



Hawki Board Materials

Monday, October 21, 2019

1. Agenda of Meeting for October 21, 2019
2. August 19, 2019 Hawki Board Meeting Minutes
3. Administrative Rules- Passive Assignment and Premium Timeline Changes
4. [MCO Quarterly Report-SFY19, Quarter 4](#)¹

¹ https://dhs.iowa.gov/sites/default/files/SFY19_Q4_Report.pdf?100920191311



**Hawki Board Meeting
August 19, 2019**

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

Call to Order and Roll Call

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

Approval of the Hawki Board Meeting Minutes

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

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

Director’s Report

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

Updates from the MCOs

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

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

ClickPay

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

Outreach

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

Public Comment

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

New Business

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

Next Meeting

The next meeting will be October 21, 2019.

Meeting adjourned at 1:36 PM.

Submitted by,

Adrian Olivares
Recording Secretary
ao

RULE LOG

SUBJECT: 20-008 HAWK-I ENROLLEMENT AND UPDATES

RULES AFFECTED: 86.1, 86.3(8), 86.5(1), 86.6, 86.7(3), 86.8, 86.20

<u>ACTUAL</u>	<u>PROJECTED</u>	TYPE OF FILING:	Regular
2/20	-----	Date Policy Analysis received a complete request.	
2/21	to 2/22	Circulation to program staff and AG	
_____	4/23	Notice review by hawk-i Board	
_____	7/11	Sent to IGOV for pre-clearance	
_____	7/23	Sent to ARC for notice publication	ARC _____
_____	8/14	Published in Iowa Administrative Bulletin	____35 days ____180 days
_____	9/10	Notice review by Administrative Rules Review Committee	
_____	9/14	Public comments due / Public hearing dates	
_____	9/24	Response to comments and final changes due to Policy Coordination	
_____	9/28	Rules to be adopted sent to hawk-i Board	
_____	10/21	Hawk-i Board action	
_____	10/30	Approved rules sent to ARC for filing	ARC _____
_____	11/20	Published in Iowa Administrative Bulletin and Code	____35 days
_____	12/10	Final review by Administrative Rules Review Committee	
_____	12/25	Effective date	

ADDITIONAL ACTIONS

Manual and form revisions due _____

State plan revision due. _____

HUMAN SERVICES DEPARTMENT [441]

Adopted and Filed

The Human Services Department amends Chapter 86, “Healthy and Well Kids in Iowa (HAWK-I) Program,” Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 514I.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 514I.

Purpose and Summary

These amendments add language to reflect the Department’s implementation of a passive managed care enrollment process. HAWK-I-eligible individuals will be passively enrolled with a managed care plan; however, the eligibility effective date will remain consistent with current practices. The amendments also add necessary definitions, revise the time frame for a decision on eligibility, clarify policy on when a waiting period does not apply, revise premium payment language, eliminate the lock-out period for premium nonpayment, make technical changes, and remove outdated program language.

Public Comment and Changes to Rule-Making

Notice of Intended Action for this rule-making was published in the Iowa Administrative Bulletin on August 28, 2019, as ARC 4627C.

The Department received one comment from the Iowa Hospital Association (IHA). The IHA stated they were broadly in favor of any proposal that seeks to increase program efficiencies in the Medicaid program while ensuring the goals of improving patient outcomes and reducing the overall cost of care. However; hospitals have concerns with the implementation of a passive managed care enrollment process for HAWK-I eligible individuals based on past experience. IHA would urge the Department to include safeguards to ensure the MCOs are aware of which members are assigned to them as soon as that assignment has been made. This will allow for eligible individuals to receive the care they need when they need it and for the providers to receive proper reimbursement. IHA does not have a problem with the expansion of the premium payment grace period to 45 days. However, IHA would urge the Department to implement a real time process to ensure the individual has medical coverage. Hospitals want to avoid situations in which the MCO’s system automatically removes or suspends the member from the MCO list for non-payment if the premium payment is made after the due date but within the 45-day grace period. IHA was concerned early removal could lead to delayed care and/or increased administrative burdens on providers.

No changes were made as a result of the concerns expressed by IHA. The Department will be monitoring any implementation issues and will address any potential problems as they occur.

These amendments are identical to those published in the Iowa Administrative Bulletin.

Adoption of Rule-Making

This rule-making was adopted by the HAWK-I Board on October 21, 2019.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its [regular monthly meeting](#) or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

The following rule-making actions will become effective on December 25, 2019.

ITEM 1. Adopt the following **new** definitions of “Enrollment broker” and “Passive enrollment process” in rule **441—86.1(514I)**:

“*Enrollment broker*” shall mean the entity the department uses to enroll eligible children with a managed care organization. The enrollment broker must be conflict-free and meet all applicable requirements of state and federal law.

“*Passive enrollment process*” shall mean the process by which the department assigns a child to a participating health or dental plan and which seeks to preserve existing provider-enrollee relationships, if possible. In the absence of existing relationships, the process ensures that members are equally distributed among all available health or dental plans.

ITEM 2. Amend subrule 86.3(8) as follows:

86.3(8) Time limit for decision. Decisions regarding the applicant’s eligibility to participate in the HAWK-I program shall be made within ~~ten~~ **45** working days from the date of receiving the completed application and all necessary information and verification unless the application cannot be processed for reasons beyond the control of the department ~~or third party administrator~~. Day one of the ~~ten day~~ **45-day period** starts the first working day following the date of receipt of a completed application and all necessary information and verification.

ITEM 3. Amend subrule 86.5(1) as follows:

86.5(1) Initial application. Coverage for a child who is determined eligible for the HAWK-I program on the basis of an initial application for either HAWK-I or Medicaid shall be effective the first day of the month following the month in which the application is filed, regardless of the day of the month the application is filed. However, when the child does not meet the provisions of paragraph 86.2(4)“a,” coverage shall be effective the first day of the month following the month in which health insurance coverage is lost. Also, a one-month waiting period shall be imposed for a child who is subject to a monthly premium pursuant to paragraph 86.8(2)“c” when the child’s health insurance

coverage ended in the month of application. EXCEPTIONS: A waiting period shall not be imposed if any of the following conditions apply:

a. to e. No change.

f. The child's parent is determined eligible for advance payment of the premium tax credit for enrollment in a qualified health plan through the Health Insurance Marketplace because the employer-sponsored insurance in which the family was enrolled is determined unaffordable in accordance with 26 CFR 1.36B-2(c)(3)(v).

g. The cost of family coverage that includes the child exceeds 9.5 percent of the annual household income.

ITEM 4. Amend rule 441—86.6(514I) as follows:

~~**441—86.6(514I) Selection of a plan.** At the time of initial application, if there is more than one participating health or dental plan available in the child's county of residence, the applicant shall select the health or dental plan in which the applicant wishes to enroll as part of the eligibility process. Upon the child's eligibility effective date, the child shall be assigned to a health or dental plan using the department's passive enrollment process. The enrollee may change plans only at the time of the annual review unless the provisions of subrule 86.7(1) or paragraph 86.6(2) "a" 86.6(1) "a" or subrule 86.6(2) apply. The applicant may designate the plan choice verbally or in writing. Form 470-3574, Selection of Plan, may be used for this purpose but is not required.~~

86.6(1) Period of enrollment. Once enrolled in a health or dental plan, the child shall remain enrolled in the ~~selected~~ health or dental plan for a period of 12 months.

a. *Exceptions.* A child may be enrolled in a plan for less than 12 months if:

(1) The child is disenrolled in accordance with the provisions of rule 441—86.7(514I). If a child is disenrolled from the health or dental plan and subsequently reapplies before the end of the original 12-month enrollment period, the child shall be enrolled in the health or dental plan from which the child was originally disenrolled ~~unless the provisions of subrule 86.7(1) apply.~~

(2) No change.

(3) A request to change plans is accepted in accordance with paragraphs ~~86.6(2) "b" and "c."~~ 86.6(1) "b."

b. *Request to change plan.* An enrollee may ask to change the health or dental plan either verbally or in writing to the enrollment broker:

(1) ~~Within 90 days following the date the initial enrollment was sent to the health or dental plan regardless of the reason for the plan change or whether the original health or dental plan was selected by the applicant or was assigned in accordance with subrule 86.6(3) of the enrollee's initial enrollment with the health or dental plan for any reason.~~

(2) At any time for cause. "Cause" as defined in 42 CFR 438.56(d)(2) as amended to ~~May 13, 2010~~ May 6, 2016, includes, but is not limited to:

1. to 4. No change.

All approved changes shall be made prospectively and shall be effective no later than the first day of the second month beginning after the date on which the change request is received.

c. *Response to request.*

~~(1) If the enrollee has not requested to change health or dental plans within 90 days following the date the initial enrollment was sent to the health or dental plan and it is determined that cause does not exist, the request to change plans shall be denied.~~

~~(2) All approved changes shall be made prospectively and shall be effective on the first day of the month following the month in which the request was made.~~

~~**86.6(2) Failure to select a health or dental plan.** When more than one health or dental plan is available, if the applicant fails to select a health or dental plan within ten working days of the written request to make a selection, the third party administrator shall select the health or dental plan and notify the family of the enrollment. The third party administrator shall select the plan on a rotating basis to ensure an equitable distribution between participating health and dental plans.~~

~~86.6(3)~~ **86.6(2)** *Child moves from the service area.* The child may be disenrolled from the health or dental plan when the child moves to an area of the state in which the health or dental plan does not have a provider network established. If the child is disenrolled, the child shall be enrolled in a participating health or dental plan in the new location. The period of enrollment shall be the number of months remaining in the original certification period.

~~86.6(4)~~ **86.6(3)** *Change at annual review.* If more than one health or dental plan is available at the time of the annual review of eligibility, the family may designate another plan either verbally or in writing to the enrollment broker. Form 470-3574, Selection of Plan, may be used for this purpose. The child shall remain enrolled in the current health or dental plan if the family does not notify the ~~third party administrator~~ enrollment broker of a new health or dental plan choice by the end of the current 12-month enrollment period.

ITEM 5. Amend subrule 86.7(3) as follows:

86.7(3) *Nonpayment of premiums.* The child shall be canceled from the program as of the first day of the month in which premiums are not paid in accordance with the provisions of subrules 86.8(3), ~~86.8(4)~~ and 86.8(5), unless premiums are subsequently received in accordance with the grace period provisions of subrule 86.8(4).

ITEM 6. Amend rule 441—86.8(514I) as follows:

441—86.8(514I) Premiums and copayments.

86.8(1) and **86.8(2)** No change.

86.8(3) *Due date.*

a. No change.

b. *Payment upon renewal.* “Renewal” means any application used to establish ongoing eligibility, without a break in coverage, for any enrollment period subsequent to an enrollment period established by an initial application.

(1) No change.

(2) All premiums due must be paid before the child will be enrolled for coverage. When the premium is received, the ~~third party administrator~~ department shall notify the health and dental plans of the enrollment.

c. *Subsequent payments.* All subsequent premiums are due by the fifth day of each month for the next month’s coverage ~~and must be postmarked no later than the last day of the month before the month of coverage.~~ Premiums may be paid in advance (e.g., on a quarterly or semiannual basis) rather than a monthly basis.

d. No change.

86.8(4) *Grace period.* A grace period shall be allowed on any monthly premium not received as prescribed in paragraph 86.8(3)“c.” The grace period shall be the ~~coverage month for which the premium is due~~ month immediately following the last month for which the premium has been paid.

a. Failure to submit a premium by the last calendar day of the grace period shall result in disenrollment.

b. If the premium for the grace period and the premium for the following month’s coverage is subsequently received within 45 calendar days following the last calendar day of the grace period, coverage will be reinstated ~~if the premium was postmarked or otherwise paid;~~ effective the first day of the calendar month following the grace period, without the need to reapply for coverage.

(1)~~In the grace period, or~~

(2)~~In the 14 calendar days following the grace period.~~

86.8(5) *Method of premium payment.* Premiums may be submitted in the form of cash, personal checks, electronic funds transfers (EFT), or other methods established by the ~~third party administrator~~ department.

86.8(6) and **86.8(7)** No change.

~~**86.8(8)** *Program lock-out.* A child who has been disenrolled from the program due to nonpayment of premiums shall be locked out of the program until the arrearage is paid in full or for a period not to~~

~~exceed 90 days, whichever occurs first.~~

~~a. Failure to pay the unpaid premiums shall result in denial of the application if less than 90 days has elapsed since the effective date of disenrollment. EXCEPTION: The unpaid premium obligation shall be reduced to zero if upon reapplication a premium would not be assessed because the household's income is less than 150 percent of the federal poverty level.~~

~~b. If the arrearage is not paid within 24 months of failing to pay a premium, the debt shall be expunged and shall no longer be owed.~~

ITEM 7. Amend subrule 86.20(3) as follows:

86.20(3) Premiums. Premiums for participation in the supplemental dental-only plan are assessed as follows:

a. No premium is charged to families who meet the provisions of subparagraph 86.8(2) "a"(1) or to families whose countable income is less than or equal to 167 percent of the federal poverty level for a family of the same size using the modified adjusted gross income methodology.

b. If the family's countable income is equal to or exceeds ~~167-168~~ percent of the federal poverty level but does not exceed 203 percent of the federal poverty level for a family of the same size, the premium is \$5 per child per month with a \$10 monthly maximum per family.

c. to e. No change.

f. The provisions of subrules 86.8(3) to 86.8(6) ~~and 86.8(8)~~ apply to premiums specified in this subrule.



Information on Proposed Rules

Name of Program Specialist Anna Ruggle	Telephone Number 515-974-3286	Email Address aruggle@dhs.state.ia.us
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1. Give a brief purpose and summary of the rulemaking:

These proposed amendments revise rules 86.1 (514I), 86.6 (514I), and 86.8 (514I) as well as subrules 86.3(8), 86.5(1), 86.7(3) and 86.20(3). The purpose of these amendments is to add language to reflect the Department's implementation of a passive managed care enrollment process. HAWK-I-eligible individuals will be passively enrolled with a managed care plan; however, the eligibility effective date will remain consistent with current practices. The proposed amendments also add necessary definitions, revise the timeframe for a decision on eligibility, clarify policy on when a waiting period does not apply, revise premium payment language, eliminate the lock-out period for premium non-payment, make technical edits, and remove outdated program language.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

Iowa Code 514I.4 and 514I.5; 42 CFR 457.

