Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

December 15, 2016

Senate Human Resources
Committee
State Capitol Building
L O C A L

House of Representatives
Human Resources
Committee
State Capitol Building
L O C A L

Joint Appropriations
Committee on Health and
Human Services
State Capitol Building
L O C A L

Dear Committee Members,

Pursuant to House File 2460, Division XXII, Section 93(4), the Department of Human Services is to submit a Medicaid Managed Care Oversight Report annually. Enclosed please find the Annual Managed Care Oversight Report for State Fiscal Year 2016.

Please contact me if you need additional information.

Sincerely,

Sally Titus
Deputy Director

ST/tam

Enclosure

cc: Terry E. Branstad, Governor

Iowa Medicaid Enterprise

Managed Care
Annual Performance Report
(April 2016 – September 2016)

Published December 15, 2016

CONTENTS

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)

This report is based on the data available as of the publishing date which includes Quarter 4 of State Fiscal Year (SFY) 2016 (April 2016 to June 2016) and Quarter 1 of SFY 2017 (July 2016 to September 2016).

The next Managed Care Annual Performance Report will transition to align to State Fiscal Years and will cover July 1, 2016 through June 30, 2017.

Understanding the Performance Data:

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

- 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 continues to work with the MCOs to ensure that data definitions are universally understood and consistently applied. From Quarter 4 SFY16 to Quarter 1 SFY17, the below key changes have been made that will impact trending assumptions. Notable changes are indicated with a red triangle throughout the report.
    - Count of members changed from unduplicated over the course of the quarter to those members that were continuously enrolled throughout the quarter
    - More clarification was given to the diagnostic coding to consider when classifying members within the behavior health population

- 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:

- Member Choice: The number of members selecting a health plan has increased to 145,153. This is a 45 % increase from Quarter 1 of the program.

- Health Risk Assessments: More than 230,000 member health risk assessments (HRAs) and outreach efforts were conducted in the first six months of operations. HRAs were not a previous requirement. These assessments help identify risk factors to provide better treatment.

- Value-Added Services: More than 40,000 value-added services have been utilized. The health plans offer dozens of value-added services that go beyond what traditional Medicaid benefits offer. These value-added services are intended for members to improve their health and well-being including health incentives and wellness programs.

- Timely Helpline Services: When members have questions they can contact the health plans' member helplines. The three MCOs exceeded the contractual timeliness requirements. The state conducts "secret shopper calls" to ensure quality of helpline services.

- Home- and Community-Based Services (HCBS) Waitlist Decrease: Since the program was implemented in April 2016, the HCBS waitlist has been reduced by 2,200. This means more high needs members are getting waiver services and in a more timely manner.

[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.

- 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.

- Increased Value-Based Purchasing Agreements: The health plans have more than doubled their value-based purchasing agreements. The health care field is shifting from volume-based services to value-based services ensuring patient-centered care. Our health plans took significant steps forward in this second quarter of reporting to lead the way in the patient-center value-based health care environment.

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.

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 development of a reporting manual as well as publication of monthly and quarterly managed care performance reports. The Department continues to work to align this reporting structure including plans to publish similar reports for the Iowa Medicaid Fee-for-Service program and the Dental Wellness Plan, which are not a part of managed care.

- Waiver Slots: The Department has worked with the MCOs to improve the process and timeline for HCBS waiver slots. These efforts have culminated in a continued reduction in the waiver waitlists, as demonstrated in the Appendix of this report.

- 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 late 2017 to allow for more stakeholder engagement, member and provider training, and communication. During SFY17, the Department will engage stakeholders in the planning for EVV program implementation as well as continue to move forward in the necessary steps towards this goal, including monitoring a pilot program.

- Implementation of Tiered HCBS Supported Community Living Rates: The Department continues 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 is engaging stakeholders in the process of development of tiered rates and will provide regular updates as we update reimbursement methodology.

- 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 for a first external quality review will be published in summer of SFY17.

Compliance:

As noted in more detail in the Appendix, 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 Issues with Remedies Enacted	27	20	13
Number of Issues with Currently Monitored Remedies	23	18	12
Number of Issues Corrected and Remedy Closed	4	2	1

**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

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

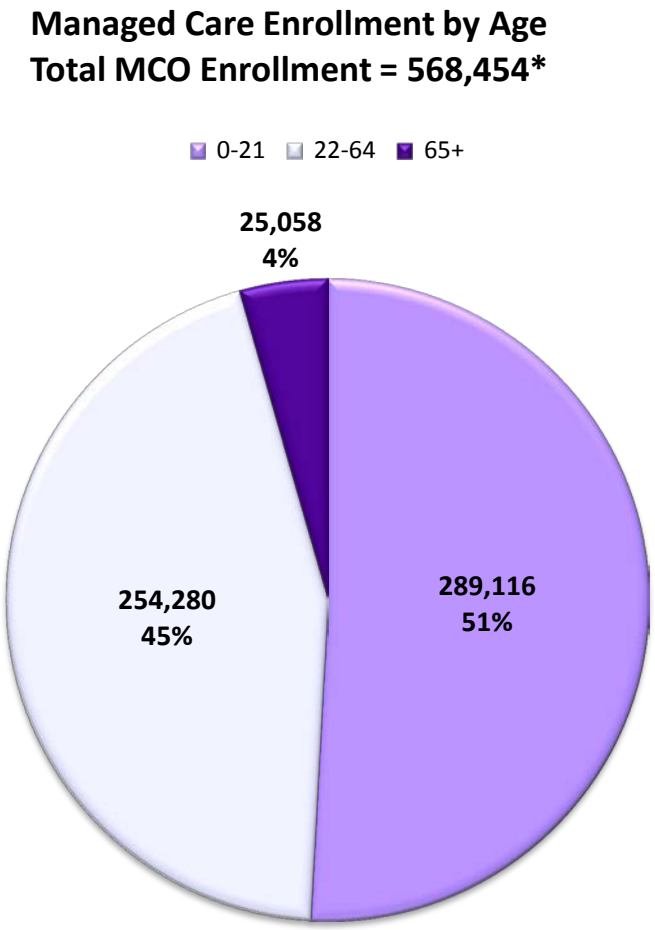
Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink

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

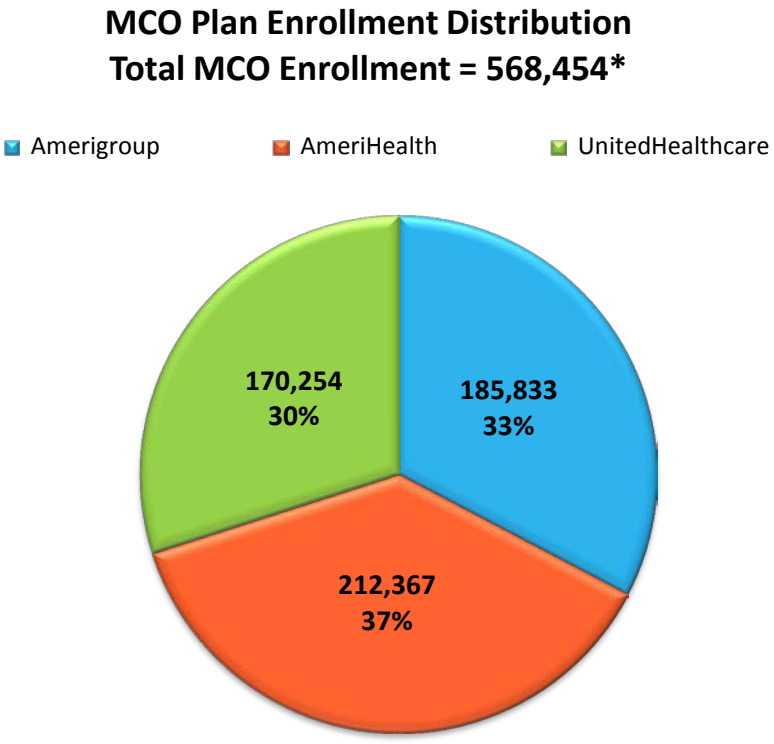
Monthly Managed Care Performance Reports can be found at https://dhs.iowa.gov/ime/about/performance-data/MC-monthly-reports

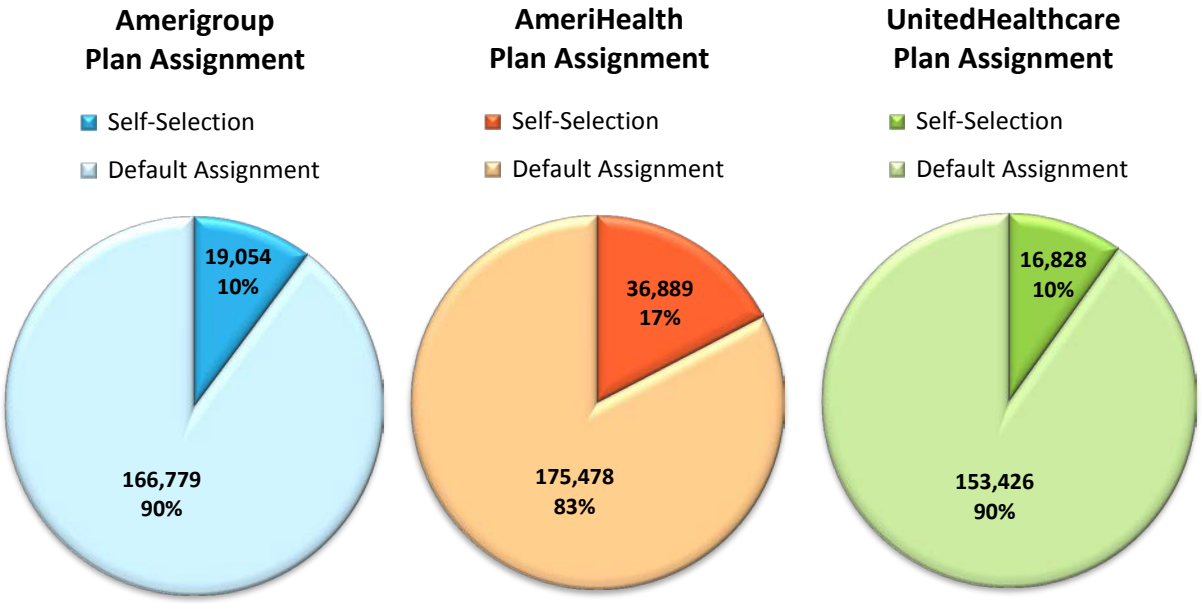
Quarterly Managed Care Performance Reports can be found at https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports

PLAN ENROLLMENT BY AGE



*September 2016 enrollment data as of October 10, 2016 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This does not include ***hawk-i*** enrollees. 49,988 members remain in the Fee-for-Service (FFS) program.





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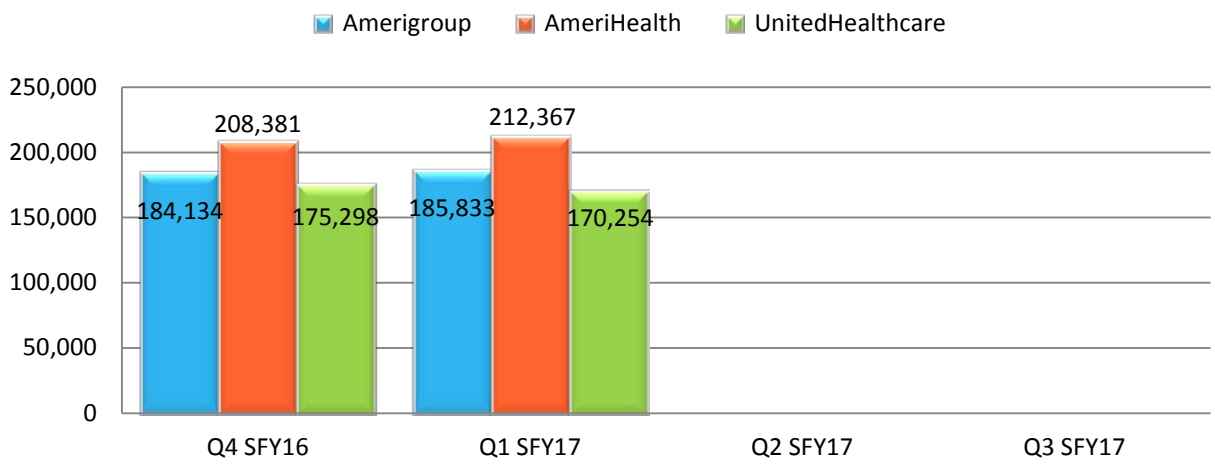
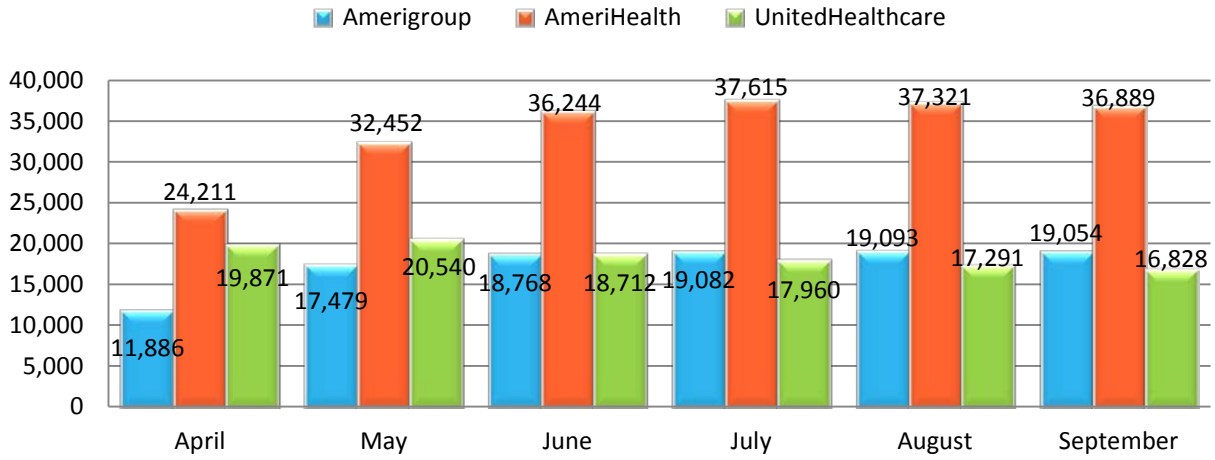
From the time tentative assignments were made in the fall of 2015 until the end of the first quarter, more than 145,000 members, including ***hawk-i*** members, self-selected an MCO.

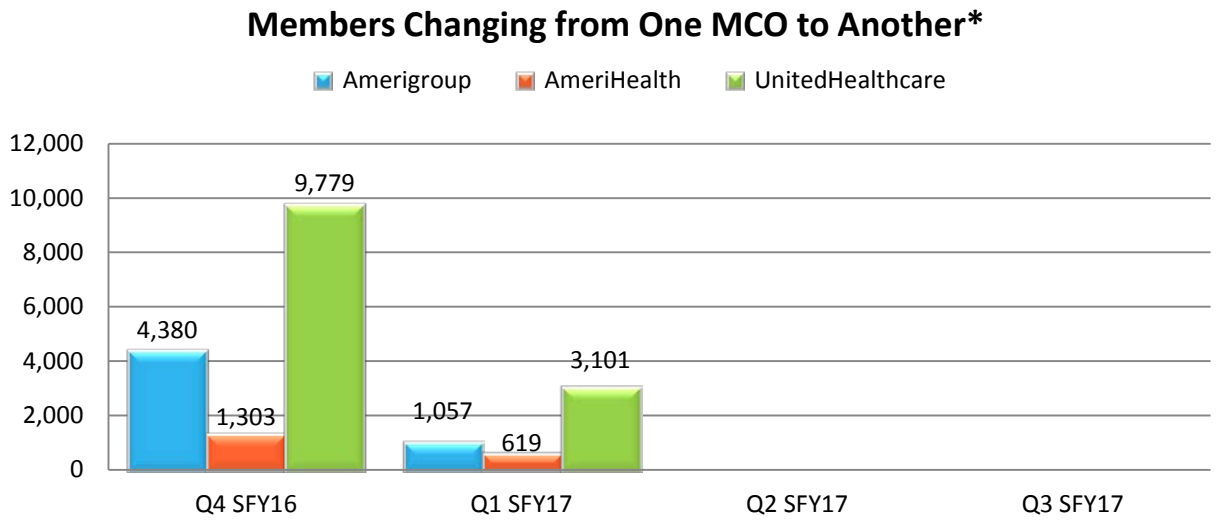
MCO Plan Enrollment Distribution



Members Actively Choosing MCO Plan*



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



*Q1 SFY17 enrollment data as of October 10, 2016 – 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 Q1 SFY17

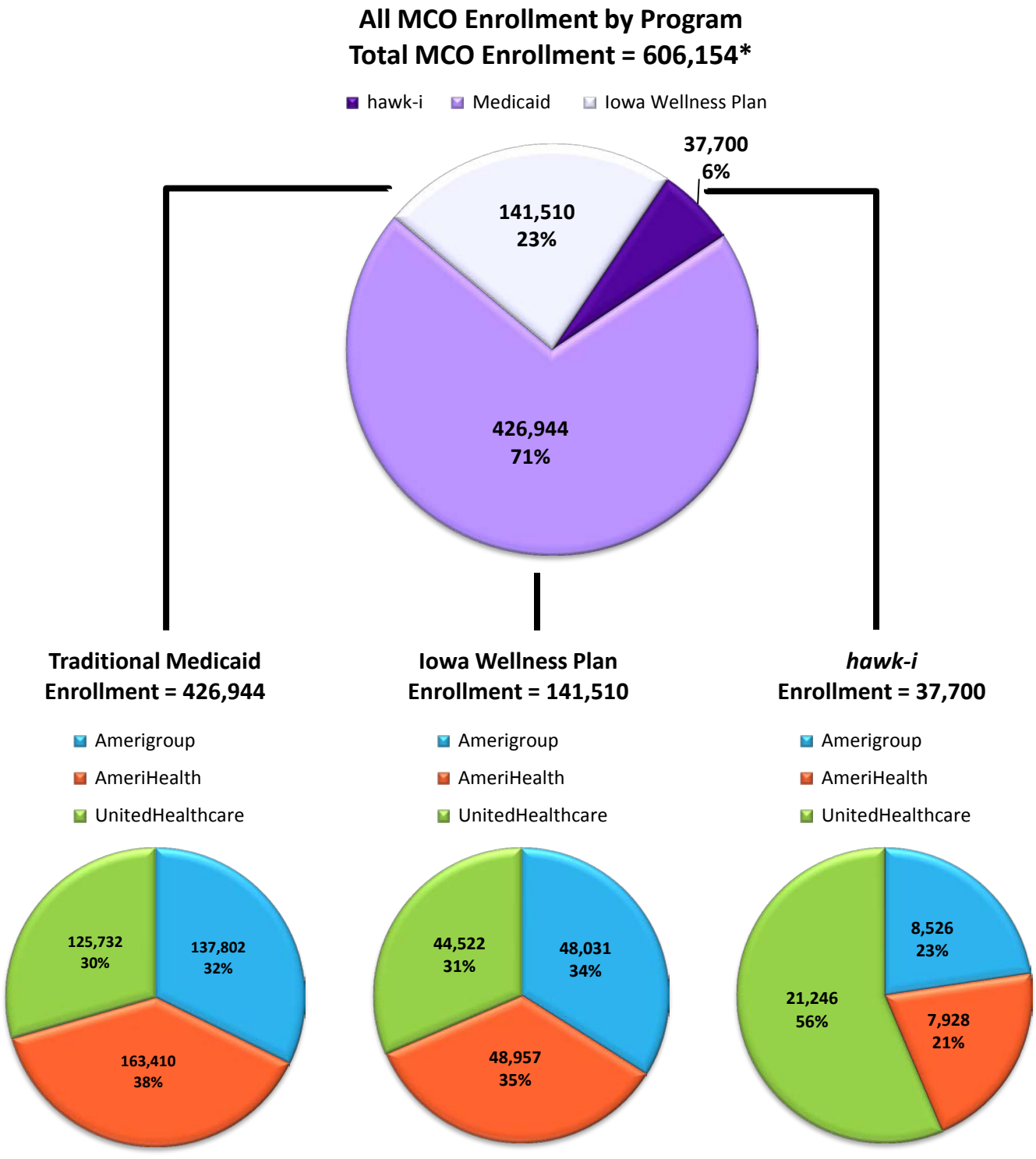
Members can disenroll for good cause any time during the year after their 90 day choice period if certain criteria are met such as:

- 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.

Summary Reason	Count
Established provider in another MCO network	3849
Continuity of care	257
Other	25
Member needed related services to be performed at the same time that were not available in MCO's provider network unnecessary risk	4
MCO did not, because of moral or religious objections, cover the service the member seeks	3

***Due to the 90 day choice period, disenrollment for "good cause" was not captured for Q4SFY16.**

PLAN ENROLLMENT BY PROGRAM



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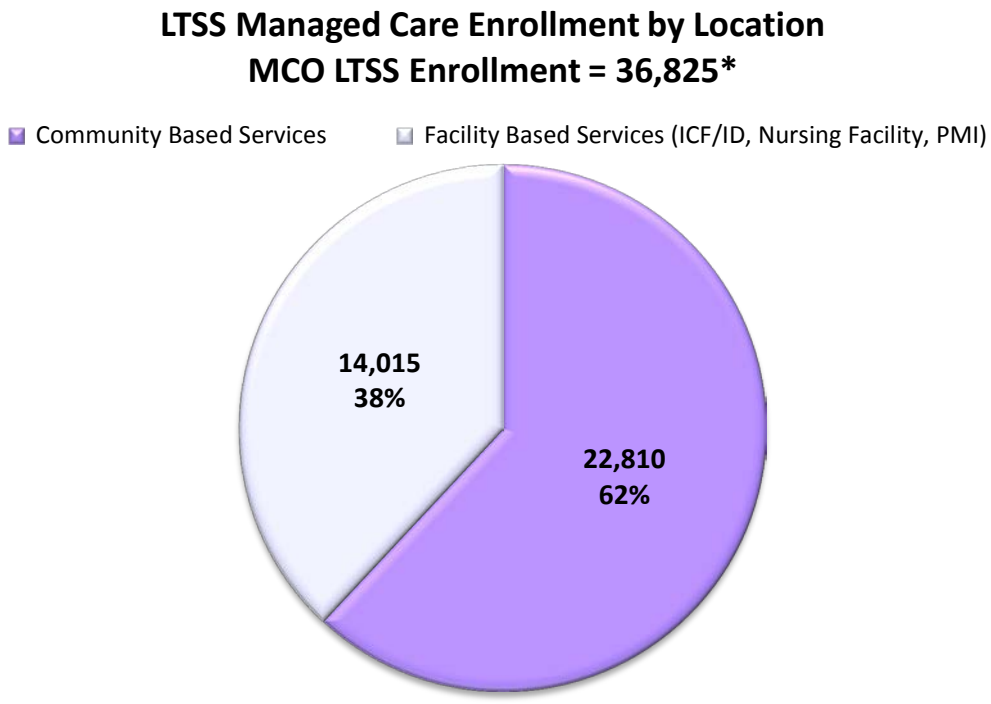
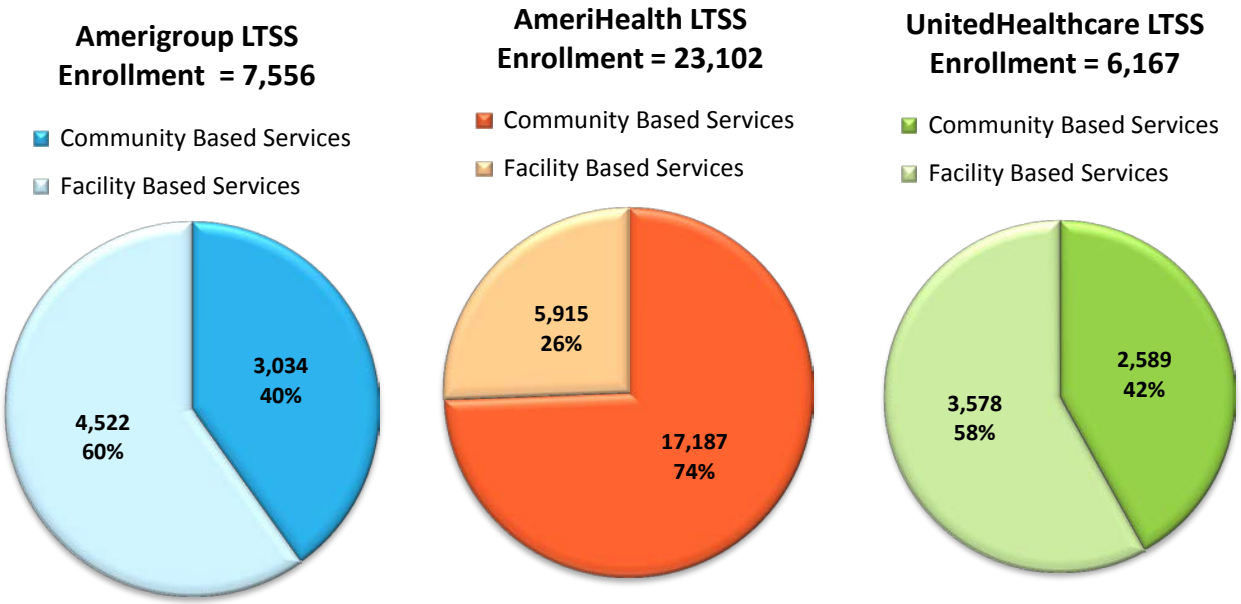


