MAAC MATERIALS

November 7, 2019

1. Agenda of Meeting for November 7, 2019
2. August 6, 2019 Full Council Meeting Minutes
3. Division XVIII of House File 766
4. Draft Administrative Rules
5. MCO Quarterly Report SFY19, Quarter 4
6. Memo- MAAC Membership Definition
7. Memo- MAAC Explanation of MCO Financials
8. Executive Talking Points August 6, 2019
9. Executive Talking Points November 7, 2019

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

AGENDA
Medical Assistance Advisory Council Meeting

Thursday, November 7, 2019
Time: 1:00 P.M. – 4:00 P.M.
Iowa Utilities Board
Hearing Room
1375 East Court Avenue
Des Moines, IA
Dial: 1-866-685-1580
Code: 000-999-0232#

1:00 Introduction and roll call – **Sarah Reisetter**

1:05 Approval of Minutes – **Sarah Reisetter**
- August 6, 2019 Meeting

1:10 Review and Approve Administrative Rules- **Sarah Reisetter**

1:50 Update from the Medicaid Director – **Mike Randol**

2:10 MCO Quarterly Report – SFY19, Quarter 4[1] – **Mike Randol and Mary Stewart**

2:40 Updates from the MCOs – **MCOs**
- Amerigroup Iowa (10 minutes)
- Iowa Total Care (10 minutes)

3:20 Open Comment – **Co-Chairs**

4:00 Adjourn

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/sites/default/files/SFY19_Q4_Report.pdf?100920191311

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
August 6, 2019

Call to Order and Roll Call

Council Co-Chair Sarah Reisetter, Iowa Department of Public Health, called the roll call at 1:02 P.M. Attendance is as reflected in the separate roll call sheet. A quorum was met.

Approval of Previous Full Council and Executive Committee Minutes

Sarah called for a motion to approve minutes from the May 7, 2019 Full Council meeting and the June 11, 2019 Executive Committee meeting.

Anthony Carroll, AARP, called for a point of order stating that he believed the roll had only been called for the Executive Committee. Several representatives of participating Professional and Business Entities echoed Anthony's concerns, generally stating confusion over which organizations would be considered members of the MAAC, and which organizations would have their attendance reflected in roll calls. Director Randol stated that IME staff would send out more information regarding membership of the MAAC. Sarah then again called for a motion to approve the minutes of May 7, 2019 and June 11, 2019. The motion carried and the minutes were approved.

Election of the Public Co-Chair

Sarah called for any interest in serving as co-chair, Jason Haglund expressed interest. Tom Broeker made a motion to nominate Jason as co-chair, Marcie Strouse seconded. The motion carried; Jason Haglund will continue serving as Co-Chair of the council.

Determining Staggered Terms for Business and Professional Members

Three of the five professional and business entities need to be identified as serving three-year terms, and two need to be identified as serving two year terms. The Council determined the terms by votes received in the recent election: of the five professional and business entities receiving the most votes, the top three vote getters would serve three-year terms, and the remaining two organizations would serve two-year terms. The Iowa Medical Society and the Iowa Pharmacy Association received the same amount of votes; a coin toss determined that the Iowa Pharmacy Association will serve a three-year term. The Iowa Hospital Association will serve a three-year term. The Iowa Health Care Association will serve a three-year term. The Iowa Medical Society will serve a two-year term. The Iowa Association of Community Providers will serve a two-year term.

Review and Approval Draft Administrative Rules

Sarah read through the Draft Administrative Rules developed by the Executive Committee. Once the MAAC approves the Draft Administrative Rules, the rules will be passed on to the Council on Human Services to formally adopt. Sen. Joe Bolkcom commented that the legislative membership of the roll call was not up to date, and raised the issue of who would be able to speak during the open comment period of the agenda. The Council further discussed who is considered a member of the council per the draft Administrative Rules and Iowa Administrative Code. The Council decided to table the adoption of the Draft Administrative Rules until clarification of membership and the open comment period was sent out by IME staff. The Council will examine this issue again in the November meeting.

Medicaid Director's Update

Director Randol stated the transition of members from UnitedHealthcare to Iowa Total Care and Amerigroup Iowa, Inc. has gone well. There have not been any widespread issues or concerns, small issues have been identified and are resolved as quickly as possible. Iowa Total Care has already successfully paid claims. Amerigroup has hired staff to take on the addition of new members. Member choice continues through September 30, 2019. The IME is monitoring member choice to maintain the equitable distribution of members between the two MCOs.

