Iowa Medicaid Enterprise

Managed Care
Annual Performance Report
(July 2016 – June 2017)

Published January 3, 2018

Iowa 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
- Information on specific population groups (General, Special Needs, Behavioral Health and Elderly)
- 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)

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, standardized health outcome measures require more experience, or at least one complete year of data, for accurate measurement. This will include measures associated with HEDIS®[1] CAHPS[2], and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state was awarded from the Centers for Medicare and Medicaid Services (CMS).

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

There are HEDIS and CAHPs measures included in the Health Outcomes Section of this report.

- 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 because 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 248,000 member health risk assessments (HRAs) were conducted since implementation of Medicaid Modernization by the health plans. HRAs were not a previous requirement. These assessments help identify risk factors to provide better treatment.

- Value-Added Services: Over 124,000 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, tobacco cessation, and wellness programs.

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

- More Patients in Home and Community Settings: Many of our long-term services and supports population prefer to be in a home and community-based setting rather than an institutional setting. Since Medicaid Modernization began, 5% more patients are in home and community-based settings.

- Claims Requirements: The MCOs exceeded the contractual expectation that ninety percent (90%) of payment claims be paid within 14 days. The average payment is made in less than 9 days. This is consistent with pre-implementation payment timelines of an average of 7 to 10 days.

- Timely Resolution of Grievances and Appeals: All the health plans resolved 100% of appeals timely in quarter 4. The old Medicaid program never had a requirement that appeals be resolved within 45 days. This expectation met by the health plans ensures patients get timely resolution. Plans have come close to resolving 100% of grievances within 30 days, with two quarters falling below 100%, but improving performance.

- Timely Pharmacy Prior Authorizations: For the fourth quarter in a row, 100% of regular prior authorizations for pharmacy were completed within 24 hours of request. This ensures timely patient access to pharmaceutical treatment to manage medical conditions

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. Below is a summary of these activities as of the date of this report.

Member Escalated Issue Tracking			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Number of Member Escalated Issues Reported to the Department	662	676	849
Number of Escalated Member Issues Considered Closed*	623	650	849
Percentage of Escalated Member Issues Considered Closed*	94%	96%	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.*

Provider Escalated Issue Tracking			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Number of Provider Escalated Issues Reported to the Department	772	781	638
Number of Escalated Provider Issues Considered Closed*	771	779	637
Percentage of Escalated Provider Issues Considered Closed*	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.*

Managed Care Related Projects:

- Health Homes: The Department partnered with the MCOs to update the Integrated Health Home and Chronic Condition Health Home programs. This project has been actively working to evaluate the Health Home programs' operation with the goal of improved processes, consistent alignment with state and federal requirements, and improved member outcomes.

- Managed Care Reporting: The Department continues to improve the reporting requirements for the MCOs to assist in oversight of the program. This work has included updates to the reporting manual as well as publication of performance reports.

- Waiver Slots: The Department has worked with the MCOs to improve the process and timeline for HCBS waiver slots.

- Analysis and Implementation of Managed Care Regulation Revisions: CMS finalized a large number of changes to the federal managed care regulations. The compliance and

applicability dates for these regulations will be phased in over the next several years. The Department will continue to implement contract changes as appropriate to comply with this phased approach.

- Electronic Visit Verification (EVV): The Department postponed a September 1, 2016, implementation date for the EVV system to allow for more stakeholder engagement, member and provider training, and communication. During SFY17, the Department is engaging stakeholders in the planning for EVV program implementation as well as continuing to move forward in the necessary steps towards this goal, including monitoring a pilot program.

- Implementation of Tiered HCBS Rates: The Department continued to work towards an updated reimbursement methodology for Supported Community Living services to align rates with the assessed need of the individual member. The department engaged stakeholders during development and tiered rates were implemented December 1, 2017.

- Expansion of State Innovation Model (SIM) Efforts: The Department continues to work with the MCOs to increase the number of members covered by value-based purchasing contracts. In addition, the Department's Value Index Score measurement for member outcomes will be expanded to include key measures for Long Term Care and Behavioral Health.

- External Quality Review: The Department is contracted with the Health Services Advisory Group (HSAG) to perform a third party assessment of each MCO's compliance with state and federal requirements as well as contract terms. The external quality review vendor additionally evaluates alignment of policies and procedures with operations and validation of data reported to the Department. A report of the first external quality review was published in July 2017 to the Department's webpage and can be found here: https://dhs.iowa.gov/sites/default/files/IA2016_EQR_Report.pdf.

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	26	19	9
Number of Remedies for Incomplete/ Untimely Reporting	14	5	7
Total Remedies Imposed State Fiscal Year 2017	40	24	16

**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

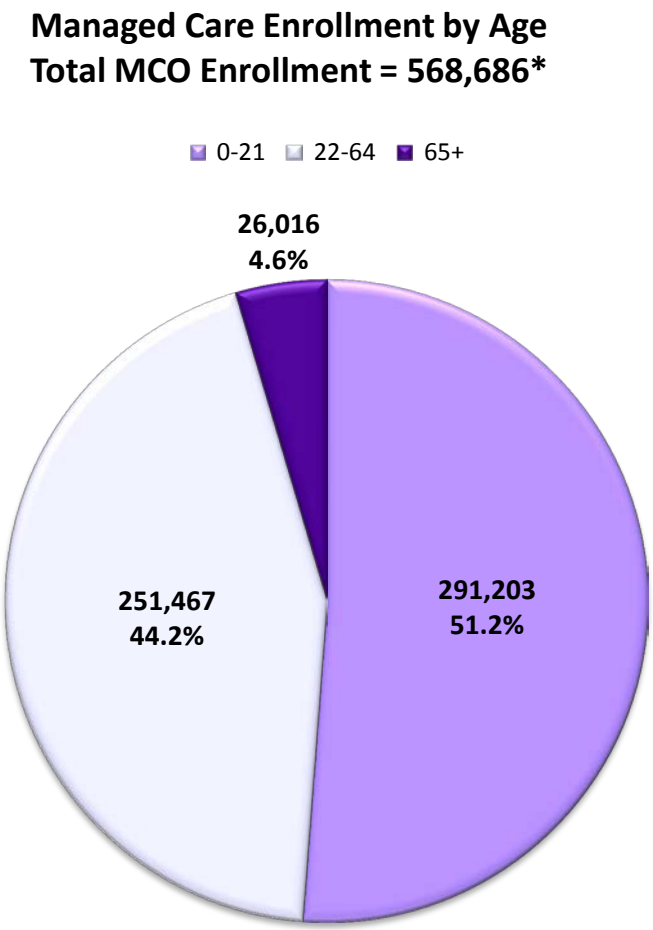
Providers and members can find more information on the IA Health Link program at
http://dhs.iowa.gov/iahealthlink

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

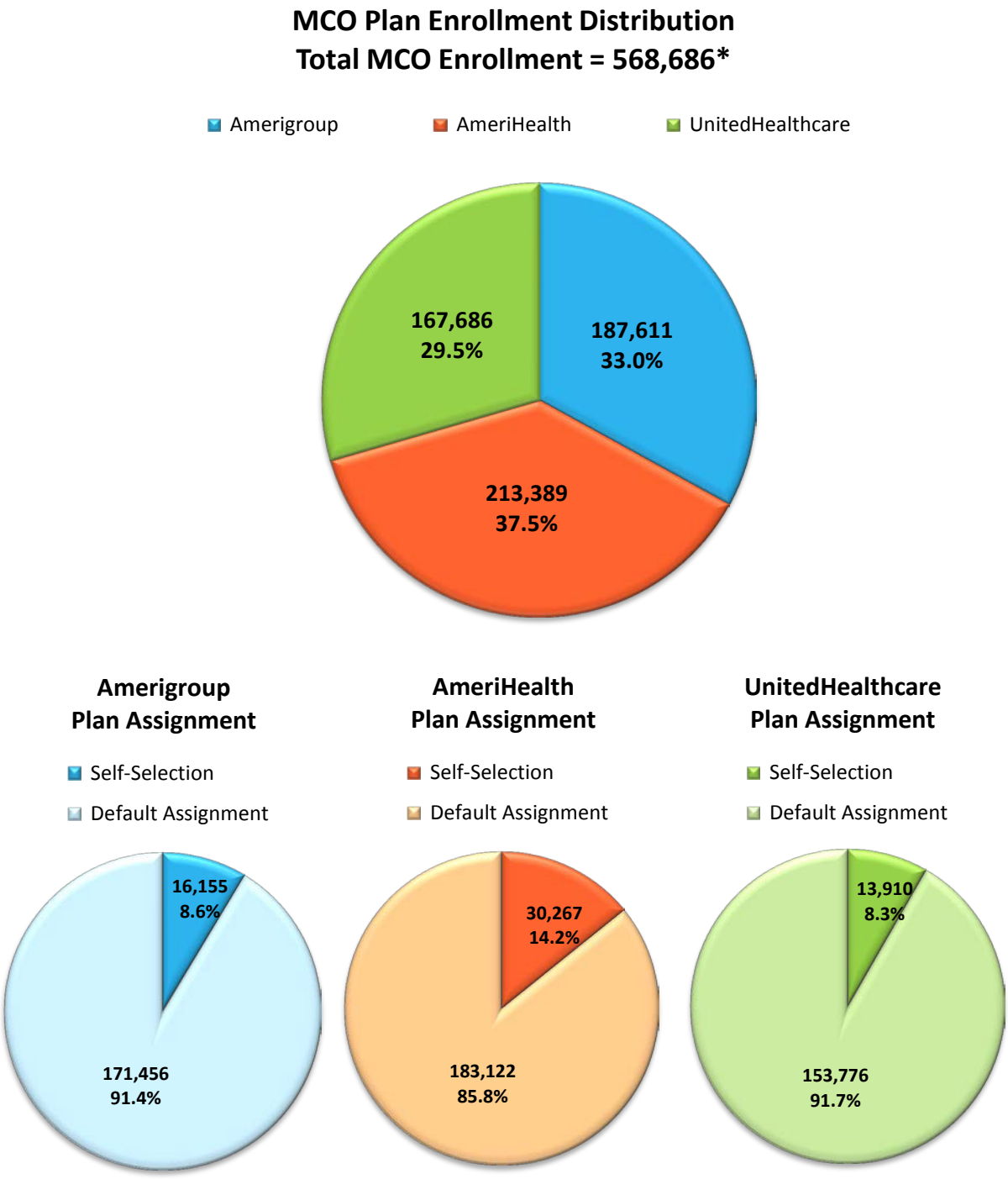
Quarterly Managed Care Performance Reports can be found at
https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports

PLAN ENROLLMENT BY AGE



*June 2017 enrollment data as of July 10, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This does not include hawk-i enrollees. This does not include approximately 50,000 members that remain in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY MCO



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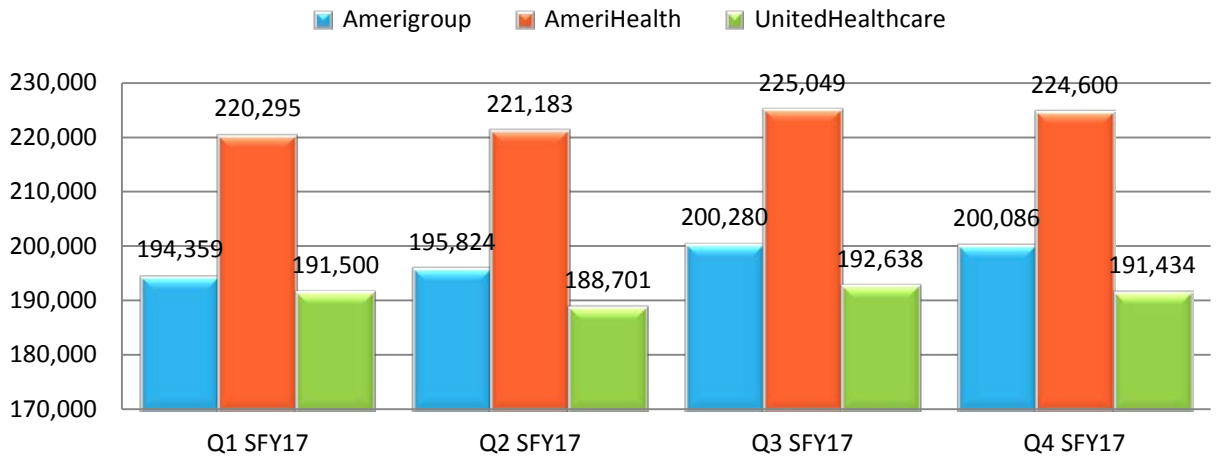
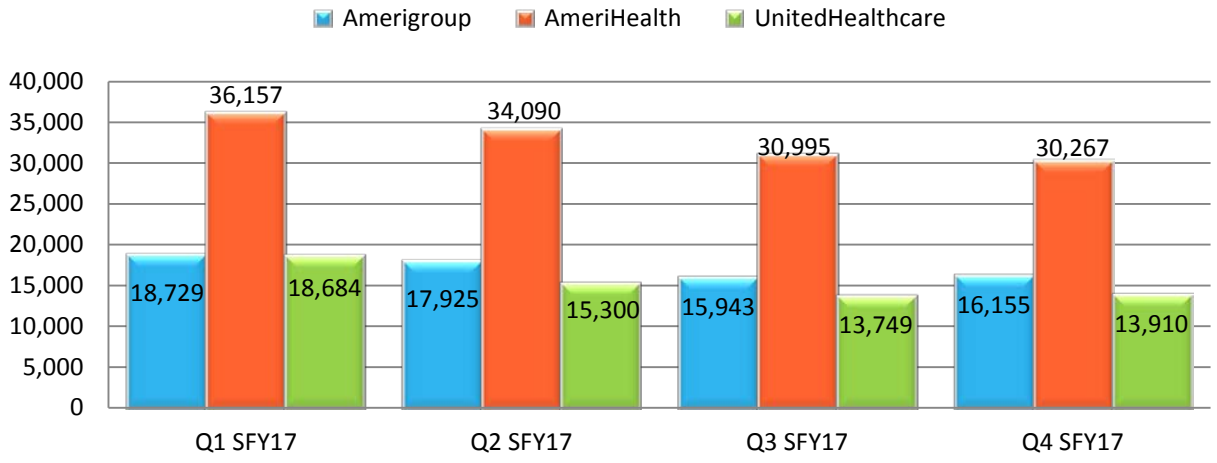
MCO Plan Enrollment Distribution

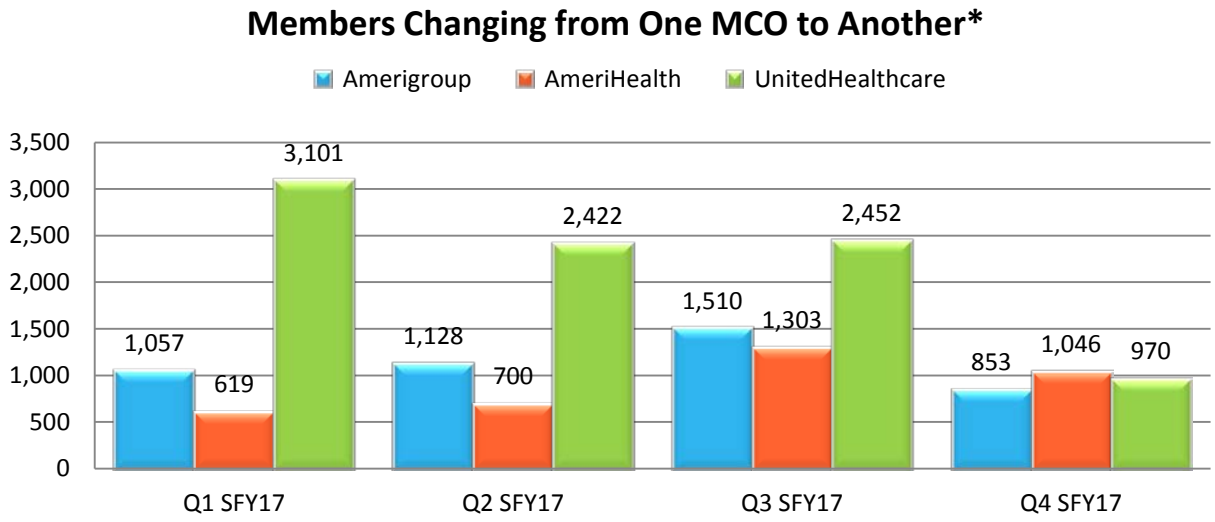


Members Actively Choosing MCO Plan*



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

PLAN DISENROLLMENT BY MCO



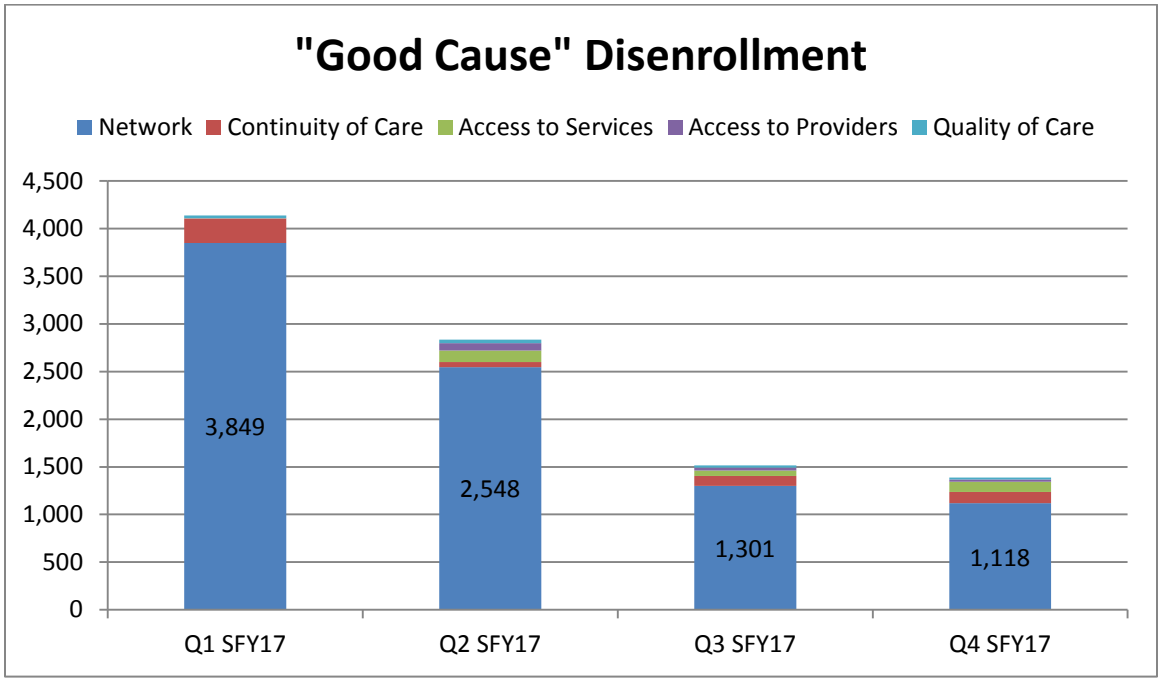
*Enrollment data as of the tenth day following the close of the reported period – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Disenrollment data refers to members who have chosen to change their enrollment with one MCO to an alternate 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.

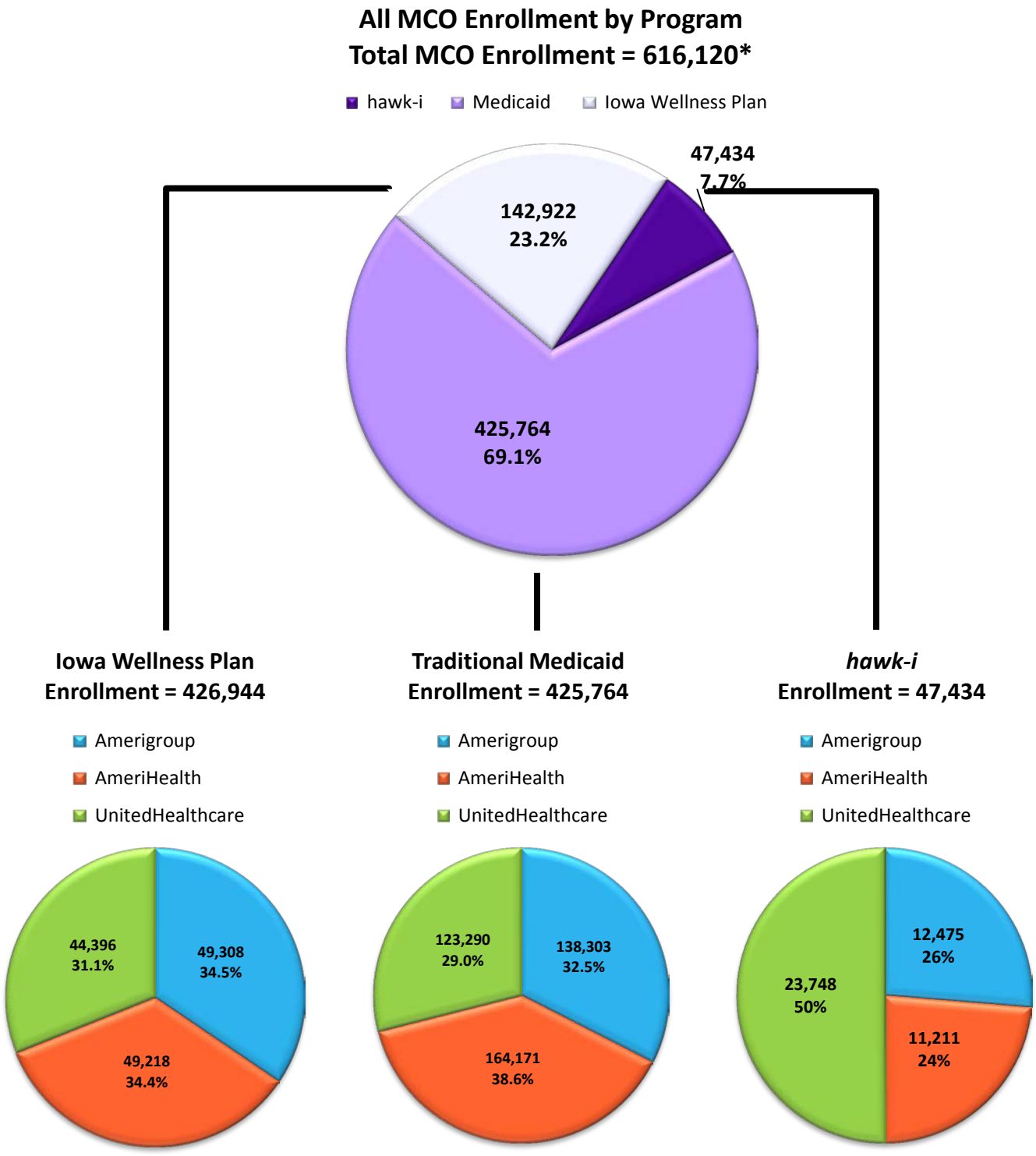
Reasons for "Good Cause" Disenrollment for SFY17

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 of 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.

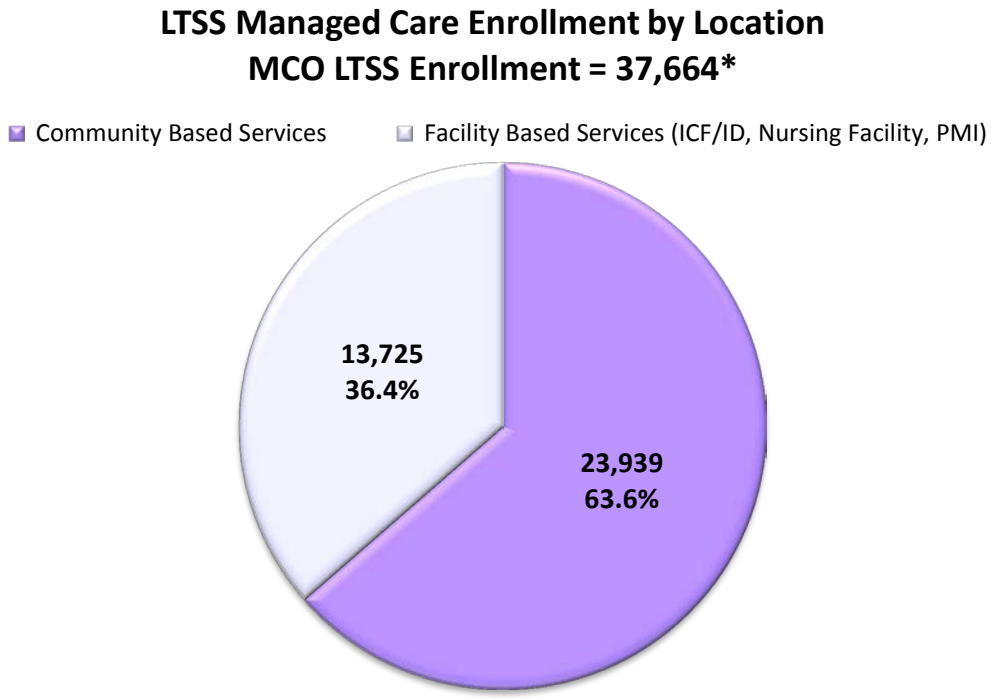

"Good Cause" Disenrollment
Network
Continuity of Care
Access to Services
Access to Providers
Quality of Care
4,500
4,000
3,500
3,000
2,500
2,000
1,500
1,000
500
0
3,849
2,548
1,301
1,118
Q1 SFY17
Q2 SFY17
Q3 SFY17
Q4 SFY17

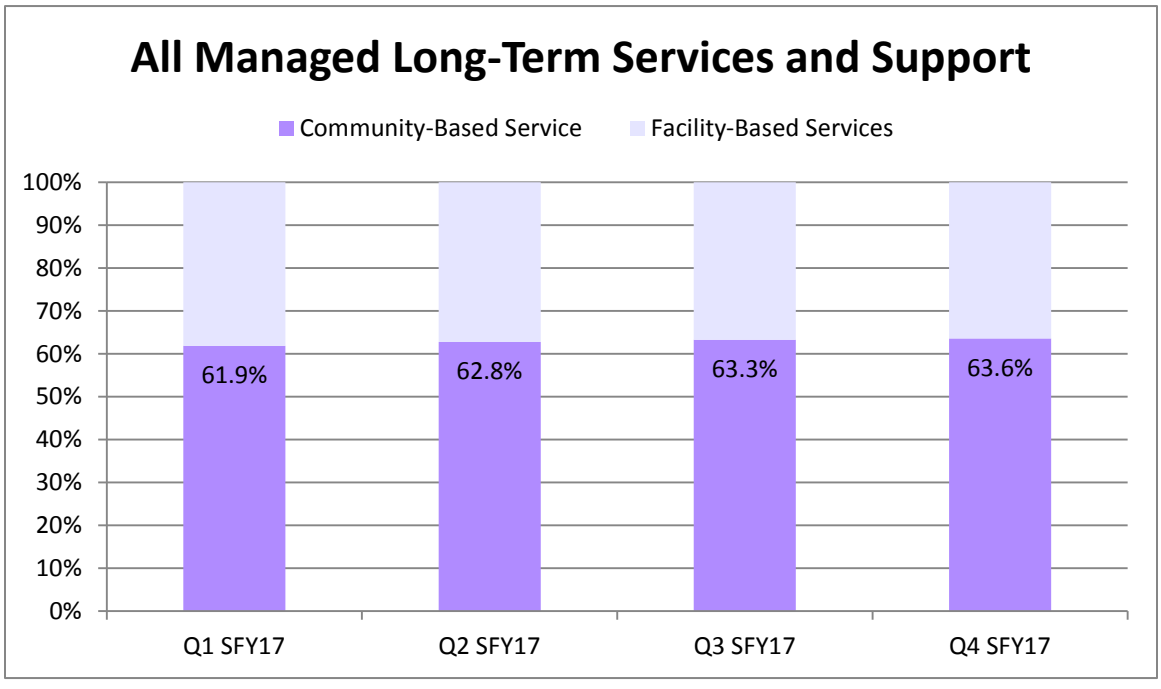
PLAN ENROLLMENT BY PROGRAM



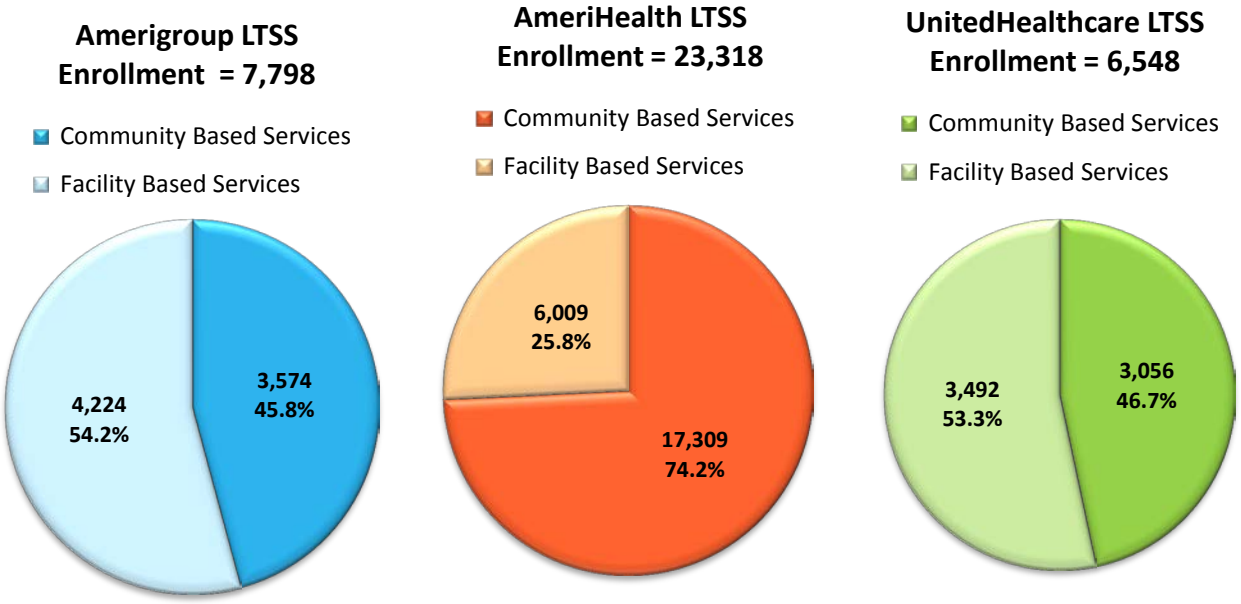
*June 2017 enrollment data as of July 10, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This does not include approximately 50,000 members that remain in the Fee-for-Service (FFS) program.

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT





Total MCO LTSS Enrollment by Plan



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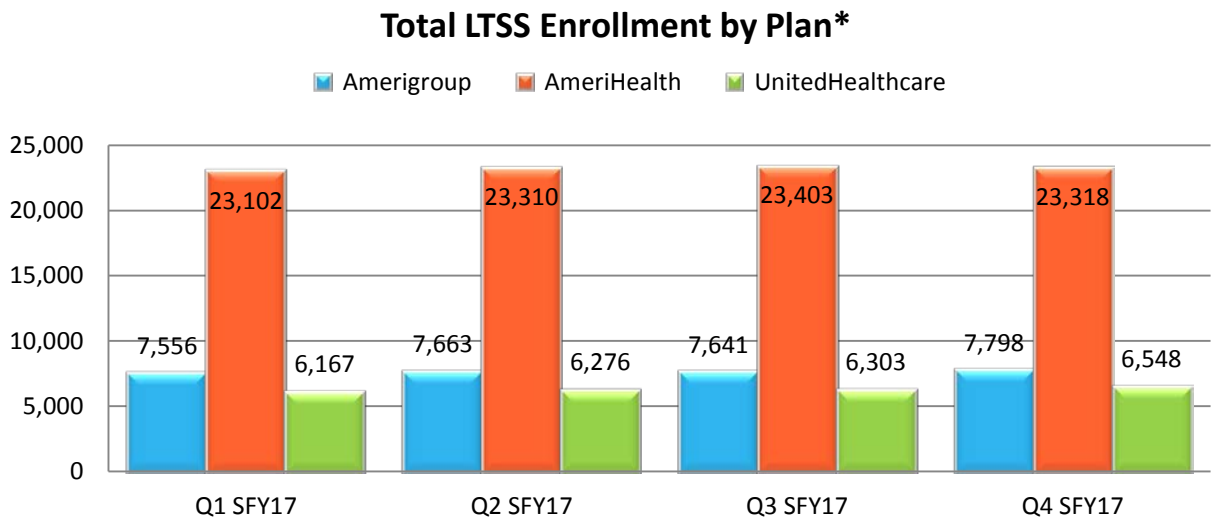
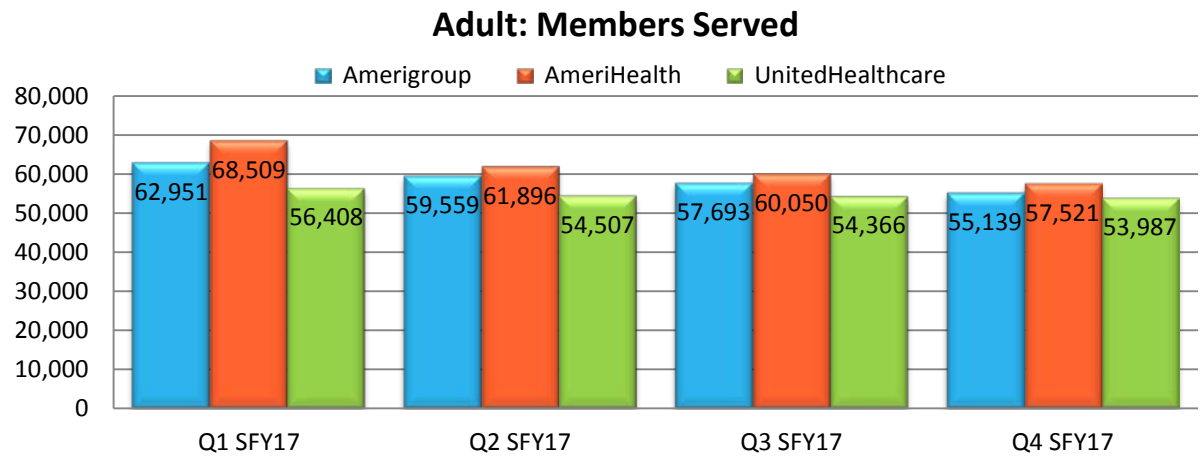


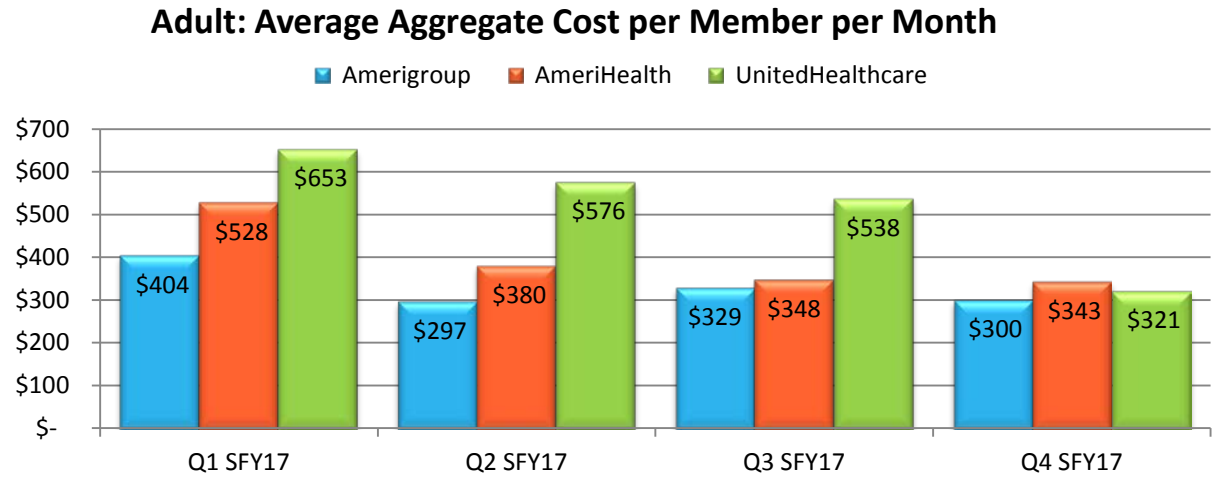
*Based on data reported in each of the quarterly reports.

Adult General Population Reporting

Adults included in this report are members between the ages of 18 and 64 as determined at the beginning of the quarter, who require basic health care services and do not have needs that require long term services and supports or behavioral health services. These members are low income and also include those on the Iowa Health and Wellness Plan.

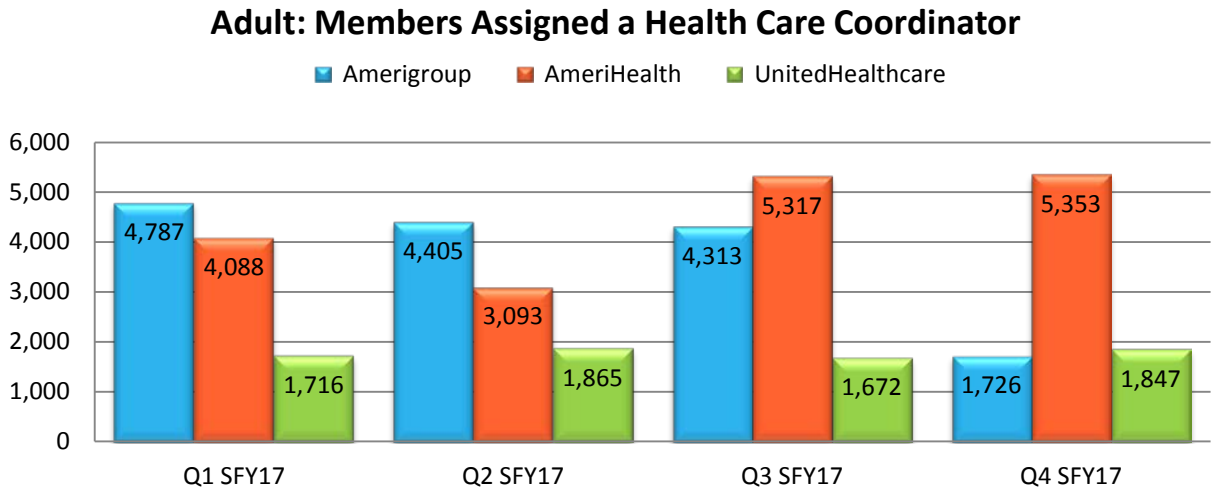


Adult: Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.



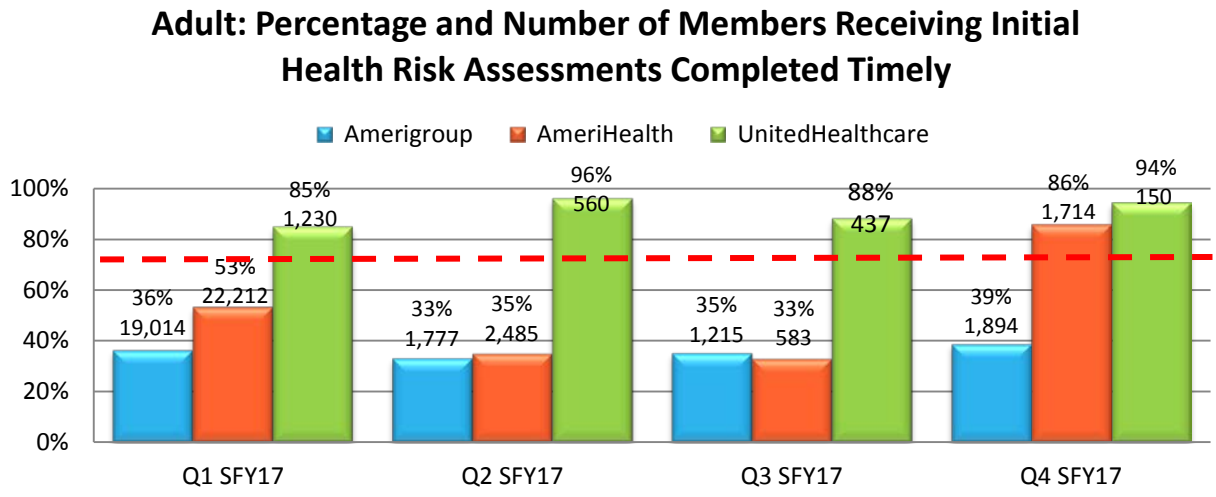
The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be

outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.



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. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service. It is anticipated that the number of members assigned to a care coordinator will increase over the first several quarters and then remain stable.

Numbers may vary across the MCOs due to the scope of care coordination services reported. For example, the numbers reported for AmeriHealth and UnitedHealthcare are representative of members assigned to a care coordinator in the field, while Amerigroup reported telephonic care coordination as well.



