch – **present**	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic – **present**	Lisa Cook - **present**

Introduction
David called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum met.

Approval of the Executive Committee Meeting Minutes of June 15, 2017
Minutes of the Executive Committee meeting on June 15, 2017 was approved.

Communication Standardization Update
Matt Highland provided an update on the initiatives that have been under development since his last update in May. He reviewed the development of standardized model language and definitions for all member handbooks, formularies for IA Health Link, digital and print provider directories, and other informational resources.

Electronic Visit Verification (EVV)
Liz Matney gave an overview and timeline of EVV and stated that size and complexity made it necessary to reset to a 2018 rollout to ensure federal compliance and that providers are prepared to engage and delivery of services to members. She explained that the 21st Century Cures Act of December 2016 required development of EVV systems for states to receive full federal match percentage on personal care and health home. Liz stated that there was an active survey which closes August 15, 2017 for providers that identified cost centers and assist in the collection of other relevant data involving EVV infrastructure and administration. Liz stated that Phase 1 was to identify existing and installed technologies that could be leveraged to assess cost. Liz confirmed that this initiative would take into account CDAC and the Home- and Community-Based Services (HCBS) waiver program but not the whole of HCBS and that the MCOs' contracts were being revised to reflect this

more narrow approach. Liz stated that Phase 2 (Fall 2017) would involve stakeholder workgroup engagement and Phase 3 was to begin in early 2018 and involve public comments on a larger group of members and providers. Liz confirmed that following the initial engagement period of the project, the rollout period will begin in 2018. Key components of the rollout would be informational materials, an EVV resource center for members and providers, statewide provider training sessions, a dedicated EVV website, FAQs, CSR scripting, and other relevant communication materials.

Action Item:

- Research national benchmark on Program Integrity fraud rate data with home health providers
- Add as a standing item in the MAAC action items document - updates on the EVV stakeholder workgroup meetings

Medicaid Director's Update

(Legislative Update, Provider Re-Enrollment and Action Items)

Mikki reviewed the outstanding items in the action items document. Liz confirmed the quarterly data reports would be available in time for the August MAAC meeting.

Action Items:

- Provide data on grievance and appeals – at the State Fair Hearing, how many cases are denied, how many are ruled in favor of an MCO, how many never go through the entire appeals process. How many are resolved at the MCO level and never go to the level of the State Fair Hearing.
- Provide data on aggregate cost per member for ICF/ID broken down by community-based ICF/ID providers, state resource centers, and out-of-state placements.

MAAC Recommendations: Mikki stated that a response to recommendations would be available shortly and there would likely be an August update via a written response from the DHS Director.

Provider Re-enrollment; Mikki stated that additional information would be presented at the August Executive Committee meeting.

Legislative Update: Mikki outlined the legislative initiatives that had to be in place by July 1, 2017 and the cost containment measures across all three MCOs. She provided additional updates regarding the IME Claims Benefit Group, Retroactive Eligibility, the new Dental Wellness program, and the State Family Planning Program (FPP).

Value-Based Purchasing (VBP): Mikki provided an overview of Value-Based Purchasing (VBP) and the use of the Value Index Score (VIS).

Retroactive Eligibility: Cindy posed a question regarding the scope of the application of Retroactive Eligibility. This will be a follow up at the next MAAC Executive Committee meeting with the staff working on this initiative.

Open Discussion

Marsha Fisher asked about the process involved in the transfer of information between MCOs when a member changes MCOs. Liz clarified that transfer of data between MCOs is only processed through the state. Marsha cited a specific example of a case management situation where member data was not transferred to the new MCO. Lori Allen asked for clarification on what standards were in place to ensure that data was transferred in a timely manner from one MCO to another.

Future Agenda Items:

- External Quality Review would be a potential agenda item for the August meeting.

Adjourn

4:21 P.M.

July 13, 2017

MAAC Full Council Meeting
Summary of Meeting Minutes
August 8, 2017

Introduction ***(See the roll call document to review the Full Council attendance.)***
Gerd called the meeting to order and performed the roll call and declared that there was quorum.

Approval of Minutes from previous meetings
Gerd asked the Council if there were any changes to the minutes of the Full Council meetings of February 14, 2017, or May 9, 2017, and the minutes stand approved.

Introduction and Remarks from Director Foxhoven
Introduction was postponed.

Communications Standardization Update
Matt Highland provided an update on the initiatives that have been under development since his last update in May. He reviewed the development of standardized model language and definitions for all member handbooks, formularies for IA Health Link, digital and print provider directories, and other informational resources.

Quarterly Data Report Review: Q3 2017
Lisa Cook presented the Quarterly Data Report. Updates included Care Coordination, Adult HRA, Grievances and Appeals, Service Plans, Level of Care, Medical Claims Payment, Prior Authorizations, Value-Added Services, and Level of Care. MCO Account Managers are meeting daily with the MCOs to ensure ongoing contract compliance and handle necessary corrective action. Mikki and Liz are also meeting with the MCOs on a monthly basis to discuss and monitor corrective action plans.

Action Item:
- Managed care division to provide a review of managed care quality performance measures – HEDIS and HSAG

Update from the Medicaid Director
(Legislative Update, Electronic Visit Verification (EVV) including Stakeholder Workgroup Meetings, Family Planning Program (FPP), Dental Wellness Plan (DWP), and Action Items)
Mikki outlined the legislative initiatives that were implemented on July 1, 2017, and cost containment measures across all three MCOs. She stated that the IME continued to monitor the Family Planning Program (FPP) and Dental Wellness Plan (DWP) following program changes on July 1, 2017. It was reported in the July 11, 2017 Executive Committee meeting that there was an Electronic Visit Verification (EVV) survey available for impacted provider populations and from that data, internal and stakeholder workgroups would be formed to make recommendations to the Director for implementation of the program. Comments and questions were gathered regarding retroactive eligibility coverage and this information was included in the 1115 Waiver that was submitted to CMS. Mikki stated the outstanding Action Items would be discussed at the August 24, 2017, Executive Committee meeting.

August 10, 2017

Director Response to the MAAC Recommendations

Speaking on behalf of Director Foxhoven, Mikki provided background on the process involved in the development of the recommendations and read each of the recommendations within Director Foxhoven's response letter.

Updates from the MCOs

a. UnitedHealthcare Plan of the River Valley, Inc.

Paige Petit outlined various upcoming UnitedHealthcare's scheduled events such as a UnitedHealthcare Provider Information Expo on October 12, 2017, which was intended for providers that served all UnitedHealthcare business units; including Medicaid. UnitedHealthcare's Stakeholder Advisory Committee was to meet in the coming months and UnitedHealthcare was to have a booth at the Iowa State Fair. It was asked if UHC considers social determinants of health in its approach to providing services to members. Paige stated that UHC makes every effort to ensure that case managers work with other team members in determining and providing for the overall needs of the member.

b. AmeriHealth Caritas Iowa, Inc.

Tracy Smith stated that AmeriHealth's contract with Mercy Hospitals had been renegotiated. She stated that AmeriHealth had 21 provider representatives across the state that provide education and training for providers and had performed 1,700 provider site-visits since January 1, 2017. In the first year following implementation, AmeriHealth's Member Services call center had fielded approximately 170,000 phone calls and their Provider Services call center had fielded approximately 227,000 phone calls. Tracy gave an update on AmeriHealth's Stakeholder Advisory Committee, the change to an in-house case management model, care coordination, the HPV vaccination program, and the "Bright Start" program. She stated that AmeriHealth was working with the IME on their Value-Based Purchasing program and would continue to report on progress in this regard.

c. Amerigroup Iowa, Inc.

Natalie Kerber stated that Amerigroup continued to add members and providers to their advisory committee, and that their Medical Advisory Committee would be meeting mid-August. Various subjects to be addressed at the Medical Advisory Committee included population management, member-focused intervention, 2017 satisfaction survey, and in- and out-patient services. She highlighted the funding of grants with the Michael Phelps program of Iowa which fostered active and healthy lifestyles and programs for health education. Natalie was asked to address the data within the quarterly report that indicated a higher rate of grievances for Amerigroup. She stated that they were formulating action plans to address this topic for improvement in the future.

Quarterly Recommendations Discussion

Public Comment Listening Sessions Update – Sioux City

Lindsay stated that the June 13, 2017, Public Comment meeting focused on topics such as Durable Medical Equipment (DME), reimbursement, billing and claims, Prior Authorizations, Non-Emergent Medical Transportation (NEMT), and case management. The next meeting would be in Bettendorf, IA on August 29, 2017.

Review of SFY Q3 2017 Memo

Gerd presented the timeline document included in the meeting materials which outlined due dates for drafting and submitting IA Health Link recommendations. He also reviewed the April 21, 2017, letter that was submitted to Director Palmer.

Discussion of recommendations for SFY Q4 2017 for the August 24 Executive Committee meeting and other budget, policy and administrative recommendations for the Executive Committee's review and response

1. Review the process involving transfer of member information from one MCO to another MCO when a member chooses to change their MCO.
2. Senator Bolkcom requested additional information on the status of rate negotiations and the new rates going into the new fiscal year.

3. It was suggested to keep the prior authorization process and the issue of secondary payment on the Executive Committee discussion agenda.
4. It was suggested to make advocacy for people receiving services from MCOs an Executive Committee agenda item.
5. Have future discussion on the role of care coordinators and case managers responsible for waivers. Which set of activities is making the greatest impact on improving outcomes?
6. Hold future discussions to determine a more proactive role in strengthening the healthcare safety net.
7. Clarify MCO's as a secondary payer.
8. Executive Committee should consider asking the LTC Ombudsman's Office for recommendations.
9. Consider a discussion relating to the federal discussions on block granting Medicaid dollars, and how the state is positioned relative to this possible outcome.

Open Comment

(Open comment opportunity for Members)

Anthony Carroll commented about the "How to be Your Own Best Advocate" document from the Long Term Care Ombudsman's Office and suggested to find as many ways possible to promote the availability of the document in both print and online.

Adjourn

3:55 P.M.

August 10, 2017

Executive Committee
Summary of Meeting Minutes
August 24, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben – **present**	Deb Johnson -
Natalie Ginty – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo (Brandon) – **present**	Lindsay Paulson - **present**
Kate Gainer –	Sean Bagniewski - **present**
Lori Allen –	Amy McCoy -
Richard Crouch – **present**	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic – **present**	

Introduction
David called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum met.

Approval of the Executive Committee Meeting Minutes of July 11, 2017
Minutes of the Executive Committee meeting on July 11, 2017 was approved.

Discussions on Recommendations
Dave suggested that there be fewer recommendations with a more clearly articulated rationale compared to the last set of recommendations. The Executive Committee agreed that previous recommendations that had been declined by Director Foxhoven were to be further reviewed by the recommendations subcommittee for future recommendation consideration. The Full Council minutes from the August 8, 2017, meeting was reviewed and the nine Council recommendations discussed. The MAAC would review the LTSS Ombudsman's reports and work with the Long Term Care Ombudsman's Office for potential recommendations. The subcommittee will consist of Dennis Tibben, Natalie Ginty, Julie Fugenschuh, Jodi Tomlonovic, Gerd Clabaugh, and David Hudson.

Subcommittee Topics for Recommendations
1. Review declined recommendations from Quarter 2 SFY2017 and Quarter 3 SFY2017
2. Review Durable Medical Equipment issues
3. Review input from the LTC Ombudsman's Office reports to identify persistent issues

LTC Ombudsman "How to be Your Own Best Advocate"
Kelli reviewed the "How to Be Your Own Best Advocate" guidebook. She stated that the goal of the Document is to inform managed care members how to file appeals and grievance forms and better understand CDAC and Case Management processes. She stated that the document is available

electronically through the State LTCO Office website.

Provider Re-Enrollment Update
Sean confirmed that of the 38,029 provider tax IDs, 9,868 have not yet re-enrolled. Of the 9,868 providers that have not re-enrolled, 5,600 have not billed the IME or the MCOs this year. He stated that of the 9,868 providers, there are 4,266 who have billed the IME or MCOs this year. Those who have not billed the IME or MCOs this year will be sent a letter informing them that they must re-enroll with the IME by September 30, 2017, or will be disenrolled with the IME and MCOs. In addition to the written document, they will receive a phone call from either the IME or MCOs. Providers who have billed the IME or MCOs this year will receive notice via email that they must re-enroll with the IME by October 31, 2017.

Medicaid Director's Update
(Including review of Action Items document)
Mikki reviewed the outstanding items in the Action Items document. Liz Matney addressed the Action Items below. Further information and data will be provided at the September 12, 2017, Executive Committee meeting.

Top Five Reasons for Grievances and Appeals to Identify Systemic Trends:

Grievances
Liz stated the top three grievances are concerning transportation, provider issues, and eligibility. There was less than 1/10 of 1% of members filing grievances given each member contacted their MCO once. All calls to the IME regarding concerns that could be classified as grievances continue to be tracked and addressed by the IME and the MCOs.

Appeals
Liz stated that the top reasons for appeals are issues with prescriptions and service authorizations. There had been 13 member appeals regarding prescriptions and approximately 79 appeals regarding service authorizations that were escalated to the state fair hearing level since implementation of the program. The most common reason for appeal denials at the state fair hearing level was that the member had not gone through their MCO's appeals process prior to filing an appeal with Iowa Medicaid.

Identifying Trends Involving Payment Issues: Liz confirmed the number of reported provider payment issues had decreased following implementation. The most prevalent payment issues are due to the process of how the rate files are loaded into the system, discrepancies in rate files due to incorrect provider type classification, changes in member eligibility, and delays in MCO credentialing. The top reason for provider calls to MCO call centers was verification of claim status.