The IME has received signed contracts from Amerigroup and Iowa Total Care for SFY 2020. There have been some program changes: members are now allowed to have whomever they wish present at their Long Term Services & Supports (LTSS) assessment. MCOs are required to notify members of their LTSS assessment 14 days in advance. MCOs are required to provide the results of the LTSS assessment to the member within three business days. The IME is funding greater access to Hepatitis C treatment, by reducing the fibrosis score required for Medicaid members to access treatment, the fibrosis score will likely be lowered again in January 2020. Provider rates were rebased for Federally Qualified Health Centers, Rural Health Clinics, and Intermediate Care Facilities for the Intellectually Disabled. MCOs are required to load their provider rates within 30 days or face liquidated damages if they fail to comply. The MCOs must complete provider credentialing and accurately load provider rosters;the IME may assess liquidated damages if the MCOs do not comply.

The IME is increasing total funding in several key areas: nursing homes by almost $60 million; additional $12.8 million for mental health; and an increase in $3.8 million for critical access hospitals. The IME is developing a critical access hospital factor that will be added on to the fee. The factor will be based on utilization and costs that are reported from those entities. Another funding increase is an additional $2.6 million for the Intellectual Disability Waiver Tiered Rate Fee Schedule effective for July 1, 2019.

Concurrent with the MCO transition, the IME had to transition its eligibility system for Hawki. This has been completed with no major impact on member eligibility.

On August 1, 2019, the IME implemented a mandatory electronic billing requirement for all providers, this includes Fee-for-Service claims as well as Managed Care claims. Individual CDAC providers are excluded, and dental providers will not be required to comply until February 2020.

At Rep. Heather Matson's request, the Director stated IME staff would send a written version of his talking points out to Council members.

Sen. Bolkcom asked the Director where the money reflected in the rate increase for State Fiscal Year 2020 would go. The Director replied that, given an understanding of capitated rates, more than 92% of the funding will go to providers. The Director stated that he would have the actuary develop a document that will explain how the funding and is distributed through capitated rates. This document will be shared with the Council.

Cindy Baddeloo asked the Director to provide an update on Electronic Visit Verification. The Director replied that the Centers for Medicare and Medicaid Services allowed the IME to submit a good faith letter, which will make the effective date for personal care services January 1, 2021. In-home health care will need to comply by January 1, 2023.

Updates from MCOs

Amerigroup Iowa, Inc.
John McCauly provided operational updates for Amerigroup Iowa, Inc. Amerigroup now has more than 380,000 members across all populations. Amerigroup has 593 employees in Iowa, in all 99 counties, with roughly 39% of employees in the Des Moines area. Amerigroup Community-Based Case Managers continue to assist members affected by the Spring 2019 flooding across the state. Amerigroup completed over 15,000 LTSS assessments in the month of July.

Anthony Carroll, AARP, asked what challenges Amerigroup has experienced as the remaining original MCO. John answered that in the most recent transition, Individual CDAC providers did not automatically contract with Amerigroup as the providers members moved to Amerigroup from UnitedHealthcare. John noted that the Medicaid program has made progress in rebalancing long-term care.

Sen. Bolkcom noted that there is a crisis in rural pre-natal care across the state, noting that rural hospitals lose money on every birth they perform. He asked John if there was any way he could increase the rate at which these providers are reimbursed. John stated that Amerigroup reimburses at the rate levels set by the state.

Iowa Total Care

Mitch Wasden, CEO of Iowa Total Care, gave an update on Iowa Total Care's first month in the managed care program. Iowa Total Care has hired 96% of their 820 Iowa based employees. Iowa Total Care has performed 14,000 health risk screenings. Iowa Total Care had 812 employees ready for July 1, 2019. Iowa Total Care has about 15,000 LTSS members. Iowa Total Care has completed over 811 LTSS assessments that were either due before July 1, or within July, and will have all assessments completed by mid-August. Iowa Total Care has just started receiving and paying claims, roughly 120,000 claims were received to date. Iowa Total Care has an active partnership with the Boys and Girls Club of Iowa, as well as the Urban League. Iowa Total Care is looking forward to moving many of their contracts into value based purchasing contracts.

Dennis Tibben, Iowa Medical Society, asked about an issue that some providers had signed contracts but did not see themselves reflected on Iowa Total Care's roster. Mitch and the Director assured Dennis that providers with this issue would be treated as in-network while Iowa Total Care is manually updating their roster.

Sen. Bolkcom asked how many employees Iowa Total Care has, and what the biggest issues have been in the transition. Mitch said their biggest concerns were managing the transition of LTSS members, and that Iowa Total Care's largest unforeseen issue was the tight labor market in Des Moines, specifically finding data analytic talent.