Total MCO LTSS Enrollment by Plan



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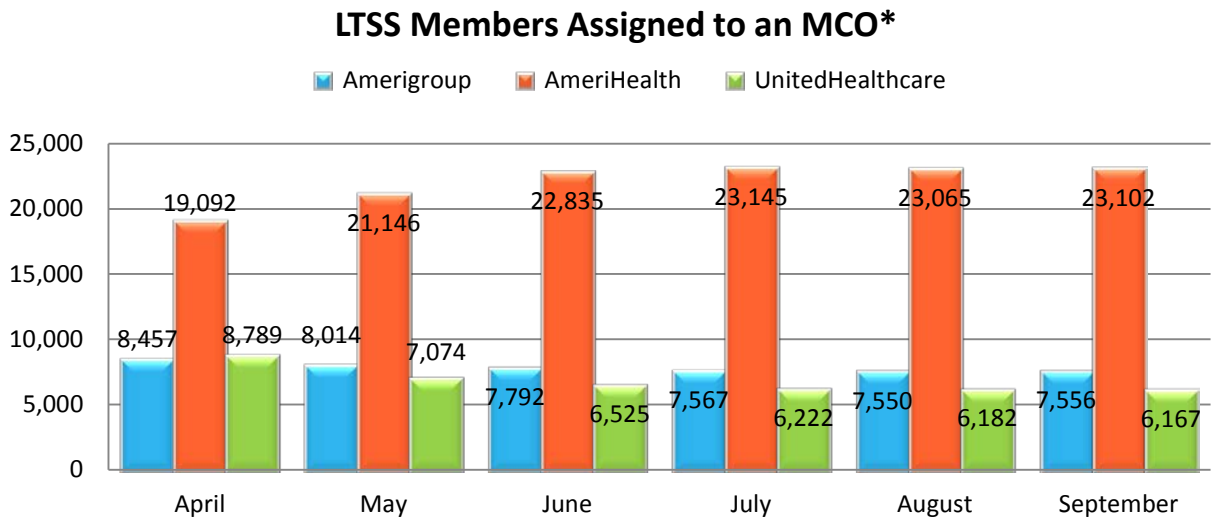
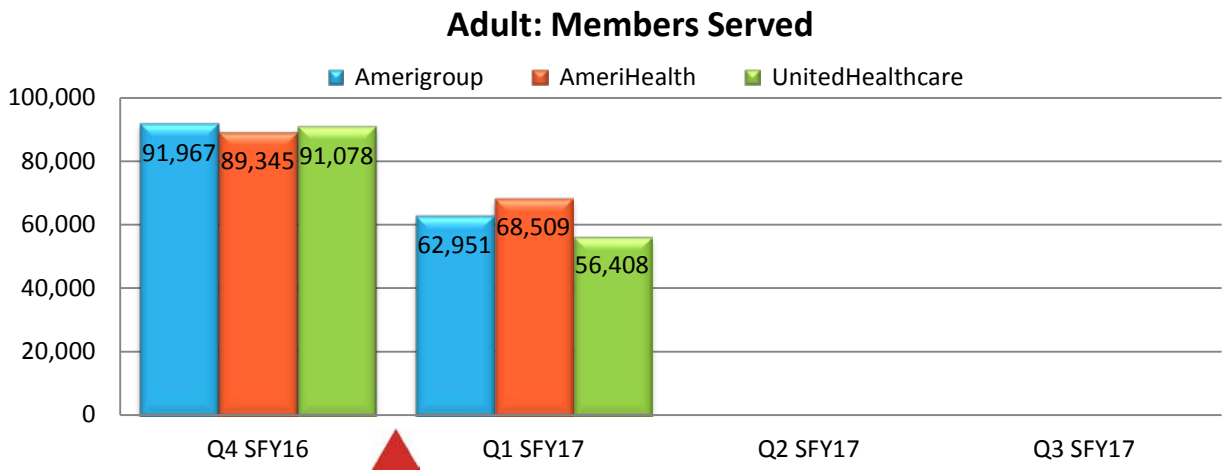


*Based on data reported in each of the monthly reports.

Adult General Population Reporting

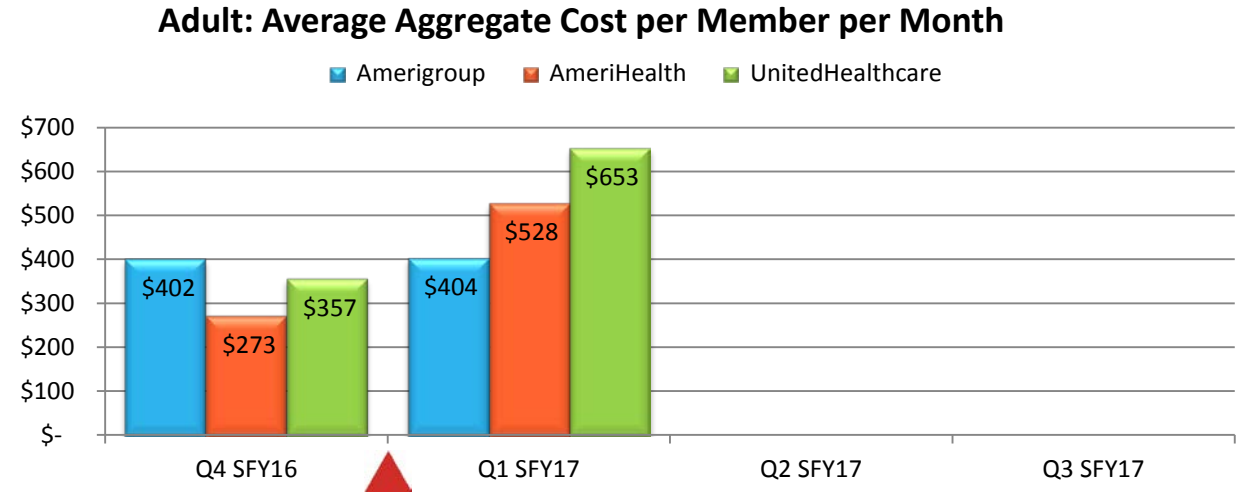
Adults included in this report are members between the ages of 18 and 64 as determined at the beginning of the quarter, who require basic health care services and do not have needs that require long term services and supports or behavioral health services. These members are low income and also include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

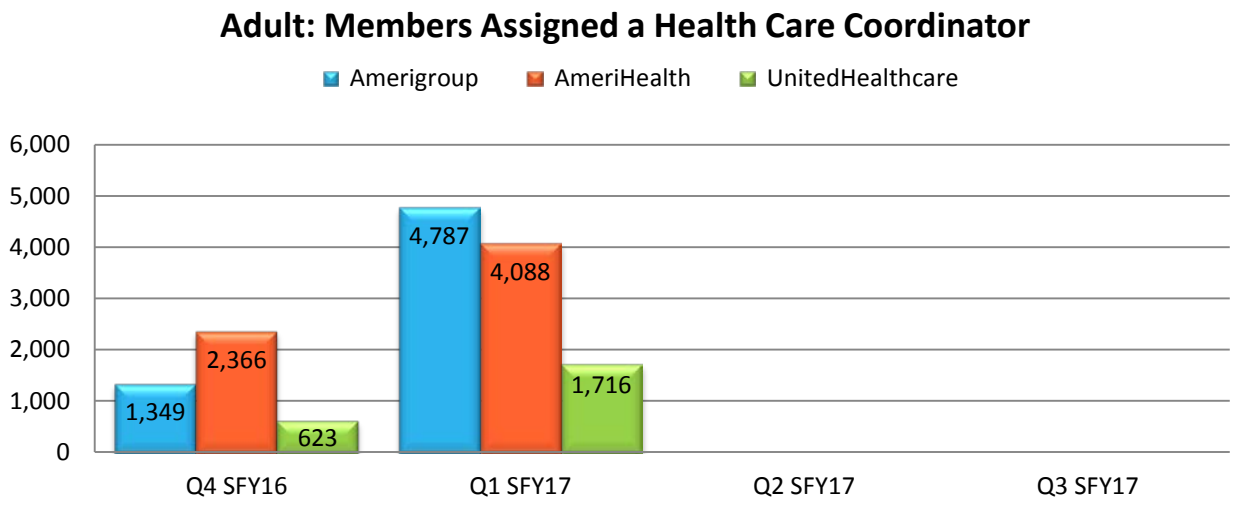
▲ Differences between quarters:

- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.



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.

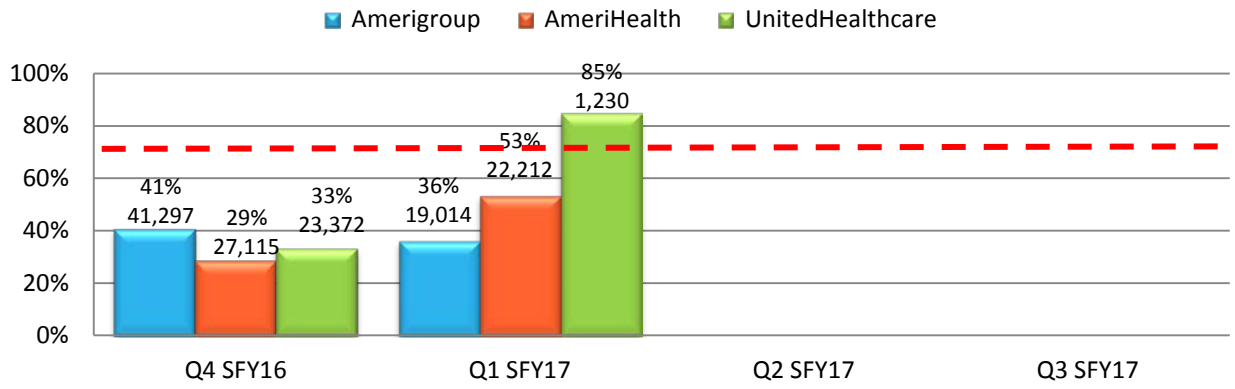
- Differences between quarters:
  - Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
  - Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.



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.

Adult: Percentage and Number of Members Receiving Initial Health Risk Assessments Completed Timely



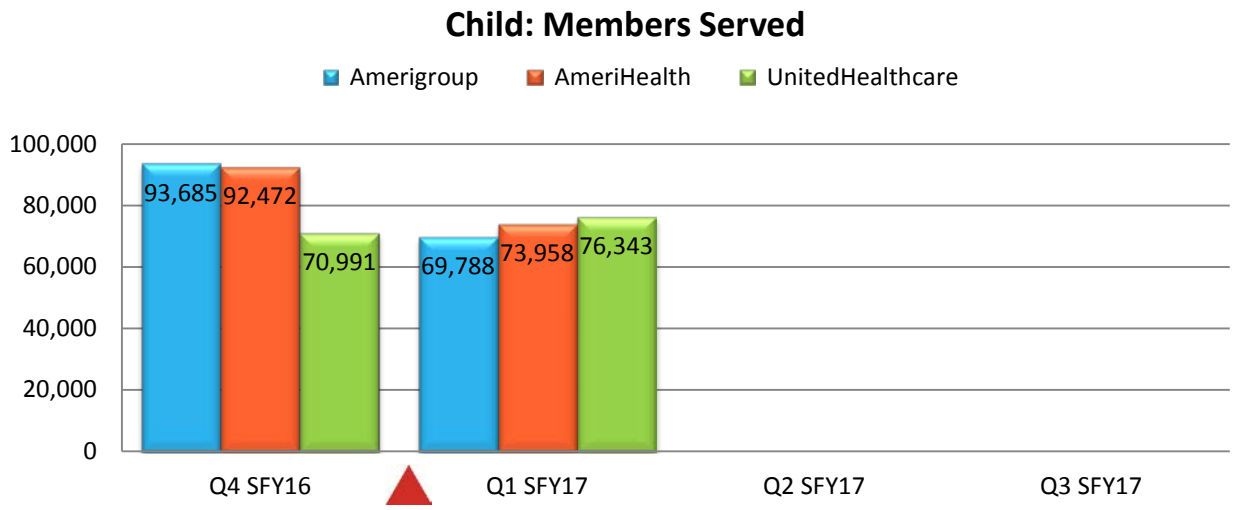
At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days and the MCO has been able to reach within three attempts. The Department has issued remedies for this performance metric and continues to monitor the MCO work 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.

▲ Differences between quarters:

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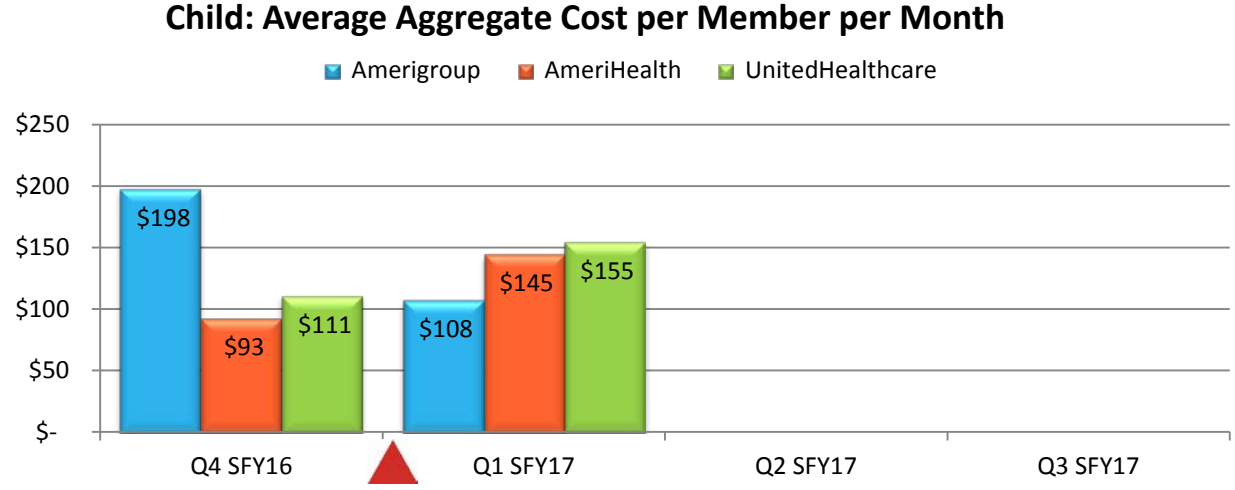

The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to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

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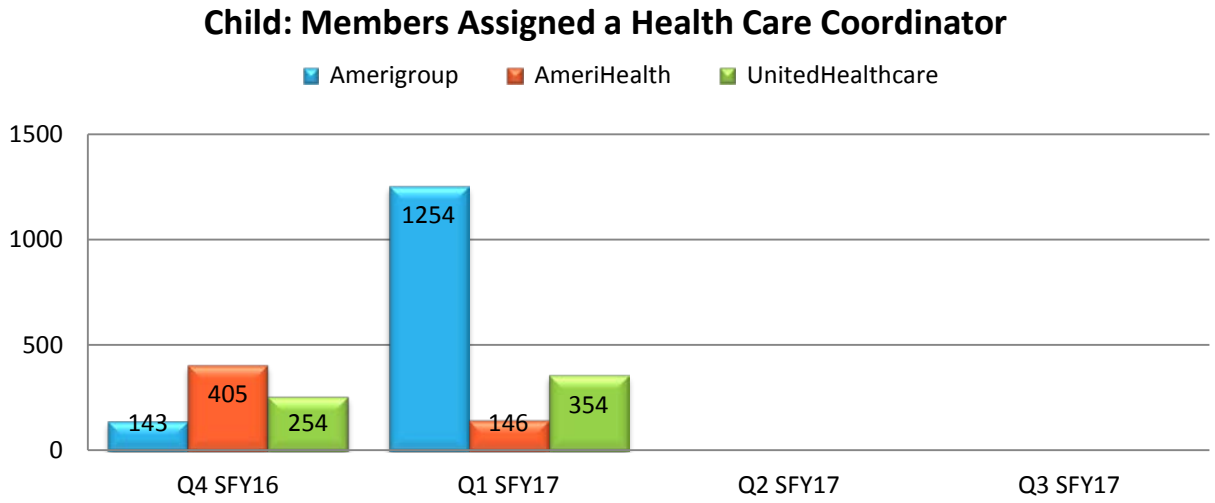
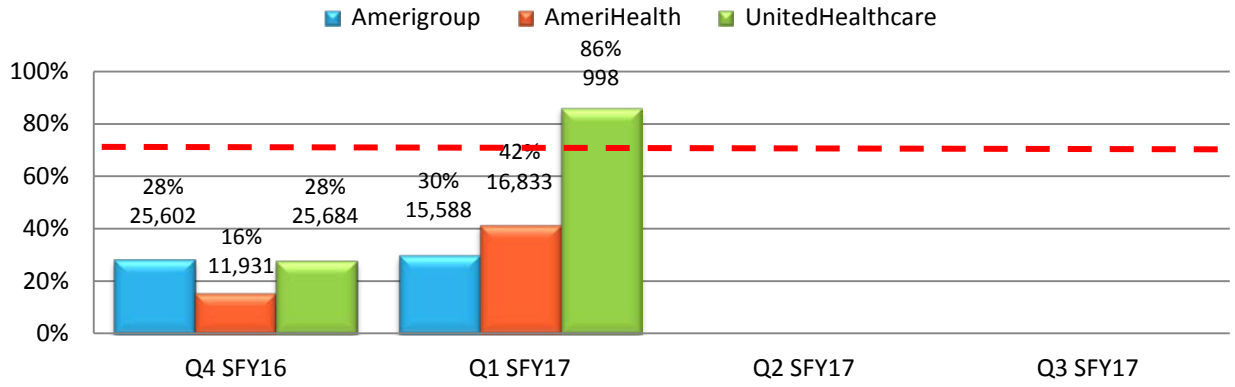


Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. This is a new and more comprehensive health care coordination 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 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.

Child: Percentage and Number of Members Receiving Initial Health Risk Assessments Completed Timely



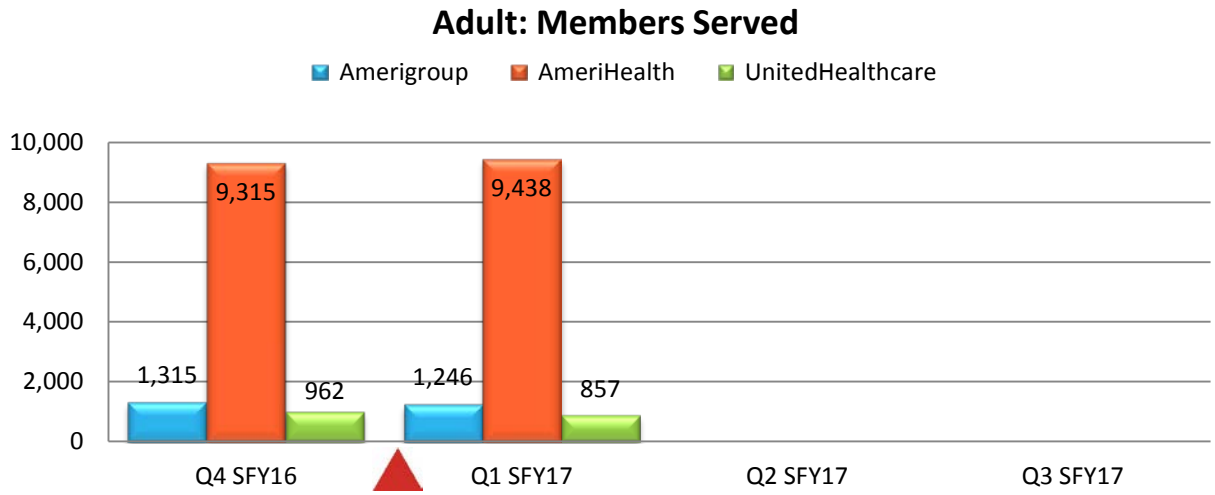
At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least 90 days and the MCO has been able to reach within three attempts. The Department has issued remedies for this performance metric and continues to monitor the MCO work towards 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 beginning of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. At this time only home- and community-based members are included in this Population Reporting. In the future the report will include facility-based members as well.



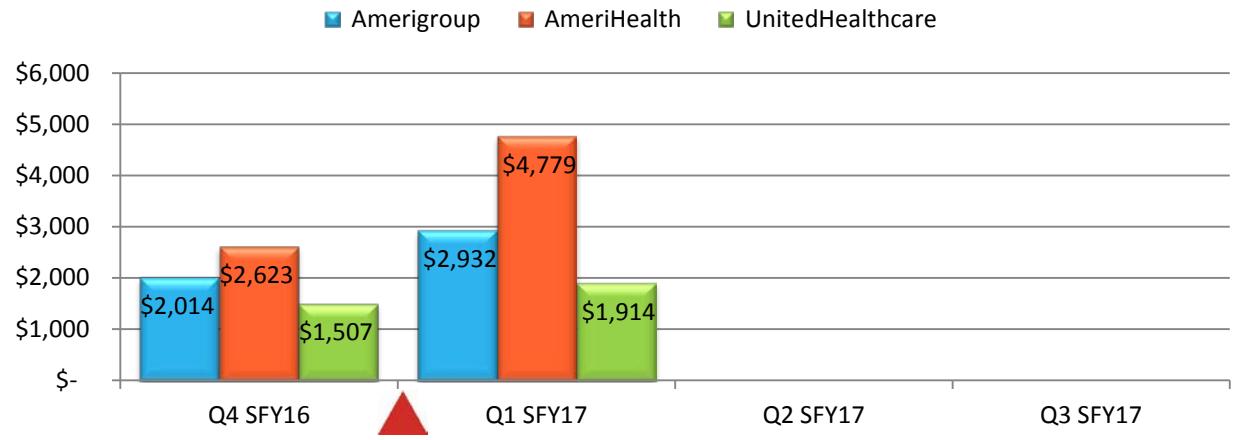
Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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.

▲ Differences between quarters:

- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

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.

- Differences between quarters:
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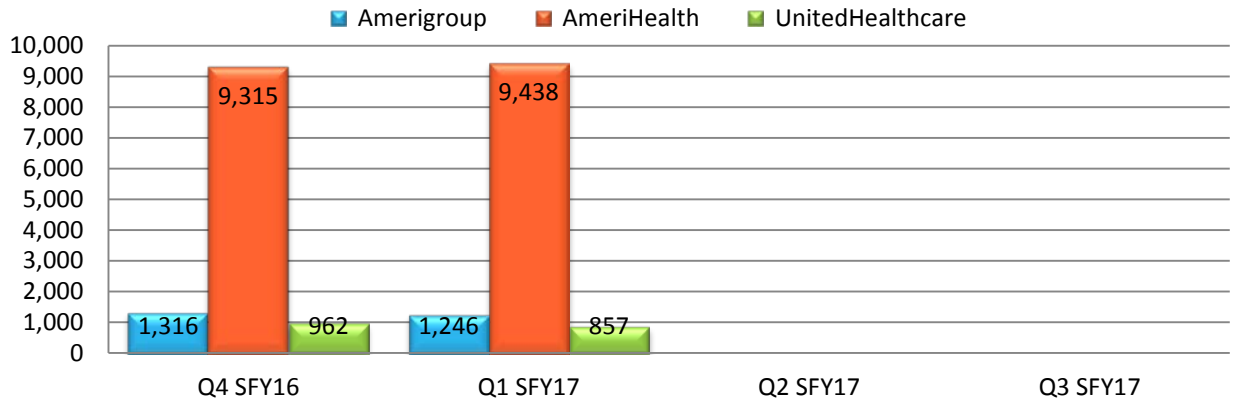
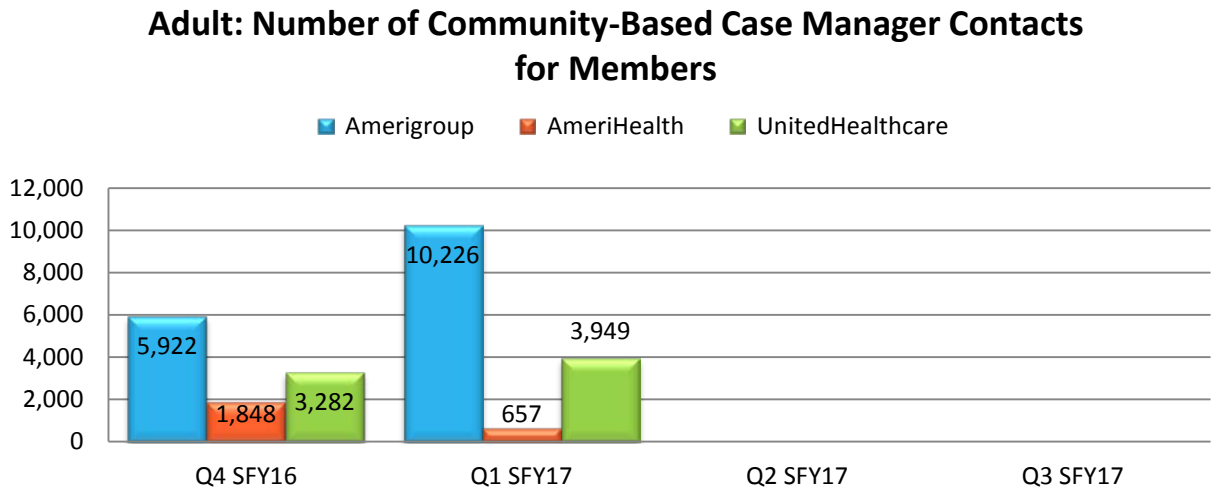
  - Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

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.



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.