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

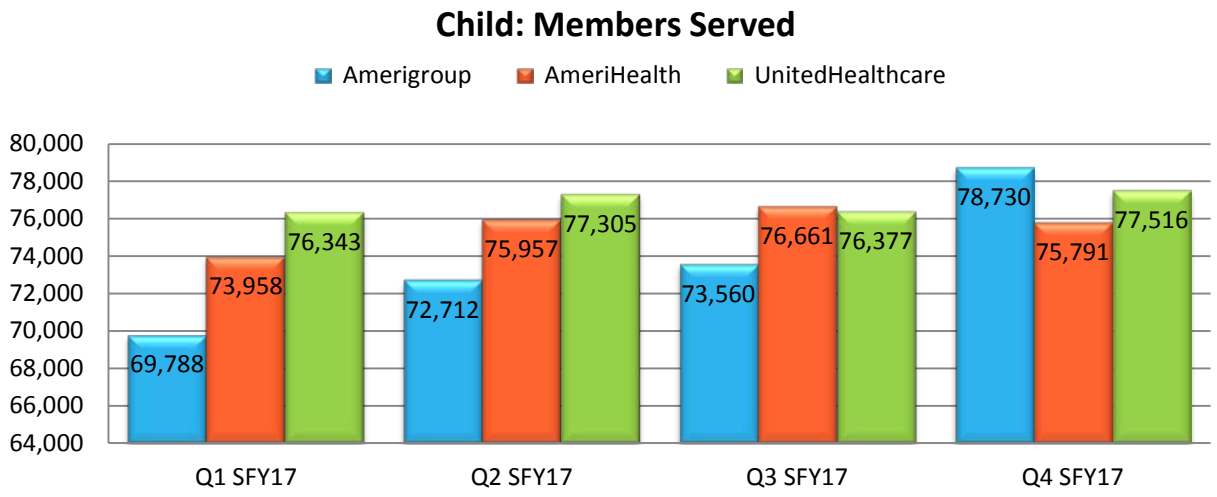
able to reach within three attempts. The department has issued remedies for this performance metric and continues to monitor the MCO work towards this goal.

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.

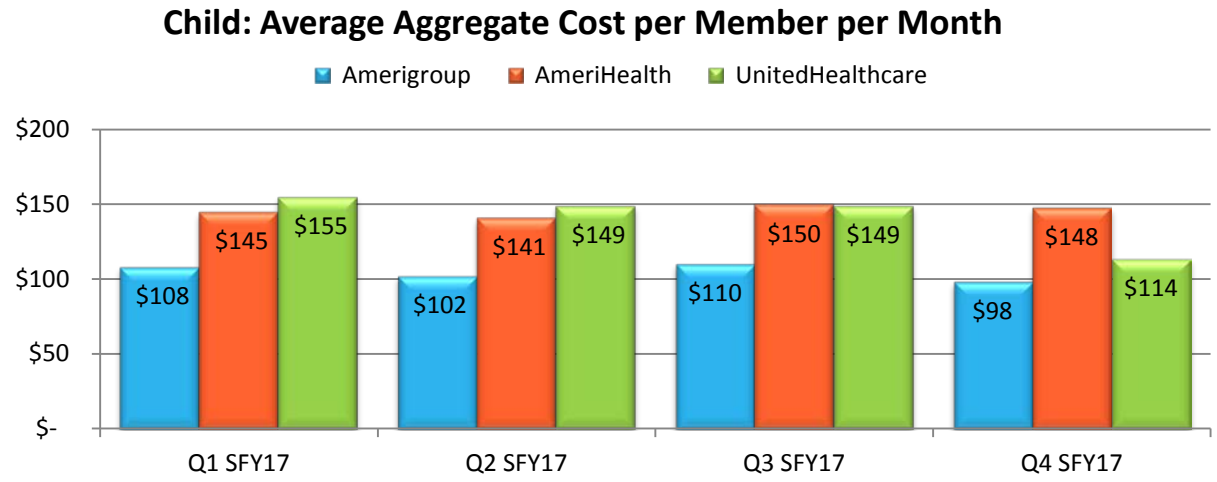
This data includes all MCO populations. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Child General Population Reporting

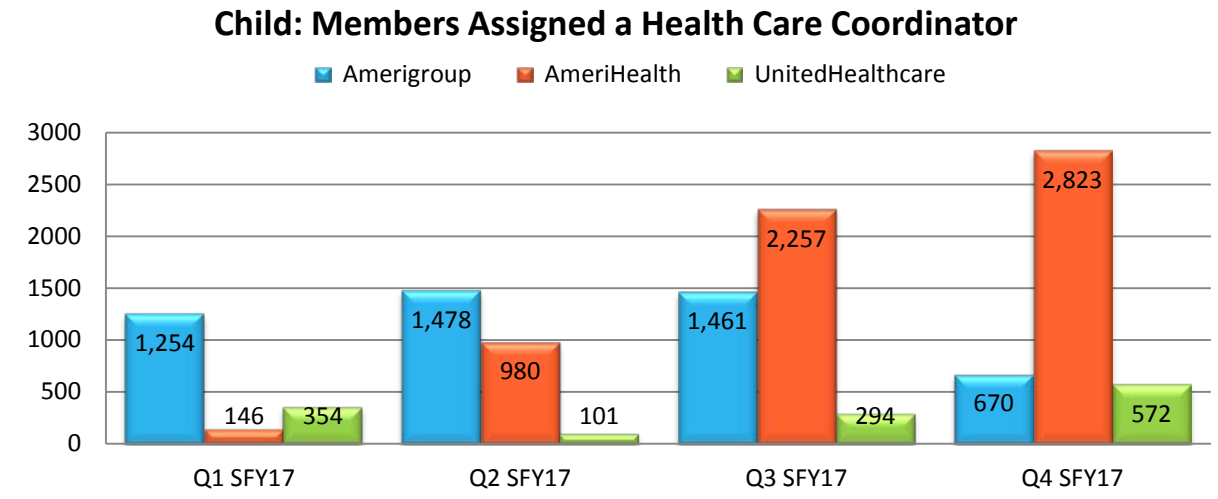
Children included in this report are members under the age of 18 as determined at the beginning of the quarter that require basic health care services and do not have needs that require long term care or supports including behavioral health services. This population includes the ***hawk-i*** and CHIP children.



Child: Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.



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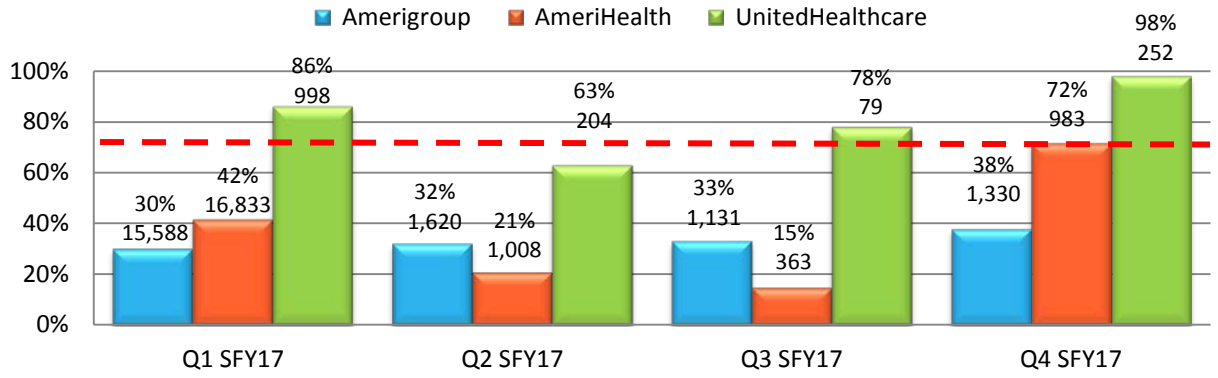
Numbers may vary across the managed care organizations due to the scope of care coordination services reported. For example, the numbers reported for AmeriHealth and UnitedHealthcare are representative of members assigned to a care coordinator in the field, while Amerigroup reported telephonic care coordination as well.



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 90 days and the MCO has been able to reach within three attempts. The department has issued remedies for this performance metric and continues to monitor the MCO work towards this goal.

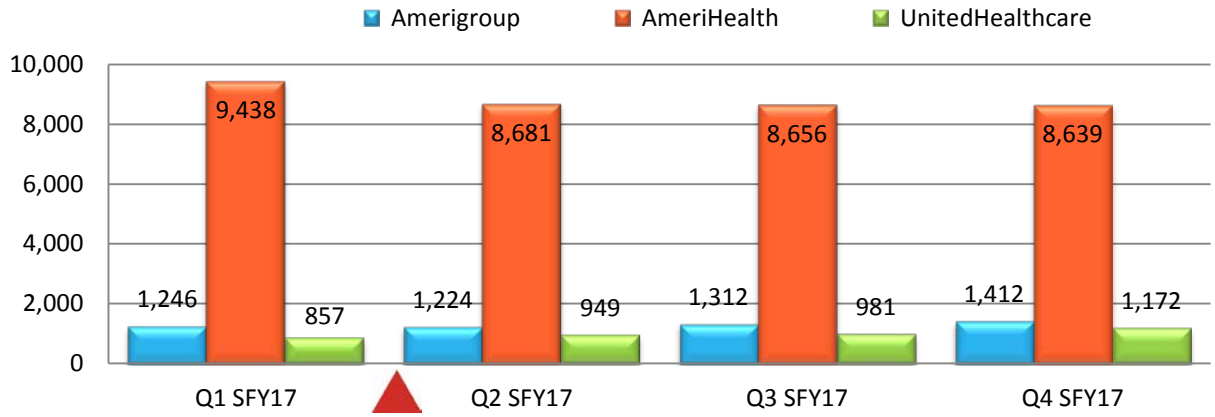
Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed.

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

Adult Special Needs Population Reporting

Adults included in this report are members between the ages of 18 and 64 as determined at the end of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. This population report reflects home and community based members as well as facility based members. These members may also be reflected in the Behavioral Health Population.

Adult: Members Served in Community-Based Settings

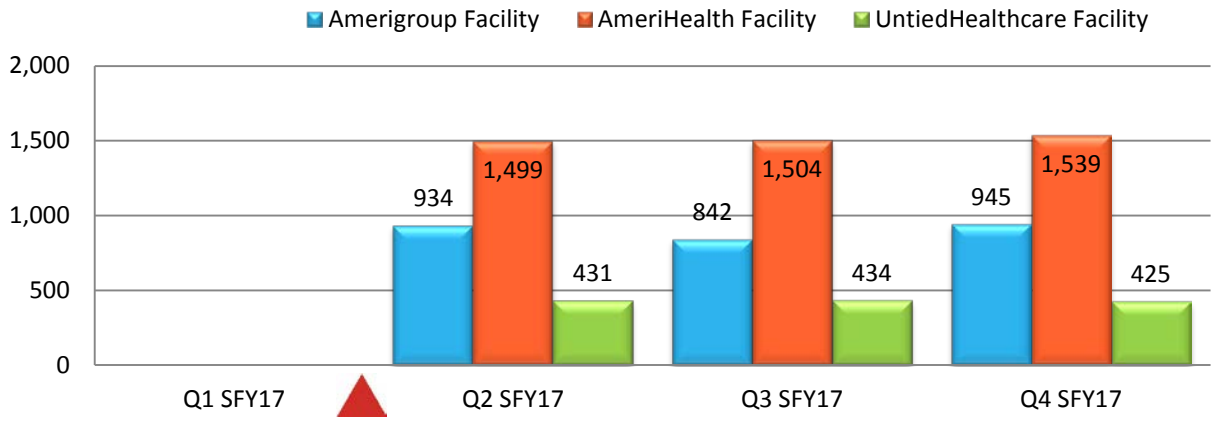


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

Adult: Members Served in a Facility

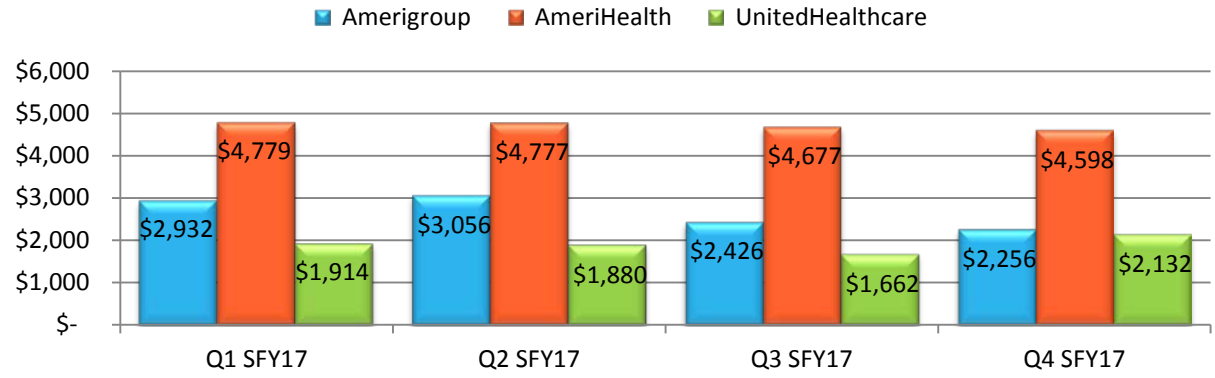


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

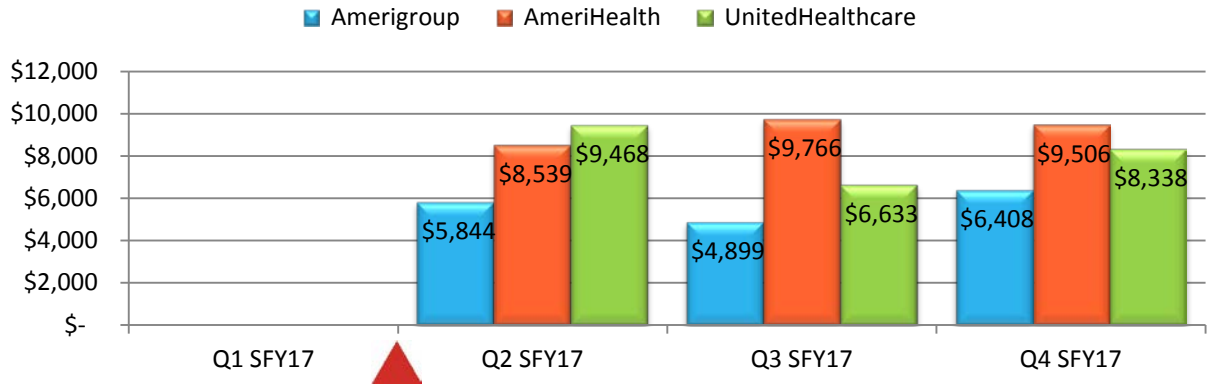
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in a facility.

Special Needs Adults in Community: Average Aggregate Cost per Member per Month



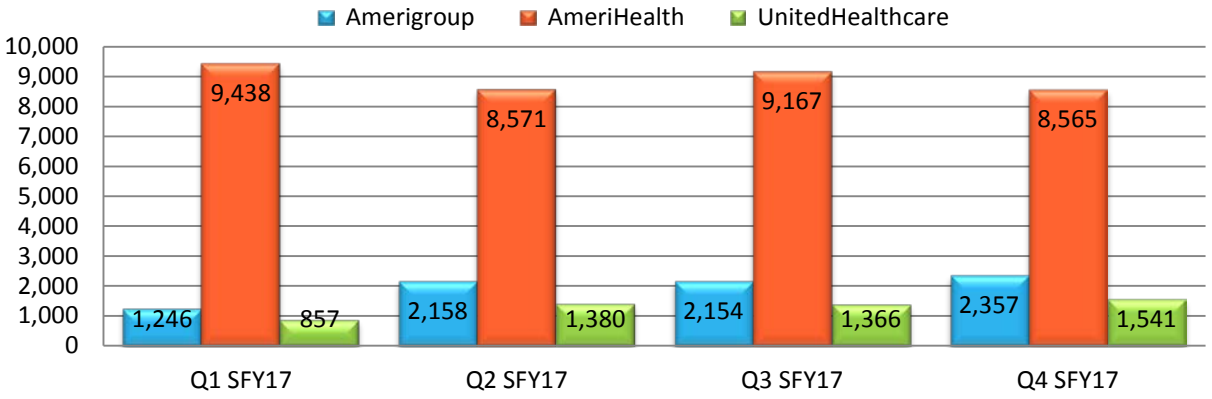
The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

Special Needs Adults in Facility Settings: Average Aggregate Cost per Member per Month



This data element was new as of Q2 SFY17. The aggregate average cost includes health care and pharmacy services for members in facility settings. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

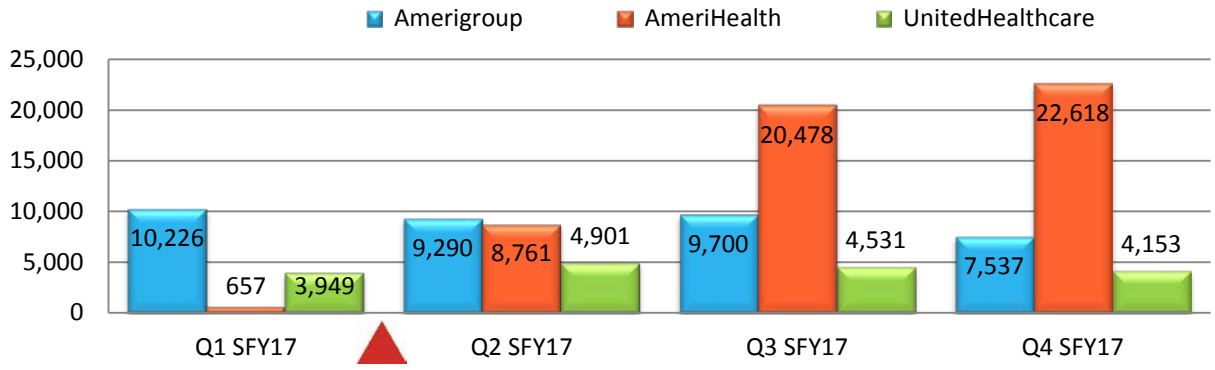
Adult: Members Assigned a Community-Based Case Manager



While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

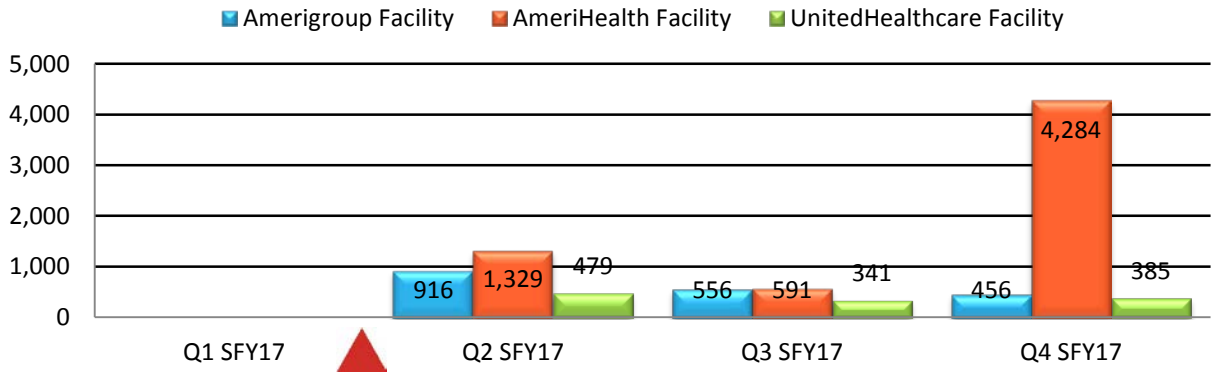
Adult: Number of Community-Based Case Manager Contacts for Members in a Community-Based Setting



▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.

Adult: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community-based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. Members in institutional

settings must have a case manager. These managers are required to have face-to-face contact on a quarterly basis with members.

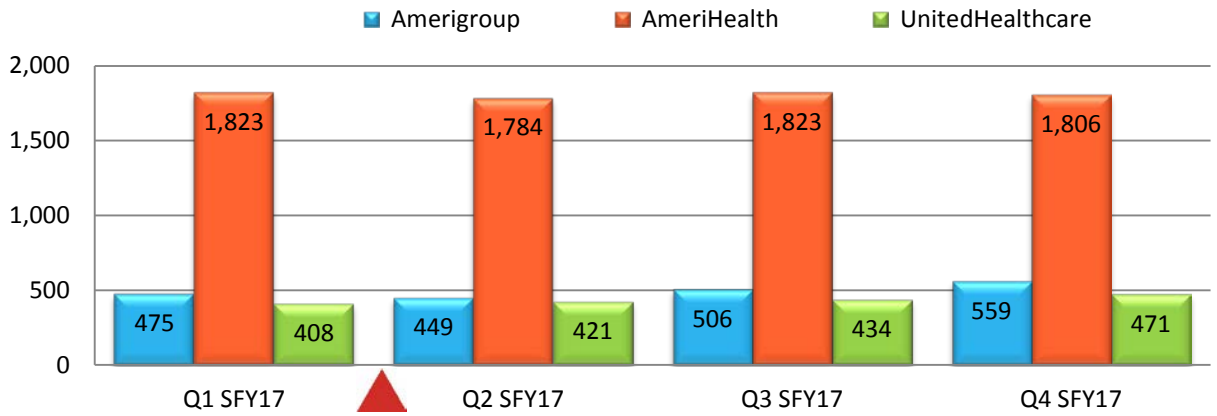
Community-Based Case Management Ratios			
The ratios below reflect combined adult and child populations for these waivers where applicable.			
Data Reported as of End of Q4 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Ratio of Member to Case Manager - Brain Injury	5.4	2.9	2.2
Ratio of Member to Case Manager - Health and Disability	12.9	2.6	5.9
Ratio of Member to Case Manager - HIV/AIDS	1.3	1.1	1.1
Ratio of Member to Case Manager - Intellectual Disability	24.0	16.4	11.1
Ratio of Member to Case Manager - Physical Disability	7.5	1.9	3.2

For this reporting period all plans are within appropriate case management ratios where defined. Iowa Medicaid requires that member to case manager ratios for the Intellectual Disability and Brain Injury Waivers is no more than 45 members to one case manager. The other Home- and Community-Based Waivers do not have member to case manager ratio requirements but the department requires the MCOs to closely monitor the ratios and ensure that all case management functions are met.

Child Special Needs Population Reporting

Children included in this report are under the age of 18 as determined at the end of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. This population report reflects home and community based members as well as facility based members. These members may also be reflected in the Behavioral Health Population.

Child: Members Served in Community-Based Settings

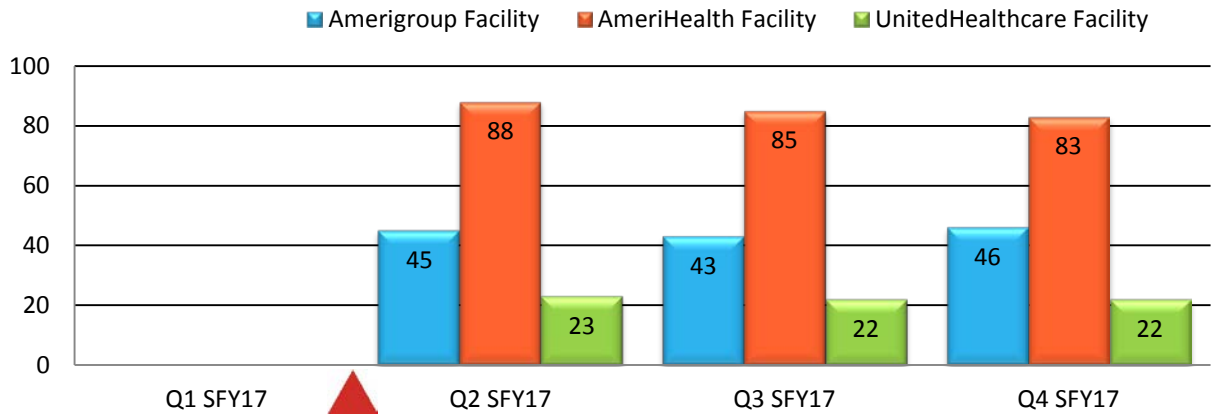


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

Child: Members Served in a Facility

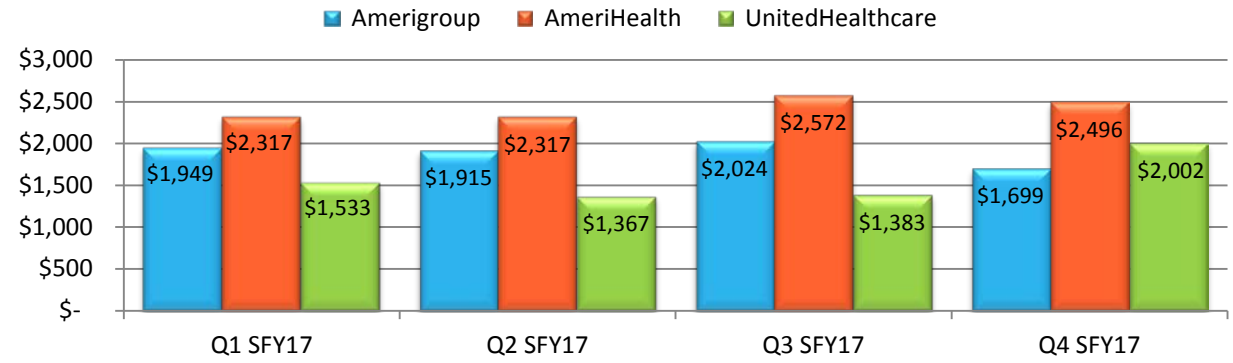


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

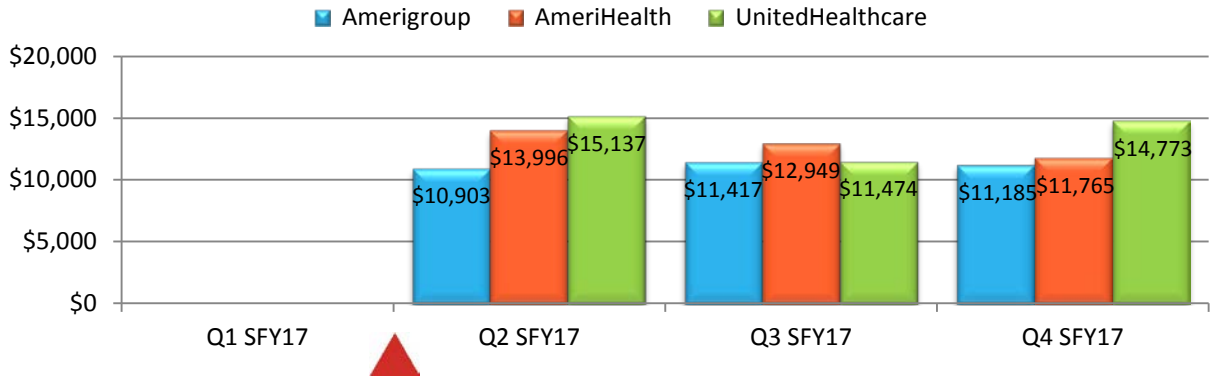
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for facility based members.

Special Needs Children in Community: Average Aggregate Cost per Member per Month



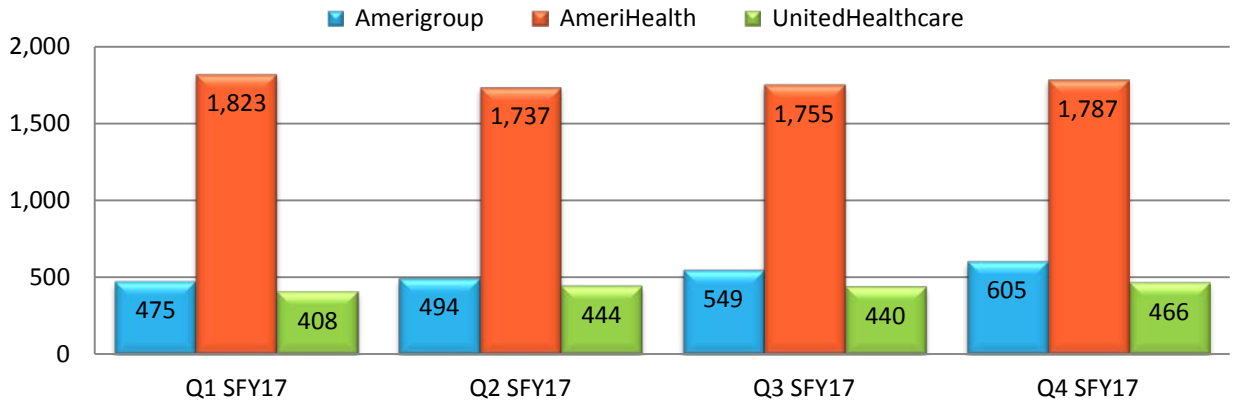
The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

Special Needs Children in Facility Setting: Average Aggregate Cost per Member per Month



This data element was new as of Q2 SFY17. The aggregate average cost includes health care and pharmacy services for members in facility settings. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that 8-12% of claims may not be included in this measure.

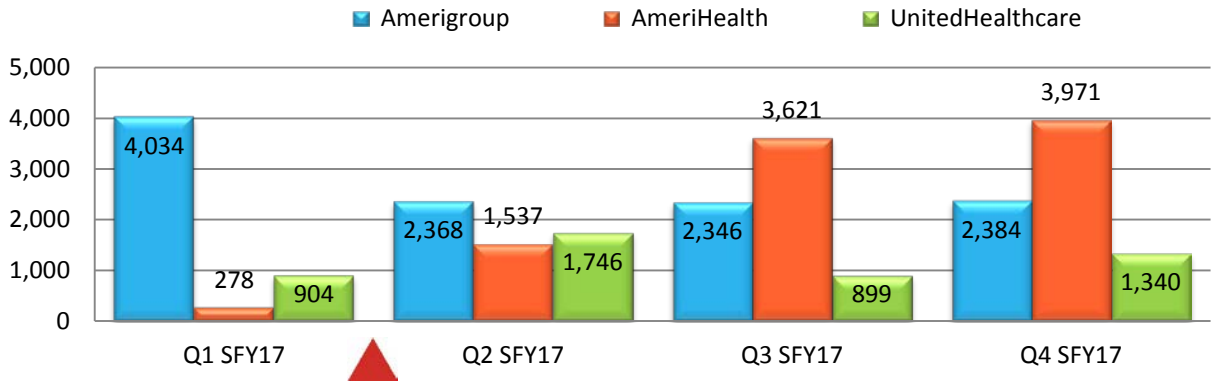
Child: Members Assigned a Community-Based Case Manager



While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

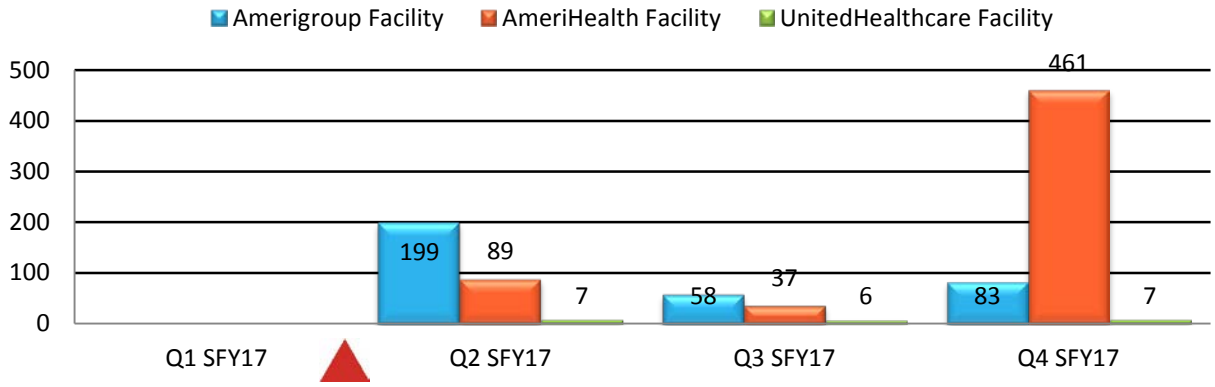
Child: Number of Community-Based Case Manager Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for community-based members.

Child: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community-based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. Members in institutional settings must have a case manager. These community-based case managers are required to have face-to-face contact on a quarterly basis with members. This data element does not have a direct benchmark to compare to historical fee-for-service data.

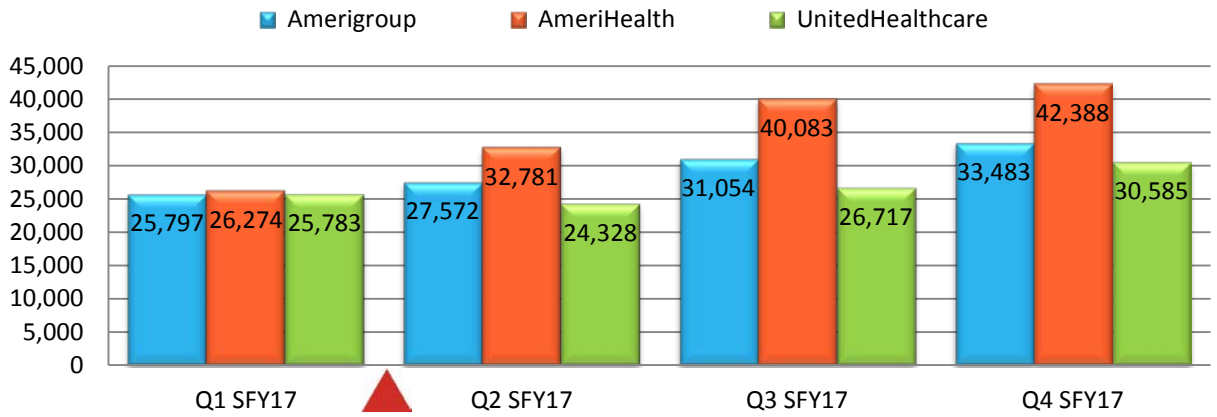
The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community-based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Adult Behavioral Health Population Reporting

Adults included in this report are members age 18 and older as determined at the beginning of the quarter who have identified behavioral health diagnoses. These members may also be reflected in the Special Needs Population and the Elderly Population report.

Adult: Members Served in Community-Based Settings

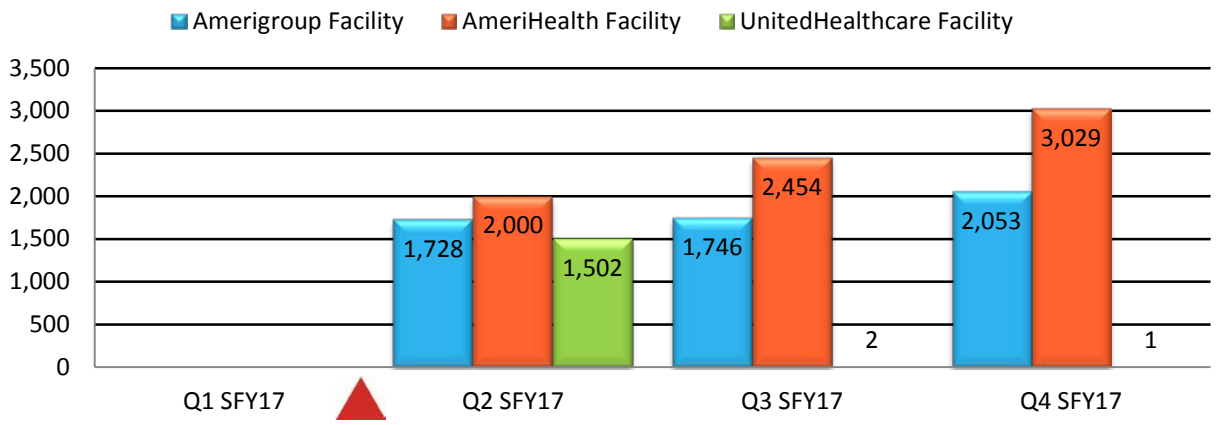


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for the increase.
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

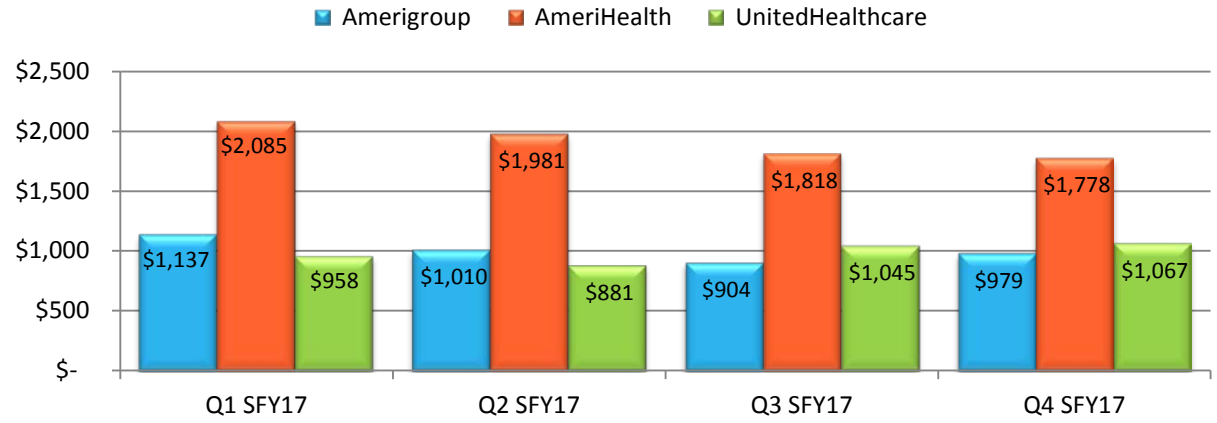
Adult: Members Served in a Facility



▲ Differences between quarters:

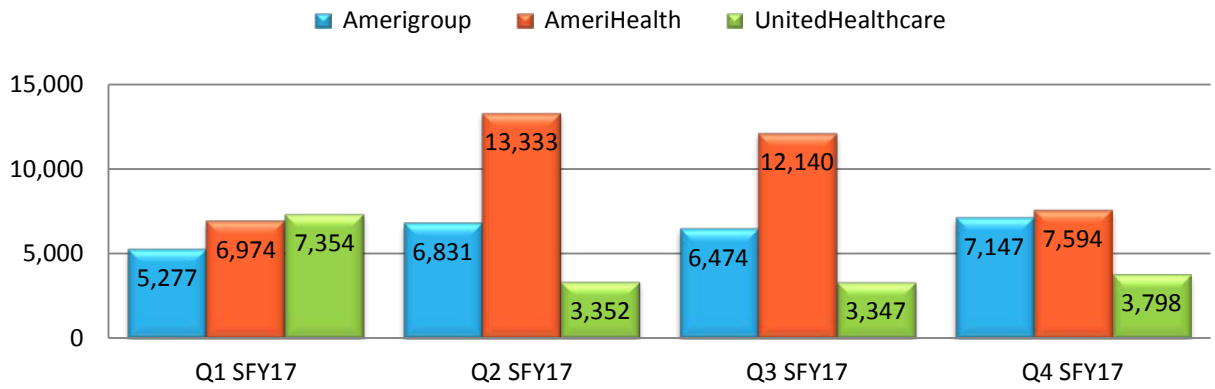
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in facility.

Adult: Average Aggregate Cost per Member per Month



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

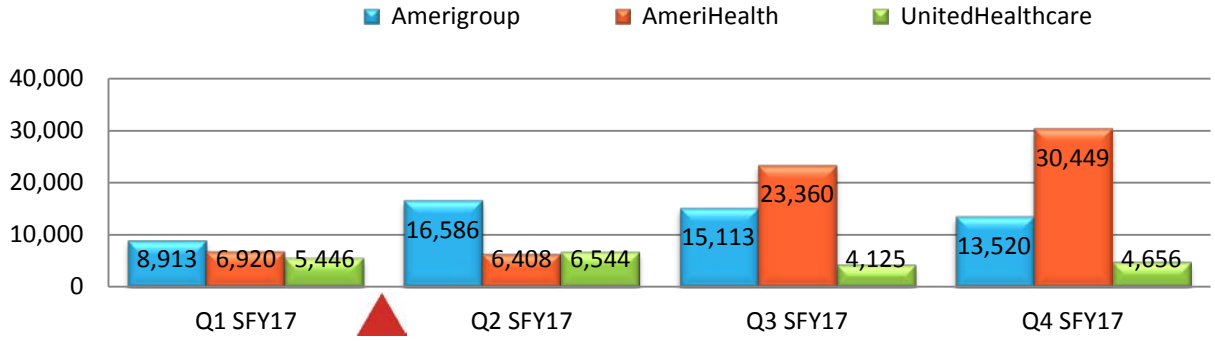
Adult: Members Assigned to a Community-Based Case Manager or Integrated Health Home Care Coordinator



Members who have an Integrated Health Home Care Coordinator have behavior health care needs and will benefit from more intensive behavioral health care management. Some of these members may have Community-Based Case Manager due to participation in a Home- and Community-Based Waiver program. Both entities are required to ensure that the member's needs are coordinated across health systems to improve the member's overall health status and quality of life.