Average Aggregate Cost Per Member Per Day for Special Needs Members in ICF/ID: Liz confirmed that the average cost per member per day for members residing in community-based ICF/IDs in the state is approximately $325. The average daily cost for members in out-of-state ICF/IDs is approximately $336 per member. The average daily cost is approximately $869 per member for those residing in state resource centers.

Out-of-State Placement for Members in Facilities: Liz stated the Department attempts to place members in the state, close to their supports and family members, and require exhaustion of in-state facility placement options prior to considering out-of-state placement. Liz confirmed there are currently 11 members residing in bordering states. There are currently 18 members placed out-of-state due to their medical conditions; with a large portion being children residing in Psychiatric Medical Institutes for Children (PMIC) facilities. Liz stated that there were currently 112 members placed in an out-of-state facility due to reasons such as the member having severe aggression or failure at other in-state facilities.

Open Discussion
David solicited comments. No comments were made.

Adjourn
4:33 P.M.

August 28, 2017

Iowa Department of Human Services

Medical Assistance Advisory Council
MAAC

Mikki Stier, Iowa Medicaid Director

Executive Committee
Summary of Meeting Minutes
September 12, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben –	Deb Johnson -
Natalie Ginty – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson -
Kate Gainer –	Sean Bagniewski -
Lori Allen – **present**	Amy McCoy -
Richard Crouch – **present**	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic –	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum met.

Approval of the Executive Committee Meeting Minutes of August 24, 2017
Minutes of the Executive Committee meeting on August 24, 2017 was approved.

Discussion on Recommendations
Gerd reviewed the September 5, 2017, Recommendations Subcommittee meeting minutes document. Subcommittee members Cindy Baddeloo, Shelly Chandler, Dennis Tibben, and Gerd Clabaugh were to meet with Long Term Care Ombudsman's Office representative, Kelly Todd, on September 20, 2017, to discuss ongoing LTC issues. The Recommendations Subcommittee was to meet in the next two weeks.

Medicaid Director's Update
Mikki reviewed the outstanding items in the Action Items document.
Liz Matney addressed the Items below.

Electronic Visit Verification (EVV):
Liz stated that the stakeholder workgroup had their first meeting on September 12, 2017. The meeting included discussion of results from the provider and stakeholder survey, updates on the status of EVV implementation, as well as an opportunity for the workgroup to questions. Liz confirmed that following the initial engagement period of the project, the rollout period would begin 2018.

September 21, 2017

Managed care quality performance measures:
Liz confirmed that the MCOs submit annual quality clinical information that is associated with the Healthcare Effectiveness Data and Information Set (HEDIS) measures as well as consumer satisfaction scores to the IME. The state's external review vendor, Health Services Advisory Group (HSAG), does a number of different functions for the IME such as validating MCO performance measures and MCO compliance reviews. The HSAG annual data is for the MCOs' accreditation with the National Committee for Quality Assurance (NCQA) and that data goes through an internal auditing and validation process prior to be provided to the IME.

Discussion on MCO to MCO transfer of information:
Liz discussed the IA Health Link annual enrollment period and the disenrollment process for reasons of good cause. Members are not disenrolled the day of their request and may be enrolled in their new MCO one to two months following their request based on system cut-off dates. The IME transfers encounter data such as claims paid, Prior Authorizations, service plan data for Home- and Community-Based Services (HCBS) members; Level of Care assessments are not included in data transfers. The IME and the MCOs utilize a portal for LOC information.

October 10, 2017 Agenda Items:
- Secondary Payer
- Review of managed care quality performance measures – HEDIS and HSAG
- SFY17 Q4 and SFY18 Q1 Recommendations

Future Agenda Items:
- MCO to MCO transfer of information workflows

Open Discussion
- Dave Hudson expressed his concern regarding Consumer Directed Attendant Care (CDAC) re-enrollment, stating that CDAC providers may have missed the June 30, 2017, deadline due to unclear information provided in an Informational Letter about re-enrollment.
- A letter from Kris Richey regarding delays in the re-authorization of services for individuals receiving Long Term Services and Supports (LTSS) services from Integrated Health Homes (IHHs) was to be shared with the Executive Committee.
- Natalie Ginty requested the status of the Department's waiver application for the Health and Wellness populations and the state plan amendment for retroactive enrollment.
- Cindy Baddeloo and Shelly Chandler requested the MAAC once again receive regular information and updates from the Department regarding changes to rules as they had prior to managed care.

Future Agenda Items:
- Update from Liz Matney regarding the Iowa Medicaid retroactive enrollment waiver application at the October 10, 2017 Executive Committee meeting.
- Compare Fee-for-Service (FFS) expenditures for Medicaid members prior to implementation to managed care expenditures following implementation:
    - HCBS Waiver population – combined total for all 7 waivers
    - Habilitation services – combined total for all habilitation services
    - Inpatient hospital stays – combined total for inpatient hospital stays; excluding behavioral health inpatient hospital stays
    - Behavioral health inpatient hospital stays – combined total for inpatient hospital stays for behavioral health reasons
    - Outpatient hospital stays – combined total for outpatient hospital stays; excluding behavioral health outpatient hospital stays
    - Behavioral health outpatient hospital stays – combined total for outpatient hospital stays for behavioral health reasons
    - Home health – combined total for home health services

Adjourn
4:30 P.M.

September 21, 2017

Executive Committee
Summary of Meeting Minutes
January 4, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski - **present**
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman -
Julie Fugenschuh – **present**	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of December 19, 2017
Minutes of the Executive Committee meeting of December 19, 2017 was approved.

Long Term Services and Supports Presentation (LTSS)
Deb Johnson handed out copies of the document, "Medicaid Home-and Community-Based Services (HCBS) Program Comparison Chart" which outlines the various services under LTSS.

She stated that LTSS consists of Home- and Community-Based Services (HCBS) Waivers and Institutional Care:

Home- and Community-Based Services (HCBS) Waivers
Deb stated that HCBS is part of the Social Security Act and is referred to as the 1915c HCBS Waivers. There are seven waivers; Health and Disability; AIDS/HIV, Elderly, Intellectual Disability, Brain Injury, Physical Disability, and Children's Mental Health. HCBS Waivers provide service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. She stated that waiver services are meant to complement or supplement the state plan or other resources that are available. Waiver participants have access to the full state plan but that they still need to meet the institutional Level of Care and services have to be cost-effective or less expensive in aggregate than what it would cost in an institution.

Institutional Care: Nursing Facilities (NFs), Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs)
Deb stated that members receiving these services need to meet the same Level of Care and income guidelines as in waiver programs. There are monthly maximums or caps on the financial amount for services in each program and this is important in determining the aggregate for cost neutrality. She added that cost-effectiveness of services is determined on an individual basis and is based on a variety of variables. Deb provided clarification on the distinction and relationships between Level of Care, service plan, and care coordination.

Quarterly Report Data Presentation
The Q1 SFY18 report was made available in the materials packet. Liz stated that all members that receive community services or are in a waiver program have an assigned care coordinator or case manager but not all members in facilities have assigned care coordinators or case managers. Liz reviewed HCBS-specific data and case management ratios of MCOs for members receiving community-based services, and discussed surveys. Liz stated she would provide additional information regarding annual state savings at a future meeting.

Care Coordination and Conflict-Free Case Management

1. **UnitedHealthcare**
   Kellyann Light-McCoroary, stated that UnitedHealthcare's Case Managers (CMs) focus on person-centered planning while ensuring compliance with state and federal regulations. UnitedHealthcare CMs are nurses as well as social workers and they have extensive training in LTSS. Upon hiring, CMs are put through training in LTSS and each CM hired is paired with a mentor. She stated that UnitedHealthcare follows conflict of interest requirements as outlined in the Code of Federal Regulations. She stated that all states are required to separate case management person-centered service planning development from service delivery. She stated that for assessments, UnitedHealthcare utilizes inter RAI and the SIS as required by the State. Assessors are certified and carry out case reviews, ride-alongs, and peer reviews.

2. **Amerigroup**
   Kelly Espeland stated that Amerigroup has assessments teams that do assessments with the members and are facilitators of those assessments. In regards to the SIS assessment, the CM is a facilitator and does not determine the score or the member's needs as this is carried out by the team. Assessors are trained by AAIDE and assesors are reviewed and certified annually by AAIDE. The information then goes to the CM, the team reviews the information, and the CM provides the service coordination to develop the member's person-center plan based on identified needs. She stated that the UM team looks at the assessment and care plan that has been developed, and a determination is then made regarding services. She stated that oversight within their organization consists of: member appeals rights available if they disagree with a decision; contractual requirements and guidelines, and; External Quality Review (EQR) audits.

   Member advocacy during appeals hearings was discussed. It was clarified that the CM facilitates the service planning meeting and the member selects their care team. Kim Foltz stated that conflict-free case management means that the provider cannot be the assessor, care planner, and the delivery/service provider. It was stated that the contract between the State and the MCOs is a risk-based arrangement.

Medicaid Director's Update
The Action Items document was made available in the materials packet. Update postponed to February 27, 2018, Executive Committee meeting.

Mobile Applications
Matt Highland to discuss at February 27, 2018, Executive Committee meeting.

Open Discussion
There was no open discussion due to lack of time.

Adjourn
4:45 P.M.

January 5, 2017

Executive Committee
Summary of Meeting Minutes
October 10, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben – **present**	Deb Johnson -
Natalie Ginty –	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland -
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Kate Gainer (Shannon Rudolph) – **present**	Sean Bagniewski -
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman - **present**
Julie Fugenschuh – **present**	Lisa Cook - **present**
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum met.

Approval of the Executive Committee Meeting Minutes of September 12, 2017
Minutes of the Executive Committee meeting on September 12, 2017 was approved.

Discussion and Actions on Recommendations
Gerd reviewed the draft Q4 SFY17 letter of recommendations and the Executive Committee voted and approved the letter of recommendations with the acknowledged revisions.

Action Items:

- MCOs to present on the service planning process between the member's Interdisciplinary Team (IDT) and Utilization Management (UM) team to ensure conflict-free case management.
- The Department and MCOs to present on secret shopper methodologies and metrics.

Medicaid Director's Update
Mikki reviewed all outstanding items in the Action Items document. Mikki reviewed recommended cost containment measures that were presented to the DHS Council. Liz Matney addressed the Items below.

a.) **National benchmark on Program Integrity fraud rate data with home health providers**
Liz provided an overview of the top provider types with the highest instances of fraud, waste, and abuse, conviction rates, and recouped fund amounts as reported by the Medicaid Fraud

Control Units (MFCU). In SFY17, the top five provider types with the highest amount of fraud, waste, and abuse allegations at the IME were personal care providers, hospitals, mental health providers, and home health agencies. Nationally, in SFY16, the provider type with the highest number of convictions for fraud, waste, and abuse were personal cares providers. Nationally, in SFY16, the top 4 provider types with the highest amount of recoupments were Home Health, personal cares, transportation, and Durable Medical Equipment (DME). Iowa's fraud, waste and abuse is in align with national standards.

b.) **MCOs as secondary payer: Coordination between Medicare and Medicaid for dual eligible members in the waiver programs**
Liz stated that most waiver services are not covered by Medicare and therefore billed directly to Medicaid. For covered Medicare services, there is a crossover and all MCOs have agreements with Medicare where the crossover calculation occurs automatically. In the instance of a crossover claim, the provider bills Medicare first and then Medicare sends the data to the MCOs to remit any balance that they may be responsible for. Liz explained the Medicare Advantage program and stated that providers must submit their initial claims to the Medicare Advantage plan then when the provider receives the remit back, the provider submits the claim and the EOB to the MCO for any additional charges the MCO is responsible.

c.) **Managed Care Division review of managed care quality performance measures – Healthcare Effectiveness Data and Information Set (HEDIS) and Health Services Advisory Group (HSAG)**
Lisa Cook handed out and reviewed a document with HEDIS data for April 1, 2016 through December 31, 2016 with measures such as the percent of expected prenatal visits completed, timeliness of prenatal and postpartum care, and follow-up after hospitalization for mental illness.

d.) **Retroactive Eligibility Waiver Update**
Mikki stated there were no updates from CMS at this time and the Executive Committee will be informed when information became available.

e.) **Review of Quarterly Report (Q4 SFY17)**
Liz gave a high level overview of the report and Mikki outlined the oversight committees that will be reviewing the report.

Action Items:
- Managed Care Division to provide first 12 months of HEDIS data when it becomes available and provide a list of what data is being tracked in the HEDIS measures.

Future Agenda Item:
- Liz to Review the Quarterly Report (Q4 SFY17) at the November 7, 2017 Full Council meeting and November 16, 2017, Executive Committee meeting.

Next Steps: November MAAC Full Council Agenda
Future Agenda Items:
- Review of the Q4 SFY17 Recommendation Letter.
- Review of Q1 SFY18 IA Health Link Public Comment session notes: Bettendorf.
- Presentation from the Long Term Care Ombudsman's Office regarding the "How to be your own best advocate" document.
- The Department to present on provider re-enrollment.
- Rules and waivers review of outstanding items.
- Electronic Visit Verification (EVV).

Open Discussion
Cindy Baddeloo requested additional information regarding fingerprinting and the provider national criminal background check.

Future Agenda Item:
- Richard Crouch's letter that was shared with the Executive Committee members was to be discussed at the November 16, 2017, Executive Committee meeting.

Adjourn
4:45 P.M.

October 12, 2017

MAAC Full Council Meeting
Summary of Meeting Minutes
November 7, 2017

Introduction ***(See the roll call document to review the Full Council attendance.)***
Gerd called the meeting to order and performed the roll call and declared that there was quorum.