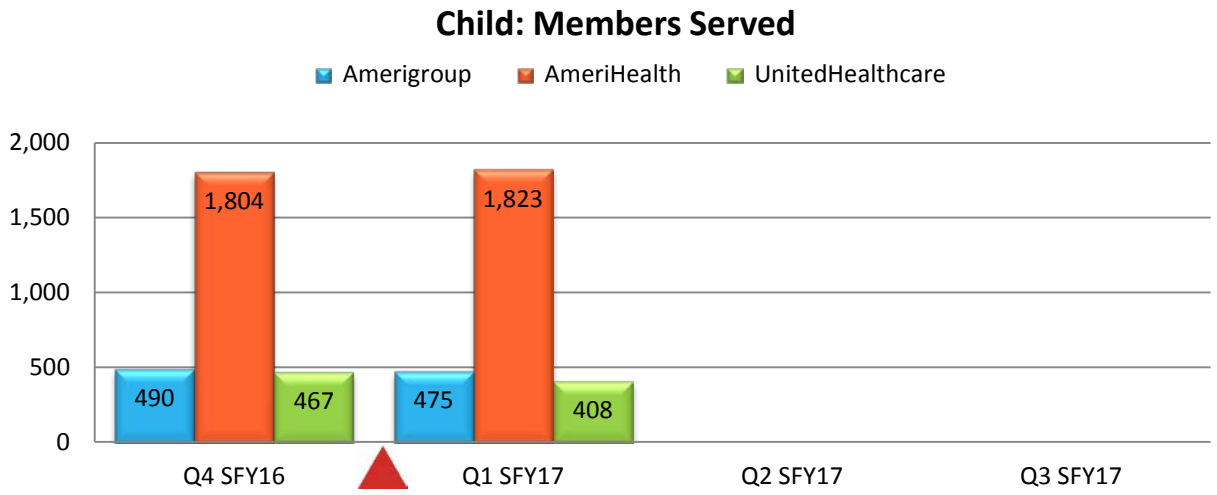
The Department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community-based case manager function. At this time, the Department believes that adequate contacts are being made but that systems are not set up to capture and report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

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 Q1 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Ratio of Member to Case Manager - Brain Injury	2.1	2.7	2.0
Ratio of Member to Case Manager - Health and Disability	6.0	2.8	3.0
Ratio of Member to Case Manager - HIV/AIDS	1.0	1.0	1.0
Ratio of Member to Case Manager - Intellectual Disability	10.9	15.5	6.0
Ratio of Member to Case Manager - Physical Disability	3.8	2.1	2.0

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 beginning of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. At this time only home- and community-based members are included in this Population Reporting. In the future the report will include facility-based members as well.



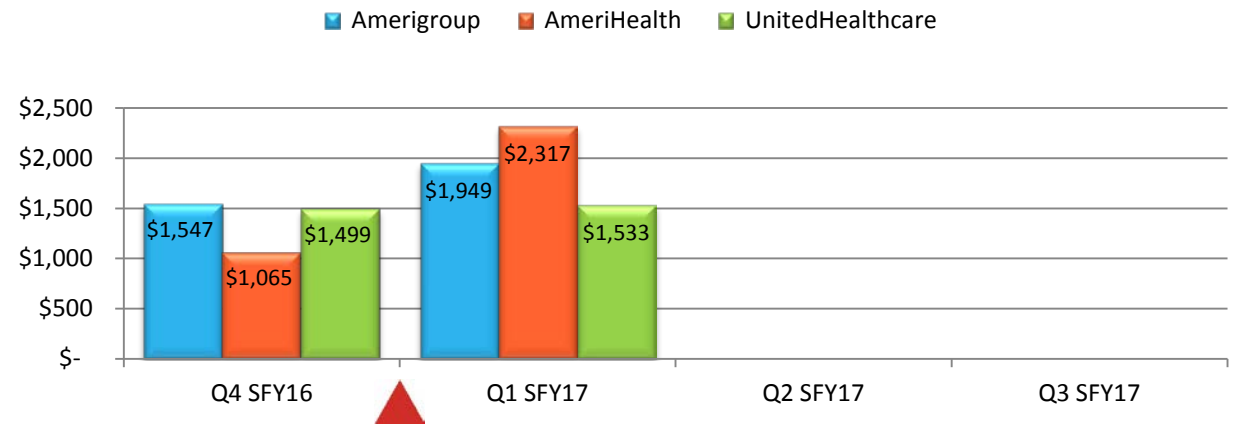
Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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.

▲ Differences between quarters:

- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

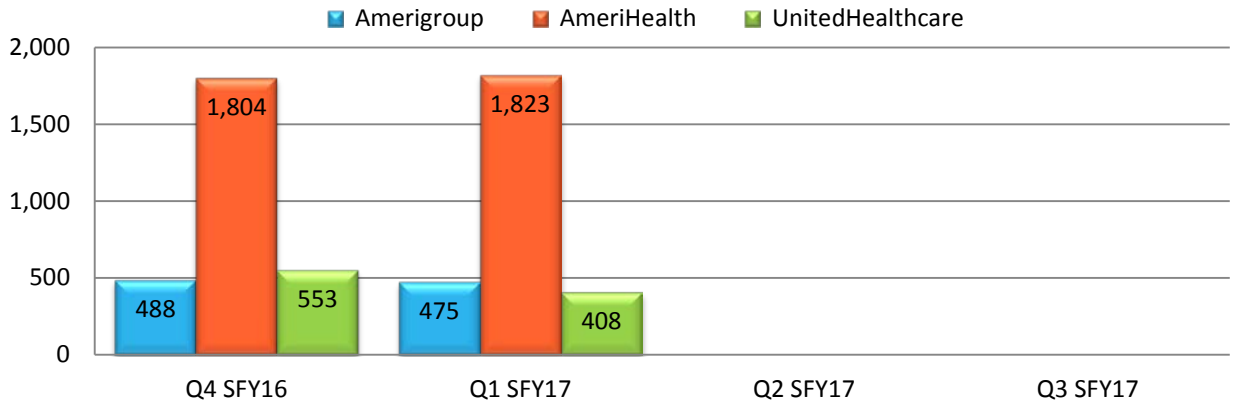
Child: Average Aggregate Cost per Member per Month



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.

- Differences between quarters:
  - Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
  - Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

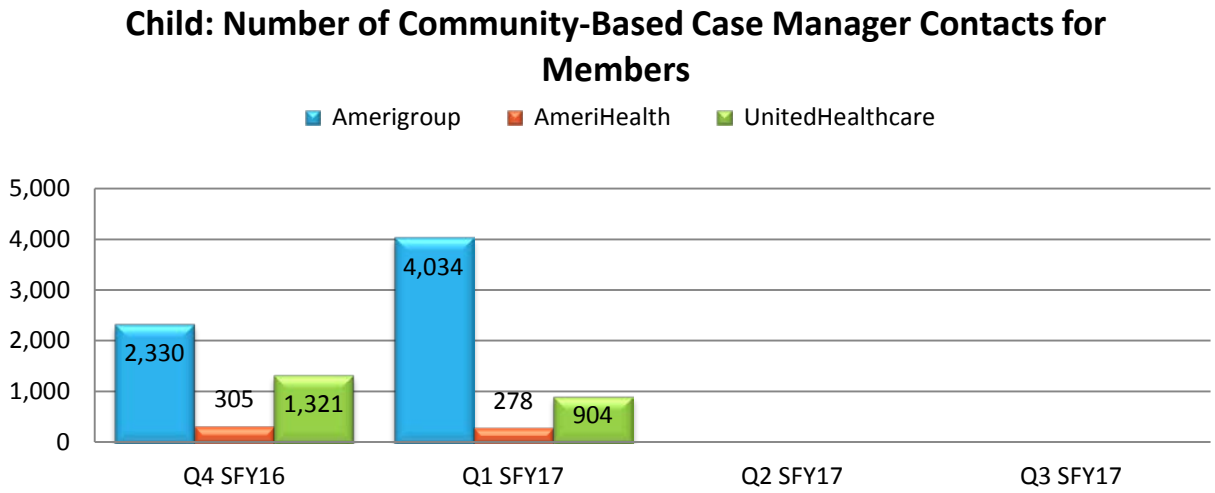
Child: Members Assigned a Community-Based Case Manager



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.

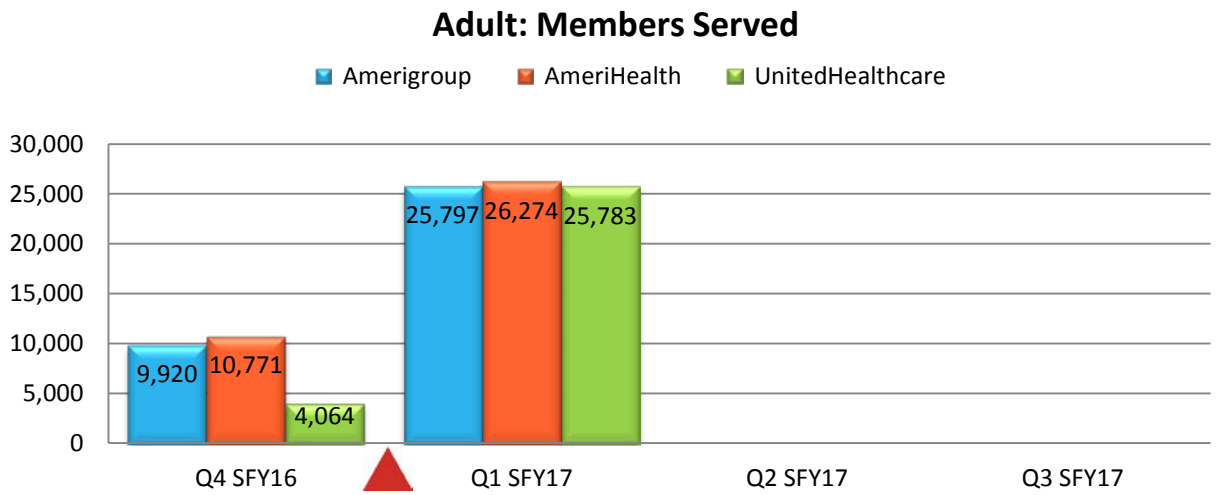


Members who receive Home- and Community-Based Waiver services must have a community-based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent.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

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.

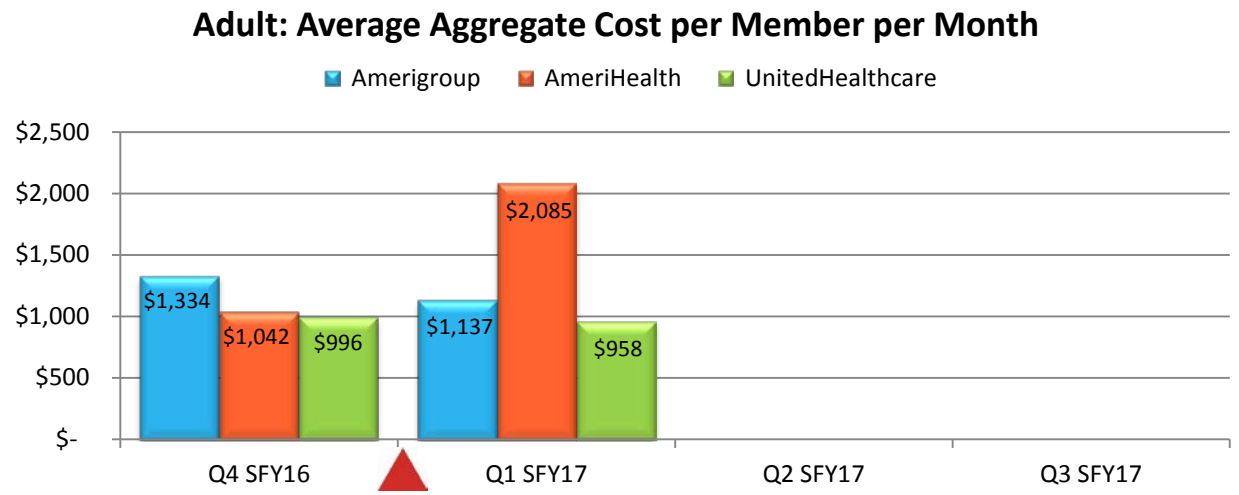


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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.

▲ Differences between quarters:

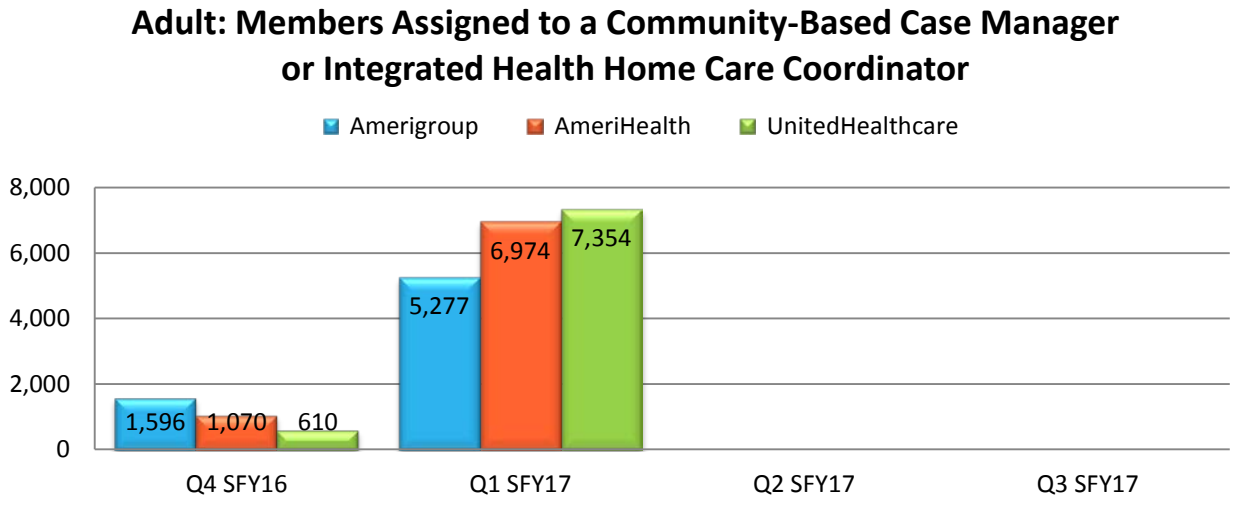
- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The Department also standardized how to identify these members for reporting which accounts for the increase.



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.

▲ Differences between quarters:

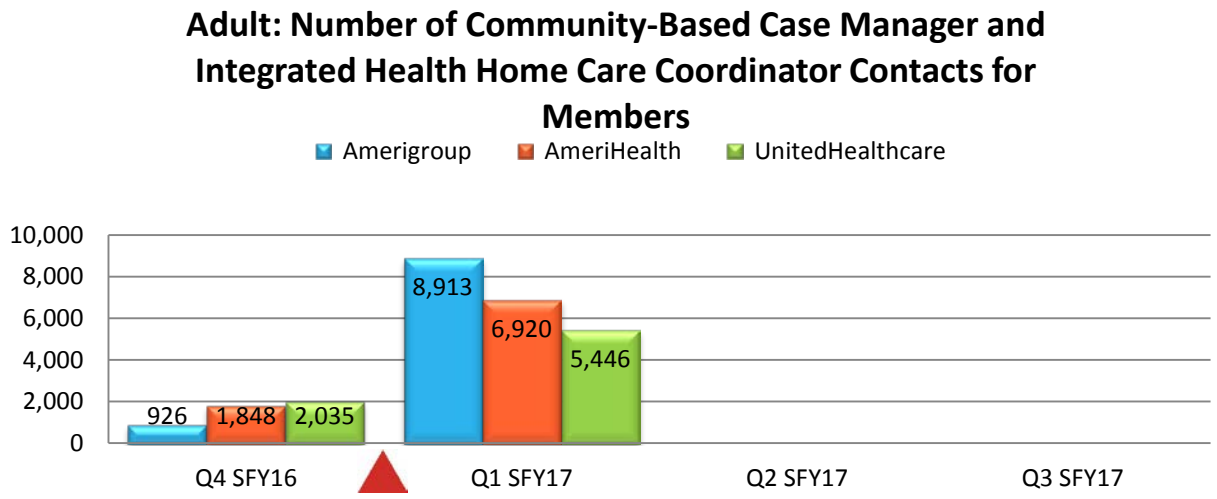
- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The Department also standardized how to identify these members for reporting which accounts for some variance.



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.



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.

▲ The increase in number of the Integrated Health Home and community based case manager contacts for members between Q4 SFY16 and Q1 SFY17 is likely due to a standardization regarding how to classify behavioral health diagnoses for reporting purposes. 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.

Integrated Health Home Ratios

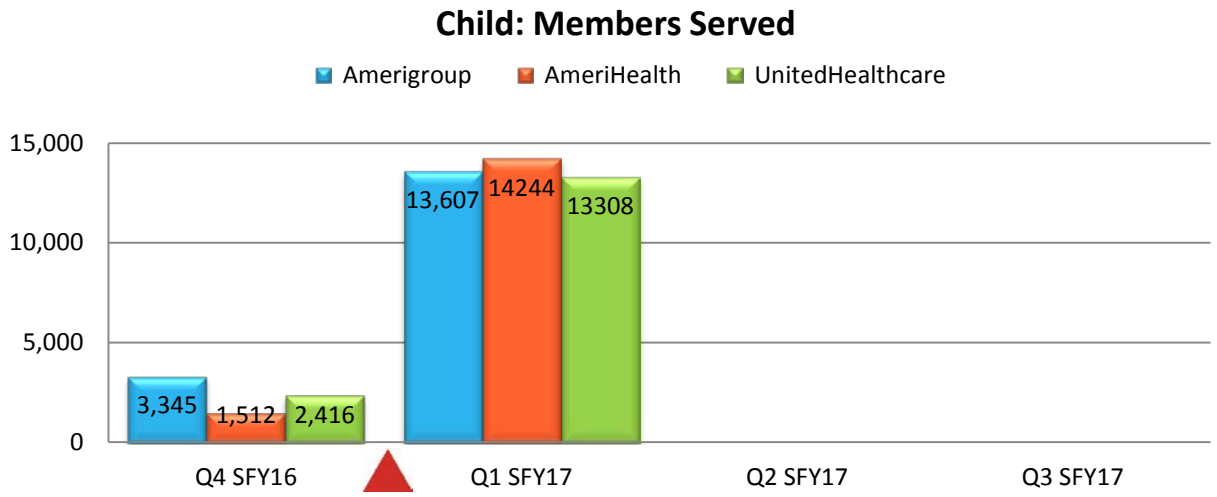
The Department collects member to community-based case manager and integrated Health Home Care Coordinator ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate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

Data Reported as of End of Q1 SFY17	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.

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.



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

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.

▲ Differences between quarters:

- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
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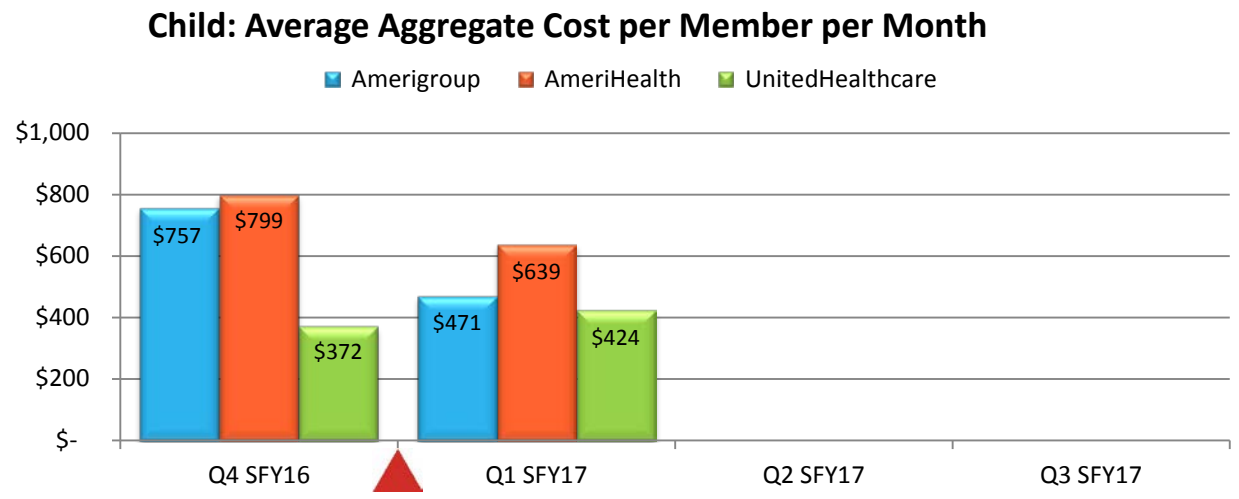

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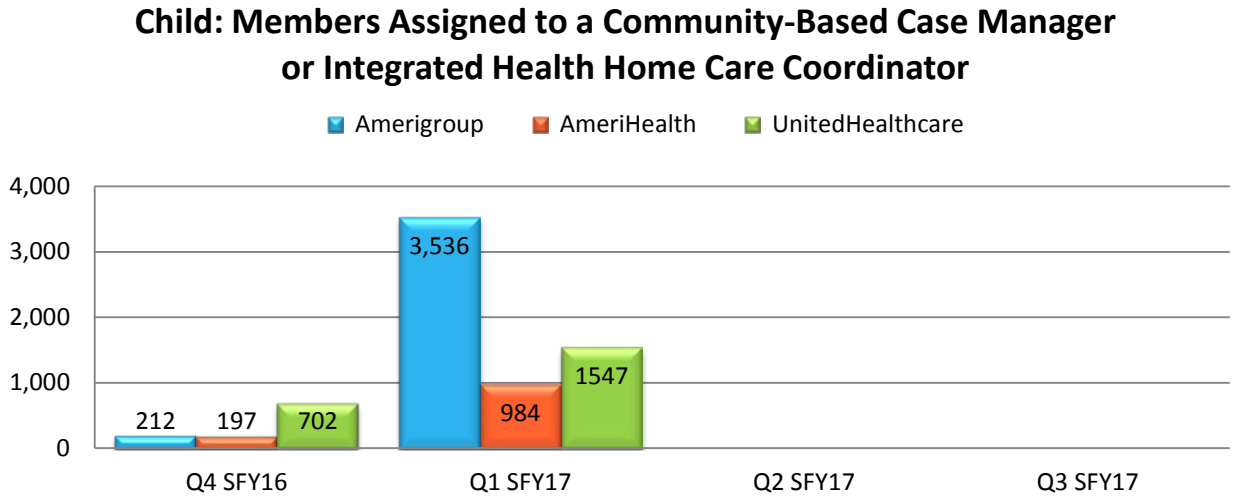
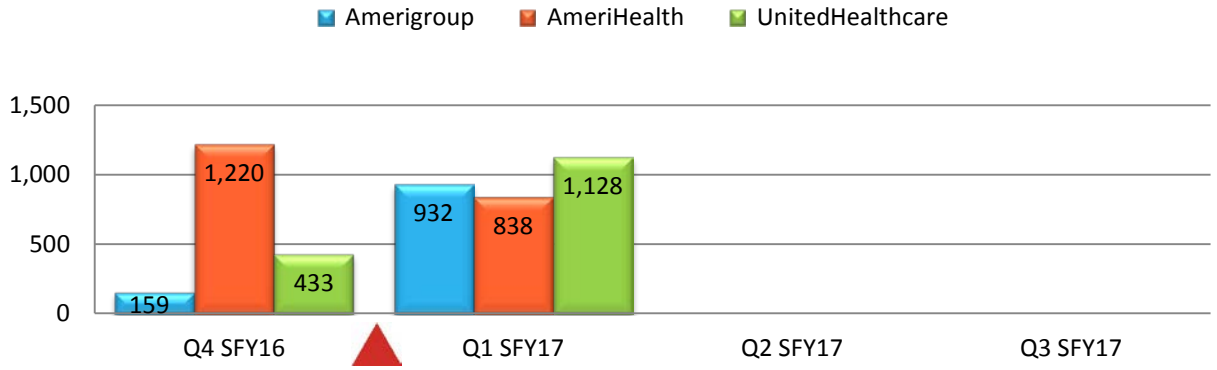


While the Department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

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



A small percentage of the members in this population receive Children's Mental Health wavier 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 Children's Mental Health wavier services is not required to have as frequent contact.

▲ The increase in number of the Integrated Health Home and community based case manager contacts for members between Q4 SFY16 and Q1 SFY17 is likely due to a standardization regarding how to classify behavioral health diagnoses for reporting purposes. 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

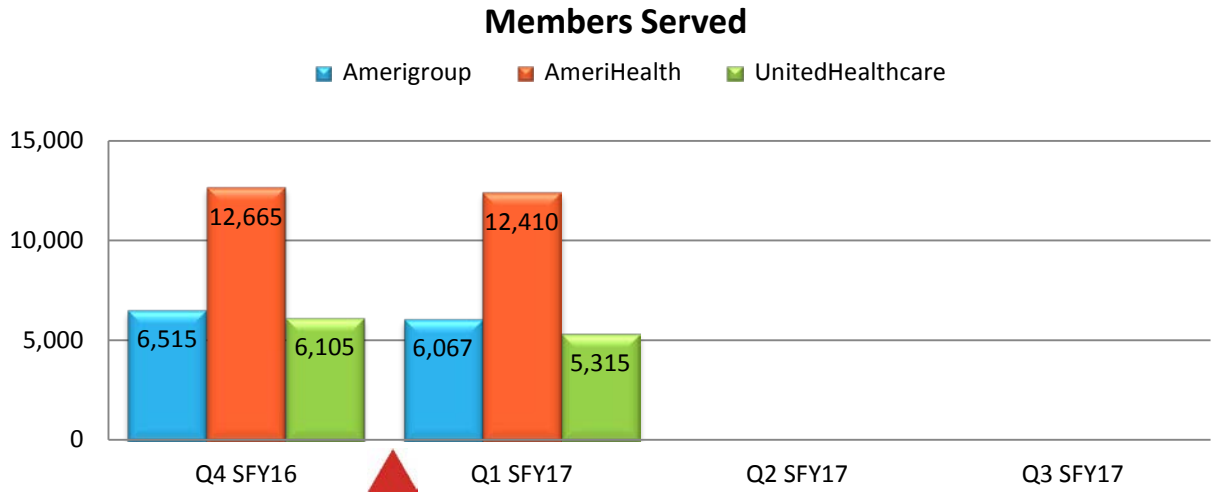
adequate contacts are being made but that systems are not set up to capture and report this information.