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

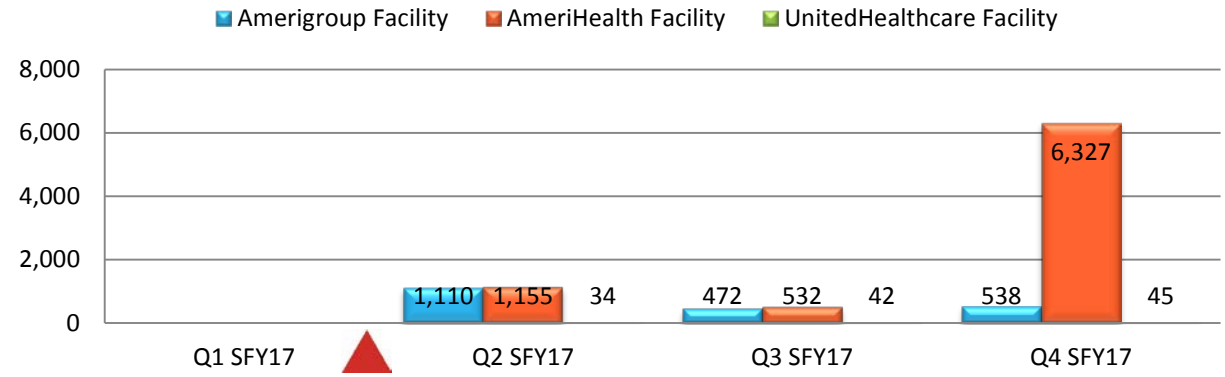
Adult: Number of Community-Based Case Manager and Integrated Health Home Care Coordinator Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows a contacts split out for community-based members.

Adult: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for contacts occurring in a facility.

A small percentage of the members in this population receive Habilitation services and must have Integrated Health Home care coordinators conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. A member not receiving Habilitation services is not required to have as frequent contact.

An increase in Integrated Health Home care coordinator contacts is expected with the increase in identified behavioral health members. Number of Integrated Health Home care coordinator for Members represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the Integrated Health Home and community based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Integrated Health Home Ratios

The department collects member to community-based case manager and integrated Health Home Care Coordinator ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of October 31, 2016*	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to IHH Care Coordinator – Behavioral Health	50	50	50

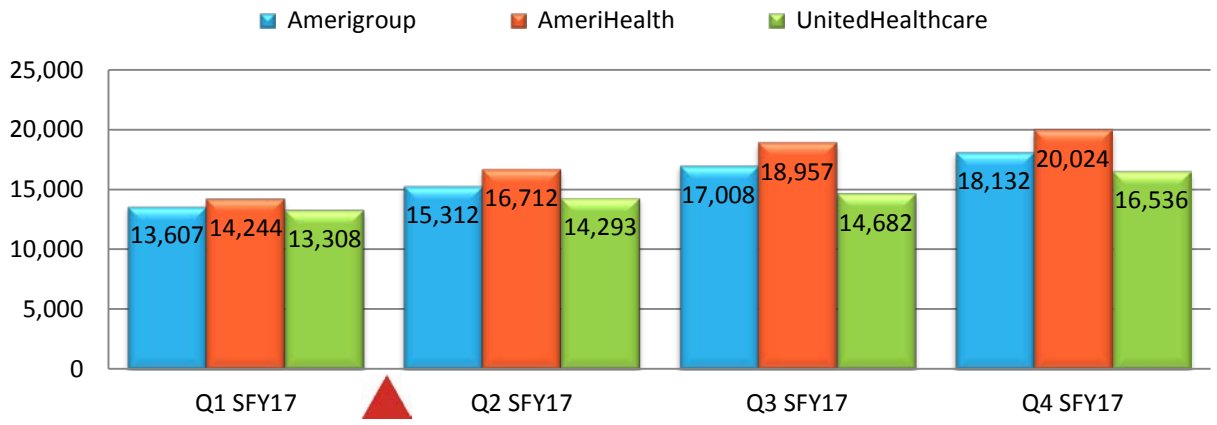
The behavioral health population does not have member to case manager or care coordinator ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

*MCOs leverage the same Integrated Health Homes. These ratios are based on a study conducted by UnitedHealthcare in Q1 SFY17.

Child Behavioral Health Population Reporting

Children included in this report are members under the age of 18 as determined at the beginning of the quarter who have identified behavioral health diagnoses. These members may also be reflected in the Special Population report. These members may receive children's mental health waiver services.

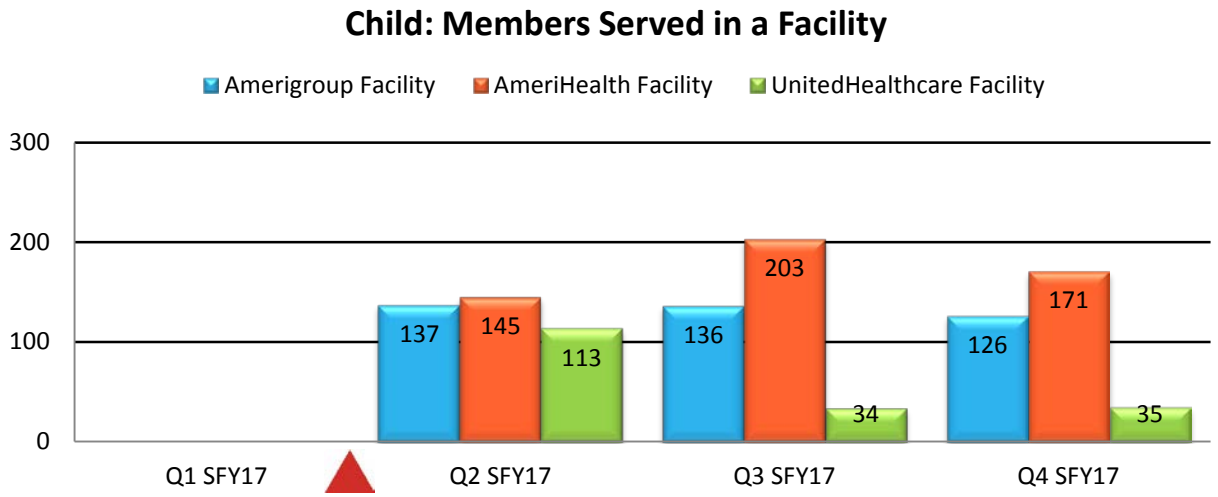
Child: Members Served in Community-Based Settings



Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

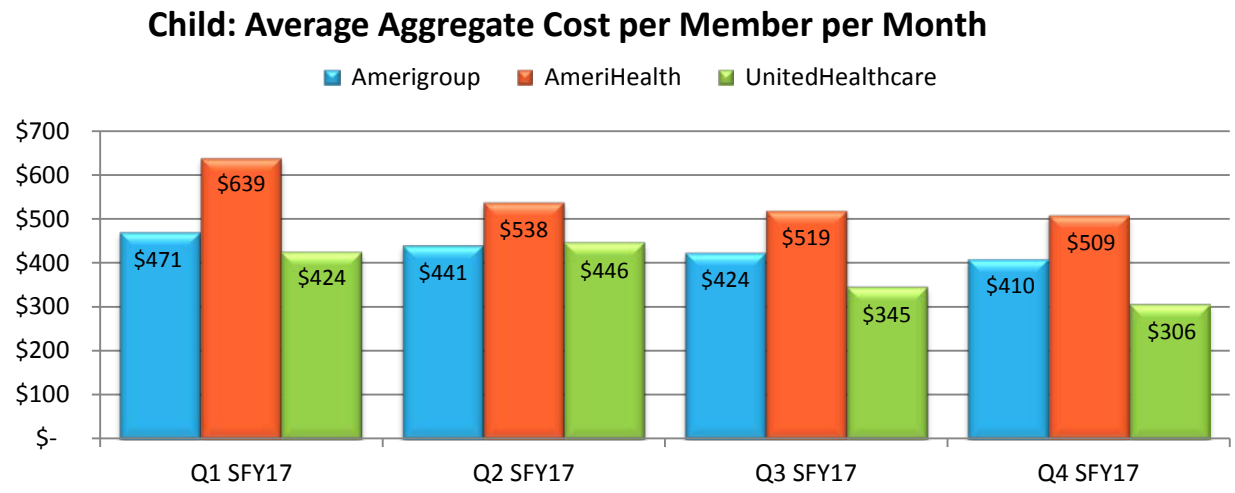
▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for the increase.
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.



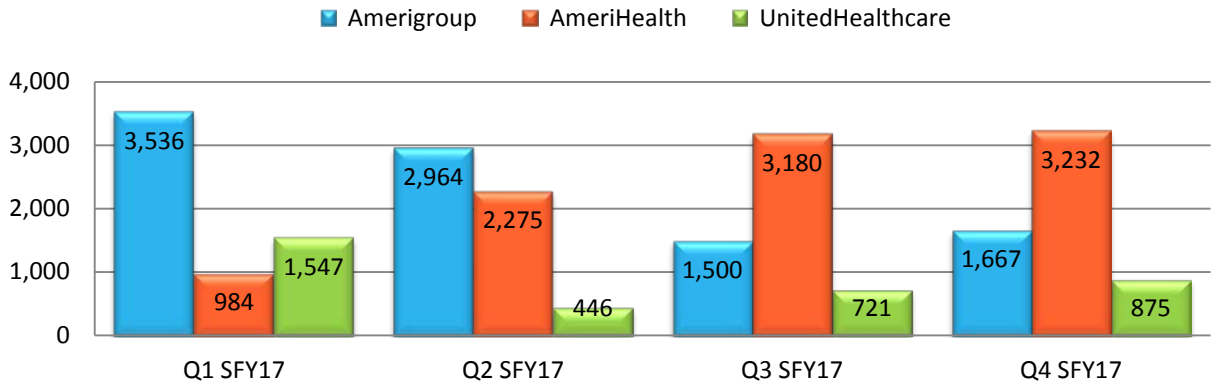
▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

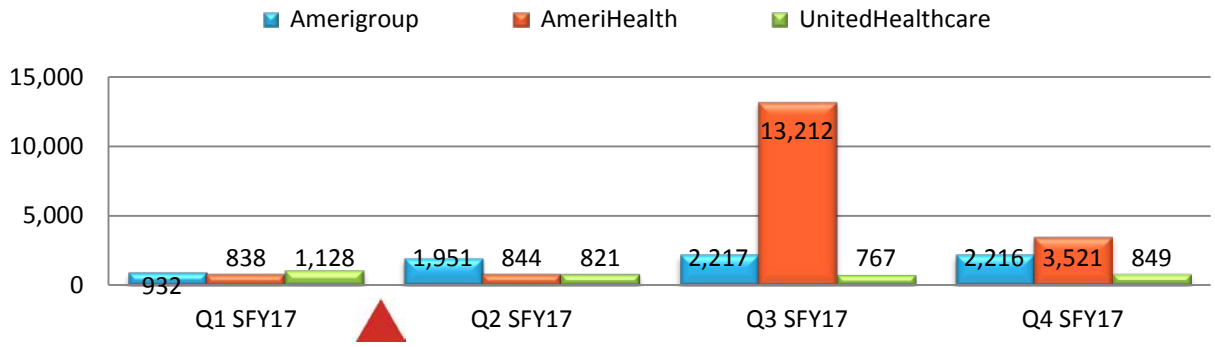
Child: Members Assigned to a Community-Based Case Manager or Integrated Health Home Care Coordinator



While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have an Integrated Health Home Care Coordinator have behavior health care needs and will benefit from more intensive behavioral health care management. Some of these members may have Community-Based Case Manager due to participation in a Home- and Community-Based Waiver program. Both entities are required to ensure that the member's needs are coordinated across health systems to improve the member's overall health status and quality of life. This data element does not have a direct benchmark to compare to historical fee-for-service data.

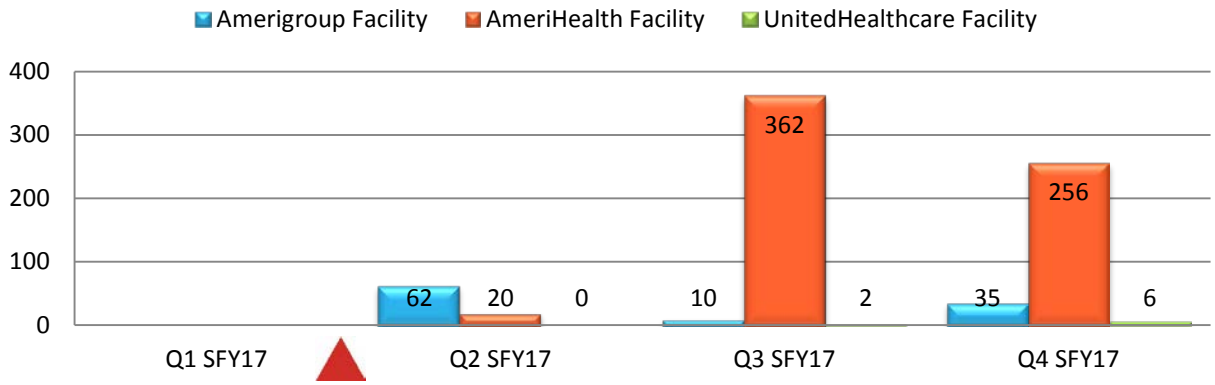
Child: Number of Community-Based Case Manager and Integrated Health Home Care Coordinator Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows a contacts split out for members in community-based settings.

Child: Number of Community-Based Case Manager Contacts for Members in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows a contacts split out for members in a facility.

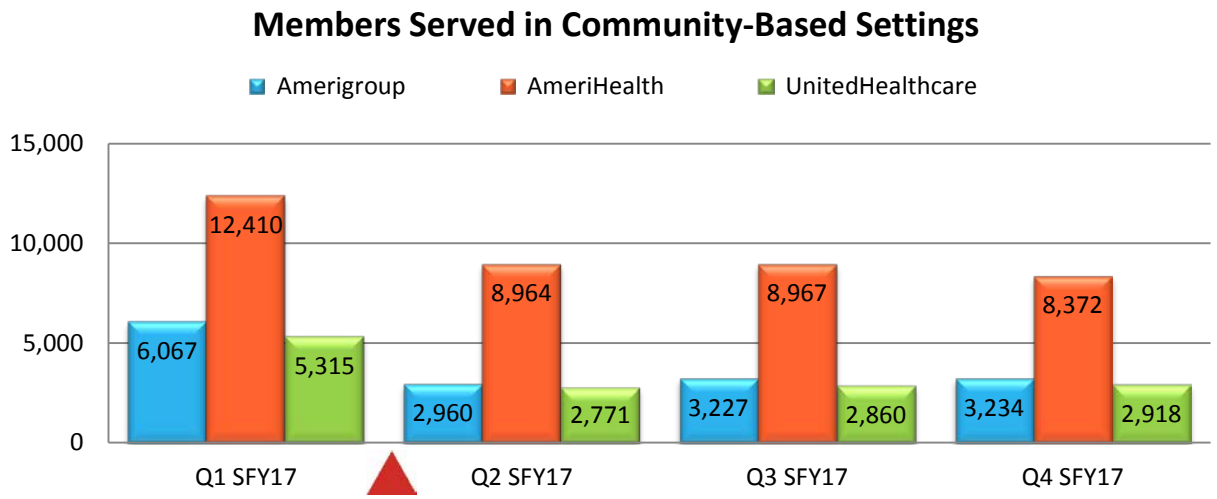
IHH Care Coordinator Ratios			
The department collects member to community-based case manager and Integrated Health Home Care Coordinator ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.			
Data Reported as of October 31, 2016*	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Ratio of Member to IHH Care Coordinator – Behavioral Health	50	50	50

The behavioral health population does not have member to case manager or care coordinator ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

*MCOs leverage the same Integrated Health Homes. These ratios are based on a study conducted by UnitedHealthcare in Q1 SFY17.

Elderly Population Reporting

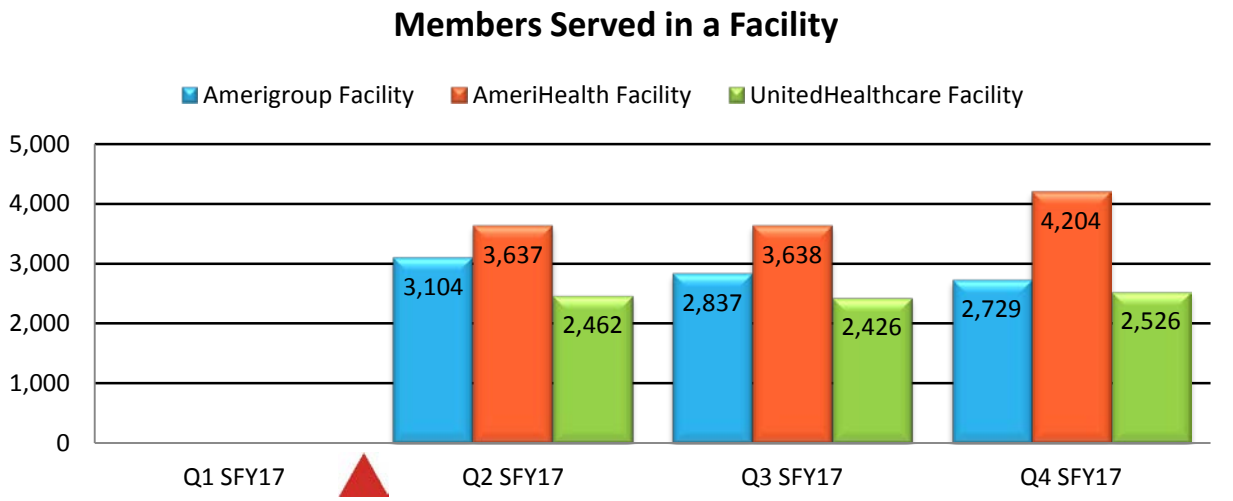
Elderly members included in this report are age 65 or older as determined at the beginning of the quarter. These members may receive elderly waiver services or institutional services. This population report reflects home and community based members only at this time but in the future will include facility based members as well.



Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

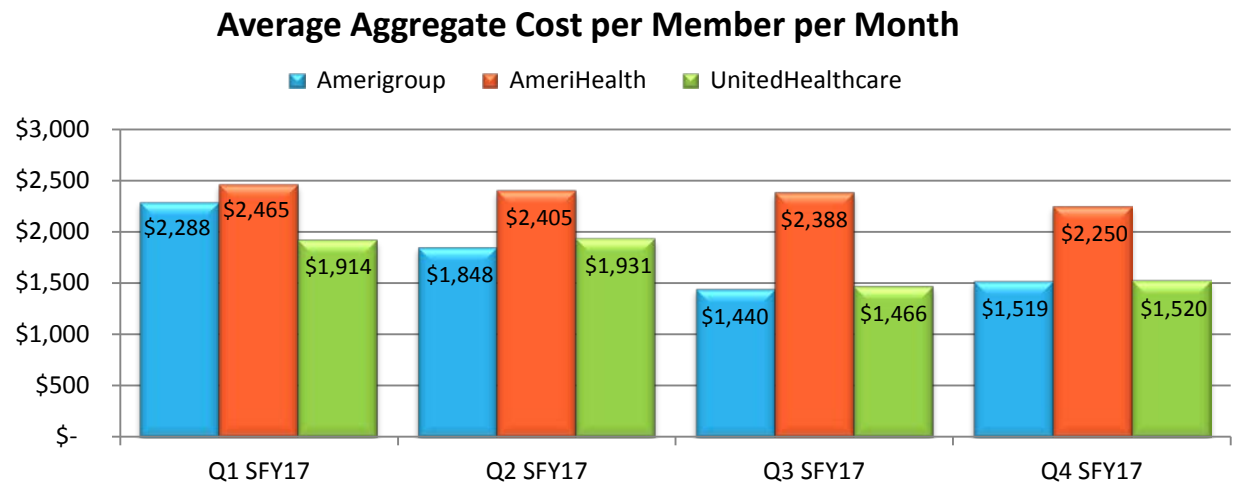
▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.



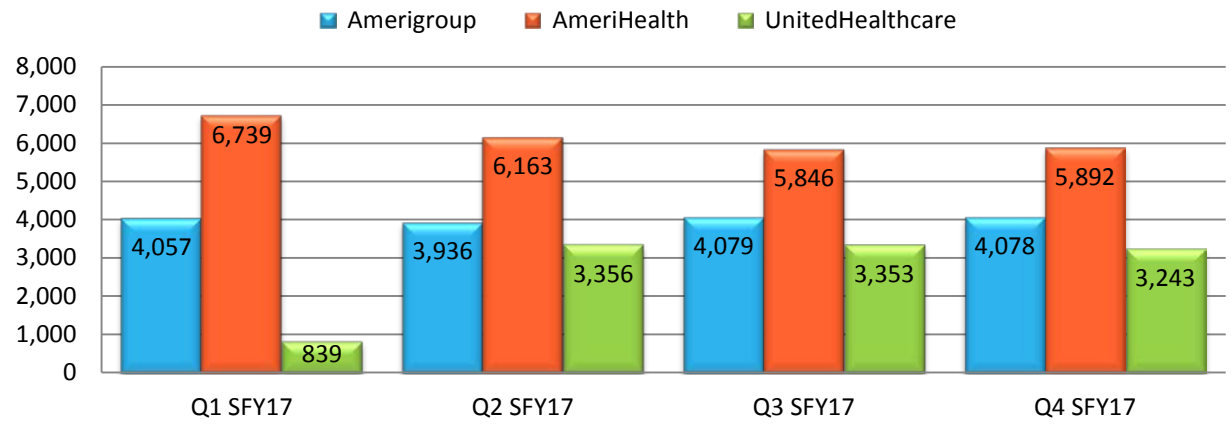
▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in a facility.



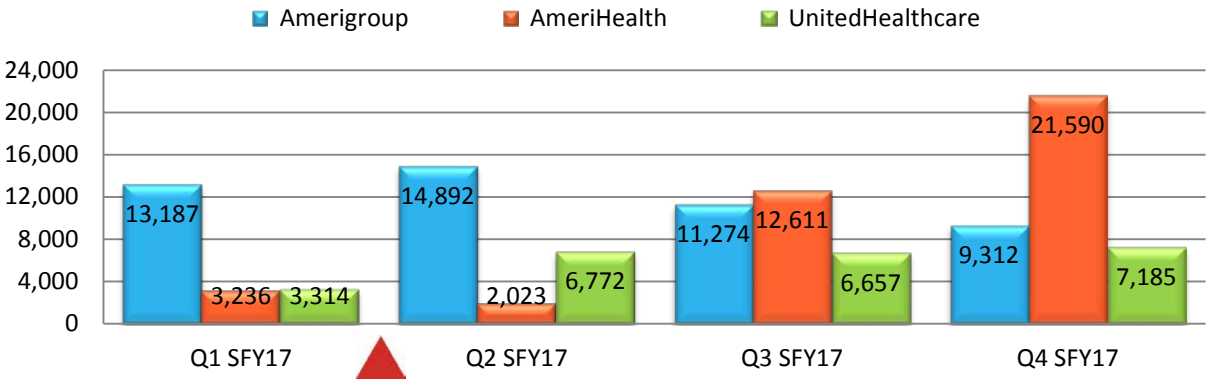
The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

Members Assigned a Community-Based Case Manager



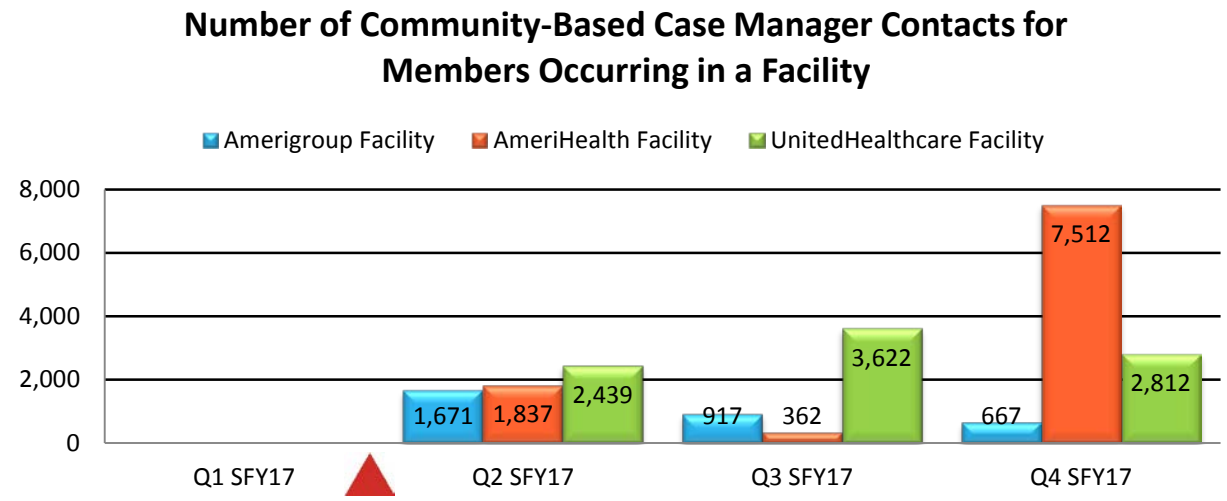
Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

Number of Community-Based Case Manager Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. Members in institutional settings must have a case manager. These managers are required to have face-to-face contact on a quarterly basis with members.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Community-Based Case Management Ratios

The department collects member to community-based case manager ratios to ensure that adequate case management services are available to members in Long Term Services and Supports (LTSS). Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of July 30, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	18.7	12.5	10.1

The Elderly population does not have member to case manager ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

MCO Member Grievances and Appeals

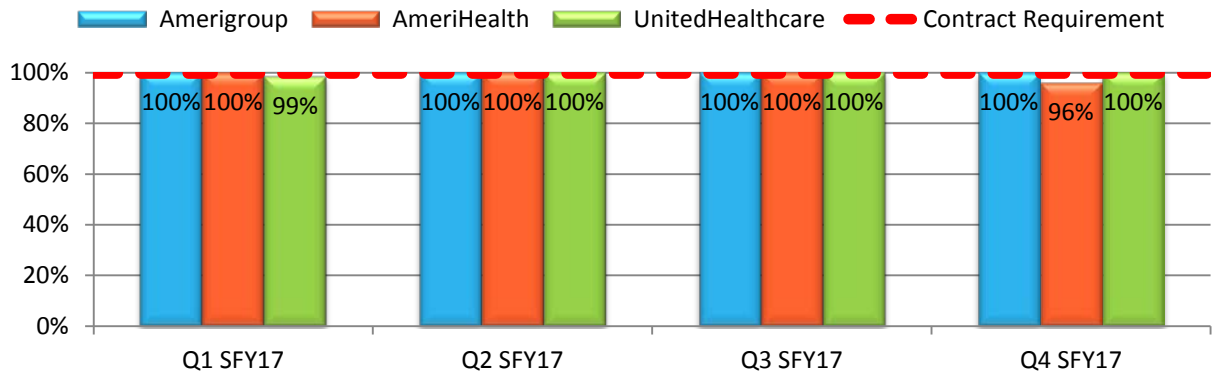
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization.

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.

100% 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 SFY17	224	133	87
Grievances Received in Q2 SFY17	201	110	96
Grievances Received in Q3 SFY17	223	115	117

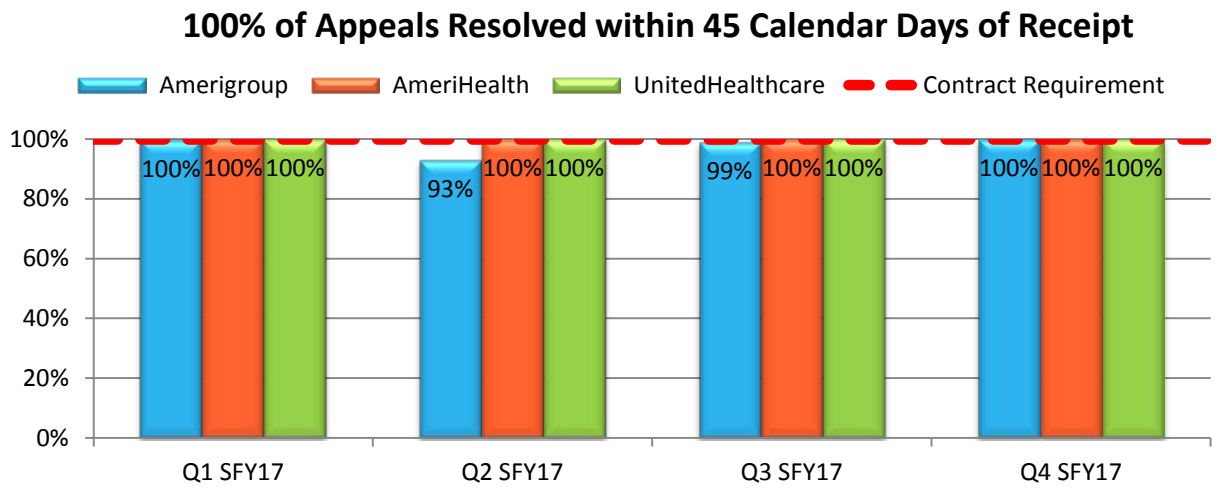
Grievances Received in Q4 SFY17	219	440	80

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 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	56	Provider Issue - Member Received Bill	273	Ambulance/Transportation – Dispute regarding non-ambulance methods of transportation	48
2	Provider Balance Billed	43	Provider Issue - Dissatisfied with Treatment or Service	31	Provider Issue- Balance Billing	21
3	Provider Attitude/ Rudeness	22	Administrative/MCO - Plan Policies and Procedures	19	Quality of Care	3
4	Treatment Dissatisfaction	10	Administrative/MCO - Issue with Service from Care Manager	12	Administration - Service Concerns	2
5	Provider Refusal to Treat	8	Transportation – No Pick-Up	12	Enrollee Access/Availability – Provider Locale Inconvenient	2

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



This measure represents appeals resolved within the contractual timeframes. If a member is not satisfied with the appeal decision, they may file an appeal with the state.

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Appeals Received in Q1 SFY17	370	216	117
Appeals Received in Q2 SFY17	473	230	76
Appeals Received in Q3 SFY17	425	413	108
Appeals Received in Q4 SFY17	361	455	143

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 SFY17

	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
#	**Appeals**	**Count**	**Appeals**	**Count**	**Appeals**	**Count**
1	Pharmacy - Non Injectable	114	Skilled Care/Nursing	131	Pharmacy - Authorization	86
2	Pharmacy - Injectable	35	Pharmacy	81	Pharmacy – Covered Services	33
3	Skilled Nursing	27	Prior Authorization	40	Medical – Utilization Review Dispute	32
4	Radiology	22	Home Health Aide	40	Medical – Authorization for Durable Medical Equipment	14
5	Therapy - PT	21	DME (Durable Medical Equipment)	40	Pharmacy - Dispute of Excluded Medication	8

State Fair Hearing Summary for Members in Managed Care CY 2017 to Date

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Level of Care	13	1	2
Medical Service Denial/Reduction	17	45	17
Pharmacy Denial/Reduction	10	0	3
Durable Medical Equipment Denial/Reduction	8	9	7

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.

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.

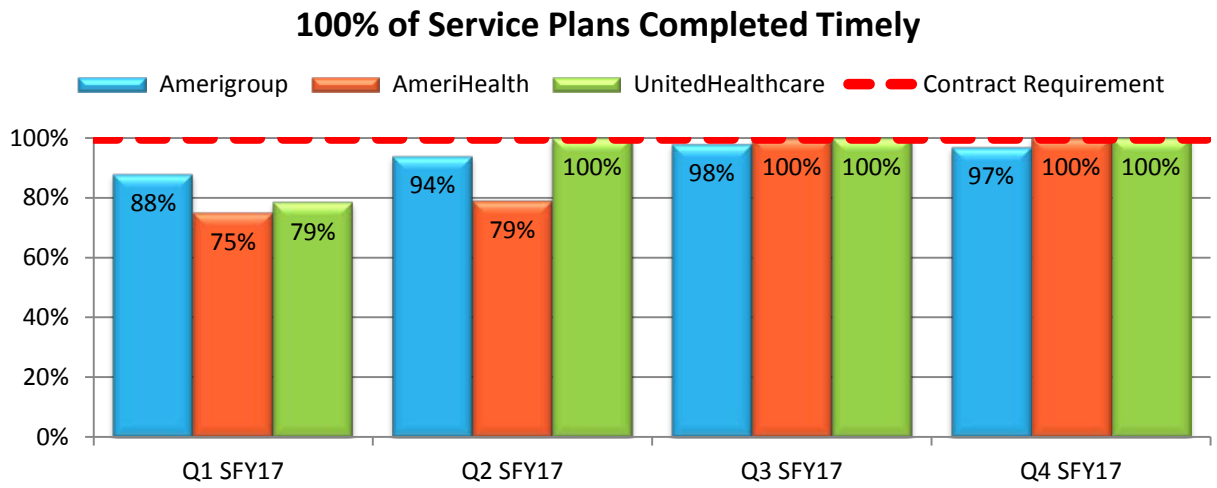
Data Reported	Amerigroup	AmeriHealth	UnitedHealthcare
Special Needs Population			
# of Critical Incidents Received for SFY17	374	4,382	360
# Critical Incidents Received and Resolved at the time of Reporting for SFY17	374	4,335	360
% Critical Incidents Resolved for SFY17	100%	99%	100%
Behavioral Health Population			
# of Critical Incidents Received for SFY17	2,401	7,058	992
# Critical Incidents Received and Resolved at the time of Reporting for SFY17	2,401	6,989	992
% Critical Incidents Resolved for SFY17	100%	99%	100%
Elderly Population			
# of Critical Incidents Received for SFY17	197	1,292	106
# Critical Incidents Received and Resolved at the time of Reporting for SFY17	194	1,263	106
% Critical Incidents Resolved for SFY17	98%	98%	100%

The department continues to monitor the number of critical incidents by plan to ensure that there are no systemic issues with provider reporting. Additional, critical incidents

are monitored to ensure that appropriate case management monitoring and provider oversight are occurring to assure the health and welfare of HCBS and Habilitation members.

Service Plans

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

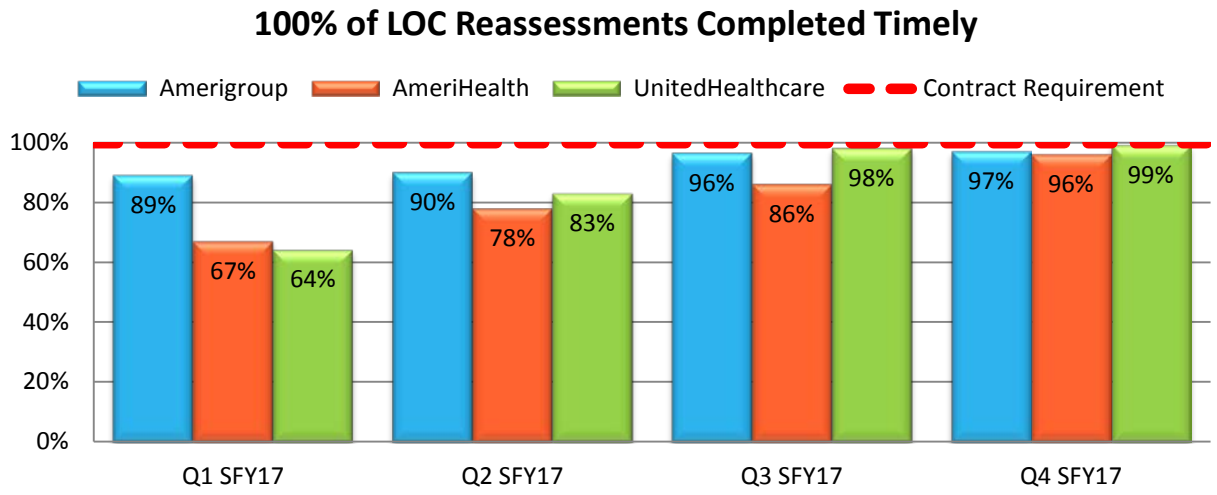


Members will continue to receive the same level of services regardless of whether service plan has been updated timely.

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

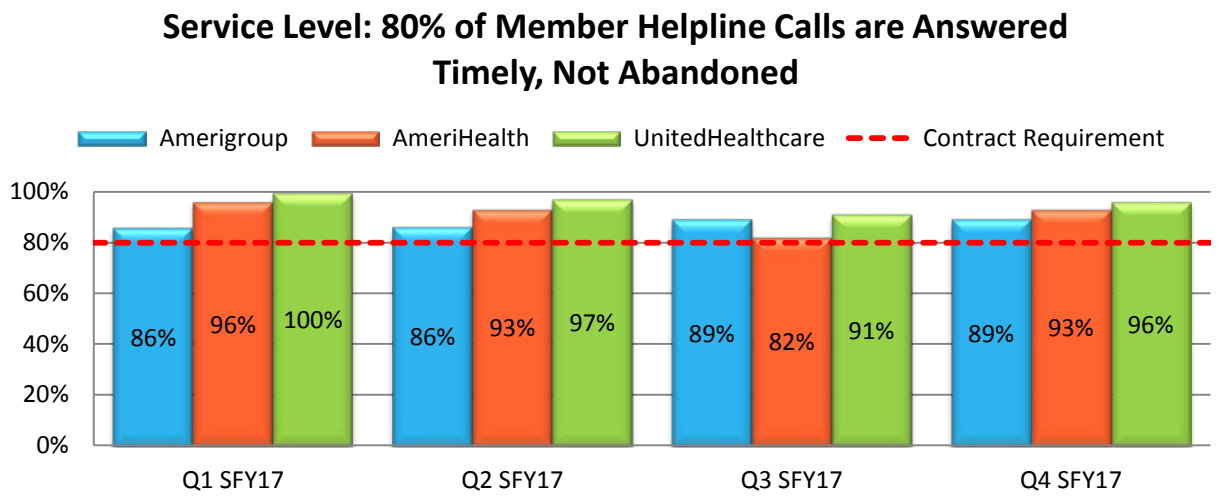
Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change.



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.

The department will be closely monitoring 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.

Member Helpline



This performance target measures the timeliness of answering the helpline calls. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines. The CAHPs surveys conducted annually also measure member satisfaction with their health plan.