Approval of Minutes from previous meetings
Gerd asked the Council if there were any changes to the minutes of the Full Council meeting of August 8, 2017. A correction to a reference to Natalie Kerber's name was requested. Gerd declared that the minutes stand approved with the correction.

Update from the Medicaid Director
Director Foxhoven addressed the Council and stated that DHS was unable to come to contract terms with AmeriHealth Caritas Iowa, Inc. (AmeriHealth) and AmeriHealth had decided to withdraw from the IA Health Link managed care program effective November 30, 2017.

A concern was expressed that AmeriHealth's case management reimbursement rates were higher than those paid by UnitedHealthcare and this may impact the availability of case managers. Mikki stated that UnitedHealthcare would continue to pay providers at the Medicaid base floor rate and maintain their service adequacy at those rates. Mikki reviewed the service oversight measures in place that are reviewed by the State to ensure member Level of Care is being met. Mikki advised that AmeriHealth will continue to have a provider call center for one year to process provider claims. She assured the Council that Amerigroup and UnitedHealthcare were meeting network adequacy standards; especially for the Long Term Services and Supports (LTSS) population, Senator Bolkcom indicated that the 30 day transition window that was allowed for AmeriHealth would present enormous hardship both for the 18,000 LTSS members and for UnitedHealthcare.

Concerns were raised regarding new provider tiered rates for members in the Waiver programs and the 30-day transition period, and it was requested that the implementation of new rates be delayed to afford providers more time to determine how to best apply the new rates to their business models. Mikki stated that the Department was directed by the Legislature to move forward with the implementation of the new tiered rates. Deb Johnson delineated the consultation process that had transpired and confirmed that provider groups, including the Iowa Association of Community Providers, were active partners over the last two years in establishing the new tiered rates. She added that the implementation process was to involve a three-part phase in period of July 2018 and July 2019 to allow providers ample time to make necessary adjustment to their businesses.

A question was asked about the Department's contingency plan to address the potential network adequacy issues that may arise from behavioral health care providers that contracted with AmeriHealth but not with UnitedHealthcare. The Department stated that they were working closely with UnitedHealthcare to expand their provider network and ensure network adequacy standards were met. The Department stated that there were plans to add an additional MCO in 2019 at the earliest and only after a readiness review has been completed with thoughtful consideration for the well-being of the affected population.

Mikki reviewed the outstanding action items in the Action Items document and gave a summary of activities involving secret shopper methods and metrics, provider reenrollment, Electronic Visit Verification (EVV), and the implementation of the new tiered rates.

Public Comment Listening Sessions Update

Lindsay Paulson gave a summary of the IA Health Link public comment listening sessions in Dubuque and Bettendorf. Lindsay informed the Council that the Des Moines meeting date and venue had changed to Tuesday, December 5, 2017, 5:00 p.m. -7:00 p.m. at the Des Moines Central Library, Meeting Rooms 1 and 2.

Quarterly Recommendations Discussion

Gerd reviewed the content of the Q4 State Fiscal Year (SFY) 2017 recommendations letter dated October 12, 2017, and advised that the Department's response would be shared with the Council when received.

Recommendations for Executive Committee Consideration

1. Understand the process at IME and monitor Level of Care is appropriate
2. Ensure availability of providers and standard rates in the mental health community subacute area
3. Monitor issues that may arise involving the LTSS transition process to UnitedHealthcare
4. Review issues with pediatric speech and hearing specialists for ***hawk-i*** with UnitedHealthcare
5. Advocacy and care needs of families in the area of care coordination for children with developmental delays (Tom Scholz letter)
6. Review the LTSS population transition in the next quarter and create a plan to ensure a seamless transition of LTSS population to UnitedHealthcare
7. Review the situations of LTC persons that have been in nursing homes
8. Review outstanding state plan amendments affected by the transition to UnitedHealthcare
9. Understand how IME will monitor efficient transfer of information from AmeriHealth to UnitedHealthcare in light of the size of the population being transitioned
10. Understand conflict-free case management within managed care
11. Understand the impact of potentially removing the LTSS population from managed care
12. Establish a better process for communication regarding transfer of information between the state, the MCOs, and case management agencies to assist members to prevent gaps in services
13. Establish clear definition of the term 'oversight" and identify roles that are involved in oversight

Long Term Care (LTC) Ombudsman Introduction and Overview on "How to be your Best Advocate"

Cindy Pederson introduced herself to the Council in her role as the new State LTC Ombudsman. She informed that their monthly report was available for download on the LTC Ombudsman Office website. Pam Hagel gave an overview of the "How to be your Best Advocate" document and stated that the document was available on the LTC Ombudsman Office website for download.

Future Agenda Item

- Cindy Pederson to present at a future Full Council meeting to address additional questions regarding the LTC Ombudsman Office's role in the IA Health Link managed care program.

Updates from the MCOs

a. Amerigroup Iowa, Inc.

Natalie Kerber gave a summary of recent and upcoming activities with Amerigroup including the upcoming Q4 meeting of their Stakeholder Advisory Board and their Medical Advisory Committee. She stated that they were restructuring and adding resources to their Provider Relations department.

b. AmeriHealth Caritas Iowa, Inc.

Cheryl Harding stated that after collaborative discussions with the State, the State and Amerigroup were not able to reach an agreement on terms for a new contract. She stated that AmeriHealth was satisfied with the services they had provided in Iowa and were working closely with the State and UnitedHealthcare to ensure a smooth transition. Senator Bolkcom questioned the decision to implement the transition within 30 days. Cheryl stated that a transition plan was in place that included the transfer of member information to DHS and from DHS to UnitedHealthcare.

c. UnitedHealthcare Plan of the River Valley, Inc.

Paige Petit stated that in light of the AmeriHealth transition, Waiver provider information was made available on the UnitedHealthcare provider website and there were provider advocates available to assist in navigating the website. She gave a summary of UnitedHealthcare activities in the State and provided an update on upcoming provider and member stakeholder meetings. She shared that Tri-State Independent Physician Association (IPA) in Dubuque had come to an agreement with UnitedHealthcare and UnitedHealthcare was working on an incentive program with Grand River Medical Group in Dubuque. She stated that UnitedHealthcare had come to an agreement with Quincy Medical Group which serves South East Iowa. The State, AmeriHealth, and UnitedHealthcare were working collaboratively to ensure the smooth transition of existing Case Management service plans and there was to be flexibility in consideration of existing Prior Authorizations for service plans, prescriptions, and other services as they were to be reviewed on a case-by-case basis.

Quarterly Data Report

Mikki provided a summary on the Quarterly Data Report. She provided data on Health Risk Assessment (HRA), LTSS population in home setting, claims data and expectation for claims payment, mental health care coordination, timely helpline services, secret shopper calls, value-added services, timely appeals process, and timely pharmacy authorization.

Open Comment

(Open comment opportunity for Members)

Flora Schmidt stated that the Council's should also consider positive outcomes of managed care such as the IME's effort in ensuring a smooth provider re-enrollment process and the AmeriHealth's initiative of ensuring that the member transition to UnitedHealthcare runs as seamless as possible.

Adjourn

3:53 P.M.

Executive Committee
Summary of Meeting Minutes
November 16, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben –	Deb Johnson -
Dan Royer – **present**	Liz Matney -
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Kate Gainer – **present**	Sean Bagniewski - **present**
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman -
Julie Fugenschuh – **present**	Lisa Cook -
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum met.

Approval of the Executive Committee Meeting Minutes of September 12, 2017
Minutes of the Executive Committee meeting on October 10, 2017 was approved.

Q1 SFY18 Recommendations Discussion
The Executive Committee discussed potential recommendations to be considered at a future recommendations subcommittee meeting to take place prior to the December 19, 2017, Executive Committee meeting. The subcommittee will consist of Shelly Chandler, Cindy Baddeloo, Jodi Tomlonovic, Gerd Clabaugh, and Dan Royer.

Subcommittee Topics for Recommendations
- Global transition captured in numbers 3, 6, and 8 found on the 'Full Council Recommendations for Consideration by the Executive Committee' document – not focusing solely on Long Term Services and Supports (LTSS) but focused more broadly; on the entire Medicaid population.
    3. Monitor issues that may arise involving the LTSS transition process to UnitedHealthcare.
    6. Review the LTSS population transition in the next quarter and review the plan that ensured a seamless transition of LTSS population to UnitedHealthcare.
    8. Understand how IME will monitor efficient transfer of information from AmeriHealth to UnitedHealthcare.
- Understand the impact of potentially moving the LTSS population from managed care.
- Follow-up on previous recommendations made to the Mental Health and Disability Services

(MHDS) Committee.

Future Agenda Items
- David to speak on CDAC provider rates
- Deb Johnson to present on tiered rates

Department and MCOs on Secret Shopper Methodologies
Postponed to December 19, 2017, Executive Committee meeting.

Medicaid Director's Update
Mikki reviewed all outstanding items in the Action Items document. Mikki stated that the Attorney General's Office is to present information to the MAAC and other IME committees at future meetings regarding topics such as Personal Health Information (PHI) and disclosure of conflicts. Mikki discussed the transition of AmeriHealth members to UnitedHealthcare and advised that the last date to make a change for a December 1, 2017, start date with AmeriHealth was November 16, 2017, although members had an additional 90 days to change their MCO for any reason. Additionally, data transfers were underway and AmeriHealth would continue to provide billing and claims services for a year.

Action Item
- The Department to present on Consumer Assessment of Healthcare Providers and Systems (CAHPS) at future Executive Committee meeting
- The Department to present on tiered rates at December 19, 2017, Executive Committee meeting
- The Department to discuss the process of how care coordination moves through conflict-free case management within an MCO, through the Utilization Management (UM) process to delivery of care payment and/or denial of payment for services. (Add to current Action Item regarding Care Coordination)

Public Comment Listening Sessions Summary
Lindsay stated that comments made at the Dubuque meeting held on October 11, 2017, were primarily in regards to Consumer Choices Options (CCO), provider network, and Long Term Care (LTC) and Home-and Community-Based Services (HCBS) Waivers. The next meeting was to take place on December 5, 2017, in Des Moines.

Open Discussion
Gerd solicited comments. No comments were made.

Gerd stated that a one hour meeting was to take place prior to the December 19, 2017, Executive Committee meeting to discuss three of the previous recommendations with the Department.

December Agenda
- Update from the recommendations subcommittee
- Secret Shopper presentation
- Supported Community Living (SCL)
- Tiered rates
- Director Foxhoven's response letter

January Agenda
- Conflict-free case management presentation

Adjourn
4:28 P.M.

Executive Committee
Summary of Meeting Minutes
December 19, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Mikki Stier - **present**
Dennis Tibben – **present**	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland -
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Kate Gainer – **present**	Sean Bagniewski - **present**
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman - **present**
Julie Fugenschuh – **present**	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of November 16, 2017
Minutes of the Executive Committee meeting on November 16, 2017 was approved.

Introduction of New Medicaid Director Michael Randol
Mikki introduced Michael Randol to the Committee.

Attorney General's Office Presentation
Gretchen Kramer distributed copies of the document outlining a general legal overview of State board and commission member responsibilities. Gretchen discussed conflict of interest and consumer confidentiality as summarized in the document. She encouraged Committee members to disclose if they deem anything a conflict of interest. She stated that all Iowa government records are public unless there's a specific statute that makes them confidential and discussions should not identify specific cases. Gretchen identified that there is an Iowa Code confidentiality provision defining that in instances involving public comment or listening sessions, there should be some prior notice issued regarding the public nature of the listening session in order to allow participants to make a conscious choice about the information they choose to share.

Recommendations Discussion
Subcommittee Update on the Q1 SFY18 Recommendations
The December 11, 2017, Subcommittee meeting summary in the materials packet was discussed. Gerd stated that discussions were in regards to the three main areas:

1. **Mental Health**
   Gerd stated that the initial recommendation of the Subcommittee is for the co-chairs of the MAAC and the co-chairs of the Mental Health and Disability Services (MHDS) Commission to meet to discuss earlier referrals made by the MAAC. The results of the meeting are to be discussed at the January Executive Committee meeting.

2. **Long-Term Support Services (LTSS)**
   Gerd stated the Subcommittee felt that this topic merits further discussion that would focus on creating an opportunity for the MAAC to learn more about the LTSS population and all services that are involved in LTSS. Gerd stated that this better understanding of the breadth of LTSS will help the Committee develop a more informed future recommendation.

3. **Transition to UnitedHealthcare (UHC)**
   Gerd stated that this is focuses on monitoring issues and member information transfer relative to the transition to UnitedHealthcare.

Mikki defined "warm transfer" relative to the transfer of information to UnitedHealthcare, stating that it involves data file transfers as well as the utilization of the IME Member Services Liaison. The Member Services Liaison assists with high-needs members, and care coordination with UnitedHealthcare and AmeriHealth Caritas by initiating dialogues with particular members relative to service plans and level of care.

Director Foxhoven Reply letter to the Q4 SFY17 Recommendations
Director Foxhoven's response letter was included in the materials packet.

Review Administrative Rules regarding goal setting in Supported Community Living (SCL)
Deb Johnson provided an overview of the LTSS program, the population groups that it serves, and the scope of the services it provides. She underscored that LTSS is a broad, needs-based program that works mainly with elderly members and members with disabilities. Deb stated that LTSS members must meet nursing home level of care and require assistance with daily living functions. She clarified that although LTSS and behavioral health are separate in managed care, someone with a mental health issue can be deemed eligible for LTSS based on their needs. Deb stated that SCL assists individuals with their daily living and has a very broad scope of services that can be provided for an hour or for 24 hours and is based on the individual's needs. The Brain Injury (BI) and Intellectual Disability (ID) waivers have SCL as the residential component of the program, allowing individuals to live in their own homes.