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 End of Q1 SFY17	**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.

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.



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

▲ Differences between quarters:

- Q4 SFY16 represents numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
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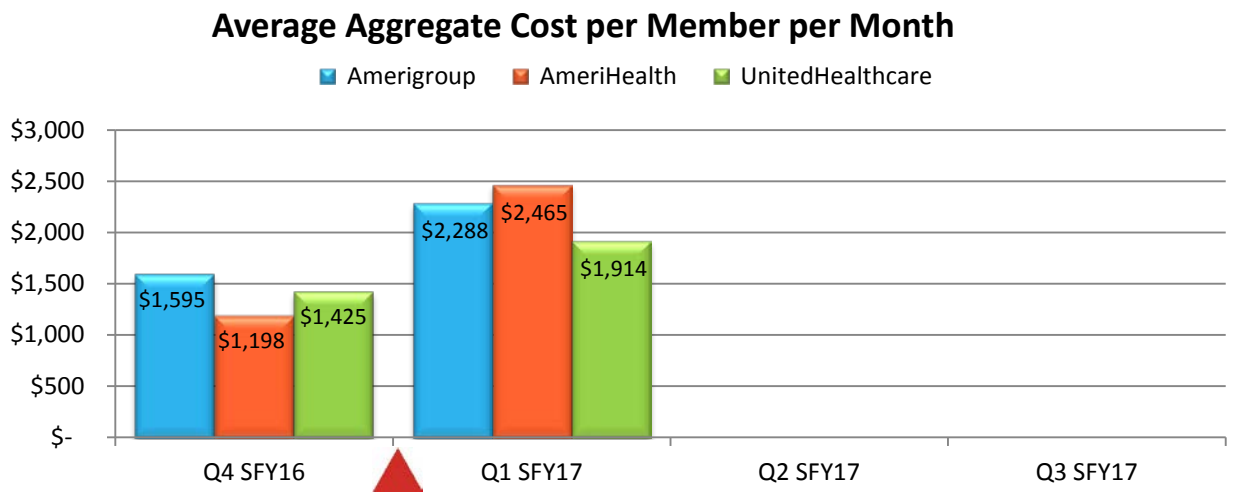

The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to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

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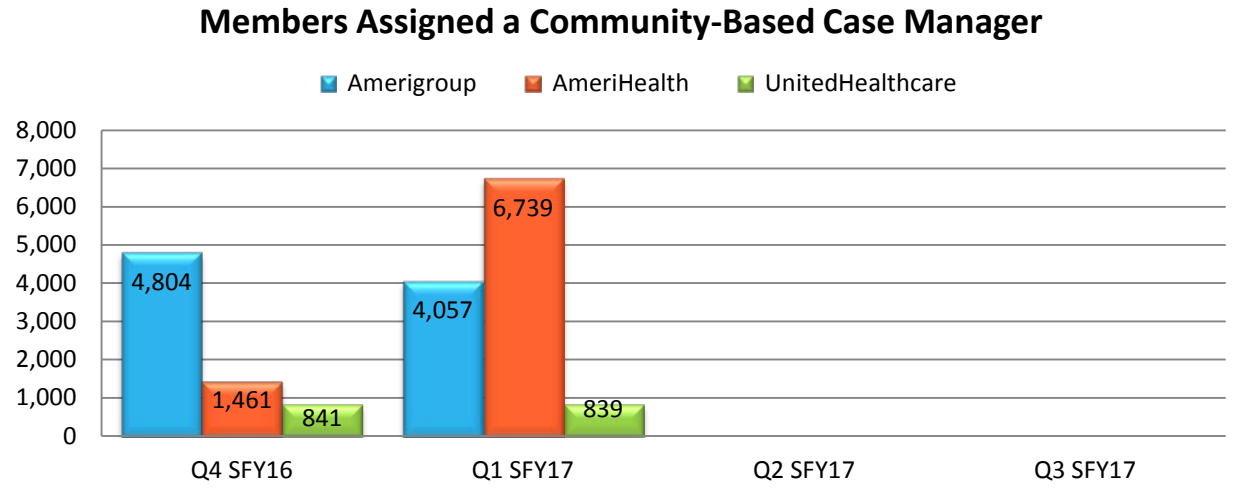
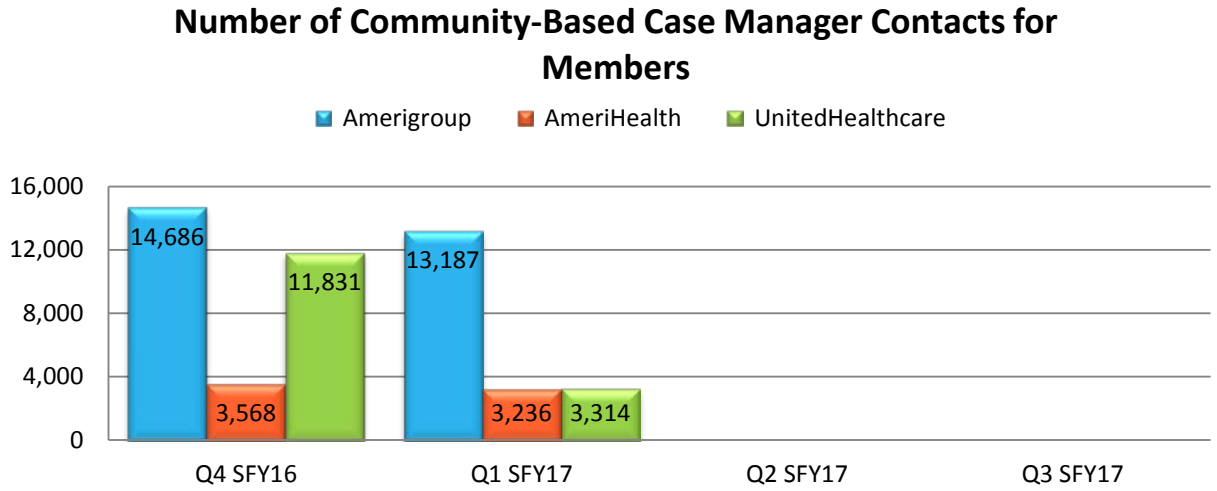


While the Department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

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.



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.

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 End of Q1 SFY17	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	9.3	17.8	6.0

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.

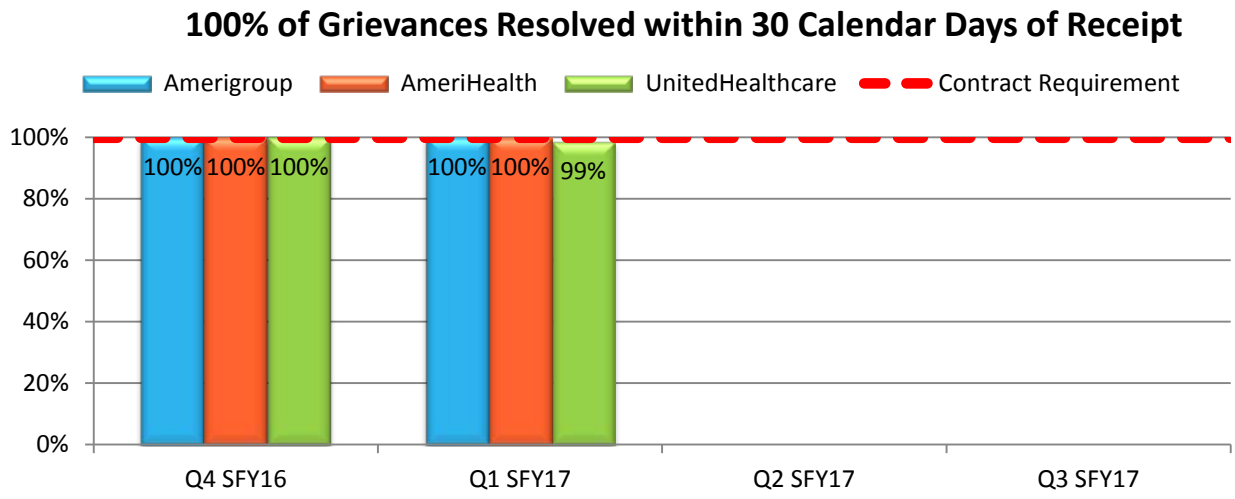
MCO Member Grievances and Appeals

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.



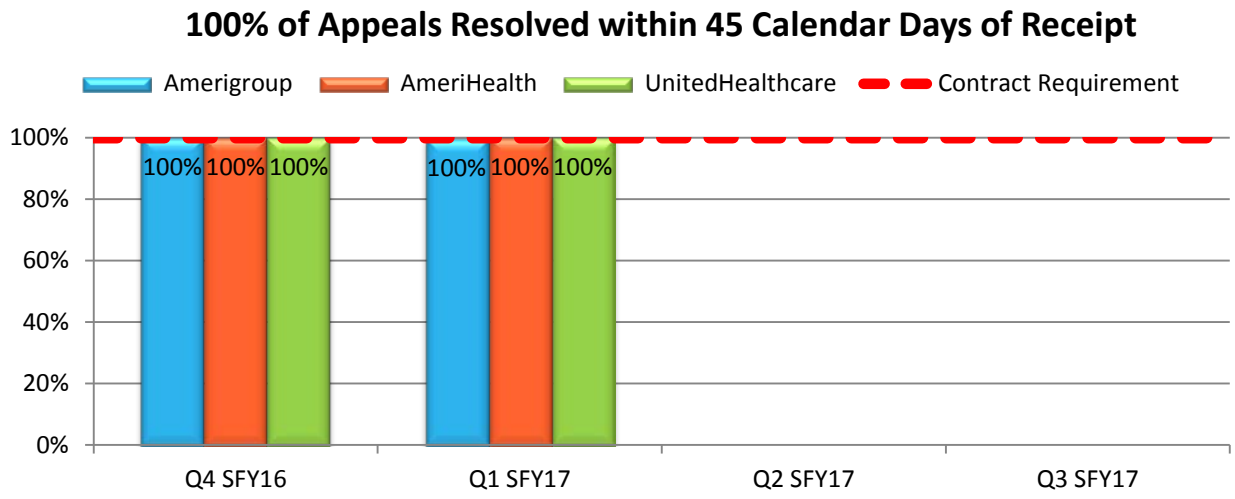
This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. If a member is not resolved with a MCO resolution to their grievance, the member may contact the Iowa Medicaid Enrollment Broker to disenroll if "good cause" 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 Q4 SFY16	145	42	40
Grievances Received in Q1 SFY17	224	133	79

Top Five Reasons for Grievances for Q1 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	79	Provider Issue - Excessive Waiting	17	Transportation - Billing	34
2	Voluntary Disenrollment Request	52	Transportation – No Pick Up	15	Provider Issue- Balance Billing	25
3	Provider Issue- Balance Billing	15	Provider Issue – Not Happy with Service	12	Transportation - Ambulance	4
4	MCO Staff - Attitude/Rudeness	12	Benefits	10	Provider Issue – Not Happy with Service	3
5	Provider Issue – Attitude/Rudeness	11	Did Not Receive ID Card	9	Provider Issue - Excessive Waiting	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 Q4 SFY16	14	52	50
Appeals Received in Q1 SFY17	370	216	100

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 Q1 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Appeals	Count	Appeals	Count	Appeals	Count
1	Pharmacy - Non Injectable	138	Pharmacy	143	Pharmacy - Authorization	88
2	Behavioral Health – Authorization for Inpatient	55	Level of Care	20	Medical – Utilization Review Dispute	33
3	Pharmacy - Injectable	36	Medical – Authorization for Durable Medical Equipment	18	Pharmacy – Covered Services	30
4	Medical – Authorization for Radiology	29	Medical – Authorization for Radiology	8	Level of Care	10
5	Medical – Authorization for Inpatient	22	Medical - Authorization	6	Medical – Authorization for Durable Medical Equipment	8

State Fair Hearing Summary for Members in Managed Care Year to Date

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Level of Care	0	0	0
Medical Service Denial/Reduction	31	30	48
Pharmacy Denial/Reduction	85	10	16
Durable Medical Equipment Denial/Reduction	4	2	5

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 due to resolution of the issue prior to hearing.

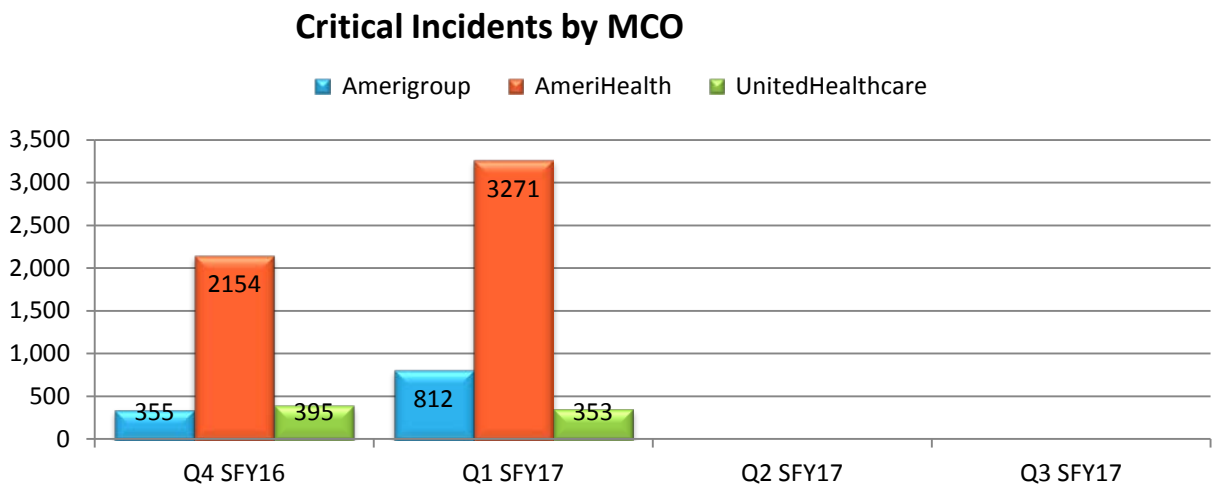
Critical Incidents

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
- Reported child or dependent abuse

Data Reported	Amerigroup	AmeriHealth	UnitedHealthcare
HCBS and Habilitation Members as of June 2016	3,110	16,837	2,639
Special Needs Population			
Total Number of Critical Incidents for Q4 SFY16	85	1,093	105
# Members Involved (unduplicated)	36	774	84
Behavioral Health Population			
Total Number of Critical Incidents for Q4 SFY16	232	868	252
# Members Involved (unduplicated)	153	476	180
Elderly Population			
Total Number of Critical Incidents for Q4 SFY16	38	193	38
# Members Involved (unduplicated)	38	184	36
Data Reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
HCBS and Habilitation Members as of September 2016	3,034	17,187	2,589
Special Needs Population			
# of Critical Incidents Received for Q1 SFY17	53	1,245	78
# Critical Incidents Received and Resolved for Q1 SFY17	53	1,236	78
% Critical Incidents Resolved for Q1	100%	99.3%	100%

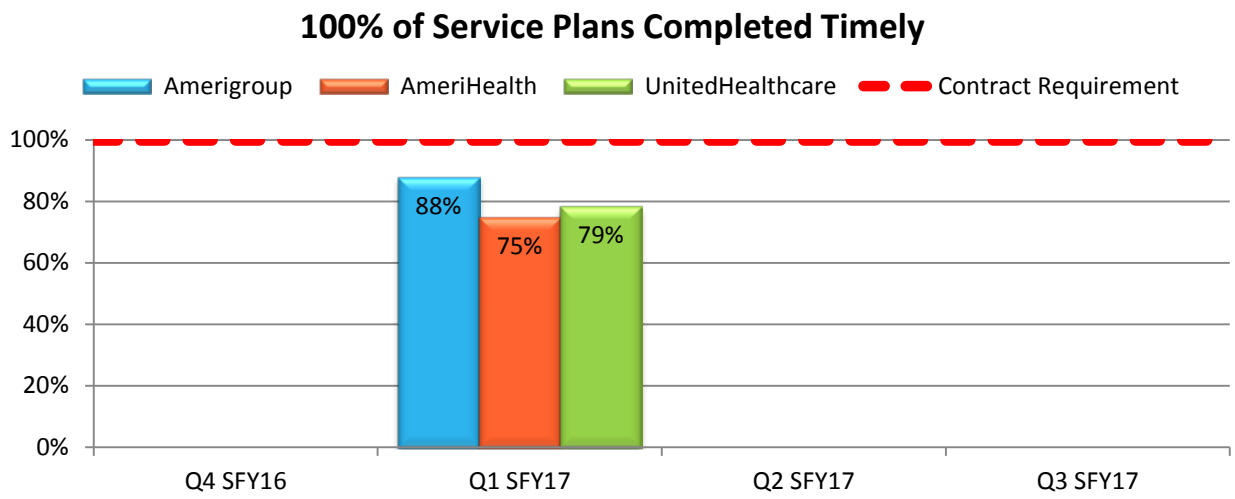
SFY17			
Behavioral Health Population			
# of Critical Incidents Received for Q1 SFY17	675	1,687	252
# Critical Incidents Received and Resolved for Q1 SFY17	675	1,679	252
% Critical Incidents Resolved for Q1 SFY17	100%	99.5%	100%
Elderly Population			
# of Critical Incidents Received for Q1 SFY17	84	339	23
# Critical Incidents Received and Resolved for Q1 SFY17	84	335	23
% Critical Incidents Resolved for Q1 SFY17	100%	98.8%	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.



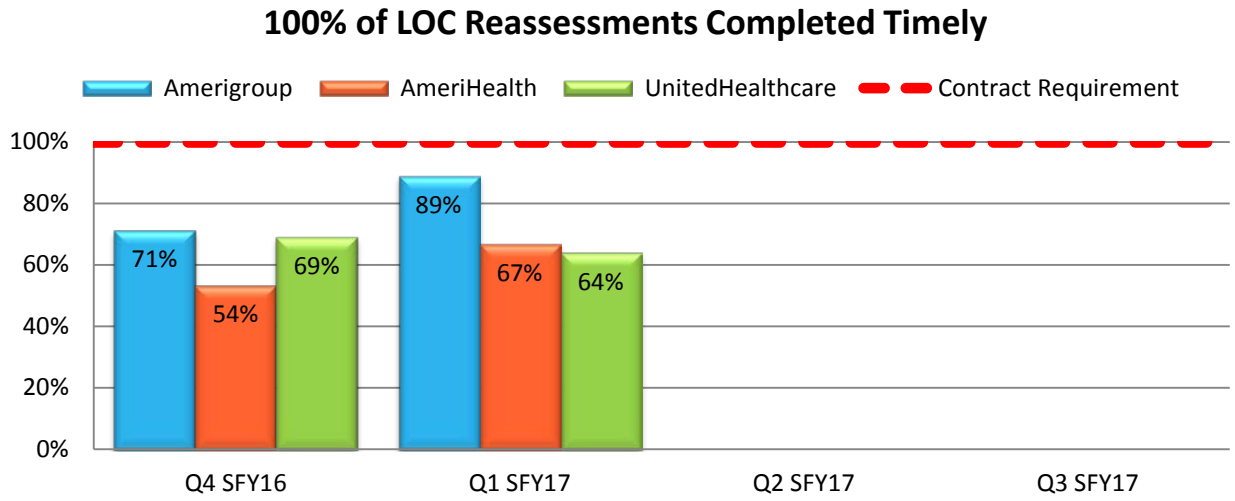
There is no data for Q4 SFY16 due to no service plans being due during that period.

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.

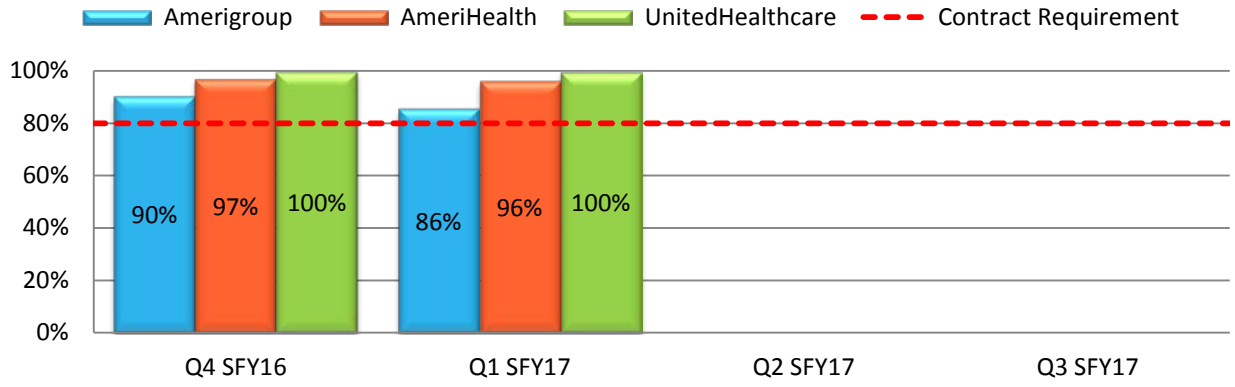


Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

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

Service Level: 80% of Member 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. The CAHPs surveys conducted annually also measure member satisfaction with their health plan.

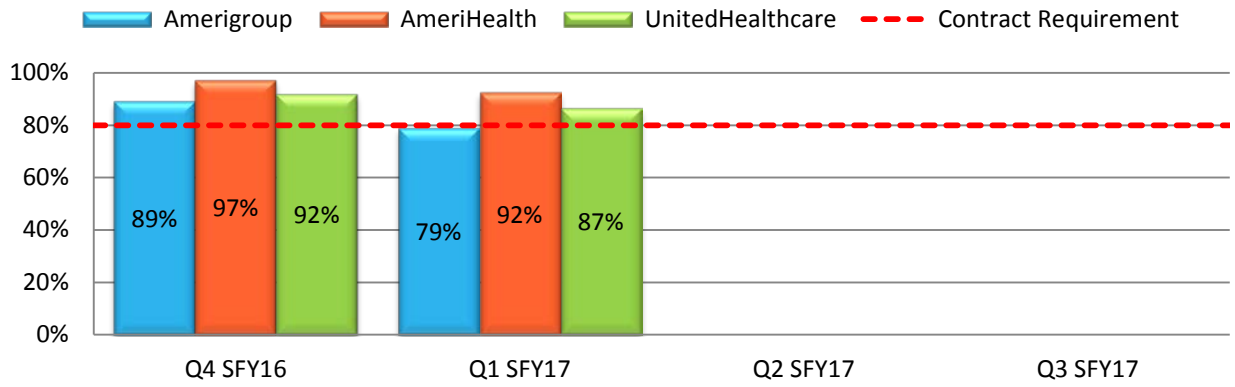
Top Five Reasons for Members Contacting Helplines for Q1 SFY17 (not collected for Q4 SFY16)

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2016						
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
5.	Pharmacy Inquiry	566	Other Programs & Services	3,986	COB Information	1,144
August 2016						
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	7,067	ID Cards	1,669

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			Request			
5.	Claim/Billing Issue	584	Other Programs & Services	4,224	COB Information	1,251
September 2016						
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

Provider Helpline

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



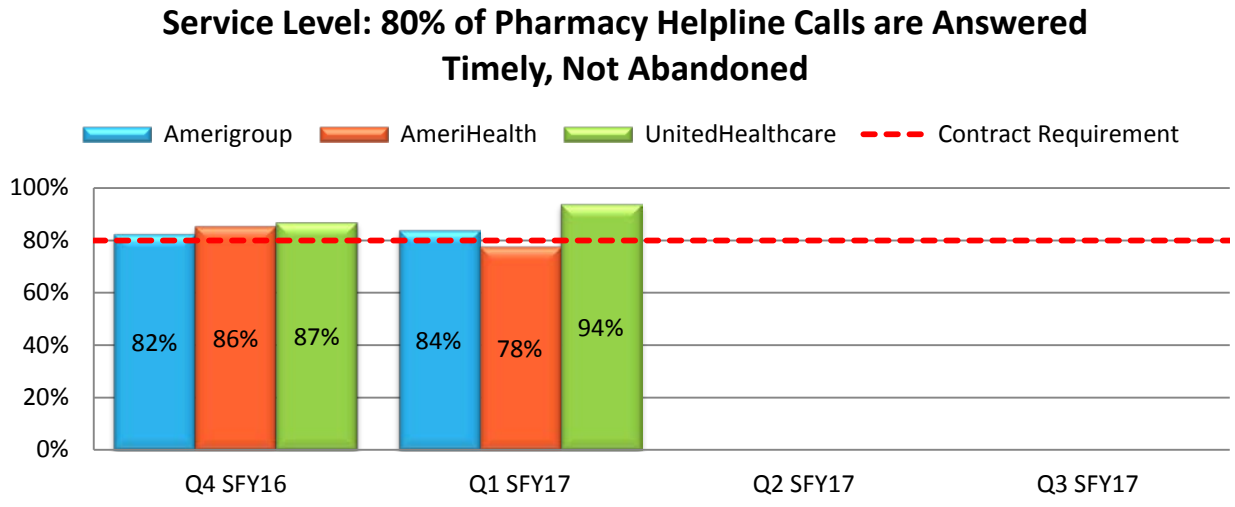
This performance target measures the timeliness of answering the helpline calls. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the Department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines.