Top Five Reasons for Members Contacting Helplines for SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
Jul-16						
1	Transportation Question	6,906	Member Changes	10,534	Benefits	5,297
2	Provider-Find/Change/Verify PCP	1,527	Member Inquiries	10,421	PCP Inquiry	3,444
3	Benefit Inquiry	1,398	Transportation Questions	9,077	Eligibility Inquiry	3,274
4	Order ID Card	624	Member Request	7,754	ID Cards	1,374

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Pharmacy Inquiry	566	Other Programs & Services	3,986	COB Information	1,144
Aug-16						
1	Transportation Question	8,395	Transportation Questions	11,028	Benefits	6,016
2	Provider-Find/Change/Verify PCP	1,912	Member Changes	8,875	Eligibility Inquiry	3,904
3	Benefit Inquiry	1,649	Member Inquiries	8,358	PCP Inquiry	3,783
4	Order ID Card	850	Member Request	7,067	ID Cards	1,669
5	Claim/Billing Issue	584	Other Programs & Services	4,224	COB Information	1,251
Sep-16						
1	Transportation Question	7,779	Transportation Questions	9,757	Benefits	4,769
2	Provider-Find/Change/Verify PCP	1,490	Member Inquiries	7,213	Eligibility Inquiry	3,652
3	Benefit Inquiry	1,374	Member Changes	7,020	PCP Inquiry	3,109
4	Order ID Card	705	Member Request	5,290	ID Cards	1,482
5	Pharmacy Inquiry	587	Other Programs & Services	3,819	COB Information	1,269
Oct-16						
1	Transportation Question	7,647	Transportation Questions	9,675	Benefits	4,357
2	Benefit Inquiry	1,324	Member Inquiries	6,741	Eligibility Inquiry	2,730

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
3	Provider-Find/Change/Verify PCP	1,233	Member Changes	6,337	PCP Inquiry	2,710
4	Order ID Card	714	Member Request	4,683	ID Cards	1,071
5	Claim/Billing Issue	516	Other Programs & Services	3,117	COB Information	967
Nov-16						
1	Transportation Question	7,366	Transportation Questions	9,183	Benefits	3,748
2	Benefit Inquiry	1,309	Member Inquiries-Plan Policy/Procedure Education	5,151	Eligibility Inquiry	2,483
3	Provider-Find/Change/Verify PCP	1,085	Member Changes-Demographic Changes	5,003	PCP Inquiry	2,478
4	Order ID Card	589	ID Card Request	4,016	ID Cards	1,425
5	Pharmacy Inquiry	539	Member Changes-PCP Change	2,566	COB Information	867
Dec-16						
1	Transportation Question	7,525	ID Card Request	10,618	Benefits	3,815
2	Benefit Inquiry	1,201	PCP Changes	9,986	Eligibility Inquiry	2,961
3	Provider-Find/Change/Verify PCP	1,003	Member Changes	9,430	PCP Inquiry	2,335
4	Enrollment Information	665	Transportation Question	9,053	COB Information	1,043

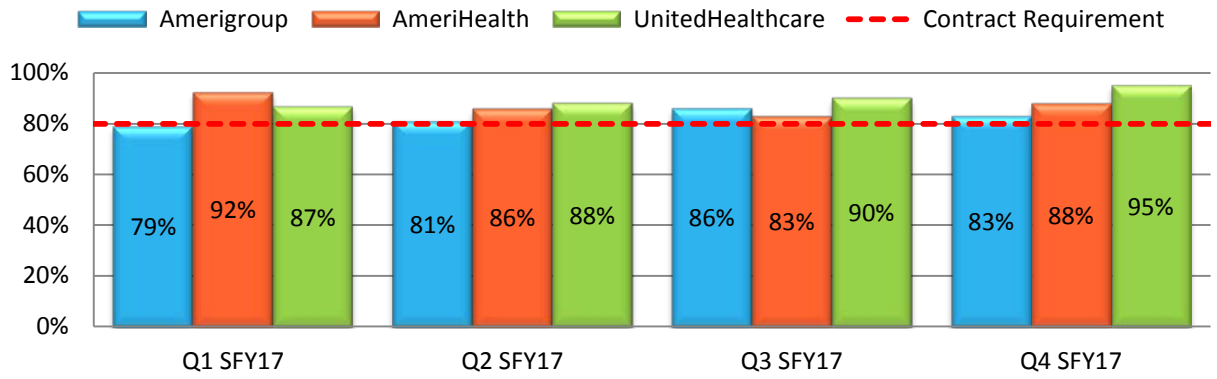
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Order ID Card	537	Plan Policy/ Procedure Education	8,359	General Inquiry	858
Jan-17						
1	Transportation Question	9,094	Transportation Questions	11,389	Benefits	4,200
2	Benefit Inquiry	1,762	Member Demographic Changes	8,633	PCP Inquiry	3,312
3	Provider-Find/Change/Verify PCP	912	Plan Policy/Procedure Education	7,906	Eligibility Inquiry	2,531
4	Pharmacy Inquiry	641	Member Request for ID Card	6,663	COB Information	1,066
5	Enrollment Information	564	PCP Change	5,617	ID Cards	982
Feb-17						
1	Transportation Question	8,042	Transportation Questions	10,435	Benefits	3,450
2	Benefit Inquiry	1,406	Plan Policy/Procedure Education	7,235	PCP Inquiry	2,740
3	Find/Change PCP	908	Member Demographic Changes	6,587	Eligibility Inquiry	2,560
4	Enrollment Information	710	Member Request for ID Card	3,772	COB Information	1,096

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5	Pharmacy Inquiry	500	PCP Change	2,814	General Inquiry	818
Mar-17						
1	Transportation Question	9,651	Transportation Questions	11,426	Benefits	3,848
2	Benefit Inquiry	1,456	Plan Policy/Procedure Education	7,828	Eligibility Inquiry	2,747
3	Enrollment Inquiry/Issue	1,126	Member Demographic Changes	6,689	PCP Inquiry	2,740
4	Find/Change/Verify PCP	968	Member Request for ID Card	3,546	COB Information	1,051
5	Pharmacy Inquiry	750	Member Eligibility	2,424	General Inquiry	1,012
Apr-17						
1	Transportation Question	8,291	Plan Policy/Procedure Education	6,305	Benefits	3,208
2	Benefit Inquiry	1,698	Member Demographic Changes	5,301	PCP Inquiry	2,789
3	Enrollment Inquiry	1,190	Member Request for ID Card	2,831	Eligibility Inquiry	2,620
4	Provider-Find/Change/Verify PCP	1,056	Benefit Inquiry	1,850	COB Information	924
5	Pharmacy Inquiry	889	Member Eligibility	1,827	Claims Inquiry	902
May-17						
1	Transportation Question	9,373	Plan Policy/Procedure Education	6,931	Benefits	3,904

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Benefit Inquiry	1,739	Member Demographic Changes	5,507	PCP Inquiry	3,195
3	Enrollment Inquiry	1,421	Member Request for ID Card	3,125	Eligibility Inquiry	3,152
4	Pharmacy Inquiry	1,031	Member Eligibility	2,357	COB Information	1,262
5	Provider-Find/Change/Verify PCP	978	PCP Change	1,984	Claims Inquiry	964
Jun-17						
1	Transportation Question	8,577	Plan Policy/Procedure Education	6,729	PCP Inquiry	4,232
2	Benefit Inquiry	1,732	Member Demographic Changes	5,547	Benefits	4,081
3	Enrollment Inquiry	1,341	Member Request for ID Card	2,836	Eligibility Inquiry	3,699
4	Pharmacy Inquiry	1,147	Member Eligibility	2,032	COB Information	1,766
5	Provider-Find/Change/Verify PCP	1,015	PCP Change	1,750	General Inquiry	926

Provider Helpline

Service Level: 80% of Provider Helpline Calls are Answered Timely, Not Abandoned



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.

Top Five Reasons for Providers Contacting Helplines for SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
Jul-16						
1	Claim Status Inquiry	1,843	Provider Inquiries	8,988	Claims Inquiry	11,308
2	Auth-Status	1,533	Provider Requests	7,507	Benefits	6,057
3	Pharmacy Department Call Inquiry	1,378	Claims	7,070	COB Information	1,146
4	Benefits Inquiry	1,181	Eligibility/Enrollment	3,388	Membership Record	686
5	Auth-New	969	Other Programs & Services	2,791	Authorization Related	449

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
Aug-16						
1	Claim Status Inquiry	2,561	Claims	9,058	Claims Inquiry	10,849
2	Auth-Status	1,832	Provider Inquiries	8,944	Benefits	5,107
3	Pharmacy Department Call Inquiry	1,799	Provider Requests	7,231	COB Information	1,264
4	Benefits Inquiry	1,232	Other Programs & Services	3,124	Membership Record	632
5	Claims Inquiry	1,210	Eligibility/Enrollment	3,809	Authorization Related	371
Sep-16						
1	Claim Status Inquiry	2,565	Claims	9,220	Claims Inquiry	10,498
2	Auth-Status	1,698	Provider Inquiries	8,046	Benefits	5,217
3	Pharmacy Department Call Inquiry	1,270	Provider Requests	7,868	COB Information	1,490
4	Claims Inquiry	1,079	Other Programs & Services	3,546	Membership Record	461
5	Benefits Inquiry	1,063	Eligibility/Enrollment	2,528	Authorization Related	338
Oct-16						
1	Claim Status Inquiry	2,876	Claims	9,401	Claims Inquiry	11,014
2	Claim Rejected	1,985	Provider Requests	7,681	Benefits	5,355
3	Auth-Status	1,633	Provider Inquiries	7,196	COB Information	1,380

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
4	Pharmacy Department Call Inquiry	1,609	Other Programs & Services	3,395	Provider-Related	605
5	Benefits Inquiry	1,068	Eligibility/Enrollment	3,050	Membership Record	581
Nov-16						
1	Claim Status Inquiry	2,954	Claims-Claim Status	8,917	Claims Inquiry	10,849
2	Claim Rejected	2,054	Provider Requests-Check Remittance Advice	7,186	Benefits	4,218
3	Pharmacy Department Call Inquiry	1,695	Provider Inquiries-Plan Policy/Procedure Education	5,515	Membership Record	1,371
4	Auth-Status	1,584	Other Programs & Services-Transfer/Redirected Call	2,748	COB Information	629
5	Claim Denial Inquiry	1,041	Eligibility/Enrollment-Member Eligibility	2,148	Authorization Related	396
Dec-16						
1	Claim Status Inquiry	3,281	Claims Status	9,828	Claims Inquiry	13,980
2	Claim Rejected	1,928	Provider Check Remittance Advice	7,464	Benefits	4,947

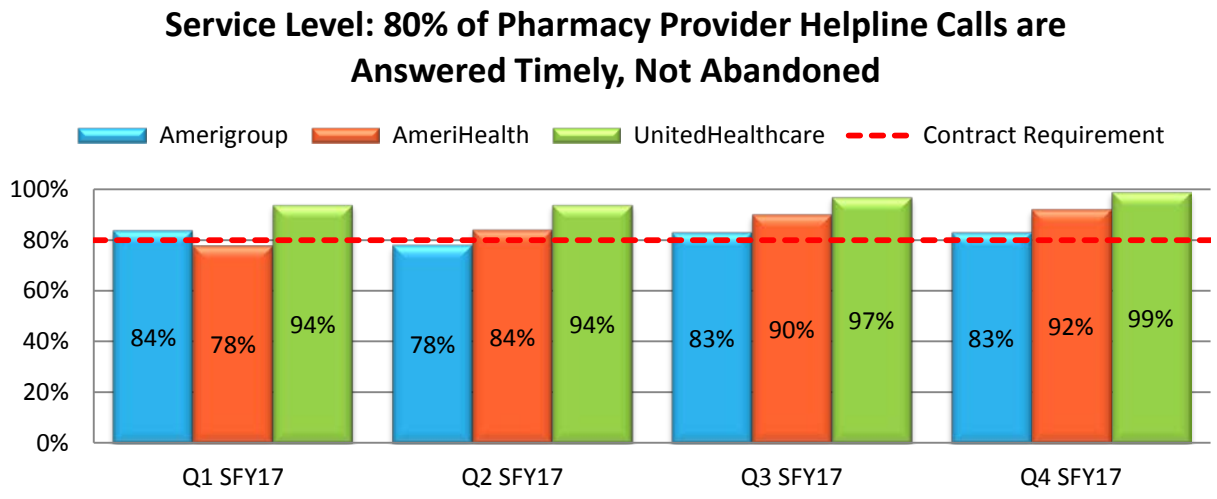
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
3	Pharmacy Department Call Inquiry	1,655	Plan Policy/ Procedure Education	5,209	COB Information	1,567
4	Authorization Status	1,612	Other Programs & Services	3,050	Membership Record	671
5	Claims Inquiry	1,083	Member Eligibility/Enrollment	2,019	Authorization Related	529
Jan-17						
1	Claim Status Inquiry	3,240	Claim Status	11,073	Claims Inquiry	13,532
2	Claim Rejected	2,316	Provider Requests-Check Remittance Advice	8,222	Benefits	4,764
3	Pharmacy Department Call Inquiry	1,729	Plan Policy/Procedure Education	6,650	COB Information	1,493
4	Authorization Status	1,565	Other Programs & Services-Transfer/Redirected Call	3,752	Membership Record	765
5	Claims Inquiry	1,175	Eligibility/Enrollment-Member Eligibility	2,646	Authorization Related	595
Feb-17						
1	Claim Status Inquiry	3,302	Claim Status	11,885	Claims Inquiry	13,357

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Claim Rejected	1,761	Provider Requests-Check Remittance Advice	8,454	Benefits	4,664
3	Pharmacy Department Call Inquiry	1,693	Plan Policy/Procedure Education	6,542	COB Information	1,568
4	Claim Denial Inquiry	1,228	Other Programs & Services-Transfer/Redirected Call	3,575	Membership Record	812
5	Claims Inquiry	1,095	Eligibility/Enrollment-Member Eligibility	2,876	Authorization Related	596
Mar-17						
1	Claims Status Inquiry	3,373	Claim Status	14,179	Claims Inquiry	13,657
2	Claim Rejected	1,964	Provider Requests – Check Remittance Advice	8,414	Benefits	4,704
3	Pharmacy Department Call Inquiry	1,908	Plan Policy/Procedure Education	7,499	COB Information	1,480
4	Claim Denial Inquiry	1,371	Eligibility/ Enrollment – Member Eligibility	3,174	Membership Record	698
5	Claims Inquiry	1,269	Claims Issues	2,145	Authorization Related	550
Apr-17						

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
1	Claim Status Inquiry	3,290	Claim Status	12,953	Claims Inquiry	18,074
2	Claim Rejected	1,942	Provider Requests-Check Remittance Advice	7,807	Benefits	6,132
3	Pharmacy Department Call Inquiry	1,763	Plan Policy/Procedure Education	5,689	COB Information	2,191
4	Benefits Inquiry	1,291	Eligibility/Enrollment-Member Eligibility	2,244	Membership Record	1,029
5	Claims Inquiry	1,175	Claim Issues	1,802	Authorization Related	829
May-17						
1	Claim Status Inquiry	3,451	Claim Status	14,913	Claims Inquiry	14,437
2	Claim Rejected	1,957	Provider Requests-Check Remittance Advice	8,614	Benefits	4,847
3	Pharmacy Department Call Inquiry	1,927	Plan Policy/Procedure Education	7,604	COB Information	1,683
4	Claim Denial Inquiry	1,218	Eligibility/Enrollment-Member Eligibility	2,674	Authorization Related	775
5	Claims Inquiry	1,211	Claim Issues	2,429	Membership Record	743
Jun-17						
1	Claims Status Inquiry	3,565	Claim Status	15,302	Claims Inquiry	12,520

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
2	Claim Rejected	1,918	Provider Requests – Check Remittance Advice	8,266	Benefits	4,129
3	Pharmacy Department Call Inquiry	1,905	Plan Policy/Procedure Education	6,982	COB Information	1,367
4	Claims Inquiry	1,381	Enrollment – Member Eligibility	2,479	Authorization Related	760
5	Claim Denial Inquiry	1,119	Claims Issues	2,077	Membership Record	722

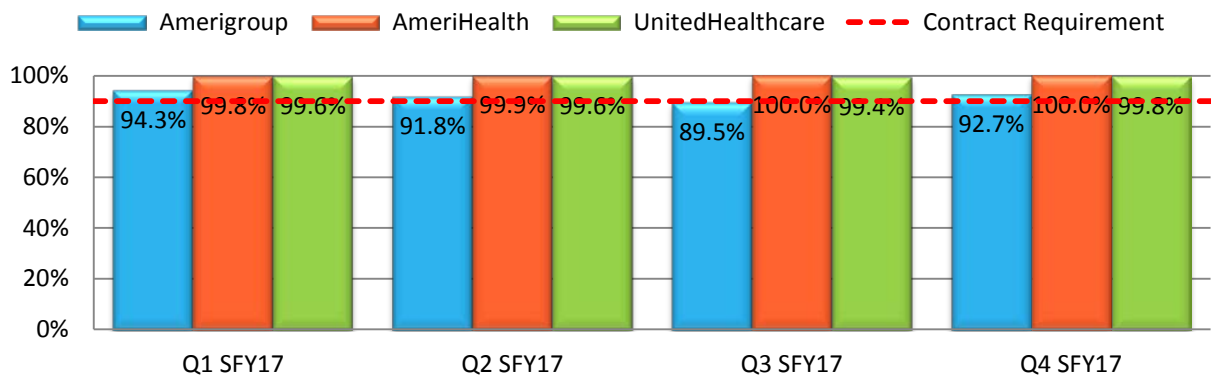
Pharmacy Services Helpline



Medical Claims Payment

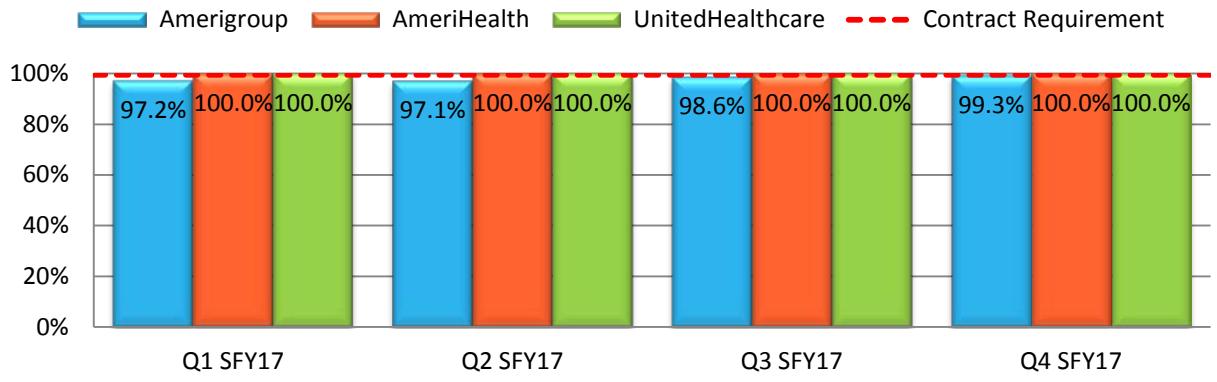
Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

90% of Clean Medical Claims Must be Paid or Denied Within 14 Days

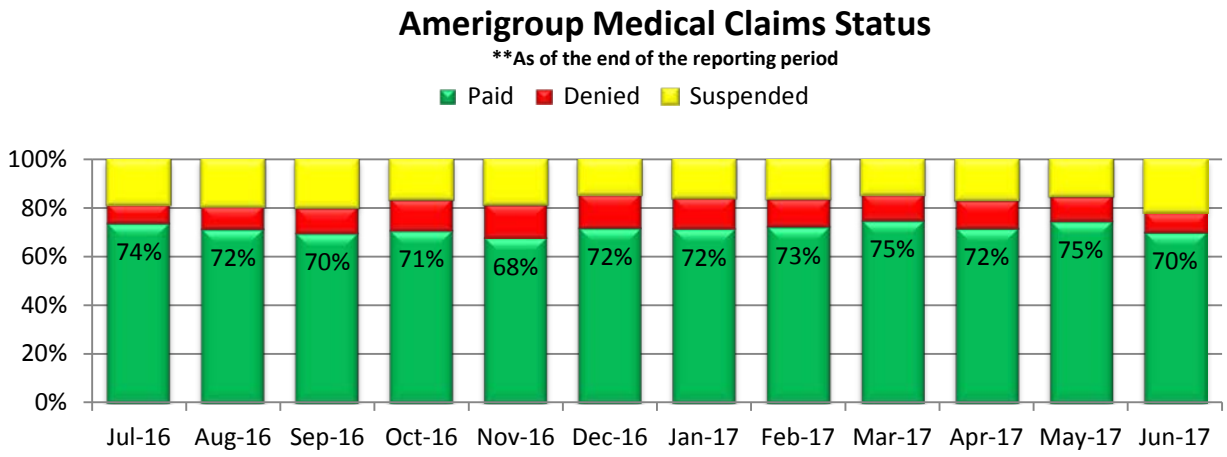


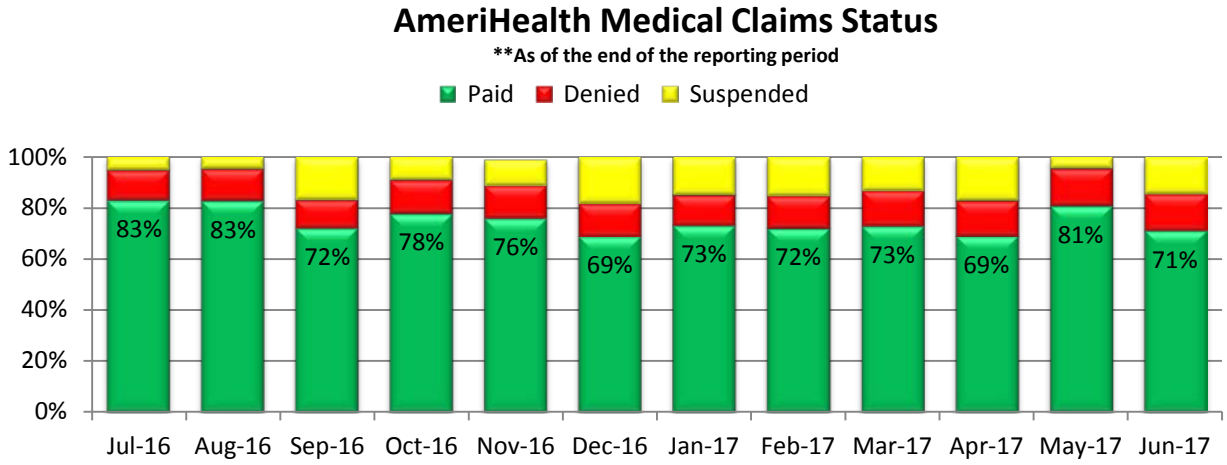
This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department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

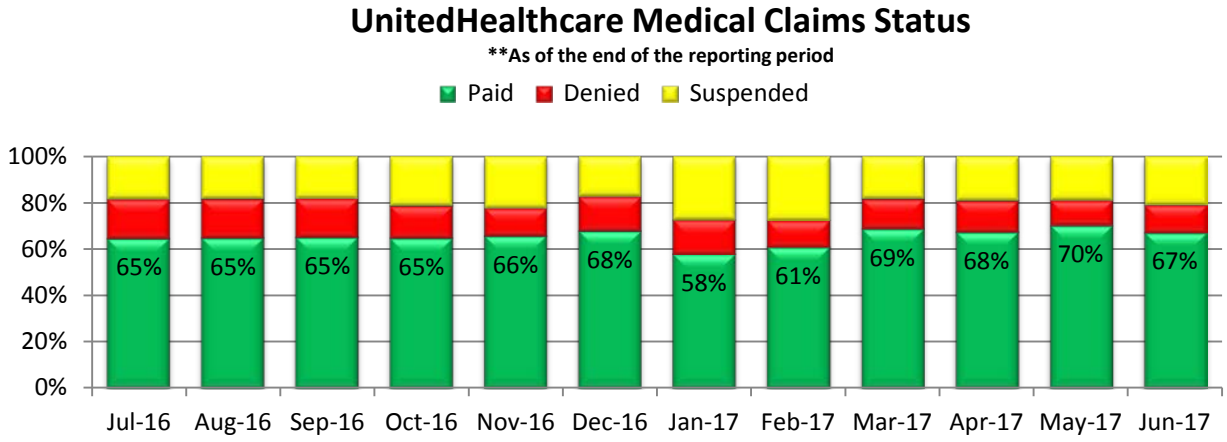
99.5% of Clean Medical Claims Must be Paid or Denied Within 21 Days



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.


Amerigroup Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
74%
72%
70%
71%
68%
72%
72%
73%
75%
72%
75%
70%
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17


AmeriHealth Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
83%
83%
72%
78%
76%
69%
73%
72%
73%
69%
81%
71%
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17


UnitedHealthcare Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
65%
65%
65%
65%
66%
68%
58%
61%
69%
68%
70%
67%
Jul-16
Aug-16
Sep-16
Oct-16
Nov-16
Dec-16
Jan-17
Feb-17
Mar-17
Apr-17
May-17
Jun-17

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
1. CARC-18 Exact duplicate claim/ service.	1. CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.	1. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement.
2. CARC-177 Patient has not met the required eligibility requirements.	2. CARC-197 Precertification/ authorization/ notification absent. -RARC-M62 Missing/ incomplete/ invalid treatment authorization code.	2. CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.
3. CARC-29 The time limit for filing has expired.	3. CARC-29 The time limit for filing has expired.	3. CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. -RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
4. CARC-197 Precertification/ authorization/ notification absent	4. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.	4. CARC-B13 Previously paid. Payment for this claim/ service may have been provided in a previous payment.
5. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement -RARC N-381 Consult our contractual agreement for restrictions/ billing/ payment information related to these charges.	5. CARC-22 This care may be covered by another payer per coordination of benefits. -RARC-N4 Missing/ Incomplete/ Invalid prior Insurance Carrier(s) EOB.	5. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.
6. CARC-252 An attachment/ other	6. CARC-8 The procedure code is inconsistent with	6. CARC-29 The time limit for filing has expired.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
documentation is required to adjudicate this claim/ service. At least one Remark Code must be provided. -RARC N-479 Missing Explanation of Benefits.	the provider type (taxonomy). RARC-N95 This provider type/ provider specialty may not bill this service.	
7. CARC-256- Service not payable per managed care contract.	7. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	7. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. -RARC-M15 Separately billed services/ tests have been bundled as they are considered components of the same.
8. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. -RARC-MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	8. CARC-236 This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier provided on the same day according to the National Correct Coding Initiative or workers compensation state regulation/ fee schedule requirements. RARC-N657This should be billed with the appropriate code for these services.	8. CARC-256 Service not payable per managed care contract.
9. CARC-97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. RARC-N432 Alert: Adjustment based on	9. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC-N253 Missing/incomplete/invalid attending provider primary identifier.	9. CARC-16 Claim/ service lacks information or has submission/ billing error(s) which is needed for adjudication. RARC-N258 Missing/ incomplete/ invalid billing provider/ supplier address.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Recovery Audit.		
10. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. RARC-N19 Procedure code incidental to primary procedure.	10. CARC-109 Claims/ service not covered by this payer/ contractor. RARC-N193 Alert: Specific federal/ state/ local program may cover this service through another payer.	10. CARC-251 The attachment/ other documentation that was received was incomplete or deficient. RARC-M127 Missing patient medical record for this service.

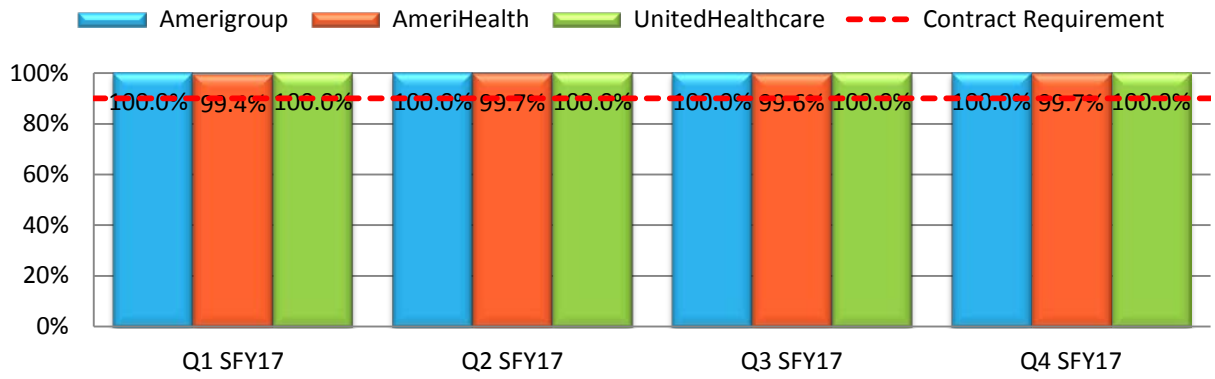
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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/

Pharmacy Claims Payment

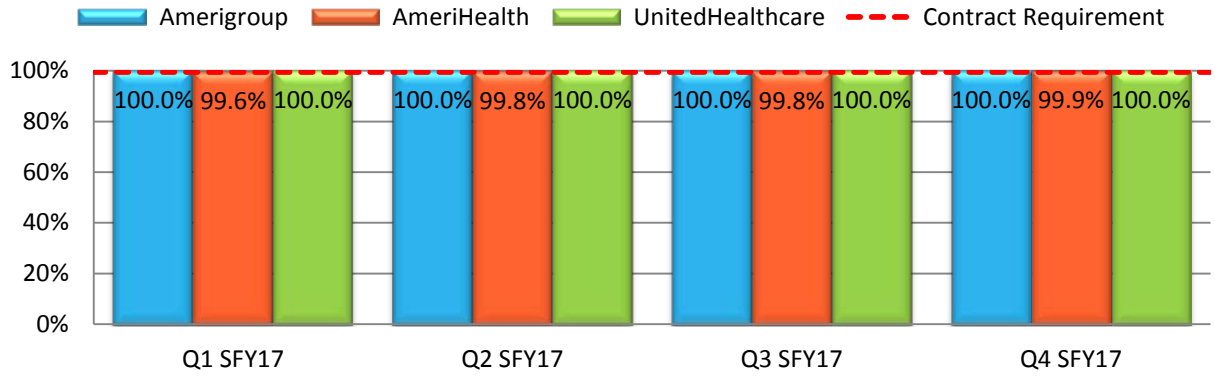
Pharmacy claims processing data is for the entire quarter.

90% of Clean Pharmacy Claims Must be Paid or Denied Within 14 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.

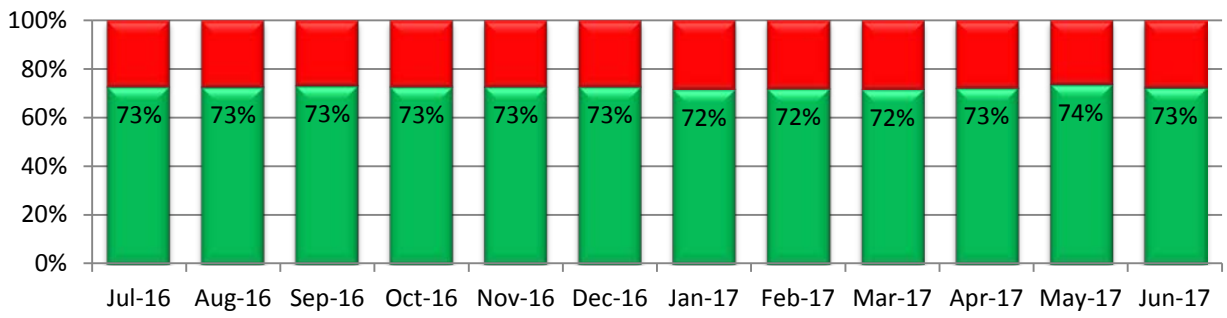
99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days



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.

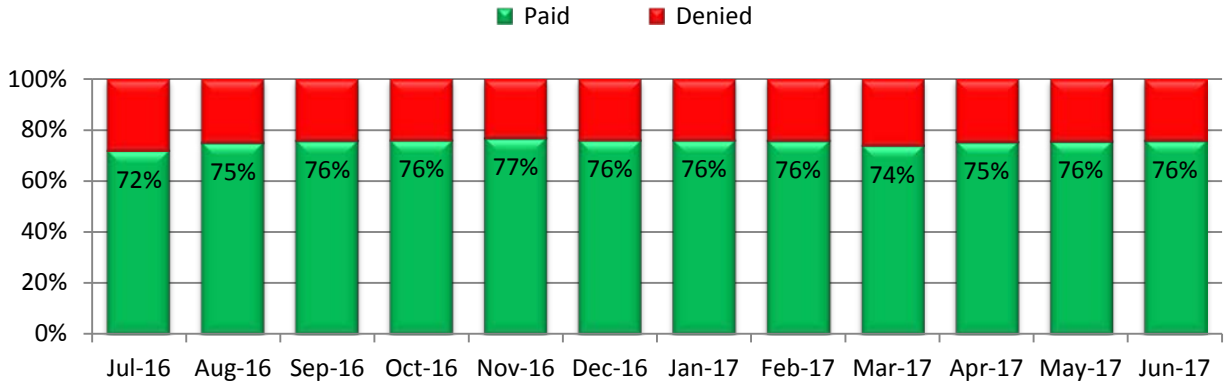
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



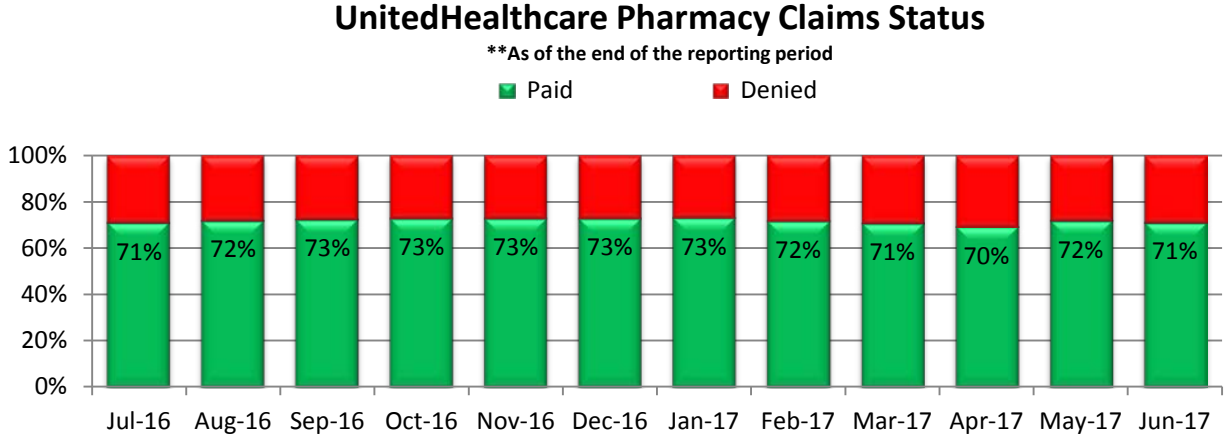
AmeriHealth Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
1. Refill Too Soon	1. Refill Too Soon	1. Refill Too Soon
2. Submit Bill To Other Processor Or Primary Payer	2. Product/Service Not Covered-Plan/Benefit Exclusion	2. Product Service Not Covered
3. Product Not On Formulary	3. Patient Is Not Covered	3. Filled After Coverage Termed
4. Prior Authorization Required	4. Prior Authorization Required	4. Prior Authorization Required
5. Days Supply Exceeds Plan Limitation	5. Submit Bill to Other Processor or Primary Payer	5. Plan Limitations Exceeded
6. Plan Limitations Exceeded	6. Plan Limitations Exceeded	6. Submit Bill To Other Processor
7. Product/Service Not Covered – Plan/Benefit Exclusion	7. Duplicate Paid/ Captured Claim	7. Missing Invalid Days Supply
8. DUR Reject Error	8. Non-Matched Product/ Service ID number	8. DUR Reject Error
9. This Medicaid Patient Is Medicare Eligible	9. DUR Reject Error	9. Missing Invalid Group Number
10. Scheduled Downtime	10. Provider Ineligible to Perform Service	10. Non-Matched Pharmacy

Utilization of Health Care Services Reported			
Data for Q1 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$13,319,409	$21,186,429	$10,607,158
Inpatient Medical Claims Reimbursed	$36,040,867	$23,626,949	$30,875,681
Inpatient Behavioral Health Claims Reimbursed	$13,303,815	$23,625,159	$2,545,170
Outpatient Claims Reimbursed	$36,874,601	$35,264,221	$38,025,560
Data for Q2 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$11,731,009	$19,297,989	$11,097,856
Inpatient Medical Claims Reimbursed	$37,473,679	$21,390,422	$26,547,433
Inpatient Behavioral Health Claims Reimbursed	$14,177,194	$21,777,454	$2,879,682
Outpatient Claims Reimbursed	$36,493,221	$31,976,808	$37,258,734
Data for Q3 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$23,345,952	$10,841,345	$6,565,427

Inpatient Medical Claims Reimbursed	$43,263,244	$22,114,039	$32,049,901
Inpatient Behavioral Health Claims Reimbursed	$15,855,399	$22,208,514	$2,842,144
Outpatient Claims Reimbursed	$57,573,241	$32,712,179	$34,987,067
Data for Q4 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$15,607,206	$10,033,488	$8,654,667
Inpatient Medical Claims Reimbursed	$43,716,265	$24,021,602	$32,606,922
Inpatient Behavioral Health Claims Reimbursed	$14,069,916	$26,623,158	$2,651,483
Outpatient Claims Reimbursed	$55,084,213	$38,469,580	$38,508,022

This data is reflective of point in time and will change to reflect reprocessing associated with rate adjustments as well as recoveries related to program integrity and third party liability coverage.

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 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Family Planning and Resources	491	1,275	742	2,508
Healthy Incentives	8,524	15,113	813	24,450
Health and Wellness	368	1,112	92	1,572
Additional Benefits	4,137	6,665	229	11,031
Tobacco Cessation	113	682	450	1,245
Q2 SFY17 Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Total**
Family Planning and Resources	5,095	1,807	989	7,891
Healthy Incentives	4,771	6,658	1,173	12,602
Health and Wellness	1,259	1,268	71	2,616
Additional Benefits	38	1,850	233	2,121
Tobacco Cessation	114	666	468	1,248
Q3 SFY17 Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Total**
Family Planning and Resources	3,739	1,755	1,254	6,748
Healthy Incentives	3,076	7,657	1,456	12,189
Health and Wellness	125	3,513	112	3,750
Additional Benefits	653	1,127	314	2,049
Tobacco Cessation	72	410	534	1,016

Q4 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Family Planning and Resources	4,121	2,539	1,165	7,825
Healthy Incentives	3,255	8,243	1,713	13,211
Health and Wellness	88	5,716	116	5,920
Additional Benefits	1,040	1,929	339	3,308
Tobacco Cessation	244	707	481	1,432

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_12_02.pdf.

NETWORK ADEQUACY AND HISTORICAL UTILIZATION

The IME and the Centers for Medicare and Medicaid Services (CMS) developed a network adequacy tool that is based on Medicaid members' historical utilization of services. **Historical utilization**, as seen in the table below, is 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.

Data below comes from the June 2017 Monthly MCO Performance Report.

	Amerigroup			AmeriHealth			UnitedHealthcare		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	85.8%	90.6%	93.4%	96.0%	99.0%	99.0%	99.5%	99.9%	99.6%
Cardiology	88.1%	95.4%	89.0%	100.0%	100.0%	80.0%	99.8%	99.8%	99.2%
Endocrinology	91.5%	63.2%	100.0%	95.0%	98.0%	100.0%	99.7%	99.8%	97.9%
Gastroenterology	88.5%	93.6%	81.1%	100.0%	96.0%	98.0%	99.5%	100.0%	99.2%
Neurology	92.5%	94.2%	99.0%	97.0%	100.0%	99.0%	98.9%	99.9%	95.5%
Oncology	76.9%	84.0%	98.0%	99.0%	100.0%	100.0%	100.0%	99.9%	99.8%
Orthopedics	71.8%	85.7%	94.3%	100.0%	100.0%	97.0%	99.9%	99.9%	99.3%
Pulmonology	79.8%	97.1%	91.2%	100.0%	100.0%	100.0%	99.8%	99.4%	97.9%
Rheumatology	100.0%	100.0%	95.0%	100.0%	97.0%	100.0%	99.8%	100.0%	100.0%
Urology	80.2%	99.0%	78.0%	98.0%	99.0%	100.0%	100.0%	99.8%	99.5%
Provider Type - Pediatric	East	Central	West	East	Central	West	East	Central	West
Primary Care	88.9%	97.3%	98.0%	95.0%	98.0%	98.0%	99.9%	100.0%	99.7%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	96.8%	98.4%	95.0%	100.0%	100.0%	99.0%	99.1%	99.2%	99.2%
Pharmacies	99.8%	99.6%	99.9%	98.0%	98.0%	97.0%	100.0%	100.0%	99.9%
ICF/ID	99.6%	100.0%	100.0%	99.0%	98.0%	97.0%	100.0%	100.0%	100.0%
ICF/SNF	94.8%	91.6%	93.2%	95.0%	97.0%	96.0%	99.5%	97.9%	99.8%

	Amerigroup			AmeriHealth			UnitedHealthcare		
Provider Type - Waiver	East	Central	West	East	Central	West	East	Central	West
AIDS/HIV Level 1: Adult Day Care	No Util	No Util	No Util	No Util	No Util	No Util	100.0%	100.0%	100.0%
AIDS/HIV Level 2: CDAC, Home Health Aide	No Util	100.0%	100.0%	100.0%	100.0%	No Util	100.0%	100.0%	100.0%
AIDS/HIV Level 4: Home Delivered Meals	100.0%	100.0%	No Util	100.0%	No Util	100.0%	100.0%	100.0%	100.0%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	93.1%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%
BI Level 2: CDAC	96.6%	97.0%	95.9%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%
BI Level 3: Supported Community Living	96.7%	95.8%	99.2%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
Elderly Level 1: Adult Day Care	91.2%	100.0%	100.0%	86.0%	100.0%	No Util	100.0%	100.0%	100.0%
Elderly Level 2: CDAC, Home Health Aide	91.7%	95.0%	95.5%	100.0%	92.0%	100.0%	100.0%	100.0%	100.0%
Elderly Level 4: Home Delivered Meals	92.4%	92.7%	95.1%	100.0%	96.0%	99.0%	100.0%	100.0%	100.0%
HD Level 1: Adult Day Care	100.0%	100.0%	No Util	100.0%	100.0%	No Util	100.0%	100.0%	100.0%
HD Level 2: CDAC, Counseling, Home Health Aide	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HD Level 4: Home Delivered Meals	91.1%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	92.4%	93.8%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	100.0%
ID Level 2: CDAC, Home Health Aide	88.5%	95.2%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%
ID Level 3: Supported Community Living	96.3%	92.3%	99.3%	99.0%	98.0%	98.0%	100.0%	100.0%	100.0%
PD Level 2: CDAC	96.2%	100.0%	98.3%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
Provider Type - Behavioral	East	Central	West	East	Central	West	East	Central	West
Behavioral Health - Inpatient	99.9%	100.0%	94.7%	100.0%	98.0%	100.0%	100.0%	97.6%	84.0%
Behavioral Health - Outpatient	95.1%	89.7%	88.4%	93.0%	98.0%	98.0%	99.5%	99.6%	99.8%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	89.5%	96.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%
Habilitation Level 3: Home Based Habilitation	97.5%	100.0%	94.6%	100.0%	99.0%	91.0%	100.0%	99.9%	94.7%
Children's Mental Health Level 1: Respite	100.0%	92.8%	69.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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.