3. Describe who this rulemaking will positively or adversely impact.

Eligibility groups mandatorily enrolled in managed care will be automatically enrolled with a managed care organization (MCO) or dental prepaid ambulatory health plan (PAHP) using the State's passive or default enrollment process, rather than requiring enrollees to make a choice for MCO or dental PAHP assignment, upon eligibility determination. This will benefit enrollees as it will ensure quicker access to efficient care coordination but will still provide that an enrollee has the ability to change plans for any reason within 90 days of their initial enrollment.

Members will also benefit by the elimination of a lock-out period for premium non-payment. Currently, individuals who have outstanding premium payments at the time of renewal or re-application are not permitted to reenroll in HAWK-I until they pay their outstanding premiums or 90 days has passed. Under this proposed rulemaking, the lock-out period is removed and repayment of premiums is no longer a condition of re-enrollment.

4. Does this rule contain a waiver provision? If not, why?

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to rule 441—1.8(17A,217).

5. What are the likely areas of public comment?

The public may comment that the State, through its default or passive enrollment process, is limiting an enrollee's choice of plans; however, these changes do not impact the ability of enrollees to change plans within 90 days of initial enrollment. The elimination of the lock-out period will likely receive comments of support from member advocates.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

These changes are not likely to have an impact on jobs or employment opportunities in Iowa.



Administrative Rule Fiscal Impact Statement

Date: February 12, 2019

gency: Human Services
AC citation: 441 IAC 86.1; 86.3(8); 86.5(1); 86.6; 86.7(3); 86.8; 86.20(3)
gency contact: Anna Ruggle

Summary of the rule:

These proposed amendments revise rules 86.1 (514I), 86.6 (514I), and 86.8 (514I) as well as subrules 86.3(8), 86.5(1), 86.7(3) and 86.20(3). The purpose of these amendments is to add language to reflect the Department's implementation of a passive managed care enrollment process. HAWK-I-eligible individuals will be passively enrolled with a managed care plan; however, the eligibility effective date will remain consistent with current practices. The proposed amendments also add necessary definitions, revise the timeframe for a decision on eligibility, clarify policy on when a waiting period does not apply, revise premium payment language, remove the lock-out period for premium non-payment, make technical edits, and remove outdated program language.

Fill in this box if the impact meets these criteria:

- No fiscal impact to the state.
 Fiscal impact of less than \$100,000 annually or \$500,000 over 5 years.
 Fiscal impact cannot be determined.

Brief explanation:

[Budget Analysts must complete this section for ALL fiscal impact statements.](#)

Though some training associated with these rule changes may be necessary, no additional staff will be necessary, the work will be handled by current staff. Any form or manual changes are expected to be minimal and not have an impact. Changes to the data system are being taken care of in the movement from the contractor to in-house (MMIS), and this project is already funded. Therefore, this change will not cause additional fiscal impact to the program.

The elimination of the lock out period will not cause an increase in enrollment nor a reduction in premium collections. The rules are being updated to align with current practice.

Fill in the form below if the impact does not fit the criteria above:

Fiscal impact of \$100,000 annually or \$500,000 over 5 years.

Assumptions:

Agency representative preparing estimate: Phil Davis - Budget Analyst III

Telephone number: 515-281-6017

Comments and Responses on ARC 4627C
Hawki Passive Enrollment
Received September 17, 2019

The following person/organization provided written comments, which are included in the summary below:

1. Erin Cubit, Director Government Relations, Iowa Hospital Association

COMMENT:

The respondent stated the Hospital Association (IHA) was broadly in favor of any proposal that seeks to increase program efficiencies in the Medicaid program while ensuring the goals of improving patient outcomes and reducing the overall cost of care. However; hospitals have concerns with the implementation of a passive managed care enrollment process for HAWK-I eligible individuals based on past experience. IHA would urge the Department to include safeguards to ensure the MCOs are aware of which members are assigned to them as soon as that assignment has been made. This will allow for eligible individuals to receive the care they need when they need it and for the providers to receive proper reimbursement.

IHA does not have a problem with the expansion of the premium payment grace period to 45 days. However, IHA would urge the Department to implement a real time process to ensure the individual has medical coverage. Hospitals want to avoid situations in which the MCO's system automatically removes or suspends the member from the MCO list for non-payment if the premium payment is made after the due date but within the 45-day grace period. IHA was concerned early removal could lead to delayed care and/or increased administrative burdens on providers.

RESPONSE:

No changes were made as a result of the concerns expressed by IHA. The Department will be monitoring any implementation issues and will address any potential problems as they occur.



September 17, 2019

Nancy Freudenberg
Iowa Department of Human Services
Hoover State Office Building, Fifth Floor
1305 East Walnut Street
Des Moines, Iowa 50319-0114
Email: appeals@dhs.state.ia.us

RE: ARC 4627C – Proposing rule making related to managed care passive enrollment

Dear Ms. Freudenberg:

On behalf of Iowa's 118 community hospitals, the Iowa Hospital Association (IHA) submits the following comments on the Iowa Department of Human Services' proposed rule on managed care passive enrollment for HAWK-I-eligible individuals.

Broadly, IHA supports any proposals that seek to increase program efficiencies in the Medicaid program while ensuring the goals of improving patient outcomes and reducing the overall cost of care, however; hospitals have concerns with the implementation of a passive managed care enrollment process for HAWK-I-eligible individuals based on past experience.

IHA does not have a problem with the expansion of the time limit for a decision and the premium payment grace period to 45 days, however, in the past, hospitals and providers have experienced having problems with the managed care organizations (MCOs) knowing which members are theirs in a timely manner when any type of interruption or change in coverage status has occurred. **IHA would urge the Department to include safeguards to ensure the MCOs are aware of which members are assigned to them as soon as that assignment has been made.** This will allow for eligible individuals to receive the care they need when they need it and for the providers to receive proper reimbursement.

IHA also has concerns with the grace period for premium payments. Again, IHA does not have a problem with the expansion of the premium payment grace period to 45 days, however, **we would urge the Department to require the MCOs to implement a real time process to ensure the individual has medical coverage.** Hospitals want to avoid situations in which the MCO's system automatically removes or suspends the member from the MCO list for non-payment if the premium payment is made after the due date but within the 45-day grace period. Oftentimes, hospitals experience a several day delay for the MCO to process any changes and have their data system accept the changes in a new cycle. This could lead to delayed care and/or increased administrative burdens on providers.

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September 17, 2019

IHA appreciates the opportunity to comment on this draft guidance. Please contact me with questions or for more information.

Sincerely,

A handwritten signature in cursive script that reads "Erin Cubit".

Erin Cubit
Director, Government Relations
Iowa Hospital Association

Iowa Medicaid Enterprise



Managed Care Organization Report: SFY 2019, Quarter 4 (April-June) Performance Data

Published October 9, 2019



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Legislative Requirements:

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

- Consumer Protection
- Outcome Achievement
- Program Integrity

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

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

This report is based on Quarter 4 of State Fiscal Year (SFY) 2019 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

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

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS^{®1} CAHPS², and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However,

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.

based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

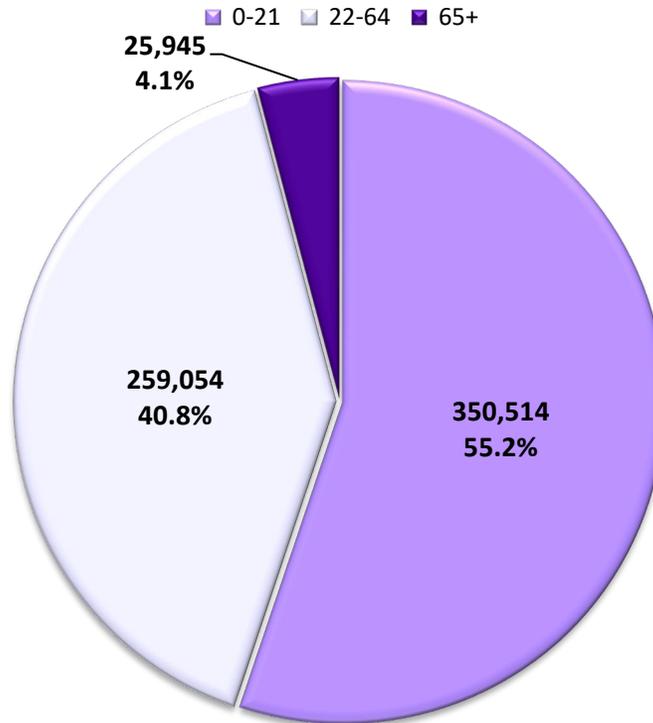
- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available Fee-for-Service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.

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

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

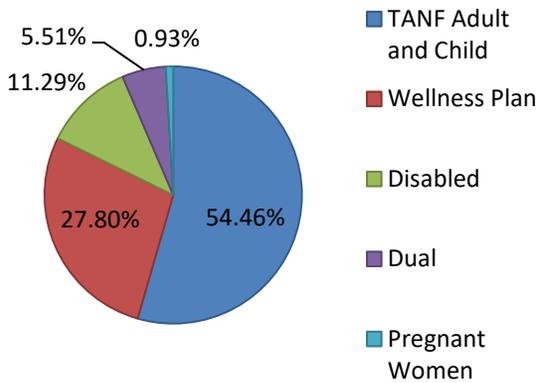
PLAN ENROLLMENT BY AGE

Managed Care Enrollment by Age Total MCO Enrollment = 635,513*

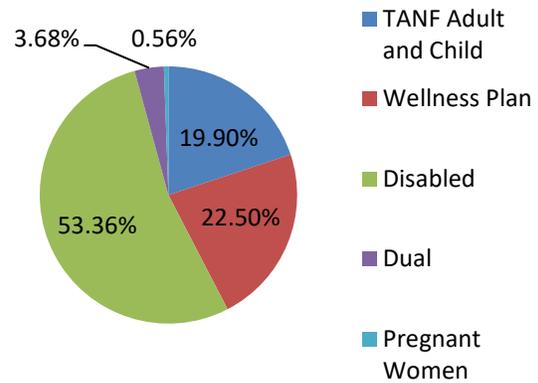


*June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes Hawki enrollees. 56,074 members remain in Fee-for-Service (FFS).