Top Five Reasons for Providers Contacting Helplines for Q1 SFY17 (not collected for Q4 SFY16)

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2016						
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	1,378	Claims	7,070	COB Information	1,146

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
	Department Call Inquiry					
4.	Benefits Inquiry	1,181	Eligibility/Enrollment	3,388	Membership Record	686
5.	Auth-New	969	Other Programs & Services	2,791	Authorization Related	449
August 2016						
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
September 2016						
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

Pharmacy Services Helpline

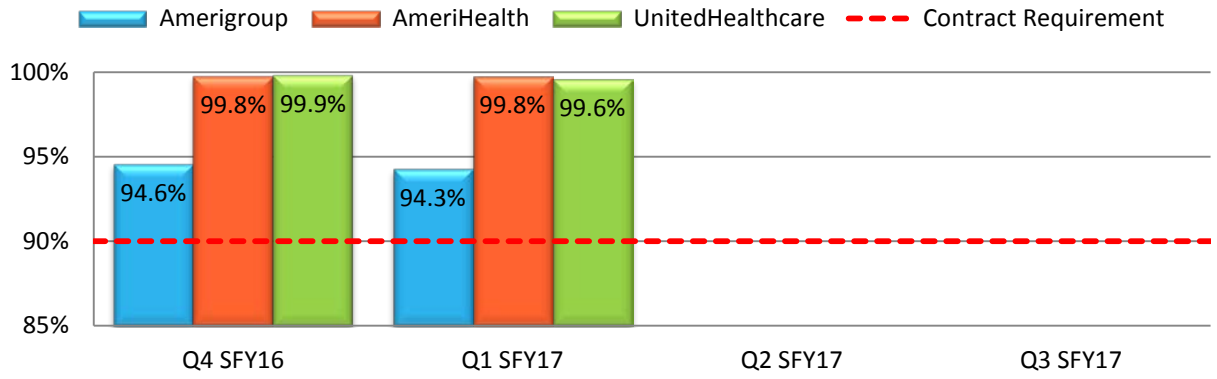


Medical Claims Payment

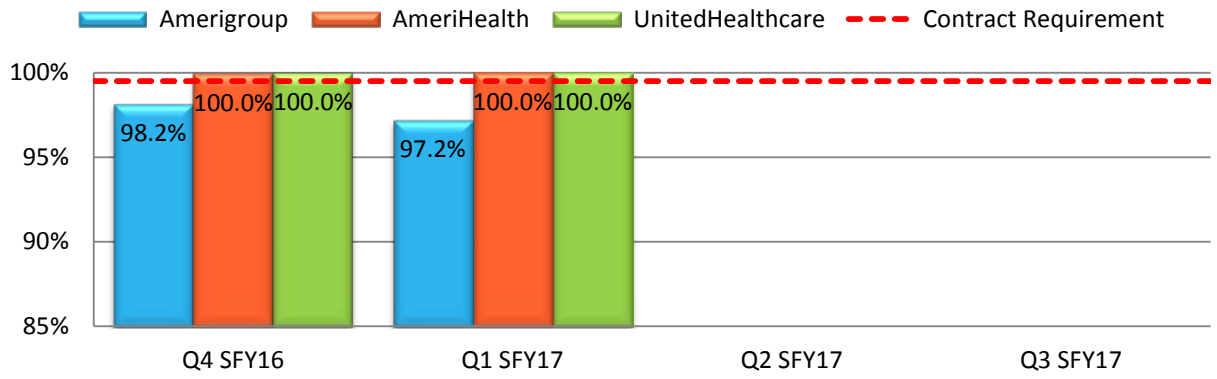
Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

The Department continues to monitor the timeliness of adjudication of clean claims. This is not a measure of correct payment, however, if a provider is reimbursed incorrectly the MCO has 15 days to correct once the issue is identified. The Department initiated a provider rate validation project with the MCOs in early SFY17 to identify rates that vary from what the Department has on file for fee-for-service and reason for this variance. As issues are identified during this project, the Department works with the MCOs to correct in accordance with the terms of the contract.

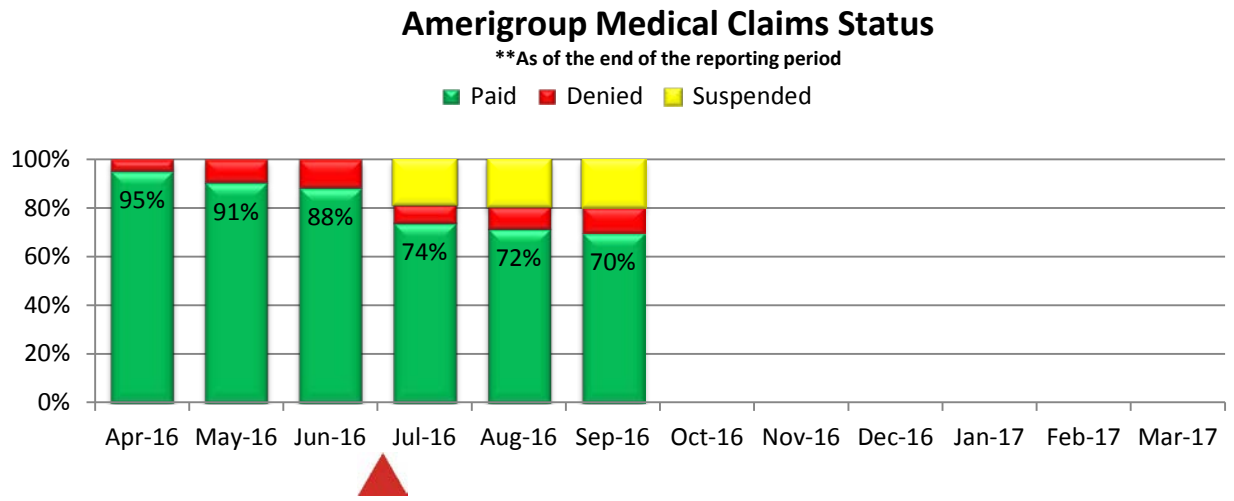
90% of Clean Medical Claims Must be Paid or Denied Within 14 Days



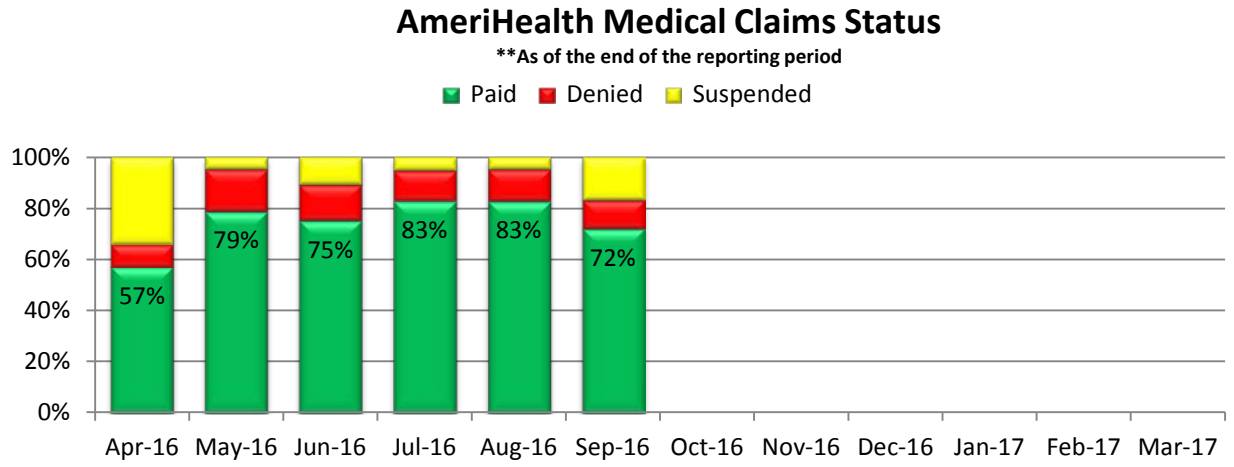
99.5% of Clean Medical Claims Must be Paid or Denied Within 21 Days

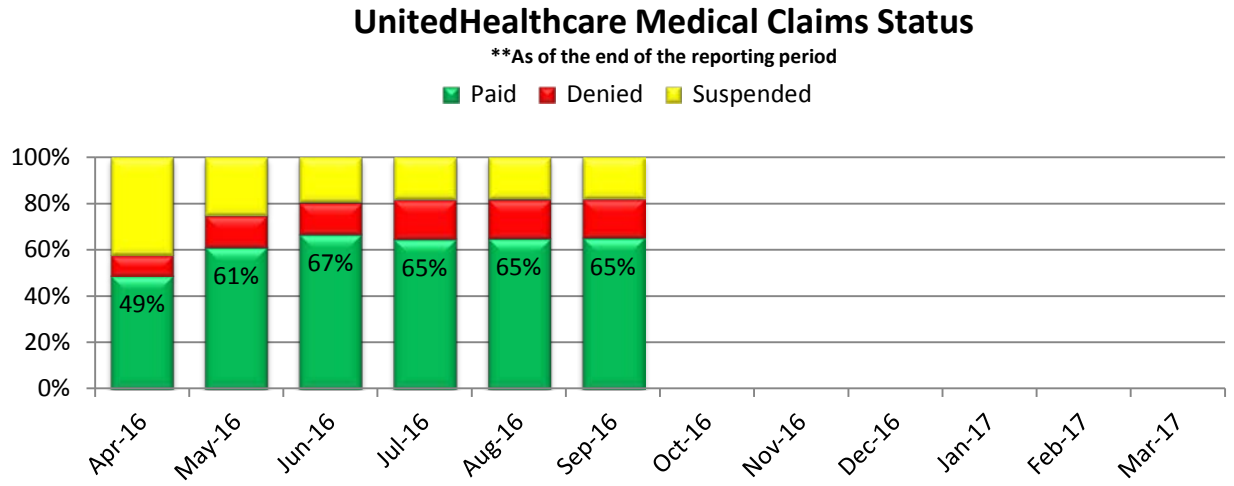


The Department is closely monitoring this measure to ensure that corrective actions are taken to remedy performance for adjudicating claims within 21 days.



▲ Amerigroup did not correctly report suspended claims in April, May, and June of 2016.





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-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.
2. CARC-197 Precertification/ authorization/notification absent.	2. CARC-8 The procedure code is inconsistent with the provider type/ specialty (taxonomy). -RARC-N95 This provider type/provider specialty may not bill this service.	2. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.
3. CARC-177 Patient has not met the required eligibility requirements.	3. CARC-22 This care may be covered by another payer per coordination of benefits. -RARC-N4 Missing/ Incomplete/ Invalid prior Insurance Carrier(s) EOB.	3. CARC-18 Exact duplicate claim/ service. -RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.
4. CARC-252 An attachment/ other documentation is required to adjudicate this claim/service. -RARC-N479: Missing Explanation of Benefits.	4. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.	4. 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.
5. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. -RARC-N381 Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	5. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated -RARC-M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	5. CARC-96 Non-covered charge(s). -RARC-N448 This drug/ service/ supply is not included in the fee schedule or contracted/ legislated fee arrangement.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
6. CARC-256 Service not payable per managed care contract	6. CARC-197 Precertification/authorization/ notification absent. -RARC-M62 Missing/ incomplete/invalid treatment authorization code.	6. 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-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.	7. CARC-A1 Claim/Service denied. -RARC-N142 The original claim was denied. Resubmit a new claim, not a replacement claim.	7. CARC-13 The date of death precedes the date of service.
8. CARC-242 Services not provided by network/ primary care providers.	8. CARC-16 Claim/ service lacks information or has submission/ billing error(s) which is needed for adjudication. -RARC-N329 Missing/incomplete/invalid patient birth date.	8. CARC-26 Expenses incurred prior to coverage. -RARC-N30 Patient ineligible for this service.
9. CARC-204 Service not payable per managed care contract -RARC-N130 Consult plan benefit documents/ guidelines for information about restrictions for this service.	9. CARC-96 Non-covered charge(s). -RARC-N381 Alert: Consult our contractual agreement for restrictions/ billing/payment information related to these charges.	9. CARC-197 Precertification/ authorization/ notification absent.
10. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been	10. CARC-16 Claim/ service lacks information or has submission/billing error(s) which is needed for adjudication. -RARC-N253	10. CARC-96 Non-covered charge(s). -RARC-N425 Statutorily excluded service(s).

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
adjudicated. -RARC-N19 Procedure code incidental to primary procedure.	Missing/incomplete/invalid attending provider primary identifier.	

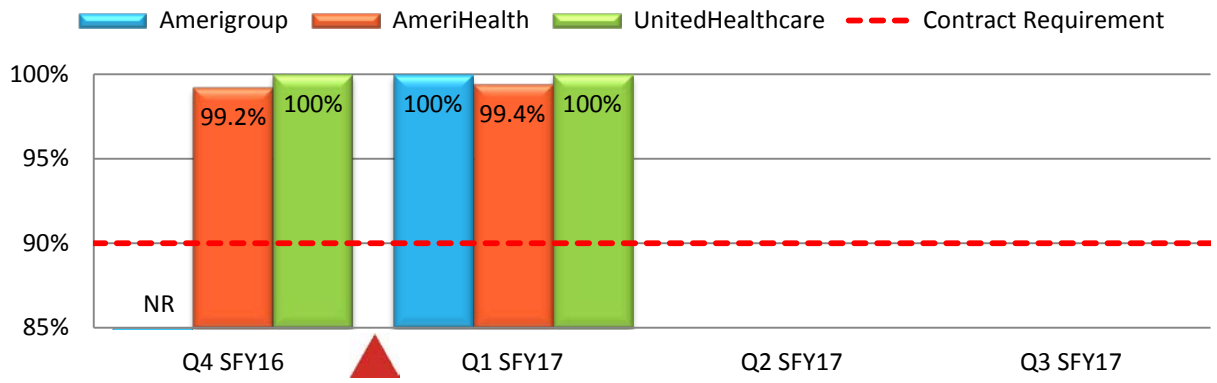
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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

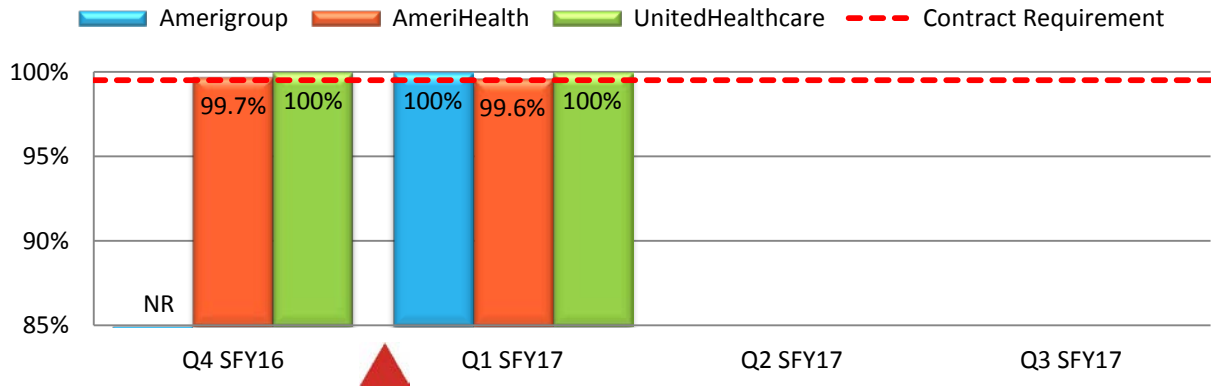
Pharmacy claims processing data is for the entire quarter.

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

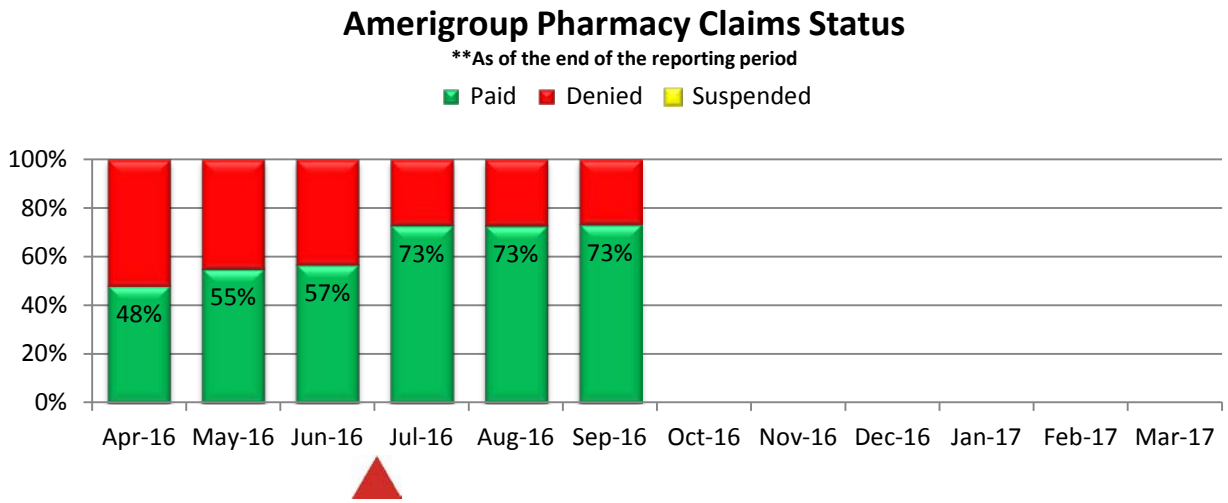


▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.

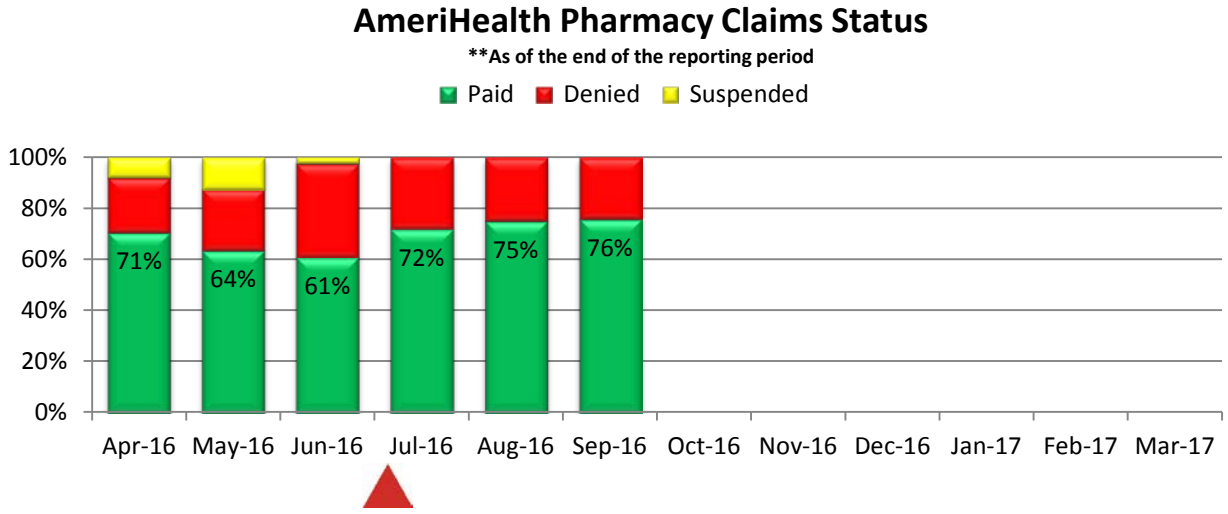
99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days



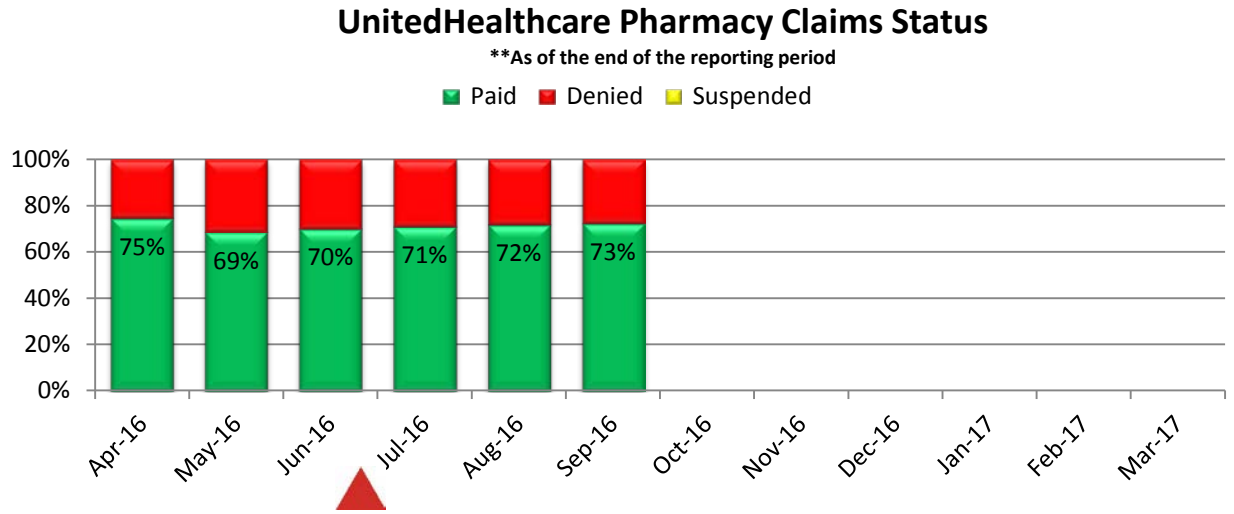
▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.



▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.



▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.



▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.

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. DUR Reject Error
2. Product Not On Formulary	2. Product/Service Not Covered-Plan/Benefit Exclusion	2. Prior Authorization Required
3. Submit Bill To Other Processor Or Primary Payer	3. Patient Is Not Covered	3. Refill Too Soon
4. Days' Supply Exceeds Plan Limitation	4. Prior Authorization Required	4. Prod/Service Not Covered
5. Prior Authorization Required	5. Plan Limitations Exceeded	5. Filled After Coverage Terminated
6. Product/Service Not Covered	6. Submit Bill To Other Processor Or Primary Payer	6. Plan Limitations Exceeded
7. Plan Limitations Exceeded	7. DUR Reject Error	7. Submit Bill To Other Processor
8. DUR Reject Error	8. Duplicate Paid/Captured Claim	8. Prescriber Is Not Covered
9. Product Not Covered Non-Participating Manufacturer	9. Non-Matched Product/Service Id Number	9. M/I Days Supply
10. Non-Matched Pharmacy Number	10. M/I Date Of Birth	10. Non-Matched Pharmacy Number

Utilization of Health Care Services Reported			
Data for Q4 SFY16	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$20,350,842	$1,288,735	$6,951,341
Inpatient Medical Claims Reimbursed	$46,305,694	$12,715,587	$18,087,466
Inpatient Behavioral Health Claims Reimbursed	$4,677,901	$2,905,204	$1,912,945
Outpatient Claims Reimbursed	$50,153,705	$6,631,812	$22,652,592
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

This type of data will undergo ongoing validation for increased accuracy.

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

This is a new reporting requirement for Q1 SFY17, so data is not available for publication for Q4 SFY16. 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 September 2016 Monthly MCO Performance Report.