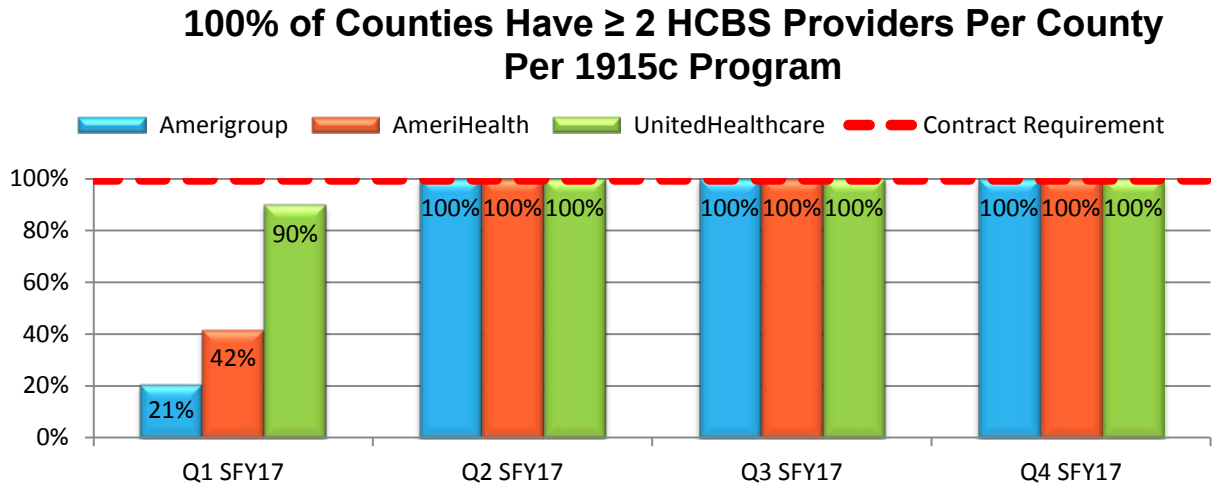
Links to time and distance reports for the last state fiscal year 2017 reporting period can be found at:

- Amerigroup:
  - https://dhs.iowa.gov/sites/default/files/AmerigroupIA_GeoAccess_SFY17_Qtr4.pdf
- AmeriHealth Caritas:
  - https://dhs.iowa.gov/sites/default/files/AmeriHealthCaritasIowa__GeoAccess_SFY17_Qtr4.pdf
- UnitedHealthcare:
  - https://dhs.iowa.gov/sites/default/files/UHC__GeoAccess_SFY17_Qtr4.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.

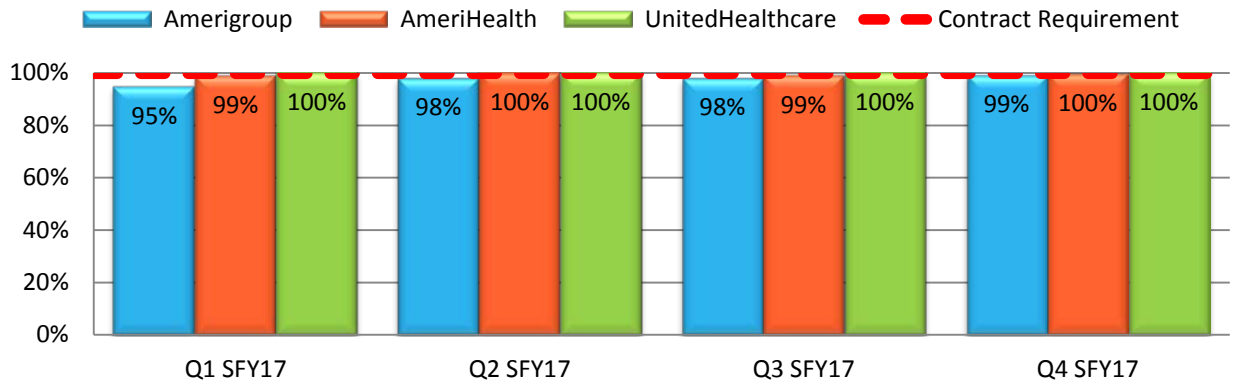
Percentage of Members with Coverage in Time and Distance Standards in Q4 SFY17									
MCO	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
Measure	**30 Min/ 30 Mile**			**30 Min/ 30 Mile**			**30 Min/ 30 Mile**		
Primary Care - Adult	100%			100%			100%		
Primary Care – Child	100%			100%			100%		
Hospital	100%			100%			100%		
Behavioral Health – Outpatient	100%			100%			100%		
General Optometry	100%			100%			100%		
Lab and X-ray Services	100%			100%			100%		
Pharmacy	100%			100%			100%		
MCO	**Amerigroup**			**AmeriHealth**			**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**	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**
ICF/SNF	100%	100%		100%	100%		100%	100%	
ICF/ID	100%	100%		100%	100%		91%	100%	
Behavioral Health – Inpatient		98%	100%		100%	100%		98%	100%



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

Prior Authorization - Medical

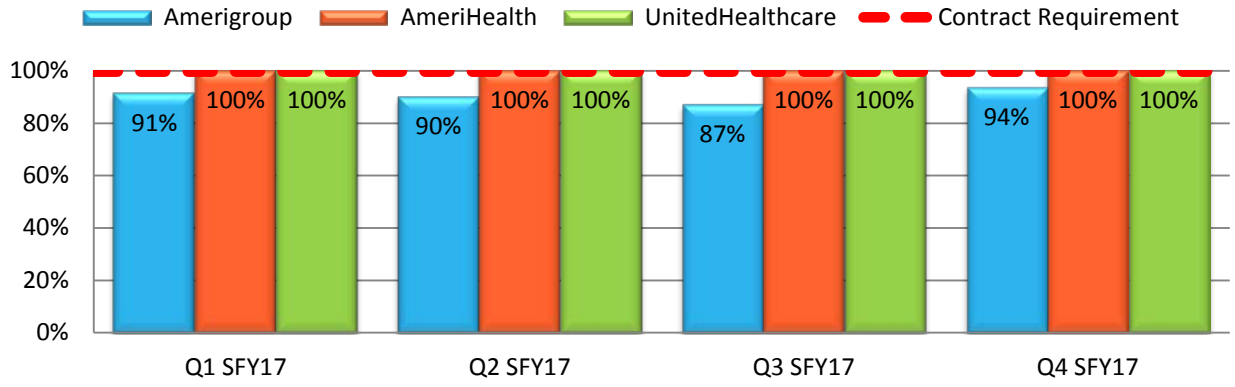
100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request



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.

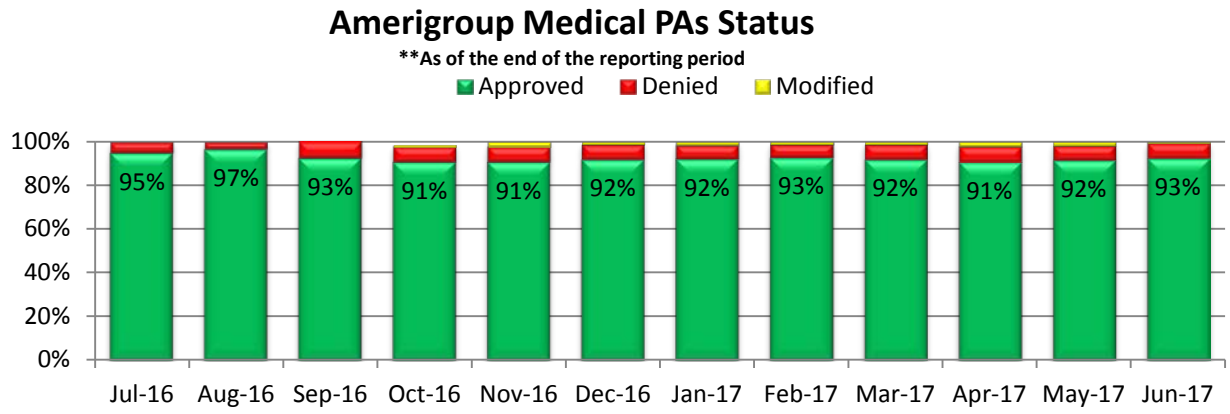
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

100% of PAs for Expedited Services Must be Authorized Within 3 Business Days of Request

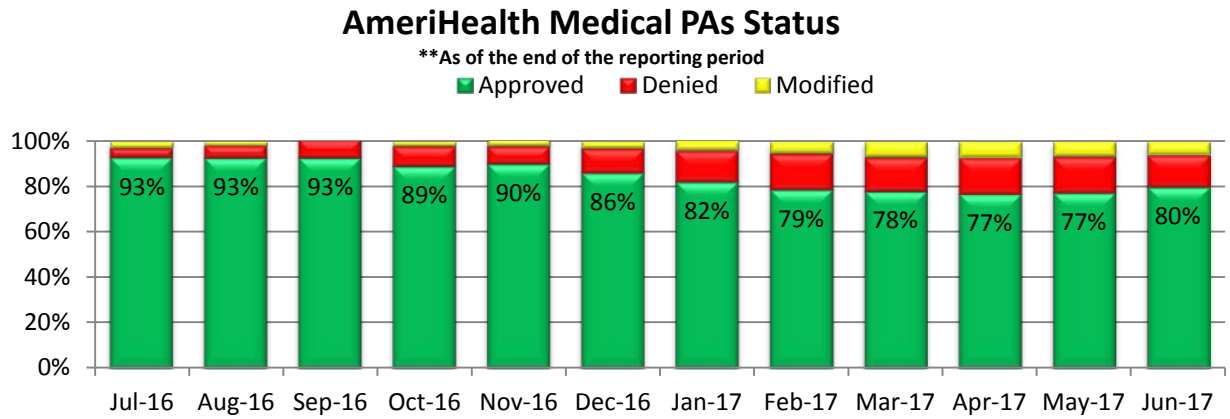


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

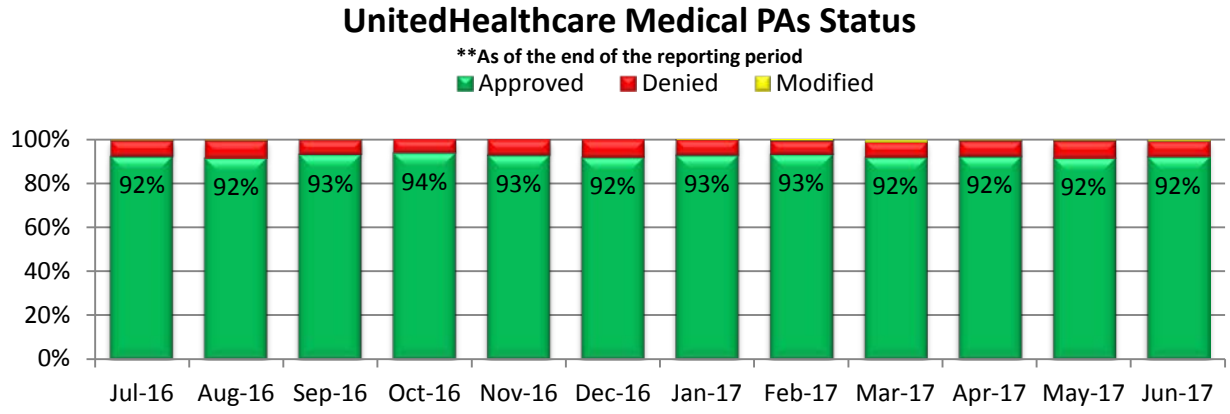
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.



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.

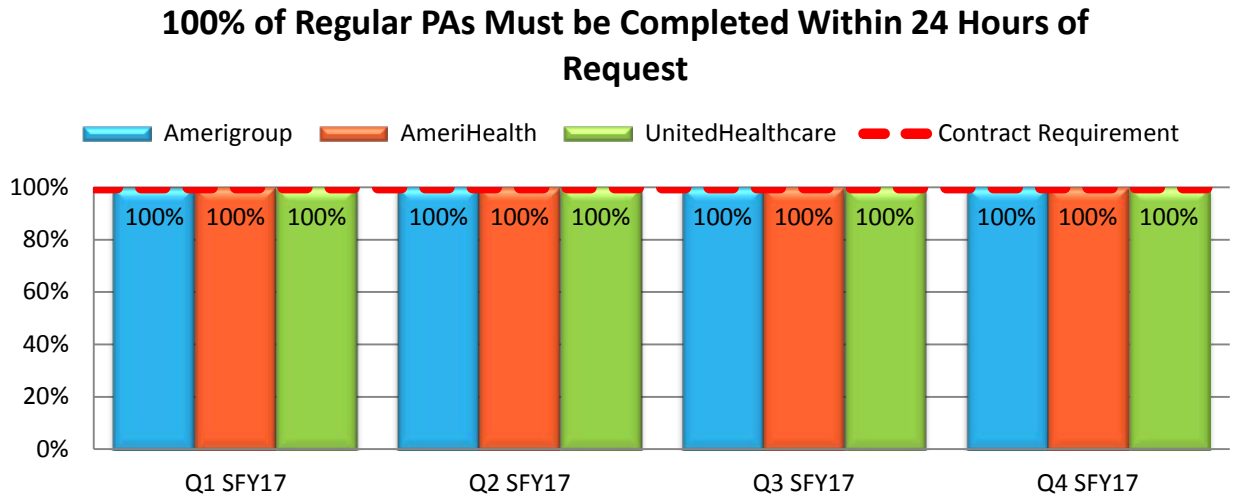


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



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.

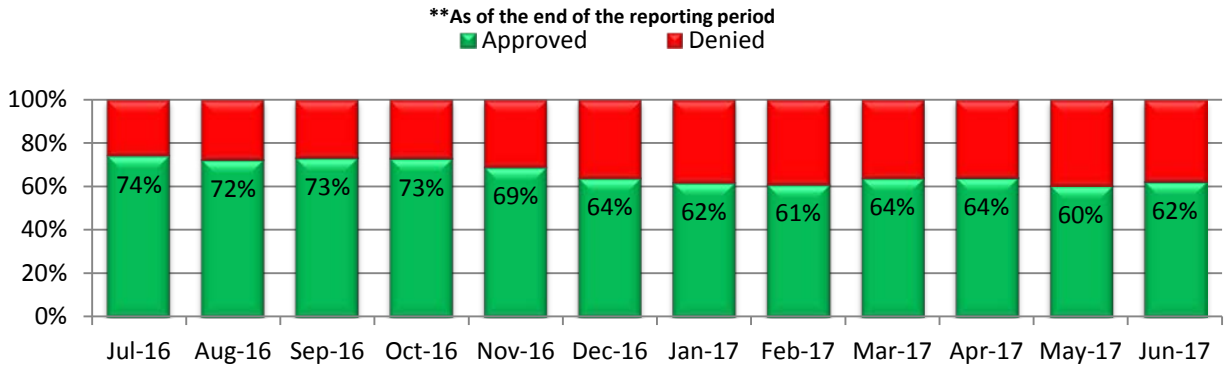
Prior Authorization - Pharmacy



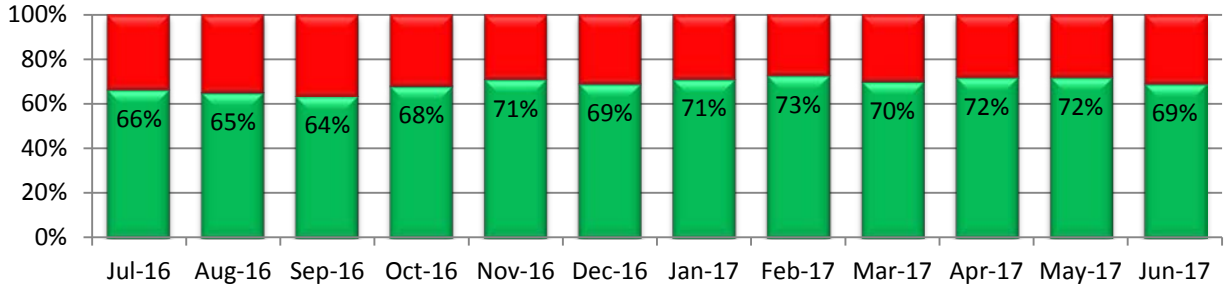
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ.

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

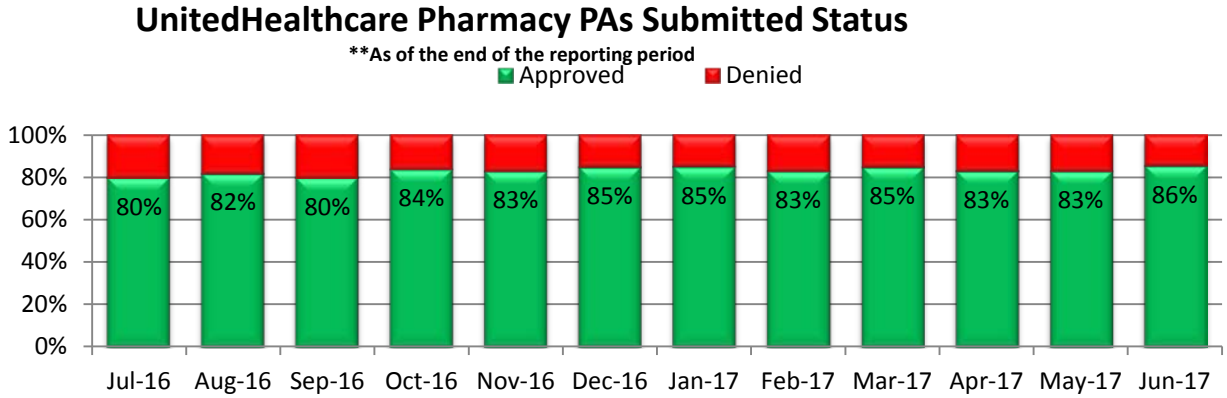
Amerigroup Pharmacy PAs Submitted Status



AmeriHealth 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	N	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	N	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
	N	Y	N	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	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement for Q1 SFY17	17%	6%	2%
% of Members Covered by a Value Based Purchasing Agreement for Q2 SFY17	16%	0%	5%

Value-Based Purchasing Enrollment			
MCOs are expected to have 40% of their population covered by a value based purchasing agreement by 2018.			
Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
% of Members Covered by a Value Based Purchasing Agreement for Q3 SFY17	16.3%	0%	9.6%
% of Members Covered by a Value Based Purchasing Agreement for Q4 SFY17	16.2%	0%	28.7%

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 SFY17 Quarter Only	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	109.92%	114.1%	99.1%*
ALR	7.85%	6.6%	12.5%*
Underwriting	-17.78%	-20.7%	-11.7%*
Data for Q2 SFY17 Quarter Only	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	115.8%*	113.2%*	101.9%*
ALR	8.3%*	7.2%*	11.8%*
Underwriting	-24.1%*	-20.4%*	-13.7%*
Data for Q3 SFY17 Quarter Only	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	94.3%*	107.1%*	100.5%*
ALR	6.4%*	5.8%*	11.6%*
Underwriting	-0.7%*	-12.9%*	-12.1%*
Data for Q4 SFY17 Quarter Only	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	101.6%	108.8%	101.2%*
ALR	6.8%	6.0%	11.5%*
Underwriting	-8.4%	-14.8%	-12.7%*

**The information provided in the above table is a special restatement performed by the Department and will not tie to any other publicly available financial information.*

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 and the table below shows financial metrics for the contract to date. Metrics that have been restated by the department to reflect consistency across periods and MCOs have been notated with an asterisk.

Data for Q1 SFY17 Contract to Date	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	116.1%*	108.6%*	98.6%*
ALR	13.3%*	6.5%*	12.0%*
Underwriting	-29.4%*	-15.1%*	-10.6%*
Data for Q2 SFY17 Contract to Date	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	116.0%	110.4%	99.7%
ALR	11.6%	6.8%	11.9%
Underwriting	-27.6%	-17.3%*	-11.6%
Data for Q3 SFY17 Contract to Date	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	109.3%	109.6%	99.9%
ALR	10.0%	6.6%	11.8%
Underwriting	-19.3%	-16.1%	-11.7%
Data for Q4 SFY17 Contract to Date	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	107.6%*	109.3%*	100.1%*
ALR	9.3%*	6.4%*	11.8%*
Underwriting	-16.9%*	-15.7%*	-11.9%*

**The information provided in the above table is a special restatement performed by the Department and will not tie to any other publicly available financial information.*

The financial ratios presented here were reported by the MCOs and are consistent with combined calendar year 2016 (Q1 and Q2 SFY17) and calendar year 2017 (Q3 and Q4 SFY17) financial information submitted to the Iowa Insurance Division by each MCO.

The financial metrics presented in the contract to date table reflect financial performance for the contract period, i.e., the period beginning April 1, 2016. Premium deficiency reserves and/or changes in premium deficiency reserves are excluded from the calculations. The department believes this approach most accurately reflects financial performance for service delivery under the contract.

It is important to note that accounting and reporting differences among MCOs may result in variance among plans beyond the variance in medical expenses per member. The department is working with the MCOs to standardize financial metrics and limit or explain controllable variances for reporting purposes.

Program Cost Savings (Annual)			
Data	**Projected State Spend Without Managed Care**	**Actual State Spend with Managed Care**	**Program Cost Savings (State)**
Program Cost Savings (State)	$1,702,214,039	$1,583,553,786	$118,660,253

Because Medicaid expenditures and revenues fluctuate on a quarterly basis due to a variety of factors (timing of retrospective rate adjustments, timing of performance withhold payments, collection of drug rebates, etc.) savings are being reported on an annual basis.

Annual savings from managed care are estimated at $118.7 million. When calculating savings, the Department is comparing what we believe we would have spent for medical assistance had the FFS system continued to what the Department is spending for medical assistance with the implementation of the IA Health Link managed care program. Speaking in broad terms, savings result from the difference between:

- The managed care adjustment (a decrease in per member per month expenditures)
- And the administrative load paid on the capitation rates.

The calculation does not consider what the MCOs have paid in claims or MCO profit/loss; rather it is a calculation of what the state has paid the MCOs versus estimated payments under the FFS system.

Savings reported are inclusive of the 2% performance withhold. It is anticipated that all or a portion of this withhold will be paid out to the managed care organizations at the end of the first performance measurement period. The managed care payments are inclusive of long term care mix (mix of institutional and waiver members) and emerging trend adjustments that have not yet been paid.

**Savings are based on a comparison of total Medical claims payments before and after the managed care transition. Non-claim costs are excluded because they are not impacted by the IA Health Link program. An example of an excluded cost is Medicare Part B premium payments.

Provider Type Reimbursement During Quarter by MCOs

Included in the data below are provider types with the highest amount of utilization. This data does not include an exhaustive list of all provider types or all reimbursements for each managed care organization.

Data for Q1 SFY17	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Hospital Claims Paid	$77,422,067	$103,953,146	$74,723,413	$256,098,626
Physician Claims Paid	$33,127,436	$42,065,712	$34,513,843	$109,706,991
HCBS Claims Paid	$9,911,741	$157,864,042	$8,803,660	$176,579,443
DME Claims Paid	$3,388,730	$10,586,891	$3,164,056	$17,139,677
Pharmacy Claims Paid	$48,332,307	$53,397,131	$40,040,427	$141,769,865
Home Health Claims Paid	$7,463,075	$20,956,062	$7,324,435	$35,743,572
Hospice Claims Paid	$5,676,988	$3,026,813	$1,791,777	$10,495,578
Nursing Facility Claims Paid	$48,652,558	$42,662,746	$48,198,337	$139,513,641
ICF/ID Claims Paid	$28,090,758	$34,181,042	$10,509,258	$72,781,058
Behavioral Health Claims Paid	$24,690,345	$32,824,642	$15,784,143	$73,299,130
Speech Therapy Claims Paid	$26,654	$35,321	$418,768	$480,743
Occupational Therapy Claims Paid	$96,011	$49,012	$292,275	$437,298
Non-Emergency Transportation Claims Paid	$1,385,565	$1,405,419	$1,572,634	$4,363,618
Data for Q2 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Total**
Hospital Claims Paid	$74,554,986	$94,663,279	$72,402,420	$241,620,685
Physician Claims Paid	$37,237,024.85	$44,675,374.96	$48,749,520	$130,661,920
HCBS Claims Paid	$12,351,692	$159,212,776	$8,272,430	$179,836,898
DME Claims Paid	$3,803,197	$9,889,505	$3,806,965	$17,499,666
Pharmacy Claims Paid	$519,900	$54,688,658	$43,980,508	$99,189,066
Home Health Claims Paid	$5,295,183	$18,543,013	$6,620,051	$30,458,247
Hospice Claims Paid	$4,944,468	$3,289,832	$1,655,394	$9,889,695
Nursing Facility Claims Paid	$44,637,766	$40,053,415	$41,539,898	$126,231,079
ICF/ID Claims Paid	$17,424,529	$27,938,018	$8,165,061	$53,527,608
Behavioral Health Claims Paid	$33,273,413	$34,499,805	$16,128,689	$83,901,907
Speech Therapy Claims Paid	$135,699	$42,270	$386,351	$564,320

Provider Type Reimbursement During Quarter by MCOs

Included in the data below are provider types with the highest amount of utilization. This data does not include an exhaustive list of all provider types or all reimbursements for each managed care organization.

Occupational Therapy Claims Paid	$1,658,060	$37,565	$257,447	$1,953,072
Non-Emergency Transportation Claims Paid	$1,807,288	$1,736,359	$1,914,848	$5,458,495
Data for Q3 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Total**
Hospital Claims Paid	$108,329,884	$88,080,246	$72,228,746	$268,638,876
Physician Claims Paid	$41,053,161	$49,725,428	$47,910,817	$138,689,406
HCBS Claims Paid	$13,797,724	$156,015,511	$8,267,966	$178,081,201
DME Claims Paid	$7,404,013	$10,020,551	$3,808,204	$21,232,768
Pharmacy Claims Paid	$57,604,135	$55,915,243	$43,955,233	$157,474,611
Home Health Claims Paid	$10,993,124	$20,680,482	$6,017,570	$37,691,176
Hospice Claims Paid	$4,945,505	$2,881,955	$1,721,379	$9,548,839
Nursing Facility Claims Paid	$41,174,733	$40,929,463	$40,483,248	$122,587,444
ICF/ID Claims Paid	$21,169,810	$36,287,062	$10,601,083	$68,057,955
Behavioral Health Claims Paid	$37,844,236	$34,249,601	$18,417,919	$90,511,756
Speech Therapy Claims Paid	$152,707	$36,403	$363,225	$552,335
Occupational Therapy Claims Paid	$889,253	$49,271	$305,175	$1,243,699
Non-Emergency Transportation Claims Paid	$2,226,100	$1,811,983	$1,501,500	$5,539,583
Data for Q4 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Total**
Hospital Claims Paid	$104,566,346	$99,491,089	$78,225,354	$282,282,789
Physician Claims Paid	$40,817,922	$48,777,058	$45,772,267	$135,367,247
HCBS Claims Paid	$22,208,133	$153,906,460	$9,116,591	$185,231,184
DME Claims Paid	$5,072,751	$10,771,592	$3,975,085	$19,819,428
Pharmacy Claims Paid	$51,917,635	$53,353,258	$42,080,144	$147,351,037
Home Health Claims Paid	$10,361,661	$18,151,023	$6,191,010	$34,703,694
Hospice Claims Paid	$6,791,548	$3,194,137	$1,725,656	$11,711,342
Nursing Facility Claims Paid	$67,237,103	$42,630,900	$44,375,817	$154,243,820

Provider Type Reimbursement During Quarter by MCOs				
Included in the data below are provider types with the highest amount of utilization. This data does not include an exhaustive list of all provider types or all reimbursements for each managed care organization.				
ICF/ID Claims Paid	$27,247,692	$35,782,943	$8,570,204	$71,600,840
Behavioral Health Claims Paid	$30,687,217	$34,446,604	$19,096,510	$84,230,331
Speech Therapy Claims Paid	$38,063	$12,001	$423,138	$473,201
Occupational Therapy Claims Paid	$2,044,204	$39,006	$322,343	$2,405,553
Non-Emergency Transportation Claims Paid	$2,475,100	$2,104,581	$1,712,523	$6,292,204

Population differences between plans are a factor in different levels of reimbursement by each plan for the provider types listed above.

This data is reflective of point in time and will change to reflect reprocessing associated with rate adjustments as well as recoveries related to program integrity and third party liability coverage.

Total Capitation Payments Made to the Managed Care Organizations				
MCO	**Q1 SFY17**	**Q2 SFY17**	**Q3 SFY17**	**Q4 SFY17**
Amerigroup	$238,096,189	$237,566,370	$250,682,589	$253,268,602
AmeriHealth	$444,903,457	$445,036,927	$457,263,121	$457,842,200
UnitedHealthcare	$209,092,263	$205,695,971	$222,018,555	$220,227,900

▲ Differences between quarters:

- Q1 SFY17 and Q2 SFY17 represent capitation payments for members in every program except for Hawk-i.
- Q3 SFY17 represents capitation payments for members in all programs managed by MCOs, including Hawk-i.
- The above totals are point-in-time representations made by DHS and may vary based on the date the data is pulled, as well as based on ongoing reconciliations.

This is a point in determination and figures will change as updated rates are approved by the Centers for Medicare and Medicaid Services are reprocessed and reimbursed to the managed care organizations.

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 SFY17	$2,861,668	$13,021,872	$6,947,462
Amount of TPL Recovered Q2 SFY17	$6,148,299	$15,797,282	$13,421,413
Amount of TPL Recovered Q3 SFY17	$8,659,664	$20,543,556	$21,885,020
Amount of TPL Recovered Q4 SFY17	$9,227,609	$26,270,230	$21,039,239

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 SFY17	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	3	30	20
Overpayments Identified During the Quarter	381	0	1
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	0	8	1
Member Concerns Referred to IME	2	15	2
Data for Q2 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Investigations Opened During the Quarter	34	49	56
Overpayments Identified During the Quarter	21	16	0
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	2	4	5
Member Concerns Referred to IME	0	27	1

Fraud, Waste and Abuse			
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.			
Data for Q3 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Investigations Opened During the Quarter	22	52	80
Overpayments Identified During the Quarter	92	3	1
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	14	15	4
Member Concerns Referred to IME	0	29	5
Data for Q4 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Investigations Opened During the Quarter	84	86	46
Overpayments Identified During the Quarter	22	0	2
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	10	42	7
Member Concerns Referred to IME	1	20	2

The MCOs have attended more than 25 meetings or on-site visits with regulators during this quarter. The plans have initiated 53 investigations in the second quarter and referred nine cases to Medicaid Fraud Control Unit (MFCU). The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse. Therefore MCO investigations, overpayment recovery, and referrals to MFCU would not occur until there is sufficient evidence to implement. It is anticipated that these activities will significantly grow with ongoing claims experience to be used for analytics.

Hospital Admissions

A goal of managed care is to reduce unnecessary hospital admissions by assuring that members receive effective care coordination and preventive services.

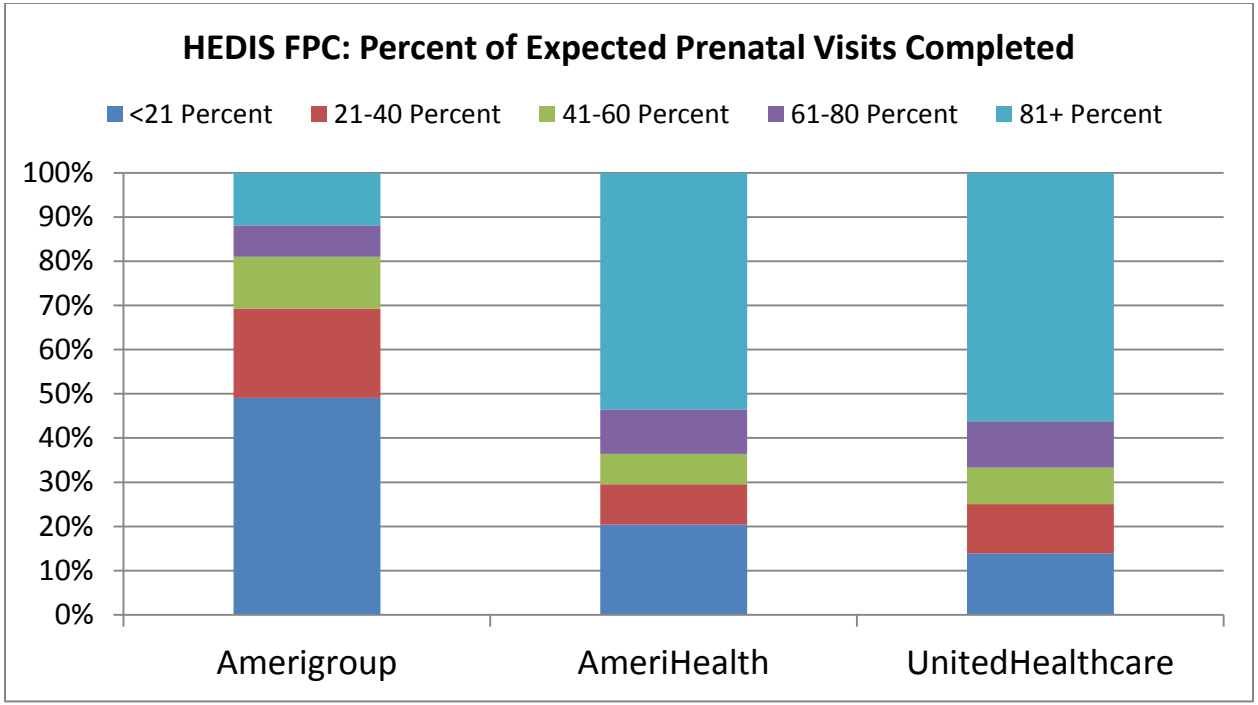
	Amerigroup			AmeriHealth			UnitedHealthcare		
Data for Q1 SFY17	**July**	**August**	**September**	**July**	**August**	**September**	**July**	**August**	**September**
Members (from IME)	192,267	193,793	194,359	218,303	220,207	220,295	193,881	193,556	191,500
Total Inpatient Admissions	2,201	2,220	2,219	1,416	1,438	1,301	2,106	1,857	1,720
Readmissions within 15 days of Discharge	285	268	280	84	79	57	150	131	106
Readmissions between 16 and 30 days of Discharge	140	171	196	58	50	44	12	73	50
Readmissions between 31 and 45 days of Discharge	62	93	132	31	30	25	5	35	29
Readmissions between 46 and 60 days of Discharge	14	25	13	29	26	26	0	11	33
Data for Q2 SFY17	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**
Members (from IME)	186,789	186,993	186,639	213,382	213,452	212,981	169,977	169,205	168,323
Total Inpatient Admissions	1,234	1,210	1,324	1,609	1,474	1,868	1,644	1,719	973
Readmissions within 15 days of Discharge	79	69	84	112	127	212	79	70	129
Readmissions between 16 and 30 days of Discharge	36	31	64	61	60	98	43	45	53
Readmissions between 31 and 45 days of Discharge	11	18	41	47	45	67	31	25	29
Readmissions between 46 and 60 days of Discharge	3	6	4	41	54	60	13	25	24
Data for Q3 SFY17	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**
Members (from IME)	200,407	200,162	200,280	225,419	225,082	225,049	192,566	192,573	192,638
Total Inpatient Admissions	1,442	1,301	1,490	1,673	1,451	1,551	1,035	912	799

Readmissions within 15 days of Discharge	107	88	90	174	125	161	150	117	93
Readmissions between 16 and 30 days of Discharge	43	29	33	76	61	53	55	36	54
Readmissions between 31 and 45 days of Discharge	9	15	9	67	52	58	21	24	18
Readmissions between 46 and 60 days of Discharge	5	3	1	64	40	58	33	16	20
Data for Q4 SFY17	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**
Members (from IME)	200,461	200,695	200,086	225,252	225,234	224,600	191,644	191,807	191,434
Total Inpatient Admissions	1,323	1,360	1,314	1,464	1,607	1,369	736	761	768
Readmissions within 15 days of Discharge	72	81	85	190	190	156	96	118	100
Readmissions between 16 and 30 days of Discharge	28	38	38	88	87	59	42	44	44
Readmissions between 31 and 45 days of Discharge	25	14	13	60	72	61	18	30	33
Readmissions between 46 and 60 days of Discharge	2	1	2	80	57	47	28	16	17

*Member totals were calculated as defined in the monthly reports– data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted.

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. All of the HEDIS measures presented are 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.



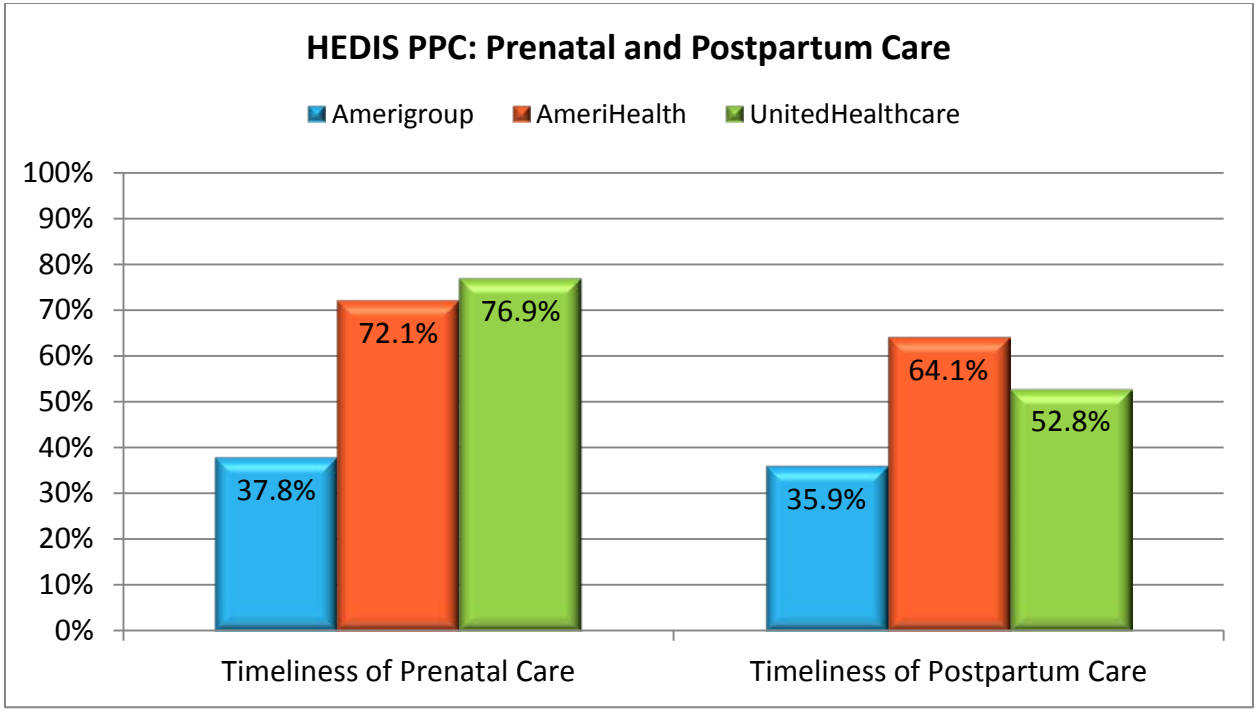
The Frequency of Prenatal Care measure is being considered for retirement because it may be redundant yet less stringent than the Timeliness of Prenatal and Postpartum Care measure. The latter measure assesses both receipt of visits and whether

visits occurred at recommended intervals. This measure is used to assess the percentage of Medicaid deliveries between November 6 of the year prior to the measurement year and November 5 of the measurement year that received the following number of expected prenatal visits:

- Less than 21% of expected visits
- 21% to 40% of expected visits
- 41% to 60% of expected visits
- 61% to 80% of expected visits
- Greater than or equal to 81% of expected visits

Visits should follow a schedule:

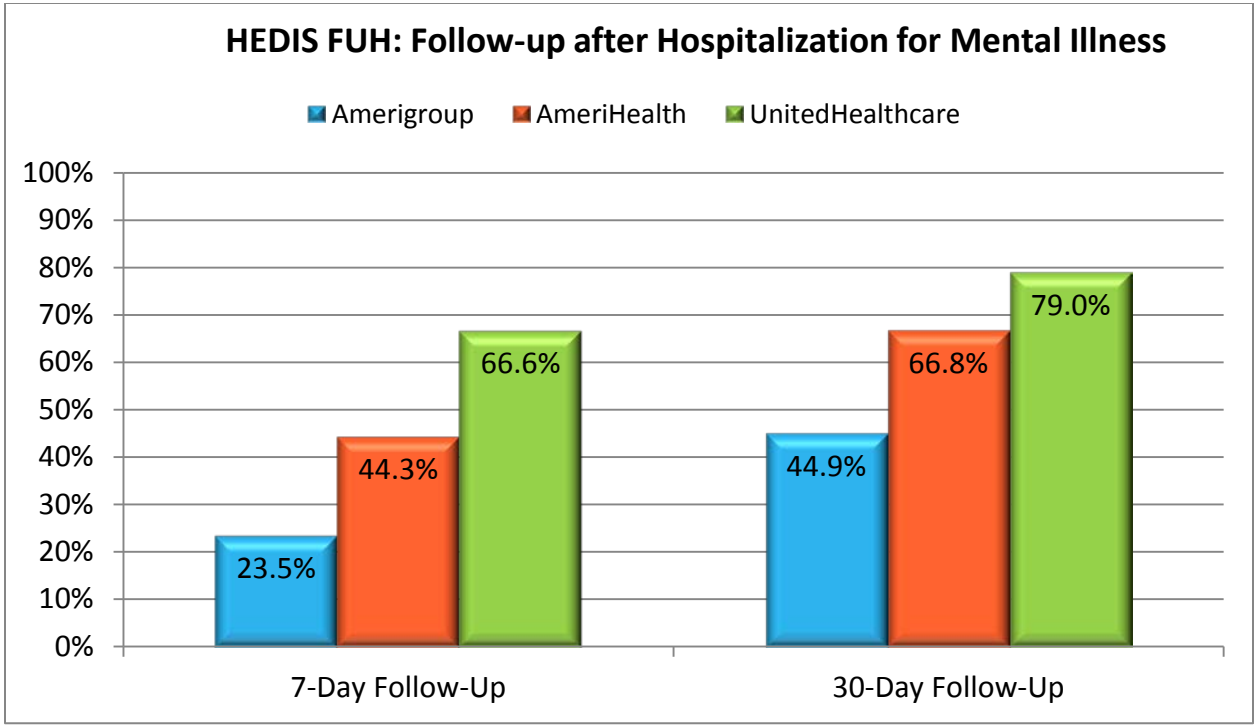
- Every 4 weeks for the first 28 weeks of pregnancy
- Every 2 to 3 weeks for the next 7 weeks
- Weekly thereafter until delivery



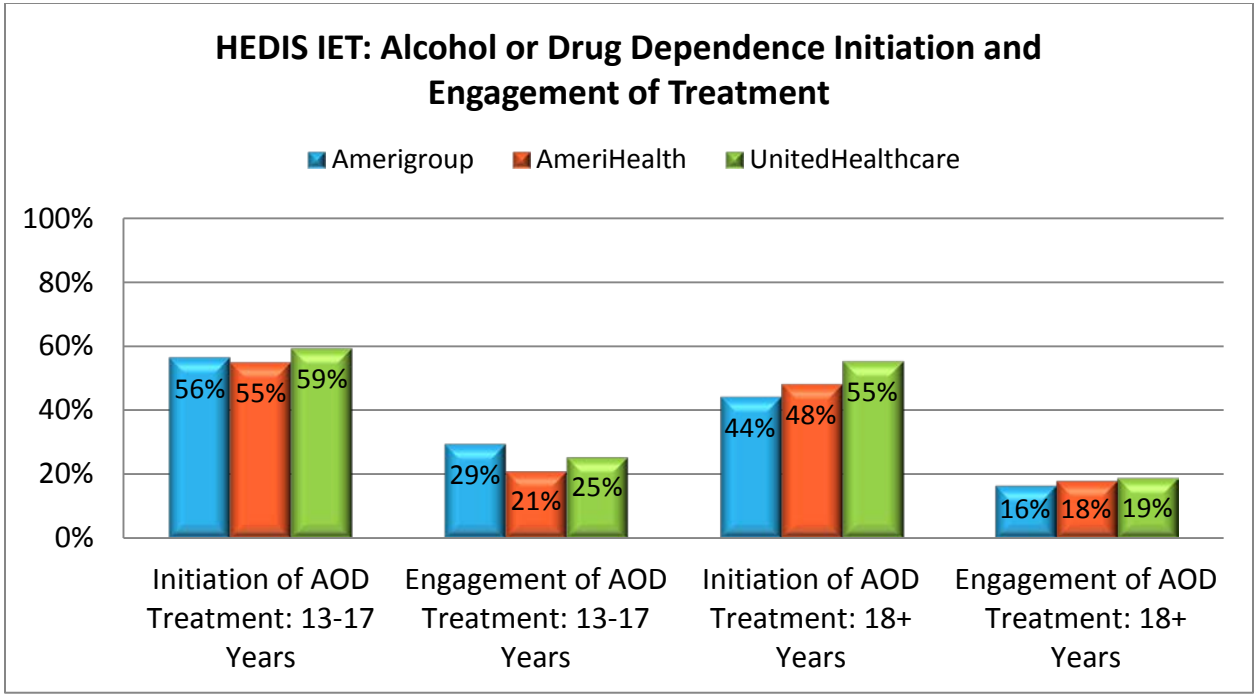
Timeliness of prenatal and postpartum care measures (shown in the table above) assess the percentage of deliveries of live births between November 6 of the year prior to the measurement year and November 5 of the measurement year. For these women, the measure assesses the following facets of prenatal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



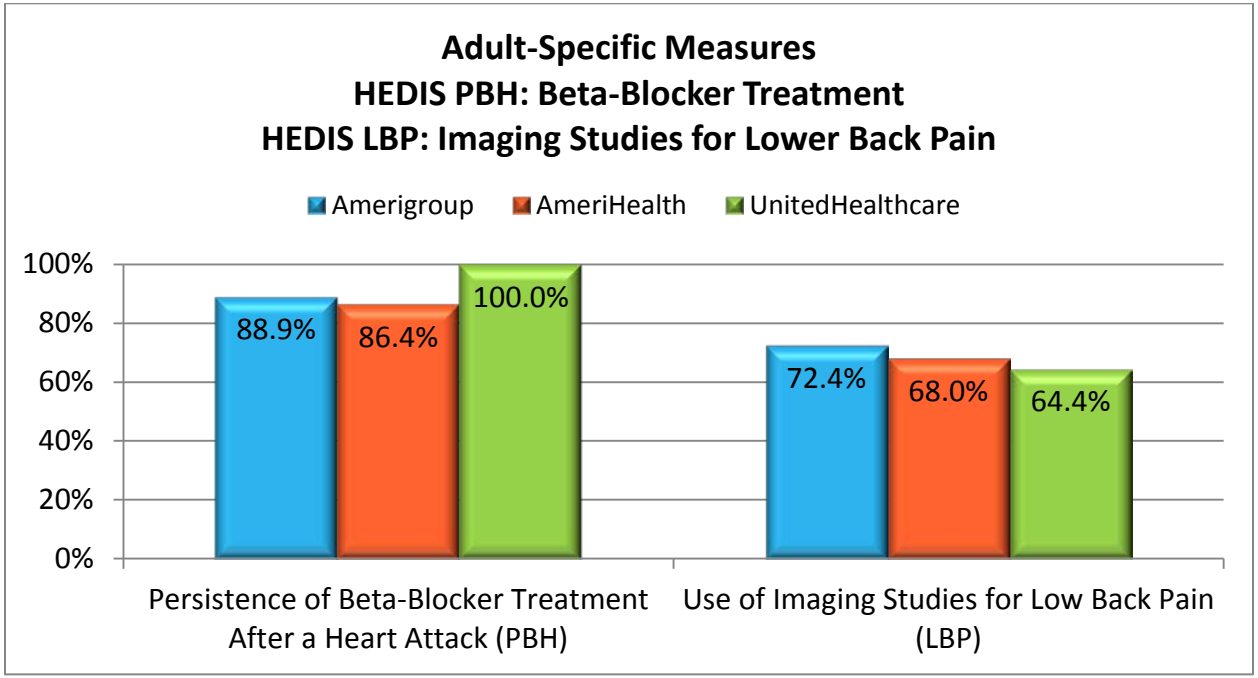
Iowa FFY 2015 data is what was reported to CMS and is published to Medicaid.gov: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/adult-core-set/index.html.