Capitated Enrollment

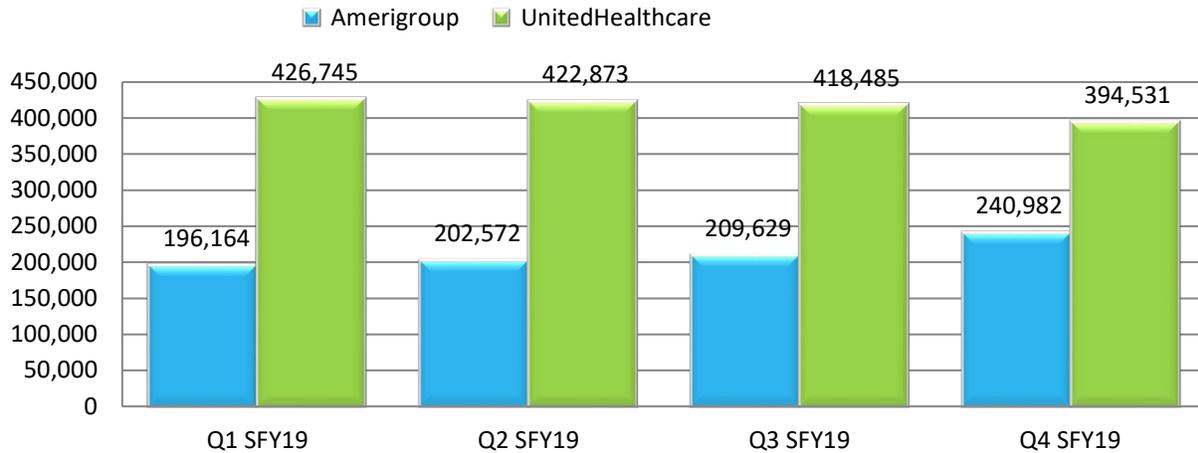


Capitation Expenditures



PLAN ENROLLMENT BY MCO

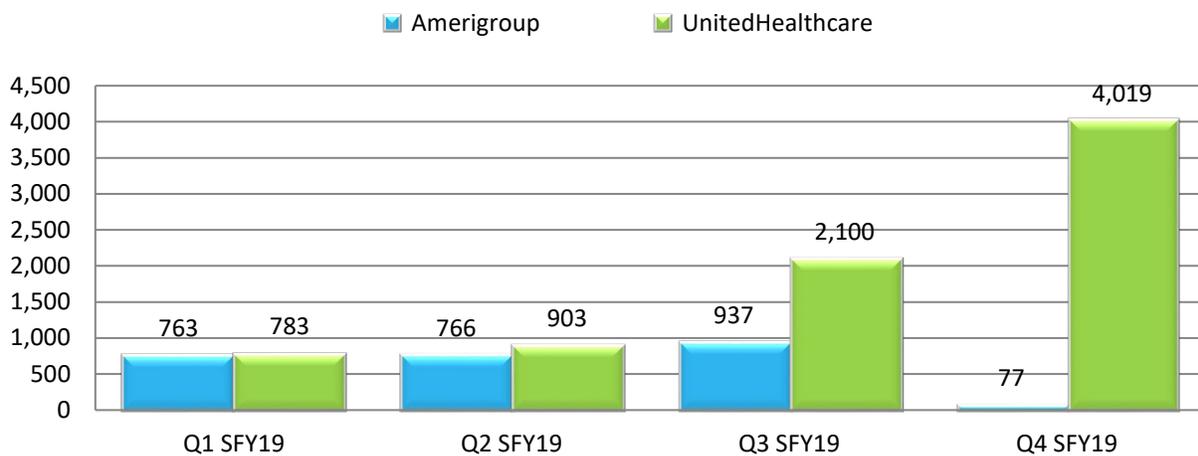
Total Plan Enrollment by MCO*



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

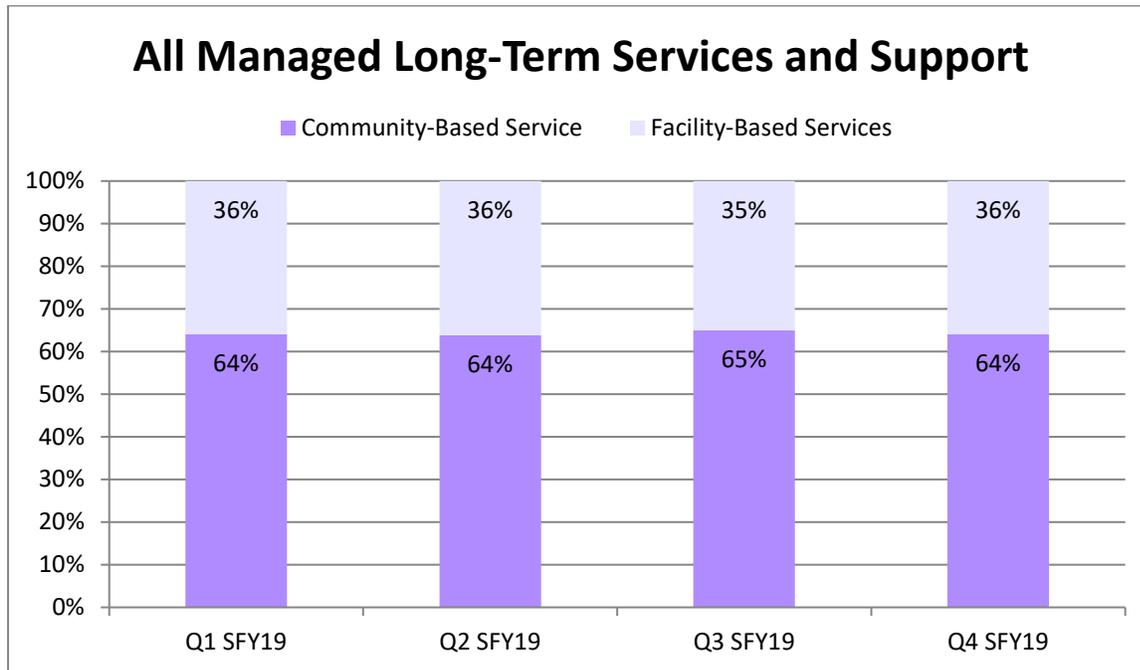
PLAN DISENROLLMENT BY MCO

Active Member Disenrollment by MCO*



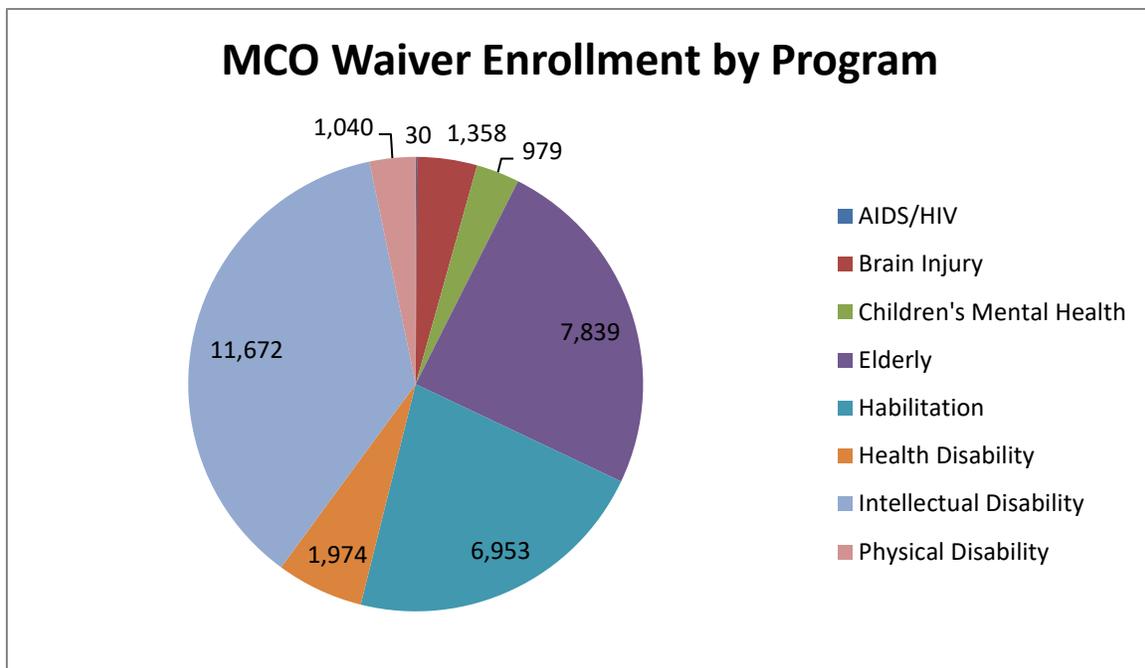
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



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

ALL MCO HOME AND COMMUNITY-BASED SERVICE WAIVER ENROLLMENT



CARE COORDINATION AND CASE MANAGEMENT

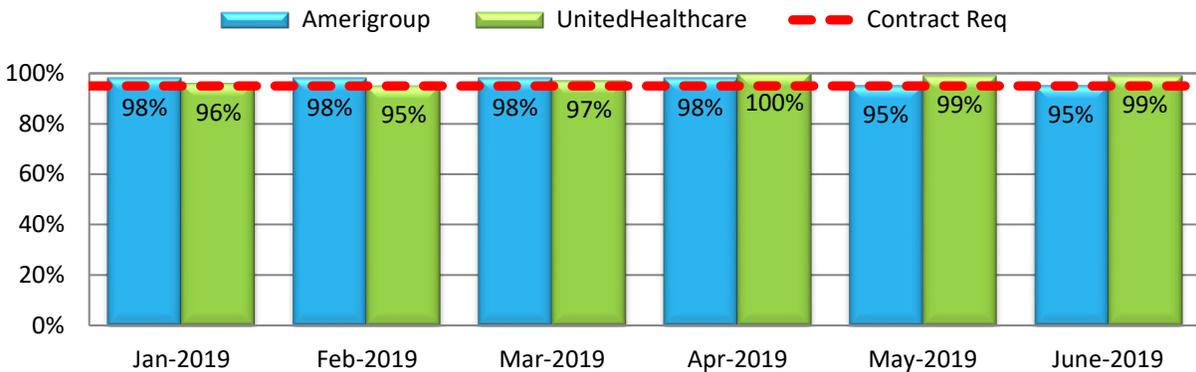
Average Number of Contacts		
Data Reported as of June 30, 2019	Amerigroup	UnitedHealthcare
Average Number of Care Coordinator Contacts per Member per Month	2.1	0.4
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.1

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

Level of Care

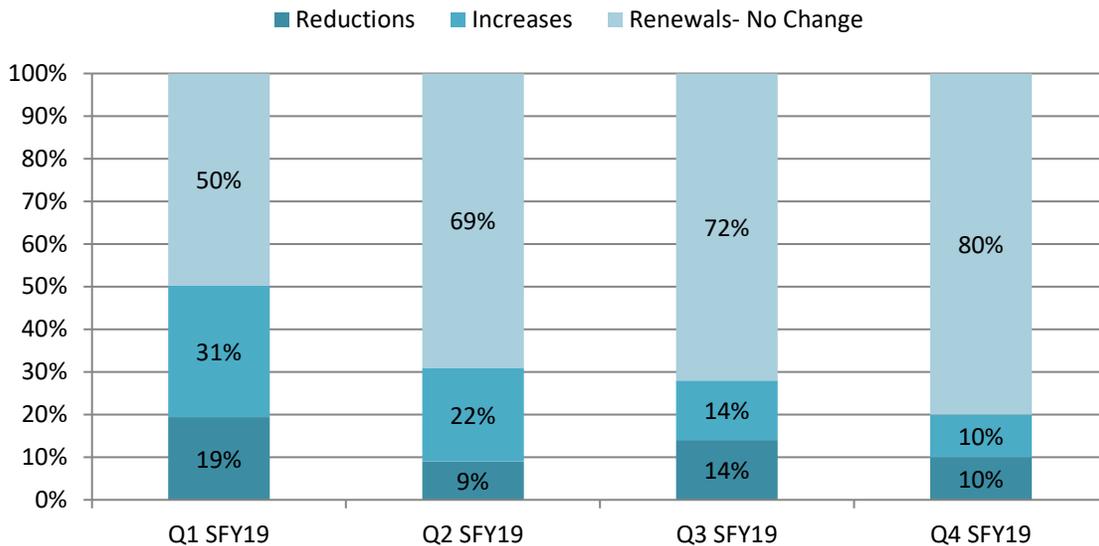
Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change.

Percentage of LOC Reassessments Completed Timely

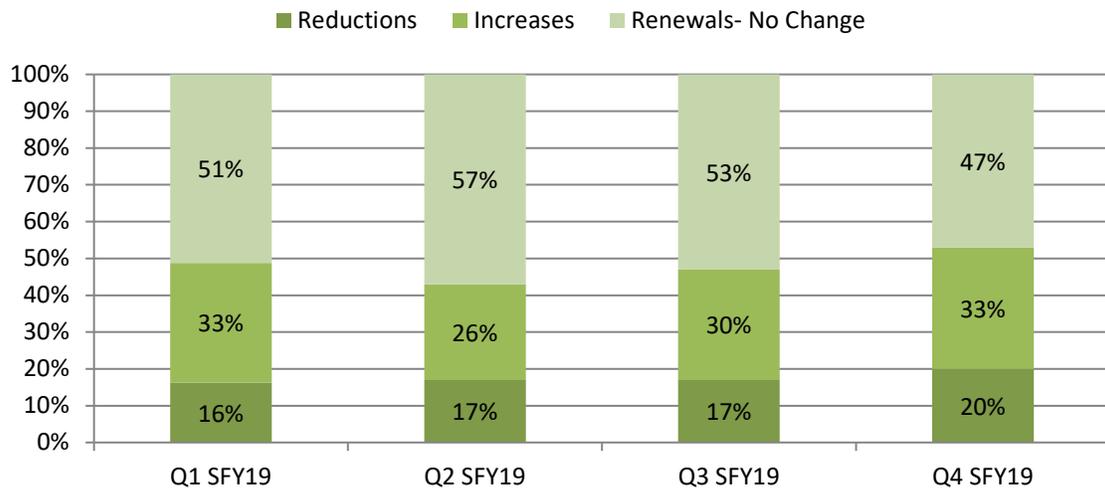


Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving Home and Community Based Services (HCBS). These are new measures for SFY 2019.

Amerigroup Service Plan Revision Outcomes



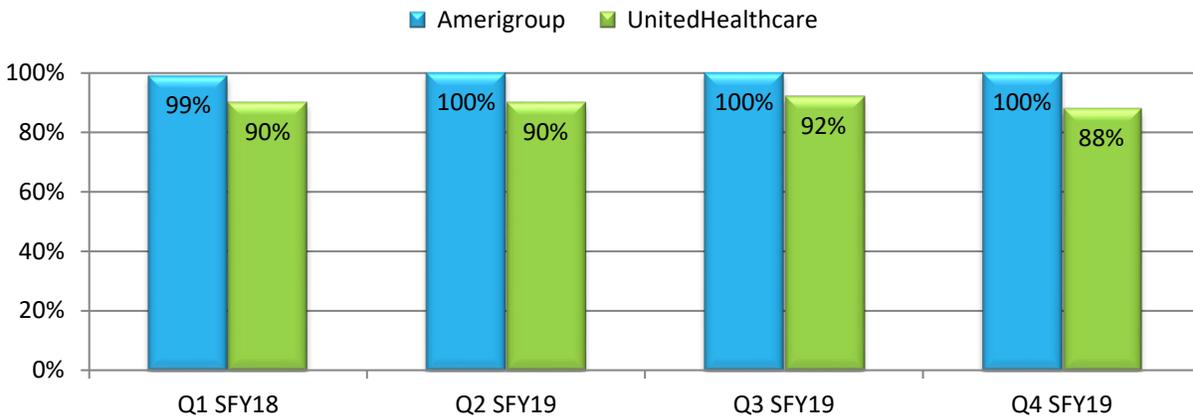
UnitedHealthcare Service Plan Revision Outcomes



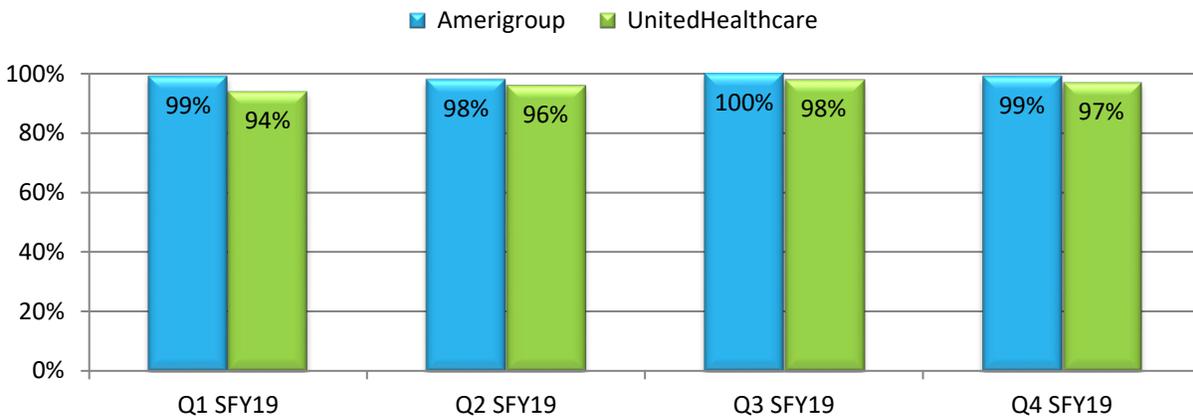
Iowa Participant Experience Survey Reporting