	AmeriHealth			Amerigroup			UnitedHealthcare		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	94.0%	98.0%	98.0%	85.78%	90.56%	93.44%	98.9%	99.6%	97.6%
Cardiology	100%	100%	98.0%	88.11%	95.41%	88.86%	99.1%	99.1%	93.8%
Endocrinology	94.0%	98.0%	100%	91.45%	63.17%	100%	98.9%	87.7%	79.5%
Gastroenterology	100%	96.0%	92.0%	88.50%	93.56%	81.05%	98.8%	99.4%	97.6%
Neurology	91.0%	100%	94.0%	95.46%	94.23%	99.01%	98.8%	99.7%	98.4%
Oncology	91.0%	97.0%	100%	76.93%	83.95%	98.03%	98.7%	99.9%	99.6%
Orthopedics	92.0%	95.0%	95.0%	72.61%	86.85%	93.04%	99.1%	80.8%	91.4%
Pulmonology	100%	100%	99.0%	79.80%	97.07%	91.16%	98.8%	100%	95.7%
Rheumatology	100%	100%	100%	100%	100%	94.74%	97.4%	100%	98.5%
Urology	98.0%	99.0%	100%	80.46%	98.96%	77.97%	99.3%	99.6%	97.0%
Provider Type - Pediatric	East	Central	West	East	Central	West	East	Central	West
Primary Care	94.0%	97.0%	99.0%	88.92%	97.29%	98.04%	98.9%	99.3%	97.2%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	99.0%	100%	99.0%	96.82%	98.40%	93.56%	99.0%	98.4%	93.0%
Pharmacies	98.0%	98.0%	97.0%	99.79%	99.58%	99.85%	100%	99.5%	100%
ICF/ID	100%	100%	100%	99.55%	100%	100%	100%	100%	100%
ICF/SNF	96.0%	95.0%	95.0%	93.04%	91.55%	93.22%	99.7%	99.2%	100%

	AmeriHealth			Amerigroup			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%	100%	100%
AIDS/HIV Level 2: CDAC, Home Health Aide	100%	100%	No Util	No Util	100%	100%	100%	100%	100%
AIDS/HIV Level 4: Home Delivered Meals	100%	100%	100%	100%	100%	No Util	100%	100%	100%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	100%	100%	100%	93.13%	100%	100%	100%	100%	100%
BI Level 2: CDAC	100%	100%	100%	96.64%	96.99%	95.86%	100%	100%	100%
BI Level 3: Supported Community Living	100%	100%	100%	96.72%	95.75%	99.21%	100%	100%	100%
Elderly Level 1: Adult Day Care	100%	100%	No Util	91.18%	100%	100%	100%	100%	100%
Elderly Level 2: CDAC, Home Health Aide	99.0%	93.0%	100%	91.73%	94.99%	95.49%	100%	100%	100%
Elderly Level 4: Home Delivered Meals	100%	96.0%	99.0%	92.38%	92.69%	95.11%	100%	100%	100%
HD Level 1: Adult Day Care	100%	100%	No Util	100%	100%	No Util	100%	100%	100%
HD Level 2: CDAC, Counseling, Home Health Aide	100%	100%	100%	96.39%	100%	100%	100%	100%	100%
HD Level 4: Home Delivered Meals	100%	100%	100%	91.11%	100%	98.98%	100%	100%	100%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	100%	100%	100%	93.28%	93.81%	100%	99.8%	100%	100%
ID Level 2: CDAC, Home Health Aide	100%	100%	100%	88.49%	95.18%	100%	100%	100%	100%
ID Level 3: Supported Community Living	100%	100%	99.0%	96.79%	92.30%	99.28%	99.9%	100%	100%
PD Level 2: CDAC,	100%	99.0%	100%	96.21%	100%	98.30%	100%	100%	100%
Provider Type - Behavioral	East	Central	West	East	Central	West	East	Central	West
Behavioral Health - Inpatient	100%	98.0%	100%	99.94%	100%	94.69%	97.4%	94.9%	41.7%
Behavioral Health - Outpatient	97.0%	98.0%	98.0%	95.12%	89.70%	88.35%	99.4%	98.9%	99.7%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	100%	100%	100%	96.59%	95.97%	100%	80.4%	97.3%	100%
Habilitation Level 3: Home Based Habilitation	100%	100%	90.0%	98.53%	99.98%	94.62%	99.8%	99.2%	94.2%
Children's Mental Health Level 1: Respite	100%	100%	100%	100%	92.77%	69.53%	100%	100%	100%

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 this reporting period can be found at:

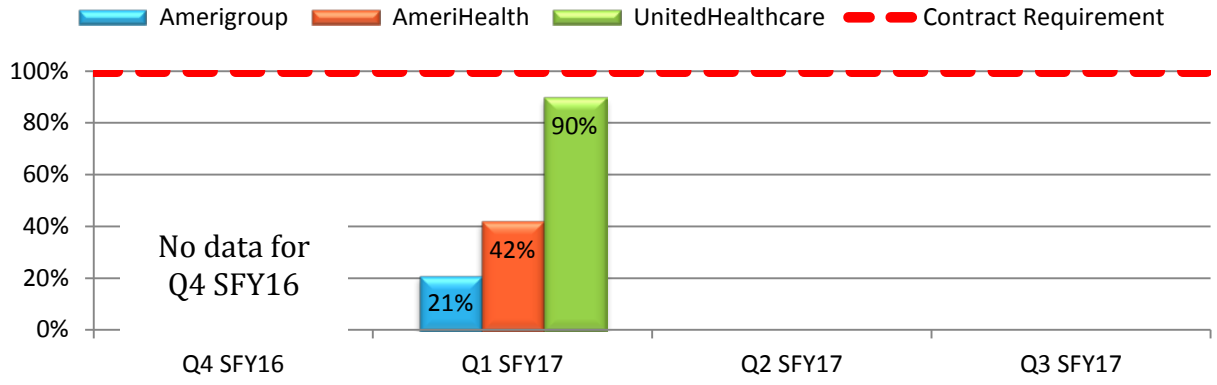
- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/Amerigroup_GeoAccess_Adequacy%2020160921.pdf.
- AmeriHealth Caritas:
    - https://dhs.iowa.gov/sites/default/files/AmeriHealth%20Caritas%20Iowa_Report%201_Maps_2016_09_26.pdf
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/UHC_Report1_Maps_20160926.pdf

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

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

Percentage of Members with Coverage in Time and Distance Standards									
MCO	**Amerigroup**			**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**
Primary Care - Adult	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Primary Care – Child	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Hospital	100%	N/A	N/A	100%	N/A	N/A	99%	N/A	N/A
ICF/SNF	50%	100%	N/A	100%	100%	N/A	100%	100%	N/A
ICF/ID	100%	100%	N/A	99%	100%	N/A	99%	100%	N/A
Behavioral Health – Inpatient	N/A	98%	100%	N/A	96%	100%	N/A	97%	100%
Behavioral Health – Outpatient	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
General Optometry	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Lab and X-ray Services	100%	N/A	N/A	98%	N/A	N/A	99%	N/A	N/A
Pharmacy	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A

100% of Counties Have ≥ 2 HCBS Providers Per County Per 1915c Program

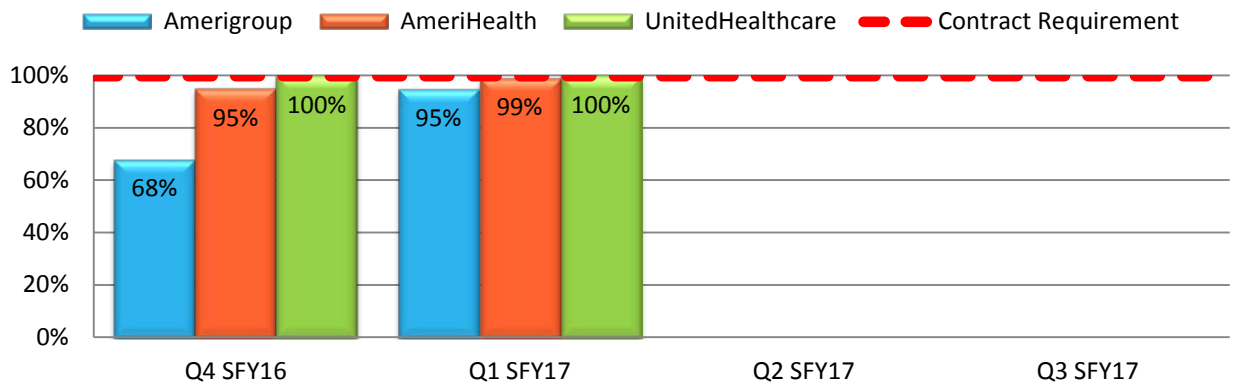


Amerigroup and AmeriHealth do not yet have approved exception requests for the network standards in Exhibit B of the contract for HCBS services. Once those have been submitted to demonstrate acceptable justifications for an exception, it is anticipated that these percentages will increase.

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

Prior Authorization - Medical

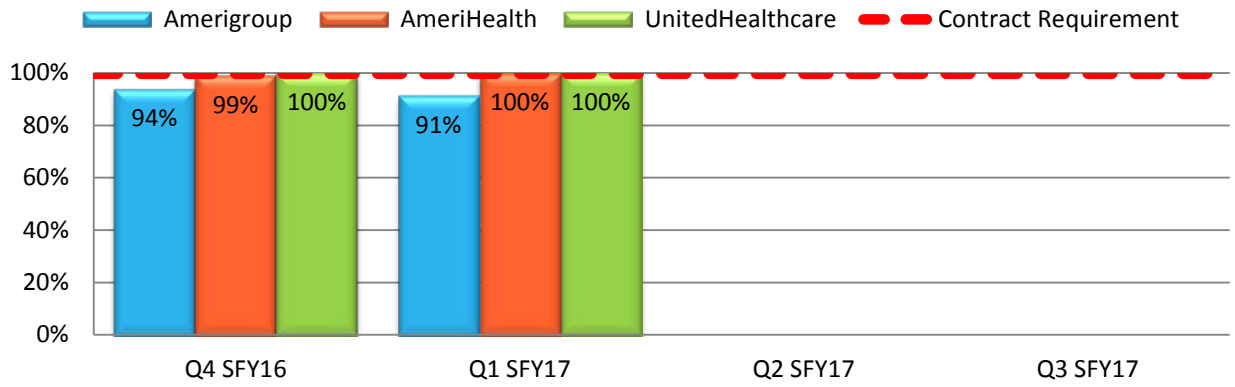
100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request



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.

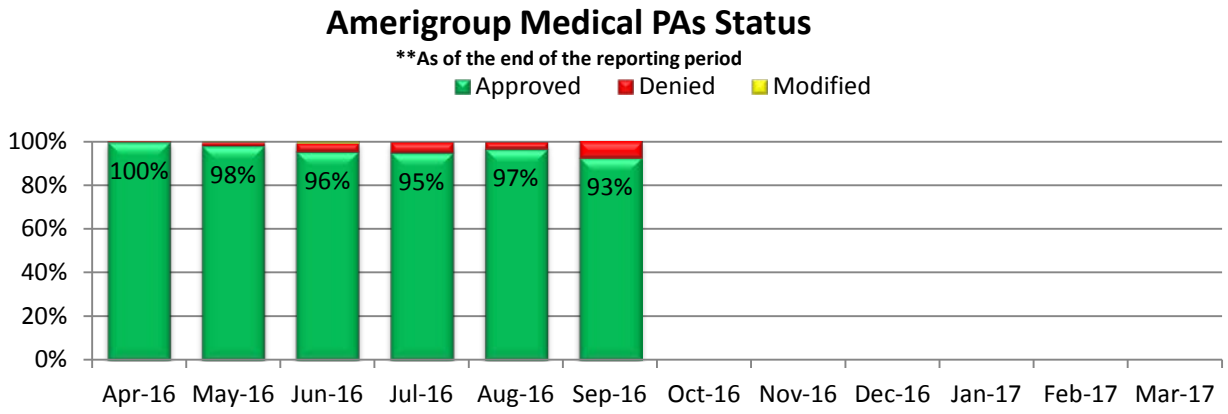
The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

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

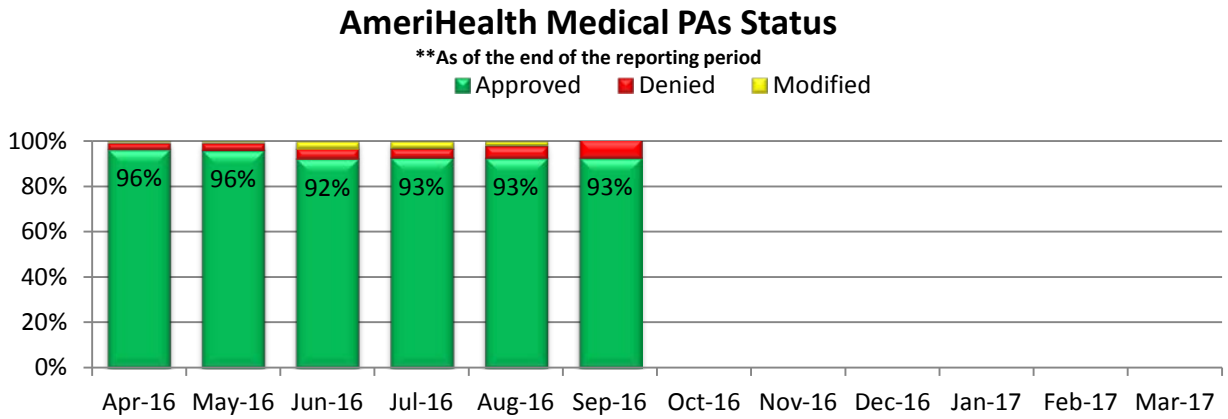


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

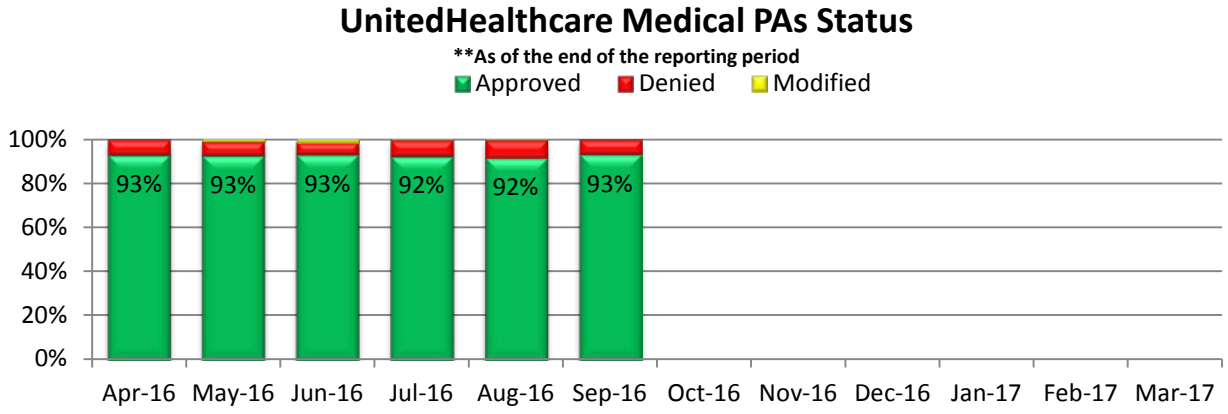
The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a prior authorization request is not approved or denied within seven days, the authorization is considered approved.



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

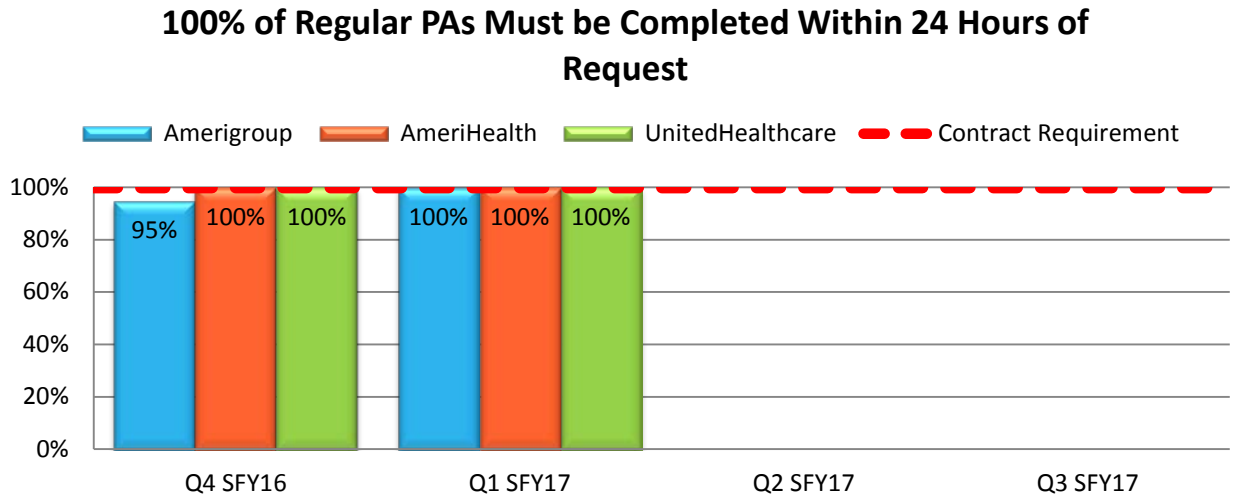


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



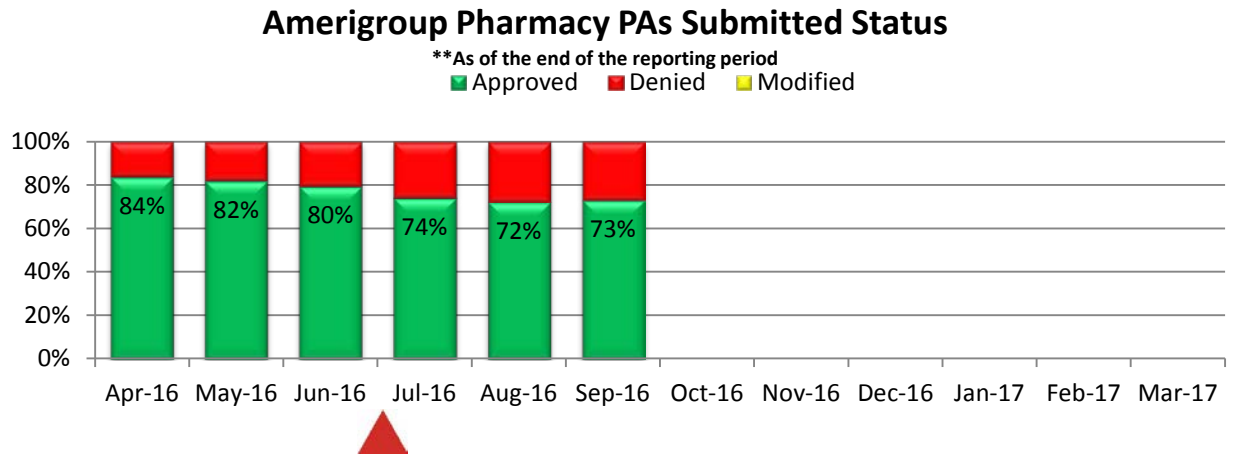
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

Prior Authorization - Pharmacy

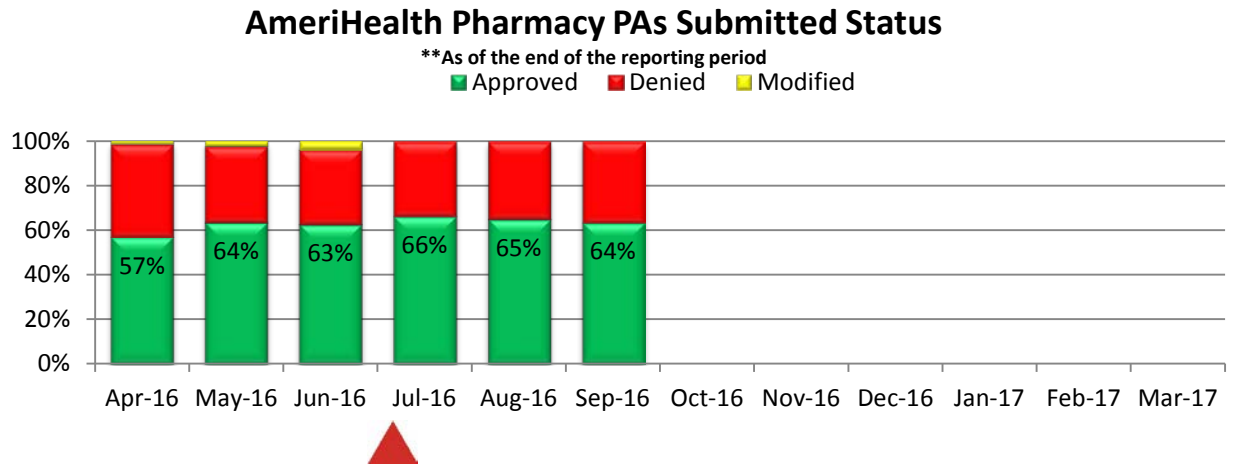


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ.

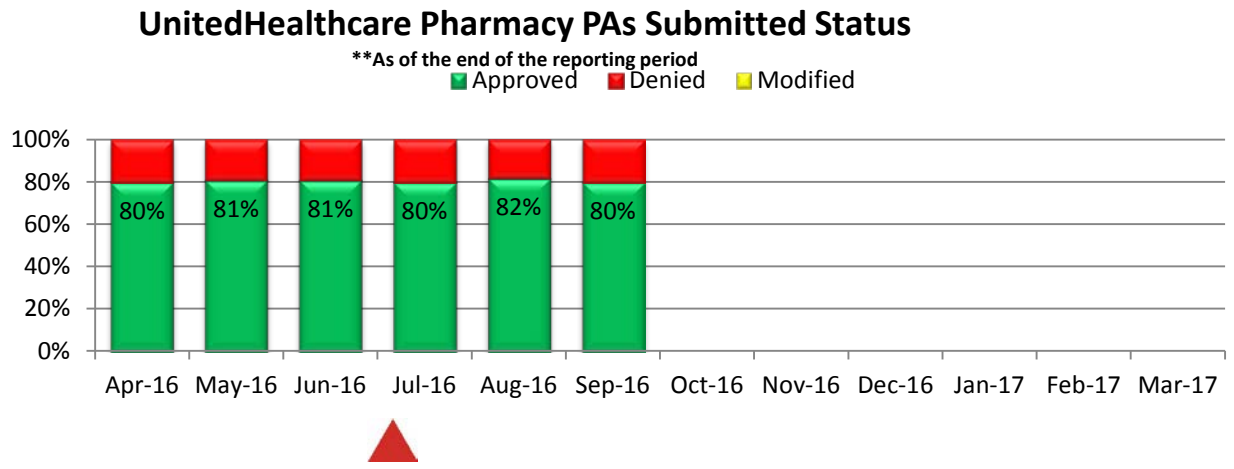
The Department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within the contract requirement, the authorization is considered approved.



▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.



▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.



▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.

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			AmeriHealth			UnitedHealthcare		
Encounter Data Submitted Timely By 20th of the Month	July	August	Sept	July	August	Sept	July	August	Sept
	Y	N	Y	Y	Y	N	N	Y	N

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 Q4 SFY16	0.0%	3.4%	0.0%
% of Members Covered by a Value Based Purchasing Agreement for Q1 SFY17	17%	6%	2%

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 Q4 SFY16	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	123.30%	102.45%	104.38%
ALR	12.33%	6.27%	12.70%
Underwriting	-35.63%	-8.72%	-17.08%
Data for Q1 SFY17	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
MLR	109.92%	114.05%	111.88%
ALR	7.85%	6.65%	13.36%
Underwriting	-17.78%	-20.70%	-25.24%

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 financial ratios presented here are consistent with Q3 calendar year 2016 (Q1 SFY17) financial information submitted to the Iowa Insurance Division by each MCO.

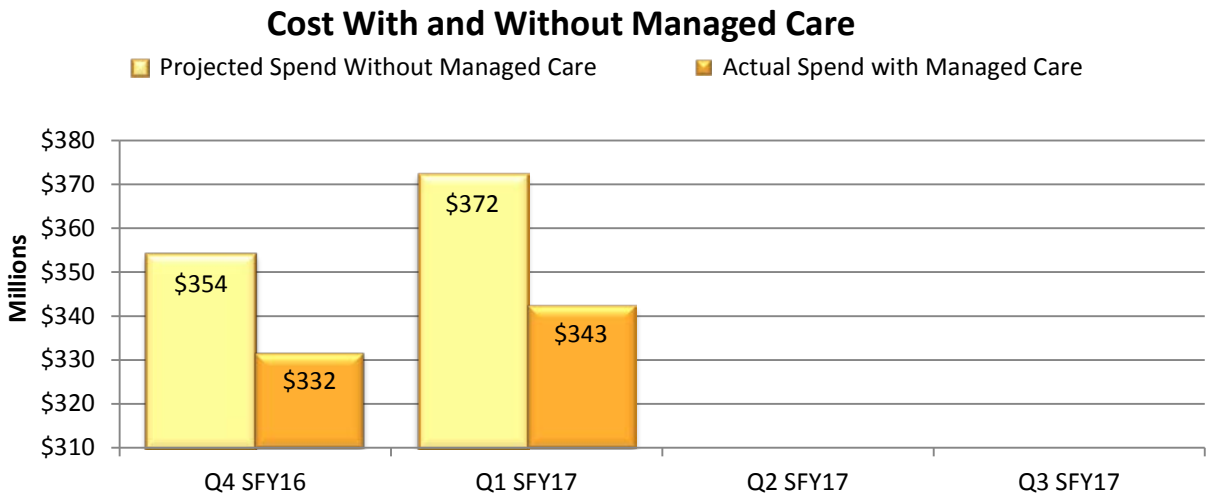
The financial metrics presented here reflect financial performance for Q1 SFY17. Premium deficiency reserves and/or changes in premium deficiency reserves are excluded from the calculations. The Department believes this approach most accurately reflects financial performance for service delivery under 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.
In this Q1 SFY17 report:

- The MCOs are not including pre-contract administration, graduate medical education, and pass-through items.
- UnitedHealthcare is the only one of the three MCOs to include an assumed return of the capitation withhold. This reduced the MLR, slightly reduced the ALR, and increased the UR, all by less than 2%.
- For AmeriHealth Caritas and United Healthcare, risk adjustment and LTSS rebalancing was included in both the Q4 SFY16 and Q1 SFY17

reports. For Amerigroup, these two adjustments were introduced with the Q1 SFY17 report, which impacts the results of both quarters.

Program Cost Savings (Quarter 1 SFY17)			
Data	**Projected State Spend Without Managed Care**	**Actual State Spend with Managed Care**	**Program Cost Savings (State)**
Program Cost Savings (State)	$372,185,691	$342,520,628	$29,665,063



Savings reported in this quarter (Q1 SFY17) 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.

Second quarter savings from managed care are being reported at $29.7 million. 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 following factors contribute to changes in savings estimates over time:

- Fluctuations in membership in total and across the rate cells as compared to earlier estimates; this includes fluctuation in waiver membership
- Timing differences relative to maternity case rates
- Timing of incentive pay outs
- Other factors outside of the current capitation rates that contribute to savings such as decreases in costs experienced prior to comprehensive managed care; this includes administrative costs paid to behavioral and voluntary managed care companies under the prior model.