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

Initiation of AOD Treatment: Adolescents and adults who initiate treatment through an inpatient AOD admission, outpatient visit, intensive outpatient encounter or partial hospitalization within 14 days of the diagnosis.

Engagement of AOD Treatment: Adolescents and adults who initiated treatment and who had two or more additional services with a diagnosis of AOD within 30 days of the initiation visit. AOD dependence is common across many age groups and a

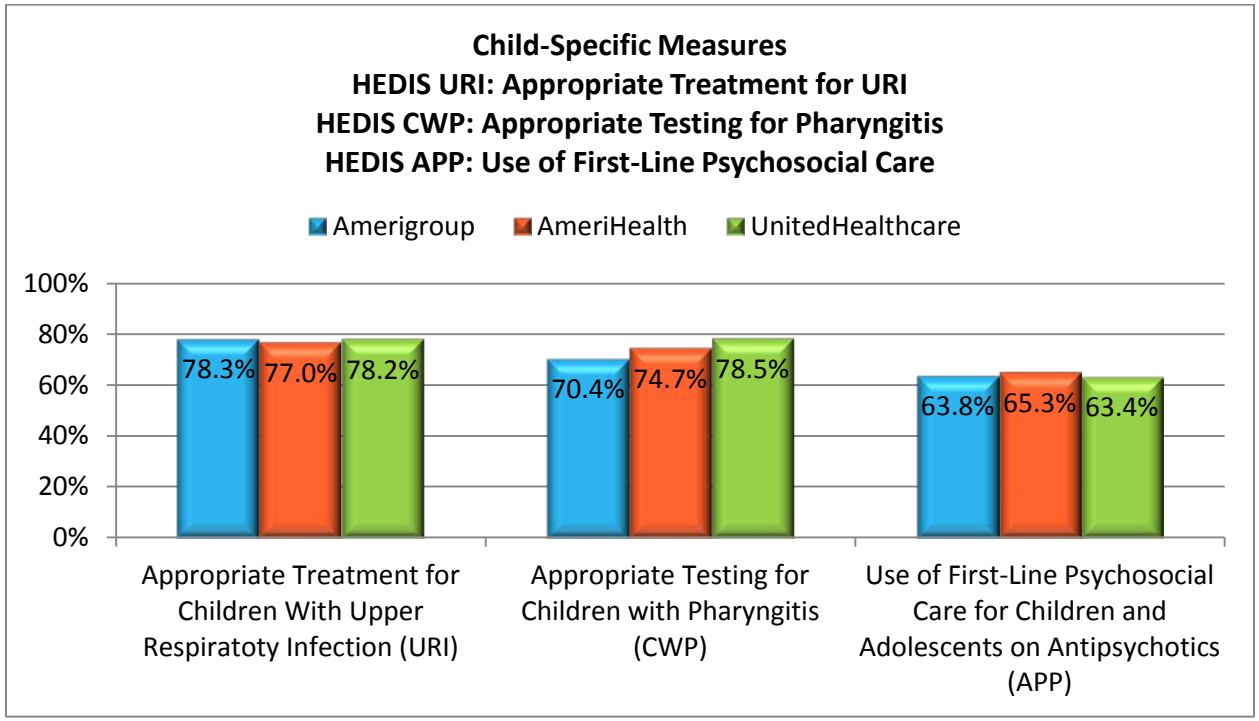
cause of morbidity, mortality and decreased productivity. There is strong evidence that treatment for AOD dependence can improve health, productivity and social outcomes, and can save millions of dollars on health care and related costs.



The Persistence of Beta-Blocker Treatment After a Heart Attack (PBH) measure (shown in the table above) assesses adults 18 years of age and older during the measurement year who were hospitalized and discharged alive with a diagnosis of acute myocardial infarction and who received persistent beta-blocker treatment for six months after discharge. Beta-blockers work by lowering the heart rate, which reduces the amount of force on the heart and blood vessels. Persistent use of a beta-blocker after a heart attack can improve survival and heart disease outcomes.

The Use of Imaging Studies for Low Back Pain (LBP) measure (shown in the table above) assesses adults 18- to 50 years of age with a primary diagnosis of low back pain who did not have an imaging study (plain X-ray, MRI or CT scan) within 28 days of the diagnosis (a higher score indicates better performance). Evidence shows that many patients diagnosed with low back pain receive excessive imaging which can lead to unnecessary worry and unneeded surgery. For the great majority of

individuals who experience severe low back pain, pain improves within the first two weeks of onset. Avoiding imaging (i.e., X-ray, MRI, CT scans) for patients when there is no clinical necessity, can prevent unnecessary harm, unintended consequences to patients and reduce health care costs.



The Appropriate Treatment for Children with Upper Respiratory Infection (URI) measure (shown in the table above) assesses children 3 months-18 years of age who were given a diagnosis of URI and were not dispensed an antibiotic prescription. A higher rate indicates appropriate treatment of children with URI (i.e., the proportion for whom antibiotics were not prescribed). Most URIs, also known as the common cold, are caused by viruses that require no antibiotic treatment. Too often, antibiotics are prescribed inappropriately, which can lead to antibiotic resistance (when antibiotics can no longer cure bacterial infections). Antibiotic resistance is a major health concern in the United States and around the world.

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

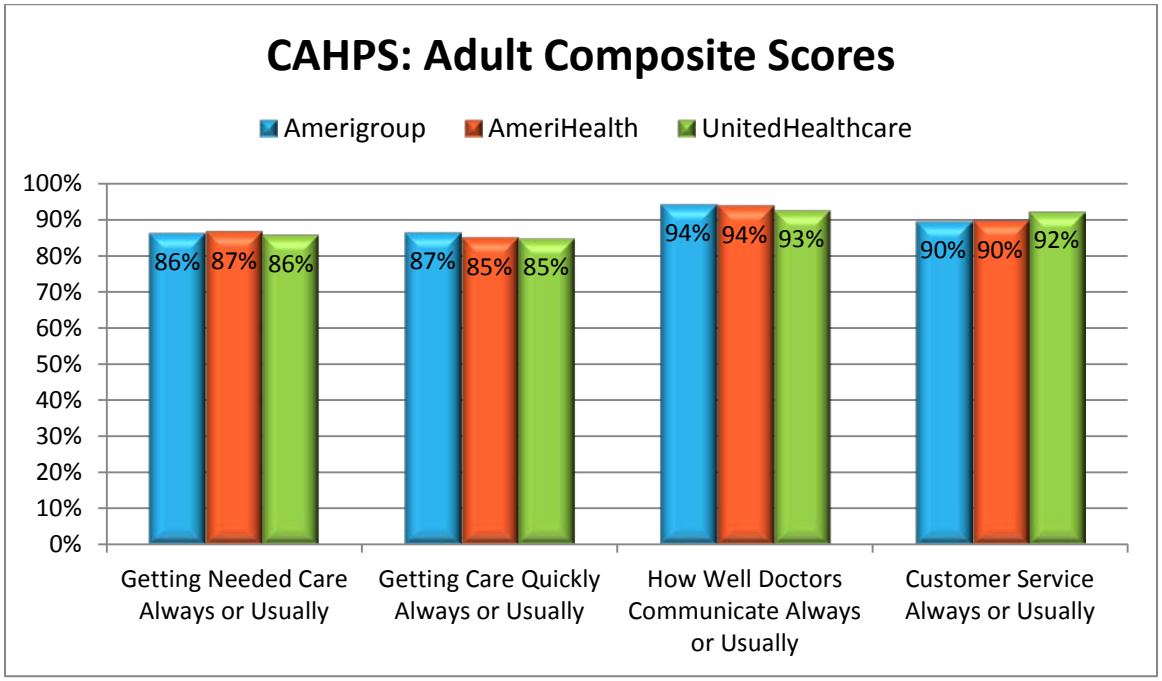
The Appropriate Testing for Children with Pharyngitis measure (shown on the previous page) assesses children 2- to 18 years of age who were diagnosed with pharyngitis, dispensed an antibiotic and received a group A streptococcus test for the episode. A higher rate represents better performance (i.e.,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

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

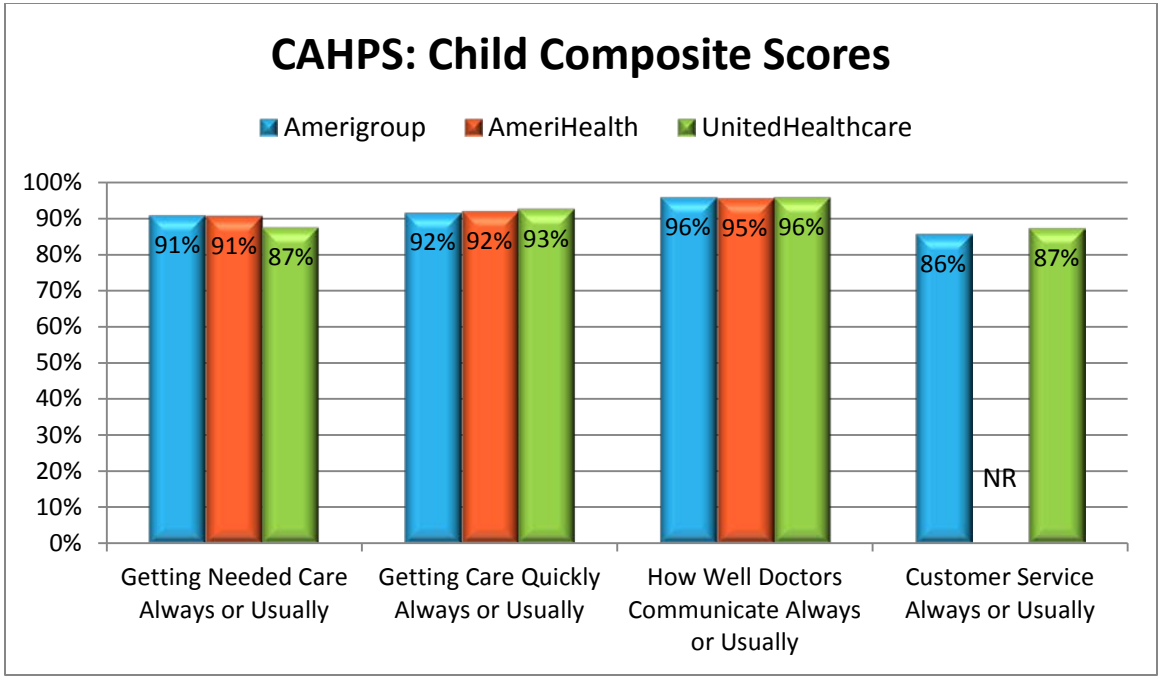
The Use of First-Line Psychosocial Care for Children and Adolescent on Antipsychotics measure (shown on the previous page) assesses whether children and adolescents without an indication for antipsychotic medication use had documentation of psychosocial care as first-line treatment before being prescribed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

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

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



The composites above reflect the number of responses to domain questions where members indicated plan performance was always or usually satisfactory.



The composites above reflect the number of responses to domain questions where members indicated plan performance was always or usually satisfactory. The National Committee for Quality Assurance, which accredits MCOs, does not consider a question statistically valid unless 100 responses are received for the question. AmeriHealth Caritas responses for Customer Service were n=95 and Specialist n=92; therefore, the result for the Customer Service Composite is not included in the Child CAHPS final results.

Emergency Department									
Data Q1 SFY17	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
	July	**August**	**September**	**July**	**August**	**September**	**July**	**August**	**September**
ED Visits for Non-Emergent Conditions – Adult	23.0	15.4	21.3	56.0	71.6	65.4	61.0	61.0	54.0
ED Visits for Non-Emergent Conditions – Child	17.9	13.6	19.4	26.4	29.7	29.4	30.0	28.0	22.0
Data Q2 SFY17	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**
ED Visits for Non-Emergent Conditions – Adult	21.7	18.4	17.3	57.1	54.7	58.5	16	15	17
ED Visits for Non-Emergent Conditions – Child	19.4	18.1	18.6	28.2	29.3	33.1	8	8	12
Data Q3 SFY17	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**
ED Visits for Non-Emergent Conditions – Adult	19.8	17.5	19.3	61.5	56.6	57.5	15	17	21
ED Visits for Non-Emergent Conditions – Child	24.6	24.7	20.3	39.5	42.1	35.6	10	15	14
Data Q4 SFY17	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**
ED Visits for Non-Emergent Conditions – Adult	19.0	18.6	19.5	55.9	56.2	54.6	15	18	18
ED Visits for Non-Emergent Conditions – Child	19.3	16.8	15.8	31.2	29.1	25.5	10	10	10
Supporting Data Q1 SFY17	**July**	**August**	**September**	**July**	**August**	**September**	**July**	**August**	**September**
Members (from IME)	192,267	193,793	194,359	218,303	220,207	220,295	193,881	193,556	191,500
Members Using ED More Than Once in 30 Days	327	193	328	2,973	3,696	2,571	2,640	2,644	1,934
Members Using ED More Than Once between 31 and 60 Days**	23	15	23	1,115	1,402	1,037	359	544	662
Supporting Data	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**

Q2 SFY17									
Members (from IME)	186,789	186,993	186,639	213,382	213,452	212,981	169,977	169,205	168,323
Members Using ED More Than Once in 30 Days	577	499	483	3,100	2,858	2,594	526	489	527
Members Using ED More Than Once between 31 and 60 Days**	341	325	323	1,433	1,266	1,177	236	244	264
Supporting Data Q3 SFY17	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**
Members (from IME)	200,407	200,162	200,280	225,419	225,082	225,049	192,566	192,573	192,638
Members Using ED More Than Once in 30 Days	523	598	506	2,854	3,270	3,213	495	612	690
Members Using ED More Than Once between 31 and 60 Days**	381	346	401	1,251	1,423	1,407	250	287	365
Supporting Data Q4 SFY17	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**
Members (from IME)	200,461	200,695	200,086	225,252	225,234	224,600	191,644	191,807	191,434
Members Using ED More Than Once in 30 Days	475	466	473	2,955	2,988	2,872	509	557	641
Members Using ED More Than Once between 31 and 60 Days**	341	314	364	1,355	1,431	1,278	256	279	274

*Member totals were calculated as defined in the monthly reports– data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted.

Out-of-State Placement*									
Data for Q1 SFY17	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
	July	**August**	**September**	**July**	**August**	**September**	**July**	**August**	**September**
Members in Out-of-State PMIC	12	12	10	4	0	3	1	1	1
Members in Out-of-State Skilled Nursing Facility	8	17	17	17	20	29	9	8	7
Members Placed in an Out-of-State ICF/ID	3	3	3	7	20	2	0	0	0
Members in Out-of-State nursing facilities	0	0	0	25	0	0	0	0	0
Members in Out-of-State Other Institutions	12	12	10	4	0	3	1	1	1
Data for Q2 SFY17	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**
Members in Out-of-State PMIC	12	9	9	12	11	10	1	1	1
Members in Out-of-State Skilled Nursing Facility	17	16	16	32	37	38	9	10	11
Members Placed in an Out-of-State ICF/ID	3	3	3	2	3	4	0	0	1
Members in Out-of-State nursing facilities	0	1	1	0	0	0	0	0	0
Members in Out-of-State Other Institutions	0	0	0	10	10	10	1	2	2
Data for Q3 SFY17	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**	**Jan**	**Feb**	**Mar**
Members in Out-of-State PMIC	9	10	10	11	11	9	1	1	1
Members in Out-of-State Skilled Nursing Facility	16	16	14	39	42	39	10	10	9
Members Placed in an Out-of-State ICF/ID	3	3	3	1	1	1	1	1	1

Members in Out-of-State nursing facilities	1	1	1	0	0	0	0	0	0
Members in Out-of-State Other Institutions	0	0	0	12	13	10	2	2	2
Data for Q3 SFY17	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**	**Apr**	**May**	**Jun**
Members in Out-of-State PMIC	10	13	11	9	8	9	0	0	0
Members in Out-of-State Skilled Nursing Facility	17	20	15	39	37	38	10	10	11
Members Placed in an Out-of-State ICF/ID	3	3	3	1	1	1	1	1	1
Members in Out-of-State nursing facilities	1	1	1	0	0	0	0	0	0
Members in Out-of-State Other Institutions	0	0	0	9	11	12	2	2	2

*IME is working with each MCO to standardize reporting of Out-of-State Placement data.

The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted.

Iowa Department of Human Services

November 15, 2017

EXECUTIVE SUMMARY

Pertinent Information Regarding the Deliberations of the Council on Human Services Relating to Medicaid Managed Care

Council on Human Services Deliberations Summary:

November 9, 2016 – Council on Human Services Meeting
The Council reviewed and discussed the annual Executive Summary due November 15, 2016.

- Sally Titus, Deputy Director, reviewed the draft of the Executive Summary for managed care as required of various oversight groups (MAAC, Council, Commission, Hawk-I). The Council's minutes are submitted quarterly to the Legislative Oversight committee. The Executive Summaries are to be incorporated into the Department's annual report. The legislature is closely monitoring Iowa's roll out of managed care and Titus noted that answers to critical questions may not be known for a year. The legislature is reviewing the data performance of the managed care organizations (MCOs) and need to know that other entities are also engaged.

- Council member Kimberly Spading shared her concerns that the summary seems to gloss over some of the comments coming out of the Council's discussions. She believes that there must be a better way of analyzing data to get to the Legislature. She notes that the Department indicates savings, but she remains unconvinced. An independent review of data is needed.

- Titus responded that the Legislature determines how they wish to receive information and the Department is obligated to respond to the legislative Oversight Committee. She noted that DHS is responsible for auditing data and have hired an external organization to conduct validation.

- Senator Mark Segebart reported that legislators have had complaints that have been "transferred down the line" and that legislators are involved on how the program is progressing.

- Titus noted that as Iowa moves from a 'fee-for-service' program, as time goes on the savings will become clearer. She noted that staff need to do a better job of educating the Council and should discuss this in greater detail.

November 29, 2016 - Council on Human Services Teleconference Meeting
Council convened to take action on the "Executive Summary of Calendar Year 2016 Council on Human Services deliberations to Medicaid Managed Care."

- The Council approved the Executive Summary after including the concerns that Council member Spading expressed at the September 14 meeting regarding managed care savings and outcomes when the 1st Quarter Performance Data Report was presented.

December 14, 2016 - Council on Human Services Meeting
Department of Human Services Medicaid staff reviewed the "Managed Care Organization Report: SFY 2017 Quarter 1 (July 1-September) Performance Data," published November 30, 2016.

- Mikki Stier, Director, Iowa Medicaid Enterprise (IME) noted:
  - Collaboration and communication is key
  - Listening sessions continue
  - Department receives constant feedback from associations
  - More detail has been added to the Executive Summary
  - More detail added to the section on Program Integrity

- Liz Matney, Bureau Chief, DHS IME, MCO Oversight and Supports, noted that the department continues to work on the reporting from the Managed Care Organizations (MCOs). It is not a static report and DHS continue to do refinements.

- Council member Kim Kudej asked what would happen if the Affordable Care Act (ACA) were abolished? Stier replied that the ACA and the Iowa Health and Wellness Plan are big components and the waiver is established for three years for that population. Stier noted that the department has ongoing dialog with the Centers for Medicaid Services (CMS). DHS Director Chuck Palmer reported that the department's job is to plan ahead and to find out as much as possible on what may happen. Iowa has a responsibility to have sustainable programs that are financially stable. As more information becomes available, it will be shared with the Council.

Matney reviewed the Quarterly Report with the Council. Highlights of the discussion:

- Spading inquired if the charts could be more 'trending' and more meaningful? Also, the graph at bottom of page 5 is not reflective of the graph above - and not reflective of this quarter (covers last quarter). Matney will look into this as well as concerns about the graph on page 7 regarding the significant decrease in hawk-I enrollments.

- Spading stated that the department needs to know that the MCOs are meeting the contract requirements for the community-based case manager function. Matney mentioned that members are surveyed regarding their satisfaction with case management.

- In response to a question from Spading, Matney noted that staff will need to follow up on any overlapping of behavioral health reporting with other reporting, i.e. special needs and elderly.

- Regarding 'Consumer Protections and Supports' Matney pointed out the additional layers members can pursue regarding grievances.

- Regarding State Fair Hearings summary data, Matney reported that the pharmacy numbers are still high. Department continues to review and clarify, noting the ongoing learning curve.

- Council member Alexa Heffernan inquired as to why the AmeriHealth numbers were so high on the Critical Incidents chart? Matney responded that AmeriHealth leveraged with existing case managers, so was at a higher risk.

- Matney spoke to the complexities of trending the critical incident reporting. The department will be closely monitoring corrective actions to ensure that level of care assessments are completed in a timely manner for all Medicaid members. The department continues to conduct secret shopper calls and each MCO is required to conduct internal quality assurance programs for their helplines. The timeliness of payment or denials of "clean claims" has improved. Matney noted that the number one reason for denied claims is duplication.

- Regarding Pharmacy Claims Payment, Matney noted that, similar to managed care payments, the MCO's are close or exceeding contract parameters/rates. Providers have questioned this reporting, so the department will monitor this closely as this is a very complex system. Stier noted that IME meets monthly with the Pharmacy Benefits Managers (BPMs) and the IME Pharmacy Director meets monthly with the MCO Pharmacy Directors. Matney reported that data is refined from last quarter and the department continues to work towards more reliable data going forward.

- Value added services utilization was discussed. Each MCO develops their own value added services.

- The department is working on improving the numbers regarding Prior Authorizations - members should not be adversely affected by untimeliness.

- Regarding 'Program Integrity', Matney reports there is still work to do. The department only has 90 days of claims to work from and as more claims data is received, the department will see issues ramp-up and see if providers need to be looked into.

- Regarding Health Care Outcomes, it will be important to look at the annual reports which will come out soon.

- In response to Heffernan question regarding number of readmissions, specifically that Amerigroup's numbers seem high - Matney responded that there are many factors involved in those numbers.

- In response to questions from Spading regarding program cost savings, Jean Slaybaugh, DHS Chief Financial Officer, reported that the department's projection is less than what was spent last year. Savings estimates result from the managed care adjustment (a decrease in per member per month expenditures); and the administrative load paid on the capitation rates. Spading noted that she does not see where the savings are coming from and requested to see the spend next to the anticipated. Slaybaugh will provide Spading with more specific information as well as information on last year's fee-for-service. Senator Segebart proposed that the total number of denied claims be listed in the report.

January 11, 2017 - Council on Human Services Teleconference Meeting
Director Palmer reported that time will be allotted on the Council's February 8th agenda to discuss how savings are calculated in the Medicaid managed care program.

February 8, 2017 - Council on Human Services Meeting
Jean Slaybaugh, DHS Chief Financial Officer, reviewed program cost savings in Medicaid managed care. Highlights of the discussion:

- DHS is charged with reporting program cost savings in quarterly reports to the Legislature.
- At this point, DHS does not have definitive cost savings absent the previous fee-for-service (FFS) for comparisons, so to develop the cost estimates, the department compared the FFS period immediately preceding the implementation of managed care (July 2015) to March 2016, looking at expenditures for that period and comparing those to expenditures under the managed care program.
- DHS is looking at the funds the department is paying out to support the program - previously that used to be largely FFS claims to providers, now it is largely capitation payments to Managed Care Organizations (MCOs) and that is where the savings estimate comes from.
- Eventually, DHS should be able to look at some 'downstream' numbers, not specifically related to dollars, but related to utilization. Outcome data takes time to develop and mature.

- Council member Spading noted that some of the administrative cost shifting goes back to providers such as the state hospital.
- Spading is also concerned with insurance companies decreasing costs by delaying or denying care and the amount of staff time to obtain prior approvals.
- Chairperson Mark Anderson noted that some cost savings are achieved by providing ancillary and health services earlier to keep people healthier.
- Slaybaugh explained how the department adjusted rates using projected emerging trends

Medicaid Director Stier provided the following update:

- One of the Managed Care Organizations, AmeriHealth Caritas Iowa, has a larger portion of the Long Term Services and Supports (LTSS) Medicaid population and are moving to a blended case management model. This means they are moving to a more internal model from a mostly external case management model. The department has approved a work plan for AmeriHealth for the transition of case management under the terms of their contract. The department will be monitoring case management ratios, where required, as well as service plans and peer assessments for all those members affected by the transition.

- Also, AmeriHealth will be transitioning contracting the Home and Community Based Services (HCBS) waiver members to the rate floor. The HCBS waiver providers who were above the floor, will now be adjusted downwards to the floor rate. Last legislative session, legislators put a 1% increase on that floor, so AmeriHealth will be bringing those providers to the floor with the 1% increase that was established last year. Entities that are affected by this will be receiving a 30-day notice that the contract rate will be changing - they will work with AmeriHealth within that rate or enter into a 90-day process in terms of transitioning from AmeriHealth. The department's responsibility is oversight, and DHS will require network adequacy and have requested a weekly status report.

Council member Kudej noted that two providers that she has been in contact with are reporting to her that they have seen progress in working with their Managed Care Providers in the payments of their bills.

March 8, 2017 - Council on Human Services Meeting
Medicaid Director Stier provided the following update:

- DHS continues to monitor AmeriHealth's transition regarding their move to a more internal case management hybrid model and also moving home and community based (HCBS) waiver providers to the rate floor. DHS monitors for network adequacy.

- AmeriHealth plans to enter into contract re-negotiations with the Mercy Health Network.

- Staff will continue to track on changes that are occurring over the next few months at the federal level.

Council member Spading noted her concern that more local case managers are losing their positions in the coming months. She is also concerned that families are having to change their case managers as some chose the AmeriHealth plan specifically so they could keep their case managers.

Director Palmer noted that he shares Spading's concerns regarding the disruptions for individuals and providers and has been in communication with Johnson County Case Management regarding the issue. After a year in Iowa, AmeriHealth, for management reasons, has decided to change course in the way they deliver case management services. DHS believes case management to be a critical service and that function still needs to meet standards. In regard to the HCBS rate floor, the floor represents what entities were being paid in the Fee-For-Service (FFS) program and are actuarially-sound and approved by the federal government.

There was some discussion regarding possible upcoming changes to the Affordable Care Act focusing on the effects to the expansion population.

April 12, 2017 - Council on Human Services Meeting
Iowa Medicaid Enterprise (IME) staff reviewed the latest quarterly "Managed Care Organization" report, published March 10, 2017 - focusing on specific areas:

- Regarding 'Percentage and number of members receiving initial health risk assessments completed timely', the department is working with the MCOs to ascertain what their barriers are and how to reach members more effectively.

- Regarding 'Member grievances and appeals,' members may file a grievance with the MCOs for any dissatisfaction that is not related to a clinical decision. Progress is being made to get to the benchmarks.

- Regarding 'Medicaid Claims Payment,' the Department continues to monitor reimbursement accuracy through analysis, validation projects, and follow-up when the Department is made aware of provider concerns. Matney noted that the Department is trying to educate providers to work with the MCOs first - which will ultimately get the fastest results.

May 10, 2017 - Council on Human Services Meeting at the Glenwood Resource Center

Director Palmer reported that the annual managed care rate updates are currently in development and a final rate book is anticipated to be completed in the next few weeks. The goal is to have the agreements in place with the managed care organizations (MCOs), and approval from the Centers for Medicare and Medicaid Services (CMS), for July 1 rate changes.

June 14, 2017 - Council on Human Services Meeting
Mikki Stier and Liz Matney, Iowa Medicaid Enterprise, provided the Council with highlights of the Managed Care Organization Report SFY 2017, Quarter 3 (January-March) Performance Data that is slated for release next week.

- Across the quarters, the data appears to be stabilizing allowing for better trending assumptions to be made.
- So far this year over 141,000 adults and 100,000 children have received an initial health assessment
- Managed Care Organizations (MCOs) appear to all be meeting their benchmarks in the handling of appeals and grievances within the required timeframes, although more scrutiny is required to review whether some double counting may be occurring.
- Improvement is being made by all MCOs in the service plan and level of care reassessments (all are above the 85% threshold)
- MCOs are operating close to or above the benchmarks for claims payment timeliness (Amerigroup is behind on their benchmarks resulting in corrective actions in place for them. Amerigroup has a subcontractor working on this issue)
- All the MCOs are above 98% in either approving or denying prior authorizations within the established timeframes.
- In July DHS will be hosting mid-term review results and will make sure the Council is aware when that is posted for the public.
- An external quality review is required under the federal managed care regulations
- A team has been assembled (MCOs and State staff) to work on standardizing the provider manual.

In response to a question from Spading about her concerns regarding payment timeliness, Stier reported that DHS, the MCOs and providers, like the University of Iowa, have made great strides in addressing those issues. Stier offered to give the Council an update on this issue at a future meeting

July 12, 2017 - Council on Human Services Meeting - Public Hearing
Mikki Stier, provided the following update:

- Effective July 1, 2017, all Medicaid fee-for-service adults will be served under a managed care Dental Wellness Plan. MCNA Dental and Delta Dental are the providers.
- IME completed the re-enrollment and on-site visits of over 25,000 providers.
- IME, in conjunction with the MCOs, have launched an initiative to revise billing claim coding to make the system more streamlined and efficient.
- The Department continues to monitor the DHS website on a daily basis to update and clarify the content regarding the Family Planning transition.

August 9, 2017 - Council on Human Services Meeting
Mikki Stier and Lisa Cook, Iowa Medicaid Enterprise (IME) reviewed the "Managed Care Organization" quarterly report, published May 31, 2017 covering January through March 2017.

- Overall measures are beginning to stabilize
- Population reports in general indicate better care coordination
- Report indicates 242,000 members have completed the health risk assessment
- All MCOs are meeting the benchmarks for processing grievances - the numbers are higher for Amerigroup and IME account managers are following up on that trend. Transportation is a top reason for grievances.
- On Level of Care all MCOs are seeing improvement
- The Department continues to conduct secret shopper calls to measure adequacy, consistency and soft skills associated with MCO helplines.
- On Medical Claim denials the Department continues to monitor reimbursement accuracy and follows up when the Department is made aware of provider reimbursement concerns - Amerigroup is close to meeting the benchmarks and have a corrective action plan in place.
- 97,000 members utilized value added services last year.
- All the MCOs are 98% or higher regarding Expedited Services requirements
- DHS received approval from the Centers for Medicaid Services (CMS) to move the dental wellness program into a managed care environment.
- DHS has been working on the initiative to complete the year-end provider re-enrollment. Staff have been working with the MCO's to track and continue to do outreach with providers that have not re-enrolled.
- Another initiative DHS is working on is provider training - to assist providers in honing their skills with billing and other issues. A schedule will be posted on the DHS website.
- In regard to the "Managed Care Ombudsman Program Quarterly Report (1st Quarter, Year 2 - Apr/May/Jun 2017), Stier noted that DHS continues to reach out to the Ombudsman's Office to obtain any specifics they have in regard to global statements of reductions in service so that DHS staff can "drill down" to solve issues. DHS continues to have monthly calls with both the State and Managed Care Ombudsman's Office as well as monthly meetings with the Director of the Department on Aging.

Anderson noted that Spading was unable to attend the meeting and will be emailing Stier with her questions regarding the quarterly report.

September 13, 2017 - Council on Human Services Meeting Budget Meeting
There were no Medicaid Managed Care Updates at this meeting

Executive Committee
Summary of Meeting Minutes
July 21, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer –
Dennis Tibben – **present**	Mikki Stier – **present**
Sara Allen – **present**	Deb Johnson –
Kristie Oliver – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Anthony Carroll – **present**	Lindsay Buechel – **present**
Jim Cushing – **present**	Sean Bagniewski – **present**
Cindy Baddeloo – **phone-in**	Amy McCoy – **present**
Kate Gainer –	Luisito Cabrera – **present**
	Alisha Timmerman – **present**

Introduction
There was a roll call of Executive Committee members.

Approval of Executive Committee Meeting Minutes from June 21, 2016
Gerd invited the group to voice comments or changes to the June 21, 2016 meeting minutes. Gerd declared that the meeting minutes of the Executive Committee (EC) held on June 21, 2016, stands approved.

Executive Committee Document Follow-Up and Further Development

Work Plan Agenda
Gerd reminded the group about the need to form the Agenda for the next Full Council meeting. He outlined the following for the Agenda:

1. Creating a report from the Executive Committee on the work we've been doing since the last meeting – a summary report to bring everyone up-to-date on the work of the MAAC.
2. Discuss the law change and the administrative rules change.
3. Further discussion of the elections in light of the law change.
4. Regular updates from the MCOs
5. Update and summary information on the Public Comment meetings

Action Items

- Report on deliberations of prior year need to be submitted by November 15. Gerd, Mikki, and Lindsay to discuss for August Full Council meeting.

July 29, 2016

Action Plan

Mikki reviewed the latest Action Items reporting grid and stated that specific items pertaining to which body can make recommendations and the differentiation between the duties of a Co-Chairperson and the Vice-Chairperson will be addressed in the draft Administrative Rules. She covered a variety of items from the reporting grid including the reporting template for what is required of the MCOs, job descriptions for the MAAC members, the dashboard, process flowcharts, table of PAs, She underscored those items that are completed and those that are still works in progress.

Action Items

- Reformat the Action Items Reporting Grid to clearly show when items have been completed but not delete any completed items. It was suggested to move the completed items at the end of the grid.

Further Discussion Regarding Legislation

Administrative Rules Workgroup Update on Progress, MAAC Meeting Guideline, Open Seat on Executive Committee

Gerd stated that the wholesale change in the makeup of the MAAC (Full Council and Executive Committee) as a result of the new law was not anticipated. Discussion ensued among the Executive Committee members pertaining to the five professional positions and the five public/consumer positions. Discussions also involved the process of filling the positions relative to the current Executive Committee members and their existing two-year terms, the necessary changes as prescribed by the new law, and the election and transition process for the new makeup of the MAAC. Gerd transitioned to discussion of the administrative rules as prescribed by the rubric of the new law.

Action Items

- Post the copy of the tracked draft version of the Administrative Rules on the MAAC web page.
- Call a special meeting by phone of Executive Committee to discuss this further and in consultation with Director Palmer.
- Executive Committee members to review and react to the details of the new administrative rules and provide substantive feedback to discuss at the special meeting prior to the August Full Council meeting with the aim to include recommendations as part of the Full Council agenda.

LTC Ombudsman Standing Item

Anthony brought up point about the monthly report from the Ombudsman's office. Mikki pointed out that there is a designated person at the Ombudsman's office who will provide the report.

Oversight and Data Workgroup

Discussion involved the availability of the data dashboard, the monthly reports, and the billing claims submission/denials data. Mikki mentioned the request by Director Palmer to form a special work group comprised of Executive Committee and Full Council members to review and to look at the role of the Committee and their oversight in looking and analyzing data. Jim suggested making the report on claims processing as a standard agenda item at the Executive Committee meetings to keep provider payments in check.

Action Items

- Formation of a special work group as previously requested by Director Palmer

Listening Session Criteria for Reporting

Anthony provided feedback on the most recent public comment meeting in Cedar Rapids indicating the claims processing/payment/denial issue that providers are encountering. He mentioned the better responses from MCOs regarding the systems that each MCO has in place regarding PAs. Lindsay stated that the issues that have been expressed at these meetings have been consistent in theme.

Action Items

- Post the summary of the Cedar Rapids Public Comment meeting on the MAAC web page.

Public Comment (Non-Executive Committee Members)

Gerd solicited comments. No comments were made.

