MAAC MATERIALS
FULL COUNCIL MEETING
February 5, 2019

1. Agenda of Meeting for February 5, 2019
2. February 19, 2018 Full Council Meeting Minutes
3. May 3, 2018 Full Council Meeting Minutes
4. August 9, 2018 Full Council Meeting Minutes
5. November 8, 2018 Full Council Meeting Minutes
6. Data Recommendations Report
7. Managed Care Ombudsman Program 2018 Quarter 3 Year 3 Report
8. Managed Care Quarterly Report\(^1\) (Q1 SFY19)

This meeting is accessible to persons with disabilities. (If you have special needs, please contact the Department of Human Services (515) 281-5452 two days prior to the meeting.) Note: Times listed on agenda for specific items are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

\(^1\) [https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports](https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports)
Introduction and Roll Call
Gerd called the meeting to order and performed the roll call. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

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

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

Recommendations Update
Q4 SFY17 Director Foxhoven Reply
Gerd gave a brief background regarding the questions posed to the Director and a copy of the reply was made available in the materials packet.

Q1 SFY18 Letter
Gerd stated that this letter is currently awaiting response from Director Foxhoven but that the items on the recommendation are already being addressed.

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

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

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

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

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

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

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

Transition Update
Natalie Kerber stated that when AmeriHealth exited the market, Amerigroup determined that in order to serve a large but unidentified influx of new members, the organization would need to build more capacity. Since that time, Amerigroup has been working closely with the IME in building said capacity. As of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members.

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

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

UnitedHealthcare Plan of the River Valley Updates

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

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

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

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

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

Marsha Fisher also stated that she does not agree with the requirement to prove that the services requested are a true need. Marsha noted that the needs are seen by the Care Coordinator, there is an assessment, and there are many persons working with the individual during their care planning although when it goes to the Utilization Management team, the member and their team are required to prove that the services are a true need; to prove beyond the information that is provided to the Utilization Management team that the services requested are needed.

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

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

**Adjourn**
4:02 P.M.
Full Council
Summary of Meeting Minutes
May 3 2018

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

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

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

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

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

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

Action Item:

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

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

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

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

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

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

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

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

**Process Improvement Working Group**
Mike stated that there had been three working group meetings and four subgroups had been developed:
1. Claims/Communications and Training/Prior Authorizations
2. Benefits and Eligibility/Reimbursement
3. Clinical and Quality Outcomes/Transparency
4. Credentialing

The next subgroup meetings are to take place on May 11, 2018, and additional information regarding the working group can be found on the Process Improvement Working Group webpage. A clinical review of appeals is to take place with the clinical team and the IME to review appeals that had been overturned, withdrawn, and dismissed. Findings are to be reported by July 15, 2018, and recommendations are to follow.

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

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

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

Open Comment (Open Comment Opportunity for Members)
Dr. Dave Carlyle stated that he would like to attend the data workshop and would like additional information regarding claims denial rates and reversals so that he can compare MCO performance.

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

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

Denise Rathman stated that she has heard from Medicaid members that they were told by the IME and DHS that Skilled Nursing Facility (SNF) benefits were the same for Iowa Health and Wellness Plan (IHAWP) members and Traditional Medicaid members. She stated that this is potentially due to the difficulty in placing IHAWP members in SNFs in central Iowa. Denise indicated that this may be due to the

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

May 8, 2018
fact that persons providing rehabilitative services to Traditional Medicaid are not required to have a license although have a higher reimbursement rate than IHAWP providers who are required to have a license. Mike advised to contact him with specific information.

Adjourn
3:57 P.M.
Introduction and Roll Call
Gerd called the meeting to order and performed the roll call. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

Approval of the Full Council Meeting Minutes of February 19, 2018, and May 3, 2018
Minutes of the Full Council meetings of February 19, 2018, and May 3, 2018, were not put to a vote because quorum was not met.

Gerd acknowledged the Governor’s appointment of four new MAAC Full Council public members; Thomas Broeker, Jason Haglund, Amy Shriver, and Marcie Strouse.

Legislative Report Subcommittee Update
Gerd stated that the subcommittee was developed in response to a requirement of Senate File 2418, Section 131 which requires the MAAC Executive Committee to review data that is being collected by the Department and recommend additional data to be included in period reports to the general assembly. He stated that the group consists of Gerd, Kacey Ficek, Shelly Chandler, Cindy Baddeloo, and Dennis Tibben. The timeline for the recommendations and future topics were reviewed.

Long-Term Care Ombudsman Update
Cynthia Pederson was not in attendance. This topic is to be discussed at the November 8, 2018, Full Council meeting. The July 2018 Long-Term Care Ombudsman report is available on the Managed Care Ombudsman Program Website.

Election of MAAC Members Update
The Executive Committee is elected for two-year terms, beginning at the start of a State Fiscal Year (SFY). Ballots were made available to Professional Entity representatives for the election of 5 Professional Entity representatives to the Executive Committee and an electronic version of the ballot was to be sent; the election was to conclude on August 23, 2018. Ballots were to be sent to public members at a later date for the election of the 5 public representatives, and co-chair to the Executive Committee. The SFY19 through SFY20 Executive Committee was to be determined by the September 2018 Executive Committee meeting.

Director Foxhoven Recommendations and Response
Gerd briefly reviewed the SFY18 Q2 recommendations response letter from Director Foxhoven that was made available in the materials packet.

Update from the Medicaid Director
Legislative Update
Mike stated that Senate File 2418 established numerous requirements for the Medicaid program that

necessitated the establishment of different workgroups to meet the various deadlines.

**Dental Wellness Plan Update:**
The IME will be implementing a $1,000 Annual Dental Benefit Maximum (ABM) effective September 1, 2018, that will not apply to preventive or emergency dental services and some specific sedation codes; informational letters have been published.

**Process Improvement Working Group:**
Additional information regarding the working group can be found on the Process Improvement Working Group website.

**MCO Contracts:**
Mike stated that he anticipates that this will be completed soon.

**Quarterly Managed Care Report**

**Updates from MCOs**

**Open Comment (Open Comment Opportunity for Members)**

**Adjourn**
Full Council
Summary of Meeting Minutes
November 8, 2018

Call to Order and Roll Call
Jason called the roll call at 1:00 P.M. Full Council attendance is as reflected in the separate roll call sheet. Quorum was not met.

Approval of Previous Full Council Minutes
A vote to approve the meeting minutes of February 19, 2018, May 3, 2018, and August 9, 2018 could not be taken because quorum was not met.

MAAC Governance
Gretchen Kraemer reviewed the rules of governance for the Medical Assistance Advisory Council (MAAC). She reviewed areas pertaining to open meetings and open records law and the Iowa Code, the process for the development of the meeting agenda and the need for the meeting to be announced in advance and be accessible to the public. She discussed issues pertaining to confidentiality for items discussed at the meetings, the use of email addresses, conflicts of interest, and other general rules that govern the meetings of the MAAC.

Data Recommendations Subcommittee Update
Gerd provided an update on the timeline for the data recommendations report with the aim to submit the document in time for the December 31, 2018 deadline. Gerd stated that the Executive Committee should expect to see a draft of the report by the November 20, 2018 Executive Committee meeting and will be given ample time to provide a final feedback. Gerd stated that the subcommittee has been focused on understanding the data and identifying where the value lies. Mike added that it is important to putting context to the metrics.

Long-Term Care (LTC) Ombudsman Update
Pamela Heagle gave an update on the LTC Ombudsman report including service reductions, advocacy, health and disability and intellectual disability waivers, issues affecting members in CDAC and CCO, Level of Care assessments, case management issues, Notice of Decision issues with MCOs, and network adequacy. She underscored that all the reports are available on the LTC Ombudsman website.

Election of MAAC Members Update
Gerd gave a brief update on the recent election of new members to the MAAC and introduced and acknowledged the new members.

Medicaid Director’s Update
Mental Health Compliance Follow-Up
Mike cited a specific communication that Dave Beeman sent to Gerd to discuss specific contractual requirements between Amerigroup and other mental health providers that places
undue burden on small providers because of network adequacy issues. Mike acknowledged
the complexity of the issue and stated that he will follow up on this concern with Amerigroup.

**Medicaid Budget Presentation**
Mike gave a high-level summary of the budget presentation to the DHS Council specifying
that in SFY18, Iowa Medicaid provided services to more than 800,000 Iowans with
approximately 58% of coverage of traditional Medicaid provided for children but that
population only accounted for 19% of the expenditures. He added that the expansion
population under the Iowa Health and Wellness Plan accounted for around 193,000 Iowans.
He gave a percentage breakdown of the population groups served from the seven waiver
programs which accounts for half of the cost. Mike stated that this is why it is important
to focus on both the long-term service and fiscal sustainability of the Medicaid program. Mike
stated that capitated rates are being renegotiated for the rate setting because Medicaid is
going to change from a fiscal year to a calendar year budget program in time of the 2019
legislative session. A robust discussion ensued regarding negotiation of capitated rates.

**Dental Wellness Plan Update**
Mike reviewed the details of the Dental Wellness Plan annual $1,000 benefit maximum and
their exclusions for adult members.

**Process Improvement Working Group Update**
Mike stated that the next meeting of this working group is slated for November 2018 and
that the working group has had eight meetings thus far that reviewed issues and identified
three high-level themes: a.) providing annual and quarterly training, b.) streamlining of
processes, and c.) improving communications.

**Health Home Program Update**
Mike stated that a working group was established to review the Integrated as well as the
Chronic Condition Health Home system. He stated that the working group has met twice
with representatives from 19 different providers. He added that feedbacks from these
stakeholders are being reviewed right now and a draft report is being finalized for review
which will be submitted to the legislature on December 15, 2018.

**Retroactive Payment Reactivation Update**
Mike reviewed Senate file 2418 reinstating the provision of three months of retroactive
Medicaid benefits for applicants who are residents of nursing facilities at the time of
application and are Medicaid eligible filed after July 1, 2018. He added that Medicaid
anticipates that this will affect only 5-7 people a month who are in nursing facilities and is
going to cost the state around $140,000.

**MCO Contracts Update**
Mike stated that the new MCO, Iowa Total Care, will begin July 1, 2019 and that they have
signed the contract and are now actively engaging providers and associations to begin to
build their network. He added that weekly meetings are being held with Iowa Total Care
through the onboarding process.

**Future Agenda Item:** Rate Setting 101 that outlines the details of how rates are set and how
it relates to the Medicaid program.
**Action Items**

No additional discussion was done for this agenda item other than an invitation from Gerd for the members to examine the Action Item document included in the materials packet.

**Quarterly Managed Care Report**

Liz Matney stated that adjustments will be made to the quarterly report for SFY 19 to include the changes intended to make the report more visual (charts and graphs that represent the data) and providing more context to rightly interpret those data. She provided a high-level review of selected data sets and extended an invitation to ask questions or make comments as she goes through the data.

**Updates from MCOs**

**Amerigroup Iowa, Inc.**

John McCauly provided operational updates for Amerigroup. He reviewed some of the new community relations activities that Amerigroup is initiating that are tied into their clinical outcomes. He stated that they have launched an update to their claims dispute system that provides an ability to track claims better and is less burdensome to providers. He provided an update on their home health processes. He also added that as of October 31, 2018, Amerigroup has waived the prior authorization requirements for people in custodial facilities and for residents of ICF/ID. They also launched a foster care transition case management project to improve member outcomes for children who are nearing aging out of traditional services. He also outlined their innovations in the LTSS area in their nursing facility quality incentive program.

**UnitedHealthcare Plan of the River Valley, Inc.**

Paige Pettit gave an update on UnitedHealthcare’s new member ID cards which will be issued around December 1, 2018 and the new paperless Explanation of Benefits (EOB) that allows members to access their EOBs on the member website. He talked about their value-added services comparison chart, their case management services and the color-coded maps that identify case managers by county and their contact information.

**Open Discussion**

Gerd solicited comments regarding the IUB venue. He also brought up the issue of meeting quorum and invited comments and suggestions on improving the level of participation in order to meet quorum.

Pat Hildebrand from the Iowa Dietetic Association asked if someone can direct her to a contact within Medicaid that can provide her information on coverage for Medical Nutrition Therapy including reimbursement rates. Gerd and Mike stated that someone will reach out to her. She also spoke on behalf of those lack technology savvy or equipment to be able to access online resources that are repeatedly cited as available on the Medicaid website.

**Adjournment**

Meeting adjourned at 4:05 P.M.

Submitted by,
Luisito Cabrera
Recording Secretary
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MAAC Data Recommendations Report

Background:

Senate File 2418 appropriates general funds to state agencies, including the Department of Human Services and the Iowa Medicaid Program. Section 131 of the bill requires the Medical Assistance Advisory Council (MAAC) executive committee to review data currently being collected and reported, and recommend to the General Assembly any changes to this data for future reporting. The text of Section 131 of SF 2418 follows:

Sec. 131. MEDICAL ASSISTANCE ADVISORY COUNCIL —— REVIEW OF MEDICAID MANAGED CARE REPORT DATA. The executive committee of the medical assistance advisory council shall review the data collected and analyzed for inclusion in periodic reports to the general assembly, including but not limited to the information and data specified in 2016 Iowa Acts, chapter 1139, section 93, to determine which data points and information should be included and analyzed to more accurately identify trends and issues with, and promote the effective and efficient administration of, Medicaid managed care for all stakeholders. At a minimum, the areas of focus shall include consumer protection, provider network access and safeguards, outcome achievement, and program integrity. The executive committee shall report its findings and recommendations to the medical assistance advisory council for review and comment by October 1, 2018, and shall submit a final report of findings and recommendations to the Governor and the general assembly by December 31, 2018.

A subcommittee of the MAAC Executive Committee was selected and met several times to evaluate the current reports, and develop recommendations on the report for the full MAAC and its Executive Committee’s consideration, according to the requirements of section 131.

More specifically, the subcommittee:

1) Reviewed the requirements of SF 2418, and 2016 Iowa Acts, chapter 1139, section 93
2) Evaluated legislatively required reporting by conducting a thorough review of the existing managed care quarterly reports
3) Discussed standards available and under development nationally for managed care reporting
4) Developed high-level recommendations for future reporting
5) Identified high priority categories of reporting as well as suggesting more specific measures to be included in future reporting for the Iowa Health Link program.

The Executive Committee established a few high level goals which guided its discussions and recommendations, as follows:

1) **Focus on health outcomes** – while a high level of interest exists to ensure that administrative processes are in place and operating effectively for the program, the overriding concern for the Medical Assistance Advisory Council should be an emphasis on health improvement for Medicaid beneficiaries under the managed care arrangement.
2) **Accessible data** – while it may be tempting to expand on the number of measures included in reports, growth in the number of measures can also create more confusion just simply in adding to the number of measures available. The subcommittee was guided by ensuring that whatever reporting is available is accessible, understandable, and meaningful to all audiences including Medicaid enrollees and the general public. This means that the committee was open to the possibility of recommending the elimination of less meaningful measures to allow more emphasis on fewer and higher quality measures to promote better understanding on the reader’s part.

**High Level Recommendations:**

1) **Process indicators versus health outcomes** – The program should create a reasonable mix of data points reported which focus on both administrative process indicators (payment timeliness, pre-authorization counts, for example) and health outcomes indicators (Percentage of Live Births that Weighed Less than 2,500 Grams, Beneficiaries who Quit Smoking, percentage MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS, for example).

2) **Report brevity and focus** – The subcommittee discussed the large number and variety of reports that the Department has made publicly available. While the sheer number and length of reports suggests a high level of transparency in communicating with the public and stakeholders on program performance, the subcommittee also felt that the volume of information can be overwhelming for the public to make good sense of the program. Policymakers and the public would be better served through a refinement of reporting that helps identify issues of key interest, and organizing this information in a way that promotes better accessibility of information by the public.

3) **Interactive report tools** – Rather than print lengthy and static reports, use of technology could assist the public and policymakers in a better understanding of program performance information. An easily accessible website-based query tool could allow more effective access to information as needed on issues of particular interest. Iowa Medicaid should consider this option as part of system updates, including modernization and modularity of the MMIS. Iowa Medicaid should publicize this tool once created to ensure that policymakers, stakeholders and the public are aware of its availability. Accomplishment of this recommendation will certainly be dependent upon resource availability and time to implement changes.

4) **Reporting Frequency and Formats** – While interactive reporting tools may be effective in distribution of some metrics, others may be best reported at less frequent intervals and lend themselves to more static (paper-based) reports. The Department should give consideration to those measures which are more accurately or productively reported on an annual basis, for example, and consider publishing those in a static report. Similarly, for measures that change more frequently, or for which quarterly reporting may be more valuable, the interactive tools may be a more effective way of reporting these metrics.
5) **Rolling periods** – While more frequent quarterly reporting is valuable, some health care measures require more data to ensure reliable and valid information is available. In other cases, claims-based reporting may require a claims run-out period to ensure that a statistically significant amount of activity in the quarter is available for analysis. For measures requiring multiple reporting periods to ensure reliability and validity, the Department should consider establishing a set of rolling quarters. In this way, more valid data will be made available on a quarterly basis, but reporting will rely on the most recent four quarters of data, for example, to keep the information current and relevant.

6) **Trends** – Data can help illuminate issues when it is performance that is being compared to similar factors. For example, presenting information as trends over time would be very valuable in ascertaining performance improvement or degradation.

7) **Comparability of data between plans** – Efforts to ensure the comparability of data between the Iowa Medicaid managed care plans is paramount to providing accurate information. In some cases, where one plan measures a process or outcome differently from another plan, the Department should take action to ensure that the data is collected and reported in a way to ensure that “apples to apples” comparisons are being made.

8) **Comparability of data across state programs** – Independent organizations such as the National Council on Quality Assurance (NCQA) and the National Quality Forum (NQF) promote patient protections and healthcare quality through administration of evidence-based standards and measures. They have worked to establish such standards and measure definitions for health care performance across the country. This standardization of measures ensures that national resources have been invested to ensure that measures do, in fact, reflect performance of the health system. Standard measures also ensure that health care providers have a single standard against which to report. Different ways of measuring the same metric cause confusion among health care providers, introduce inefficiencies in collecting and reporting data, and create confusions for information consumers because measures that sound similar are not measuring the same activity.

9) **Elimination of measures from current reports** - Where performance is high and has been consistent following the implementation of managed care, consideration should be given to eliminate these in the public reports indicators. These indicators may certainly have administrative importance and be retained for performance monitoring, but in order to economize on space, and communicate on those indicators which are meaningful and changing, the Department should be provided some flexibility, with the concurrence of the Medical Assistance Advisory Council, for example, to make these report adjustments. The following indicators in the existing reports are recommended for elimination:
a. Secret shopper data in the current quarterly report is more useful than all member response timeliness, because data is not changing

b. Payment timeliness data in the quarterly reports may reflect payments made but could be partial, incomplete or inaccurate. Measures in the current quarterly report do not reflect these nuances. To better inform quality improvement efforts, perhaps adjustments to these metrics could be made to refocus the data on the particularly services for which payments are timely – hospitalizations, pharmaceuticals, etc.

c. Timely submission of files as reported in the quarterly reports are not very useful. Focus could instead be placed on actual health care utilization data.

d. Subcommittee to identify additional metric candidates for elimination (and justification as to why elimination is recommended) which reflect consistently high performance, several quarters of no material change, or meet other criteria for elimination.

MAAC MCO Report Modification Recommendations

(if not mentioned in the table below, the committee’s recommendation is that the existing measure be retained in the Department’s reporting requirements. References to “eliminate” measurements from the report, below, indicate that these measures will not be present in report format, but will continue to be available from IME online in an accessible format and upon request or in other periodic reporting.)
<table>
<thead>
<tr>
<th>Measure (Page Number)</th>
<th>Eliminate/Modify</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>MCO Enrollment Data (5,6,8)</td>
<td>Modify</td>
<td>Break Out Data By Specific Program/Waiver Populations</td>
</tr>
<tr>
<td>Care Coordination Reporting – Population-Specific Supporting Data (9-10)</td>
<td>Available on request</td>
<td>Demographic Data of Limited Value, Outcomes Data More Useful</td>
</tr>
<tr>
<td>Health Risk Assessments (9)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Chronic Health Homes – Population-Specific Supporting Data (11)</td>
<td>Available on request</td>
<td>Demographic Data of Limited Value, Outcomes Data More Useful</td>
</tr>
<tr>
<td>Non-LTSS Care Plans – Members with Care Plans Updated Timely (12)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Non-LTSS Care Plans – Population-Specific Supporting Data (12)</td>
<td>Available on request</td>
<td>Demographic Data of Limited Value, Outcomes &amp; Member Participation Data More Useful</td>
</tr>
<tr>
<td>Integrated Health Homes – Population-Specific Supporting Data (13)</td>
<td>Available on request</td>
<td>Demographic Data of Limited Value, Outcomes Data More Useful</td>
</tr>
<tr>
<td>LTSS/HCBS Care Coordination – Members Assigned a Case Manager</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Member Participation Data More Useful</td>
</tr>
<tr>
<td>HCBS Service Plans Completed Timely (17)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value</td>
</tr>
<tr>
<td>Member Grievance &amp; Appeals – Percentage Resolved within 30 Days (22)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value</td>
</tr>
<tr>
<td>Percentage of Appeals Resolved within 30 Days (24)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value</td>
</tr>
<tr>
<td>Member Helpline – Percentage of Calls Answered Timely (26)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Provider Helpline – Percentage of Calls Answered Timely (29)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Pharmacy Services Helpline – Percentage of Calls Answered Timely (31)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Medical Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (32)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value</td>
</tr>
<tr>
<td>Medical Claims Status (33)</td>
<td>Modify</td>
<td>Data Insufficient to Provide Value; Additional Data on Suspended &amp; Denied Claims of Greater Value</td>
</tr>
<tr>
<td>Provider Adjustments Reprocessed within 30 Days (36)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value</td>
</tr>
<tr>
<td>Pharmacy Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (37)</td>
<td>Available on request</td>
<td>Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value</td>
</tr>
<tr>
<td>Value-Added Services (39)</td>
<td>Modify</td>
<td>Data Insufficient to Provide Value; Additional Information on Specific Services of Greater Value</td>
</tr>
</tbody>
</table>
10) **Meaningful and sufficient data in report** – Some metrics in the current report lack a level of meaningfulness and sufficiency to be important and informative. For example, confusion exists over value-added services in the report. Categories are too broad to be meaningful, and the enrollment counts, as a result, don’t provide meaningful and useful information on service use. Similarly, information in the report reflecting the use of value-based purchasing also lacks a level of meaningfulness to provide useful insights into utilization of value-based purchasing to advance quality improvement in the program.

11) **Periodic review** – the Executive Committee recommends that it conduct periodic reviews of data to be reported to ensure that measures that are being reported continue to be valuable, and that additional measures are incorporated as needs arise.

**Specific Measure Recommendations**

The committee recommends the following as it relates to specific measures:

1) The Department identifies existing, nationally endorsed key performance measures in the following categories of health outcomes:
   a. Overall acute care
   b. Long Term Supports and Services
   c. Behavioral Health
   d. Substance Use Disorder
   e. Long Term Care

2) **Healthcare Effectiveness Data and Information Set (HEDIS)** - Iowa’s Medicaid Program requires each managed care organization to be accredited by the National Committee on Quality Assurance (NCQA). Becoming accredited means that MCOs are capable of
reporting on a standard list of measures called the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the NCQA. These measures are revised and updated each year, and the 2018 set of measures is included in Appendix A of this report. IME’s use of these measures for reporting will ensure reliance on a national standard of measures that will simplify reporting by MCOs and their provider partners, and ensure comparability from state to state in gauging performance of Iowa’s plans.

3) Beyond HEDIS data, additional information should be incorporated in reports, as follows:
   a. Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update – Considerations should be given to adding metrics to the report which capture additional information on the Long Term Services and Supports (LTSS) available to Iowans. These additional metrics might include data regarding the completion of comprehensive assessments of plan development, which break out data points by waiver/population and/or age should be included in this analysis. Another metric to consider would be care plan updates’ timeliness also broken out by population and age.
   b. Data which would allow the analysis of actual costs of care for certain populations.

4) Long-Term Services and Supports (LTSS) Reassessment/Care Plan Update after Inpatient Discharge—Consideration should be given to adding metrics to the report which capture additional information which is outcome-based rather than process-oriented. Recommendations include:
   a. Members feel that they are a part of service planning.
   b. Members feel safe where they live.
   c. Percent of members who are involved in employment activities.
   d. Rate of member falls.
   e. Medication adherence for individuals with behavioral health diagnosis

Other Recommendations
   a) While quarterly reports can be made available through a database of information which provides appropriate patient level protections for confidentiality as dictated by HIPAA, a standard annual report for the program should continue to be provided.
   b) Similarly, if the recommendation to post data on the website and make the information accessible, a more frequent hard copy report may be unnecessary to publish.
   c) Consider including statistics in the current enrollment information that reflect behavioral health and LTSS along with traditional Medicaid enrollment
   d) Consider including B3 report-type data.
e) Consideration should be given to include health outcomes specific data to individuals receiving health home program benefits.

f) In the current report sections which recap the “Top 5 Reasons”, including data that would reflect trends over time would be particularly beneficial to show how the processes in the program are changing over time.

g) Fair Hearing data in the current quarterly report should include trends to better show change over time.

h) Prior Authorization denials in the current report do not provide enough information to be valuable. Reasons for denials also need to be addressed and integrated into MCO, health care provider, and program quality improvement efforts.

i) Regarding value-added services, meaningful comparisons of these services by MCO are difficult because all these services are not required. Instead, perhaps more granular reporting of the 40 value added services and their connection to “base” benefits, and utilization that supports health improvement might yield more interesting insights.
MANAGED CARE
OMBUDSMAN PROGRAM
QUARTERLY REPORT

Year 3, Quarter 3
(Oct 1 - December 31, 2018)
EXECUTIVE SUMMARY

The Office of the State Long-Term Care Ombudsman’s Managed Care Ombudsman Program advocates to resolve managed care issues on behalf of Medicaid managed care members who receive care in a health care facility, assisted living program, or elder group home, or who are enrolled in one of the seven home and community-based services (HCBS) waiver programs, which include: AIDS/HIV Waiver, Brain Injury Waiver, Children’s Mental Health Waiver, Elderly Waiver, Health and Disability Waiver, Intellectual Disability Waiver and Physical Disability Waiver.

For this reporting quarter, the office experienced a slight fluctuation of contacts per month, with 148 contacts in October, 159 in November and 144 in December.

The issues identified for the third quarter are the primary issues addressed in October, November and December 2018. The Office works with a variety of stakeholders who are necessary to address and resolve issues, and does so through a variety of methods, including encouraging use of best practices; facilitating and coordinating communication with necessary parties; and referring to outside agencies as necessary. During Quarter 3-Year 3 of Medicaid managed care, members reported the following primary issues:

1. Services are being reduced, denied or terminated for members needing long-term services and supports. Members reported reductions or denials in their HCBS waiver services in their homes or assisted living programs. This often affected consumer directed attendant care (CDAC) and consumer choice options (CCO) service hours. In response to reductions in services, members are requesting formal appeals and fair hearings to access the services they feel are necessary for their health and safety.

2. Members are needing support during care planning participation. New and existing Medicaid members requested assistance for their upcoming yearly assessment and care plan meetings. Members reported they feel their health needs are not being individually addressed. Members also reported they were unaware of who their case manager would be or how often they were to have meetings.

3. Access to preferred/necessary durable medical equipment. Waiver members reported having to wait for medically necessary durable equipment to be approved and accessed. Members have reported denials for requests of DME (Durable Medical Equipment), resulting in members filing appeals and/or fair hearing requests. Members have also reported a lack of DME providers contracted with the MCO’s.

The report that follows includes an overview of the third programmatic quarter of Year 3 (October, November and December 2018), as well as an update on the program, community partnerships and outreach efforts and administrative activities.

For further information, please contact the Managed Care Ombudsman Program at (866) 236-1430 or managedcareombudsmanprogram@iowa.gov.
The Managed Care Ombudsman Program reports issues on a monthly basis. For analysis purposes, this report provides a high-level overview of the data aggregated over the three months of October, November and December 2018.

Contacts

The Managed Care Ombudsman is available by telephone, email and mail; however, most contacts made to the program are received via telephone. The total number of contacts fluctuates among months for various reasons, such as when Medicaid members transition between Medicaid programs as well as from one MCO to another.

Top Issues

There are nine major issue categories that the program tracks on a monthly basis (please refer to the Monthly Report for the categories). Each major category has subcategories that further define the issue. The most prevalent issues addressed during this quarter included:

- Service reduced, denied or terminated
- Care planning participation
- Access to preferred/necessary durable medical equipment

Program

During Year 3, Quarter 3, the majority of calls received came from members enrolled in the Elderly Disability Waiver, Intellectual Disability Waiver and Health and Disability Waiver programs.

The Managed Care Ombudsman Program continues to assist members who experience their services reduced, denied or terminated. A Medicaid managed care member receiving services in his home, had filed for an appeal to maintain all services. The appeal was denied and the member then filed for a fair hearing. A few days before the fair hearing date, the MCO reinstated all of the members requested services. The Medicaid member was then able to remain in his home with the reinstated waiver services.
Grievances/Appeals/Fair Hearings

The Managed Care Ombudsman Program attempts to resolve issues informally in an effort to expedite resolution. For Year 3, Quarter 3, the Managed Care Ombudsman Program received 16 contacts regarding a grievance and 87 regarding an appeal. There have been 4 contacts regarding a fair hearing during this quarter. The table below shows a side-by-side comparison of the data discussed:

<table>
<thead>
<tr>
<th>Month</th>
<th>Number of Contacts</th>
<th>Top Three Issues</th>
<th>Average Resolution Time</th>
<th>Program</th>
<th>Contacts per MCO</th>
<th>Contacts Related to Grievances/Appeals/Fair Hearings</th>
</tr>
</thead>
<tbody>
<tr>
<td>November</td>
<td>159</td>
<td>1. Service reduced, denied or terminated Access to information or information sharing Care planning participation</td>
<td>30 days</td>
<td>1. Health and Disability Waiver</td>
<td>Amerigroup: 14 United: 137 FFS: 5</td>
<td>Grievances: 5 Appeals: 50 Fair Hearings: 2</td>
</tr>
<tr>
<td>December</td>
<td>144</td>
<td>1. Service reduced, denied or terminated Care planning participation Level of care assessment</td>
<td>25 days</td>
<td>1. Elderly Waiver</td>
<td>Amerigroup: 27 United: 116 FFS: 0</td>
<td>Grievances: 1 Appeals: 19 Fair Hearings: 1</td>
</tr>
<tr>
<td>Q3 Total</td>
<td>451</td>
<td>1. Service reduced, denied or terminated Care planning participation Access to preferred/necessary durable medical equipment</td>
<td></td>
<td>1. Elderly Waiver</td>
<td>Amerigroup: 73 United: 360 FFS: 7</td>
<td>Grievances: 16 Appeals: 87 Fair Hearings: 4</td>
</tr>
</tbody>
</table>

TABLE 1: QUARTER 3 CONTACT DATA (OCTOBER, NOVEMBER AND DECEMBER 2018)
MANAGED CARE OMBUDSMAN PROGRAM TRENDS

In addition to tracking member issues on a monthly basis, the Managed Care Ombudsman Program documents and tracks trends discussed by members. Issues and trends identified this quarter included:

1. CDAC and CCO Impacts. Consumer Directed Attendant Care and Consumer Choice Options, are choices available to Medicaid members who are eligible for one of the home and community-based services (HCBS) waiver programs and is a service frequently used by HCBS waiver members. The Managed Care Ombudsman Program has a high number of contacts from members reporting dissatisfaction with changes made to their CDAC services. Changes include service reductions or denials, and also changes that impact the day to day use of CDAC services. Members reported issues accessing the CDAC provider of their choosing, barriers to using CDAC services they would like, and perceived decreased flexibility within the service. Members were also concerned over their CDAC provider not receiving payment on time. Medicaid members have reported CCO budgets have not been completed on time, effecting the members ability to schedule staff to provide services needed.

2. Lack of Providers. Members have reported a lack of approved CDAC providers as well as an overall lack of providers accessible to the members to provide services. For members living in remote rural areas, this issue was more prevalent.

3. DME Access. Medicaid members experienced denials when trying to obtain durable medical equipment (DME) prescribed and recommended by their physician. Members reported the lack of contracted providers willing to work with the MCO’s, and approved bids by the assigned MCO created more barriers. These barriers continued to affect the quality of life for the member.

4. Lack of Notice of Decisions. The Managed Care Ombudsman Program continuously serves members who have reported they did not receive written notifications from their MCO regarding a change in their care such as a reduction in hours of a particular service or denial of a previously authorized benefit or service. Instead, members consistently receive verbal decisions not written decisions about a change in their care from their case manager or provider.

5. Level of Care Assessment and Care planning. Members are requesting new level of care assessments which would support their overall healthcare needs. Members are in disagreement with level of care assessment outcomes. Members feel there is a direct conflict of interest with the Managed Care Organization completing LOC assessments internally and providing internal Case Management.
COMMUNITY PARTNERSHIPS AND OUTREACH

Advocacy is more than complaint resolution or assistance with filing a grievance, appeal or fair hearing. It includes providing education, information, consultation, technical assistance or making a referral to the appropriate entity to ensure members have the information needed to make informed decisions regarding their care, in addition to partnering with community stakeholders to connect members to resources beyond the Managed Care Ombudsman’s scope.

The Managed Care Ombudsman Program networks with other advocacy and provider groups, associations, organizations and agencies to coordinate the provision of assistance to members. The Managed Care Ombudsman Program also participates, when possible, in various forums and work groups on a regular basis to inform and discuss and to address collective concerns expressed.

Additionally, the Managed Care Ombudsman Program maintains a website with information regarding the program’s services, informational materials and links to other resources. Electronic versions of communications materials and tools can be found at https://www.iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program.

The Managed Care Ombudsman Program advocated for a Medicaid member receiving benefits under the Elderly Waiver Program. The member had been approved for the Elderly Waiver yet waited several weeks to hear from an MCO. The Medicaid member and the guardian had not received their MCO materials and did not know who to contact to establish a care plan and receive in home services. Due to the advocacy of a Managed Care Ombudsman, the Elderly Waiver member was contacted by an MCO and their Case Manager. Level of Care and Care planning meetings were then completed.
COMPLAINTS & CASES

OCTOBER

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In October, the 148 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 55 individual members. The top complaint received in October was in regard to services reduced, denied or terminated (12 members). Additional complaints included:

- Access to Services/Benefits-Other (10 members)
- Access to preferred/necessary durable medical equipment (8 members)
- Access to information or information sharing (7 members)
- Care planning participation (7 members)
- Care coordinator/case manager was rude or gave poor customer service (6 members)
- Transportation not available, timely or adequate (5 members)
- Other service/coverage gap issue (5 members)
- Level of care assessment (5 members)
- MCO was rude or gave poor customer service (3 members)
- Provider/pharmacy/hospital not in network (3 members)
- Discharge (3 members)
- Member needs assistance with acquiring Medicaid eligibility information (3 members)
- Change in care setting (2 members)
- Access to preferred/necessary medication (1 member)
- Home/vehicle modifications (1 member)
- Transition services/coverage inadequate or inaccessible (1 member)
- Billing-Other (1 member)
- Scheduling (1 member)
- Member needs assistance with checking on application status (1 member)
- Guardianship documents not on file (1 member)

NOVEMBER

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In November, the 159 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 37 individual members. The top complaint received in November was in regard to services reduced, denied or terminated (16 members). Additional complaints included:

- Access to information or information sharing (8 members)
- Care planning participation (8 members)
- Access to preferred/necessary durable medical equipment (3 members)
- Access to Services/Benefits-Other (3 members)
- Level of care assessment (3 members)
COMPLAINTS & CASES

MCO was rude or gave poor customer service (3 members)
Discharge (2 members)
Care Coordinator/case manager was rude or gave poor customer service (2 members)
Home/vehicle modifications (2 members)
Other service/coverage gap issue (2 members)
Transition services/coverage inadequate or inaccessible (2 members)
Provider/pharmacy/hospital not in network (1 member)
Selecting/changing MCO (1 member)
Guardianship documents not on file (1 member)
Member needs assistance with acquiring Medicaid eligibility information (1 member)
Member has lost eligibility status or was denied (1 member)
Member has not received MCO card or other materials (1 member)
Guardian not receiving information (1 member)
Change in care setting (1 member)
Member needs assistance with checking on application status (1 member)

DECEMBER

The data reported on page 3 of this report provides detailed information about all of the contacts made to the Managed Care Ombudsman Program over the course of the month. The number of contacts reported is representative of the number of times the Managed Care Ombudsman Program is contacted; it does not represent the number of complaints made to the Managed Care Ombudsman Program. In December, the 144 contacts reported on page 3 resulted in the Managed Care Ombudsman Program working on complaints from 42 individual members. The top complaint received in December was in regard to services reduced, denied or terminated (23 members). Additional complaints included:

Care planning (9 members)
Level of care assessment (7 members)
Access to information or information sharing (6 members)
Access to preferred/necessary durable medical equipment (3 members)
Transition services/coverage inadequate or inaccessible (3 members)
Access to Services/Benefits-Other (3 members)
Care coordinator/case manager was rude or gave poor customer service (2 members)
MCO was rude or gave poor customer service (2 members)
Change in care setting (2 members)
Discharge (2 members)
Home/vehicle modifications (1 member)
Provider/pharmacy/hospital not in network (1 member)
Transportation not available, timely or adequate (1 member)
Other service/coverage gap issue (1 member)
Member has not received MCO card or other materials (1 member)
Member needs assistance with acquiring Medicaid eligibility information (1 member)
Guardian not receiving information (1 member)
## COMPLAINTS BY PROGRAM TYPE

<table>
<thead>
<tr>
<th>OCTOBER</th>
<th>Amerigroup Iowa</th>
<th>UnitedHealthcare Plan of the River Valley</th>
<th>Fee for Service</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>AIDS/HIV Waiver</td>
<td>1</td>
<td>-</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>Brain Injury Waiver</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>3</td>
</tr>
<tr>
<td>Children's Mental Health Waiver</td>
<td>-</td>
<td>-</td>
<td>-</td>
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*data may be incomplete due to data collection issues this reporting period

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### COMPLAINTS BY PROGRAM TYPE

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### GRAND TOTAL

|          | 28 | 104 | 2 | 129 |

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Managed Care Ombudsman Program
A Division of the Office of the State Long-Term Care Ombudsman

Jessie Parker Building
510 E. 12th Street, Ste. 2
Des Moines, IA 50319
www.iowaaging.gov

866.236.1430
ManagedCareOmbudsman@iowa.gov
Iowa Medicaid Enterprise

ia health link

Managed Care Organization Report: SFY 2019, Quarter 1
(July-September)
Performance Data

Published January 7, 2019
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EXECUTIVE SUMMARY

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

- Consumer Protection
- Outcome Achievement
- Program Integrity

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

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

This report is based on Quarter 1 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
Managed Care Enrollment by Age
Total MCO Enrollment = 622,909*

*September 2018 enrollment data as of October 31, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes hawk-i enrollees. 75,417 members remain in Fee-for-Service (FFS).

Capitated Enrollment

Capitation Expenditures
**PLAN ENROLLMENT BY MCO**

**Total Plan Enrollment by MCO***

<table>
<thead>
<tr>
<th>Plan</th>
<th>Total Enrollment</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Q2 SFY18</td>
<td>391,921</td>
<td>190,561</td>
<td>201,360</td>
</tr>
<tr>
<td>Q3 SFY18</td>
<td>418,251</td>
<td>189,820</td>
<td>228,431</td>
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<tr>
<td>Q4 SFY18</td>
<td>427,402</td>
<td>190,205</td>
<td>237,277</td>
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<tr>
<td>Q1 SFY19</td>
<td>426,745</td>
<td>196,164</td>
<td>230,581</td>
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* September 2018 enrollment data as of October 31, 2018 – 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***

<table>
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<td>1,166</td>
<td>359</td>
<td>807</td>
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<tr>
<td>Q3 SFY18</td>
<td>1,229</td>
<td>24</td>
<td>1,205</td>
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<tr>
<td>Q4 SFY18</td>
<td>567</td>
<td>652</td>
<td>945</td>
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<tr>
<td>Q1 SFY19</td>
<td>763</td>
<td>783</td>
<td>980</td>
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* September 2018 enrollment data as of October 31, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.
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](http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers).

**ALL MCO Home- and Community-Based Service (HCBS) Waiver Enrollment**

![MCO Waiver Enrollment by Program](chart.png)
### Average Number of Contacts

<table>
<thead>
<tr>
<th>Data Reported as of September 30, 2018</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
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<tbody>
<tr>
<td>Average Number of Care Coordinator Contacts per Member per Month</td>
<td>1.7</td>
<td>1.1</td>
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<tr>
<td>Average Number of Community-Based Case Manager Contacts per Member per Month</td>
<td>1.4</td>
<td>1.9</td>
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### Member to Coordinator Ratios

<table>
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<tr>
<th>Data Reported as of September 30, 2018</th>
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<tr>
<td>Ratio of Members to Care Coordinators</td>
<td>20</td>
<td>51</td>
</tr>
<tr>
<td>Ratio of HCBS Members to Community-Based Case Managers</td>
<td>51</td>
<td>45</td>
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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

- Reductions
- Increases
- Renewals- No Change
UnitedHealthcare Service Plan Revision Outcomes

- Reductions
- Increases
- Renewals - No Change

Q1 SFY19: 51%
Q2 SFY19: 33%
Q3 SFY19: 16%
Q4 SFY19: 0%
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 HCBS 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

<table>
<thead>
<tr>
<th>Quarter</th>
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<th>UnitedHealthcare</th>
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<tbody>
<tr>
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<td>94%</td>
<td>90%</td>
</tr>
<tr>
<td>Q3 SFY18</td>
<td>100%</td>
<td>87%</td>
</tr>
<tr>
<td>Q4 SFY18</td>
<td>99%</td>
<td>88%</td>
</tr>
<tr>
<td>Q1 SFY19</td>
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<td>90%</td>
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### Members Reporting They Feel Safe Where They Live

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<td>99%</td>
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<td>Q3 SFY18</td>
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<td>94%</td>
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Members Reporting Their Services Make Their Lives Better

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</tr>
<tr>
<td>Q1 SFY19</td>
<td>99%</td>
<td>97%</td>
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</table>
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

<table>
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<tr>
<td>Q3 SFY18</td>
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<tr>
<td>Q4 SFY18</td>
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</tr>
<tr>
<td>Q1 SFY19</td>
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### Supporting Data

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<th>UnitedHealthcare</th>
<th>% Pop</th>
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<tbody>
<tr>
<td>Grievances Received in Q2 SFY18</td>
<td>244</td>
<td>0.12%</td>
<td>247</td>
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<tr>
<td>Grievances Received in Q3 SFY18</td>
<td>276</td>
<td>0.13%</td>
<td>471</td>
<td>0.10%</td>
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<tr>
<td>Grievances Received in Q4 SFY18</td>
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<td>745</td>
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<tr>
<td>Grievances Received in Q1 SFY19</td>
<td>228</td>
<td>0.10%</td>
<td>471</td>
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### Supporting Data

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<td>Appeals Received in Q2 SFY18</td>
<td>499</td>
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<td>% Claims</td>
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<td>325</td>
<td>260</td>
</tr>
<tr>
<td>% Claims</td>
<td>0.02%</td>
<td>0.01%</td>
</tr>
<tr>
<td>Appeals Received in Q4 SFY18</td>
<td>309</td>
<td>320</td>
</tr>
<tr>
<td>% Claims</td>
<td>0.01%</td>
<td>0.01%</td>
</tr>
<tr>
<td>Appeals Received in Q1 SFY19</td>
<td>285</td>
<td>385</td>
</tr>
<tr>
<td>% Claims</td>
<td>0.01%</td>
<td>0.01%</td>
</tr>
</tbody>
</table>

### Amerigroup Appeal Outcomes

- Overturned: 5%
- Partially Overturned: 33%
- Upheld: 61%
- Withdrawn: 1%
UnitedHealthcare Appeal Outcomes

- Overturned: 58%
- Partially Overturned: 2%
- Upheld: 40%
- Withdrawn: 0%

Quarterly MCO Data
**Member Helpline**

**Service Level: Percentage of Member Helpline Calls Answered Timely**

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>85%</td>
<td>92%</td>
<td>87%</td>
</tr>
<tr>
<td>May-18</td>
<td>87%</td>
<td>97%</td>
<td>90%</td>
</tr>
<tr>
<td>June-18</td>
<td>87%</td>
<td>90%</td>
<td>92%</td>
</tr>
<tr>
<td>July-18</td>
<td>88%</td>
<td>92%</td>
<td>88%</td>
</tr>
<tr>
<td>August-18</td>
<td>88%</td>
<td>93%</td>
<td>82%</td>
</tr>
<tr>
<td>September-18</td>
<td>94%</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Secret Shopper: Member Helpline Average Monthly Score**

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>May-18</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>June-18</td>
<td>7</td>
<td>7</td>
</tr>
<tr>
<td>July-18</td>
<td>9</td>
<td>10</td>
</tr>
<tr>
<td>August-18</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>September-18</td>
<td>7</td>
<td>9</td>
</tr>
</tbody>
</table>
Provider Helpline

Service Level: Percentage of Provider Helpline Calls Answered Timely

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>83%</td>
<td>96%</td>
<td></td>
</tr>
<tr>
<td>May-18</td>
<td>85%</td>
<td>98%</td>
<td></td>
</tr>
<tr>
<td>June-18</td>
<td>84%</td>
<td>97%</td>
<td></td>
</tr>
<tr>
<td>July-18</td>
<td>82%</td>
<td>95%</td>
<td></td>
</tr>
<tr>
<td>August-18</td>
<td>74%</td>
<td>92%</td>
<td></td>
</tr>
<tr>
<td>September-18</td>
<td>83%</td>
<td>90%</td>
<td></td>
</tr>
</tbody>
</table>

Secret Shopper: Provider Helpline Average Monthly Score

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>May-18</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>June-18</td>
<td>5</td>
<td>9</td>
</tr>
<tr>
<td>July-18</td>
<td>7</td>
<td>8</td>
</tr>
<tr>
<td>August-18</td>
<td>8</td>
<td>9</td>
</tr>
<tr>
<td>September-18</td>
<td>10</td>
<td>9</td>
</tr>
</tbody>
</table>
Pharmacy Services Helpline

Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely

Service Level: Percentage of Pharmacy Provider Helpline Calls Answered Timely

Amerigroup  UnitedHealthcare  Contract Requirement

<table>
<thead>
<tr>
<th></th>
<th>April-18</th>
<th>May-18</th>
<th>June-18</th>
<th>July-18</th>
<th>August-18</th>
<th>September-18</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerig.</td>
<td>93%</td>
<td>89%</td>
<td>90%</td>
<td>96%</td>
<td>97%</td>
<td>96%</td>
</tr>
<tr>
<td>Uni.</td>
<td>97%</td>
<td>87%</td>
<td>85%</td>
<td>92%</td>
<td>99%</td>
<td>99%</td>
</tr>
</tbody>
</table>

0% 20% 40% 60% 80% 100%
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

- Amerigroup
- UnitedHealthcare
- Contract Requirement

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

- Amerigroup
- UnitedHealthcare
- Contract Requirement
Average Days for Non-Pharmacy Claims Payment

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>May-18</td>
<td>6</td>
<td>6</td>
</tr>
<tr>
<td>June-18</td>
<td>7</td>
<td>9</td>
</tr>
<tr>
<td>July-18</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>August-18</td>
<td>6</td>
<td>8</td>
</tr>
<tr>
<td>September-18</td>
<td>6</td>
<td>8</td>
</tr>
</tbody>
</table>

Amerigroup Non-Pharmacy Claims Status
**As of the end of the reporting period**

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-17</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>11%</td>
<td>89%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>May-18</td>
<td>-9%</td>
<td>91%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>-9%</td>
<td>91%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>10%</td>
<td>90%</td>
</tr>
</tbody>
</table>

UnitedHealthcare Non-Pharmacy Claims Status
**As of the end of the reporting period**

<table>
<thead>
<tr>
<th>Month</th>
<th>Paid</th>
<th>Denied</th>
</tr>
</thead>
<tbody>
<tr>
<td>Oct-17</td>
<td>18%</td>
<td>82%</td>
</tr>
<tr>
<td>Nov-17</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Dec-17</td>
<td>15%</td>
<td>85%</td>
</tr>
<tr>
<td>Jan-18</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Feb-18</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Mar-18</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Apr-18</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>May-18</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Jun-18</td>
<td>13%</td>
<td>87%</td>
</tr>
<tr>
<td>Jul-18</td>
<td>13%</td>
<td>88%</td>
</tr>
<tr>
<td>Aug-18</td>
<td>12%</td>
<td>86%</td>
</tr>
<tr>
<td>Sep-18</td>
<td>14%</td>
<td></td>
</tr>
</tbody>
</table>
## Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period

CARC and RARC are defined below table

<table>
<thead>
<tr>
<th></th>
<th>Amerigroup</th>
<th></th>
<th>UnitedHealthcare</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reason</td>
<td>%</td>
<td>Reason</td>
<td>%</td>
</tr>
<tr>
<td>1.</td>
<td>18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO)</td>
<td>30%</td>
<td>CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim</td>
<td>18%</td>
</tr>
<tr>
<td>2.</td>
<td>27-Expenses incurred after coverage terminated</td>
<td>15%</td>
<td>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.</td>
<td>15%</td>
</tr>
<tr>
<td>3.</td>
<td>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)</td>
<td>8%</td>
<td>CARC-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.</td>
<td>10%</td>
</tr>
<tr>
<td>4.</td>
<td>29-The time limit for filing has expired</td>
<td>7%</td>
<td>CARC-208 National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.</td>
<td>9%</td>
</tr>
<tr>
<td>5.</td>
<td>256-Service not payable per managed care contract</td>
<td>7%</td>
<td>CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service</td>
<td>6%</td>
</tr>
<tr>
<td>6.</td>
<td>197-Precertification/authorization/notification absent</td>
<td>5%</td>
<td>CARC-29 The time limit for filing has expired.</td>
<td>5%</td>
</tr>
<tr>
<td>7.</td>
<td>23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)</td>
<td>4%</td>
<td>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.</td>
<td>4%</td>
</tr>
<tr>
<td>8.</td>
<td>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)</td>
<td>4%</td>
<td>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.</td>
<td>3%</td>
</tr>
</tbody>
</table>
# Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period

<table>
<thead>
<tr>
<th>#</th>
<th>Reason</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>9.</td>
<td>N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges</td>
<td>97%</td>
<td>CARC-23 The impact of prior payer(s) adjudication including payments and/or adjustments.</td>
</tr>
<tr>
<td>10.</td>
<td>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</td>
<td>N432-Alert: Adjustment based on a Recovery Audit</td>
<td>CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.</td>
</tr>
</tbody>
</table>


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.

<table>
<thead>
<tr>
<th>Supporting Data</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>All Rx and NonRx Claims</td>
<td>6,094,006</td>
</tr>
<tr>
<td>All Rx and NonRx Reprocessing for Provider Requests or Errors</td>
<td>224,921</td>
</tr>
<tr>
<td>All Rx and NonRx Prior Authorizations</td>
<td>78,818</td>
</tr>
<tr>
<td>Appeals</td>
<td>670</td>
</tr>
</tbody>
</table>
Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>92%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>May-18</td>
<td>100%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>June-18</td>
<td>97%</td>
<td>100%</td>
<td></td>
</tr>
<tr>
<td>July-18</td>
<td>100%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>August-18</td>
<td>100%</td>
<td>99%</td>
<td></td>
</tr>
<tr>
<td>September-18</td>
<td>100%</td>
<td>97%</td>
<td></td>
</tr>
</tbody>
</table>
Pharmacy claims processing data is for the entire quarter.

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>May-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>June-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>July-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>August-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Month</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Contract Requirement</th>
</tr>
</thead>
<tbody>
<tr>
<td>April-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>May-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>June-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>July-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>August-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
<tr>
<td>September-18</td>
<td>100%</td>
<td>100%</td>
<td>100%</td>
</tr>
</tbody>
</table>
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

<table>
<thead>
<tr>
<th>#</th>
<th>Reason</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Refill Too Soon</td>
<td>34%</td>
<td>Refill Too Soon</td>
</tr>
<tr>
<td>2.</td>
<td>Product Not On Formulary</td>
<td>10%</td>
<td>Prior Authorization Reqrd</td>
</tr>
<tr>
<td>3.</td>
<td>Days Supply Exceeds Plan Limitation</td>
<td>8%</td>
<td>Prod/Service Not Covered</td>
</tr>
<tr>
<td>4.</td>
<td>Product/Service Not Covered – Plan/Benefit Exclusion</td>
<td>6%</td>
<td>Filled After Coverage Trm</td>
</tr>
<tr>
<td>5.</td>
<td>Submit Bill To Other Processor Or Primary Payer</td>
<td>6%</td>
<td>Sbmt bill to other procr</td>
</tr>
<tr>
<td>6.</td>
<td>Plan Limitations Exceeded</td>
<td>4%</td>
<td>Plan Limitations Exceeded</td>
</tr>
<tr>
<td>7.</td>
<td>Prior Authorization Required</td>
<td>4%</td>
<td>DUR Reject Error</td>
</tr>
<tr>
<td>8.</td>
<td>DUR Reject Error</td>
<td>4%</td>
<td>Prescriber is Not Covered</td>
</tr>
<tr>
<td>9.</td>
<td>This Medicaid Patient Is Medicare Eligible</td>
<td>3%</td>
<td>Non-Matched Pharmacy Nbr</td>
</tr>
<tr>
<td>10.</td>
<td>Product Not Covered Non-Participating Manufacturer</td>
<td>3%</td>
<td>Patient is Not Covered</td>
</tr>
</tbody>
</table>

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.

<table>
<thead>
<tr>
<th>Q1 SFY19 Data</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>Additional Benefits</td>
<td>311</td>
<td>959</td>
<td>1,270</td>
</tr>
<tr>
<td>Family Planning and Resources</td>
<td>0</td>
<td>2,398</td>
<td>2,398</td>
</tr>
<tr>
<td>Health and Wellness</td>
<td>57</td>
<td>273</td>
<td>330</td>
</tr>
<tr>
<td>Healthy Incentives</td>
<td>4,483</td>
<td>0</td>
<td>4,483</td>
</tr>
</tbody>
</table>

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](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

Amerigroup  UnitedHealthcare  Contract Requirement

April-18  May-18  June-18  July-18  August-18  September-18

Average Days for Regular PA Processing

Amerigroup  UnitedHealthcare

April-18  May-18  June-18  July-18  August-18  September-18
Percentage of PAs for Expedited Services Completed Within 72 Hours of Request

**Amerigroup Non-Pharmacy PAs Status**
**As of the end of the reporting period**

- **Approved**
- **Denied**
- **Modified**

**UnitedHealthcare Non-Pharmacy PAs Status**
**As of the end of the reporting period**

- **Approved**
- **Denied**
- **Modified**

Quarterly MCO Data
Prior Authorization - Pharmacy

Percentage of Regular PAs Completed
Within 24 Hours of Request

Amerigroup  UnitedHealthcare  Contract Requirement

April-18  May-18  June-18  July-18  August-18  September-18

99% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100% 100%
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.

<table>
<thead>
<tr>
<th>Performance Measure</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Encounter Data Submitted By 20th of the Month</td>
<td>Jul</td>
<td>Aug</td>
</tr>
<tr>
<td></td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>

**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.

<table>
<thead>
<tr>
<th>Data as of September 2018</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards</td>
<td>32%</td>
<td>46%</td>
</tr>
</tbody>
</table>
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.

<table>
<thead>
<tr>
<th>Q1 SFY19 Data</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>MLR</td>
<td>91.0%</td>
<td>91.6%</td>
</tr>
<tr>
<td>ALR</td>
<td>6.0%</td>
<td>7.9%</td>
</tr>
<tr>
<td>Underwriting</td>
<td>3.0%</td>
<td>0.5%</td>
</tr>
</tbody>
</table>
Capitation Payments Made to the MCOs

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

<table>
<thead>
<tr>
<th>MCO</th>
<th>Q1 SFY19</th>
<th>Q2 SFY19</th>
<th>Q3 SFY19</th>
<th>Q4 SFY19</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amerigroup Total</td>
<td>$417,598,591</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustments</td>
<td>$97,848,029</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>$312,420,560</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Reinstatements and Retroactive Eligibility</td>
<td>$7,330,002</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>UnitedHealthcare Total</td>
<td><strong>$768,872,756</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Adjustments</td>
<td>$78,327,083</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>$671,528,707</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Member Reinstatements and Retroactive Eligibility</td>
<td>$19,016,967</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

MCO Reported Reserves

<table>
<thead>
<tr>
<th>Data reported</th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*</td>
<td>Y</td>
<td>Y</td>
</tr>
</tbody>
</table>
Third Party Liability Recovery (Millions)

Amerigroup  UnitedHealthcare

$9M  $17M
$17M  $29M
$7M  $35M
$8M  $36M

Q2 SFY18  Q3 SFY18  Q4 SFY18  Q1 SFY19
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.

<table>
<thead>
<tr>
<th></th>
<th>Amerigroup</th>
<th>UnitedHealthcare</th>
</tr>
</thead>
<tbody>
<tr>
<td>Investigations Opened During the Quarter</td>
<td>15</td>
<td>151</td>
</tr>
<tr>
<td>Overpayments Identified During the Quarter</td>
<td>11</td>
<td>15</td>
</tr>
<tr>
<td>Cases Referred to the Medicaid Fraud Control Unit During the Quarter</td>
<td>8</td>
<td>14</td>
</tr>
<tr>
<td>Member Concerns Referred to IME</td>
<td>0</td>
<td>11</td>
</tr>
</tbody>
</table>

In prior reports, dollars recovered through Program Integrity efforts were reported on a quarterly basis. However, 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 166 investigations in the first quarter and referred 22 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.
Inpatient Admissions per 1,000 Members Per Month

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

**MCO Abbreviations:**

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

**Glossary Terms:**

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

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

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

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

**Appeal process:** The MCO process for handling of appeals, which complies with:
- The procedures for a member to file an appeal
- The process to resolve the appeal
- The right to access a state fair hearing and
- The timing and manner of required notices

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

**Capitation Payment:** Medicaid payments the Department makes on a monthly basis to MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member’s eligibility.
**CARC:** Claim Adjustment Reason Code. An explanation why a claim or service line was paid differently than it was billed. A **RARC** – Readjustment Advice Remark Code provides further information.

**Care Management:** Care Management helps members manage their complex health care needs. It may include helping 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 service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

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

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

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

CDAC services include:
- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

**Critical Incidents:** When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to
the HCBS member’s MCO in a clear, legible manner, providing as much information as possible regarding the incident.

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

**DHS:** Iowa Department of Human Services

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

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

**ED:** Emergency department

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

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

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

The following are examples of emergencies:

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

**Emergency Medical Transportation:** Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.
**Emergency Room Care:** Emergency Room Care is provided for Emergency Medical Conditions.

**Emergency Services:** Covered inpatient or outpatient services that are:
- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

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

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

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

**Fraud:** An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; the 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 days of the date the decision is being appealed.
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.

**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:** 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.