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 Q4 SFY16	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Hospital Claims Paid	$58,821,540	$23,483,915	$47,165,099	$129,470,554
Physician Claims Paid	$80,388,610	$20,577,749	$3,219,047	$104,185,406
HCBS Claims Paid	$57,150,836	$63,991,468	$6,607,076	$127,749,380
DME Claims Paid	$31,822,459	$2,144,113	$1,757,751	$35,724,323
Pharmacy Claims Paid	$31,675,007	$50,701,666	$41,586,516	$123,963,189
Home Health Claims Paid	$24,907,269	$5,638,926	$2,758,004	$33,304,199
Hospice Claims Paid	$19,604,714	$1,171,549	$155,942	$20,932,205
Nursing Facility Claims Paid	$43,383,537	$22,388,394	$24,727,481	$90,499,412
ICF/ID Claims Paid	$8,764,795	$14,345,835	$14,555,366	$37,665,996
Behavioral Health Claims Paid	$65,142,064	$19,537,194	$3,542,021	$88,221,279
Speech Therapy Claims Paid				
Occupational Therapy Claims Paid				
Non-Emergency Transportation Claims Paid	$1,298,516	$1,200,597	$755,553	$3,254,666

This data is under review due to data reconciliation issues.

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

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	**Q4 SFY16**	**Q1 SFY17**	**Q2 SFY17**	**Q3 SFY17**
Amerigroup	$237,540,157	$238,096,189		
AmeriHealth	$408,575,970	$444,903,457		
UnitedHealthcare	$229,442,968	$209,092,263		

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 Q4 SFY16	$6,746,400	$13,842,202	$7,651,869
Amount of TPL Recovered Q1 SFY17	$2,861,668	$13,021,872	$6,947,462

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 reported	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	3	30	20
Overpayments Identified During the Quarter	381	0	1
Amount of Recovery for the Quarter	$26,548	$0	$3,897
Amount of Recovery Year to Date	$26,604	$0	$4,076
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	0	8	1
Member Concerns Referred to IME	2	15	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.

Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	April	May	June	April	May	June	April	May	June
Members (from IME)	186,363	190,991	192,678	201,935	209,917	216,591	211,352	203,756	198,708
Total Inpatient Admissions	1,302	1,639	2,262	507	5,454	11,722	2,096	1,800	1,680
Readmissions within 15 days of Discharge	89	227	288	15	80	259	106	104	88
Readmissions within 30 days of Discharge	6	47	153	0	9	86	9	54	39
Readmissions within 45 days of Discharge	0	64	126	0	3	36	5	25	20
Readmissions within 60 days of Discharge	0	8	15	0	0	16	0	10	30
Data	**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

*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.

Emergency Department									
Data Q4 SFY16	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
ED Visits for Non-Emergent Conditions – Adult	14.1	14.3	21.8	17.2	52.2	133.1	58.0	59.0	49.0
ED Visits for Non-Emergent Conditions – Child	14.7	13.8	18.1	12.0	30.5	77.8	29.0	28.0	21.0
Data Q1 SFY17	**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
Supporting Data Q4 SFY16									
Members (from IME)	186,363	190,991	192,678	201,935	209,917	216,591	211,352	203,756	198,708
Members Using ED More Than Once in 30 Days	178	168	302	182	2,046	5,464	2,030	1,092	795
Members Using ED More Than Once between 31 and 60 Days**	0	10	10	0	31	1,239	372	391	378
Supporting Data Q1 SFY17									
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

*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 Q4 SFY16	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Members in Out-of-State PMIC	15	19	20	0	0	0	2	2	2
Members in Out-of-State Skilled Nursing Facility	11	20	17	0	0	0	3	7	7
Members Placed in an Out-of-State ICF/ID	4	3	0	67	66	66	1	1	1
Members in Out-of-State nursing facilities	0	0	0	0	0	0	2	0	0
Members in Out-of-State Other Institutions	0	0	0	0	0	0	0	1	1
Data for Q1 SFY17	**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

*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.

HEALTH CARE OUTCOMES

Iowa Department of Human Services

Terry E. Branstad, Governor | Kim Reynolds, Lt. Governor | Charles M. Palmer, Director

October 13, 2016

Senate Human Resources Committee
State Capitol Building
L O C A L

House of Representatives Human Resources Committee
State Capitol Building
L O C A L

Joint Appropriations Committee on Health and Human Services
State Capitol Building
L O C A L

Dear Committee Members,

Pursuant to House File 2460, the Council on Human Services, Medical Assistance Advisory Council, and the hawk-i Board are to submit minutes of their respective meetings during which the council or board addressed Medicaid managed care.

Enclosed please find minutes from the following meetings:

Council on Human Services .....July 13, 2016
Council on Human Services.....August 10, 2016
Council on Human Services.....September 14, 2016
Medical Assistance Advisory Council - Executive Committee.....July 21, 2016
Medical Assistance Advisory Council - Executive Committee.....August 5, 2016
Medical Assistance Advisory Council - Full Council .....August 17, 2016
Medical Assistance Advisory Council - Executive Committee.....August 18, 2016
Medical Assistance Advisory Council - Executive Committee.....September 28, 2016
Healthy and Well Kids in Iowa (hawk-i) Board .....August 15, 2016

Please feel free to contact me if you need additional information.

Sincerely,

Paige M. Thorson
Policy Advisor

Attachment

Iowa Medicaid Enterprise – 100 Army Post Road - Des Moines, IA 50315

COUNCIL ON HUMAN SERVICES

MINUTES

July 13, 2016

COUNCIL

Mark Anderson
Phyllis Hansell (absent)
Alexa Heffernan
Kimberly Kudej
Guy Richardson
Kim Spading
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

Representative Joel Fry (absent)
Representative Lisa Heddens (absent)
Senator Amanda Ragan (absent)
Senator Mark Segebart (present)

STAFF

Chuck Palmer
Sandy Knudsen
Mikki Stier
Sally Titus
Vern Armstrong
Nancy Freudenberg
Paige Thorson
Amy McCoy
Jean Slaybaugh
Rick Shults

GUESTS

Andrew Allen, Youth and Shelter Services
Scott Jensen, Juvenile Court Services Association
Chad Jensen, Juvenile Court Services, 5th District
Tom Southard, Juvenile Court Services, 2nd District
Sara Allen, Iowa Hospital Association
Kristie Oliver, Coalition for Family and Children's Services in Iowa
Bill Nutty, Iowa Health Care Association/Iowa Center for Assisted Living
Jeff Steggerda, Iowa Health Care Association/Iowa Center for Assisted Living
Cindy Baddeloo, Iowa Health Care Association/Iowa Center for Assisted Living
Tom Swanson, Iowa Health Care Association/Iowa Center for Assisted Living
Stacy Heidja, Iowa Health Care Association/Iowa Center for Assisted Living
Shannon Henson, ABCM, Iowa Council for Health Care Centers
Brianna Hilmer, Iowa Center for Home Care
Jodi Tomlonovic, Family Planning Council of Iowa
Shanell Wagler, Early Childhood Iowa

Jerome Greenfield, Mental Health Services/Iowa Dept of Corrections
Suzanna DeBaca, Planned Parenthood of the Heartland
Lon Anderson, Iowa Alliance in Home Care
Jim Cushing, Iowa Association of Area Agencies on Aging
Lana Shope, Iowa Community Action Association
Liz Cox, Prevent Child Abuse Iowa
Terri Bailey, Achieving Maximum Potential (AMP)
Bekah Mahan, AMP Youth
Halli Buckels, AMP Youth
Bill Kallestad, Lutheran Services in Iowa
Mike Buck, Lutheran Services in Iowa
Deann Cook, United Ways of Iowa
Edward Hotchkin, DM First Unitarian Church
Nancy Augustine, Public/Child Welfare
Kris Bell, Senate Democratic Caucus
Larry Kudej, Older Iowans Legislature
John Harvey, VOCAL
Don Burgmaier
Angel Banks-Adams, Legislative Services Agency
Jess Benson, Legislative Services Agency
June Rumelhart
Nancy Stillians, Family Advocate

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m. on Wednesday, July 13, 2016, at the Polk County River Place Building, Conference Room 1, in Des Moines.

ROLL CALL

All Council members were present with the exception of Hansell. All ex-officio legislative members were absent with the exception of Senator Mark Segebart.

PUBLIC HEARING ON DHS FISCAL YEAR 2018-2019 BUDGET RECOMMENDATIONS AND LEGISLATIVE PACKAGE

This portion of the meeting was held for the purpose of hearing public comments as the Department of Human Services develops its FY 2018-2019 budget recommendations and legislative package. (All testimony is on file and available in the Director's Office.)

Those persons/groups presenting and sharing written comments were:

- Andrew Allen, Youth & Shelter Services, Inc. (YSS)
- Tom Southard, Juvenile Court Services, 2nd District

- Chad Jensen, Juvenile Court Services, 5th District
- Sara Allen, Iowa Hospital Association
- Kristie Oliver, Coalition for Family and Children's Services in Iowa
- Stacy Heidja, Tom Swanson, Brianna Hilmer, Iowa Health Care Association/Iowa Council of Health Care Centers
- Jodi Tomlonovic, Iowa Family Planning Council
- Shanell Wagler, Early Childhood Iowa & State Child Care Advisory Committee
- Jerome Greenfield, Mental Health Services-Iowa Department of Corrections and Iowa Psychiatric Society
- Suzanna DeBaca, Planning Parenthood of the Heartland
- Lon Anderson, Iowa Alliance in Home Care
- Jim Cushing, Iowa Association of Area Agencies on Aging
- Lana Shope, Iowa Community Action Association
- Liz Cox, ACEs Policy Coalition
- Bekah Mahan, AMP (Achieving Maximum Potential) Youth
- Halli Buckels, AMP (Achieving Maximum Potential) Youth
- Bill Kallestad & Mike Buck, Lutheran Services in Iowa
- Deann Cook, United Ways of Iowa
- Tom Swanson IHCA/ICAL

Those organizations that submitted written comments but did not present were:

- NAMI of Greater Des Moines
- AFSCME

RULES

Nancy Freudenberg, Bureau of Policy Coordination, presented the following rule to Council:

R-1 Amendments to Chapter 109, "Child Care Centers." Implements a required orientation training in health and safety content areas for all staff within 3 months of employment and enhances emergency planning requirements. Adopts safe sleep practices. Provides for enhancements to current rules including a requirement for the regulatory fee to be part of a sufficient application. Provides technical clean-up of the rule chapter as a whole.

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

R-2 Amendments to Chapter 110, "Child Development Homes." Updates and revises Chapter 110. Incorporates changes required by the Child Care Development Block Grant (CCDBG). Improves rules regarding the safety of children in care. Updates the chapter to ensure technical compliance.

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

R-3 Adopts a new Chapter 120, "Child Care Homes." Implements new federal rules outlining health, safety, and fire standards for child care providers that receive child care assistance funding.

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

R-4 Amendments to Chapter 170, "Child Care Services," Revises the chapter to reflect new federal CCDBG rules regarding child care assistance eligibility. Revises in-home provider language to conform with new federal regulations.

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

APPROVAL OF MINUTES

A motion was made by Wallace to approve the minutes of June 8, 2016 and seconded by Richardson. MOTION CARRIED UNANIMOUSLY.

ELECTION OF OFFICERS

A motion was made by Wallace and seconded by Kudej to retain the current slate of officers: Mark Anderson, Chair and Phyllis Hansell, Vice-Chair. MOTION UNANIMOUSLY CARRIED.

OVERSIGHT OF MANAGED CARE

Council discussed how they would like to approach their oversight duties in regard to managed care. The Council asked that DHS staff continue to send them information on managed care and at their August meeting hear a general report from staff. As the September Council meeting is devoted to reviewing the budget, the Council at the October meeting will review the legislation requirements for oversight and focus discussion on preparing for the report.

COUNCIL MEMBERS UPDATE

Anderson reported that he met with the CEOs of Lutheran Services of Iowa, Bartels Lutheran Retirement Community, Larrabee Center and numerous others regarding their concerns on managed care. Spading reported that she will be meeting with the Iowa Pharmacy Association.

DIRECTOR'S REPORT

Sally Titus, Deputy Director, reported that if Council members hear specific concerns regarding provider billing problems, Director Palmer would appreciate learning about them. DHS continues to work with the Managed Care Organizations (MCOs) on clarifying system issues.

NEXT MEETING

The next meeting of the Council on Human Services is Wednesday, August 10, 2016.

ADJOURNMENT

Council adjourned at 2:30 p.m.

Submitted by,

Sandy Knudsen
Recording Secretary

sk

COUNCIL ON HUMAN SERVICES

MINUTES

August 10, 2016

COUNCIL

Mark Anderson (absent)
Phyllis Hansell
Alexa Heffernan
Kimberly Kudej
Guy Richardson
Kim Spading
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

Representative Joel Fry
Representative Lisa Heddens (absent)
Senator Mark Segebart (absent)
Senator Amanda Ragan (absent)

STAFF

Chuck Palmer
Sandy Knudsen
Nancy Freudenberg
Jean Slaybaugh
Janee Harvey
Ryan Page
Mikki Stier
Liz Matney
Amy McCoy
Joe Havig
Matt Highland

GUESTS

Lawrence Kudej, Older Iowans Legislature (OIL)
Ashley McGuire, UHC
Kent Ohms, Legislative Services Agency
Kris Bell, Senate Democratic Caucus
Sandi Hurtado-Peters, Department of Management
Jodi Tomlonovic, Family Planning Council of Iowa
Tom Fey, Iowa Podiatric Medical Society
Leslie Stonehocker, Iowa Child Care Resource and Referral

CALL TO ORDER

Phyllis Hansell, Vice- Chair, called the Council meeting to order at 10:00 a.m.

ROLL CALL

All Council members were present with the exception of Anderson. All Ex-officio legislative members were absent with the exception of Representative Fry.

NOTICES OF INTENDED ACTION

Nancy Freudenberg, Bureau of Policy Coordination, presented the following Notices of Intended Action to the Council.

N-1. Amendments to Chapters 105, 113, 114, and 202, regarding Child Abuse, Child Welfare, and Foster Care. These amendments implement the federal law, "Preventing Sex Trafficking and Strengthening Families Act." The amendments also update language regarding liability of foster parents and add new requirements about annual fire inspections and building codes. Finally, these amendments change the requirement for provision of transition plan documents to any child leaving foster care at the age of 18 or older.

N-2. Amendments to Chapter 175, regarding Child Abuse. These amendments implement the federal law, "Justice for Victims of Trafficking Act (P.L.114-22)," which requires state child protective agencies to consider a child to be a victim of "child abuse and neglect" and of "sexual abuse" if the child is identified as being a victim of sex trafficking or a victim of a severe form of trafficking in persons. These amendments also require individuals who patronize or solicit persons for a commercial sex act to be equally culpable for sex trafficking offenses.

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

APPROVAL OF MINUTES

A motion was made by Kudej to approve the minutes of July 13, 2016 and seconded by Richardson. MOTION CARRIED UNANIMOUSLY.

CHILD CARE REAUTHORIZATION IMPLEMENTATION UPDATE

Ryan Page, DHS Division of Adult, Children and Family Services, and Leslie Stonehocker, Iowa Child Care Resource and Referral, addressed the Council regarding the "Reauthorization of the Child Care and Development Block Grant."

Highlights of presentation:

- Child Care Assistance Program (implementation July 1, 2016)
  - Moving from 6-month to 12-month eligibility
  - Allowance for temporary changes in work, training or education activities
  - Allowance for job search activities

- Program exit eligibility
- Reimbursement rates to child care providers

- Health and Safety of Children
  - Pre-inspection for providers wanting to become a Child Development Home
  - Health and Safety Training on 10 specific training topics
  - Annual, unannounced provider monitoring visits, including visits to non-registered Child Care Assistance (CCA)-paid providers
  - Emergency preparedness plans

- Provide consumer education resources.

- Enhance communication with providers.

Ms. Page reported that the second phase of implementation would be regarding 'background checks' and DHS is waiting for additional guidance in that area.

Director Palmer suggested that the 'DHS background check process' be an agenda item for a future Council meeting.

OVERSIGHT OF MANAGED CARE

Mikki Stier, Director, Iowa Medicaid Enterprise, and Liz Matney, Bureau Chief, Iowa Medicaid Enterprise, addressed the Council. They noted that the Iowa Medicaid program has undergone fundamental changes as it moved to managed care. They also noted that Iowa is one of 11 States that received the State Innovation Model (SIM) grant from the Centers for Medicaid Services. SIM is a statewide effort to improve outcomes and service delivery as well as lowering costs.

- The move to managed care has been a major transition for Iowa as 500,000 Iowan's were moved to managed care. Ms. Stier stated she is confident people are getting the services they depend on.

- The majority of providers are being paid appropriately. There have been some billing problems and the Department wants to be informed of any problems so that the issues can be resolved as quickly as possible. The Department is aware that some providers are experiencing cash flow concerns. The Department has attended "listening sessions" across the state and regularly meets with organizations to identify and resolve issues related to managed care.

- Matney reviewed the bid process used to award the managed care contracts. She reported that the request for proposal (RFP) included key state initiatives, outcomes, accountability with sustainability. Staff talked

with a number of other states when developing the RFP. 11 bids were received and went through a detailed evaluation with guidance from the Attorney General's Office. Once awarded, all the requirements in the RFP were folded into the contracts. The primary objective was the safety of members, that members receive better services, that providers receive timely payments and that the program is well-managed.

- There are a variety of mechanisms for oversight. Data monitoring is conducted on a monthly, quarterly and annual basis. The 'Managed Care Oversight and Supports Bureau' reviews and analyzes the data. The 'Medical Services Unit' also looks at the data that supports and measures data like 'denial rates.' Also, 'systems' staff look at claims processing data and makes comparisons to the department's fee for service experience. There are a wide range of options for the Department regarding remedies for non-compliance and the Department coordinates with the Attorney General's Office on those progressive remedies.

- The Iowa Medicaid Enterprise 'iahealthlink" Managed Care Reports for April 2016 and May 2016 were distributed and reviewed. Palmer reported that the quarterly report will contain more thorough data.

Palmer noted that the Council is a key oversight entity and the Department is committed to providing the best information it can to build the Council's understanding of its role. The Council was encouraged to ask questions and provide comments in this arena for the next few months.

Matney told the Council there is 'no wrong door' on how the issues are relayed to the Department.

COUNCIL UPDATES

Spading reported that she has had conversations with the CEO of the Iowa Pharmacy Association, Kate Gainer regarding managed care. Monthly calls with Mikki Stier and DHS Pharmacist Susan Parker are continuing. In response to a question regarding capitation rates and savings, Jean Slaybaugh reported that there are a number of variables that affect capitation rates, and savings may or may not go to the managed care organizations.

Spading noted her concern about what appears to be a lack of beds for mental health patients that do not require acute care - but rather more intermediate care beds may be needed.

Hansell reported that she has received email comments on reimbursement problems (from Iowa Psychologist Association list serve). She said it was interesting to hear about the issues and will pass along the comments/concerns to the Department.

DIRECTOR'S UPDATE

Director Palmer reported:

- There are several variables concerning the availability of psychiatric beds. The chart "Inpatient Psychiatric Hospital Bed Availability" was distributed. The chart depicts the numbers of beds available in March, July and August of 2016. On average, the state has 100 beds available every day. The most difficult population to manage are adult males with combinations of mental illness and substance abuse problems as well as those with a dual diagnosis of mental illness and intellectual disabilities. Nursing facilities are under increased scrutiny especially in the use of psychotropic drugs and many are reluctant to accept the difficult to serve clients due to risk management. Answers are not simple and the MCOs are working on this.

- Palmer discussed the 'carve out' population as it relates to Medicaid in response to a question from Kimberly Kudej.

- The Department is tracking billing problems related to managed care. Palmer stated that no problem that has been identified is unable to be fixed and that communication is a significant part of the equation.

- Jean Slaybaugh spoke to the Council regarding next month's meeting on the budget. This year's budget will cover two fiscal years (State Fiscal Years 2018 and 2019). Council will receive the full budget narrative, an explanation of the programs, who they serve, key budget drivers, changes in regulations, funding/match rates and funding sources.

Council proposed an in-depth informational session prior to next month's budget meeting. Council suggested the session begin just prior to the September 13 meeting's start time for approximately 1 1/2 hours.

NEXT MEETING/ADJOURNMENT

The next meeting of the Council on Human Services will be the annual budget meeting: Tuesday, September 13 and Wednesday, September 14, 2016.

Council adjourned at 1:50 p.m.

Submitted by Sandy Knudsen
Recording Secretary

COUNCIL ON HUMAN SERVICES

MINUTES

September 14, 2016

COUNCIL

Mark Anderson
Phyllis Hansell
Alexa Heffernan
Kimberly Kudej
Guy Richardson
Kim Spading (absent)
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

Representative Joel Fry (absent)
Representative Lisa Heddens (absent)
Senator Mark Segebart (present)
Senator Amanda Ragan (absent)

STAFF

Chuck Palmer
Sandy Knudsen
Amy McCoy
Jean Slaybaugh
Mikki Stier
Liz Matney
Markie Channon

GUESTS

Sandi Hurtado-Peters, Department of Management
Jess Benson, Legislative Services Agency
Angel Banks-Adams, Legislative Services Agency
RG Schwarm, Brown Winick
Ashley McGuire, UnitedHealthCare
Kris Bell, Senate Democrat Caucus

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 9:00 a.m.

ROLL CALL

All Council members were present with the exception of Spading. All Ex-officio legislative members were absent with the exception of Senator Segebart.

MANAGED CARE OVERSIGHT:

Introduction and Role of Council

Chuck Palmer, Director, read for the Council the legislation related to their oversight duties per House File 2460:

"The council on human services shall regularly review Medicaid managed care as it relates to the entity's respective statutory duties. These entities shall submit executive summaries of pertinent information regarding their deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15, annually, for inclusion in the annual report as required under this sections."

And also: *"The council on human services shall submit to the chairpersons and ranking members of the human resources committees of the senate and the house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of their respective meetings during which the council or board addressed Medicaid managed care."*

The language above instructs the Council to submit an executive summary of the Council's deliberations related to managed care to the Department no later than November 15. A way to look at it is, is managed care achieving its primary goals in improving the health status of Medicaid-eligible Iowans and is the program sustainable going forward? The Council plays an important role and each member comes with their own rich perspective.

Responsibility of Iowa Medicaid Enterprise (IME)

Mikki Stier, Medicaid Director, distributed copies of the table of organization for the Iowa Medicaid Enterprise (IME). The Bureau of Managed Care Oversight and Supports is headed by Liz Matney.

27 staff support the IME along with key vendors that support much of the managed care oversight. Stier provided a listing of the primary contracts pertaining to fee for service and Managed Care Organizations (MCOs) to assist in oversight responsibilities:

- External Quality Review Organization (EQRO)
- Core Services
- Medical Services
- Member Services
- Milliman (Actuarial)
- Pharmacy Medical Services
- Program Integrity

- Provider Cost Audit and Rate Setting
- Provider Services
- Revenue Collections
- 3M
- University of Iowa

A small portion of Medicaid is still fee for service.

Stier reported that IME staff review the reports produced by the MCOs (Monthly, Quarterly and Annually). Staff take a comprehensive approach to reviewing timely payments, remedies and compliance. Staff meet weekly with the MCOs and Stier and Matney meet monthly with each MCO Director individually.

Role of Other Oversight Entities

Paige Thorson, Policy Advisor, noted that HF 2460 also speaks to Medicaid Assistance Advisory Council (MAAC) membership changes, and an addition of another position for the managed care ombudsman's office (for a total of three). The Citizen's Aid Ombudsman also has a role in oversight as well as the Hawk-i board (focusing on children only) and the Mental Health and Disability Commission.

The Legislature's Health Policy Oversight Committee meets at least twice during the legislative interim (August and December) to provide continuing oversight for Medicaid managed care. "Listening Posts" are occurring statewide. The Department has responded to over 2,000 'Requests for Information" with the majority on managed care.

External Communications

Amy McCoy, Public Information Officer, reported to the Council on the multiple communications used in regard to managed care. Highlights of some of the communications:

- In 2016 350,000 family mailings
- On-going monthly mailings (10,000 mailings each month)
- Outreach pamphlets, etc. provided by the MCO's
- 28,000 calls per month at DHS call centers (MCO's also have their own call centers)
- E-news garners 5,000 views each month
- "Ia Health Link" garners 16,000 views each month
- 130 Informational Letters sent
- Two provider trainings provided (3,000 providers attended)
- Quick Reference Guides available for "Prior Authorization"
- Listening Sessions held

- 365 Public Meetings held
- 12 Press Releases
- CMS hosted calls

Review of the "Managed Care Organization Report on First Quarter Performance Data" Report (dated August 26, 2016)

Liz Matney, Managed Care Director, reviewed the "Managed Care Organization First Quarter Performance Data" report, published August 26, 2016.

A copy of the report can be found on the Department's website: http://dhs.iowa.gov/news-releases/story_2

Much of the data in the report is self-reported by the Managed Care Organizations (MCOs). Additional data on demographics and level of capitation payments was provided by the Iowa Medicaid Enterprise. An independent audit will be conducted beginning in November and a report will be available early next year.

This report signifies the first set of comprehensive data since the program started.

Members may change from one MCO to another for any reason in the first 90-days, or at their annual re-enrollment. Members may also make a switch for 'good cause.'

When there are contractual non-compliance issues, the Department assures the MCO's meet the terms and obligations of the contracts. The Department could take several steps including:
- review if IME made correct calculations
- remedy recommendations
- corrective action plans
- assessment of liquidated damages
- continual monitoring by the IME

Palmer noted that compliance is a subject the Department takes seriously, and that decisions are made publicly.

Community-based Case Management ratios are monitored very closely. For this reporting period all plans are within appropriate case management ratios where defined. MCOs can have different ratios and must meet requirements set forth in their contracts.