Tiered Rates Presentation
Deb Johnson stated that tiered rates became effective December 1, 2017. She clarified that instead of managing individual budgets for thousands of people in SCL at various rates, rates have changed to a standardized payment rate under the ID waiver within the funds that are available based on the acuity and needs of the member. She explained that the development of the tiered rate approach involved the active participation of providers since 2013, using an assessment tool developed by the American Association for Individuals with Developmental Disabilities (AAIDD) called the Support Intensity Scale (SIS). The use of the SIS assessment tool yielded six tiers of payment. She added that implementation of the tiered rates is going to be a gradual phase-in process to accommodate the changes for the business practices of providers. Deb stated that there is more money for instances of higher acuity to compensate for any additional staffing needs. In instances where the assessment in the SIS is not accurate, there is a 30-day period to review and evaluate the information. Liz Matney stated that the independent assessors go through a liability process to check for consistency in the application of the assessment and the department also has two practices as a quality control safeguard.

Action Item:
- Deb Johnson is to present on LTSS in future Executive Committee meetings.

Department and MCOs on Secret Shopper Methodologies and Metrics
Liz reviewed the Q1 SFY 18 managed care report and called attention to the inclusion of the secret shopper report which reflects one of the MAAC recommendations. She stated that moving forward, reports will reflect information on timeliness and accuracy of payment in claims processing as well as key results of the Iowa Participant Experience Survey. Mikki stated that the quarterly report will be delivered to the MAAC one month in advance to allow for a review prior to presentation at the MAAC meetings.

Future Agenda Item:
Review Q1 SFY18 managed care report at the January Executive Committee meeting.

December 21, 2017

DHS
Liz provided information on the accuracy and timeliness involved in the monitoring of the call centers. Liz stated that initially, questions are developed weekly for each call center (IME, ***hawk-i***, and transportation); then, secret shopper specialists conduct calls for accuracy on a weekly basis to each MCO; finally, feedback is sent to the MCO regarding the results of their calls. She stated that secret shopper calls are also conducted at the IME for accuracy of Fee-for-Service information. Liz stated that when reoccurring issues are identified, the questions are repeated in subsequent weeks to monitor if MCOs are taking corrective actions.

MCO

- Amerigroup representative, Natalie Kerber, reiterated Liz's statements and identified that information provided by the State is added to the Amerigroup database in real-time where the information is then made available to the Amerigroup call center representatives. She stated that CSR scripting is updated immediately based on IME feedback and calls are recorded for training purposes.

- Paige Petit (UnitedHealthcare) stated that UnitedHealthcare utilizes a process similar to that of Amerigroup and that they conduct a joint meeting with both provider and member call centers to identify other areas that can be improved.

Medicaid Director's Update
Mikki reviewed the items listed on the Action Items document. She reviewed the work that has transpired in ensuring the smooth transition of members to UnitedHealthcare as well as the 10,000 members who transitioned to FFS.

Future Agenda Item:

- Presentation on care coordinators and conflict-free case management at the January Executive Committee meeting

UnitedHealthcare Update
Paige Petit reviewed recent developments in UnitedHealthcare's effort to expand network adequacy and community outreach. She also gave a synopsis of what UnitedHealthcare has been doing to expand staffing following the transition of AmeriHealth Caritas members to UnitedHealthcare. She stated that staffing includes case managers, RNs, and assessors; outlining recent agency agreements for case management in various counties.

Mikki stated that some previous DHS Total Case Managers (TCMs) may be hired by UnitedHealthcare which would allow some members to keep their previous case managers.
Kim Foltz confirmed that UnitedHealthcare continues to onboard case managers.

Public Comment Listening Sessions Summary – Des Moines, December 5, 2017
Summary was made available in the materials packet.

Open Discussion
Flora Schmidt requested additional information regarding the prior authorization process following the transition of AmeriHealth Caritas members to UnitedHealthcare. Kim Foltz clarified that if previous prior authorizations did not transfer, UnitedHealthcare is contacting the member's pharmacy for verification of a previous prior authorization and UnitedHealthcare had also received an updated file from AmeriHealth on December 18, 2017, and they were working to update member prior authorizations. Kim stated that an additional reason for authorization denials was that the prescribing providers were not enrolled Medicaid providers, and UnitedHealthcare had been contacting the member's pharmacy to determine if there was another provider at the prescribing provider's office that was enrolled with Medicaid to authorize the script. Mikki stated that the IME was working to enroll the non-enrolled prescribing providers.

Adjourn
4:55 P.M.

December 21, 2017

Full Council
Summary of Meeting Minutes
February 19 2018

Introduction and Roll Call
Gerd called the meeting to order and performed the roll call. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

Approval of the Full Council Meeting Minutes of November 7, 2017
Minutes of the Executive Committee meeting of November 7, 2017 was not put to a vote because quorum was not met.

Long-Term Care Ombudsman Report
Cynthia Pederson reviewed the January 2018, Managed Care Ombudsman Monthly Report and the Managed Care Ombudsman Quarterly Report for the last calendar quarter of 2017 available in the materials packet. She stated that the office also provides a quarterly report that reflects a three month compilation of data gathered from the monthly reports. She underscored that the last quarter of 2017 which included the transition period from AmeriHealth Caritas did not result in an increase in the number of contacts received by the Ombudsman program during the quarter. She noted trends involving an increase in contacts regarding selecting or changing an MCO, an increase in contacts regarding continuity of care and services during the transition, and an increase in AmeriHealth members needing assistance in connecting with new case managers. She also noted the decrease in the number of contacts regarding grievances, appeals, and fair hearings.

Recommendations Update
Q4 SFY17 Director Foxhoven Reply
Gerd gave a brief background regarding the questions posed to the Director and a copy of the reply was made available in the materials packet.
Q1 SFY18 Letter
Gerd stated that this letter is currently awaiting response from Director Foxhoven but that the items on the recommendation are already being addressed.

Update from the Medicaid Director
(Electronic Visit Verification (EVV), Legislative Update, Action Items, MCO RFP Development, Status of Choice given only two MCOs)
Mike Randol stated that a vendor(s) had not yet been determined for the EVV initiative nor whether there would be separate vendors for MCOs and Fee-for-Service (FFS). He stated that the EVV is to be implemented by January 1, 2019, and a process timeline is currently being developed to meet that implementation date that covers both education and communication on how to move forward. Mike stated that he did not have a legislative update at that time. In regards to the MCO Requests for Proposals (RFPs), he stated that due dates for RFPs is March 6, 2018, and they will follow standard process of RFP evaluation.. He stated that there may be one or two additional MCOs added to the managed care program with an effective contract date for the selected MCO(s) of July 1, 2019. He stated that as of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members. Mike and Liz Matney confirmed that the objective of HSB 632 is to ensure that the data that is being reported is useful data that allow for meaningful analysis. There was a suggestion that the MAAC or a subcommittee of the MAAC hold future discussions with the department to discuss what data elements will be useful for the MAAC especially in light of data reporting changes that will result from HSB 632. Liz added that it is important to understand that data elements will continue to be

collected but that the reports should be able to meaningfully answer questions that are being asked. Mike stated that there is now a process improvement working group and one of the sub-groups is data transparency dashboards which can help in answering questions about the data. Mike also reviewed the action items document and provided an update on the status of each item.

Action Item:

- Add to action items a presentation at a future Executive Committee meeting on value-based purchasing threshold requirements for MCOs.

Long-Term Care Services and Support (LTSS) Presentation

Deb Johnson handed out copies of the document, "Medicaid Home-and Community-Based Services (HCBS) Program Comparison Chart" which outlines the various services under LTSS. She stated that LTSS consists of Home- and Community-Based Services (HCBS) Waivers and Institutional Care:

Home- and Community-Based Services (HCBS) Waivers

Deb stated that HCBS is part of the Social Security Act and is referred to as the 1915c HCBS Waivers. There are seven waivers; Health and Disability; AIDS/HIV, Elderly, Intellectual Disability, Brain Injury, Physical Disability, and Children's Mental Health. HCBS Waivers provide service funding and individualized supports to maintain eligible members in their own homes or communities who would otherwise require care in a medical institution. She stated that waiver services are meant to complement or supplement the state plan or other resources that are available. Waiver participants have access to the full state plan but that they still need to meet the institutional Level of Care and services have to be cost-effective or less expensive in aggregate than what it would cost in an institution.

Institutional Care: Nursing Facilities (NFs), Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs)

Deb stated that members receiving these services need to meet the same Level of Care and income guidelines as in waiver programs. There are monthly maximums or caps on the financial amount for services in each program and this is important in determining the aggregate for cost neutrality. She added that cost-effectiveness of services is determined on an individual basis and is based on a variety of variables. Deb provided clarification on the distinction and relationships between Level of Care, service plan, and care coordination.

Care-Coordination and Conflict-Free Case Management

Amerigroup Iowa, Inc.

Kelly Espeland provided the Centers for Medicare and Medicaid Services (CMS) definition of Conflict-Free Case Management and stated that it is a requirement for the MCOs per their contracts with the State. Additionally, the MCOs must administer case management in a conflict-free manner consistent with the Balancing Incentive Program. The Balancing Incentive Program rebalances the State's program and aims to get more persons into the community and out of facilities. She stated that the MCOs complete member assessments, inform the state of the member's care needs and the State makes the final eligibility determination. In regards to the SIS assessment, the Case Manager (CM) is a facilitator and does not determine the score or the member needs as this is carried out by the team. The information then goes to the CM, the team reviews the information, and the CM provides the service coordination to develop the member's person-centered plan based on identified needs. The Utilization Management (UM) team looks at the assessment and care plan that has been developed, and a determination is then made regarding services in accordance with the Iowa Administrative Code. Conflict-Free Case Management oversight is carried out through regular reports provided to the State and involvement from stakeholder groups such as the MAAC.

UnitedHealthcare Plan of the River Valley, Inc.

Paige Pettit stated that UnitedHealthcare's process is similar to Amerigroup's with slight distinctions. UnitedHealthcare's CMs focus on person-centered planning while ensuring compliance with state and federal regulations. UnitedHealthcare's CMs are nurses as well as social workers and have extensive training in LTSS. Upon hiring, CMs are put through training in LTSS and each CM hired is paired with a mentor. Quality is assured through case reviews, ride-alongs, peer reviews, ongoing education and maintenance of certification is mandatory for all assessors.

Amerigroup Iowa, Inc. Updates

Transition Update

Natalie Kerber stated that when AmeriHealth exited the market, Amerigroup determined that in order to serve a large but unidentified influx of new members, the organization would need to build more

capacity. Since that time, Amerigroup has been working closely with the IME in building said capacity. As of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members.

Integrated Health Home Funding
Natalie stated that Amerigroup continues to support the work of the Integrated Health Home (IHH) program and they will continue to work with the Department, UnitedHealthcare, and Health Home providers to identify ways to strengthen the program.

Value-Based Purchasing
Amerigroup's contract benchmarks for members covered by Value-Based provider arrangements are 30% by July 1, 2018, and 40% by the end of 2018. Natalie stated that Amerigroup is on track to meet these goals and they are currently approaching 30% in Value-Based arrangements and fully anticipate meeting their goals. Additionally, Amerigroup has been piloting two quality incentive programs with LTSS providers; Anthem Nursing Facility Quality Incentive Program and Anthem Personal Attendant Care Quality Incentive Program. In these programs, providers are measured on outcomes over an entire year and then there are quarterly reports that are designed to discuss the quality measures with participating providers in order to coach them on improving their performance to meet the pilot goals throughout the year.

UnitedHealthcare Plan of the River Valley Updates
Transition Update
Paige Pettit stated that UnitedHealthcare has hired 525 new employees to accommodate new members and of the 525 new employees, 470 are CMs. Community-Based Case Managers (CBCMs) continue training and member outreach, and all members have been assigned a CBCM. Provider advocates are also traveling across the state to meet with providers on a weekly basis.

Integrated Health Home Funding
The Department is currently conducting a review of the State's health plan program and the associated state plan amendments; the Department will work collaboratively with both MCOs through this process. Given the potential for program changes to occur as a result of the review, the MCOs have delayed the IHH transition. As of March 1, 2018, the IHHs will need to complete for UnitedHealthcare the appropriate documentation to enroll individuals into the IHH that assures compliance with the state plan amendment. As of last week, UnitedHealthcare's clinical staff had conducted joint operating committee meetings with 25 of the IHHs to address their questions.

Quarterly Data Report Update
The Q1 SFY18 report was made available in the materials packet and Liz Matney stated that the report had been updated with information requested from oversight entities and the information had been restructured. She provided data on claims payment accuracy, rate reprocessing, consumer satisfaction survey specific to LTSS members receiving HCBS services, employment services for HCBS Waiver members, HRA completion, claims timeliness, service levels, and Prior Authorizations (PAs).

Secret Shopper Methods and Metrics
Liz stated that someone in the Iowa Medicaid managed care bureau made daily calls to different MCO helplines; provider services, member services, Non-Emergent Medical Transportation (NEMT), and ***hawk-i***. The questions utilized for calls are based on information that the IME is receiving from stakeholder groups, legislators, members, and providers. This information is included in the quarterly report and will be ongoing.