Open Discussion

Shelly Chandler, Iowa Association of Community Providers, asked about an issue she and her providers have seen with the Mandatory Reporter training discussed at the last MAAC Executive Committee Meeting. Director Randol stated that the IME would distribute an update on this issue to the members of the council before the next MAAC meeting.

Dave Carlyle, Iowa Academy of Family Physicians, raised concerns that the Administrative Rules and Iowa Code do not comply with federal regulations, specifically that committee membership requirements are being met given the reduced size of the council. Director Randol stated that he believed the draft administrative rules and Iowa Code complied with federal regulations, but that the draft rules will be reviewed again to ensure compliance.

Adjournment

Meeting adjourned at 2:52 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

by striking the subsection.

Sec. 89. 2005 Iowa Acts, chapter 117, section 4, subsection 3, is amended by striking the subsection.

DIVISION XVIII

MEDICAL ASSISTANCE ADVISORY COUNCIL

Sec. 90. Section 217.3, subsection 4, Code 2019, is amended to read as follows:

4. Approve the budget of the department of human services prior to submission to the governor. Prior to approval of the budget, the council shall publicize and hold a public hearing to provide explanations and hear questions, opinions, and suggestions regarding the budget. Invitations to the hearing shall be extended to the governor, the governor-elect, the director of the department of management, and other persons deemed by the council as integral to the budget process. The budget materials submitted to the governor shall include a review of options for revising the medical assistance program made available by federal action or by actions implemented by other states as identified by the department, the medical assistance advisory council ~~and the executive committee of the medical assistance advisory council~~ created in section 249A.4B, and by county representatives. The review shall address what potential revisions could be made in this state and how the changes would be beneficial to Iowans.

Sec. 91. Section 249A.4B, Code 2019, is amended to read as follows:

249A.4B Medical assistance advisory council.

1. A medical assistance advisory council is created to comply with 42 C.F.R. §431.12 based on section 1902(a)(4) of the federal Social Security Act and to advise the director about health and medical care services under the medical assistance program. The council shall meet no more than quarterly. The director of public health and a public member of the council selected by the public members of the council ~~specified in subsection 2, paragraph "b",~~ shall serve as co-chairpersons of the council.

2. *a.* The council shall consist of the following voting members:

(1) Five professional or business entity members selected

by the entities specified pursuant to subsection 3, paragraph "a".

(2) Five public members appointed pursuant to subsection 3, paragraph "b". Of the five public members, at least one member shall be a recipient of medical assistance.

b. The council shall include all of the following nonvoting members:

(1) The director of public health, or the director's designee.

(2) The director of the department on aging, or the director's designee.

(3) The long-term care ombudsman, or the long-term care ombudsman's designee.

(4) The dean of Des Moines university - osteopathic medical center, or the dean's designee.

(5) The dean of the university of Iowa college of medicine, or the dean's designee.

(6) A member of the hawk-i board created in section 514I.5, selected by the members of the hawk-i board.

(7) The following members of the general assembly, each for a term of two years as provided in section 69.16B:

(a) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(b) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

~~2.~~ 3. The voting membership of the council shall ~~include all of the following voting members~~ be selected or appointed as follows:

a. The five professional or business entity members shall be selected by the entities specified under this paragraph "a". The five professional or business entity members selected shall be the president, or the president's representative, of ~~each of~~ the ~~following~~ professional or business ~~entities~~ entity, or a member of ~~each of~~ the ~~following~~ professional or business ~~entities, selected~~ entity, designated by the entity~~:~~.

(1) The Iowa medical society.
(2) The Iowa osteopathic medical association.
(3) The Iowa academy of family physicians.
(4) The Iowa chapter of the American academy of pediatrics.
(5) The Iowa physical therapy association.
(6) The Iowa dental association.
(7) The Iowa nurses association.
(8) The Iowa pharmacy association.
(9) The Iowa podiatric medical society.
(10) The Iowa optometric association.
(11) The Iowa association of community providers.
(12) The Iowa psychological association.
(13) The Iowa psychiatric society.
(14) The Iowa chapter of the national association of social workers.
(15) The coalition for family and children's services in Iowa.
(16) The Iowa hospital association.
(17) The Iowa association of rural health clinics.
(18) The Iowa primary care association.
(19) Free clinics of Iowa.
(20) The opticians' association of Iowa, inc.
(21) The Iowa association of hearing health professionals.
(22) The Iowa speech and hearing association.
(23) The Iowa health care association.
(24) The Iowa association of area agencies on aging.
(25) AARP.
(26) The Iowa caregivers association.
(27) Leading age Iowa.
(28) The Iowa association for home care.
(29) The Iowa council of health care centers.
(30) The Iowa physician assistant society.
(31) The Iowa association of nurse practitioners.
(32) The Iowa nurse practitioner society.
(33) The Iowa occupational therapy association.
(34) The ARC of Iowa, formerly known as the association for retarded citizens of Iowa.
(35) The national alliance on mental illness.
(36) The Iowa state association of counties.