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

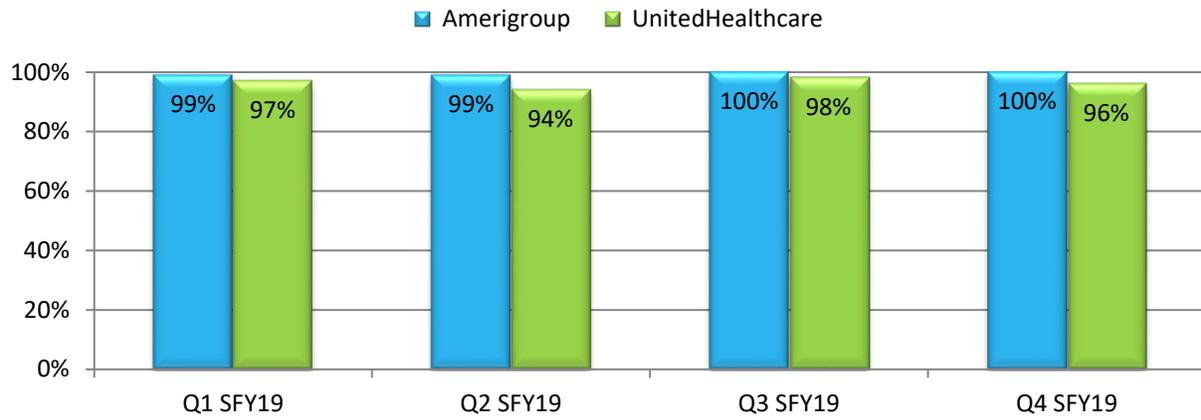
Members Reporting They Were Part of Service Planning



Members Reporting They Feel Safe Where They Live



Members Reporting Their Services Make Their Lives Better



MCO Member Grievances and Appeals

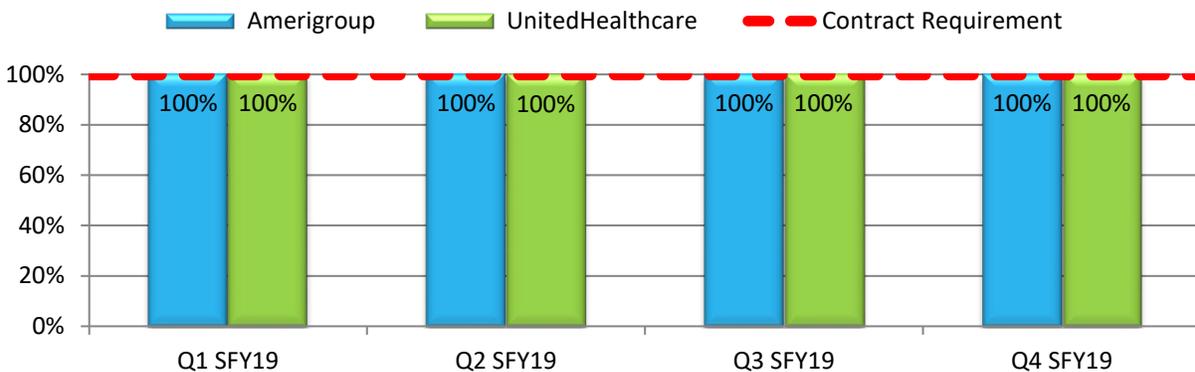
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the MCO.

Grievance: A written or verbal expression of dissatisfaction.

Appeal: A request for a review of an MCO’s denial, reduction, suspension, termination or delay of services.

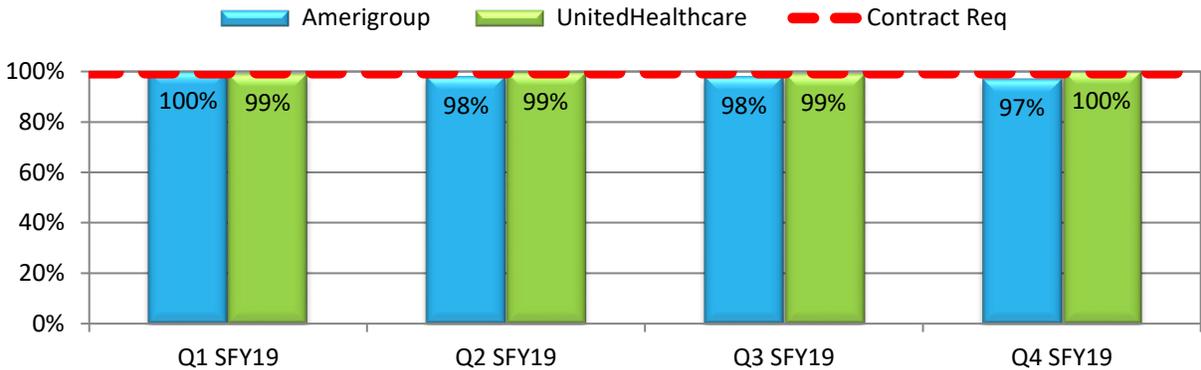
Resolved: The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Grievances Resolved within 30 Calendar Days of Receipt



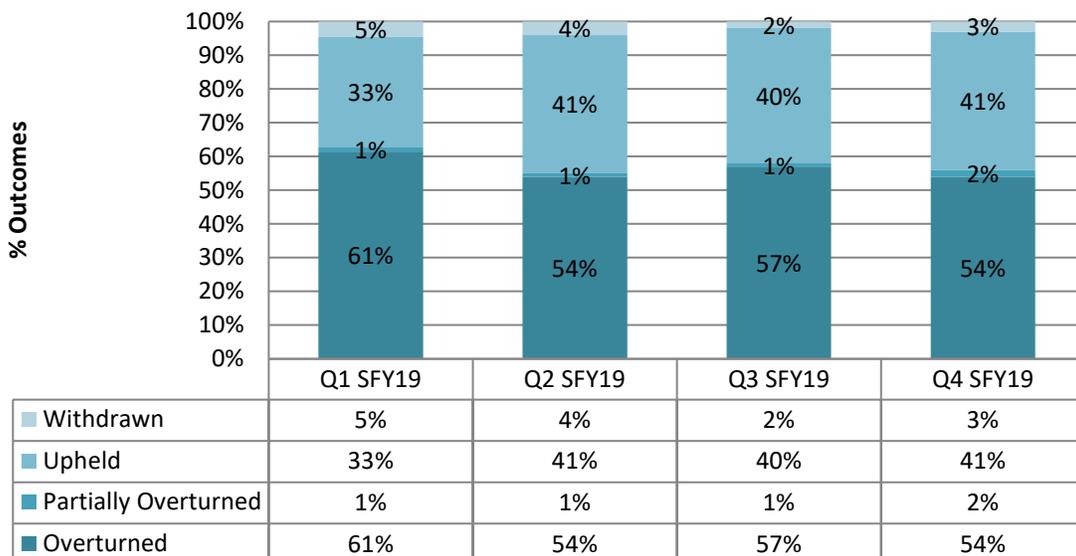
Supporting Data				
Metric	Amerigroup		UnitedHealthcare	
	Count	% Pop	Count	% Pop
Grievances Received in Q1 SFY19	228	0.10%	471	0.10%
Grievances Received in Q2 SFY19	280	0.13%	474	0.10%
Grievances Received in Q3 SFY19	314	0.14%	307	0.07%
Grievances Received in Q4 SFY19	248	0.09%	205	0.05%

Percentage of Appeals Resolved within 30 Calendar Days of Receipt

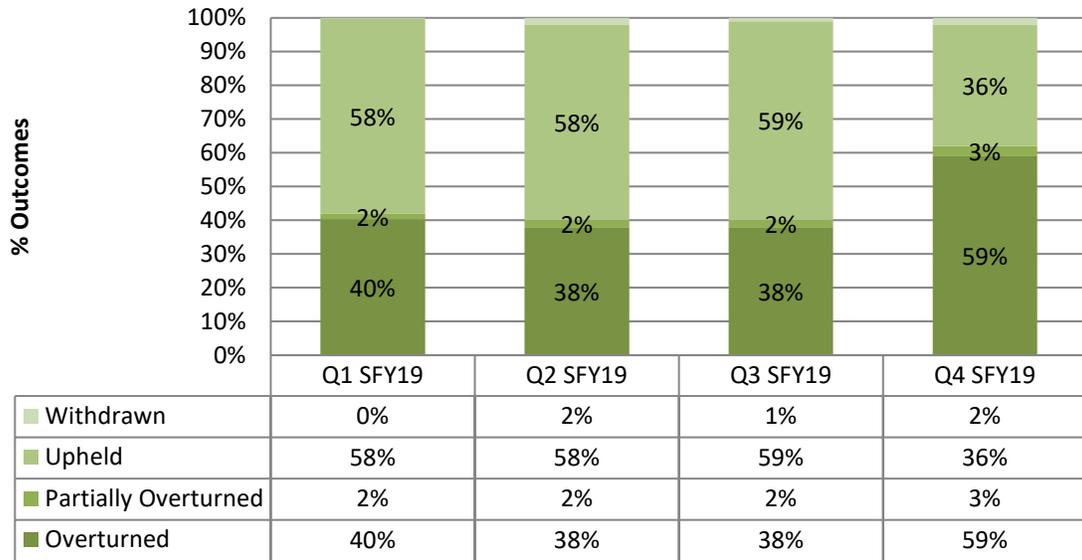


Supporting Data				
	Amerigroup		UnitedHealthcare	
Metric	Count	% Claims	Count	% Claims
Appeals Received in Q1 SFY19	285	0.01%	385	0.01%
Appeals Received in Q2 SFY18	239	0.01%	317	0.01%
Appeals Received in Q3 SFY19	233	0.01%	252	0.01%
Appeals Received in Q4 SFY19	211	0.01%	225	0.01%