Open Comment (Open Comment Opportunity for Members)
Marsha Fisher stated that her son is an LTSS member. She stated that she has received emails from persons in north eastern Iowa stating that they have gone through repeated appeals to obtain LTSS services, and it seems as though this is what the MCOs expect; this is the process for obtaining LTSS services. Marsha gave an example of a woman whom she knows and who has two small children with severe disabilities receiving LTSS services and her children have been denied services; requiring they go through the appeals process. She stated that the appeals process was frustrating, and requires a lot of effort. Marsha expressed concern if whether this was the process for obtaining LTSS services and stated that it is a problem that the Department needed to be aware of.

Marsha Fisher also stated that she does not agree with the requirement to prove that the services requested are a true need. Marsha noted that the needs are seen by the Care Coordinator, there is an assessment, and there are many persons working with the individual during their care planning

although when it goes to the Utilization Management team, the member and their team are required to prove that the services are a true need; to prove beyond the information that is provided to the Utilization Management team that the services requested are needed.

Marsha Fisher stated that communication continues to be a problem without personalization and individualization. She identified that she had received a satisfaction survey from her son's MCO that had the correct address although was addressed to someone else and the document was in Spanish. She stated that she was concerned about the validity of some of the documents provided to members in the general Medicaid population as well as LTSS members.

Potential Topics for Future Recommendations:

- Percentage of claims that are suspended; suspended versus denied claims. Request that information be provided in future quarterly reports.
- In regards to data within reports, request the addition of measures and information regarding quality. Example: Is the decision made timely and is the decision made correctly?
- Request clearer guidelines of what information is required when requesting services for LTSS members. (See Marsha Fisher's comments outlined above).

Adjourn
4:02 P.M.

March 1, 2018

Iowa Department of Human Services

Michael Randol, Iowa Medicaid Director

Medical Assistance Advisory Council MAAC

Executive Committee
Summary of Meeting Minutes
February 27, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney -
Shelly Chandler –	Kevin Kirkpatrick - **present**
Cindy Baddeloo – **present**	Lindsay Paulson -
Casey Ficek –	Sean Bagniewski -
Lori Allen –	Luisito Cabrera - **present**
Richard Crouch –	Alisha Timmerman - **present**
Julie Fugenschuh –	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was not met.

Approval of the Executive Committee Meeting Minutes of January 4, 2018
Minutes of the Executive Committee meeting of January 4, 2018, were not approved as quorum was not met.

Long Term Services and Supports Presentation (LTSS)
Long Term Services and Supports
Deb Johnson discussed and defined the Program of All Inclusive Care for the Elderly (PACE) program, Hospice Services, Targeted Case Management (TCM), Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs), Residential Care Facilities (RCFs), Nursing Facilities, and Skilled Nursing Facilities as outlined on the Long Term Care webpage[1].

Home- and Community-Based Services (HCBS) Waivers
Deb Johnson advised that the link to the HCBS Waiver Program webpage[2] was provided in the agenda and reviewed the Medicaid Home and Community Based Services (HCBS) Program Comparison Chart[3]. Deb clarified that Medicaid pays for Consumer Directed Attendant Care (CDAC) supervising nurse costs under the Medicaid State Plan. Deb also explained that members residing in

[1] https://dhs.iowa.gov/ime/members/medicaid-a-to-z/long-term-care
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers
[3] https://dhs.iowa.gov/sites/default/files/Medicaid_HCBS_Program_Comparison_Chart.pdf

ICF/IDs are enrolled in managed care and may access some additional medical services outside of the ICF/ID; such as x-rays for a broken arm. It was also identified that the case manager and Interdisciplinary Team (IDT) assist the member in person-centered planning to determine which HCBS services are best suited for the member. Deb stated that some of the available services under the HCBS programs are currently underutilized due to a limited number of providers available to provide the services and lack of member demand. To determine which programs may be available to individuals, members may contact the Area Agency on Aging, LifeLong Links, their local DHS office, the Iowa Department of Public Health (IDPH), or access the Compass website. Deb acknowledged that prior to receiving HCBS services individuals must first be determined Medicaid eligible and then meet LOC for the services; however, prior to receiving HCBS services the member is eligible for State Plan benefits.

Medicaid Director's Update
The Action Items document was made available in the materials packet. Mike Randol stated that on March 1, 2018, former AmeriHealth Caritas members who temporarily transitioned to Fee-for-Service (FFS) will be moved to Amerigroup. Requests for Proposals (RFPs) for potential MCOs are due on March 6, 2018, and the new MCO contract will be awarded in April 2018; information regarding RFP submissions will be made available in the next couple of weeks. Mike stated that issues were identified in the February 22, 2018, Process Improvement Workgroup and Medicaid staff will be categorizing the issues to determine subgroups. He indicated that report will be created providing outcomes from the Process Improvement subgroups and workgroup. Mike acknowledged that cost avoidance estimates will no longer be available in the quarterly reports as there is a six month lag in claims data which makes the information inaccurate and difficult to compare.

Mobile Applications
Kevin Kirkpatrick stated that both Amerigroup and UnitedHealthcare have mobile applications available for download on Google Play and iTunes. Some functions available on the applications are: member ID cards; emailing to Member Services; provider look-up; English and Spanish versions of the applications, and; claims history. In the future, the application download options are to be made available on the DHS website.

Q2 SFY18 Recommendations Subcommittee
It was decided that a subcommittee be created to discuss Q2 SFY18 recommendations. The individuals below will be on the subcommittee and an email is to be sent to Executive Committee members requesting additional persons participate in the subcommittee.

- David Hudson
- Dennis Tibben
- Dan Royer

Open Discussion
David solicited comments. No comments were made.

Adjourn
4:30 P.M.

Iowa Department of Human Services

Medical Assistance Advisory Council
MAAC

Michael Randol, Iowa Medicaid Director

Executive Committee
Summary of Meeting Minutes
March 20, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler –	Kevin Kirkpatrick - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski -
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch –	Alisha Timmerman -
Julie Fugenschuh –	
Jodi Tomlonovic –	

Introduction
David called the roll call. Executive Committee attendance is as reflected above and quorum was not met.

Approval of the Executive Committee Meeting Minutes of February 27, 2018
Minutes of the Executive Committee meeting of February 27, 2018 were not approved because quorum was not met. David asked that an electronic vote be initiated for Executive Committee members to approve the minutes of the January 4 and February 27 Executive Committee meetings.

Recommendations Discussion
Q2 SFY18 Recommendations Subcommittee Update
David referred to the draft of the Q2 SFY18 recommendations document and gave an update from the March 8, 2018 subcommittee meeting. He stated that the aim is to get the recommendations to Director Foxhoven by the April 11, 2018 Executive Committee meeting and to share them at the next Full Council meeting on May 3, 2018. Lindsay explained that the current recommendations are for Q2 SFY18 IA Health Link public comment meetings and, as the meetings have concluded, no further recommendations for the meetings are required per legislation. The MAAC may continue to make general recommendations at any time. David invited feedback from the Committee on the draft recommendations. Dan Royer suggested more clarification on data regarding claims that are suspended versus denied and Cindy suggested that dollar amounts for items such as inpatient and outpatient claims paid be provided by the Department. David referenced the March 9, 2018, email from Dan Royer that had been distributed to Executive Committee members regarding how Medicaid and MCO operations are impacting hospitals and health systems. He stated that he would like to include some of the relevant recommendations from his document in the Q2 SFY18 recommendations. David suggested discussing Dan's ideas at the March 30, 2018, recommendations subcommittee meeting.

Long Term Services and Supports Presentation (LTSS)

Deb Johnson reviewed the Home- and Community-Based (HCBS) Waiver application process. Applicants can be self-referred, referred by schools, referred by local DHS offices, MCOs, and many other avenues. Income Maintenance Workers (IMWs) assist with the Waiver application and the applicant has to choose between institutional or community services. If determined financially eligible for Medicaid and HCBS services, the IMW requests a waiver slot. If a waiver slot is not available, the applicant will be put on a waiting list and a Notice of Decision will be sent to the applicant. If a waiver slot is available, the next step is completion of a Level of Care (LOC) assessment. An LOC determination is then made upon review of the individual's needs as identified in the assessment. An LOC is not an approval of services but rather a determination of HCBS eligibility. The approval process for HCBS applicants can take several months to complete, depending upon how quickly the assessment can be scheduled and completed, and whether all necessary information is submitted timely for the LOC decision. If approved for LOC and HCBS services, it is determined whether the member is eligible to enroll with an MCO to receive services or receive services under the Fee-for-Service (FFS) program. Once the applicant has been determined eligible for HCBS and Medicaid coverage, either a case manager from the member's selected MCO, or a FFS case manager will develop a service plan with the member and the member's Interdisciplinary Team (IDT). The service plan can change in accordance with the member's needs and the LOC, Medicaid eligibility, and service plan is re-evaluated annually. Deb clarified that service plans are authorized by the state or the MCO; not the case manager. Deb stated that the provider manual details this process and that she will develop a work flow chart on the waiver application process for distribution at the April Executive Committee. Deb stated that a member can have additional services provided either by utilizing state plan or by paying for it themselves with the agreement of the member.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Liz stated that CAHPS is intended to measure consumer experience within the healthcare system, not consumer satisfaction. She stated that the Department requires the MCOs to perform areas that are specific to the healthcare delivery systems. She indicated that there are surveys for both adults and children that look at the member's experience with their insurance provider and provider network. The surveys contain questions regarding four main areas: Getting needed care; Getting care quickly; How well doctors communicate; and Health plan information and customer service. She stated that the MCOs use independent contractors to conduct these surveys and the MCOs are required to report the CAHPS data to the Department. She stated that in the 2017 metrics, all MCOs scored above the national median in adult surveys although one area of the children surveys was below the national median; 'The customer services always or are usually helpful'. Liz indicated that CAHPS data is in the quarterly reports. She indicated that the department conducts a variety of surveys and is currently reviewing existing surveys to ensure collection of meaningful data. She mentioned that CAHPS and Healthcare Effectiveness Data and Information Set (HEDIS) data are a part of National Committee for Quality Assurance (NCQA) ratings.

Medicaid Director's Update

Process Improvement Workgroup:
Mike stated that the workgroup was to meet on March 23, 2018, and that feedback is being reviewed so that sub-workgroups may be formed to address the feedback before moving forward.

Amerigroup Transition:
Mike confirmed there are no known issues with the transition of the 10,000 members to Amerigroup. He stated that the IME and the MCOs continue to work closely to ensure a smooth transition and transfer of members and member data. Effective May 1, 2018, Amerigroup will begin accepting new members.

New MCO RFP Process:
He stated that two organizations submitted responses and they were received on March 6, 2018. He stated that the department is currently evaluating the RFPs that were received with the intent to select the new MCO by the end of April 2018 with contract negotiations and a readiness timeline for a July 1, 2019 start.

Mike stated that in adding new MCO(s), an algorithm-based methodology will be developed for distributing membership equitably across the MCOs but that all members will have choice.

Open Discussion

David stated that a provider had informed him that there were a number of people being audited by AmeriHealth Caritas in an effort to collect funds that had been lost. Cindy stated that providers receive

letters stating that the MCO is auditing claims, or there are special projects that they are reviewing. Mike stated that he would review the information and documentation.

David asked if the MCO contracts provide for a definition of "medical necessity" as he did not see it defined clearly in the Amerigroup contract; asking within the context of denial of a service deemed to not be medically necessary. Mike offered to address this by stating that the complex nature of the Medicaid member population groups and their various needs make defining the term medical necessity difficult however, there are however clinical guidelines that define medical necessity. Mike stated that medical necessity is not determined by a case manager it is determined by clinicians in the specified area. Liz stated that there is an outline that is consistent with the federal program for Medicaid and Medicare. In the glossary there is a definition of medical necessity and the contractor uses their Utilization Management guidelines to determine medical necessity.

David inquired about House File (HF) 2292 and HF 2462. Mike offered to sit down privately with David about his questions regarding these bills but that a legislative update will be provided at the next Executive Committee meeting in April.

Flora Schmidt asked that the Department provide an update on the Department's Health Home reviews. Mike stated that the Health Home contractor will be providing an update that includes a project timeline within the next two weeks and once completed, he would like to commence department and stakeholder/provider engagement to develop a robust and comprehensive communications plan on Health Homes.

Agenda Item:

- Legislative update by Mike Randol for the April Executive Committee meeting.

Adjourn
4:19 P.M.

Executive Committee
Summary of Meeting Minutes
April 11, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol -
Dennis Tibben – **present**	Julie Lovelady - **present**
Dan Royer – **present**	Deb Johnson - **present**
Shelly Chandler –	Liz Matney - **present**
Cindy Baddeloo –	Kevin Kirkpatrick - **present**
Casey Ficek –	Lindsay Paulson -
Lori Allen – **present**	Sean Bagniewski -
Richard Crouch –	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic – **present**	

Introduction
Gerd called the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of February 27, 2018
It was confirmed that the minutes of the January 4, 2018, and February 27, 2018, Executive Committee meetings were approved via electronic voting. The minutes of the March 20, 2018, Executive Committee meeting were approved.

Recommendations Discussion

Q2 SFY18 Recommendations Letter
Gerd presented the draft recommendations letter. A vote was taken, and the recommendations letter was approved. The letter was to be sent to Director Foxhoven and included in the May 3, 2018, MAAC Full Council materials packet. He informed the Committee that this is the last of the legislatively required quarterly recommendations letter but that the Committee will continue to discuss recommendations within the context of the work of the MAAC.

Future Agenda Item:
- Discuss statutory language of existing legislation regarding MAAC Executive Committee recommendations.