Adjourn

4:40 P.M.

July 29, 2016

MAAC Full Council Meeting
Summary of Meeting Minutes
August 17, 2016

Introductions *(See the roll call document to review the Full Council attendance.)*
Gerd Clabaugh welcomed the new members. He called the roll call of those in attendance (in-person and on the phone) and declared that there was a quorum.

Approval of May 17, 2016 Full Council Meeting Minutes
Gerd asked the Council if there were any changes to the minutes of the Full Council meeting of May 17, 2016. It was indicated that there was an unfinished sentence on the first page of the minutes. Gerd stated that the minutes are approved upon completion of the suggested correction. Gerd invited DHS Director Chuck Palmer to say a few words.

Executive Committee Report
Gerd commended the work of the Committee and expressed gratitude on the various good work that has been accomplished in facilitating the work of the council.

Legislative Update

- **Changes in Law**
  Gerd pointed out that the changes in the law directly impacted the makeup of the Council. He summarized changes in the membership both in the Executive Committee and the Full Council including the creation of the position of Co-Chairperson and the new public member positions that have been recently filled the position in the *hawk-i* board and the LTC Ombudsman. Gerd mentioned the creation of a sub-committee to take a look at how to best operationalize the administrative code changes within the context of the administrative rules.

- **Administrative Rules**
  Lindsay stated that this work has been closely coordinated with the Attorney General's office to ensure full compliance with the law. She went through the details of the administrative rules including the roles of the various officers of the Council, the meetings process, and the process for discussions and making recommendations. She referred Council members to the handout that was given out that details the various roles of Council members and how the Council operates. She explained the process outlined in the administrative rules and invited Council members to provide comments or suggestions. Dave Beeman pointed out his concern about how the Full Council and the Executive Committee work together. Dennis and Shelly pointed out that the AG's office was involved in formulating the process of how the Council and the Committee would carry out its work and how recommendations are made. Senator Ragan's representative (Kris Bell) expressed some of the Senator's concerns regarding the administrative rules specifically on the appointment of the Co-Chairperson versus the Vice-Chairperson and the appointment of the public members. Mikki and Gerd acknowledged Kris Bell's concerns and responded that they would reevaluate HF2460 and make appropriate modifications to the draft version of the administrative rules. Gerd stated that he would like to get a general consensus from the members of the Council on whether they give the administrative rules thumbs up or thumbs down during these

discussions. There was general consensus among the Council member that the rules are a good direction for the Council.

Action Point:

- Gerd stated that DHS will look into the point made about the mechanics of what is illustrated in the flowcharts relative to the administrative code.

MAAC Elections

Gerd explained the process for the elections and the background regarding the changes in the makeup of the Executive Committee. Gerd and Lindsay went over the logistics of the election process and invited the Council members to submit their ballots today or to complete the electronic form that will be sent out later. New Executive Committee members will have their first meeting in September's Executive Committee meeting.

Action Point:

- Submit completed ballots for tabulation.

Update from the Medicaid Director

IHAWP- SIM Grant. Mikki provided background on Iowa Health and Wellness Plan (IHAWP) and the State Innovation Model (SIM) initiatives relative to Medicaid. She explained the relevance of the Value Index Score (VIS) relative to performance measurements on the SIM initiative as well as MCOs and ACOs relative to the SIM. She provided updates on where the SIM project is currently. She reviewed May 2016 report reflecting prior authorizations (PA) and claims processing. Liz Matney provided an update on the Managed Care transition covering the past three and half months. Liz stated that Medicaid received monthly and quarterly data. She went over the May performance data and cited improvement in the June performance data based on addressing identified issues from previous report. She reviewed data validation and the role of Program Integrity in ensuring that provider payments are made accurately.

Updates from MCOs

a. **Amerigroup Iowa, Inc.**
   The representative provided a general update on service efforts to members and providers.

b. **AmeriHealth Caritas, Iowa, Inc.**
   The representative stated 1.3 million processed claims to date and outlined statistical data on members and providers.

c. **UnitedHealthcare Plan of the River Valley**
   The representative provided a general member outreach and provider update.

Public Comment Listening Sessions

Lindsay provided a quick update on the first five public comment meetings and the general subject areas discussed by the attendees and the common issues that have been raised. Summaries will continue to be provided that reflects the key issues brought up at these public comment meetings.

Report from the Long Term Care Ombudsman

Kelly provided a Monthly Program Report. She outlined the data from month to month indicating the variance changes. She also outlined various metrics that are being measured. She briefly updated the group regarding grievances, billing, care planning etc. She outlined the various services offered by the Ombudsman's office.

Public Comments

No comments from the Council.

Adjourn

3:50 p.m.

August 22, 2016

Executive Committee
Summary of Meeting Minutes
August 18, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer – **present**
Dennis Tibben – **present**	Mikki Stier – **present**
Sara Allen –	Deb Johnson – **present**
Kristie Oliver – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Anthony Carroll – **present**	Lindsay Buechel – **present**
Jim Cushing – **present**	Sean Bagniewski – **present**
Cindy Baddeloo – **phone-in**	Amy McCoy –
Kate Gainer –	Luisito Cabrera – **present**
Natalie Guinty (for Sara Allen) – **present**	Alisha Timmerman – **present**

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

Approval of Executive Committee Meeting Minutes from July 21, 2016
Gerd invited the group to voice comments or changes to the July 21, 2016 meeting minutes. Request was made to correct the spelling of Natalie Guinty's name. Gerd declared that the meeting minutes of the Executive Committee (EC) held on July 21, 2016, stands approved upon completion of this correction.

Update from Medicaid Director
Mikki mentioned the drafting of quarterly summaries of all the minutes from previous Full Council and Executive Committee MAAC meetings in preparation for the oversight. Gerd felt that no further action needs to be made on these summaries as they are summaries of previously approved documents. Gerd invited questions.

Action Items:

- Follow up on Electronic Visit Verification (EVV) systems (Cindy)
- Outstanding status of the Public Comment Summary (Anthony)
- Any other items to add to the presentation for the oversight committee (Gerd)

Committee members stated that the Committee has worked hard to make the itself a responsible body with discipline and structure and that the MAAC has improved communications and streamlined processes such as prior authorizations, credentialing, etc. and that the Committee has resolved issues through dialogue and discussions without necessarily having to make formal recommendations. Gerd

asked to identify key issues that new incoming Committee should try to practice diligence:

- Representation at public hearings
- Attendance at meetings
- State Innovation Model (SIM) follow up
- Issues surrounding the Waiver programs
- Data Task Force
- Program Integrity oversight of MCOs

MAAC Minutes Summary
No further discussion was added to the previous discussions at the August 17, 2016 MAAC Full Council Meeting.

Public Comment Listening Sessions Summary
Lindsay explained the content of the report and asked for recommendations.

Action Items:

- Dennis made recommendation to add consistent responses regarding Prior Authorizations from the MCOs and also not honoring the authorizations when submitting the claims –

Transition of the Executive Committee
No further discussion was added to the previous discussions at the August 17, 2016 MAAC Full Council Meeting.

Action Items Update
No further discussion was added to the previous discussions at the August 17, 2016 MAAC Full Council Meeting.

Public Comment (Non-Executive Committee Members)
Dan Brit asked for help from AmeriGroup about payment in accordance with fee schedule as this is causing hardship. AmeriGroup representative at the meeting will reach out to Dan Britt. Jim Cushing discussed conversation with Dave Beeman regarding the difference between state and federal code regarding the voting rights/process of the FC and the EC and whether the FC would have the ability to make the recommendations as well.

Adjourned
4:08 P.M.

August 22, 2016

Executive Committee
Summary of Meeting Minutes
September 28, 2016

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

Introduction

Gerd called the meeting to order and performed the roll call. He welcomed the new members of the Executive Committee to their first meeting. Executive Committee attendance is as reflected above.

Approval of the Executive Committee Meeting Minutes of August 18, 2016

Minutes of the Executive Committee meeting of August 18, 2016 was approved with correction to the spelling of Natalie Ginty's last name.

Transition of the Executive Committee Members

MAAC Meeting Guidelines and Administrative Rules

Gerd asked the earlier Committee members that were involved in the draft document of the rules and guidelines to take up the responsibilities of drafting the final version of the document reflecting the changes as discussed in the last Full Council meeting. He cited himself, Shelly, and Dennis to take up this task but also suggested one additional person from the public members. The aim is to get the final draft ready in three weeks in time for the October 18 Executive Committee meeting. David volunteered to be part of the group. Gerd stated that a meeting will be scheduled prior to October 18 to further discuss this point.

Action Item:

- Previous members of the Executive Committee plus one new member will meet to draft the final rules and guidelines document (Gerd, Shelly, Dennis, and David) for October 18.

October 4, 2016

Work Plan and Action Items

Gerd gave the new members a brief overview of the purpose of the work plan document as a tracking tool for all the MAAC work in progress. He explained how the work plan itemized the work that is in the pipeline and that it worked hand in hand with the action items document which gives a status report on items that require action. As a briefing for the new Committee members, Mikki reviewed the Action Items document starting with all the items that have been completed and then with the items that are still outstanding. Mikki mentioned the various Medicaid work processes flow charts that have been developed and completed that can be found on the DHS website[1] under the "News and Announcements" section. Chuck Palmer gave a brief overview of the role of the Executive Committee and its function as part of the larger Full Council in making recommendations to him. The Executive Committee is an arm of the Full Council therefore speaks and makes recommendations on behalf of the Full Council.

MAAC Minutes Summary

Mikki stated that this document is a summary of the MAAC Executive Committee and Full Council work pertaining to the managed care transition. She stated that the MAAC is required to provide this summary of the MAAC's managed care transition implementation activities for 2015 and 2016. She mentioned that the 2016 document will continue to be updated until the end of the year. Cindy inquired about the appointment of a member and a provider liaison. Mikki stated that these positions have been in place now for a while:

Member Liaison: Stephanie Madsen / **Provider Liaison:** Inde Seedorff

Gerd stated that these are summaries of already approved minutes and therefore do not require further approval. Mikki stated that both a quarterly report and an annual report are required. David inquired about how issues are brought to the MAAC and if the administrative rules specify this point. Chuck provided insight regarding this process and stated that any member of the MAAC or the public can make a public comment and bring any issue for discussion. He stated that this may develop into an actual recommendation to the DHS. Dennis inquired about a more concrete date for in-depth discussion on these summaries for the purpose of making a recommendation. Gerd stated that the October 18 Executive Committee meeting would be the opportunity to have this substantive discussion to meet the November 15 report deadline.

Action Item:

- Begin in-depth discussions on summaries and potential subsequent recommendations for meeting the November 15 report deadline

Data Workgroup

Chuck stated that this work group resulted from asking the question, "what kind of information do we need to do the job as the MAAC and to come to some conclusion about how the program is working?" He stated further that answering this question will allow us to come up with a set of recommendations. He stated that the MAAC was viewed as the natural body to carry out this task of oversight. Chuck provided an overview of the process for the data workgroup. He suggested that the "data" is essentially asking, "What do you think do you need to arrive at recommendations". Gerd stated that this has been discussed in the context of a "work group" and that it might be useful to start appointing persons from the Executive Committee and the Full Council to begin the process. Gerd suggested four from the Executive Committee and perhaps two from the Full Council. He asked for any volunteers to be part of this work group. Anthony Carroll and Jim Cushing indicated that they would like to be part of this work group. Gerd stated that almost everyone in the room indicated that they wish to be part of the work group (except David). Cindy suggested that perhaps a good start would be to simply identify a list of data groups or data points solicited from the larger MAAC group before appointing a select work group. Dennis recommended that at the next MAAC Full Council meeting – ask everyone to prepare to share data points for drill down. Not to debate but to outline as Executive Committee and drill down as Full Council and tie it to the goals.

Action Item:

- Request MAAC Full Council members to prepare to share data points and appoint Executive Committee and Full Council members to form part of the Data Work Group.

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

October 4, 2016

Public Comment Listening Sessions

Matt provided a quick review of the last two Public Comment Meetings in Fort Dodge and Waterloo. He provided some of the key issues that were raised in the meetings as reflected in the summary documents. It was pointed out that there have been a diminishing number of attendees but this may be emblematic of the fact that providers now have more sources to obtain information and more mechanism for feedback which can explain the decrease in attendance at formal public meetings. Laurie sighted the challenge that is posed by a 3pm-5pm meeting time slot for members and suggested that the meetings should perhaps focus on members given that providers have more avenues for information. Cindy volunteered to join Dennis for the October meeting in Sioux City and Shelly volunteered for the November meeting in Ottumwa. Summaries of all completed public comment meetings are found on the DHS website[2].

Action Item:

- Need another Executive Committee member for the November Public Comment meeting in Ottumwa.

Public Comment (Non-Executive Committee Members)

Dan Britt stated that things have been going quite well with AmeriHealth and United Healthcare but are still encountering ongoing systemic challenges with AmeriGroup on speech therapy claims. Dan wanted to know if the IME monitors recoupment data and how this information in being monitored. Gerd and Mikki stated that this will be checked and will reach out for feedback.

Action Item:

- Reach back to Dan Britt regarding his query involving recoupment data collection and monitoring by the IME.

Jim indicated that there seems to be a disconnect between the IME staff, the MCOs with respect to the status of individuals as they move out of elderly waiver facilities and back to their homes. He cited the issue of the 30-day trigger but evidently this required them to go through the entire Medicaid approval process all over again. He stated that this needs to be looked into. Cindy: agreed that this is happening more frequently. Mikki stated IME will look into this.

Action Item:

- Look into the Medicaid re-application process that is being triggered when someone in Elderly waiver facility moves back home.

Adjourned

4:40 PM

[2] https://dhs.iowa.gov/iahealthlink/IHL-Public-Comment-Meetings

Executive Committee
Summary of Meeting Minutes
November 4, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer –
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 – **present**
Kate Gainer – **present**	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy –
Richard Crouch –	Luisito Cabrera – **present**
Julie Fugenschuh – **present**	Alisha Timmerman – **present**
Jodi Tomlonovic – **present**	

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

Approval of the Executive Committee Meeting Minutes of September 28, 2016
Minutes of the Executive Committee meeting of September 28, 2016 was approved.

Administrative Rules Draft Review and Approval
After initial discussions at the August Full Council meeting and subsequent discussions thereafter, the revised draft of the Administrative Rules was provided to the Committee which included minor updates on the distinction between the co-chair and the public co-chair, clarification on voting and non-voting members in the Council, the rules governing the drafting of recommendations to the Department, and clarification on the process for voting for business and professional entities in the Executive Committee. It was made clear that members were to be elected as an entity and not the individual, and that business and professional entities were to then choose their representative for the position. It was made clear that public members vote for public and professional entities vote for the business and professional entities. Gerd suggested that the Attorney General's office be requested to give an orientation for the Executive Committee to clarify expectations in addition to governance training and recommended that the document should also specify details of any special election process and that ballots only include the entity name and not the name of the representative.

November 8, 2016

Gerd clarified the process of recommendations to the Department. The Administrative Rules Draft was approved with correction to previously specified vacancy amendments and the addition of a preamble detailing suggested changes to the document.

Action Items:

- Request that the Attorney General's office attend a future meeting for orientation and the expectations for the Executive Committee members in addition to governance training and new sunshine advisory. To take place in January 2017.
- Bring back the AG's office as an update of the change in governance
- One-pager as preamble to Administrative Rules outlining changes that have been made to the document and submitted to the DHS Council

Action Items Update

Mikki reviewed the outstanding items on the Action Items document. The reports on deliberations were to be discussed in the day's Committee meeting as well as discussion regarding the development of a workgroup for analyzing data. The determination of Committee members to attend future public comment meetings was outstanding pending the development of a 2017 schedule.

Public Comment Listening Sessions Summary

Lindsay stated that had thus far held 8 sessions and that the next meeting would be November 17, 2016 in Ottumwa, IA and the last meeting had taken place in Sioux City on October 11, 2016. Per legislation, beginning in March 2017, meetings to take place every other month through December 31, 2017.

Action Items:

- 2017 IA Health Link Public Comment meetings calendar
- Determine volunteers from the Executive Committee to attend the 2017 IA Health Link Public Comment meetings

Update on Required Legislative Reports

Public Comment Meeting Summary – Quarterly Recommendations

Lindsay discussed that per House File 2460, the Executive Committee is to make recommendations on a quarterly basis to the Department based on the feedback in Public Comment meeting summaries. The Committee agreed that recommendations should remain at a high level based on overarching issues within the summaries and from personal experiences. One-off situations to be handled by the Department and are tracked to determine root cause for resolution. Topic is to be further discussed in November 21, 2016, Full Council meeting and recommendations to be made for Executive Committee review in November 29, 2016 meeting. Additional general recommendations from the Committee are also to be a standing agenda item with assistance of quarterly reports and data provided by the Department.

Action Items:

- Calendar to be developed by the Department regarding when reports are to be due and process timeline for when data is to be reviewed and recommendations made. Information to be added to the work plan.

Summary of Discussions Regarding Managed Care

Summaries are to be submitted by the Council on Human Services, the MAAC, the ***hawk-i*** Board, the Mental Health and Disability Services Commission, and the Office of Long-Term Care Ombudsman regarding discussions of managed care in meetings. Executive summaries are to be submitted to DHS no later than November 15, annually, for inclusion in the annual report submitted as required in House File 2460. Summaries of approved minutes for past year's MAAC Council and MAAC Committee meeting discussions of managed care in meeting materials. MAAC minutes had been approved so no approval was necessary for summaries and to be submitted to the Department.

November 8, 2016

Work Plan and Report Review Workgroup

The November 21, 2016, agenda was discussed in day's meeting. Report Analysis Workgroup will meet immediately after the November 29 Executive Committee meeting by extending that meeting for approximately two hours. The Report Analysis Workgroup is to be open to all Full Council members to discuss Medicaid Managed Care Reports (monthly, quarterly geographic access, and statistical) in order to make recommendations to the Department and determine what is necessary for the program to operate successfully. The January 2016, Committee meeting will include a training from the Attorney General's Office regarding the governance of the Committee.

Action Items:

- Update on the new CMS managed care rules and whether changes are necessary to be in compliance.

Public Comment (Non-Executive Committee Members)

Jim Cushing requested additional information than the current data provided by the Department. Jim recommended that DAS present to the Council on how to review data and interpret the data. Anthony Carroll inquired the length of time that the MCOs are processing Prior Authorizations

Action Items:

- The Department to provide information on status of individuals who are institutionalized in a hospital or facility for beyond 30 days and had been on waiver services although when transitioning out of institution lose their waiver services.

Adjourned

2:03 P.M.

November 8, 2016

MAAC Full Council Meeting
Summary of Meeting Minutes
November 21, 2016

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 August 17, 2016 Full Council Meeting Minutes
Gerd asked the Council if there were any changes to the minutes of the Full Council meeting of August 17, 2016. It was indicated that Natalie Ginty's name had been spelled incorrectly. Gerd stated that the minutes were approved upon completion of the suggested edit.

Administrative Rules Update
The revised draft of the Administrative Rules was provided to the Council which included minor updates on the distinction between the co-chair and the public co-chair, clarification on voting and non-voting members in the Council, the rules governing the drafting of recommendations to the Department, and clarification on the process for voting for business and professional entities in the Executive Committee. Gerd discussed the summary of changes and the process of recommendations to the Department of Human Services (DHS) Council. The Council had made suggestions in the August 17, 2016 Council meeting and the Committee updated the rules with suggestions from the meeting therefore, the document would be sent to the DHS Council for review.

Public Comment Listening Sessions Update
Summary of notes from the Public Comment Listening Sessions between March 2016 and October 2016 were provided to the Council. The summaries included comments and questions identified at each location. Per House File 2460, the Council and Committee were to make recommendations on a quarterly basis to the Department based on the summaries. The Council was encouraged to attend future meetings for additional insight in recommendations.

Executive Committee Summary
Summaries of approved minutes for 2015 and 2016 to date Council and Committee meeting discussions of managed care in meeting materials were provided. Recommendations to the Department may be based on information within the summaries. Gerd advised that Council members may speak with any Committee members if they have additional recommendations.

Updates on Required Legislative Reports

- **Executive Committee Summaries**
  Executive summaries to be submitted to DHS no later than November 15, annually, for inclusion in the annual report.

- **Public Comment Meeting Summary**
  The Committee to make recommendations on a quarterly basis to the Department based on the feedback in the Public Comment Listening Sessions summaries. The Council to

make suggestions regarding summaries, the Committee to then make recommendations based on Council suggestions and then suggestions to be sent to the Department.

Recommendations to the Department of Human Services (DHS)

Gerd suggested the following draft motion:
The MAAC Full Council recommends that the MAAC Executive Committee consider the following recommendations relating to the issues identified either through the Public Comment Listening Sessions or general recommendations to be sent to the Department:

- Prior Authorization
- Medication approval
- Case Management
- Credentialing
- Dual Eligibility coordination
- Timeliness of reimbursements
- Consistency of MCO customer service
- Increase in provider administrative costs
- Housing for mental health and cognitive patients and its impact on the patient on their caregiver
- Overall mental health plans
- Health Home
- Access to care
  - Low reimbursement rates resulting in reduced access to care
- Mental health access
  - Broad system access
- Reduced geographical access
  - Particularly rural areas
- Consumer navigation of new system
  - Collecting patient stories and how IME works with Case Managers in improving consumer experience
- Medicaid reapplication process being triggered when member receiving Elderly Waiver Services is admitted to Nursing Facility for greater than 30 days and moves back home, losing their services

A vote was taken and motion carried.

Report from the Long Term Care Ombudsman

Kelli Todd from the LTC Ombudsman's Office briefed the Council on the monthly reports from the Ombudsman's Office as required by CMS and stated that the report was available on their website. She outlined the data from month to month indicating relevant variance changes and the metrics used. She also provided key issues the Office had encountered that aligned with some of the key recommendations that had been discussed at this Council meeting.

The monthly and quarterly program reports of the Long-Term Care Ombudsman Program can be accessed online.[1]

Report Analysis Workgroup

Mikki informed the Council that the workgroup meeting would be incorporated into the next Executive Committee meeting on November 29, 2016. Gerd extended an invitation to the members of the Council to attend or call in to the meeting if they would like to contribute to the workgroup discussion.

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

November 28, 2016

Update from the Medicaid Director

Mikki provided an update regarding the continuation of work being done with the MCOs including making sure the correct rates were established with each MCO. The IME continued to work with CMS regarding the credentialing of providers and Mikki informed the Council that the IME was currently in the process of re-enrolling all of its providers which added a strain on the credentialing process; she encouraged the Council to remain vigilant for more informational letters regarding these important points. The IME continued to do outreach for associations, providers, and MCO partners to ensure a smooth transition.

Updates from MCOs

a. **Amerigroup Iowa, Inc.**
   The representative discussed community outreach and volunteering throughout the state.

b. **AmeriHealth Caritas Iowa, Inc.**
   The representative outlined statistical data on member- and provider-services call centers and stated they had increased staffing for provider network team. Member/Provider Stakeholder Advisory Committee Meeting to take place on December 8, 2016, between 5 p.m. and 7 p.m. at the AmeriHealth Caritas Wellness center, 3420 Martin Luther King Jr. Parkway, Des Moines, IA 50310.

c. **UnitedHealthcare Plan of the River Valley, Inc.**
   The representative provided general information regarding additional assistance available to providers and stated documents were available on the UnitedHealthcare website to assist providers.

Public Comments

No comments from the Council.

Adjourn

3:00 p.m.

November 28, 2016

Executive Committee
Summary of Meeting Minutes
November 29, 2016

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

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

Approval of the Executive Committee Meeting Minutes of November 4, 2016
Minutes of the Executive Committee meeting of November 4, 2016 was approved.

Review and Discuss the Sixteen Recommendations from the Full Council Meeting
Gerd and Dennis' recommendation documents were presented to the Committee. The Committee reviewed the 16 recommendations on the documents, discussing additional recommendations, and agreed that the recommendations would be divided as follows:

Quarterly Public Comment Listening Session Recommendations
1. Prior Authorization
2. Case Management
3. Credentialing
4. Timeliness of reimbursement
5. Consistency of MCO customer service
6. Access to care
7. Mental health access
8. Reduced geographical access

November 30, 2016

9. Increase in provider administrative cost recommendation
10. Consumer navigation of new system

General Recommendations

1. Medication approval
2. Dual eligibility coordination
3. Housing for mental health and cognitive impairment and impact on patient and care
4. Overall mental health plans
5. Health Home
6. Medicaid reapplication

The Committee agreed that a subcommittee workgroup would be developed to evaluate recommendations and Public Comment Listening Session notes to bring feedback to the Committee for quarterly suggestions and recommendations to the Department. The workgroup would consist of David, Natalie, Dennis, and Julie and the first feedback would be presented at the December 20, 2016, Executive Committee meeting. The general recommendation topics of Medication Approval and Dual Eligibility Coordination were discussed.

Medication Approval

Clarification was given that Medication Approval was to reference when members transitioned to a Managed Care Organization (MCO) and were required to restart the step therapy process under the Preferred Drug List (PDL). Recommendations were to consider members being removed from non-preferred medications and placed on preferred medications. Mikki stated that the IME sends MCO files with member medication information when members transition and that the IME and MCOs had recently met to discuss the PDL process and requirements. The Committee agreed with recommendations made regarding Medication Approval as outlined in Dennis' document and the recommendation that the MCOs provide data regarding medication denial rates for the Committee to monitor for future recommendations. A vote was taken to approve the two recommendations and motion carried.

Dual Eligibility Coordination

It was clarified that there had been a lack of communication and coordination between Medicare and the MCOs for members who were dual eligible to crossover information from Medicare. A recommendation was made to develop consistent communication for providers and ACOs related to care coordination between payers such as Medicare and Medicaid. It was suggested that the recommendation be discussed in the subcommittee. A vote was taken and motion carried.

The four remaining general recommendations were to be discussed at the December 20, 2016, Executive Committee meeting.

Review Action Items Update

Mikki reviewed the outstanding items on the Action Items document. The clarification on the EVV process was completed with the issuance of IL 1739-MC, and the report on deliberations of the prior year was reviewed and completed in the November 4, 2016, Committee meeting. The 2017 IA Health Link Public Comment meetings calendar was distributed at the November 21, 2016, Full Council meeting and Committee members to attend are to be determined.

Public Comment Listening Sessions Summary

Matt stated that the last meeting had taken place in Ottumwa on November 17, 2016 and next meeting would be December 7, 2016, in Des Moines. Matt provided some key issues that were raised in the Ottumwa meeting as reflected in the summary document. Discussion primarily focused on Integrated Health Homes and the denial or services delivered in the same day which resulted in scheduling issues and member accessibility to services.

November 30, 2016

Health Policy Oversight Committee Meeting
Gerd informed the Committee that they had been invited to attend the December 13, 2016, Health Policy Oversight Committee meeting. The Executive Committee is to give a presentation regarding the IA Health Link Public Comment Listening Sessions and an update for the Health Policy Oversight Committee on the status of discussions about quarterly recommendations.

Public Comment (Non-Executive Committee Members)
Gerd solicited comments. No comments were made.

Adjourned
4:34 P.M.

November 30, 2016

Executive Committee
Summary of Meeting Minutes
December 20, 2016

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Chuck Palmer –
David Hudson – **present**	Mikki Stier –
Dennis Tibben – **present**	Deb Johnson – **present**
Natalie Ginty – **present**	Liz Matney – **present**
Shelly Chandler –	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer –	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy –
Richard Crouch –	Luisito Cabrera –
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.

Approval of the Executive Committee Meeting Minutes of November 29, 2016
Minutes of the Executive Committee meeting on November 29, 2016 was approved.

Review and Discuss the Ten Primary Set of Recommendations Relating to Public Listening Sessions – Subcommittee Update
The Public Comment Listening Sessions Subcommittee Recommendations document was presented to the Committee. The Committee reviewed the 10 recommendations and discussed additional current and potential future recommendations to be presented to the Department.

Prior Authorization
Clarification was given that Prior Authorization (PA) recommendations were regarding inconsistency in PA approvals for the same service within MCOs, as well as consistency amongst the MCOs for immediate approval of an alternate PA when a similar service is deemed more appropriate at the time of the scheduled appointment. Additionally, it was identified that each MCOs contract with the state specified that if a PA was not approved within 7 days it would automatically be considered approved however, this standard was not being applied in all instances.

Formal Recommendations

1. Require that all provider manuals be clearly posted in an easily accessible format and location.
2. Develop a new methodology to track consistency of authorization within MCOs.
3. Enforce and communicate to the MCOs the cap after which a Prior Authorization request is deemed approved if the MCO has not taken action; the MCOs are then to communicate this information to providers.

Future Discussion

1. Encourage the MCOs to have alignment in areas of care to develop consistent service groups or crosswalk standards for Prior Authorizations to allow for instances where approval is obtained for a specific service. Also request that the MCOs consider developing an exemption process based on medical necessity.
2. Develop standardized PA requirements across MCOs

Credentialing

It was discussed that the MCOs had different credentialing requirements. Liz and Sean confirmed that per MCO contracts with the state, the MCOs are allowed to have additional and different credentialing requirements due to NCQA standards and requirements specific to their organization. The Committee also recognized that providers were having issues with the timeliness of credentialing.

Formal Recommendations

1. The Department to determine the differences in credentialing between the MCOs and develop a comparison grid of what additional measures beyond the universal credentialing application form each individual MCO requires.

Timeliness of Reimbursement

The accuracy of claims payments was discussed and it was determined that additional information would be needed regarding the percentage of clean claims prior to making additional recommendations. Clearinghouse to clearinghouse data would also be requested from the MCOs to determine denial rates of claims submissions.

Formal Recommendations

1. Determine the percentage of clean claims payments that were paid on time and at the established rate floors and MCO contracted rates to track the accuracy of provider payments and initial claims rejection rates.
2. Regarding clearinghouse to clearinghouse issues: Request that the MCOs provide data related to the denial rates from the clearinghouses and include this data in the Quarterly Report.

Consistency of MCO Customer Service

The Committee noted that there had been inconsistency in information provided to both providers and members by the MCO Customer Services Representatives. Lindsay stated that there was currently a secret shopper quality assurance process carried out by Iowa Medicaid to ensure accurate information is provided by the MCOs.

Formal Recommendations

1. Consider adding the accuracy and consistency information provided by the MCO Customer Service Representatives to both providers and members in the Quarterly Report.
2. Add secret shopper results to the Quarterly Report.

December 22, 2016

Increase in Provider Administrative Cost

Topic addressed in number 1 and 5 of the document.

Consumer Navigation of New Systems

It was discussed that members were not able to access the same level of care depending on which MCO the member was enrolled. Members were also not aware of what services were available to them, why some services were being denied, and what resources were available to them to assist with said information.

Formal Recommendations

1. Encourage to develop a standardized process across the MCOs regarding consistent messaging that informs members what services will be provided by each MCO, the process for denying those services, and what resources will be given to review available services. Also encourage greater patient communication from the MCOs in a more approachable and easily understandable manner concerning said service information.

Numbers 7 of the recommendations document to be deferred to the Mental Health and Disabilities Services (MHDS) Commission as they specifically address mental health issues. Additional information regarding Case Management, Access to Care, Reduced Geographical Access, and Consumer Navigation of new System was to be gathered from listed individuals for further discussion at the MAAC Executive Committee meeting to be held January 12, 2017.

Review the Four Remaining Secondary Set of Recommendations from the Full Council Meeting

Further information is to be obtained regarding numbers 3 and 4 from Full Council member, Dave Carlyle for January 19, 2017 Executive Committee meeting. Discussion ensued regarding the Medicaid Reapplication process for Elderly Waiver services recipients.

Medicaid Reapplication

It was clarified that members receiving Elderly Waiver services were removed from the waiver program following a 30 day or more stay in a nursing facility per the Iowa Administrative Code. Once released from the nursing facility, members who had been removed from the Elderly Waiver program were required to reapply for program which resulted in a delay of services.

Potential Future Recommendation

1. Extend the allotted 30 day nursing facility stay for Elderly Waiver recipients to 120 days and then evaluate how this extension impacts other waiver services programs.

Gerd and David were to select approximately 3 to 4 persons from the Full Council, including Cindy, for a subcommittee who would provide further insight into the Medicaid reapplication process. The information gathered in the subcommittee meeting is to be communicated to the Executive Committee at the Committee meeting to be held January 19, 2017.

Presentation of the SFY17 Quarterly Report

Liz presented updates on progress that had been made following implementation. Updates included Integrated Health Homes and Chronic Health Homes, data, quality assurance, waiver slot processes, CMS regulatory changes, and Electronic Visit Verification (EVV). Lori suggested that the resources being used for EVV would be better utilized in the payment of persons who deliver services to members. The following potential recommendations in regards to the EVV are to be discussed at a future Committee meeting:

Potential Future Recommendation

1. Provide data regarding the way in which funds are paid to service providers and evaluate ways to increase payment to said individuals.
2. Request that the Department supply the research used to determine how much fraudulent billing and service delivery is occurring.

The Managed Care Quarterly Report was presented and Liz reviewed the document

Review Action Items Update
Action Items were not reviewed.

Public Comment Listening Sessions Summary
Lindsay stated that last meeting had taken place in Des Moines on December 7, 2016 and the next meeting would be January 19, 2017, in Fort Madison. Issues discussed at the Des Moines meeting were reflected in the summary document. Members, stakeholders, and providers presented comments about the advertisement of meetings and value-added services while also echoing comments that had been made at prior meetings such as NEMT services.

Public Comment (Non-Executive Committee Members)
Jim Cushing with the Iowa Association of Area Agencies on Aging encouraged the state to examine how the MCOs reported their data differently, especially in the area of Case Management as the information within the Quarterly Report had been unclear and appeared inaccurate.

Adjourned
4:50 P.M.

December 22, 2016

Executive Committee
Summary of Meeting Minutes
January 19, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer –
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 – **present**
Kate Gainer – **present**	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy –
Richard Crouch – **present**	Luisito Cabrera – **present**
Julie Fugenschuh –	Alisha Timmerman – **present**
Jodi Tomlonovic – **present**	

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

Approval of the Executive Committee Meeting Minutes of December 20, 2016
Minutes of the Executive Committee meeting on December 20, 2016 was approved.

Review and Discuss the Primary Set of Recommendations Relating to Public Listening Sessions – Subcommittee Update
The draft letter to Director Palmer that contained all recommendations of the subcommittee was distributed. Lindsay stated that after having been reviewed by the Executive Committee several times, the intent at this meeting was to vote formally on this first round of recommendations that was to be submitted and to review the reports timeline to ensure that everyone was clear on the schedule for the next round of recommendations. Gerd reviewed the sixteen categories of recommendations from the November Full Council meeting that was parsed to two sets of recommendations. Additional recommendations regarding Consumer Navigation of New Systems from Anthony Carroll and Jim Cushing were distributed and it was agreed they would be discussed at future meetings for future recommendations. There was discussion regarding the use of "plain language" and this topic would be added to the Action Items for future discussion and explanation by the Department. Gerd reiterated the point that the recommendations were meant to ensure that, moving forward, the MAAC remain engaged in ongoing dialogue regarding these recommendations and these recommendations would continue to evolve as a result of ongoing dialogue.

January 26, 2017

Summary of adjustments to the letter:

- Prior Authorization (PA) Recommendation I, following "...provider manuals be clearly posted in an easily accessible format and location on the MCOs' websites" have an addition of "...and available in hardcopy."
- PA Recommendation I was to be made a general recommendation in the document and removed from the PA category.
- PA Recommendation IV and through future PA section, "...a particular service" was to be changed to "...particular services or products."

Gerd asked if the Committee approved the edits to the document and would like to submit the recommendations to the Department, the Committee voted and approved, and the motion carried.

HCBS Waiver Recommendations Workgroup update

Dave recapped the two earlier waiver subcommittee meetings and discussed the two HCBS Waiver Workgroup documents within the materials. He stated that as a result of the two meetings, a subcommittee was formed and a charge for the subcommittee was drafted to look at all seven waivers. Mikki stated that in dealing with the Elderly waiver, there should be an examination and consistent analysis of the potential impact on all the other waivers to ensure that there was no negative outcome. Dave mentioned the availability of other resources that were possibly not being utilized for the Elderly waiver population, especially in cases of dual eligibility and suggested that these additional resources be identified and added to future discussion. Lindsay stated It was clarified that there was no time limit for action by the subcommittee Lindsay stated that the subcommittee meeting would take place on January 26, 2017, and Gerd confirmed that this would be part of the MAAC agenda for upcoming meetings for more substantive discussions and reporting.

Review the remaining three out of the six secondary set of recommendations from the Full Council meeting

Lindsay stated that the general recommendations were more informal and open to further discussion by the Committee without a definite timeline for submission to the Department. Gerd recapped all six general recommendations indicating that item 6 was being addressed by the HCBS waiver subcommittee. It was agreed that items 3 and 4would be discussed further at the February Full Council meeting. Mikki stated that there were Medicare ACOs contracted with providers, there were also ACOs contracted with MCOs and what the coordination was between the Medicaid ACO and the Medicare ACO was the issue because there was a member in the middle who was dually eligible. There had been a lack of communication and coordination between Medicare and the MCOs for members who were dual eligible to crossover information from Medicare. It was agreed that Dr. Carlyle would be asked to provide additional information for item 2 and 5 regarding Dual Eligibility Coordination and Health Home, and requested to potentially draft recommendations to be discussed at the February 14, 2017, Full Council meeting. It was clarified that Medication Approval had been discussed at the November 29, 2016, Committee meeting with agreement on Dennis Tibbens' and additional recommendation, and these were to be added to the General Recommendations document.

Summary of actions regarding the general recommendations:

- **Item 1 regarding Medication Approval:** As outlined in the General Recommendations, Medication Approval should consider members being moved from non-preferred medications to preferred medications, should create a consistent, prompt step therapy exemption process across the MCOs, and should have MCOs provide data regarding medication denial rates for the Committee to monitor for future recommendations.
- **Items 2 and 5 regarding Dual Eligibility and Health Homes:** Consult Dr. Carlyle for clarification on topic for discussion in February 14, 2017, Full Council meeting.
- **Items 3 and 4 regarding Mental Health Housing and Plans:** Discuss in February 14, 2017, Full Council meeting.

January 26, 2017

Review Action Items Update

Mikki reviewed the items on the action items list. She stated that the one pager regarding the role of the MAAC based on the Administrative Rules was done and would be sent via email to Committee members. The invitation to the Attorney General's Office was moved back because of the activities around the drafting of the recommendations and they would be requested to attend the February Full Council meeting. It was agreed by the Department and Committee that updates on the new CMS managed care rules would be broken into different sections to be discussed and scattered amongst future Committee meetings.

Public Comment Listening Sessions Summary – Mikki Stier

• Fort Madison Session (January 12, 2017)

Lindsay stated that the meeting was positive and received feedback from members and providers with discussions on program improvements. Familiar issues were raised consistent with previous meetings that continued to be addressed. Matt Highland clarified that advertisement and promotion for meetings included Medicaid e-news, social media, promotion to MAAC members and interested parties, and would soon include newspapers and radio stations. The MAAC Public Comment Meeting attendee calendar was presented and Gerd encouraged Committee members to sign up for one or more of the upcoming meetings. Lindsay reviewed the MAAC Legislative Reports and Recommendations Timeline document that outlined due dates for various legislative reports, minutes, and recommendations for the public comment meetings.

Public Comment (Non-Executive Committee Members)

Anthony Carroll expressed concern about getting caught up on the broader issues involving the effort to look into the issues involving the waiver programs and how each is impacted. Dan Britt raised ongoing issues regarding billing claims/payments and claims going to appeals of more than 90 days. Brenda Young are having same issue as Dan on claims not being processed.

Adjourned

4:30 P.M.

January 26, 2017

MAAC Full Council Meeting
Summary of Meeting Minutes
February 14, 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 not a quorum.

Approval of November 21, 2016 Full Council Meeting Minutes
Gerd asked the Council if there were any changes to the minutes of the Full Council meeting of November 21, 2016. No changes were made and the minutes stand approved.

AG Office Presentation
Gretchen Kraemer from the Attorney General Office reviewed the Open Meetings Law as outlined in the Iowa Administrative Code. Agendas were to be available 24 hours in advance of the meeting or within reason and all new topics raised in the course of a meeting were to be placed on future agendas to ensure accessibility to the public. It was also affirmed that any discussions regarding topics of the MAAC between two or more members of the Council are subject to Open Meetings Law.

Report from the Long Term Care Ombudsman
Kelli Todd from the LTC Ombudsman's Office briefed the Council on the third quarter report and went over the issues that they have encountered from October, November, and December of 2016. One of the issues that was raised was the appeals process and will be further discussed in the MACC Executive Committee.

General Recommendations Update
Gerd refreshed the Full Council about ongoing discussions they have had with regard to the feedback from the listening sessions. He stated that they filter through the listening session recommendations to refine it prior to final submission. He went over the Medication Approval, HCBS Waiver, and Mental Health recommendations and stated that these recommendations and referrals are a long-term commitment and that the Full Council and Executive Committee continue to be engaged in this work. He expressed that the Dual Eligibility and Health Homes recommendations have yet to be robustly discussed. It was suggested that the general recommendations as well as the consumer friendliness of member-facing materials be additional topics for discussion at the next MAAC Executive Committee meeting.