Amerigroup Appeal Outcomes

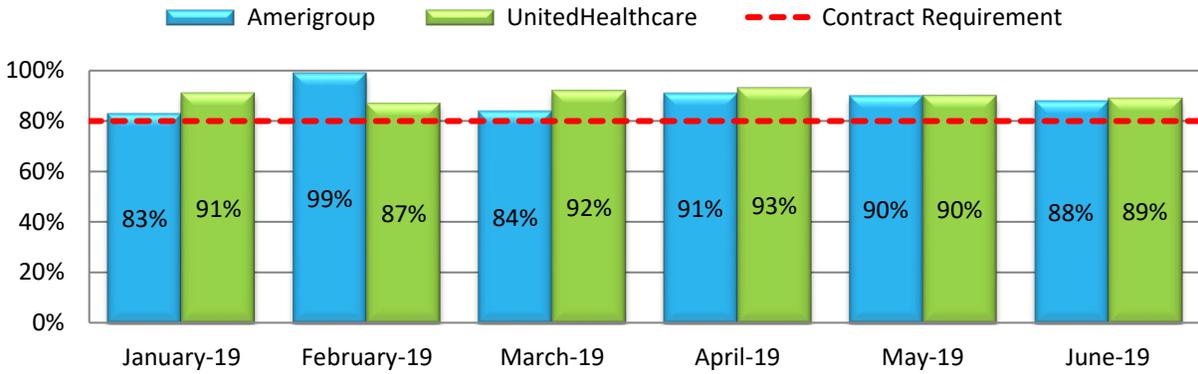


UnitedHealthcare Appeal Outcomes

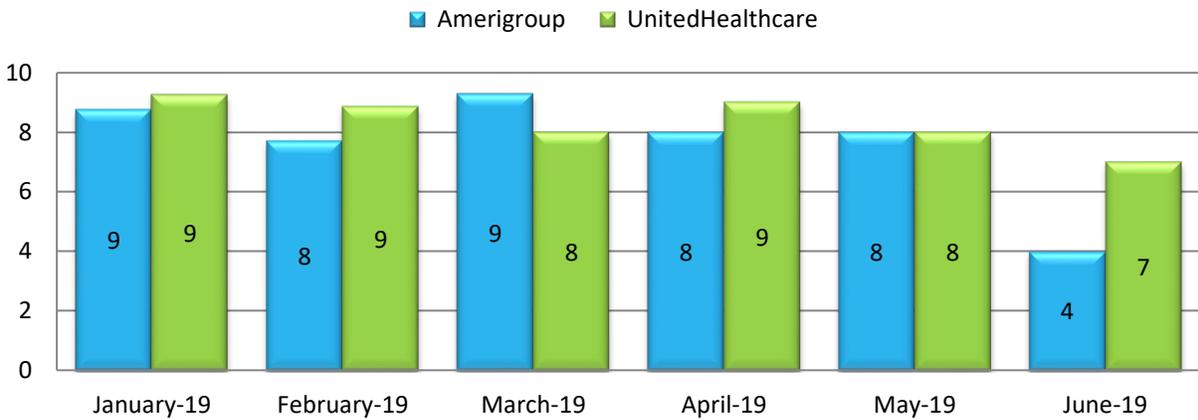


Member Helpline

Service Level: Percentage of Member Helpline Calls Answered Timely

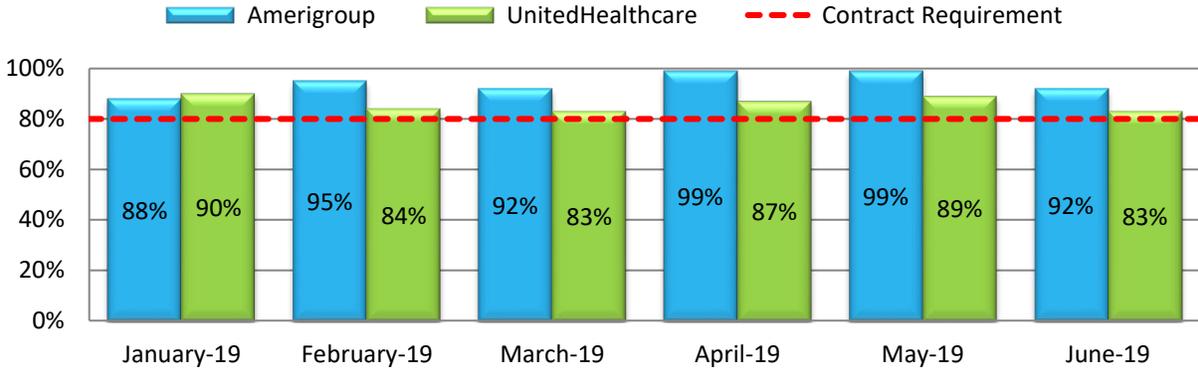


Secret Shopper: Member Helpline Average Monthly Score

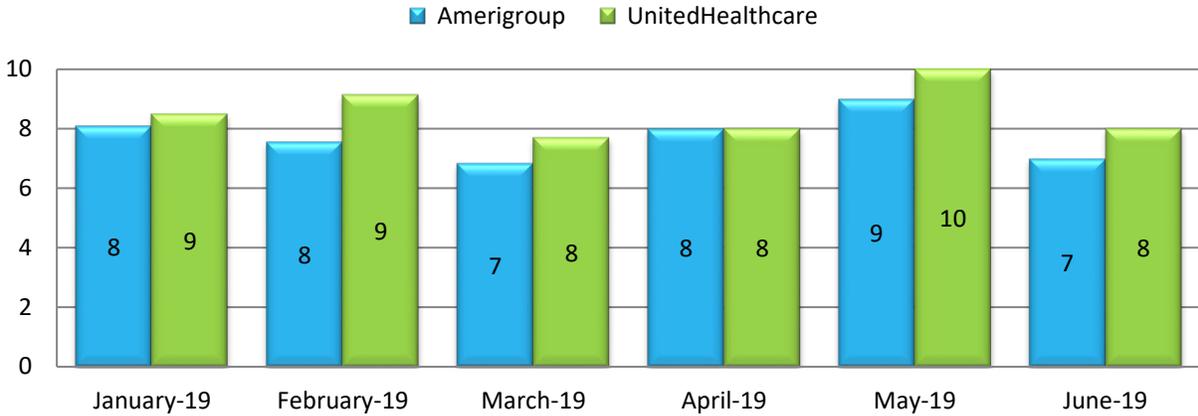


Provider Helpline

Service Level: Percentage of Provider Helpline Calls Answered Timely

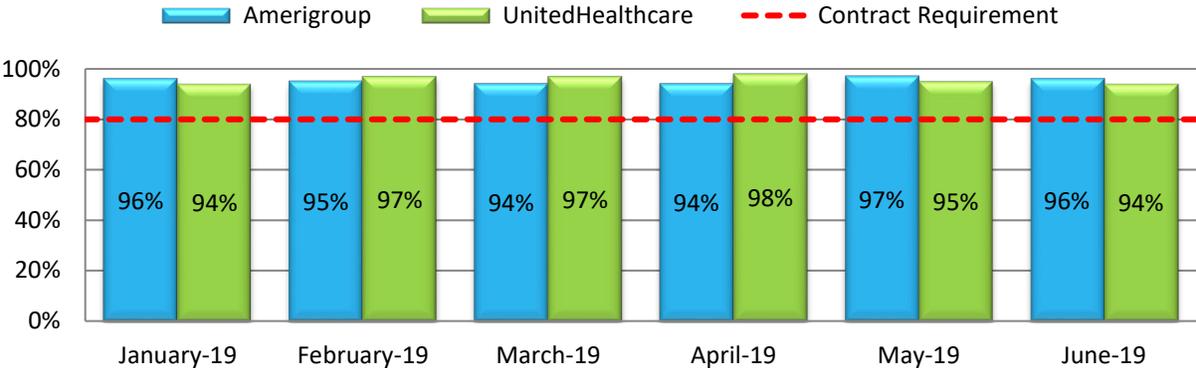


Secret Shopper : Provider Helpline Average Monthly Score



Pharmacy Services Helpline

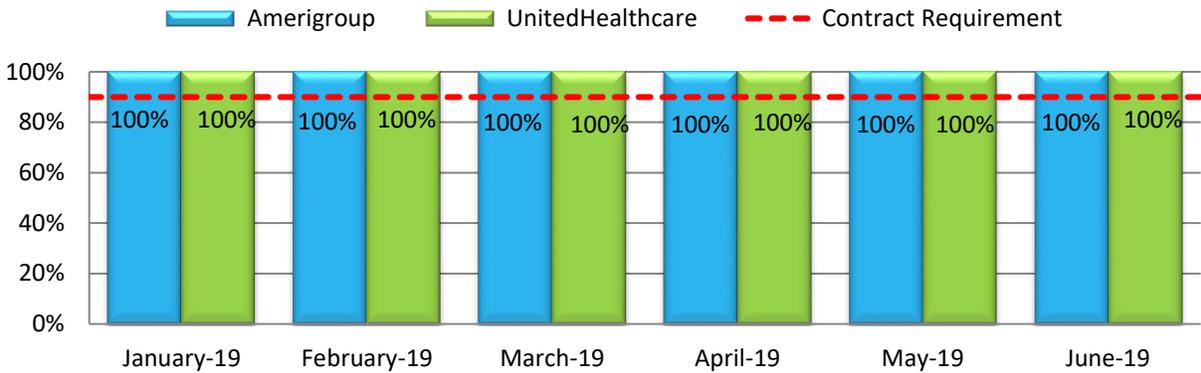
Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely



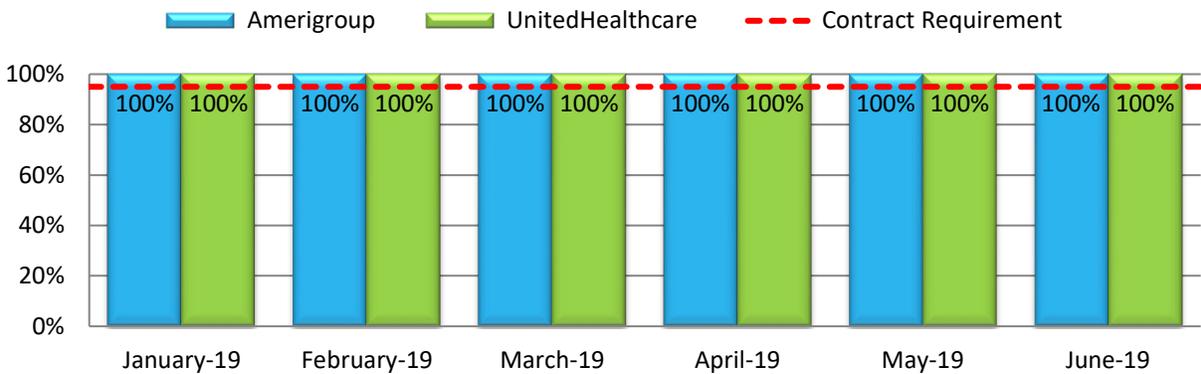
Non-Pharmacy Claims Payment

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

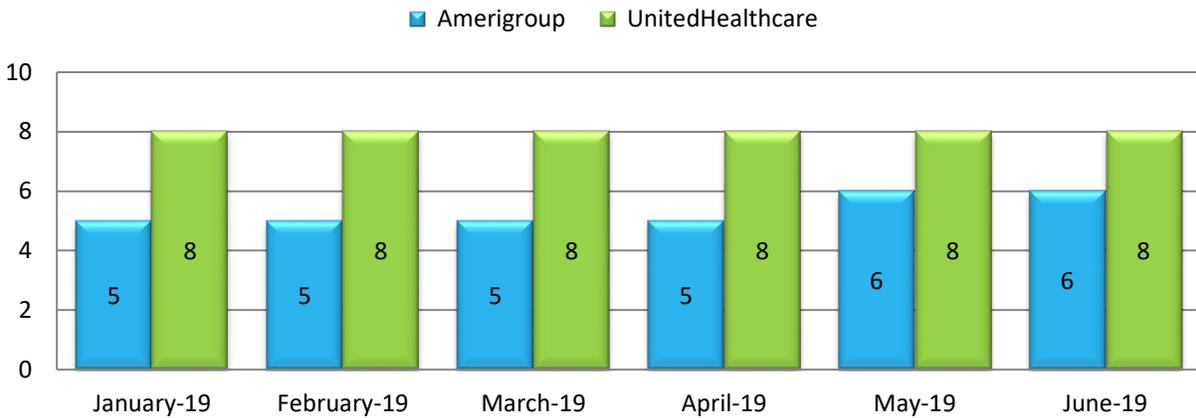
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days



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

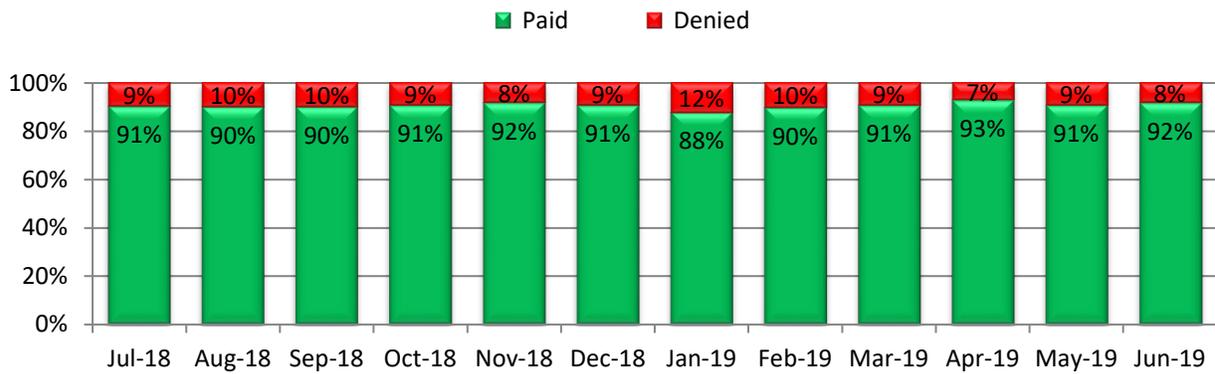


Average Days for Non-Pharmacy Claims Payment



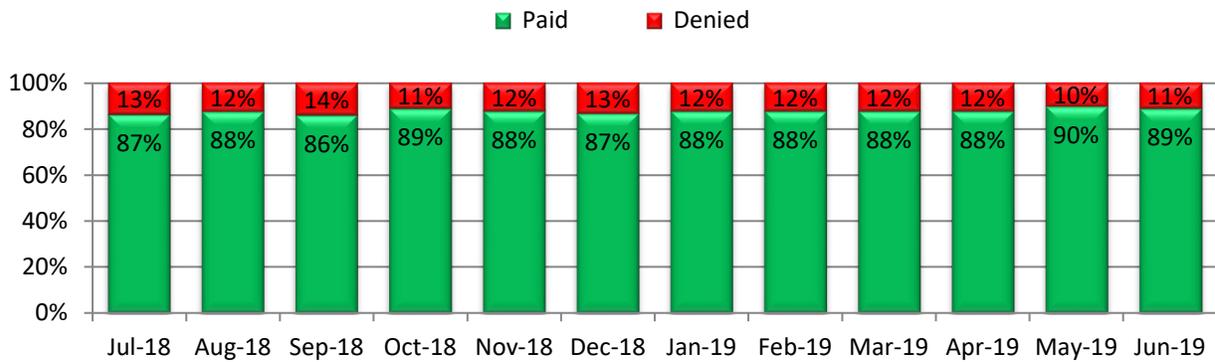
Amerigroup Non-Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Non-Pharmacy Claims Status

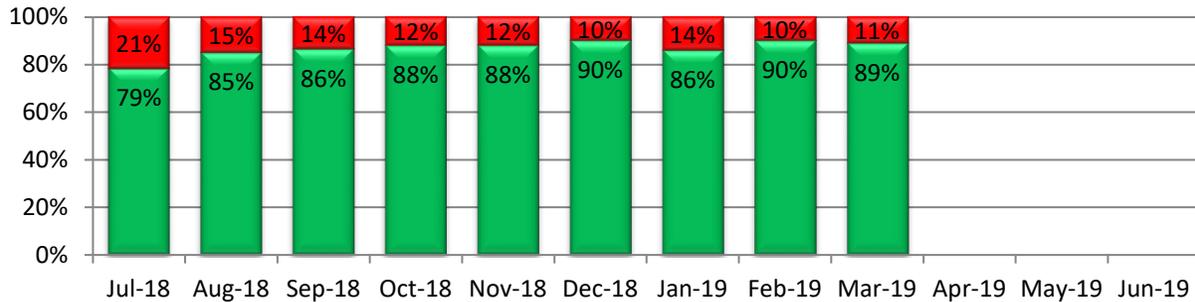
**As of the end of the reporting period



Amerigroup Suspended Non-Pharmacy Claims Payment Rates

**As of the end of the reporting period

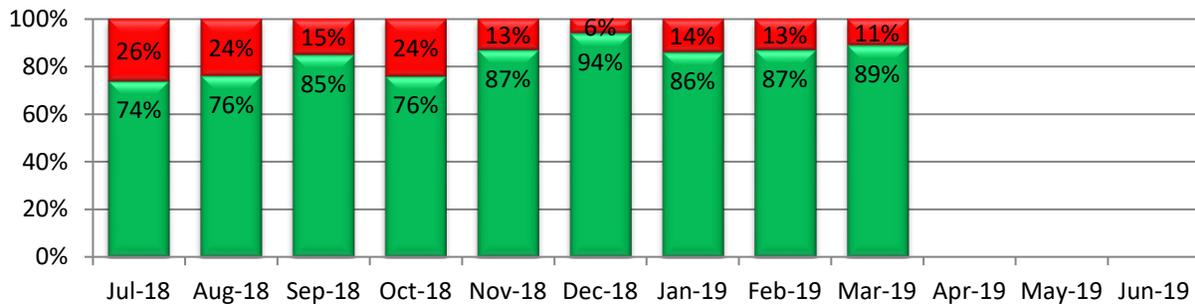
■ Paid ■ Denied



UnitedHealthcare Suspended Non-Pharmacy Claims Payment Rates

**As of the end of the reporting period

■ Paid ■ Denied



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

CARC and RARC are defined below table

#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)	30%	CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim	15%
2.	27-Expenses incurred after coverage terminated	15%	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary	13%