Integrated Health Homes and Health Homes Project
Deb Johnson discussed Integrated Health Homes (IHHs) and Chronic Condition Health Homes (CCHH). Deb stated that the department with its contractor, Telligen, is in the process of reviewing the effectiveness of the program and determining if services may be duplicative of other care coordination

efforts available through Accountable Care Organizations (ACOs). She stated that IHH and CCHH are paid a monthly capitation rate and there are six domains of services that IHH and CCHH programs are required to do that the department is reviewing: *Comprehensive Care Management, Care Coordination, Comprehensive Transitional Care, Health Promotion, Individual and Family Support, and Referral to Community and Social Services*. She stated that there are approximately 23,000 IHH members and 4,000 CCHH members; 98% of whom are enrolled in managed care. She stated the department is doing an audit of the entire health home program to identify where the six domains of services are being provided and is examining the payment model to determine their cost-effectiveness. The department will also be examining current processes concerning how to monitor and mentor the health home services and a draft report is to be ready by the end of June 2018. Deb stated that MCOs are required to have an adequate provider network to ensure that the six domains of services are available to members. Deb stated that there has been some indication of duplicative work between the MCOs and health home providers and that this is part of what is being clarified in the current discussions. Paige Pettit (UnitedHealthcare) explained that if a member is enrolled with an ACO and also receiving services through an IHH, there is a high risk for duplication of the services being provided; especially around care coordination. Paige stated that the objectives of the audit include identifying where members are getting duplication of services and determining which of the six services domains are being offered by health homes. It was stated that the audit is intended to be a continuous quality improvement cycle to ensure the highest quality service for the members in the Medicaid program.

Future Agenda Item:

- IHH and CCHH update to take place in the June 12, 2018, Executive Committee meeting

Managed Care Quarterly Report Presentation

Liz reviewed the SFY18 Q2 report. She indicated the content in the report reflected AmeriHealth's transition out of the program which impacted areas such as the UnitedHealthcare percentage of Level of Care reassessments data on page 18. She discussed Health Risk Assessments (HRAs), the percentage of HCBS members assigned to Community-Based Case Managers (CBCMs), the Iowa purchase experience survey, the CAHPS experience survey, grievance and appeals, member and provider helplines, the secret shopper process, payments and prior authorizations, claims denials, Home Health authorizations, continuity of care, Value-Added Services, average cost per member per month (PMPM), hospital admissions, and emergency department data.

Liz explained that there are a number of sources for secret shopper questions such as Requests for Information (RFIs) and the MAAC and the department would be open to suggestions from Medicaid providers.

Medicaid Director's Update

Amerigroup Transition:

Julie Lovelady stated that the transition is going well and there have not been significant concerns or complaints. Tentative MCO assignment has resumed and members are once again able to choose their MCO. She stated the department is monitoring the call centers to ensure that issues are addressed and CSRs trained appropriately.

Provider Re-enrollment

Julie stated that the provider re-enrollment process has been completed. She stated that high-risk providers now have to go through appropriate federal safeguard measures. Lapsed providers received outreach messaging for re-enrollment and to ensure that they were able to re-enroll if they wished to continue to be part of the provider network. She added that of the approximate 40,000 providers, only 547 were terminated.

Process Improvement Working Group:

Julie stated that there had been two working group meetings; the first meeting identified key issues while the second meeting focused on establishing five working groups to discuss the various issues. Liz stated that the five working groups were:

1. Claims and PAs
2. Training and Communications
3. Data Transparency
4. Clinical Outcomes
5. Credentialing

Julie stated that individuals in the working group chose which of the five groups to take part in and that the five groups will be separated for individual discussion in subsequent meetings.

Kevin stated that all the documents that result from the working group meetings are posted on the Process Improvement Working Group web page[1].

Open Discussion

Jodi suggested a future discussion on President Trump's Executive Order about work requirement for welfare or means-tested service recipients. She stated that she was not certain if this affects Medicaid members.

Future Agenda Item:

- Discussion at the May 15, 2018, MAAC Executive Committee about how the President's Executive Order regarding the requirement for recipients of federal aid programs to work may impact Medicaid recipients. .

Adjourn

4:33 P.M.

[1] https://dhs.iowa.gov/ime/about/advisory_groups/piwg

Iowa Department of Human Services

Medical Assistance Advisory Council
MAAC

Michael Randol, Iowa Medicaid Director

Full Council
Summary of Meeting Minutes
May 3 2018

Introduction and Roll Call
Gerd called the meeting to order and performed the roll call. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

Approval of the Full Council Meeting Minutes of February 19, 2018
Minutes of the Executive Committee meeting of February 9, 2018, were not put to a vote because quorum was not met.

Long-Term Care Ombudsman Report
Cynthia Pederson reviewed the 2017 Quarter 4 Managed Care Ombudsman Report available on the Managed Care Ombudsman Program website[1]. She noted that the contacts reported represented any time a contact was made with the Ombudsman and did not represent the number of complaints received or the number of managed care members assisted by the program. Cynthia identified the following trends within the report:

- Issues regarding Amerigroup's acceptance of new members who had temporarily transitioned to Fee-for-Service following AmeriHealth Caritas Iowa, Inc.'s withdrawal from the program.
- Transportation issues concerning a lack of transportation providers as well as provider and member communication.
- Delays in Home- and Community-Based Services (HCBS) waiver eligibility and Level of Care (LOC) assessments.
- Delays in completion and approval of individual member budgets which resulted in a delay in payments and services.
- Issues in the transfer of guardianship documentation when transitioning between MCOs as well as guardians being excluded from meetings and member assessments.

She noted an increase in the number of contacts regarding grievances and a decrease in contacts regarding appeals and State Fair Hearings. Cynthia stated that the May edition of the State Long-Term Care (LTC) Ombudsman's Office e-newsletter, The Advocate, would be available on May 7, 2018, and would provide information regarding care planning issues and the care planning process. Future monthly and quarterly reports will contain greater detail regarding the reason for calls; such as the member's concern, their waiver program, and issue resolution.

Q2 SFY 18 Recommendations Letter
Gerd provided a brief summary of the recommendations letter provided in the materials packet and stated that this letter is currently awaiting a response from Director Foxhoven. The legislative directive outlined that the MAAC was to make quarterly recommendations regarding IA Health Link public comment meetings and, as there were to be no further meetings, additional recommendations of this kind were no longer required. Moving forward, the MAAC may make general recommendations to the Department regarding the medical assistance program.

Action Item:

- The Department is to present information regarding Long Term Services and Supports (LTSS) at the August 9, 2018, Full Council meeting.

[1] https://www.iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program

May 8, 2018

Election of MAAC Members Update

Public representatives on the Full Council are appointed by the governor for staggered terms of two years each and a portion of MAAC public members' terms will end on June 30, 2018, so the Governor will make appointments for said positions at that time. The Executive Committee is elected for two-year terms, beginning at the start of a state fiscal year. The last election occurred in August of 2016, and the next election for both business and public positions will take place at the MAAC Full Council meeting to be held on August 9, 2018.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Lisa Cook explained that CAHPS is an experience survey that is overseen by the Agency for Healthcare Research and Quality and conducted by a third party using the Healthcare Effectiveness Data and Information Set (HEDIS) specifications. The measures are standardized and validated; thus informing the Department of their performance in comparison with Medicaid programs throughout the country. The surveys include questions regarding members receiving needed care, receiving care quickly, provider and member communication, health plan information, and customer service. Last year, in all adult metrics composite scores, Iowa Medicaid was above the national average for all of the health plans and was above average for most child CAHPS assessments. This information is provided in the Medicaid Managed Care Annual Reports[2].

Quarterly Data Report Update

The Q2 SFY18 report was made available in the materials packet. Lisa provided data on Health Risk Assessments (HRAs), Community-Based Case Management (CBCM) assignment, CBCM contacts, service plans, LOC assessments, Iowa Participant Experience Survey (IPES) results, Grievances and Appeals, member and provider helpline performance, claims, Value Added Services, Prior Authorizations (PAs), average cost Per Member Per Month (PMPM), hospital admissions, Emergency Department utilization, and the Home- and Community-Based Services (HCBS) Waiver waitlist. It was identified that members of the MAAC may contact the IME with suggestions for secret shopper questions.

Update from the Medicaid Director

Electronic Visit Verification:

Mike Randol stated that the Department will be contacting the Centers for Medicare and Medicaid Services (CMS) to request an extension on the timeline for implementation of the program. The extension would provide additional time to better define areas such as required participants and ensure a smooth transition for both members and providers.

Legislative Update:

Mike briefly discussed House File 2483 and stated that it included a requirement that the Department and a third party reviewer conduct a review of small claims that were paid to HCBS providers to determine denial rates and appropriate payment.

MCO RFP Update

Mike stated that an announcement of the award(s) is to occur in May of 2018 with contracts effective in July of 2019. Mike indicated that implementation in July of 2019 will allow for an appropriate transition and timeline while also ensuring an effective readiness review.

Status of MCO Choice

Mike identified that the approximate 10,000 members who had temporarily transitioned to Fee-for-Service were transitioned to Amerigroup on March 1, 2018, and that Amerigroup began accepting new members as of May 1, 2018.

Process Improvement Working Group

Mike stated that there had been three working group meetings and four subgroups had been developed:

1. Claims/Communications and Training/Prior Authorizations
2. Benefits and Eligibility/Reimbursement
3. Clinical and Quality Outcomes/Transparency
4. Credentialing

The next subgroup meetings are to take place on May 11, 2018, and additional information regarding the

[2] https://dhs.iowa.gov/ime/about/performance-data/annualreports

working group can be found on the Process Improvement Working Group webpage[3].

A clinical review of appeals is to take place with the clinical team and the IME to review appeals that had been overturned, withdrawn, and dismissed. Findings are to be reported by July 15, 2018, and recommendations are to follow.

UnitedHealthcare Plan of the River Valley, Inc. Updates

Paige Petit gave a summary of recent and upcoming activities with UnitedHealthcare including staff participation in the Iowa Association of Community Providers Annual Conference, the Leading Age Iowa Spring Conference, and a HyVee Health Fair. Paige discussed recent UnitedHealthcare bulletins such as the Care Provider Access and Availability Requirements Reminder bulletin that was fax-blasted to in-network Primary Care Providers (PCPs) and specialty providers in an effort to further educate care providers on contractual requirements in preparation for an upcoming audit. The bulletin was a reminder for providers to update their office hours, phone information, contacts for provider offices, ages and genders served, languages spoken by staff and, whether providers are accepting new patients. Paige stated that a satisfaction survey for medical providers was to be sent in September of 2018 and surveys for HCBS providers were to be conducted between July of 2018 and September of 2018. Paige identified that each MCO must establish Value-Based Payment (VBP) models that cover 40 percent of their member population and that UnitedHealthcare is currently working with providers to meet that requirement.

Amerigroup Iowa, Inc. Updates

Natalie Kerber stated that provider workshops had been provided throughout the state in April and were a means for one-on-one issues to be reviewed and resolved on site with Provider Relations representatives, their management, and representatives specialized in behavioral health, physical health, and LTSS. Additionally, Clinic Days were being coordinated throughout the state and are to occur in the summer and fall of 2018. Clinic Days target members who haven't received recommended preventive screenings and services within the calendar year. Natalie discussed Amerigroup's involvement with the Young Women's Resource Center through the Foundation for the Better Beginnings for Young Moms program.

Executive Committee Agenda Items:

- Claims Adjustment Reason Code (CARC) 45 and Remittance Advise Remark Codes (RARC) discussion with Mike Randol and MCOs
- Mike Randol to provide summary of monthly reports on service terminations and reductions that are provided to the Iowa Office of Ombudsman. (Standing Item)

Open Comment (Open Comment Opportunity for Members)

Dr. Dave Carlyle stated that he would like to attend the data workshop and would like additional information regarding claims denial rates and reversals so that he can compare MCO performance.

Marsha Fisher stated that she agreed with the Department's decision to request an extension for the implementation of the EVV program. She indicated that her family would be impacted by the EVV program as her and her husband care for their son in their home. Marsha identified that her and her husband assist their son with various activities throughout the day and that having to report over the phone each time that they do so will be cumbersome. Marsha stated that she felt it to be an infringement on their care and there should be a caveat for persons caring for their family members with a broader focus.

Steve Bowen indicated that the facility ChildServe has not received payment for services rendered to Medicaid recipients for several months. Mike advised to contact him with specific information.

Denise Rathman stated that she has heard from Medicaid members that they were told by the IME and DHS that Skilled Nursing Facility (SNF) benefits were the same for Iowa Health and Wellness Plan (IHAWP) members and Traditional Medicaid members. She stated that this is potentially due to the difficulty in placing IHAWP members in SNFs in central Iowa. Denise indicated that this may be due to the fact that persons providing rehabilitative services to Traditional Medicaid are not required to have a license although have a higher reimbursement rate than IHAWP providers who are required to have a license. Mike advised to contact him with specific information.

Adjourn

3:57 P.M.

[3] https://dhs.iowa.gov/ime/about/advisory_groups/piwg

Executive Committee
Summary of Meeting Minutes
May 15, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben – **present**	Julie Lovelady -
Dan Royer – **present**	Deb Johnson - **present**
Shelly Chandler –	Liz Matney - **present**
Cindy Baddeloo – **present**	Kevin Kirkpatrick - **present**
Casey Ficek –	Lindsay Paulson - **present**
Lori Allen – **present**	Sean Bagniewski - **present**
Richard Crouch – **present**	Luisito Cabrera - **present**
Julie Fugenschuh – **present**	Alisha Timmerman - **present**
Jodi Tomlonovic – **present**	

Introduction
Gerd called the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of April 11, 2018
A vote was taken to approve the April 11, 2018 Executive Committee meeting minutes. The meeting minutes was approved.