(37) The Iowa developmental disabilities council.

(38) The Iowa chiropractic society.

(39) The Iowa academy of nutrition and dietetics.

(40) The Iowa behavioral health association.

(41) The midwest association for medical equipment services or an affiliated Iowa organization.

b. ~~Ten~~ The five public members shall be public representatives which may include members of consumer groups, including recipients of medical assistance or their families, consumer organizations, and others, appointed by the governor for staggered terms of two years each, none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented under paragraph *"a"*~~, and a majority of whom shall be current or former recipients of medical assistance or members of the families of current or former recipients~~.

~~*c. A member of the hawk-i board created in section 514I.5, selected by the members of the hawk-i board.*~~

~~3. The council shall include all of the following nonvoting members:~~

~~*a. The director of public health, or the director's designee.*~~

~~*b. The director of the department on aging, or the director's designee.*~~

~~*c. The long-term care ombudsman, or the long-term care ombudsman's designee.*~~

~~*d. The dean of Des Moines university — osteopathic medical center, or the dean's designee.*~~

~~*e. The dean of the university of Iowa college of medicine, or the dean's designee.*~~

~~*f. The following members of the general assembly, each for a term of two years as provided in section 69.16B:*~~

~~(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.~~

~~(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader~~

~~of the senate.~~

~~4. *a.* An executive committee of the council is created and shall consist of the following members of the council:~~

~~(1) Five of the professional or business entity members designated pursuant to subsection 2, paragraph "*a*", and selected by the members specified under that paragraph, as voting members.~~

~~(2) Five of the public members appointed pursuant to subsection 2, paragraph "*b*", and selected by the members specified under that paragraph, as voting members. Of the five public members, at least one member shall be a recipient of medical assistance.~~

~~(3) The director of public health, or the director's designee, as a nonvoting member.~~

~~*b.* The executive committee shall meet on a monthly basis. The director of public health and the public member serving as co-chairperson of the council shall serve as co-chairpersons of the executive committee.~~

~~*c.*~~ 4. Based upon the deliberations of the council ~~and the executive committee~~, the ~~executive committee~~ council shall make recommendations to the director regarding the budget, policy, and administration of the medical assistance program.

5. For each council meeting, other than those held during the time the general assembly is in session, each legislative member of the council shall be reimbursed for actual travel and other necessary expenses and shall receive a per diem as specified in section 7E.6 for each day in attendance, as shall the members of the council ~~or the executive committee~~ who are recipients or the family members of recipients of medical assistance, regardless of whether the general assembly is in session.

6. The department shall provide staff support and independent technical assistance to the council ~~and the executive committee~~.

7. The director shall consider the recommendations offered by the council ~~and the executive committee~~ in the director's preparation of medical assistance budget recommendations to the council on human services pursuant to section 217.3 and in implementation of medical assistance program policies.

441—79.7 (249A) Medical assistance advisory council.

79.7(1) *Officers*.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019 will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the Council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership*. The membership of the council and shall be as prescribed at Iowa Code 249A.4B

a. Council membership.

(1) Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A. Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

1. An initial election of five business and professional members shall be held. From this initial election of five members: three members shall serve a three year term and two members shall serve a two year term. Once these members have served their initial term the length of term for all following elected members shall be two years.

2. Elections shall be organized along the following guidelines.

a. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

b. The five entities that receive the most votes shall serve on the council.

3. Should any vacancy occur on the council, the entity that received the sixth most votes in the most recent election shall serve on the council.

4. If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification the voting entities seat will be considered vacant and will be filled as outlined in 79.7(2)(a)(1)"3".

(2) Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public members will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

(3) A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a non-voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

1. Partner agency and medical school representatives will be nonvoting members of the council.

2. If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

3. Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

(5) The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

1. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

2. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

79.7(3) *Responsibilities, duties and meetings*. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services.

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. *Council*. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be disturbed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (5 persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present voting council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council.

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council.