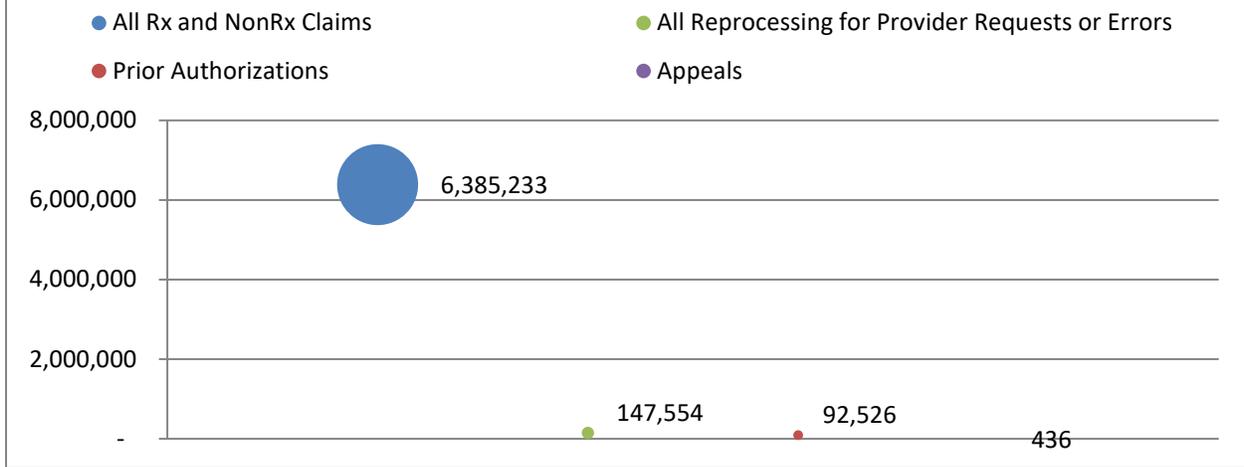
Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			payer. The information was either not reported or was illegible.	
3.	252-An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT) N479-Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)	9%	CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.	12%
4.	256-Service not payable per managed care contract	6%	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service	11%
5.	45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges	6%	CARC-29 The time limit for filing has expired.	6%
6.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	5%	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.	6%
7.	29-The time limit for filing has expired	5%	CARC-256 Service not payable per managed care contract. RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.	4%
8.	197- Precertification/authorization/notification absent	5%	CARC-97 The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately billed services/tests have been bundled as	3%

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

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

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

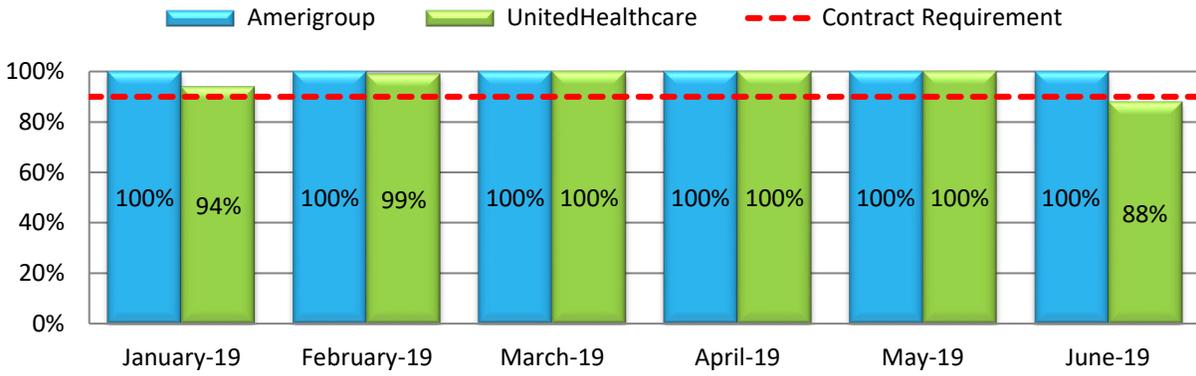
Quarterly Scope of Claims, Reprocessing, PAs, and Appeals



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

Supporting Data		
All Rx and NonRx Claims	6,385,233	% of Claims Universe
All Rx and NonRx Reprocessing for Provider Requests or Errors	147,554	2.31%
All Rx and NonRx Prior Authorizations	92,526	1.45%
Appeals	436	0.01%

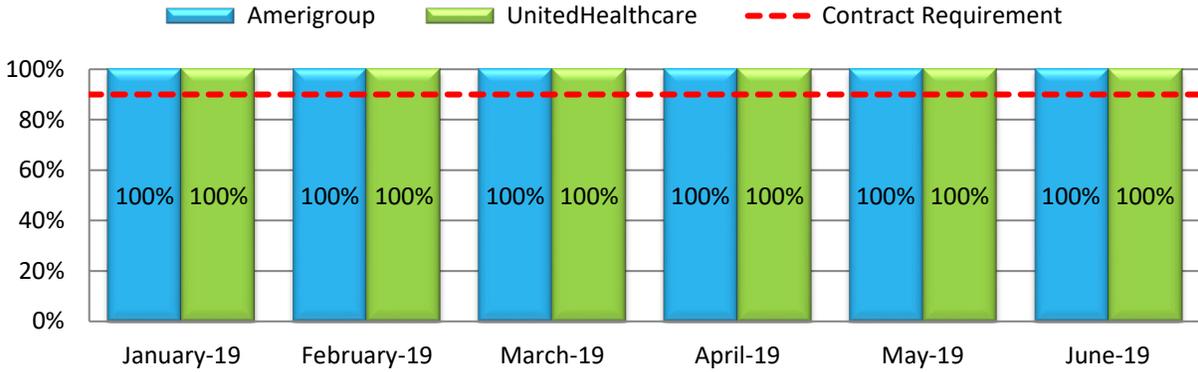
Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification



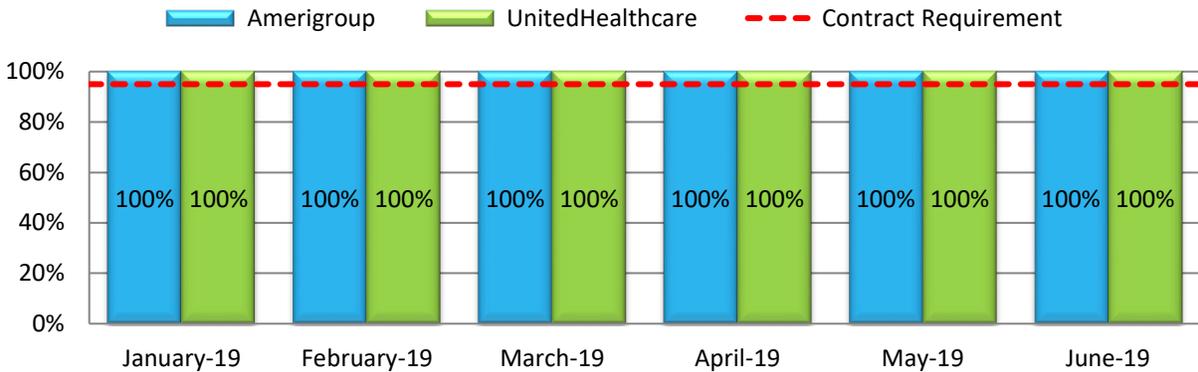
Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

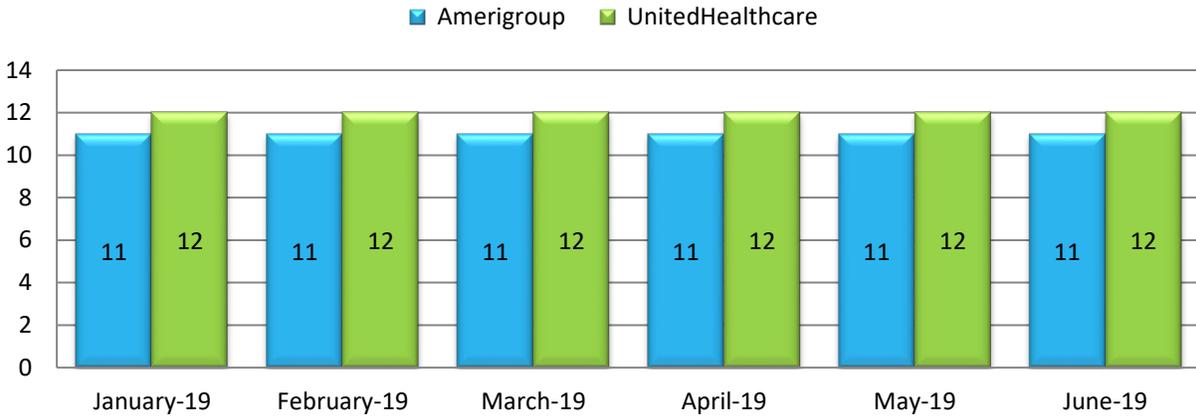
Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days



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

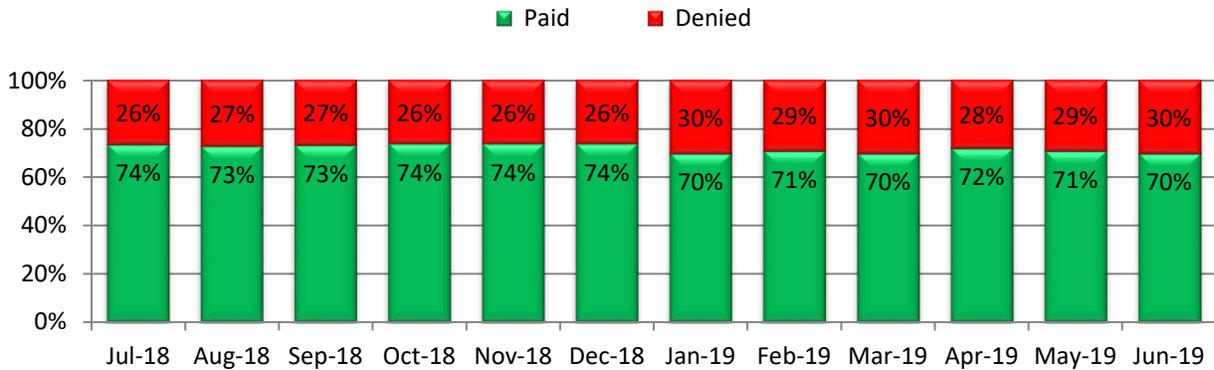


Average Days for Pharmacy Claims Payment



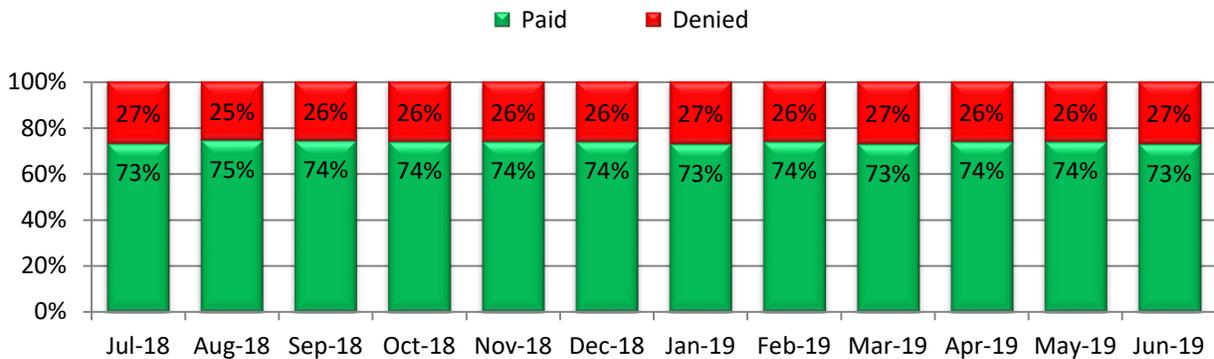
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



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

Utilization of Value Added Services Reported Count of Members	
MCOs 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.	
Q4 SFY19 Data	UnitedHealthcare
Baby Blocks	2,985
School/Camp/Sports Physicals	48
Non Emergent Transportation	932
Weight Watchers	105

Utilization of Value Added Services Reported Count of Members

MCOs 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.

Q4 SFY19 Data	Amerigroup
Weight Watchers	169
Exercise Kit	45
Dental Hygiene Kit	35
Personal Bag for Belongings with Comfort Item	9
SafeLink Mobile Phone	83
Healthy Families Program	25
Community Resource Link	625
Live Health Online	25
Healthy Rewards	2,394
Taking Care of Baby and Me	4,671
Boys & Girls Club	67
Personal Care Attendant	7
Home Delivered Meals	10
Post-Discharge Stabilization Kit	1

The Department is in the process of reviewing how this information is shared on its website and will provide an updated link in the next report.