Public Comment Meeting Recommendations
Gerd informed the Full Council that the recommendation letter is ready for submission and informed the Council that it includes topics that the group discussed at the November Full Council meeting. Lindsay explained that the public comments are due on a quarterly basis and that there has been a shift in times for the public comment meetings so that consumers would be able to attend. She also stated that the public comment meeting information is now advertised through various outlets and encouraged others to share this information. She commented that DHS will also be reaching out to the MCOs about posting the listening and public comment meetings schedule which is also accessible on the MAAC web page.

Quarterly Report Update
Gerd stated that in the November Full Council meeting, there was considerable interest in available

data and in determining a systematic and meaningful way for interpreting this data for the Full Council and the Executive Committee. He stated that Liz Matney spoke about one of the quarterly reports at the December Executive Committee meeting and that she provided the Committee with a better understanding of the data and how to access them.
The report can be accessed at First Quarter (SFY2017) Performance Data Report.

Dental Procurement

Mikki stated that there was a question raised regarding dental procurement. She gave an overview of the dental program to Medicaid, Fee-for-Service (FFS), and the Dental Wellness Program (DWP). DHS has sent out an RFI regarding the Dental programs to gain information from Providers about the current Dental Programs.

Update from the Medicaid Director

Mikki provided a quick update on the new items that are on the Action Items document. Mikki also stated that the Action Items document will also now feature the recommendations that are in the letters that are going to be submitted. She stated that this will allow us to keep track of the actions that will be taken to move them forward.

Public Comment Listening Sessions Update

Lindsay provided a brief recap of the IA Health Link public comment meeting in Fort Madison. The meeting yielded some positive feedback although some of the previous points such as those involving billing, prior authorization, etc. continue to be brought up. She stated that MCO representatives were on hand to provide direct access to members or providers. She stated that they also encountered questions regarding transportation and providers classifying emergency and non-emergency medical transportation.

Updates from MCOs

a. Amerigroup Iowa, Inc.

Natalie stated that Amerigroup has a Medical Advisory Committee and a Stakeholder Advisory Board and that their feedback is critical to ensure quality care and to ensure a positive experience for members and providers.

Stakeholder Advisory Board

She stated that the purpose of the board is to provide input on quality management issues, process improvement strategies and policy and procedure development

- Comprised of members' representatives of the different populations enrolled in the program, family members and providers.
    - The board is to have an equitable representation of it's members in terms of race, gender, special populations and Iowa geographic areas.
    - At least fifty-one percent of the board is comprised of members and/or their representatives (e.g., family members or caregivers).
    - Provider membership is to be representative of the different services covered under the Contract, including, but not limited to: (i) Nursing Facility Providers (ii) Behavioral Health Providers (iii) Primary Care (iv) Hospitals (v) 1915(c) HCBS Waiver Providers (vi) 1915(i) Habilitation Providers.

Medical Advisory Committee

She stated that the purpose of the Committee was to assist with the monitoring and evaluation of all aspects across the continuum of the quality health care delivery system (quality management, case management, utilization management) and includes member and practitioner/other health care professionals and directed initiatives. This committee serves as a review/continuous improvement forum for accreditation, regulatory and contractual requirements, as well as serving as the guides for how to work best with the medical community in Iowa.

- Comprised of physicians who are experienced in health care governance, with representation from the large health systems in Iowa.
- Medical Director, Dr. Mark Levy, chairs the committee.

If interested in serving as a member in the board or committee, persons may contact:

Updated: May10, 2017

Natalie Koerber, Ombudsman Liaison
Email: Natalie.Koerber@Amerigroup.com

b. AmeriHealth Caritas Iowa, Inc.

Tracy stated that AmeriHealth Caritas committee structure is overseen by one main committee:

Quality Adjustment and Performance Improvement Committee (QAPIC)

She stated that this group meets quarterly to review the reports of all the committees and subcommittees under it and reports directly to the Board of Directors. She outlined the various committees and subcommittees that report to QAPIC as follows:

- Stakeholder Advisory Committee
  - Comprised of 11 members and 10 providers that meet quarterly
  - 2017 meeting schedule can be found on the AmeriHealth Caritas Iowa, Inc. website[1]
- Credentialing Committee
- Service Improvement Committee
- Utilization and Care Management Committee
  - Appeals and Grievances Subcommittee
  - Pharmacy and Therapeutic Subcommittee
- Quality of Clinical Care Committee
  - Culturally and Linguistically Appropriate Services (CLAS) Subcommittee

Dave suggested hearing more about the reimbursement rate reduction and the transition from external case management to internal case management before the next Full Council meeting. It was agreed that this will be added to the agenda of the February 23, 2017 Executive Committee meeting.

c. UnitedHealthcare Plan of the River Valley, Inc.

Mary stated that UnitedHealthcare has a committee structure that reports to the Board of Directors. She stated that there is a Quality Management Committee that oversees all the other subcommittees but that she wanted to highlight two specific subcommittees, the Provider Affairs Subcommittee and the Stakeholder Advisory Subcommittee.

UHC of the River Valley Board of Directors

She stated that this is the governing body of the Health Plan and Quality Improvement (QI) Program.

- Comprised of UHC executive leadership and community business leaders. Currently all positions are full.

Quality Management Committee (QMC)

She stated that this committee is the oversight of the QI Program. This committee is responsible for the implementation, coordination and integration of all QI activities.

- Comprised of UHC Chief Medical Officer, department leadership, and three UHC network practitioners. Practitioners must be practicing practitioners participating in the UHC network and have completed the UHC credentialing process.

Provider Advisory Committee

She stated this is local participating practitioners who provide input and recommendation for improvement to UHC programs and policies.

- Comprised of UHC Chief Medical Officer for Physical Health, Behavioral Health and LTSS as well as seven Primary Care and Speciality Care UHC network practitioners. Practitioners must be practicing practitioners, participating in the UHC network and that have completed the UHC credentialing process.

Stakeholder Advisor Committee (SAC)

She stated that this committee serves as a forum for members or their representatives and providers to advise the health plan. The committee provides input on issues such service delivery, Member Rights and Responsibilities, operational issues, member materials and

[1] https://dhs.iowa.gov/sites/default/files/ACIA_Stakeholder%20Advisory%20Board%202017%20Schedule%20%281%29.pdf
Updated: May10, 2017

education programs and quality of care. It is also a forum for issues identified as priority by members.

- Fifty-one percent of the membership is UHC members. Plan providers can also be members.
- There are currently 17 members and seven providers.

If interested in serving as a member in the committees, persons may contact:

Mary Sweeney, Quality Director
Telephone: (563) 388-2012
Email: mary.d.sweeney@uhc.com

Public Comments

Dave Beeman commented that there has been improvement with MCOs regarding providing services but there are still issues with reimbursement on secondary payer to their health insurance. Tom Ryan made a comment regarding the need for more mental health crisis intervention beds and stated that the hospital in Mason City is always full in their mental health facility. He also stated that even if referred to Waterloo, the facilities are always full and the patient treatment center has a four month waiting list. Jim Cushing and Dave Beeman stated that they appreciated the work that went into the recommendations letters and were pleased with the end product.

Adjourn

3:46 p.m.

Updated: May10, 2017

Executive Committee
Summary of Meeting Minutes
February 23, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer –
David Hudson – **present**	Mikki Stier – **present**
Dennis Tibben –	Deb Johnson –
Natalie Ginty – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer –	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy –
Richard Crouch – **present**	Luisito Cabrera – **present**
Julie Fugenschuh –	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 January 19, 2017
Minutes of the Executive Committee meeting on January19, 2017 was approved.

Review and Discuss the General Recommendations
General recommendations reflected in the draft letter regarding Medication Approval, HCBS Waiver, and the Access to Care and Mental Health Referrals were reviewed. It was agreed that Dual Eligibility and Health Homes will not be a part of the formal recommendation letter but should be kept as topics for further monitoring and discussion in future meeting agendas. A motion was made to approve the letter. The Committee came to a unanimous decision to approve the letter.

Review of Timeline for Future Recommendations
The timeline for drafting future recommendations were briefly revisited and it was suggested that a subcommittee be formed prior to April Executive Committee meeting to draft the next set of recommendations.

Grievance and Appeals Discussion
Questions had been raised at the February 14, 2017, Council meeting about the accessibility of

information regarding the grievance and appeals process on the Medicaid website. It was discussed that members were to navigate the MCO and IME handbooks and websites for the information which presented difficulty in finding necessary content. Matt confirmed that standardization of MCO and IME content in publications was currently in process with consistency in areas such as titles, definitions and sections in handbooks.

Action Item

Under the heading of the existing Action Item regarding updates to new CMS managed care rules. Matt Highland is to present information and progress on new standardization of member content and format in publications at the March 14, 2017, Executive Committee meeting. Within presentation, will also discuss how standardization will impact the grievance and appeals process content.

MCO Rate Reductions and Potential Reductions and AmeriHealth Case Management Changes

Mikki affirmed that contract negotiations are between providers and the contracted MCOs however, providers must be paid at least the floor rate established by the Department. If contracted rates are above the floor rate, it is the discretion of the MCO to alter the rate so long as it is no less than the established floor rate. Shelly raised concern regarding a discrepancy between Home- and Community-Based waiver providers, specifically those serving the Intellectual Disability population.

AmeriHealth Caritas, Iowa

AmeriHealth Caritas Iowa representative, Tracy Smith, stated that floor rates are determined by provider type and that some providers had been contracted at a rate above the floor while others were paid at the floor. It was identified that a factor in AmeriHealth Caritas' larger HCBS population, when compared to the other MCOs, had been due to their initial hybrid model for case management, incorporating both internal and external case managers. Tracy stated that provider contracts were proprietary information and that individual provider rates were not discussed amongst providers and that only a portion of providers were paid above the floor. It was stated that for future sustainability, changes must be made within the program such as those to provider rates and case management however, this would not interrupt the care provided to members or the care that providers were offering to members. Tracy stated that all members, service plan providers and external case management agencies were notified by letter regarding the change in their case management model. Members, service plan providers and current case managers are also to be notified if they will be affected, and to begin a 30 day transition phase that ensures no service plan or service delivery interruption. It was also confirmed that while the model is changing, current contracts with external case management agencies would not be terminated although agencies were notified that they have the opportunity to opt-out of their contracts. Mikki confirmed the State and AmeriHealth Caritas have a workplan and the State will place AmeriHealth Caritas back into the initial implementation oversight of case management as had taken place beginning April 1, 2016, and will continue to ensure that members are served with the right kind and quality of care. Tracy stated that further investigation regarding the number of providers who discontinue contracts will take place following implantation of their new model.

Amerigroup Iowa

Amerigroup Iowa representative, Natalie Kerber, stated that stated that at this time all providers will continue to be paid at the rates established in their contracts.

UnitedHealthcare Plan of the River Valley

UnitedHealthcare Plan of the River Valley representative, Paige Pettit, stated that they have contracted with all providers at the established floor rates and all established rates will continue unless otherwise amended by the state.

Mikki stated that during the RFP process and contracting process, capitation rates were calculated by the State and agreed upon by the MCOs. However, capitation rates continue to be evaluated based on emerging trends. The state last fall adjusted for emerging trends and did an LTSS Risk adjustment for long-term services. Mikki confirmed that MCOs in other states have seen loss in the first year of

managed care implementation. Capitation rate adjustments will also take place annually.

Review Action Items Update
Mikki briefly reviewed the new outstanding items on the document and stated that the document will now include the recommendations within the recommendation letters to allow the Committee to keep track of the actions to be taken in moving them forward.

Public Comment Listening Sessions Summary – Mikki Stier
• Spirit Lake Session (February 15, 2017)
Lindsay provided a brief summary of the Spirit Lake meeting and apprised the Committee of the need to provide clarification regarding the difference between emergency and non-emergency transportation. Mikki noted the importance of providers to review member eligibility for non-emergent transportation as populations such as those in the Iowa Health and Wellness Plan and ***hawk-i*** are not eligible for the services. It was also explained that many of the issues presented within the listening session summaries are resolved following the meetings and therefore may not require additional review.

Public Comment (Non-Executive Committee Members)
It was expressed that in the area of Intellectual Disabilities, there have been issues involving access to care in certain areas of the state where there were no available provides offering the needed services. Concern regarding reimbursement rate reduction was expressed in relation to sustainability of the services provided. Particular concern was expressed regarding the AmeriHealth Caritas Iowa rate reduction strategy in case management and it's anticipated impact on providers, and that fundraising would not avoid the inevitable impact on the member's level of care.

Adjourned
4:39 P.M.

February 24, 2017

Iowa Department of Human Services

Medical Assistance Advisory Council
MAAC

Mikki Stier, Iowa Medicaid Director

Executive Committee
Summary of Meeting Minutes
March 14, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer – **present**
David Hudson – **present**	Mikki Stier – **present**
Dennis Tibben – **Present**	Deb Johnson – **present**
Dan Royer (Natalie Ginty) – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer –	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy – **present**
Richard Crouch – **present**	Luisito Cabrera – **present**
Julie Fugenschuh – **present**	Alisha Timmerman – **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 February 23, 2017
Minutes of the Executive Committee meeting on February 23, 2017 was approved.

Update from IME Communications
Matt reviewed the communications standardization of managed care regulations and stated that the State and MCOs are to be in compliance by July 1, 2017. Some communications requirements include:

1. The state provide model language and definitions to the MCOs to use within their member handbooks;
2. Standardization of member handbooks;
3. Standardization of formularies or Preferred Drug Lists (PDLs); and,
4. Timeliness of updates in provider directories

Regulations require particular terms to be present in the handbooks. MCO member handbooks will be updated with standardized organization, table of contents, and a style template. Current content within member materials will also be revised to be between a fourth and sixth grade reading level and

reviewed for ease of readability. Matt confirmed that members can find much of the necessary information regarding managed care on the Medicaid website and members are also able to contact the Member Services phone line for additional assistance. The MCOs have mobile applications and websites available for their members or members may also call the MCO Member Services phone lines.

Matt presented and navigated the Medicaid webpages.

Action Items

- Matt Highland and representatives from the three MCOs are to present information regarding mobile applications at a future Executive Committee meeting; after July meeting.
- Matt Highland to give an update regarding Communications Standardization for Managed Care Regulations at a future MAAC Executive Committee meeting; after July meeting.

Presentation on Integrated Health Home and Health Home Projects

Deb stated that there are two main types of Health Homes:

1. Chronic Condition Health Home (CCHH)
2. Integrated Health Home (IHH)

Joyce Vance outlined the various conditions required to be in a CCHH and to be in an IHH and underscored that the focus of a health home environment is on overall patient-centered care. She stated that activities for the past nine months have focused on provider training and the review of all the Chronic Health Homes to determine the accreditation status of each by the National Committee for Quality Assurance (NCQA) with the aim to ensure that all are certified.

Joyce stated that in July 2016, there were onsite reviews of IHHs to determine if they were meeting the requirements of the State Plan amendments. The MCOs were asked to conduct on-site reviews involving the member processes.

The question was asked why patient-centered planning would have inefficiencies. Joyce stated that part of the issue is the lack of knowledge within the various care coordinators on how to meet the requirements and that to address this issue they have been conducting various patient-centered training webinars. Deb stated that IHHs are integral in the Medicaid system with respect to the Medicaid effort to ensure that the appropriate human and financial resources are provided at the right time and under the right circumstances.

Action Items

- Deb Johnson and Joyce Vance are to be invited again to the April Executive Committee meeting to continue the discussion on Chronic and Integrated Health Homes..

Review Action Items Update

Mikki briefly provided an update on the Action Items document. The presentations regarding Integrated Health Homes and the Health Homes project were discussed in the March 14, 2017, meeting however, there will be a follow-up presentation in April 2017. Discussion regarding Dual Eligibility was to be discussed in the May 2017 Executive Committee meeting

Public Comment Listening Sessions Summary – Spirit Lake (March 9, 2017)

Lindsay provided a brief summary of the Spirit Lake meeting and informed the Committee that approximately 55 to 60 people had been in attendance. The hospitals in the area had experienced staffing changes and many of those in attendance had been current and former employees of the hospitals. Issues discussed at the meeting had involved access to care in rural communities, Prior Authorizations, and standardized processes and procedures. Billing and claims questions had also been discussed in regards to wrap-around payment issues.

Recommendations Sub-Committee
The next public comment recommendations were to be submitted by April 15, 2017. The recommendations are based off of the January, February and March public comment meetings held in 2017. The subcommittee would consist of Gerd, David, Dennis, Natalie and Julie. Gerd advised the group that the meeting was open to the public. The group was to meet prior to the April 11, 2017, MAAC Executive Committee meeting for discussion of recommendations.

Public Comment (Non-Executive Committee Members)
Gerd solicited comments. No comments were made.

Adjourned
4:34 P.M.

March 15, 2017

Executive Committee
Summary of Meeting Minutes
March 14, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer – **present**
David Hudson – **present**	Mikki Stier – **present**
Dennis Tibben – **Present**	Deb Johnson – **present**
Dan Royer (Natalie Ginty) – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer –	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy – **present**
Richard Crouch – **present**	Luisito Cabrera – **present**
Julie Fugenschuh – **present**	Alisha Timmerman – **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 February 23, 2017

Minutes of the Executive Committee meeting on February 23, 2017 was approved.

Update from IME Communications

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1. The state provide model language and definitions to the MCOs to use within their member handbooks;
2. Standardization of member handbooks;
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Action Items

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Review Action Items Update

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Recommendations Sub-Committee
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Public Comment (Non-Executive Committee Members)
Gerd solicited comments. No comments were made.

Adjourned
4:34 P.M.

March 15, 2017

Executive Committee
Summary of Meeting Minutes
April 11, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer – **present**
David Hudson – **present**	Mikki Stier – **present**
Dennis Tibben – **present**	Deb Johnson – **present**
Natalie Ginty – **present**	Liz Matney – **present**
Shelly Chandler – **present**	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer – **present**	Sean Bagniewski – **present**
Lori Allen –	Amy McCoy –
Richard Crouch –	Luisito Cabrera – **present**
Julie Fugenschuh – **present**	Alisha Timmerman – **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 March 14, 2017
Minutes of the Executive Committee meeting on March 14, 2017 was approved.

Quarterly Report Data Presentation
Liz presented updates on progress that had been made following implementation. Updates included Adult HRA, Adult Special Needs Population, Elderly Population, Grievances and Appeals, Service Plans, Level of Care, Medical Claims Payment, Provider Network Access, Hospital Admissions, and Out-of-State Placement. Cindy requested additional information about the average aggregate cost per member per day for special needs members in ICF/ID.

Action Item

1. Gather previous quarterly report data regarding the top five reasons for grievances and appeals for comparison to assist in determination if there are systemic trends in the information. The Department is to determine if a quarter by quarter comparison chart regarding this topic should be included in future quarterly reports.
2. Determine average aggregate cost per member per day for special needs members in ICF/ID.

April 13, 2017

3. Examine out-of-state placement for members in facilities to determine the impact on members as well as program.
   - Border issues
   - Medical conditions
   - Ages
   - Other factors leading to out-of-state placement

Review of the MAAC Recommendations Letters with the Director

Director Palmer stated that additional time would be necessary to have a thorough discussion on topics raised in recommendations letters, and therefore he would return for discussion at the May Executive Committee meeting. Gerd requested that Committee members review the Quarter 2 SFY 17 report to determine if topics within the recommendations letter had been addressed as well as bring items and current examples associated with the recommendations contributing to the letters for discussion with the Director.

May Executive Committee Agenda

1. Director Palmer to attend to discuss Quarter 2 SFY17 recommendation letters.

Vote on the next set of recommendations

A subcommittee meeting had taken place on April 5, 2017, and it was determined that no recommendations were to be made for third quarter of SFY 17 as previous recommendations made in second quarter of SFY17 had not yet been addressed. The draft letter for third quarter SFY17 was presented. A motion was made to approve the letter. The Committee came to a unanimous decision to approve the letter.

Review Action Items Update

Mikki briefly reviewed the action items and stated that the Medicaid and Medicare discussion was to take place in the June 2017 Executive Committee meeting instead of the May 2017 meeting. The recommendations were to be discussed with the Director in the May 2017 Executive Committee meeting.

Public Comment Listening Sessions Summary

Lindsay stated that the Mason City meeting was to take place on April 12, 2017, and that all future meetings would be every other month. The next meeting was to take place on June 13, 2017 in Sioux City, and the August meeting would be August 29, 2017, in Bettendorf.

May Full Council Meeting Agenda

1. MCO presentations
2. Action Items
3. LTC Ombudsman
4. Introduction of new members
5. Letters of recommendations
6. Single-case agreements

Open Discussion

Tom Scholz of the American Academy of Pediatrics pointed out the billing issues that they have encountered and commended the Committee for continuing discussion regarding appeals and grievances. Sue Whitty of the Iowa Nurses Associkation requested additional updates regarding the recent changes with AmeriHealth Caritas involving Case Management. Mikki suggested that this should be addressed by AmeriHealth Caritas at the May Full Council meeting. Shelly requested that there should be more substantive discussion on mental health issues in future MAAC meetings.

May Full Council Meeting Agenda

1. AmeriHealth Caritas to discuss changes to Case Management

Adjourn

4:31 P.M.

April 13, 2017

MAAC Full Council Meeting
Summary of Meeting Minutes
May 9, 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 not a quorum.

Gerd reminded public Full Council members whose terms would be ending on June 30, 2017, that they may reapply for their positions through the Governor's website. He mentioned the addition of Eric Kohlsdorf, Senator Joe Bolkcom, Senator Tom Greene, and Representative Kevin Koester to the MAAC.

Approval of February 14, 2017 Full Council Meeting Minutes
Gerd asked the Council if there were any changes to the minutes of the Full Council meeting of February 14, 2017. Dave Beeman asked to remove the line, "as speech pathologist" under the Public Comments section. Approval of the minutes was deferred to the August 8, 2017, Full Council Meeting due to not having a quorum.

Introduction of New Members
Introduction of new members was made.

Report from the Long Term Care Ombudsman (LTCO)
Kelli Todd from the LTCO Office stated that all LTCO reports were available on their website. She stated that the LTCO Office received 556 contacts in March 2017 and 448 contacts in April 2017. She stated that the contacts were primarily concerning termination and reduction of waiver and institutional care services, Consumer Directed Attendant Care (CDAC) services, Case Management, and changes in hours and units for Consumer Choices Option (CCO). The LTCO Office will be publishing a guidebook, "How to be Your Own Best Advocate," to inform managed care members how to utilize and file appeals and grievance forms and better understand CDAC and Case Management processes. She mentioned that the LTCO Office has a Medicaid Managed Care Complaint Form on their website and to request that the LTCO Office reach out for direct assistance.

Letters of Recommendation Update
Gerd gave a brief summary of the three Recommendation Letters that were submitted to Director Palmer since the February 14, 2017, Full Council meeting. He stated that Director Palmer would attend the May 18, 2017, Executive Committee meeting to address some of the topics presented in the recommendation letters.

Gerd noted that Non-Emergent Medical Transportation (NEMT) and Durable Medical Equipment (DME) were topics presented in Quarter 3 SFY17 IA Health Link Public Comment Meetings and would be monitored and discussed for future potential recommendations.

Update from the Medicaid Director
Mikki provided an update on the new items that were on the Action Items document. She mentioned that work plans were being developed around several pieces of legislation that were still pending enactment. Dave Beeman mentioned that he has reached out to the IME about credentialing of psychologists and provisional licensing and Mikki stated that a response to his query was sent out by the IME. It was acknowledged that members of the MAAC may write the department for additional information regarding any concerns that they may have, or contribute feedback and items

may be placed on the Action Items document for follow up. Marsha Fisher commented on the level of training that the MCOs offered to CDAC providers regarding the billing process. Mikki stated that efforts to provide proper training was done through the IME Annual Provider Training and this topic will be considered for future trainings.

Quarterly Report Data Update

Liz stated that the number of reported member and provider issues had declined and that there was greater engagement between members, providers and the MCOs which resulted in faster resolution of issues. It was confirmed that the IME was in the process of implementing several managed care regulations and collaboration with the MCOs to streamline timely updating and application of fee schedules. As a CMS requirement, the IME engaged a contractor to perform an independent review of MCO compliance with state and federal regulations, performance measures, encounter data, and other processes. Liz briefly reviewed Health Risk Assessments (HRA), Service Plans, Level-of-Service, Medical Claims, Claims Denials, and LTSS data within the quarterly report.

Updates from MCOs

(List of advocacy councils, case management changes, and single case management)

a. **UnitedHealthcare Plan of the River Valley, Inc.**
Paige Petit stated that UnitedHealthcare has a Stakeholder Advisory Committee that meets quarterly and is made up of seven providers, 17 United Healthcare Members, and 14 health plan staff. The Committee discusses topics such as the Community Rewards Program for members, the member handbook, website development, case management, the Nurse Line for members, and other relevant points of discussion. It was confirmed that UnitedHealthcare will continue to use internal Case Managers and case management agencies. She stated that single case agreements were to only be considered if an in-network provider was not available to meet the member's specific medical needs.

b. **AmeriHealth Caritas Iowa, Inc.**
Tracy Smith stated that AmeriHealth has a Quality Assessment and Performance Improvement Committee (QAPIC) that reports directly to the Board of Directors and meets quarterly to review the reports of all AmeriHealth committees and subcommittees. The QAPIC consists of 11 internal members and five external providers, who discuss topics such as case management processes, performance monitoring activities, clinical services activities, clinical outcome measures, and contractual, regulatory, and legal requirements. AmeriHealth also has a Stakeholder Advisory Committee that meet quarterly and is comprised of members, member representatives, and providers. The last Stakeholder Committee meeting covered the changes involving case management as well as the grievance process. Tracy acknowledged the changes in their case management program and that they continued to hire and train additional Case Managers as they transitioned to internal case management. Members affected by the change in case management were to be sent letters with information regarding the transition. She stated that they currently had 125 Case Managers and continued to assess the case loads of each Case Manager. It was confirmed that AmeriHealth single case agreements were reviewed on a case-by-case basis by an internal committee. Tracy also fielded queries regarding the status of the Mercy Hospital negotiations, case management transition, monitoring, and performance, and a decrease in ER admissions.

c. **Amerigroup Iowa, Inc.**
Natalie Kerber stated that Amerigroup has a Stakeholder Advisory Board that met once in February 2017 and would meet again on May 23, 2017. The Stakeholder Advisory Board is comprised of members, advocates, and providers, and the agenda is driven primarily by issues that are expressed by the members; future topics would include member onboarding, community activities, Health Risk Assessments, and quality assurance. She stated that the Medical Advisory Committee had met once in February 2017 with a focus on state and entity rate requirements and gathering data on various programs and reports. There would be no change in the AmeriGroup case management program. John Hedgecoth, Director of Contracting for AmeriGroup, stated that single case agreements were handled on a case-by-case basis with specific provisions for specific circumstances such as non-covered/excluded scenarios, out-of-state ER visits, elective out-of-state providers (e.g. PMIC cases, Mayo Clinic), and elective out-of-state providers based on the complexity of the member needs.

Communications Standardization Overview

Matt reviewed the communications standardization of managed care regulations and stated that the State and MCOs are to be in compliance by July 1, 2017. He outlined some of the key initiatives that are in progress such as work with SMEs and MCOs to determine key words and terminologies, plain language and reading level standards below 6th grade reading level, standardized organization of member and provider handbooks, manuals and directories through the use of templates.

Public Comment Listening Sessions

Spirit Lake / Shenandoah / Mason City

Lindsay directed members to the three Public Comment summaries for details regarding the meetings in Spirit Lake, Shenandoah, and Mason City. She highlighted the new concerns that have emerged at the recent meetings include Non-Emergency Medical Transportation (NEMT) and Durable Medical Equipment (DME). Representatives from the MCOs had been present at all meetings to assist members and providers in resolving one-off situations. She noted the attrition in attendance levels in recent meetings and also noted that most issues are one-off and are almost always resolved on the spot.

Public Comments

(Non-Executive Committee Members)

Jennifer Harbison inquired about the availability of information regarding cost containment provisions included in the Health and Human Services. Iowa Medicaid will review the legislation once enacted and develop additional communication for providers prior to implementation. Kevin Kruse inquired about an Informational Letter regarding provider renewal. Sean clarified that the Informational Letter was a reminder for providers who had not renewed their provider enrollment to do so.

Adjourn

3:49 p.m.

May 22, 2017

Executive Committee
Summary of Meeting Minutes
May 18, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Chuck Palmer –
David Hudson – **present**	Mikki Stier – **present**
Dennis Tibben – **present**	Deb Johnson –
Natalie Ginty – **present**	Liz Matney –
Shelly Chandler – **present**	Matt Highland – **present**
Cindy Baddeloo – **present**	Lindsay Paulson – **present**
Kate Gainer –	Sean Bagniewski – **present**
Lori Allen – **present**	Amy McCoy –
Richard Crouch – **present**	Luisito Cabrera – **present**
Julie Fugenschuh – **present**	Alisha Timmerman – **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 April 11, 2017
Minutes of the Executive Committee meeting on April 11, 2017 was approved.

Director Palmer on Recommendations
Recommendations were postponed.

***hawk-i* Clinical Advisory Committee**
Eric Kohlsdorf, Chair of the ***hawk-i*** Clinical Advisory Board, stated that the ***hawk-i*** program currently served over 40,000 recipients and explained program eligibility requirements. Current topics of discussion within the ***hawk-i*** Clinical Advisory Board were prior authorizations for prescriptions, access to care, provider networks, the credentialing process, and the renewal of the Delta Dental contract. He stated that ***hawk-i*** was working with Matt Highland for communication standardization and that information regarding the program could be found on their website and within their newsletter.

Medicaid Director's Update
Effective July 1, 2017, the Dental Wellness Plan DWP would be restructured to provide dental coverage for all adult Iowa Medicaid members, age 19 and older, in both the Iowa Health and Wellness Plan (IHAWP) and Fee-for-Service (FFS) programs. The new DWP would no longer be a tiered benefits model and all members would receive full dental coverage in their first year of service.

May 22, 2017

DWP members must complete 'Healthy Behaviors' during the first year of the new Dental Wellness Plan to keep their full benefits the next year and avoid a monthly premium. Jodi stated there had been concern regarding the timely release of new DWP fee schedule information given the July 1, 2017, start of the new program.

Mikki provided an update on the cost containment initiatives that were passed by legislators this year. There are Informational Letters (ILs) related to recent cost containment measures. Measures were to be implemented by July 1, 2017, although some required CMS approval so once approved would be retroactively effective. New ILs to be released regarding cost containment discussed:

1. Crossover Claims
2. Time of Service
3. The elimination of the primary enhanced payments
4. Changes to anesthesiology
5. Consultation codes
6. Inpatient changes
7. Retroactive eligibility

An IL would soon be released explaining the new family planning program. The state had been working with CMS concerning retroactive eligibility with changes to begin pending CMS approval. IME Policy staff was in the process of reviewing all ILs to update ICD 9 information to ICD 10. Information regarding changes will be communicated through e-newsletters, ILs, and the DHS website.

Public Comment Listening Sessions Summary
Lindsay stated that comments made at the Mason City meeting held on April 12, 2017, were in regards to provider access, reimbursement rates for providers, requests for universal prior authorization forms, and timeliness of prior authorization processing. The next meeting was to take place on June 13, 2017 in Sioux City, and August meeting would be August 29, 2017, in Bettendorf.

Open Discussion
Gerd reminded public Executive Committee members that they may reapply for their positions through the governor's website. He reviewed the future Executive Committee and Full Council meeting potential agenda items.

Gerd suggested that MAAC members review quarterly reports to determine what recommendations and public comments may have been addressed, and what data could be tracked and discussed for future potential recommendations.

Richard Crouch stated that the Committee had compiled a broad range of topics for future discussion that will assist with more conducive conversations in meetings going forward.

Adjourn
4:26 P.M.

May 22, 2017

Executive Committee
Summary of Meeting Minutes
June 15, 2017

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Chuck Palmer – **present**
David Hudson – **present**	Jerry Foxhoven - **present**
Dennis Tibben – **present**	Mikki Stier - **present**
Natalie Ginty – **present**	Deb Johnson -
Shelly Chandler – **present**	Liz Matney - **present**
Cindy Baddeloo – **present**	Matt Highland - **present**
Kate Gainer –	Lindsay Paulson - **present**
Lori Allen – **present**	Sean Bagniewski - **present**
Richard Crouch – **present**	Amy McCoy -
Julie Fugenschuh – **present**	Luisito Cabrera - **present**
Jodi Tomlonovic – **present**	Alisha Timmerman - **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 May 18, 2017
Minutes of the Executive Committee meeting on May 18, 2017 was approved.

Director Palmer on Recommendations
Director Palmer introduced Director Foxhoven to the Executive Committee and explained to him the role of the Committee as an oversight group for the Medicaid program. Director Palmer stated that he had read each recommendation and would continue to convey his thoughts to the Council through the Medicaid Director. Lindsay reviewed the IA Health Link Public Comment recommendations letter. In response to the two recommendations concerning timeliness of reimbursements, Director Palmer suggested identifying the largest issues and the areas where they are most prevalent. Regarding the HCBS Waiver recommendation, Mikki stated that the 120 day rule change had already been presented to the Rules Committee and was in process.

In review of the General Recommendations letter, Director Palmer gave general comments about prioritizing recommendations and working closely with the MCOs to identify ways of achieving better outcomes for the members while not overwhelming MCO processes or the provider community.

June 19, 2017

Action Item

1. Identify trends involving payment issues:
    - The largest issues
    - Where issues are most prevalent and if this trend changes over time
    - Where issues continue to reside
    - If the same issues affect different provider types
    - The proportion of issues that occur with the MCOs versus with provider organizations
    - The top reasons why payment issues persist
    - Identify if the top reasons for payment issues change over time

Director Foxhoven assured the Executive Committee that he would review and consider all recommendations made by the MAAC and respond to the recommendations in a timely manner for greater efficiency in Medicaid improvement.

Medicaid Director's Update

Mikki reviewed the Action Items document. Provider manuals continued to be updated. The Quarterly Report was to be released in the coming weeks. Data was being gathered for appeals and grievances, average aggregate cost for special needs members in Intermediate Care Facilities for the Intellectually Disabled, and out-of-state placement was being gathered and would be discussed at future Executive Committee meetings.

Cost containment initiatives impacting Medicaid were ready for implementation on July 1, 2017. Informational Letters (ILs) regarding cost containment measures had been released, and additional ILs with scenarios and fee schedules would be released prior to July 1, 2017. Mikki stated that the IME was developing communications for the Medicaid Institutions for Mental Disease (IMD) exclusion to be implemented on July 1, 2017 as the IMD exclusion would impact two of Iowa's institutions.

Public comment meetings regarding retroactive eligibility were to take place within the next 30 days. Following public comment, a draft waiver was to be sent to CMS. Communications were being developed that would include scenarios considering enrollment, re-enrollment and reinstatement. Data was being gathered from other states that had eliminated retroactive eligibility for general guidance on the initiative.

Public Comment Listening Sessions Update

Lindsay stated that there were approximately 30 to 40 individuals at the Sioux City meeting held on June 13, 2017, and that comments made were primarily concerning billing and claims, changes to- and prior authorization of- Durable Medical Equipment (DME), Home Health, and Non-Emergent Medical Transportation (NEMT). Members and providers also expressed concerns with the timeliness of responses from the MCOs.

Open Discussion

Members of the Executive Committee expressed their appreciation for Director Palmer's service.

Adjourn

4:32 P.M.

June 19, 2017

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 long-term care ombudsman/managed care ombudsman, advocates for concerns and rights of Medicaid managed care members who receive long-term services and supports in health care facilities or through one of the seven home and community-based waiver programs.

Long-term care ombudsman/managed care ombudsman are charged with assisting recipients with understanding members' rights regarding services, care and access to managed care. Long-term care ombudsman/managed care ombudsman also provide advice and assistance to managed care members that wish to file complaints, grievances and appeals.

House File 2460 directed the OSLTCO to review Medicaid managed care as it relates to the OSLTCO's statutory duties and annually submit an executive summary of pertinent information. OSLTCO's statutory duties include advocacy and assistance for recipients of long-term supports and services provided by the Medicaid program. This Executive Summary contains a summary of the member issues brought to the attention of the OSLTCO for the time period of October 1, 2016 through September 30, 2017, as well as issues to watch.

I. Member Issues

The OSLTCO has received a total of 4,187 contacts regarding managed care from October 1, 2016 to September 29, 2017. 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 top three issues raised by those contacting the OSLTCO.

Months	Total Contacts	Top 3 Issues
October 2016	152	• Change in care setting • Transition services inadequate/inaccessible • Other service gap/coverage issue

Months	Total Contacts	Top 3 Issues
November 2016	181	• Transition services inadequate/inaccessible • Change in care setting • Access to preferred/necessary durable medical equipment
December 2016	181	• Service reduced, denied, terminated • Guardianship documents not on file • Transition services inadequate/ inaccessible
January 2017	273	• Services reduced, denied, terminated • MCO was rude or gave poor customer service • Other service gap/coverage issue
February 2017	355	• Service reduced, denied, terminated • Care planning participation • Change in care setting
March 2017	556	• Service reduce, denied, terminated • Care coordinator/case manager was rude/gave poor customer service • Care planning participation

Months	Total Contacts	Top 3 Issues
April 2017	448	• Service reduced, denied, terminated • Other • Care planning participation
May 2017	439	• Service reduced, denied, terminated • Access to information/information sharing • MCO was rude or gave poor customer service
June 2017	466	• Service reduced, denied, terminated • Access to information/information sharing • Care planning participation
July, 2017	354	• Service reduced, denied or terminated • Access to information/information sharing • Care planning participation

Months	Total Contacts	Top 3 Issues
August 2017	468	• Service reduced, denied, terminated • Access to preferred/necessary durable medical equipment • Access to information/information sharing
September 2017	314	• Service reduced, denied, terminated • Access to preferred/necessary durable medical equipment • Home/vehicle modifications

In addition to the issues in the table above, the OSLTCO tracked resolution times for issues reported to the OSLTCO by managed care members, or someone reporting on their behalf. Resolution times fluctuated from a low of 5 days in October 2016, to a high of 29 in January 2017.

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

II. Issues To Watch

CDAC providers and their members have reported continued issues with payment. While payment is not a specific member issue, members are often concerned about losing a trusted CDAD provider as a result of payment issues.

The OSLTCO noted an increase in the number of contacts from managed care members or someone reporting on their behalf regarding state fair hearings. For the months of October, November and December of 2016, the OSLTCO had 18 contacts regarding state fair hearings. For the months of July, August and September of 2017 the number of contacts regarding state fair hearings had increased to 169 contacts.

Iowa Department of Human Services

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

Iowa Mental Health and Disability Services Commission

November 14, 2017

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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 16, 2017 - MHDS Commission Meeting
Mikki Stier, Director of Iowa Medicaid Enterprise (IME), presented to the Commission on the transition to IA Health Link. There was discussion on the timeliness of provider payments, reimbursement rates, and case management.

April 20, 2017 - MHDS Commission Meeting
Theresa Armstrong, Bureau Chief of Community Services and Planning, in a review of 2017 legislation presented to the Commission on the direction the managed care organizations (MCO) were given on the expansion of Assertive Community Treatment in Iowa.

July 20, 2017 - MHDS Commission Meeting
Rick Shults, Division Administrator of Mental Health and Disability Services presented to the Commission on the progress of the approval of codes for crisis services with the MCOs. Rick presented on the legislation that directs the MCOs and MHDS Regions to enter into MOUs.

September 21, 2017 - MHDS Commission Meeting
The Commission discussed its executive summary to the Department and the members' thoughts on Medicaid Managed Care over the previous year.

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

During the course of their deliberations, the Commission has heard of a number of concerns from stakeholders that are the same as the concerns reported in the 2016. The Commission has 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
- 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
- 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

Executive Summary of the Healthy and Well Kids in Iowa (***hawk-i***) Program SFY 17

The number of children enrolled in the program increased in SFY 17. The ***hawk-i*** enrollment was 42,984 and 3,361 were enrolled in the ***hawk-i*** Dental Only program. This was 3.1 percent increase in haw***k-i*** and 3.6 percent in dental only.

Managed Care Organizations
All ***hawk-i*** members had a choice of three Managed Care Organizations (MCOs) for health care coverage in SFY17. These MCOs were Amerigroup Iowa, Inc., AmeriHealth Caritas 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, ended on September 30, 2017. The Department continues to monitor for federal legislation on CHIP reauthorization. The Department has been in discussions with the Centers for Medicare and Medicaid Services and other states regarding options if CHIP is not reauthorized.

Premiums
In June 2017, 83 percent of enrolled hawk-i families paid a monthly premium which ranged from $5 to $40 depending on coverage type and number of children in the family.

Outreach
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. Four focus areas of outreach include schools, faith-based communities, diverse ethnic populations, and medical/dental providers.

APPENDIX

APPENDIX: HCBS WAIVER WAITLIST

HCBS Waiver Waitlist – July 2017*							
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	34	1,459	1,037	7,918	2,178	12,004	940
Number of Individuals on Waiver Waitlist (DHS Function)	0	953	1,067	0	2,770	2,760	1,214
Waitlist Increase or (Decrease)	0	+156	+232	0	+172	+378	-120

*As reported in July 2017. 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.