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B , IAB 11/4/09, effective 12/9/09; ARC 3006C , IAB 3/29/17, effective 6/1/17]

Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2019, Quarter 4

(April-June)

Performance Data

Published October 9, 2019

Department of HUMAN SERVICES

CONTENTS

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 4 of State Fiscal Year (SFY) 2019 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

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

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS®[1] CAHPS[2], and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However,

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

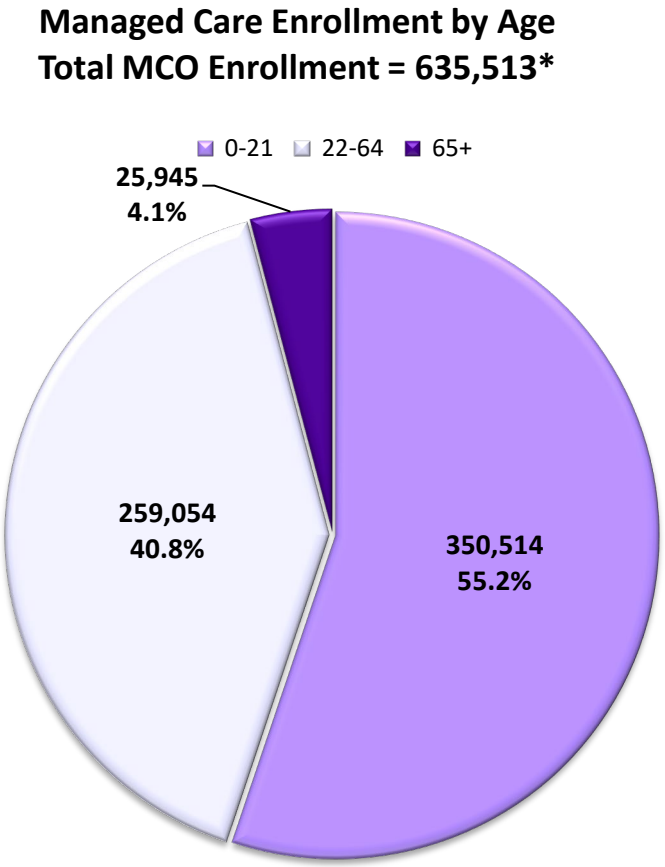
based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

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

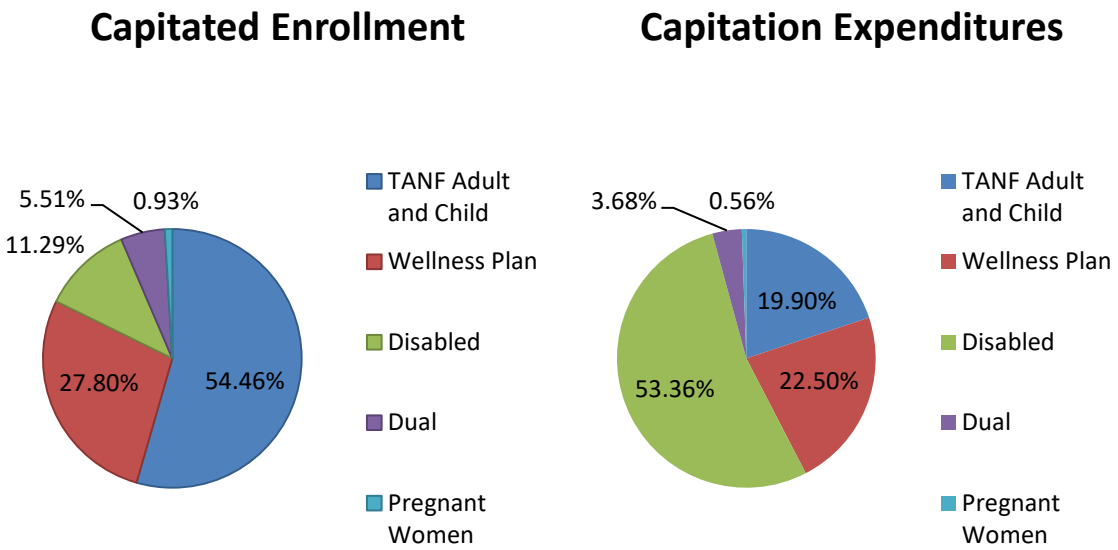
More information on the move to managed care is available at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization.