Provider Network Access

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

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

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

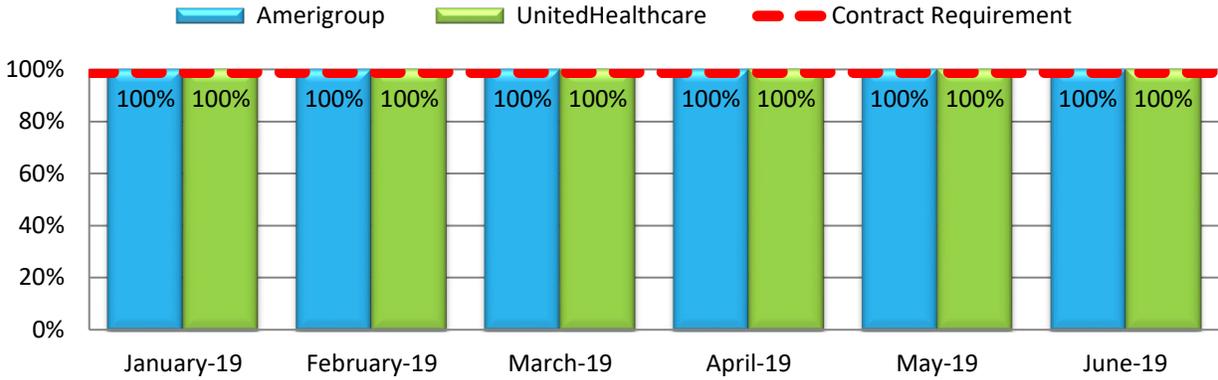
- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

Links to time and distance reports can be found at:

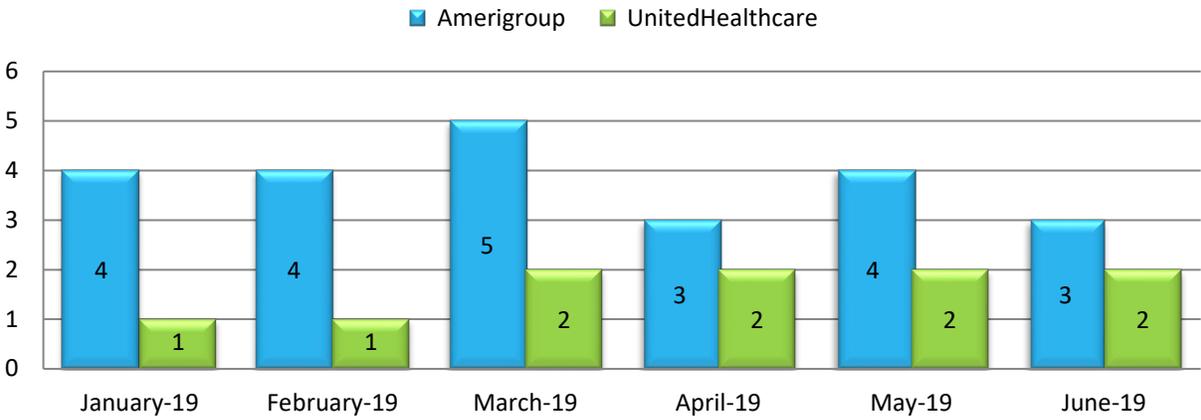
<https://dhs.iowa.gov/ime/about/performance-data-GeoAccess>.

Non-Pharmacy Prior Authorization

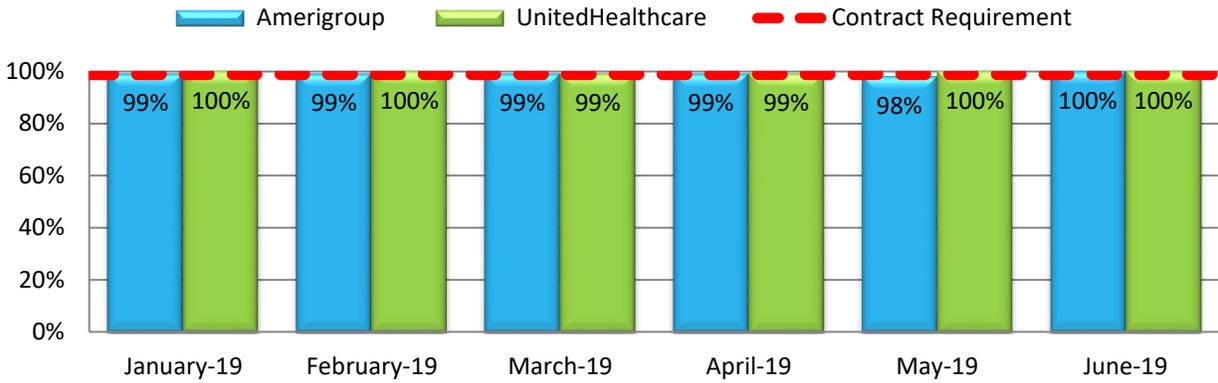
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request



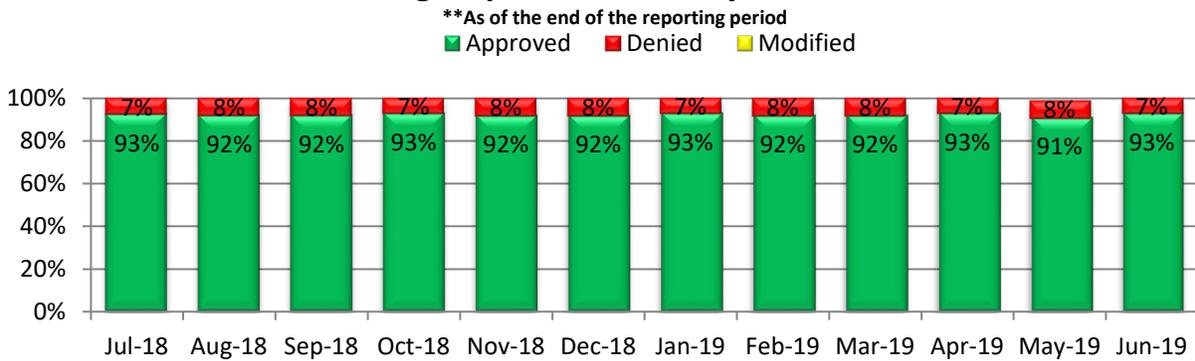
Average Days for Regular PA Processing



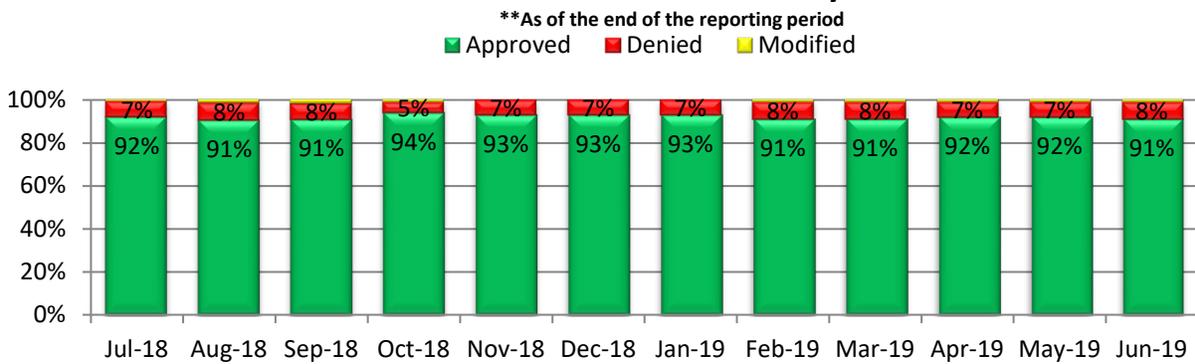
Percentage of PAs for Expedited Services Completed Within 72 Hours of Request



Amerigroup Non-Pharmacy PAs Status



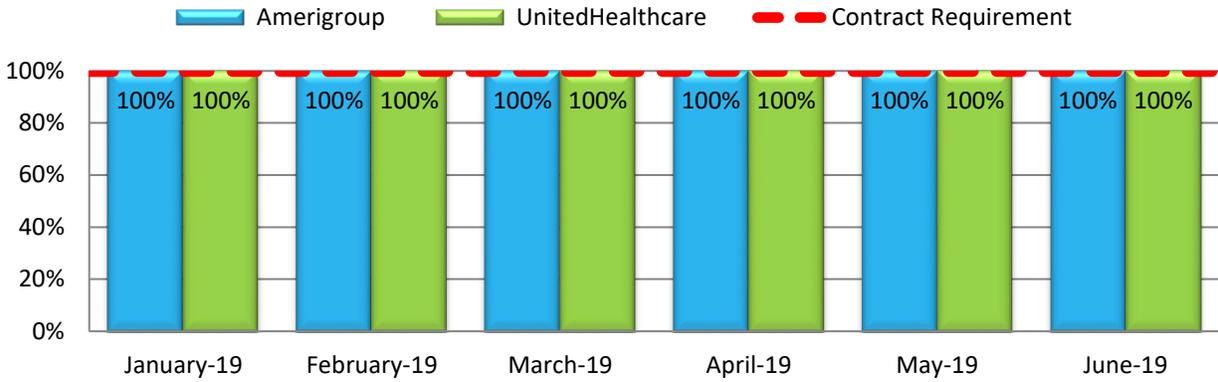
UnitedHealthcare Non-Pharmacy PAs Status



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

Prior Authorization - Pharmacy

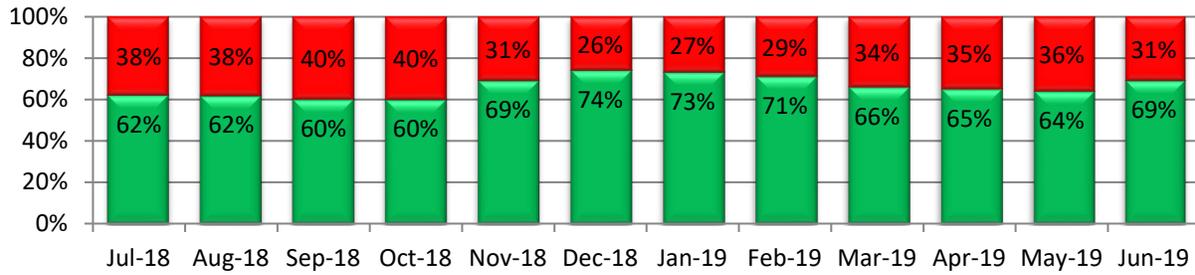
Percentage of Regular PAs Completed Within 24 Hours of Request



Amerigroup Pharmacy PAs Submitted Status

**As of the end of the reporting period

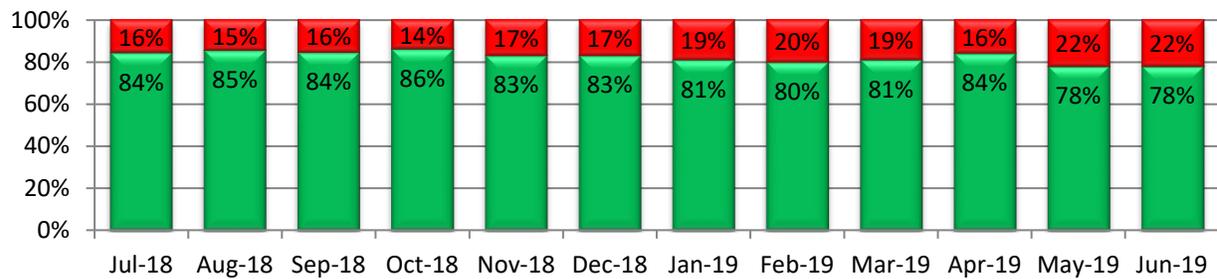
■ Approved ■ Denied



UnitedHealthcare Pharmacy PAs Submitted Status

**As of the end of the reporting period

■ Approved ■ Denied



Encounter Data Reporting

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			UnitedHealthcare		
Encounter Data Submitted By 20 th of the Month	Apr	May	Jun	Apr	May	Jun
	Y	Y	Y	Y	Y	Y

Value Based Purchasing Enrollment

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

Data as of June 2019	Amerigroup	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards	47%	54%

MLR/ALR/Underwriting

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the Department and the MCOs.

- 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.

Q4 SFY19 Data	Amerigroup	UnitedHealthcare
MLR	98.1%	92.2%
ALR	6.2%	9.1%
Underwriting	-4.3%	-1.3%

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

Capitation Payments Made to the Managed Care Organizations

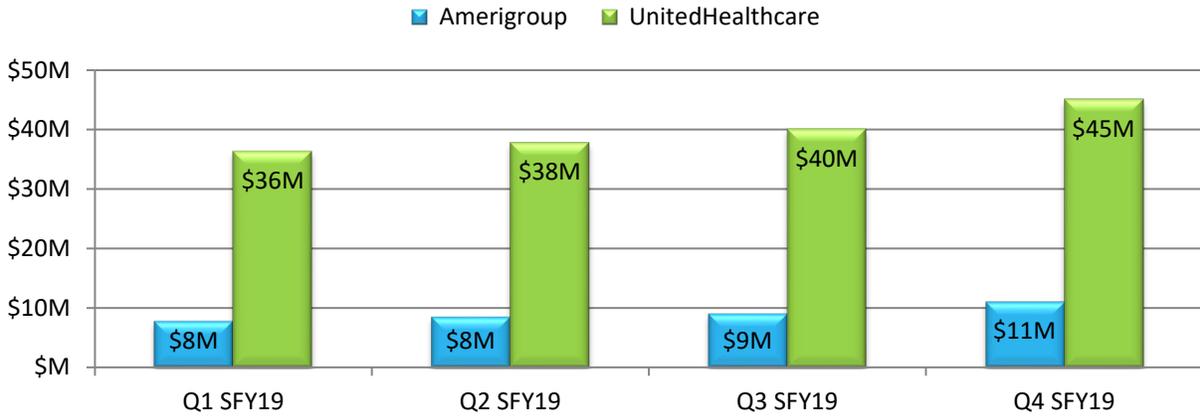
Capitation payments include payments made for the reported quarter's enrollment, adjustments, and member reinstatements and retroactive eligibility. Quarterly Performance Reports in previous fiscal years only included payments for the current quarter's enrollment, which is why previous quarters are not provided.

MCO	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Amerigroup Total	\$417,598,591	\$429,046,037	\$376,525,389	\$402,424,413
Adjustments	\$97,848,029	\$72,262,766	(\$509,327)	(\$313,567)
Current	\$312,420,560	\$347,223,304	\$365,336,282	\$391,378,265
Member Reinstatements and Retroactive Eligibility	\$7,330,002	\$9,559,966	\$11,698,434	\$11,359,715
UnitedHealthcare Total	\$768,872,756	\$865,012,150	\$763,249,472	\$497,225,366
Adjustments	\$78,327,083	\$121,133,543	\$673,460	(\$604,321)
Current	\$671,528,707	\$722,723,962	\$738,949,197	\$483,286,115
Member Reinstatements and Retroactive Eligibility	\$19,016,967	\$21,154,644	\$23,626,815	\$14,543,572

Managed Care Organization Reported Reserves

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

Third Party Liability Recovery (Millions)



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.