Value-Based Purchasing (VBP) Arrangements
Paige Petit stated that UnitedHealthcare (UHC) currently has eight Accountable Care Organization (ACO) contracts.. She stated that UnitedHealthcare currently meets the State's contractual requirements and the organization is currently working with providers to meet the requirement for forty percent of their members to be enrolled in ACOs by the end of 2018. Paige outlined the eight ACOs with whom UHC currently has contracts; Broadlawns Hospital, Iowa Health Plus, Mercy Hospital, UnityPoint Health, University of Iowa Hospitals and Clinics, McFarland Clinic, UniNet Healthcare Network, and Sanford Health (by July 2018). Mike Randol advised that, similar to Fee-for-Service, MCOs are normally paid a capitation payment. He stated that states and the federal government are moving toward a payment mechanism based on value for health outcome wherein instead of paying for the service, the payment is for quality outcomes. Mike stated that with the combination of reduction of cost and improved outcomes for the members, the savings is shared. Paige clarified that the member's Primary Care Provider (PCP) oversees the care of the member to achieve better health outcomes and that the providers membership to an ACO is invisible to a member. J John Hedgecoth stated that Amerigroup has a state contract performance goal of thirty percent of membership in a VBP agreement by July 1, 2018, and forty percent by December 31, 2018. He stated that Amerigroup is making sufficient progress to meet both the July 1, 2018, and December 31, 2018, goals. He stated that Amerigroup uses two key tools to achieve the VBP requirements;Quality Incentive Programs (QIP) and Shared Savings Agreement. QIPs have individual contracts with providers using flexible measurement tools customized by provider type that include programs designed for primary care practices, nursing facilities, and soon for behavioral health providers and facilities. He stated that Amerigroup plans to have six QIPs in place by early 2019. John stated that Shared Savings Agreements are designed for

larger hospital systems and are characterized by individual provider groups who are interested in quality and performance as part of their contract with Amerigroup. John advised that18 of Amerigroup's 20 Medicaid states have some form of VBP program and overall, Amerigroup has 38 percent of their Medicaid services being performed by providers who are part of a VBP contract. Paige stated that UnitedHealthcare is also looking into other hybrid programs such as partnering with smaller providers because if a provider is not part of a large health system, then achieving a larger member enrollment threshold may not be achievable. John stated that in January 2019,Amerigroup is planning to launch QIP programs that are intended to capture in the range of 250-999 members called "*PQIP Essentials*". Mike Randol added that the potential for smaller groups is still being evaluated for viability.

Review of Iowa Code Chapter 249A.4B and Associated Administrative Rules

Gerd reviewed the documents in the materials packet regarding the role of the MAAC and advised of aspects of the medical assistance program that may be considered for future recommendations. Gerd stated that the administrative rules do not prevent the Committee from making recommendations regarding the budget and that this may be a topic for consideration given the meeting of the Council on Human Services regarding legislative directives in August of 2018.

Medicaid Director's Update

Legislative Update

Mike stated that the legislative session has concluded and that there were a number of MCO oversight items present in the appropriations bill that the Department is currently evaluating. The Department will continue to update councils such as the MAAC as additional information becomes available. Some of the reports required for submission to the legislature involve Integrated Health Homes and Health Homes, Medicaid to Medicaid fee schedule alignment, and cost reports for Targeted Case Managers (TCMs). The Department will also be carrying out a Long Term Services and Supports (LTSS) small claims audit, altering Psychiatric Medical Institutions for Children (PMIC) reimbursement from a cost-basis to fee schedule, and continue to have a dedicated provider relations group for provider assistance.

MCO Contracts

Mike informed the Committee that an announcement of award would occur in the near future.

President's Executive Order

Mike advised that the Department is currently evaluating the potential impact of the president's executive order on the state of Iowa and additional information is not available at this time. In regards to capitation rates, Mike stated that they are risk adjusted, all base rates are the same, and the Department will work with the actuary to ensure that rates are actuarially sound for the services that the Department is requesting the MCOs provide. Amerigroup's risk corridor amendment was discussed and Mike advised that the process will take approximately nine months following the conclusion of the fiscal year; six months for accurate claims analysis, approximately 60 days for reconciliation, and a 30 day period in which payment can be made. The final payment determination is made by the Department.

Claims Adjustment Reason Code (CARC) 45 and Remittance Advise Remark Codes (RARC)

Jill Cook of Amerigroup stated that when the code is submitted to them for processing, it must be "clean," without defects, include all necessary information required for processing, and be submitted within the timely filing period. She stated that these are standard insurance billing requirements and added that once clean claims are submitted, providers may check the status of their claim by accessing the Amerigroup provider portal, calling provider services, or working with their clearinghouse. She stated that once a claim has been adjudicated, it will either be paid or denied and if denied, it will be assigned an explanation or reason code. Jill advised that the reason codes utilized are industry standard and the same codes across all payers. She stated that even if Amerigroup uses different internal numbers for codes such as CARC and RARC, they will always correlate to the appropriate industry standard CARC and RARC code number which is reflected in all remittance advices. Jill explained that CARC and RARC do not always mean that the claim has been denied and the internal explanation code explains what action is needed for adjudication. She explained that CARC 45 may explain that the billing has been made for something that the provider is not contracted for or the claim was paid at the existing fee schedule and not at the amount that was billed in the claim. Jill suggested that in anomalous cases of claims payment that it is best to go through the normal claims dispute process.

Open Discussion

David referenced an email he had sent to Director Foxhoven regarding medical necessity

Executive Committee Agenda Item:

- David' to discuss email to Director Jerry Foxhoven regarding medical necessity.

Adjourn

4:11 P.M.

May 16, 2018

Executive Committee
Summary of Meeting Minutes
June 12, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol -
Dennis Tibben – **present**	Julie Lovelady - **present**
Dan Royer – **present**	Deb Johnson - **present**
Shelly Chandler – **present**	Liz Matney -
Cindy Baddeloo – **present**	Kevin Kirkpatrick - **present**
Casey Ficek – **present**	Lindsay Paulson -
Lori Allen –	Sean Bagniewski -
Richard Crouch –	Luisito Cabrera - **present**
Julie Fugenschuh –	Alisha Timmerman -
Jodi Tomlonovic – **present**	

Introduction
Gerd called the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of May 15, 2018
A vote was taken to approve the May 15, 2018, Executive Committee meeting minutes. The meeting minutes were approved.

Recommendations Response Letter
The SFY18 Quarter 2 recommendations response letter was made available in the materials packet. Gerd advised that the legislature is requesting the Committee review data and provide feedback to the legislature by December 31, 2018, and that the first recommendation is a topic for this feedback.

Email to Director Foxhoven regarding medical necessity
A copy of David's email was made available in the materials packet and the document was reviewed. David's recommendations to Director Foxhoven:

- The MCO contracts enable the MCOs to establish protocols that determine medical necessity. It is David's recommendation that standards or guidelines are developed to determine medical necessity and said standards be conveyed to members.
- David recommended that the MCOs provide a rationale to members when services are modified if they are modified due to their being considered not medically necessary.

Action Item:
The Department to discuss medical necessity at a future Executive Committee meeting: the process for medical necessity determinations; IME's role in the approval of determinations/changes to medical necessity, and; standards for determinations.

Legislative Lobbying
David stated that last fiscal year the MCOs spent a combined $126,198 on lobbying and noted some

of the items that they lobbied against. Gerd and David will discuss legislation and regulations regarding MCO lobbying, as it relates to contracting with the Department, with Gretchen Kraemer. David's email with Gretchen Kraemer was discussed; document available in the materials packet.

Medicaid Director's Update

Legislative Update

Julie stated that the Department was currently reviewing Senate Bill 2418 and will provide a summary of the Bill to the MAAC at a future date. Julie advised that pertinent information within the Bill will be conveyed to providers via Informational Letters and providers may also contact Julie should they have additional questions.

MCO Contracts

Julie informed the Committee that contract negotiations with Amerigroup Iowa, Inc. (Amerigroup) and UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare) were underway. Iowa Total Care would begin providing coverage for managed care members July 1, 2019, and members would be notified by mail when they are able to select the new MCO. Additional information regarding the introduction of Iowa Total Care in the program will be shared at a later date.

Dental Wellness Plan (DWP)

Effective July 1, 2018, an Annual Benefit Maximum (ABM) will be implemented for every adult Medicaid member, age 21 and older enrolled in the DWP. The ABM amount of $1,000 is per state fiscal year (July 1-June 30). The $1,000 ABM will not apply to certain services such as preventive and emergent services.

Home- and Community-Based Services (HCBS) Quality Performance Measurements and State Plan Amendment (SPA) Updates

Julie stated that the Department received approval from the Centers for Medicare and Medicaid Services (CMS) for the HCBS Quality Performance Measurements; changing from 44 to 22 measures. There were 4 HCBS waivers and habilitation in public comment period, ending on July 2, 2018. The measures were the same as those approved for the Health and Disability (HD) HCBS waiver and are listed on the Public Notices website[1]. Julie advised of additional SPAs that were in public comment period; information available on the Public Notices website.

Process Improvement Working Group

The next meeting was to be held on Thursday, June 21, 2018 and additional information regarding the working group can be found on the Process Improvement Working Group website[2]. David expressed concern that working group discussions focus primarily on provider experiences and not those of consumers. Julie stated that working group discussions focus on consumer and provider concerns and a report regarding topics, discussions, and resolutions will be made available on the website and to the MAAC later in 2018.

Summary of monthly reports on service terminations and reductions that are provided to the Iowa Office of the Ombudsman

This topic is to be discussed at the July 3, 2018, Executive Committee meeting.

Action Item:

- Mike Randol to discuss Medicaid cost savings following the implementation of managed care at future Executive Committee meeting.

Open Discussion

Gerd discussed Section 131 of the appropriations bill stating that the Committee is to review data collected and analyze the information for inclusion in periodic reports that are due to the legislature; particularly reports that were required in Section 93 in Chapter 1139 that was passed by the 2016 Iowa Acts. The annual report is due December 31, 2018, although per legislation, initial information must be made available by October 1, 2018. A subcommittee consisting of David, Shelly, Cindy, Dennis, Casey, and Gerd was developed to discuss the reporting requirements. The first meeting was to take place prior to the Full Council meeting on August 9, 2018, with subsequent meeting dates to be determined.

Casey Ficek stated that the Iowa Pharmacy Association (IPA) had been made aware of issues regarding diabetic testing supplies due to the change in reimbursement rates for preferred brand products that Medicaid members were required to utilize. He stated the concern was in pharmacists no longer serving Medicaid members due to the decrease in reimbursement rates and the IME was currently assisting the IPA with their concerns.

David noted that in review of the capitation payments and medical loss ratios in the quarterly reports, it appeared that the MCOs have not earned a profit on services rendered.

Adjourn

4:08 P.M.

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[1] http://dhs.iowa.gov/public-notices

[2] https://dhs.iowa.gov/ime/about/advisory_groups/piwg

Office of the State Long-Term Care
OMBUDSMAN
Established within the Iowa Department on Aging

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Executive Summary

The Office of the State Long-Term Care Ombudsman (OSLTCO), through the Managed Care Ombudsman Program (MCOP), advocates for managed care members who receive long-term services and supports (LTSS) in health care facilities or through one of the seven home and community-based (HCBS) waiver programs.

The MCOP assists these managed care members with understanding their rights regarding services, care and access to managed care. The MCOP does not advocate for managed care members who are not in a health care facility or who do not receive LTSS under one of the seven HCBS waivers. In addition, the MCOP does not advocate for providers.

This executive summary is submitted to fulfill the requirements of HF 2460 regarding the OSLTCO's advocacy and assistance for managed care members who are in a health care facility or who receive LTSS under one of the seven HCBS waiver. This executive summary summarizes member issues brought to the attention of the OSLTCO for the time period of October 1, 2017 through September 30, 2018.

I. Member Issues

The OSLTCO has received a total of 2,792 contacts regarding managed care from October 1, 2017 to September 30, 2018. Contacts were made with the OSLTCO by telephone and email. Members, their legal decision makers, and caregivers were the source of contacts with the OSLTCO. The following table identifies the total contacts received by month and the three issues most frequently raised by those contacting the OSLTCO. The number of contacts reported is representative of the number of times MCOP was contacted; it does not represent the number of complaints made to the MCOP.

Months	Total Contacts	Most Frequently Raised Issues
October 2017	318	• Service reduced, denied or terminated • Care planning participation • Access to information or information sharing
November 2017	223	• Transition services/coverage inadequate or inaccessible • Selecting/changing MCO • Services reduced, denied or terminated
December 2017	173	• Service reduced, denied or terminated • Care coordinator/case managed was rude or gave poor customer service • Care planning participation
January 2018	273	• Change in care setting • Transition services/coverage inadequate or inaccessible • Care planning participation
February 2018	225	• Service reduced, denied or terminated • Access to preferred/necessary durable medical equipment • Discharge
March 2018	214	• Level of care assessment • Service reduced, denied or terminated • Care planning participation
April 2018	211	• Care planning participation • Level of care assessment • Service reduced, denied or terminated
May 2018	213	• Care planning participation • Service reduced, denied or terminated • Level of care assessment
June 2018	250	• Service reduced, denied, terminated • Level of care assessment • Care planning participation
July, 2018	209	• Service reduced, denied or terminated • MCO was rude or gave poor customer service • Care planning participation
August 2018	316	• Service reduced, denied, or terminated • Care planning participation • MCO was rude or gave poor customer service
September 2018	167	• Service reduced, denied or terminated • Access to Services/Benefits-CCO/CDAC • Care planning participation

Most of the contacts the OSLTCO received were from Elderly Waiver managed care members or someone contacting the MCOP on their behalf.