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

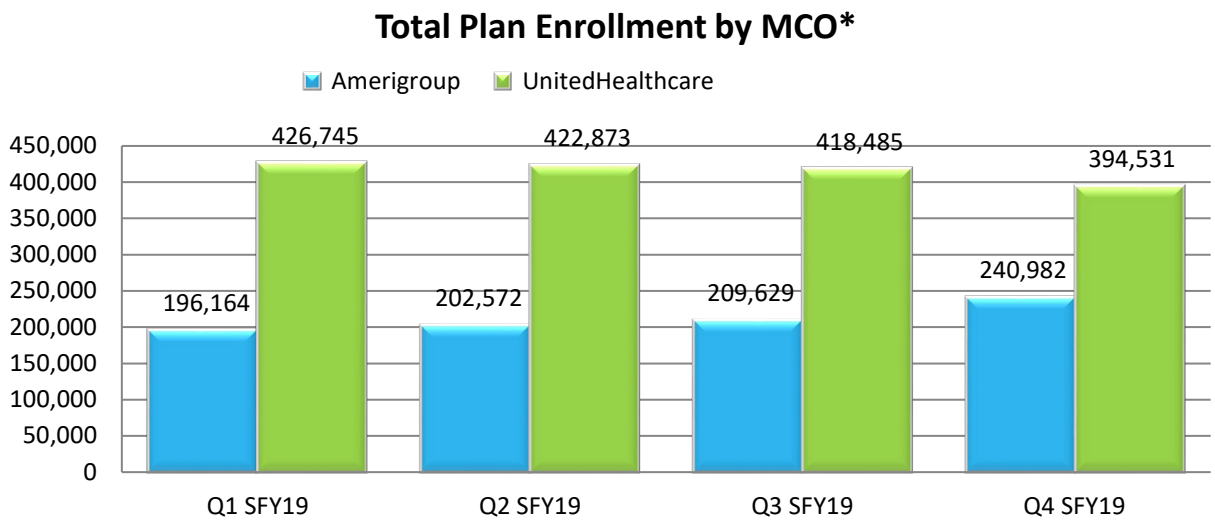
PLAN ENROLLMENT BY AGE



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

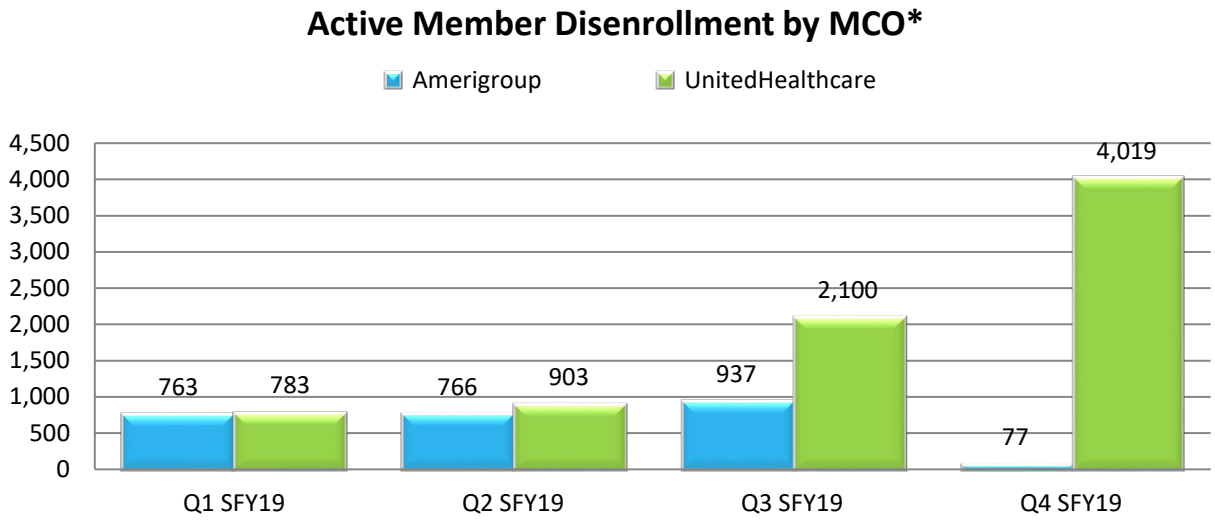


Plan Enrollment by MCO



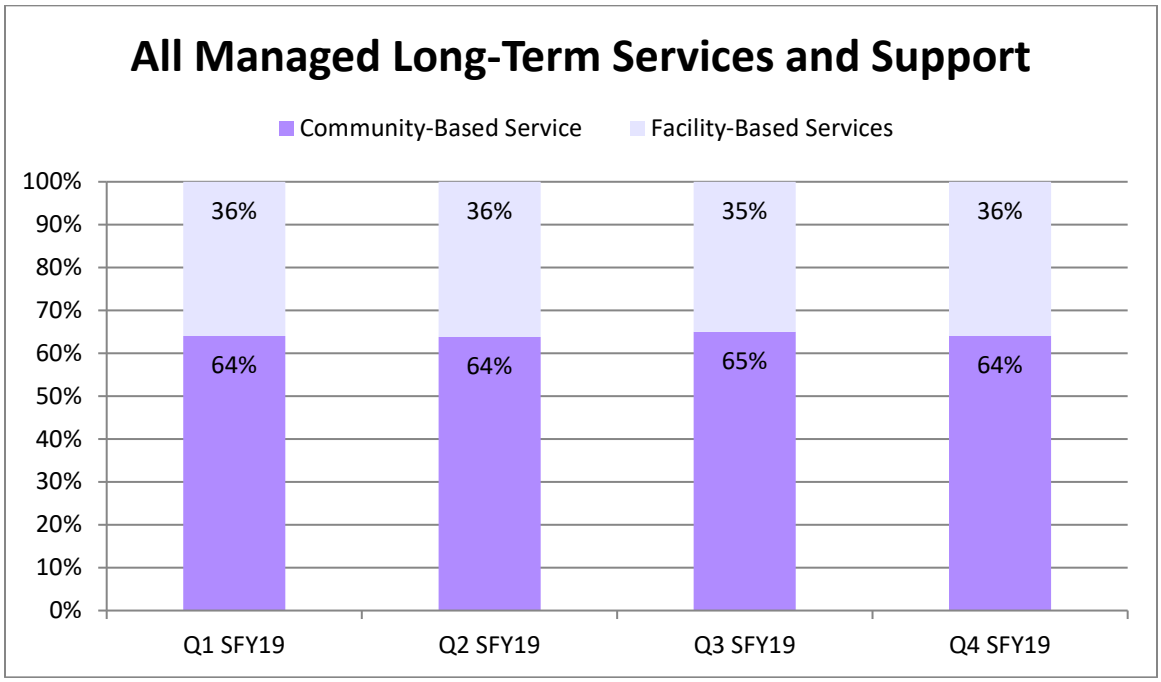
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Plan Disenrollment by MCO



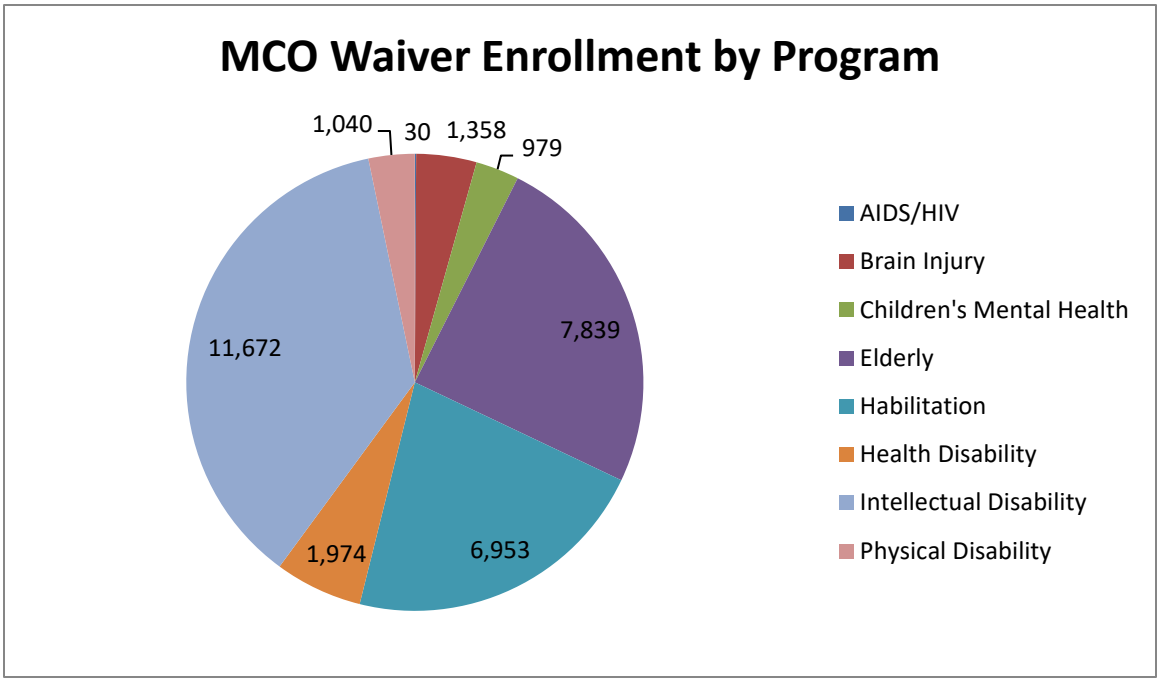
* June 2019 enrollment data as of July 31, 2019 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