If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization. Appeals are

usually due to prior authorization denial. The Department will be looking at trends to see why certain programs receive more grievances from members than others.

Timeliness of claims processing is an important issue. The Department looks to timeliness of payment as well as if the full amount was paid and at the right rate. IME has dedicated staff to review escalated issues and encourages providers to provide IME as much information as possible.

Regarding the 'Member Hotline' - the MCO's themselves utilize the 'secret shopper' method to monitor how calls are handled. Using industry standards, they measure soft skills, lost calls, etc. IME works diligently to correct member helpline call problems.

The Department is keeping a close eye on 'Prior Authorizations' (PAs) as PAs must be completed within 7 calendar days of request.

Jean Slaybaugh gave an overview of the plan's financial performance measures (pages 47-50). 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.

In the next quarterly report, the department will work with the MCOs to standardize reporting of financial metrics and minimize controllable variances. This will enhance benchmarking of performance across the plans.

Council Discussion and Wrap Up Role of Council

Anderson thanked staff and noted that the report is very helpful in meeting the goals on oversight.

Hansel also thanked staff and noted that the Council is receiving good information. She is concerned for the providers in the system and the energy they are expending to succeed and are in need of encouragement.

Council Update

Hansel reported she has had good connections with UnitedHealthCare and IME liaisons to resolve issues.

Director's Report

Director Palmer thanked the Council for their engagement over the last two days. This meeting was designed to begin to give the Council some exposure to the

complexities and layers of the managed care system. He encouraged the Council to give their feedback to Mark Anderson as the agendas for the next meetings are crafted.

NEXT MEETING/ADJOURNMENT

The next meeting of the Council on Human Services will be Wednesday, October 12, 2016.

Council adjourned at 1:45 p.m.

Submitted by Sandy Knudsen
Recording Secretary

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

Executive Committee
Summary of Special Meeting Minutes
August 5, 2016

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

Introduction
There was a roll call of Executive Committee members.

Election of Executive Committee Members
Regarding the five professional positions and the five public/consumer positions, Director Palmer suggested the election nominees for Committee positions include all members of Full Council for impartiality and the Committee agreed. It was determined that ballots were to be handed out and election of positions be held during the next Full Council meeting on August 18, 2016. A Biography Request Form was to be sent to Council members prior to the meeting and responses to be distributed to the Council for informed voting. Executive Committee would discuss at next Committee meeting how to transition information from current Committee members to new Committee members for smooth transition.

Administrative Rules
Lindsay reviewed drafted Administrative Rules by section. It was agreed that the statement regarding co-chairperson term in section 79.7(1) *Officers* would be updated to state that a co-chairperson shall serve no more than two consecutive terms. Regarding Section 79.7(2) *Membership*, discussion ensued concerning the presence of members sending representatives in their absence and whether they should have the authority to vote and participate; the Committee was to come back to this in a future meeting. Standing agenda item to be added regarding addition of procedures as deemed by the director and other members of the Committee.

Adjourn
3:30 P.M.

August 11, 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

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

hawk-i
Healthy and Well Kids in Iowa

BOARD MEETING MINUTES
August 15, 2016

BOARD MEMBERS

Angela Burke Boston
Jim Donoghue
Eric Kohlsdorf
Kelly Renfrow
Dr. Bob Russell

EX-OFFICIO LEGISLATIVE MEMBERS

Representative John Forbes
Senator Janet Petersen (absent)
Representative Ken Rizer (absent)
Senator Jack Whitver

Staff

Mikki Stier
Debbie Johnson
Liz Matney
Anna Ruggle
Matt Highland
Nick Peters
Dr. David Smith

Guests

Joe Estes, MAXIMUS
Lynh Patterson, Delta Dental
Jean Johnson, IDPH
Patty Funaro, Legislative Services Agency
Jess Benson, Legislative Services Agency
Lesley Christensen, VNS of Iowa
Kris Bell, Senate Democratic Caucus
Nancy Lind, United Health Care of the River Valley, Inc.
Sandi Hurtado-Peters, IDOM
Rebecca Anderson, University of Iowa College of Pharmacy
Lauren Hansen, Amerihealth Caritas

CALL TO ORDER

Dr. Bob Russell called the meeting to order at 12:38 p.m.

ROLL CALL

All Board members were present. Two ex-officio legislative members were present

REPORT OF NOMINATING COMMITTEE AND ELECTION OF OFFICERS

Jim Donoghue reported for Nominating committee. He provided historical information that leadership has come from the public members. The committee recommends that Eric Kohlsdorf be chair for upcoming year and that Kelly Renfrow serve as vice-chair. A motion was made by Burke Boston and seconded by Donoghue to accept slate of officers. MOTION CARRIED UNANIMOUSLY.

APPROVAL OF MINUTES

Burke Boston pointed out two typographical errors on April 16, 2016 Meeting Minutes. A motion was made by Kohlsdorf and seconded by Donoghue to approve the April 16, 2016 meeting minutes as corrected and accept the May 19, 2016 minutes. MOTION CARRIED UNANIMOUSLY.

DIRECTOR'S REPORT

Director Mikki Stier introduced Liz Matney, IME bureau Chief for Managed Care who will give her overview later in the meeting.

Stier gave Managed Care transition update, this information has been presented to Department of Human Services (DHS) Council and will be presented to the Medical Assistance Advisory Committee (MAAC) later this week.

Stier highlighted pre-MCO initiatives:

- Iowa Health and Wellness Program (IHAWP) risk assessments and outcomes
- ***hawk-i*** care to children in Iowa
- State Innovation Model (SIM) to encourage more value-based services and the ability to quantify services

The move to Medicaid transformation includes:

- Improve access and quality of programs as well as measuring outcomes
- Accountability for our patients
- Create a more predictable and sustainable budget for Medicaid

Stier noted that the transformation was done with extensive collaboration with the Centers for Medicare and Medicaid Services (CMS):

- Review of a major coverage transformation moving more than a half-million individual's to a new program.
- CMS asked that members are able to access services that they have always depended on
- A majority of providers being paid in a timely manner.
- System issues being addressed timely and accurately

- Up-to-date information produced as quickly as possible and made available for review
- Challenges are addressed quickly, a Member Liaison has been added and will triage all departments to assure that issues are addressed
- MAAC Council continues to have monthly listening posts throughout the state for members, family members and providers ask questions and voice concerns to DHS.

Stier gave brief description of Iowa Health Link reports:

- Most states produce quarterly reports, Iowa Health Link will produce monthly reports on basic information.
- Legislation requires the production of quarterly and annual reports.
- Monthly reports include demographics; any trending will be seen in quarterly reports.
- Compliance issues will be seen in quarterly reports.
- Quarterly reports will be more in-depth and will be reviewed with the ***hawk-i*** board.

Matney reviewed the request for proposal (RFP) process and utilizing the RFP in building the contracts with the Managed Care Organizations (MCOs).

Oversight activity as defined in the RFP and contracts is carried out by a variety of parties:

- Staff at IME
- A variety of vendors that have expertise in Member, Provider, and Medical Services that know how things are supposed to work and can review information that the MCO's submit.
- DHS Fiscal Division that reviews and monitors expenses

Remedies are available if noncompliance is evident with the MCOs and their contracts.

Matney reported that four months into the transition, performance data is becoming available. Unfortunately, it is compiled so it is not real time. She reports that the data will be refined and defined as the program evolves.

Matney reviewed the April and May Managed Care Performance data reports. The quarterly reports, which will be much more comprehensive, will be available in the future.

Highlights of the reports:

- Data broken into three different program types
  hawk-i
  Iowa Wellness Plan
  Medicaid

- All three of the programs have different benefit structure.
  Traditional Medicaid is the largest program.

A majority of ***hawk-i*** members are enrolled in United Healthcare as of the May, 2016 report
Any differences in enrollment numbers have to do with reenrollments and rolling enrollment.
Collected data is a shot in time
Default assignments are made when the member chooses not to change MCO after they are initially assigned.

- Age breakdown of members shows that the biggest population is 0-21 of age.

- Community-based care versus facility-based care is important because Iowa received a Balancing Incentives Grant (BIP) approximately 4 years ago that provided funds for more tools to keep people in their community location.

Key measures in the monthly reports include:

- Whether providers received payment in the contract specified time of 14 days. This is only for clean claims that are completed correctly
- Services that are prior authorized (PA) for medical and pharmacy billing according to timelines established in the contract
- Call centers are answering calls with the time frames required in the contracts
- CMS required a certain threshold of historical utilization being met for the managed care environment before authorization. This was provided and included existing data for the MCOs to compare and ensure that all members would have current services available with the new networks.

HF 2460 CHANGES TO *hawk-i* PROGRAM AND BOARD RESPOSIBILITIES

Debbie Johnson reported that House File (HF)2460, passed in the last legislative session required that occupational therapy services, both rehabilitative and habilitative, be added to provided services offered by the MCOs. This change is included in the new rules discussion later in the meeting.

Stier reported that a member of the ***hawk-i*** board needs to be appointed to the MAAC that meets quarterly. The ***hawk-i*** representative will not attend the monthly executive meeting. The next MAAC meeting is Wednesday 8/17/16 at 1:00 p.m. Burke Boston moves that Eric Kohlsdorf, new ***hawk-i*** board chair, be appointed to serve as the representative to the MAAC. Donoghue seconded the motion. MOTION CARRIED UNANIMOUSLY.

Stier outlined additional reporting needed for the Legislative Oversight committee will include the performance reports and the minutes of ***hawk-i*** board meetings. Monitoring of the board is defined as anytime the ***hawk-i*** board discusses managed care that it is reflected in the minutes.

REPORT BY *hawk-i* CLINICAL ADVISORY COMMITTEE

Dr. David Smith, Iowa Medicaid Medical Director, introduced himself and gave a report on the ***hawk-i*** Clinical Advisory Committee. He defined the role of the committee during the transition and the ongoing role advising the ***hawk-i*** board. The committee has addressed the evaluation of the metrics that will be coming from the MCOs and think those numbers will suffice to draw conclusions for reaction from the committee.

OUTREACH REPORT

Jean Johnson, Iowa Department of Public Health (IDPH) ***hawk-i*** Outreach Coordinator, gave a report to the board about outreach activities. Johnson provided a written report to the board. In the last quarter, her time has been spent with the statewide outreach coordinators to determine what outreach activities they are conducting and providing information and answering questions about the MCO transition.

COMMUNICATION UPDATES

Matt Highland reported that the ***hawk-i*** website move to the DHS site has been delayed due to need for an encrypted information form frequently used on the current website. Highland also announced the creation of a ***hawk-i*** e-news that is available to everyone through subscription on the ***hawk-i*** and IME website.

RULES

Debbie Johnson described the new rules, which had been previously mentioned, adds occupational therapy services to ***hawk-i*** coverage. The rule also clarifies the guidelines of the Federal Poverty Limit (FPL) adjustment increase because of the Affordable Care Act (ACA). Additionally, the rule includes translation and interpretation services for hawk-i services. Johnson points out that this rule will have a minimal fiscal impact. Donoghue moves to adopt the rules. Kohlsdorf seconded the motion. MOTION CARRIED UNANIMOUSLY

PUBLIC COMMENT

Lesley Christensen made comments about the following items:

- Questions if the monthly reports will break down the number of denials?
- Questions if satisfaction results be included in the reports? Her worry is that the call centers answer calls timely, however, they Customer Service Representative may not provide the answers that are asked by the member
- Voiced concern about newborns not having coverage because of movement to the incorrect coverage area after birth
- Concerns about dental coverage and a request for greater outreach to the ***hawk-i*** population
- Voiced concern about transportation guidelines and the need for additional passengers if a child needs to be accompanied by family members

NEXT MEETING

The next meeting will be October 17, 2016.

ADJOURNMENT

The Chair asked for a motion to adjourn. A motion was made by Burke Boston and seconded by Kohlsdorf. MOTION CARRIED UNANIMOUSLY. Meeting adjourned at 1:48 p.m.

Submitted by,

Nick Peters, Recorder of Minutes

Iowa Department of Human Services

Terry E. Branstad
Governor

Kim Reynolds
Lt. Governor

Charles M. Palmer
Director

Iowa Mental Health and Disability Services Commission

November 8, 2016

EXECUTIVE SUMMARY

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

Mental Health and Disability Services Commission Deliberations Summary:

January 21, 2016 - MHDS Commission Meeting
Deb Johnson, Bureau Chief of Long Term Care at Iowa Medicaid Enterprise (IME), presented to the Commission on the transition to IA Health Link. There was discussion of member and provider communication, network adequacy, and how IME was working to get approval to move forward with the transition from the Centers for Medicare and Medicaid (CMS).

February 18, 2016 - MHDS Commission Meeting
Rick Shults presented to the Commission on the Department's progress towards the transition to IA Health Link, and the letter from the Center on Medicare and Medicaid Services laying out the pathway to approval for Iowa's waiver application.

June 16, 2016 - MHDS Commission Meeting
Mikki Stier, Director of Iowa Medicaid Enterprise, presented to the Commission on the Medical Assistance Advisory Council (MAAC). She shared the make-up, the statutory duties, and the role of the MAAC in the Medicaid program.

September 15, 2016 - MHDS Commission Meeting
Liz Matney, Bureau Chief for Managed Care, presented the first Quarterly Report from IA Health Link, and discussed the progress and challenges of IA Health Link from the last three months.

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

October 20, 2016 - MHDS Commission Meeting

The Commission discussed its executive summary to the Department and the members' thoughts on Medicaid Managed Care over the previous year. The MHDS Commission sees value in managed care as a way to innovate and produce better health outcomes for Iowans. The Commission has noticed that the Medicaid Managed Care Organizations (MCO) have been involved with the provider community and are working with stakeholders in the community to develop service capacity. However, to this date, the Commission is not aware that any new significant services have been approved or implemented.

During the course of their deliberations, the Commission has heard of a number of concerns from stakeholders 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 and short notices of discharge result in a lack of appropriate and effective planning for transitions into community treatment
- 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

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

Jessie Parker Building
510 E 12th Street, Ste. 2
Des Moines, IA 50319
515.725.3333 | 866.236.1430
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Executive Summary

In July 2015, the Office of the State Long-Term Care Ombudsman (OSLTCO) became the advocate for 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.

In response to that charge, the OSLTCO created the Managed Care Ombudsman Program to formalize and promote our advocacy role related to the rights and needs of Medicaid managed care members receiving care in a health care facility such as nursing homes, assisted living programs (ALP), elder group homes, or intermediate care facilities for the intellectually disabled (ICF/ID) as well as members enrolled in one of the seven home and community-based services (HCBS) waiver programs. This equates to serving just under 57,000 members receiving long-term services and supports (LTSS) or approximately 10 percent of the total Medicaid managed care population.

Since the transition to managed care, the Office has been addressing member concerns and issues, and tracking and monitoring systemic issues affecting members at large. Over the course of the year, the Office has been meeting with the Iowa Medicaid Enterprise (IME), managed care organizations (MCO), and other community stakeholders through routine monthly meetings and as a member of the Medical Assistance Advisory Council (MAAC) to deliberate on these issues and to develop practical policy solutions.

House File 2460 directed the OSLTCO to regularly review Medicaid managed care as it relates to the Office's respective statutory duties and submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care. This Executive Summary, in furtherance of that requirement, will provide: 1) a summary of the member and systemic issues brought to the attention of the Office since the initial launch date of Medicaid managed care on January 1, 2016; 2) an overview of the Office's programmatic and administrative efforts; 3) a list of considerations for process and policy improvement; and 4) issues to watch as the State progresses toward year two of implementation.

I. Member Issues

The Office has been assisting Medicaid members and tracking issues since the initial launch date of January 1, 2016. The Office has received a total of 1,337 contacts from January 1, 2016 to October 31, 2016. Contacts were made to the office by both telephone and email and by members or their caregivers. The following table identifies the total contacts received per month and the top issues addressed. Examples have been provided for further information.

Month	Total Monthly Contacts	Top Issue	Examples
January & February	405	• Members' MCO selection were not being recorded at IME • IME Member Services call center had a wait time of up to 2 hours • Members did not understand letters sent to them from IME • Provider directories were inconsistent between IME and the MCOs	• Members reported issues primarily related to member's MCO selection not being recorded, challenges with reaching someone at IME within a reasonable amount of time about their issue, understanding what is expected of them with the transition, and identifying providers contracted with each MCO to make informed MCO selections.
March	42	• Access to services/benefits • Enrollment • Other service/coverage gap issue	• Members had difficulty with accessing a type of provider or service in their area since their provider had yet to contract with an MCO, selecting an MCO or enrolling in Medicaid or a waiver program.
April	143	• Keeping their care coordinator or case manager • Access to services/benefits • Eligibility	• Members reported being pressured to change their case manager prior to the 6 month transition date, unable to access their provider due to being out of network, not receiving communication regarding their Medicaid application, and long wait times before being able to receive services once determined eligible.

May	89	• Access to services/benefits • Customer service • Care planning	• Members continued to report issues with selecting or changing their MCO, lengthy wait times to receive services once determined eligible, participating in their care plan, and CDAC enrollment and reimbursement.
June	107	• Change in care setting • Member lost eligibility or was denied • Transition services/coverage inadequate or inaccessible	• Members reported difficulty with transitioning from care settings and, upon returning home, losing their waiver services. Transitioning between care settings were reported as extremely challenging.
July	81	• Access to preferred/necessary DME • Change in care setting • Service reduced, denied or terminated	• Members experienced difficulty with obtaining necessary DME as prescribed by their provider, finding in-state placement while working with their MCO, and having service hours reduced.
August	130	• Prior authorizations (PA) • Change in care setting • Care coordinator/case manager was rude	• Members continued to experience issues with finding an appropriate care setting and with receiving communication regarding a PA that was submitted on their behalf. Members reported poor customer service from MCO representatives.
September	188	• Change in care setting • Member has lost eligibility status or was denied • Access to services/benefits – Other	• Members experienced difficulty with transitioning between settings such as from a hospital or nursing home back home or finding appropriate care placement. Members continued to report losing their waiver services upon returning home from receiving skilled nursing in a facility.

October	152	• Change in care setting • Transition services/coverage inadequate or inaccessible • Other service/coverage gap issue	• Members continue to experience difficulty with transitioning between care settings once discharged from a hospital or skilled care facility or finding appropriate care placement with facilities not accepting new Medicaid members due to lack of reimbursement. Provider reimbursement, particularly for CDAC providers, continues to be an issue. Members have also reported issues with obtaining home and vehicle modifications necessary to live independently in their home.

II. Systemic Issues

The Office tracks and monitors issues that are systemic in nature, particularly those which impact multiple members and populations across the state, and works within the system to seek resolution. These issues are then highlighted in the Managed Care Ombudsman Program quarterly reports. The following issues have been pervasive since the launch of managed care and in some cases, existed prior to managed care but continue to require resolution:

a) Members are waiting 3 to 6 months to receive waiver services from the date of obtaining financial and medical eligibility approval by IME. This delay has resulted in the degradation of members' health which can lead to needing long-term care services in a facility setting and places additional financial strain on the member. This has also resulted in providers and facilities not being paid.

b) Members enrolled in a waiver who receive skilled care for 30 or more days have been losing their waiver services upon returning home and are required to go through the Medicaid application process again. This issue is particularly common among members enrolled in the Elderly Waiver program. Losing waiver services upon returning home from placement in a temporary skilled care facility has resulted in members accruing debt to providers or forgoing the services until their Medicaid application for waiver services is approved again. The re-application process appears to be an unnecessary step, as most members' financial and medical eligibility have not changed.

c) Providers have been receiving delayed reimbursement, inadequate reimbursement or no reimbursement at all since April 1st, 2016. As a result, many providers are refusing to accept new Medicaid members, reducing their case load and staff, and/or taking out business loans to remain solvent. This impacts not only the provision of care for members, but also provider network adequacy standards required by the Centers for

Medicare and Medicaid Services (CMS).

d) Members are not receiving a Notice of Action when a change in their service or covered benefit occurs or written prior authorization approval and denial letters for pharmaceuticals. As a result, members have been learning of the change in their care or benefit through their provider and are not given ample time to find an alternative to the service or benefit no longer provided. Additionally, without a written Notice of Action, the member does not have documentation of the decision or action taken by the MCO and, in many cases, does not then know of their rights to file an appeal or request a fair hearing as a result.

e) Members' grievances are not being documented and maintained in the MCO's system thus denying any record of such grievance being filed. As a result, the member's expression of dissatisfaction remains unacknowledged which circumvents the member's right to file a grievance and to receive written disposition of the resolution from the MCO.

f) There remains widespread miscommunication regarding various policies and procedures including the following:

   - Which party has authority to issue exceptions to policy (ETP): Prior to managed care, IME maintained authority to issue ETPs. This has caused confusion among members who need to request additional or other services and have caused delays in receiving those services due to not understanding the process.

   - Understanding of CDAC policies: Both members and providers have reported confusion regarding the ability for individuals to register and serve as an individual CDAC provider post June 30, 2016.

   Understanding of the role of the Managed Care Ombudsman Program: As the State's designated advocate for Medicaid managed care members receiving long-term services and supports (LTSS), the Office plays a unique role in advocating on behalf of members and in resolving issues within the system. There remains a lack of understanding regarding the specific role of the Managed Care Ombudsman Program, the broader role of the Office of the State Long-Term Care Ombudsman and the OSLTCO's ability to access documents and obtain confidential information with member consent in order to resolve issues among the MCOs. This lack of understanding has resulted in delayed issue resolution and interference of the work conducted by the Office.

III. Policy and Process Considerations

The following should be considered in reviewing the Medicaid managed care system:

a) **Improve communications within IME, among MCOs, and with Medicaid managed care members and their approved representative, and adopt consistent use of terminology.**

Oftentimes systems within an agency communicate in silos which frequently results in information not being shared with or transferred to the appropriate entity.

b) **Standardize claims submission processes.** Many providers have contracted with all three MCOs thus requiring them to understand and utilize three unique processes and procedures for submitting claims. This can be timely and expensive for small provider groups. Providers can only withstand not being paid for a period of time until they can no longer operate as a business entity and provide care to members.

c) **Create an advocacy ombudsman-type system for Medicaid members not served through the LTSS Managed Care Ombudsman Program.** The Office has received numerous contacts from populations outside the scope of the Office's authority. While the Office employs a policy that ensures all contacts receive a warm referral to the appropriate entity, the need for an advocate for the Medicaid population at large is evident. In 2015, the Office was required to convene a Health Consumer Ombudsman Alliance workgroup per Senate File 505 to develop a proposal for the establishment of a permanent coordinated system of independent consumer supports. The following were recommendations from that report:

   i. Develop a Medicaid Managed Care Information Program to assist Medicaid members in obtaining objective and unbiased information, counseling and options for enrollment,

   ii. Implement a statewide single point of entry to the system to facilitate seamless access to resources, supports, and assistance with issues related to health care services, coverage, access, and rights,

   iii. Expand the role of the advocacy ombudsman-type system to serve as an advocate for all Medicaid members, not just Medicaid managed care members receiving long-term services and supports,

   iv. Ensure capacity for legal advocacy for Medicaid members by expanding the current legal assistance network, and

   v. Establish a Health Consumer Ombudsman Alliance to identify gaps and discuss overall health care needs of Iowans and make recommendations to address issues encountered.

IV. Issues to Watch

1. Wait time for members to receive waiver services once determined financially and medically eligible for Medicaid
2. Loss of waiver services if a member on a waiver receives skilled care in a facility for a brief period of time and returns home without the ability to promptly resume their

waiver services even though their financial and medical status have not changed

3. Providers denying admission to new Medicaid residents and tenants at their facility or no longer taking on new Medicaid members or case work due to lack of or inadequate reimbursement

4. Provider network adequacy as providers continue to deny admission or caring for new Medicaid members

5. Options for care placement as members seek residency of their choice that meets their needs

6. Circumvention of member's rights

APPENDIX

HCBS Waiver Waitlist – October 2016*							
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	32	1,220	715	7,774	2,057	12,064	775
Number of Individuals on Waiver Waitlist (DHS Function)	0	813	1,223	0	2,375	2,216	1,149
Waitlist Increase or (Decrease)	0	-182	-349	0	-246	-268	-243

*As reported in October 2016. October data represents September eligibility statistics.

Type of Noncompliance by MCO				
Identified Reporting or Compliance Issue	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
24 Hour Provider Access Report	1		1	2
Adult Preventative Care Report		1		1
Behavioral Health Population Report			1	1
Care Coordination Report			1	1
Correct Coding Initiative Report	1	1		2
Claims Processing Report	3			3
Elderly Population Report			1	1
Fall Risk Report		2		2
General Population Report			1	1
Geographic Access Report	4	4	2	10
Level of Care Assessment Report	3	2	2	7
Med PA – Regular Report	3	3		6
Not Report Related (Other Contract Compliance Issue)	4	2	2	8
Pharmacy Helpline Report		2		2
Prenatal and Childbirth Outcomes Report	1			1
Program Integrity Report	1		1	2
Provider Credentialing Report	1	1		2
Provider Helpline Report	2			2
Risk Assessment Report	1	1		2
Special Needs Population Report	1		1	2
Value Based Purchasing Report	1			1
Waivers Report		1		1
Grand Total	**27**	**20**	**13**	**60**

Type of Noncompliance Identified by MCO				
Type of Noncompliance	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
Did not meet performance standard	15	12	5	32
Does not meet contract requirements	4	2	2	8
Incomplete	8	5	1	14
Untimely		1	5	6
Grand Total	**27**	**20**	**13**	**60**

Remedies are subject to change due to review of information received from the managed care organizations following publication of this report.

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. PA 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.