In April 2018, MCOP began distilling additional information from the contacts that had been reported previously. The MCOP now tracks information on the type and number of complaints that managed care members, or someone acting on a managed care member's behalf, present to the MCOP for assistance. This data is reflected in the table below.

Month	Complaint	Members Affected
April	Services reduced, denied or terminated	23
	Care planning	4
	Eligibility	4
	Service coverage gap issues	2
	Case manager rude or poor customer service	1
	Change in care setting	1
	Level of care assessments	1
	Case manager not getting paid	1
	Provider not in network	1
	Transition services/coverage inadequate/inaccessible	1
	Transportation	1
May	Services reduced, denied or terminated	17
	Care planning	12
	Level of care assessments	10
	Access to preferred/necessary durable medical equipment	7
	Care coordinator/case manager was rude or gave poor customer service	5
	Member needs assistance with acquiring eligibility information	5
	Other service/coverage gap issue	5
	Access to information sharing	4
	Change in care setting	4
	Member has lost eligibility status or was denied	4
	Scheduling	4
June	Services reduced, denied or terminated	24
	Level of care assessment	13
	Care coordinator/case manager was rude or gave poor customer service	9
	Access to preferred/necessary durable medical equipment	6
	Care planning participation	5
	Other access to services/benefits issue	5
	Other	4

Month	Complaint	Members Affected
	Other billing issue	4
	Member needs assistance with acquiring eligibility information	4
	MCO was rude or gave poor customer service	3
	Other service/coverage gap issue	3
	Scheduling	3
	Transition services/coverage inadequate or inaccessible	3
	Change in care setting	2
	Access to preferred/necessary medication	1
	Disenrollment from MCO - good cause eligible	1
	Disenrollment from Medicaid program	1
	Guardian not receiving information	1
	Provider/pharmacy/hospital not in network	1
	Member has not received MCO materials	1
	Member has lost eligibility status or was denied	1
	N/A	1
	Transportation not available, timely or adequate	1
July	Services reduced, denied or terminated	22
	MCO was rude or gave poor customer service	8
	Access to preferred/necessary durable medical equipment	7
	Care coordinator/case manager was rude or gave poor customer service	7
	Care planning participation	7
	Level of care	7
	Other access to services/benefits issue	6
	Member needs assistance with acquiring Medicaid eligibility information	4
	Access to information or information sharing	3
	Access to preferred/necessary medication	3
	Other billing issue	3
	Discharge	2
	Home/vehicle modifications	2
	Provider/pharmacy/hospital not in network	2
	Transportation not available, timely or adequate	2
	Change in care setting	2
	Other service/coverage gap issue	2
	Disenrollment from MCO - good cause eligible	1
	Member needs assistance checking on application status	1
	N/A	1
	Other	1
	Transition services/coverage inadequate or inaccessible	1
August	Services reduced, denied or terminated	27

Month	Complaint	Members Affected
	Care planning participation	11
	MCO was rude or gave poor customer service	11
	Level of care	7
	Member needs assistance checking on application status	7
	Other service/coverage gap issue	6
	Access to preferred/necessary durable medical equipment	6
	Other access to services/benefits issue	6
	Access to information or information sharing	5
	Care coordinator/case manager was rude or gave poor customer service	5
	Access to preferred necessary medication	4
	Other billing issue	4
	Member needs assistance with acquiring Medicaid eligibility information	3
	Home/vehicle modifications	3
	Change in care setting (2 members)	2
	Discharge	2
	Provider/pharmacy/hospital not in network	2
	Transition services/coverage inadequate or inaccessible	2
	Other customer service issue	1
	Guardian not receiving information	1
	Member charged improper cost sharing	1
	Member has lost eligibility status or was denied	1
	N/A	1
	Other	1
September	Services reduced, denied or terminated	11
	Access to Services/Benefits-Other	8
	Home/vehicle modifications	5
	Care coordinator/case manager was rude or gave poor customer service	5
	Care planning participation	4
	Other service/coverage gap issue	4
	Access to information or information sharing	4
	Scheduling	3
	Member needs assistance with checking on application status	3
	Discharge	3
	Access to preferred/necessary durable medical equipment	2
	Prior authorization	2
	Provider/pharmacy/hospital not in network	2
	Level of care assessment	2
	MCO was rude or gave poor customer service	2

Month	Complaint	Members Affected
	Transportation not available, timely or adequate	2
	Transition services/coverage inadequate or inaccessible	1
	Member charged improper cost sharing	1
	Other billing issue	1
	Change in care setting	1
	Access to preferred/necessary medication	1
	Member has lost eligibility status or was denied	1
	Selecting/changing MCO	1
	Guardianship documents not on file	1

In addition, the complaints presented are now being tracked by program type. This information is presented in the table below for April, May and June.

Complaint	April	May	June
AIDS/HIV Waiver	-	-	-
Brain Injury Waiver	4	2	6
Children's Mental Health Waiver	3	3	1
Dental	-	-	-
Duals	4	5	6
Elderly Waiver	7	16	12
Habilitation	-	1	2
Health & Disability Waiver	4	7	5
HIPP	-	2	2
Institutional Care	-	-	-
Iowa Health & Wellness	-	-	-
Intellectual Disability Waiver	9	14	17
Medicare	2	-	-
PACE	-	-	-
Physical Disability Waiver	1	1	1
QMB or SLMB	-	-	1
Traditional Medicaid	2	3	2
Other	-	-	1
N/A	-	1	-
Unknown	3	5	5
Q1 Total	40	60	61

COMPLAINTS BY TYPE (APRIL, MAY AND JUNE 2018)

And beginning with the data for July, August and September the complaints, by program type and MCO are reflected in the tables below.

July		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Complaint(s) by Program Type	AIDS/HIV Waiver	-	-	-	0
	Brain Injury Waiver	3	3	-	6
	Children's Mental Health Waiver	1	-	-	1
	Dental	-	1	-	1
	Duals	1	2	-	3
	Elderly Waiver	4	4	-	8
	Habilitation	-	-	-	0
	Health & Disability Waiver	2	9	1	12
	HIPP	-	-	1	1
	Institutional Care	-	1	-	1
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	3	11	1	15
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	1	-	1
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	-	2	1	
	Other	-	2	-	2
	N/A	-	-	-	0
	Unknown	-	-	-	0
	TOTAL:	14	36	4	54

August		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Case(s) by Program Type	AIDS/HIV Waiver	-	-		0
	Brain Injury Waiver	3	6	-	9
	Children's Mental Health Waiver	-	1		1
	Dental	-	-		0
	Duals	2	1	-	3
	Elderly Waiver	8	10	-	18
	Habilitation	-	-		0
	Health & Disability Waiver	2	10	-	12
	HIPP	-	-	1	1
	Institutional Care	-	-		0
	Iowa Health & Wellness	-	-		0
	Intellectual Disability Waiver	2	17	1	20
	Medicare	-	-		0
	PACE	-	-		0
	Physical Disability Waiver	-	2		2
	QMB or SLMB	-	-		0
	Traditional Medicaid	2	3	2	7
	Other	-	2		2
	N/A	-		-	0
	Unknown	-		-	0
	TOTAL:	19	52	4	75

September		Amerigroup Iowa	UnitedHealthcare Plan of the River Valley	Fee for Service	Total
Complaint(s) by Program Type	AIDS/HIV Waiver	1	-	-	1
	Brain Injury Waiver	2	1	-	3
	Children's Mental Health Waiver	-	2	-	2
	Dental	-	-	-	0
	Duals	-	1	-	1
	Elderly Waiver	5	6	-	11
	Habilitation	-	1	-	1
	Health & Disability Waiver	1	6	-	7
	HIPP	-	-	-	0
	Institutional Care	-	-	-	0
	Iowa Health & Wellness	-	-	-	0
	Intellectual Disability Waiver	3	9	2	14
	Medicare	-	-	-	0
	PACE	-	-	-	0
	Physical Disability Waiver	-	2	-	2
	QMB or SLMB	-	-	-	0
	Traditional Medicaid	-	-	-	0
	Other	-	1	-	1
	N/A	-	-	-	0
	Unknown	-	-		0
	TOTAL:	12	29	2	43

II. Trends Tracked By The Managed Care Ombudsman Program October 1, 2017 to September 30, 2018

The most frequent reason that managed care members, or someone acting on the managed care member's behalf, contacted the MCOP, or requested assistance from the MCOP involved an issue with services being reduced, denied or terminated. The program that most frequently resulted in a managed care member or someone acting on the managed care member's behalf, contacting the MCOP or requesting assistance from the MCOP was the elderly waiver.

Iowa Department of Human Services

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

Iowa Mental Health and Disability Services Commission

November 20, 2018

Commissioners

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Kathy A. Johnson (Vice Chair)

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Representative David Heaton

Senator Liz Mathis

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:

February 15, 2018 - MHDS Commission Meeting
Rick Shults, Division Administrator of Mental Health and Disability Services, in a review of 2018 legislation presented to the Commission on a piece of legislation that encouraged the managed care organizations (MCO) and MHDS Regions to work together for individuals with complex service needs.

March 15, 2018 - MHDS Commission Meeting
Theresa Armstrong, Bureau Chief of Community Services and Planning, in a review of 2018 legislation presented to the Commission on the changes to Iowa Code 331 to strengthen the language regarding the managed care organizations (MCO) responsibility to fund Medicaid services for eligible Medicaid recipients.

May 16, 2018 - MHDS Commission Meeting
Mike Randol, Director of Iowa Medicaid Enterprise (IME), presented to the Commission on exception to policies, integrated health home review, and DHS oversight of the managed care organizations.

August 16, 2018 – MHDS Commission Meeting
Le Howland, IME staff, presented to the Commission on HCBS waiver eligibility including the role of MCOs in determining eligibility for home and community based services.

1305 E. Walnut Street, Des Moines, IA 50319-0114

September 20, 2018 - 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 2017. 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
- Reduced lengths of stay in residential treatment have been resulting in an increased level of recidivism
- Confusion over the administrative requirements for Integrated Health Homes
- Confusion over use of the 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
- Consistent communication from the MCOs and the Department and within the MCOs
- Lack of accessibility to additional 1915(b)(3) services under the Medicaid fee-for-service system
- Increasing development of quality services, including evidenced based practices
- Increasing community capacity to serve the most vulnerable individuals
- Reducing the 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

EXECUTIVE SUMMARY

This is the State Fiscal Year 2018 (SFY18) (July 1, 2017 to June 30, 2018) Annual Report for the Healthy and Well Kids in Iowa ***(hawk-i)*** program.

The number of children enrolled in the program increased in SFY 18 by 8,339 for the ***hawk-i*** program and by 455 for the ***hawk-i*** Dental Only program. Outreach activities continue to increase awareness of the program to help assure that low-income children in Iowa get the health care they need either through Medicaid or the ***hawk-i*** program.

MANAGED CARE ORGANIZATIONS

All ***hawk-i*** members had a choice of two Managed Care Organizations (MCOs) for health care coverage in SFY18. These MCOs were Amerigroup Iowa, Inc., and United Healthcare Plan of the River Valley, Inc. Dental coverage was provided through Delta Dental of Iowa.

REAUTHORIZATION OF THE PROGRAM

The federal funding for the Children's Health Insurance Program (CHIP), which in Iowa is the ***hawk-i*** program and the Medicaid Expansion for children, was reauthorized for 10 years in January 2018.

APPENDIX

APPENDIX: HCBS WAIVER WAITLIST

HCBS Waiver Waitlist – July 2018*							
HCBS waivers have a finite number of slots budgeted and authorized by CMS. These allow members to receive services in the community instead of a facility or institution.							
Waiver	AIDS	Brain Injury	Children's Mental Health	Elderly	Health and Disability	Intellectual Disability	Physical Disability
Number of Individuals on Waiver	31	1,433	962	7,758	2,232	11,996	980
Number of Individuals on Waiver Waitlist (DHS Function)	0	1,098	688	0	2,144	1,802	707
Waitlist Increase or (Decrease)	0	93	40	0	-100	20	-121

*As reported in July 2018. July data represents June eligibility statistics.

APPENDIX: GLOSSARY

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.
ACIA: AmeriHealth Caritas 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.

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.

CBCM: Community based case management. Community based case managers are responsible for coordinating services and health outcomes for Medicaid LTSS members.

CDAC: Consumer Directed Attendant Care. In the Home and Community Based Services (HCBS) waiver program, there is an opportunity for people to have help in their own homes. CDAC services are designed to help people do things that they normally would for themselves if they were able such as bathing, grocery shopping, medication management, household chores.

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.

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.

DME: Durable Medical Equipment

ED: Emergency Department

Fee-for-Service (FFS): Some Iowa Medicaid members are served through a Fee-for-Service (FFS) system where their health care providers are paid separately for each service (like an office visit, test, or procedure). Members who are not transitioning to the IA Health Link managed care program will remain in Medicaid FFS.

HCBS: Home and Community Based Services, waiver services

hawk-i: 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: An individual on staff or subcontracted with a managed care organization that manages the health of members with chronic health conditions.

Health Risk Assessment (HRA): A questionnaire to gather health information about the member which is used to evaluate health risks and quality of life.

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: A program that provides in-home medical services by Medicare-certified home health agencies.

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: A team of professionals working together to provide whole-person, patient centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

LOC: Level of Care.

LTSS: Long Term Services and Supports

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

MCO: Managed Care Organization

NF: Nursing Facility

PA: Prior Authorization. A PA is a requirement that the provider obtain approval from the health plan to prescribe medication or service. PAs ensure that services and medication delivered through the program are medically necessary.

PCP: Primary Care Provider

PDL: Preferred Drug List

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.

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.