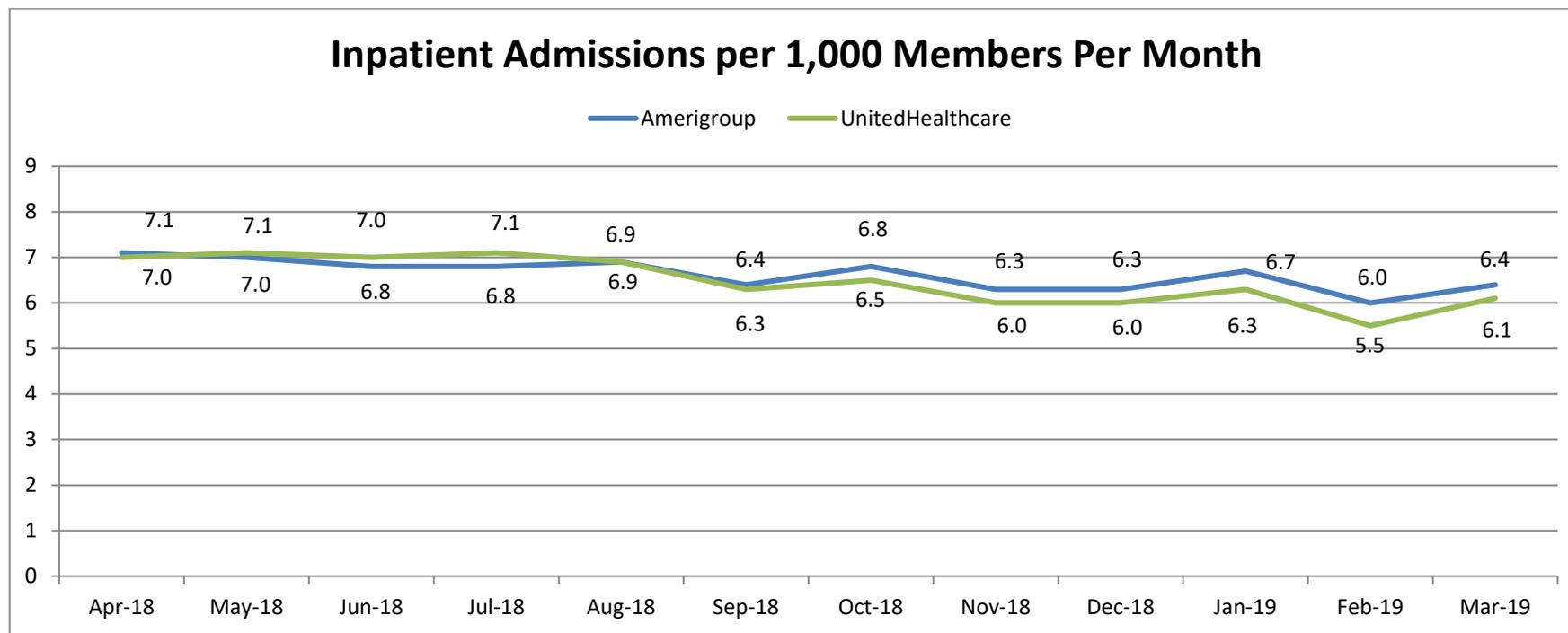
Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

Fraud, Waste and Abuse

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

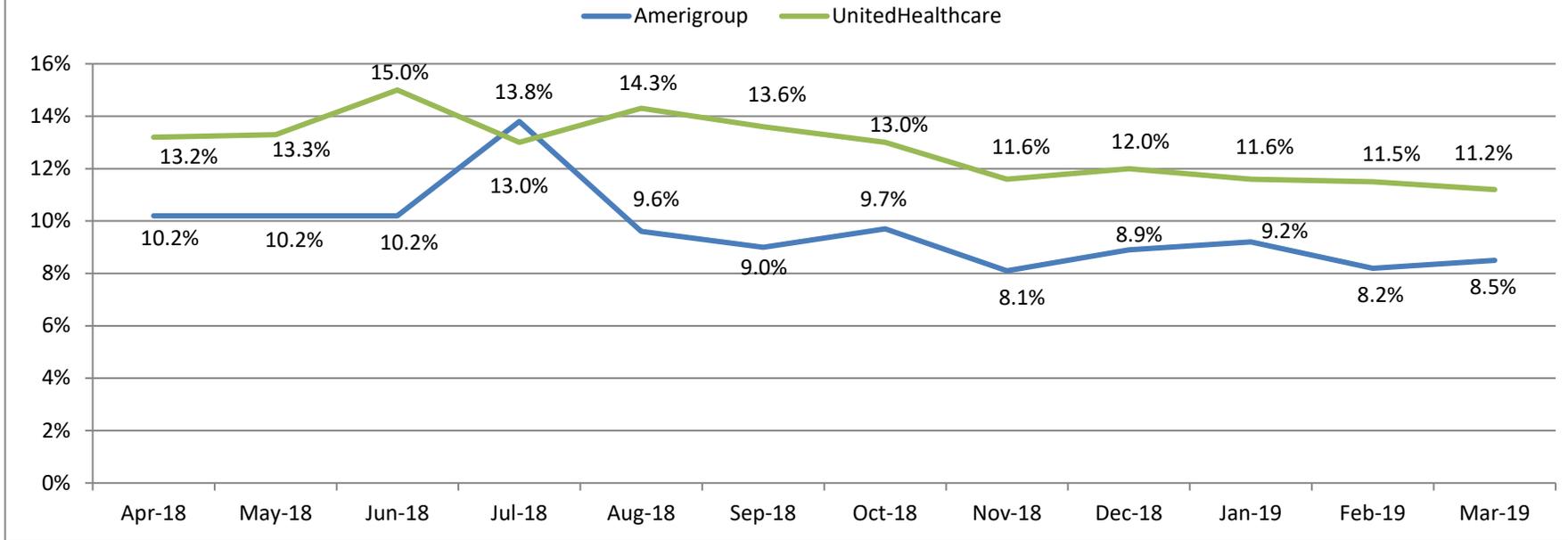
Q4 SFY19 Data	Amerigroup	UnitedHealthcare
Investigations Opened During the Quarter	30	12
Overpayments Identified During the Quarter	14	10
Cases Referred to the Medicaid Fraud Control Unit (MFCU) During the Quarter	15	16
Member Concerns Referred to the IME	8	12

In prior reports, dollars recovered through program integrity efforts were reported on a quarterly basis. However, the MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The plans have initiated 42 investigations in the fourth quarter and referred 31 cases to 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.



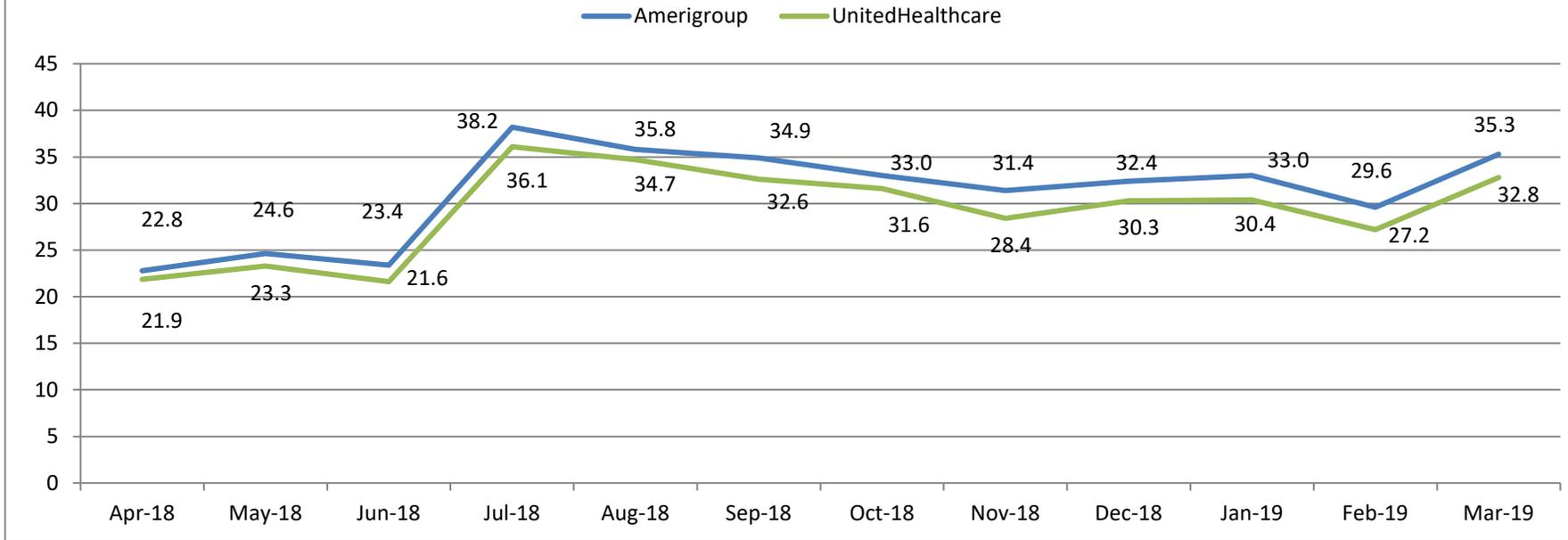
Encounter Data Disclaimer: The data provided by the IME is provided “as is.” The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the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

All Cause Readmissions within 30 Days



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

Adult Non-Emergent ED Use Per 1,000 Member Months



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

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

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

APPENDIX

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.

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

Glossary Terms:

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

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

Actions that a member may choose to appeal:

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

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

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

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

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

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

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

Care Management: Care Management helps members manage their complex health care needs. It may include helping a member get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

Clean Claims: The claim is on the appropriate form, identifies the service provider that provided the service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing facility or home supports.

Community-Based Case Management (CBCM): Community-Based Case Management helps Long-Term Services and Supports (LTSS) members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. Community-Based Care managers (CBCMs) make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (CDAC): Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.

CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Critical Incidents: When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to

the HCBS member's MCO in a clear, legible manner, providing as much information as possible regarding the incident.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

DHS: Iowa Department of Human Services

Disenrollment: Refers to members who have chosen to change their enrollment with one MCO to an alternate MCO.

Durable Medical Equipment: Durable Medical Equipment (DME) is reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

ED: Emergency department

Emergency Medical Condition: An Emergency Medical Condition is any condition that the member believes endangers their life or would cause permanent disability if not treated immediately. A physical or behavioral condition medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or body part.

If a member has a serious or disabling emergency, they do not need to call their provider or MCO. They should go directly to the nearest hospital emergency room or call an ambulance.

The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Fee-for-Service (FFS): The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through FFS Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: Members may request to change their MCO during their 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.

Some examples of Good Cause for disenrollment include:

- A member's provider is not in the MCO's network.
- A member needs related services to be performed at the same time. Not all related services are available within the MCO's provider network. The member's primary care provider or another provider determined that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- The member's provider has been terminated or no longer participates with the MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by the member's MCO.
- The MCO plan does not cover the services the member needs due to moral or religious objections.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30

calendar days from the date the matter occurred. Examples include but are not limited to:

- The member is unhappy with the quality of your care.
- The doctor who the member wants to see is not an MCO doctor.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

HCBS: Home and Community Based Services, waiver services. Home and Community Based Services (HCBS) provide supports to keep Long-Term Services and Supports (LTSS) members in their homes and communities.

Hawki: A program that provides coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the Federal Poverty Level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology.

Health Care Coordinator: A Health Care Coordinator is a person who helps manage the health of members with chronic health conditions.

Health Risk Assessment (HRA): A Health Risk Assessment (HRA) is a short survey with questions about the member's health.

Historical Utilization: A measure of the percentage of assigned members whose current providers are part of the managed care network for a particular service or provider type based on claims history.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides and therapists.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services
- Observation services
- Outpatient surgery
- Lab tests.
- X-rays

ICF/ID: Intermediate Care Facility for Individuals with Intellectual Disabilities.

IHAWP: Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act.

IID: Iowa Insurance Division.

IME: Iowa Medicaid Enterprise.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

Level of Care (LOC): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long-Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

Long Term Care Services:

- Home and Community Based Services (HCBS)
- Intermediate Care Facilities for Persons with Intellectual Disabilities
- Nursing Facilities and Skilled Nursing Facilities

MCO: Managed Care Organization.

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

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: Each MCO has a network of providers across Iowa who their members may see for care. Members don't need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

NF: Nursing Facility.

PA: Prior Authorization. Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription.

PCP: Primary Care Provider. A Primary Care Provider (PCP) is either a physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member will see for checkups, health concerns, health screenings, and specialist referrals.

PDL: Preferred Drug List.

Person-centered Plan: A Person-centered Plan is a written individual plan based on the member's needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP) or individual education plan (IEP).

PMIC: Psychiatric Medical Institute for Children.

Rejected Claims: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

SMI: Serious mental illness.

SED: Serious emotional disturbance. Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.

SED does not include:

- Neurodevelopmental disorders
- Substance-related disorders
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED).

Service Plan: A Service Plan is a plan of services for HCBS members. A member's service plan is based on the member's needs and goals. It is created by the member and their interdisciplinary team to meet HCBS waiver criteria.

Skilled Nursing Care: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. The member must be medically and financially eligible. If the member's care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding their care, then a skilled level of care is assigned.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Suspended Claims: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

TPL: Third-party liability. This is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: A health plan accepts responsibility for paying for the health care services of covered individuals in exchange for dollars, which are usually referred to as premiums. This practice is known as underwriting. When a health insurer collects more premiums than it pays in expense for those treatments (claim costs) and the expense to run its business (administrative expenses), an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs.