

Iowa Department of Human Services



Findings from the 2015 MCO Readiness Review Process



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TABLE OF CONTENTS

- I. INTRODUCTION 3
- II. READINESS REVIEW PROCESS 3
- III. KEY FINDINGS AND RECOMMENDATIONS 7
- IV. RECOMMENDED MCO RISK MITIGATION STEPS 15
- V. TIME MONITORING RECOMMENDATIONS 18
- APPENDIX A. CMS GATE REVIEW CROSSWALK..... 19
- APPENDIX B. FOLLOW UP ITEMS REQUESTED POST ONSITE REVIEW..... 30
- ATTACHMENT A. READINESS REVIEW TOOL
- ATTACHMENT B. STATUS OF INFORMATION SYSTEMS TESTING AND DATA EXCHANGE

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

I. INTRODUCTION

The State of Iowa is working to implement a comprehensive risk-based Medicaid managed care program, IA Health Link, by January 1, 2015. The State procured four managed care organizations (MCOs), including UnitedHealthcare Plan of the River Valley (UnitedHealthcare or UHC), to administer services for State Medicaid members. As part of implementation planning, the Department of Human Services (DHS), Iowa Medicaid Enterprise (IME) contracted with Navigant Consulting, Inc. to conduct a readiness review of each participating MCO.

Readiness reviews are a critical task in implementing Medicaid managed care programs to confirm if the contracted MCOs are making significant process in preparing for the transition, including activities such as establishing local offices, recruiting and training staff, contracting with local providers, uploading automated data about new Medicaid members and providers in their systems, adapting care management programs, developing policies and procedures for member and provider services, educating providers about managed care processes and outreaching to potential enrollees. A primary objective of the readiness review is to verify that MCOs are ready to provide services for the covered populations in accordance with the State’s contract, state and federal laws.

Navigant, along with IME staff, are conducting seven key tasks involved in the readiness process as illustrated below. This report provides the results of the first five tasks below and will help DHS understand the progress UnitedHealthcare is making to go live. While DHS will use this and other information to make a “go/no-go” decision – in other words, to decide if they will allow UnitedHealthcare to begin full operations on January 1, 2016 – it is only one of many key steps in program transition and implementation. This report identifies where there are risks and points to areas for further follow up, corrective action and monitoring that IME will want to undertake as transition planning and implementation continue.



The following sections and appendices summarize Navigant’s process for conducting desk and onsite readiness reviews, and identifies subsequent findings and recommendations. Additionally, Appendix A provides a crosswalk of our findings to the CMS gate reviews specific to MCO readiness.

II. READINESS REVIEW PROCESS

In this section, we detail the process followed to conduct the first five tasks of the readiness review process for each MCO.

Develop Readiness Review Process

Navigant and IME met to develop the process for conducting readiness activities. Based on that process we developed a work plan and timeline to align with IME’s planned November 30, 2015 go/no go decision. Figure 1 outlines the timeline for conduct of these review tasks for UnitedHealthcare.

Figure 1. Readiness Reviews for UnitedHealthcare

Activity	Timeline
Receive UnitedHealthcare’s desk review materials	October 12
Conduct desk reviews	October 11 – 25
Conduct onsite reviews (with DHS staff)	November 2 – 3
Request follow up items from onsite reviews	November 13
Conduct desk re-reviews	November 3 – 17
Issue report to DHS	November 19

Develop Readiness Review Tool and Share with MCOs

Navigant developed a Readiness Review Tool that outlined 528 contract requirements needing review as part of readiness and identified deliverables for the MCOs to submit as evidence that they will meet the associated requirements. As shown in Figure 2, Navigant grouped requirements into 20 functional areas.

Figure 2. Readiness Review Functional Areas

Functional Area	# of Requirements	Functional Area	# of Requirements
A. General Administrative	27	K. Member Services	48
B. Staffing	9	L. Grievances and Appeals	7
C. Financial Stability	8	M. Care Coordination	19
D. Scope and Covered Benefits	51	N. Quality Management	22
E. Pharmacy Benefits	25	O. Utilization Management	39
F. Behavioral Health Benefits	25	P. Program Integrity	15
G. Long-term Services & Supports	98	Q. Information Technology	45
H. Billing and Collections	5	R. Claims Processing	14
I. Provider Network	61	S. Performance and Reporting	3
J. Enrollment	6	T. Termination	1

The Readiness Review Tool in its simplest form houses the contract requirements designated as important to assess the MCO’s ability to comply with state, federal and contractual requirements. Navigant developed this tracking document to function as a vehicle for

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

exchanging information between reviewers and UnitedHealthcare. The full Readiness Review Tool with complete findings is included in Attachment A.

Conduct Desk Reviews

For desk reviews, UnitedHealthcare submitted requested documentation, and Navigant reviewed these materials to determine readiness and to identify risk areas to explore further during onsite reviews. Navigant used the following scale to conduct initial desk reviews:

- **Complete:** Submitted materials satisfactorily addressed readiness review requirement
- **Pending:** MCO submitted materials but additional information is required, will be obtained during the onsite review, or submitted materials do not satisfactorily address readiness review requirement
- **Incomplete:** No information was provided or the submitted materials do not meet readiness review requirement

Navigant populated the Readiness Review Tool with our findings and returned the Tool to UnitedHealthcare to respond to requests for additional information.

Conduct Onsite Reviews

After completion of the desk reviews, Navigant scheduled a two-day onsite review with UnitedHealthcare. The onsite review allowed for:

- A review of MCO key systems as described in their applications and desk review documents to confirm they are in place, operational and capable of performing their intended function(s).
- An opportunity for face-to-face discussion with MCO operational staff to confirm status of key activities (e.g., hiring, training, systems development, etc.) as well as to better understand, for example, processes and procedures reviewed during desk reviews but for which discussions will provide more clarity.

Navigant developed a structured agenda, facilitated site-visit meetings and demonstrations and provided post site-visit exit interviews. Subject matter experts from DHS also participated in these meetings. After completing the onsite visit, we developed a listing of follow-up items, as identified in Appendix B, for which we requested UnitedHealthcare to provide additional information for review.

Conduct Final Reviews and Develop Report

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

For those requirements Navigant reviewed during the initial desk or onsite reviews and that we determined did not satisfactorily address requirements, we requested UnitedHealthcare to submit updated or additional information. In conducting onsite reviews and re-reviews of updated materials to finalize our findings, Navigant used the following scale:

- **Complete:** Submitted materials and/or requested re-submissions satisfactorily address readiness review requirements and onsite discussions further support these findings
- **Pending:** Items are necessary for full assessment of readiness but Navigant was unable to conduct reviews due to timing of transition activities as determined by IME¹
- **Incomplete:** UnitedHealthcare did not provide a document, or the submitted document does not meet the readiness review requirement, or UnitedHealthcare could not demonstrate readiness during onsite reviews

Navigant updated the Readiness Review Tool with our final findings and developed this final report based upon those findings. Section III provides a summary of our overall findings and recommendations based on all information submitted as well as interviews and demonstrations conducted onsite. Section IV and V provide recommended mitigation strategies for UnitedHealthcare and potential monitoring activities by IME in December and post go-live. Also, see Attachment A, Readiness Review Tool, for completed status of each readiness review item and additional detail about findings for individual review items.

¹ IME staff will provide supplemental information to the IME Management Team as to readiness as these activities occur.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

III. KEY FINDINGS AND RECOMMENDATIONS

Navigant identified key findings from the desk and onsite reviews, which highlighted strengths and areas of risk related to UnitedHealthcare’s ability to be fully ready for operations on January 1, 2016.

These findings are based on desk and onsite reviews as of November 17, 2015. Considering this evaluation is based on progress towards readiness more than one month before the anticipated January 1, 2016 implementation date, we recognize that UnitedHealthcare is continuing to make progress in their preparations. However, findings from the desk and onsite reviews allow us to assess the status of readiness, identify potential risks based on that status, and recommend actions that IME and UnitedHealthcare conduct to monitor progress towards readiness and to mitigate risks prior to the go-live of IA Health Link.

Figure 3 outlines these findings and provides a breakdown of the number of requirements we identified as complete, incomplete, pending, as well as the percent of requirements that are complete by functional area.

Figure 3. UnitedHealthcare of Iowa – Summary of Completed Requirements

Type of Requirement	Number of Requirements				Percent of Requirements that Complete Review*
	Complete	Incomplete	Pending	Total	
General Administrative Requirements	25	2		27	93%
Staffing	6	3		9	67%
Financial Stability	8			8	100%
Scope and Covered Benefits	49	2		51	96%
Pharmacy Benefits	23	2		25	92%
Behavioral Health Benefits	24	1		25	96%
LTSS	85	13		98	87%
Billing and Collections	4	1		5	80%
Provider Network Requirements	56	5		61	92%
Enrollment	6			6	100%
Member Services	40	8		48	83%
Grievances and Appeals	7			7	100%
Care Coordination	19			19	100%
Quality Management and Improvement Strategies	21	1		22	95%
Utilization Management	38	1		39	97%
Program Integrity	13	2		15	87%
Information Technology	36	7	2	45	80%
Claims Processing	11	2	1	14	79%
Performance Targets and Reporting Requirements	2		1	3	67%
Termination	1			1	100%
Total	474	50	4	528	90%

*Number of requirements that pass review divided by the total number of requirements with a completed initial review (readiness status of pass, fail, or pend)

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Additionally, Figure 4 provides detail about the requirements that remained incomplete at the completion of the reviews.

Figure 4: Breakdown of the Number of Incomplete Requirements

Description	Number of Incompletes	Comments
1. Requirement identified as an operational deficiency during desk and onsite reviews.	29	Follow up on these items is considered in overall mitigation and monitoring recommendations outlined in Sections IV and V.
2. Additional information or detail resubmitted by UnitedHealthcare did not fully satisfy the readiness requirement. Examples include: <ul style="list-style-type: none"> • Policies and procedures must be submitted in response to Contract requirements • Additional language must be added to policies and procedures to adhere to Contract requirements 	18	Incompletes will be easily rectified by resubmission of materials, which highlight changes per comments provided in the Readiness Review Tool (see Attachment A).
3. UnitedHealthcare did not resubmit any new documents to address previous comments made in the Readiness Review Tool.	3	Incompletes will be easily rectified by resubmitting new information to address initial desk review findings, per comments in the Readiness Review Tool (see Attachment A).

The tables below further identify risks that may affect UnitedHealthcare’s readiness on January 1, 2016 based on our desk and onsite findings. We identified five key operational areas with varying levels of deficiencies:

1. Long-Term Services and Supports (LTSS)
2. Information Systems
3. Provider Network
4. Hiring and Staff Training
5. Office Space

We have prioritized these risks based on those which we think are most critical and could have the most impact to the member population if sufficient progress is not made to address these

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

risks throughout December. We also provide recommended follow up that IME should conduct in December and post go-live to monitor UnitedHealthcare’s progress in mitigating these risks. See Sections IV and V for these follow up recommendations.

Table 1. Long-Term Services and Supports (LTSS)	
<p>UnitedHealthcare has a sound approach to training and staffing for LTSS. Further, UnitedHealthcare’s care management tools are deployable and ready of the Iowa program. However, there are key dependencies on securing an adequate LTSS provider network, training LTSS care managers, creating a seamless approach to care management for those with multiple and more complex needs and obtaining current care plans to ensure continuity of care.</p>	
<p><i>Degree of Impact</i> HIGH</p>	<p>Members receiving LTSS are a high-touch population. As a result, there is potentially a relatively high likelihood of an adverse impact on continuity of care and patient safety if the MCO does not address the issues we raise below.</p>
<p><i>Risk Areas</i></p>	<p><i>Care Management Approach and Integration</i></p> <ul style="list-style-type: none"> • There is uncertainty as to the level of collaboration and required transitions that will occur between the various types of care managers (physical health, behavioral health, LTSS). For example, there is uncertainty as to how integrated the approach will be with Targeted Care Managers and Integrated Health Homes with their long-term care managers. While UnitedHealthcare described a multidisciplinary care team approach for integration, it was not clear if this process would be seamless for their members without resulting in confusion. <p><i>Staffing and Training</i></p> <ul style="list-style-type: none"> • The LTC Medical Director position remains vacant as of November 17, 2015. UnitedHealthcare was unable to provide a clear timeline for hiring and training this individual. • UnitedHealthcare’s timelines for care management training may threaten their ability to complete this exercise for all staff prior to the January 1 go-live. Further, the training program is for an aggressive 2 week session. This will be important for IME to monitor. <p><i>Timely Availability of Member Information</i></p> <ul style="list-style-type: none"> • All MCOs requested that IME consider provision of current LOC assessments and care plans prior to mid-December to allow proactive planning for care management and to identify members who will require reassessments in January. This could create issues with, for example uploading of information to systems, completion of transitions to new care managers and completion of reassessments due in January could be delayed depending on issues such as format in which care plans are received. <p><i>Provider Network</i></p>

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Table 1. Long-Term Services and Supports (LTSS)

	<ul style="list-style-type: none"> • Provider network development continued to provide challenges (also see Provider Network table). While UnitedHealthcare has agreed to pay non-participating providers for the first 90 days of the Contract, having a well-developed LTSS network at “go-live” will help to decrease need for later transition of providers in care plans and will help to target provider education which may be more extensive than typical for some LTSS providers.
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Table 2. Information Systems

<p>Navigant reviewed submitted materials and received systems demonstrations as part of onsite reviews. We found that UnitedHealthcare has innovative, intuitive, easy-to-use systems, which are integrated across various functional areas and capture a significant amount of detail for staff to use in supporting members and providers.</p> <p>The MCOs are continually working with IME to build out file layout and specifications for their system. Given the timeline for this work, we were not able to fully review information systems readiness and have noted a few concerns. IME staff have provided a timeline to the MCO for testing and interface development and will monitor progress. See Attachment B for IME’s timeline status as of November 17th.</p>	
<p><i>Degree of Impact</i></p> <p>HIGH</p>	<p>While services will likely continue to be delivered, without proper testing and validation of supporting claims and information systems, there are significant risks related to accurate and timely billing, payment, concern regarding accuracy of information shared with providers and members, etc. Due to the lack of data sharing and testing at this stage of implementation we see this area as one of significant concern.</p>
<p><i>Risk Areas</i></p>	<ul style="list-style-type: none"> • UnitedHealthcare did not demonstrate progress in incorporating IA Health Link specific information into their systems (e.g., demonstrated current Iowa <i>hawk-i</i> webpages, portals, etc.). • Systems testing is underway. Typically, modifications will be identified during testing, and IME staff involved in this process will provide results and status updates to the IME Management Team. <p><i>Enrollment Files</i></p> <ul style="list-style-type: none"> • UnitedHealthcare did not have the test files to begin loading member information and benefits into their system at the time of our onsite visit. <ul style="list-style-type: none"> – Area of biggest concern is the 834 enrollment files. Without the 834 files, it is difficult to work through the other information system issues. – As noted during test calls with member services, lack of member data and information significantly impedes the member services area from assisting the member or potential enrollee.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Table 2. Information Systems	
	<p><i>Testing Exchanges and other UAT testing</i></p> <ul style="list-style-type: none"> • Without key files, UnitedHealthcare had yet to test exchanges with IME, and glitches in these areas could result in various down-stream issues • At the time of onsite reviews, UnitedHealthcare did not yet have other key files to allow for proper UAT testing including: <ul style="list-style-type: none"> - Claims history - Care Plan authorizations - Prior Authorizations • Member assignments (834). Beyond test files, the actual files are needed to facilitate outreach to current care managers for assigned members, support member services and initiate member enrollment packet mailings

Table 3. Provider Network	
<p>While UnitedHealthcare has, in general, made the most progress in provider contracting across all four MCOs, significant contracting issues exist with hospitals/health systems and other key specialists. Some of this challenge is due to provider resistance to implementation of Medicaid managed care in the State.</p>	
<p><i>Degree of Impact</i></p> <p>Medium to High</p>	<p>Network adequacy is an indicator of <i>potential concerns</i> for access and availability of care. However, this is not necessarily an indicator that there will be access issues – particularly given that UnitedHealthcare has agreed to pay non-participating FFS providers for the first 90 days of the Contract. However, potential impacts still exist, such as:</p> <ul style="list-style-type: none"> • Potential for providers to elect to not treat members on a non-participating status. • Potential for a high degree of confusion for providers who will be learning multiple billing systems. If not part of the MCO network, there is less opportunity for coordination and training. This may result in delayed payments. • Member care planning could be impacted if a care plan is established that requires initiation of treatment with a non-participating provider and changes are required after the 90 days and/or when participating providers become available. • Member ability to make informed choice for MCO selection if current providers are not contracted.
<p><i>Risk Areas</i></p>	<ul style="list-style-type: none"> • At time of reviews, IME and the MCOs were in process of developing standardized definitions and methodology for calculating percent of FFS providers that have been contracted. However, data provided indicated significant deficiencies in provider network development. See UnitedHealthcare’s Provider Network Reports submitted November 17th.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Table 3. Provider Network

	<ul style="list-style-type: none"> • At the time of onsite reviews, certain provider rates had not yet been made available. Each MCO voiced that they anticipated certain provider types to agree to contracting after receiving rates. • Common issues that MCOs have raised that they have encountered in contracting efforts include: <ul style="list-style-type: none"> – Provider resistance to implementation of Medicaid managed care – Several major hospitals and health systems have not yet contracted which is impacting specialist contracting given most work with health systems. If at least one health system agrees to contract, the percent of providers across specialties will increase significantly. – Critical access hospitals are raising considerations for historical cost settlements. – Some providers have indicated they have until December 31st to sign a contract.
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Table 4. Hiring and Staff Training

<p>Given the varying degree of risk with each area, we have provided overall risk related to staffing deficiencies for each area in this table.</p> <p>UnitedHealthcare has pursued an aggressive hiring strategy and has a sound contingency approach to using existing resources and their national implementation team to address concerns during this time. However, there is a large volume of new hires engaged in training. Ensuring that these staff are well versed on the Iowa program and United Operations will be important for IME to continue to monitor. Below we highlight additional areas for targeted considerations.</p> <p><i>Note that staffing data is current as of November 17th.</i></p>	
<p><i>Degree of Impact</i> LOW</p>	<p>While the overall risk status for UnitedHealthcare staffing is LOW as the large majority of Key Staff positions and other important operational and clinical areas are filled, there are some areas of concern where we have elevated the risk level for this specific subset of staffing.</p>
<p>Risk Areas</p>	<p><i>Call Center Services (Medium)</i></p> <ul style="list-style-type: none"> • The Provider Call Center is only 36 percent filled; staffing plan anticipates 100 percent for go-live, and UnitedHealthcare noted ability to use back-up staff from national resources. • Pre-Implementation: The results of “secret shopper” calls to call center services staff receiving pre-enrollment calls raised concerns about need for additional training and resources.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Table 4. Hiring and Staff Training	
	<ul style="list-style-type: none"> • Post-Implementation: Call center representatives who will staff call centers after implementation were not available for interviews; therefore, Navigant was not able to assess training or representatives' understanding of Iowa Medicaid. • Effective January 1, 2016, United HealthCare anticipates 73 Call Center Professionals to be dedicated to IA Health Link member calls at the Moline, IL call center. See comments in Table 5, Office Space, below. <p>Care Management (Medium)</p> <ul style="list-style-type: none"> • There are still a number of vacancies for care management field staff. To ensure continuity of care and proper training, progress will need to be closely monitored. <ul style="list-style-type: none"> - Only 21 percent of the behavioral health care manager positions had been filled. There is lack of detail on the breakout for substance abuse care management staff or use of peer support counseling. Given time needed for onboarding and training, this too is an areas of elevated concern. <p>Key Personnel (Low)</p> <p>Four key personnel positions had yet to be filled with permanent staff.</p> <ul style="list-style-type: none"> • Interviewing underway and targeted to be filled by December 15th: <ul style="list-style-type: none"> - Compliance Officer (filled in interim) - Program Integrity Manager (filled in interim) - Behavioral Health Director (filled in interim) • Offer extended, onboarding and targeted to be filled by January 11, 2016: <ul style="list-style-type: none"> - Chief Financial Officer • Currently sourcing for and targeted to be filled by December 14th: <ul style="list-style-type: none"> - Long Term Care (LTC) Medical Director

Table 5. Office Space	
<p>UnitedHealthcare has local office completed in West Des Moines with plans for satellite locations around the State including buildout of a member call center in Davenport, IA that will go-live March 2016.</p>	
<p>Degree of Impact LOW</p>	<p>Staffing changes will result in need for training of additional member services representatives. Moving could result in disruptions in phones and IT systems. Current space will primarily support clinical staff and care managers. UnitedHealthcare also relies on a work from home model which makes Iowa office space less concerning. There are several post implementation changes scheduled for member and provider call centers. These transitions are common in health plans and</p>

Table 5. Office Space	
	for similar transitions. While the risk level is low, IME should carefully evaluate these transitions.
<i>Risk Areas</i>	<ul style="list-style-type: none"> • No concerns for January 2016 go-live date. • Raising to IME for monitoring of go-live for Davenport call center.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IV. RECOMMENDED MCO RISK MITIGATION STEPS

Navigant has recommended several mitigation steps for DHS to consider requiring UnitedHealthcare to implement for each of our key findings to confirm progress towards successful implementation and go-live on January 1, 2016. Figure 5 provides a breakdown of these mitigation strategies by key area.

Figure 5: Recommended UnitedHealthcare Mitigation Strategies

Recommended Mitigation Steps to Complete for a January 1, 2016 Implementation				
	By December 4, 2015	By December 11, 2015	By December 18, 2015	By December 25, 2015
LTSS	<ul style="list-style-type: none"> • Fill 80 percent of all LTSS care management staff positions • Provide contingency plans detailing how full operations will be supported without full staffing and ability to complete training by go-live 	<ul style="list-style-type: none"> • Fill 85 percent of all LTSS care management staff • Submit weekly status report verifying training is progressing as scheduled. Include in report: <ul style="list-style-type: none"> - Training start dates - Number of staff that started on each date - Number of trainee completion and dates of completion • Provide IME access to attend trainings and to interview staff in training or who have completed training 	<ul style="list-style-type: none"> • Fill 90 percent of all LTSS care management staff • Demonstrate progress on contracting with LTSS providers to compliance with Provider Network standards outlined in contract for 75 percent of members • Provide plan for and status of provider education and community outreach to ensure continuity of care and payment for participating and non-participating providers • Develop transition plan based on receipt of claims history and other data files from IME 	<ul style="list-style-type: none"> • Submit schedule for care plan annual assessments due for Q1
Provider Network	<ul style="list-style-type: none"> • Continue providing daily updates to IME on network development 	<ul style="list-style-type: none"> • Develop contingency plan to ensure access based on current status of network 	<ul style="list-style-type: none"> • Provide a status of efforts to ensure continuity of care, particularly for non-par providers regarding provider education and outreach 	

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Recommended Mitigation Steps to Complete for a January 1, 2016 Implementation					
		By December 4, 2015	By December 11, 2015	By December 18, 2015	By December 25, 2015
		status and methods being implemented to address ongoing challenges	<ul style="list-style-type: none"> Provide status on loading contracts 	<ul style="list-style-type: none"> Provide status of integration models with care management and discharge planners, alerts from non-contracted hospitals, etc. 	
Information Systems	<ul style="list-style-type: none"> Participate in various testing and data summit meetings with IME Provide updates on ability to complete exercises as staged 	<ul style="list-style-type: none"> Must adhere to and have successful completion of all test dates Provide updates on ability to complete exercises as staged Immediately report to IME any areas of concern or identified challenges with interface or exchange Implement contingencies as needed Initiate member mailings Submit verification to IME that all exchanges with subcontractors are tested and ready NOTE: IME will continue to evaluate MCO progress with State's test file schedule and track any issues or concerns (See Attachment B) 			
Hiring and Staffing	<ul style="list-style-type: none"> Complete the following hiring: <ul style="list-style-type: none"> 80 percent of all provider call center staff positions 80 percent of all CSN positions 80 percent of behavioral health staff positions 80 percent of pharmacy staff positions Provide detailed contingency regarding how operations will be 	<ul style="list-style-type: none"> Complete the following hiring: <ul style="list-style-type: none"> 90 percent of all provider call center staff positions 90 percent of all CSN positions 90 percent of behavioral health staff positions 90 percent of pharmacy staff positions Submit status report verifying training is progressing as scheduled. Submit trainee certificates of completion Provide IME access to attend trainings and to interview staff in training or who have completed training to confirm their understanding of IA Health Link 			

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

Recommended Mitigation Steps to Complete for a January 1, 2016 Implementation				
	By December 4, 2015	By December 11, 2015	By December 18, 2015	By December 25, 2015
	supported for each area without defined staff • Submit finalized scripts and other resources the MCO has developed specific to pre-enrollment calls (member and provider)			
Office Space	<ul style="list-style-type: none"> • Submit transition plan for call center functions, including when telephone lines and systems will be ready. Include in the plan how United Healthcare will assure no disruption in services for members or providers • Determine if notices should be provided to any stakeholders (e.g., if telephone numbers will change) • Provide hiring and training schedules for call center personnel 			

V. IME MONITORING RECOMMENDATIONS

As UnitedHealthcare continues to take corrective actions and address areas of concern identified in the readiness review, Navigant also recommends that IME continued monitoring the MCO’s progress to make certain that it is addressing risks in a satisfactory manner. Figure 6 highlights some of the monitoring efforts we recommend.

Figure 6: Recommended IME Monitoring Post Go-Live

Key Areas	Monitoring Activities
LTSS	<ul style="list-style-type: none"> • If hiring and training not complete, continue to review weekly updates as to status • Require reports on completion of annual assessments due for Q1 noting delays, reasons for challenges in timely completion of due assessments • Require weekly call center reports for any LTSS and care management issue • Track complaints about continuity of care, access to care managers and access to providers and how those complaints are resolved • Track trends in provider complaints and require updated plans for outreach and education • Confirm that access to non-participating providers is allowed
Hiring and Staffing	<ul style="list-style-type: none"> • Continue with test calls • Require more routine reporting of call center statistics • Require evaluation of care management duties, touches, etc. • Require reporting and evaluation of training classes for first 90 days • Evaluate for staff retention • Require status on all transitions for various call center functions
Provide Networks	<ul style="list-style-type: none"> • Evaluate claims status reports on weekly basis • Review denial reason report weekly for first 30 to 90 days • Continue to evaluate network development status weekly for provider types for which network adequacy continues to be low • Evaluate every other week the status of key issues, provider outreach, call center statistics related to access or provider concerns • Require weekly reporting of member complaints about provider access – monitoring instances where non-participating providers are electing not to provide care
Information Systems	<ul style="list-style-type: none"> • Evaluate claims status reports on weekly basis • Review claim denial reason report weekly for first 30 – 90 days • Monitor daily file transactions (834, pregnancy alerts, death alerts, etc.)
Office Space	<ul style="list-style-type: none"> • Interview newly hired staff after completion of training to confirm thoroughness of training • Confirm operations commence in their permanent space • Conduct “secret shopper” calls after call center is operational • Require more routine call center reporting for 60 days or later if reporting shows concerns (e.g., increased member complaints, abandoned calls, etc.) • Status on all transitions for various call center functions

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

APPENDIX A. CMS GATE REVIEW CROSSWALK

Figures A.1 and A.2 identify criteria for the CMS gate review, which was provided by CMS as checkpoints to ensure state and MCO readiness prior to go-live of the Medicaid managed care program. The below figures focus only on those criteria that CMS identified for which MCO readiness review information applies (e.g., the CMS gate review also included IME readiness items, and those are not included in this appendix).

Figure A. Gate 1: CMS Criteria for Iowa Health Care Initiative Preliminary Readiness

IA Health Link Program Implementation		
Operation Activities for Assessment	Action Steps	Navigant Comments
Condition #2	<p>Every MCO documents it has contracted with and credentialed 50 percent of current FFS providers in the following categories:</p> <ul style="list-style-type: none"> • Primary care, adult and pediatric • OB/GYN • Five most common adult and pediatric specialty providers • Hospital • Pharmacy • LTSS providers • Behavioral providers, adult and pediatric (use Magellan’s directory versus FFS for this provider type) 	<p>Provider contracting of total active FFS providers as of 11/17/15</p> <ul style="list-style-type: none"> • See UnitedHealthcare’s Provider Network Adequacy report. • UnitedHealthcare has not yet achieved 50 percent of current FFS providers. • Although not at 50 percent, UnitedHealthcare has contracted with the largest number of PCPs.
Condition #3	<p>Every MCO documents it has hired at least 50 percent of its projected staff, especially customer service center.</p>	<ul style="list-style-type: none"> • Has filled 76 percent (514 new hires) of 673 new hires for all business in staffing plan for all business areas. • Member Call Center is 100 percent filled.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation		
		<ul style="list-style-type: none"> Provider Call Center is 36 percent filled; anticipate 100 percent in time for go-live.

Figure A.2. Gate 2: CMS Criteria for Iowa Health Care Initiative Full Readiness

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
1.	Administration <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> State Resources for Program Operations Interagency Coordination Stakeholder Engagement 	<ul style="list-style-type: none"> Hiring plan including job descriptions 	<ul style="list-style-type: none"> Submitted hiring plan, including contingency plan for training of staff hired at late dates.
		<ul style="list-style-type: none"> Building readiness including work space and accessibility 	<ul style="list-style-type: none"> Operating in permanent Iowa headquarters located in West Des Moines. Plan to open satellite offices around the State.
		<ul style="list-style-type: none"> System capacity to report member service calls and issues daily during the transition period 	<ul style="list-style-type: none"> Demonstrated call tracking and reporting capabilities.
		<ul style="list-style-type: none"> Training schedule and materials prepared 	<ul style="list-style-type: none"> Some trainings had started at time of readiness reviews; however, UnitedHealthcare indicated most will occur in December.
		<ul style="list-style-type: none"> Contingency plans to pull from other health plans cannot hire enough for start date 	<ul style="list-style-type: none"> Contingency staffing is already underway with use of Call Center Professionals in other states trained on Iowa specific information and interim personnel from national headquarters in Minneapolis to leverage the staff in Iowa.
2.	Enrollment-Related Functions	<ul style="list-style-type: none"> Member materials developed and approved by the state 	<ul style="list-style-type: none"> Submitted member materials to IME for review. This process is ongoing.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<p><i>Operation Activities for Assessment</i></p> <ul style="list-style-type: none"> • Enrollment and Disenrollment • Auto-assignment • Enrollment Broker • Choice Counseling and Beneficiary Support system • Eligibility and Enrollment Systems • Outreach • Enrollee Information • Marketing • Fraud and Abuse 	<ul style="list-style-type: none"> • Call center scripts developed and approved and staff trained on benefits 	<ul style="list-style-type: none"> • Demonstrated resources for use by Call Center Professionals representatives (e.g., myCoach, standard operating procedures, FAQs, knowledge management and reference materials, etc.). • “Secret shopper” calls to Call Center Professionals taking pre-enrollment calls identified need for additional training and resources. Staff training on benefits not completed at the time of reviews.
		<ul style="list-style-type: none"> • Call center contingency plans developed 	<ul style="list-style-type: none"> • Contingency workforce is in place with 143 percent of member call center open requisitions are filled. • Have national resources available to serve as back-up for overflow calls.
		<ul style="list-style-type: none"> • Compliance officer hired and employee fraud prevention and notification materials signed 	<ul style="list-style-type: none"> • Compliance officer position is currently filled with interim staff until permanently filled.
3.	<p>Member Services</p> <p><i>Operation Activities for Assessment</i></p> <ul style="list-style-type: none"> • Member Handbook and Enrollee Information • MCO and State Customer Services 	<ul style="list-style-type: none"> • Develop member handbook and get approved by the state 	<ul style="list-style-type: none"> • Member handbook under review by IME. IME has provided comments to the MCO for update and then final review by IME.
		<ul style="list-style-type: none"> • Load LTSS service plans as authorizations 	<ul style="list-style-type: none"> • Timeline indicates that IME will provide LTSS service plans to MCOs mid-December.
		<ul style="list-style-type: none"> • Similar functions to enrollment and interface with state and enrollment broker 	<ul style="list-style-type: none"> • Navigant unable to review given timeline for testing and file transfer with IME; desk review materials indicate processes for accepting enrollment files.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<ul style="list-style-type: none"> Outreach, Scheduling, and Transportation Enrollee Services and Supports 	<ul style="list-style-type: none"> Policies and procedures about member information and outreach Continuously updated provider directory for call center staff to reference 	<ul style="list-style-type: none"> Policies and procedures about member information and outreach completed; materials pending IME approval at time of reviews. Provider directory will be available online and updated daily for call center staff reference.
4.	<p>Service Provision</p> <p><i>Operation Activities for Assessment</i></p> <ul style="list-style-type: none"> Utilization Management Service Delivery Service Planning 	<ul style="list-style-type: none"> Policies and procedures developed and staff trained Practice guidelines developed and approved for use by the state Inter-rater reliability tested Case management system functioning and staff trained on person-centered planning, system usability and level of detail in documentation necessary 	<ul style="list-style-type: none"> Has developed policies and procedures. Training was just beginning for some staff at time of onsite reviews, with plans for more trainings beginning mid-November to early December. Practice guidelines developed and submitted; pending IME approval. Policies and procedures as well as onsite discussion detailed process for inter-rater reliability testing. Annual competency plan consists of Milliman Care Guidelines and inter-rater reliability course with 90 percent mastery. Case management system demonstrated during onsite review appears to be user-friendly and thorough in information captured. Training just beginning for some staff at time of onsite reviews, with plans for more trainings beginning mid-November to early December.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
		<ul style="list-style-type: none"> Interface with HCBS case managers to integrate into plan case management system 	<ul style="list-style-type: none"> UnitedHealthcare (UHC) indicated all members are assigned a UHC Community Based Case Manager (CBCM) to serve as the member’s key point of contact and who will coordinate and manage all physical and behavioral health services. Existing external Targeted Case Managers (TCM) will manage and coordinate all HCBS services and engage with CBCM to ensure all services are coordinated. This will be transitioned to a UHC CBCM over six-month timeframe. All services and activities are documented and tracked on UnitedHealthcare’s Community Care Platform.
		<ul style="list-style-type: none"> Staff trained on all services available in the appropriate c waivers and community based supports resources 	<ul style="list-style-type: none"> Training was just beginning for some staff at time of onsite reviews, with plans for more trainings beginning mid-November to early December. UnitedHealthcare also developed a member manual and provider manual specific to HCBS waivers.
5.	<p>Access</p> <p><i>Operation Activities for Assessment</i></p> <ul style="list-style-type: none"> Provider Network Adequacy Access and Availability Access for People with Disabilities or Other Special Needs MCO Contracts with Network Providers 	<ul style="list-style-type: none"> Plans do provider outreach to enroll providers and provide assistance through the credentialing process 	<ul style="list-style-type: none"> Recruiting strategy includes amending existing UnitedHealthcare contracted providers to lengthen contracted time. National Credentialing Center (NCC) located in Westerville, Ohio will handle provider initial and re-credentialing application processing for non-delegated entities cross all states and lines of business under UnitedHealthcare and its affiliate organizations.
		<ul style="list-style-type: none"> Plans provide in person assistance to the LTSS providers to train them on provider enrollment and 	<ul style="list-style-type: none"> Policies and procedures indicate that all provider advocates or health plan staff will be trained accordingly, including LTSS providers.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
		credentiaing practices as well as how to appropriately bill for claims to get paid timely	<ul style="list-style-type: none"> During onsite reviews, UnitedHealthcare indicated they will provide in-person support when necessary for providers, such as CDAC providers, to assist with billing.
		<ul style="list-style-type: none"> Work with providers to ensure appropriate and accurate information collected during credentialing process to ensure provider directory is accurate and can include information like cultural competency, disability accessibility and open panels 	<ul style="list-style-type: none"> Provider directory demonstrated onsite indicates if providers are accepting new patients. The provider manual provides information about the credentialing and recredentialing processes for providers.
		<ul style="list-style-type: none"> Policies and procedures developed on provider credentialing process and ability for credentialing committee to meet more frequently if necessary 	<ul style="list-style-type: none"> Policies and procedures outline the role of the credentialing committee, as well as the provider credentialing and recredentialing process.
		<ul style="list-style-type: none"> Ability to pull from corporate staff if necessary to credential and enroll providers more quickly 	<ul style="list-style-type: none"> Noted across all areas the ability to pull from corporate staff as needed to support implementation and facilitate transition. Specifically, the Work Force Management team has the ability to skill (group) agents to specific markets.
		<ul style="list-style-type: none"> Single case agreement process developed to handle out of network providers 	<ul style="list-style-type: none"> Policies and procedures address how UnitedHealthcare would handle non-participating providers, including out of network providers.
		<ul style="list-style-type: none"> Outreach and education plan in place for all providers being handled out of network 	<ul style="list-style-type: none"> UnitedHealthcare indicated onsite that they will work with non-participating providers to ensure that they will be able to bill and process claims accordingly. In addition, UnitedHealthcare will use this opportunity to outreach to these providers to join the network.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
6.	Continuity and Coordination of Care <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> Identifying and Assessing Health Care Needs Primary and Specialty Care Coordination Continuity of Care during transition from FFS Coordination with Carved-Out Services, Community Services, or Other State Programs/ Agencies 	<ul style="list-style-type: none"> Hire and train case managers in regular case management and in HCBS (even though people will be able to keep their case managers) 	<ul style="list-style-type: none"> Training was just beginning for some staff at time of onsite reviews, with plans for most trainings to begin early December.
		<ul style="list-style-type: none"> Develop strategy to cull data to pull people into the category of benefiting from case management 	<ul style="list-style-type: none"> Comprehensive approach to risk stratification as well as identifying members in other forums (e.g., referrals) is in place.
		<ul style="list-style-type: none"> Ensure systems are in place to follow continuity of care procedures outlined in contract and by the state to ensure claims and services are not denied for the incorrect reasons 	<ul style="list-style-type: none"> Systems demonstrations indicated prior authorization criteria, benefits, etc. will be loaded upon receipt from IME for use in review of services for approval. Approval and denial decisions are recorded and used in processing claims.
		<ul style="list-style-type: none"> Policies and procedures developed related to continuity of care 	<ul style="list-style-type: none"> Policies and procedures describe the care model and integrated health care needs to members to ensure that continuity of care is upheld.
7.	Grievance, Appeal, and Fair Hearing Process <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> General Requirements Enrollee Reporting of Grievances and Appeals 	<ul style="list-style-type: none"> Training of call center and other enrollee facing staff to recognize when an issue is a grievance or appeal and when it should be referred to other staff at the plan to handle 	<ul style="list-style-type: none"> UnitedHealthcare’s One Source and FAQs for member call center staff provide overview of grievance, appeal and state fair hearing.
		<ul style="list-style-type: none"> Tracking mechanism is in place for all staff to track when a grievance or appeal is filed with internal notifications for processing 	<ul style="list-style-type: none"> Policies and procedures identify how grievances and appeals will be tracked within their systems.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<ul style="list-style-type: none"> Handling Grievances and Appeals Monitoring Grievances and Appeals 	<ul style="list-style-type: none"> Develop state specific reporting mechanism 	<ul style="list-style-type: none"> Reporting processed identified within policies and procedures.
8.	Critical Incident Monitoring and Reporting <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> Monitoring LTSS member health and welfare Incident reporting and structural safeguards 	<ul style="list-style-type: none"> Train staff (call center and care coordination) on state requirements for monitoring health and welfare 	<ul style="list-style-type: none"> Training was just beginning for some staff at time of onsite reviews, with plans for more trainings beginning mid-November to early December.
		<ul style="list-style-type: none"> Maintain easily accessible public reporting system for critical incidents with policies and procedures for investigation and disposition, including emergency institutional placement if needed 	<ul style="list-style-type: none"> Discussed with UnitedHealthcare during onsite review the challenges with certain providers' lack of access to computers. Consideration needed for how the requirements/obligations to submit critical incident reports can be met.
9.	Quality <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> Elements of State Quality Strategy MCO Structural and Operational Standards Quality Assessment and Performance Improvement 	<ul style="list-style-type: none"> Quality management plan developed and staff trained on the management plan 	<ul style="list-style-type: none"> UnitedHealthcare's quality management workplan describes their planned quality improvement initiatives for the next five years. This work plan will be used when training staff regarding quality initiatives and strategies for Iowa. Demonstrated how measures will be reported in their system to the Agency and used internally.
		<ul style="list-style-type: none"> Policies and procedures created related to the quality systems in place 	<ul style="list-style-type: none"> UnitedHealthcare submitted policies and procedures describing their quality systems and quality management processes.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<ul style="list-style-type: none"> External Quality Reviews 	<ul style="list-style-type: none"> Performance Improvement projects developed and committees set up to measure any improvements 	<ul style="list-style-type: none"> Provided description of PIP program methodology.
10.	Systems <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> General MMIS Operations Payment Systems Eligibility and Enrollment Third Party Liability (TPL) MCO Information Systems, including Provider Payment Systems 	<ul style="list-style-type: none"> See finance and encounter data. 	<ul style="list-style-type: none"> Demonstrated onsite FACET systems, which will capture finance and encounter data.
		<ul style="list-style-type: none"> Provide status of system readiness based on testing 	<ul style="list-style-type: none"> Systems demonstrations indicated prior authorization criteria, benefits, etc. will be loaded upon receipt from IME for use in review of services for approval.
11.	Program Integrity <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> State Administrative Structure, Communication, and Reporting Finance, Data and Systems Assurance 	<ul style="list-style-type: none"> Develop systems to track and collect program integrity issues 	<ul style="list-style-type: none"> Demonstrated systems that will be used to track and collect program integrity issues, including grievances and appeals.
		<ul style="list-style-type: none"> Hire compliance officer and train staff on identification of fraud and abuse 	<ul style="list-style-type: none"> Interim compliance officer and acting program integrity manager are in place.
		<ul style="list-style-type: none"> Develop reporting structure for the state when issues are identified 	<ul style="list-style-type: none"> Policies and procedures describe UnitedHealthcare overseeing programs including subcontracted relationships to report fraud and abuse information to UnitedHealthcare.

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<ul style="list-style-type: none"> General Contractor Oversight and Reporting Provider Screening and Enrollment 	<ul style="list-style-type: none"> Develop plan to report any collection of overpayment to the systems process 	<ul style="list-style-type: none"> Policies and procedures describe their processes in reporting overpayments, including how they will report this information to the State.
12.	Encounter Data <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> Encounter Data System Design Standards for Collection of Encounter Data Using Encounter Data System to Monitor Managed Care performance 	<ul style="list-style-type: none"> Test file transfers with the state and remedy any issues 	<ul style="list-style-type: none"> Systems demonstrations indicated prior authorization criteria, benefits, etc. will be loaded upon receipt from IME for use in review of services for approval. Readiness reviews occurred prior to beginning of testing schedule; therefore, IME staff conducting testing will be monitoring status.
		<ul style="list-style-type: none"> Develop policies and procedures about timeliness and frequency of data transfers 	<ul style="list-style-type: none"> Policies and procedures submitted to describe the encounter submission process and requirements. This includes the timeliness, frequency, and method of data transfer.
		<ul style="list-style-type: none"> Develop any contracts with subcontractors about encounter data submission so it complies with how the state will need to collect it 	<ul style="list-style-type: none"> Indicated onsite that they will oversee and monitor the encounter data submissions of the subcontractors and take responsibility of making sure this data complies with State requirements.
		<ul style="list-style-type: none"> Develop testing plan to prevent duplicates and other erroneous encounters being sent to State 	<ul style="list-style-type: none"> Readiness reviews occurred prior to beginning of testing schedule; therefore, IME staff conducting testing will be monitoring status.
13.	Finance <i>Operation Activities for Assessment</i> <ul style="list-style-type: none"> General Financial Oversight Payments to Providers 	<ul style="list-style-type: none"> Test claims payment functions and have working policies and procedures on timely payment of claims 	<ul style="list-style-type: none"> Policies and procedures describe submission of timely payment of electronic and paper claims.
		<ul style="list-style-type: none"> Train staff on other areas of TPL to ensure appropriate billing of third parties 	<ul style="list-style-type: none"> UnitedHealthcare plans to train 106 claims operations individuals, including managers, team leads, and supervisors. Indicated they will follow the state TPL policy; if the service code billed is listed on the State's TPL Non-covered list

Findings from 2015 UnitedHealthcare Plan of the River Valley of Iowa Readiness Review

IA Health Link Program Implementation			
No.	CMS Identified Functional Area	CMS Identified Action Steps for MCOs	Navigant Comments
	<ul style="list-style-type: none"> • Third Party Liability (TPL) and Coordination of Benefits 		(blanket denial list), a remittance advice or other documentation from the primary insurance is not required.
		<ul style="list-style-type: none"> • Provider TA on filing a clean claim – especially for LTSS providers 	<ul style="list-style-type: none"> • Specified onsite that they developed a full provider communication and are actively working to educate providers; level setting on how to submit a claim.
		<ul style="list-style-type: none"> • Develop system edits for specific benefits including which services need prior authorization 	<ul style="list-style-type: none"> • Demonstrated onsite how the system will identify benefits that require prior authorization, how this will be recorded in the system, and how this information will be relayed to members.
		<ul style="list-style-type: none"> • Create any system edits necessary to account for claims from LTSS providers which may have unique service codes or other pertinent factors 	<ul style="list-style-type: none"> • Demonstrated systems to account for claims from LTSS providers; testing is occurring at a later date with IME staff.
		<ul style="list-style-type: none"> • If necessary, ensure ability of LTSS providers to bill with paper claims if systems capabilities are not as advanced 	<ul style="list-style-type: none"> • Specified in the provider manual the UnitedHealthcare address providers are to submit initial paper claims and corrected paper claims.

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

APPENDIX B. FOLLOW UP ITEMS REQUESTED POST ONSITE REVIEW

Navigant identified need for the below follow up items from UnitedHealthcare during on-site meetings. **Except where noted please provide information indicated in items 1 through 7 via email to Nancy Kim at nancy.kim@navigant.com no later than Monday, November 16, 2015.**

- 1. Key Personnel.** Provide a detailed plan that describes how and when UnitedHealthcare anticipates filling Key Personnel positions that remain open or for which interim staff are in place. Provide a hiring status for each Key Personnel position using the below matrix. Open positions should include those filled with interim staff until permanently filled. *Given this information is changing frequently more time is allowed for submission. Please provide no later than close of business Tuesday, November 17, 2015.*

Table 1. Hiring Status of Key Personnel

Open Positions (Include those filled in interim)	Status (Posted, Interviewing, Offer Out, etc.)	Target Hire Date	Target Start Date	Length of Training	Contingency Plan
Filled Positions	Name	Hire Date	Start Date	Training Schedule	

- 2. Staffing.** Provide a detailed staffing and training plan that describes how and when UnitedHealthcare anticipates filling open positions. Use Table 2 at the end of this document to provide hiring and training status. In addition, provide an explanation of how UnitedHealthcare has estimated the number of staff required to fulfill the requirements stipulated in the Contract for case management, member services and provider services. *Given this information is changing frequently more time is allowed for submission. Please provide no later than close of business Tuesday, November 17, 2015.*
- 3. Care Management:** Provide a detailed care management workflow(s) as to how the process will work for members, particularly those with multiple care managers. Provide a detailed plan as to how various care managers will work together and their different roles and responsibilities. Please include estimated ratios of members to care managers, and your rationale for these ratios. Note if ratios differ across service areas (physical health, behavioral health and long-term supports and services).

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

4. **Provider Network:** Continue to submit provider network adequacy reports as requested by IME to demonstrate progress. *Navigant will review the regular submissions. Separate information does not need to be submitted.*
5. **Subcontracts:** Submit the following subcontracts to IME. Per the Agreement, IME may elect to request others for review:
 - a. MTM
 - b. Veridian Fiscal Solutions
 - c. Telligen

For Veridian Fiscal Solutions and Telligen, provide a summary of services each will provide and a workplan detailing readiness activities and timeline for completion. Provide UnitedHealthcare's process for oversight of the subcontractor's activities to assure they are ready to begin services January 1, 2016. Activities should include:

- Estimated contract signature date
- Number of staff being hired and hiring status for the Iowa market
- Staff training dates

For MTM, provide a summary of the services MTM will provide including an overview of the anticipated use of vehicles (e.g., MTM vehicles, public transportation, member's own vehicles, ride-sharing services such as taxis, Ubers, etc.). Provide UnitedHealthcare's process for oversight of the subcontractor's activities to assure they are ready to begin services January 1, 2016. Also, provide a workplan detailing readiness activities and timeline for completion. Activities should include:

- Estimated contract signature date
- Provider network development activities and status
- Call center location, number of staff being hired and hiring status for the Iowa market
- Staff training dates

6. **Provider Call Center:** Provide a detailed plan explaining transition to the permanent Call Center on January 25.
7. **Member Services Call Center:** Provide resource tools, such as FAQs and scripts, prepared for call center representative use for pre-enrollment calls and the workplan for training of staff who are receiving these calls.

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

UnitedHealthcare also noted a variety of information from and testing is needed with IME for system readiness. A summary of those are listed below.

1. UnitedHealthcare noted a need of the following from IME:
 - Test plan, test file, test cases, file layouts (834 file is priority) (*A timeline for receipt of test files and certain test files have been provided*)
 - Benefits configuration at the code level
 - Historical claims data
 - Duals: crossover claims data
 - Encounter editing
 - CDAC providers – need results of further data mining
 - Q&A IT grid – need responses to questions
 - Level of Care Assessments and Care Plans – these are not planned to be provided until after member files are provided December 17. UnitedHealthcare noted that these are priority and requested reconsideration for provision at an earlier date with approval to begin outreach to identified members prior to January 1.
 - Rates/fee schedules (*have since been provided*)
 - PDL at the code level (*has since been provided*)
2. UnitedHealthcare requested status of approval of all member and provider materials.
3. Discussion is needed about members being eligible for more than one eligibility category. This will impact UnitedHealthcare’s systems, so they need to understand when these instances will occur for programming purposes.
4. Discussion is needed about UnitedHealthcare’s proposed EVV solution.

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

Table 2. Hiring Status by Service Area

Please complete and submit the below matrix. Note that position titles are general and may vary for your MCO. Please add rows as needed if you are hiring other types of staff that will support each service area (e.g., for Care Management areas, initial intake coordinators, care coordinators, etc.). Additionally, if positions are not separate, please note such (e.g., behavioral health and physical health case managers are not separate positions). For each area, please note contingency plans if positions are not filled (this can also be provided as a separate detailed narrative).

Service Area/ Positions	Total Number Staff Needed	Percent Complete	Filled ²	Actively Recruiting	Pending Offers	Weeks of Training Required	Number Staff Who Have Started Training	Dates Trainings to Begin ³	Contingency Plan
Member Call Center Representatives									
Provider Call Center Representatives									
LTSS:									
Care Management Supervisors									
Care Managers - Telephonic									

² Filled should include only positions that have been filled to meet Iowa staffing needs. It should not include interim/contingency staff.

³ This could include multiple dates.

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

Service Area/ Positions	Total Number Staff Needed	Percent Complete	Filled ²	Actively Recruiting	Pending Offers	Weeks of Training Required	Number Staff Who Have Started Training	Dates Trainings to Begin ³	Contingency Plan
Care Managers - Field									
Behavioral Health Care Management									
Care Management Supervisors									
Care Managers - Telephonic									
Care Managers - Field									
Physical Health Care Management									
Care Management Supervisors									
Care Managers - Telephonic									

UnitedHealthcare
Readiness Review On-Site Summary
November 2-3, 2015

Service Area/ Positions	Total Number Staff Needed	Percent Complete	Filled ²	Actively Recruiting	Pending Offers	Weeks of Training Required	Number Staff Who Have Started Training	Dates Trainings to Begin ³	Contingency Plan
Care Managers - Field									
Utilization Management									
Claims									
Credentialing									
Member and Provider Grievance									
Pharmacy Call Center									
Transportation Broker Call Center									