All MCO Long Term Services and Supports (LTSS) Enrollment



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

All MCO Home and Community-Based Service Waiver Enrollment



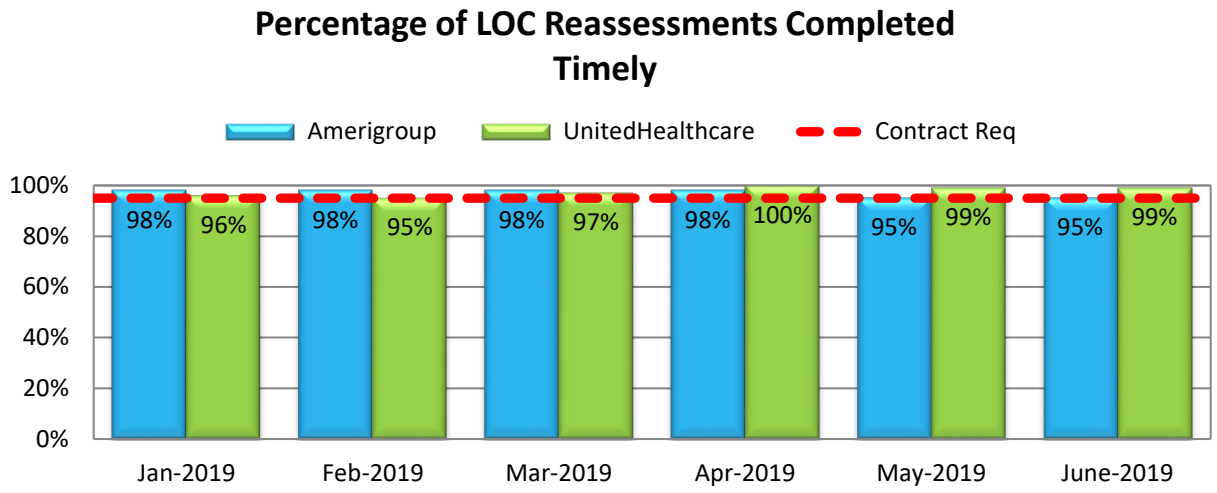
CARE COORDINATION AND CASE MANAGEMENT

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

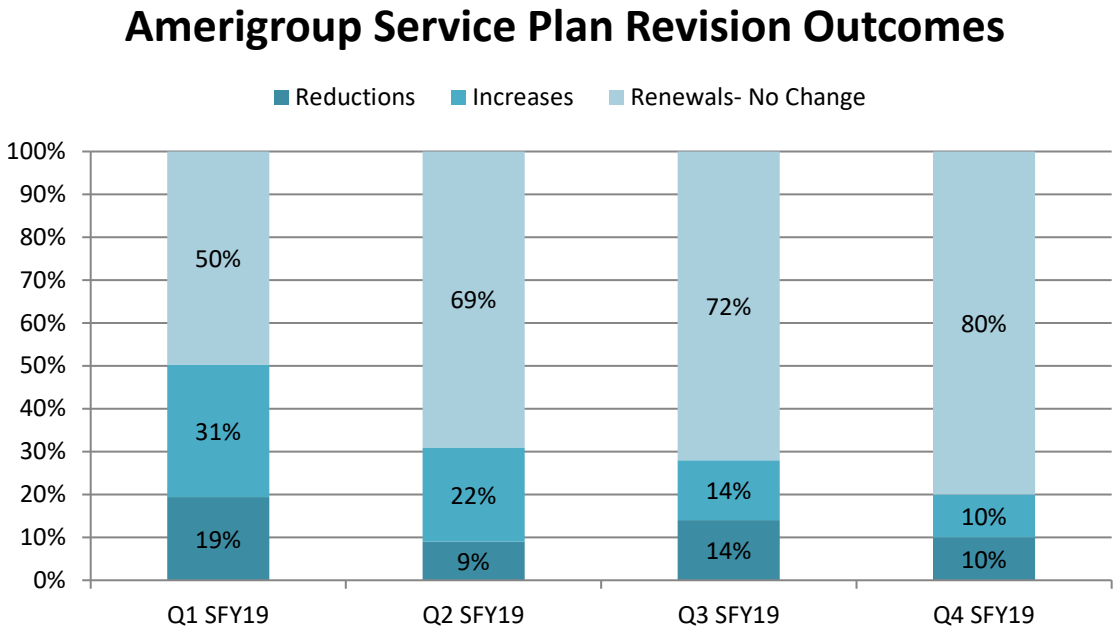
Member to Coordinator Ratios		
Data Reported as of June 30, 2019	**Amerigroup**	**UnitedHealthcare**
Ratio of Members to Care Coordinators	9	130
Ratio of HCBS Members to Community-Based Case Managers	64	95

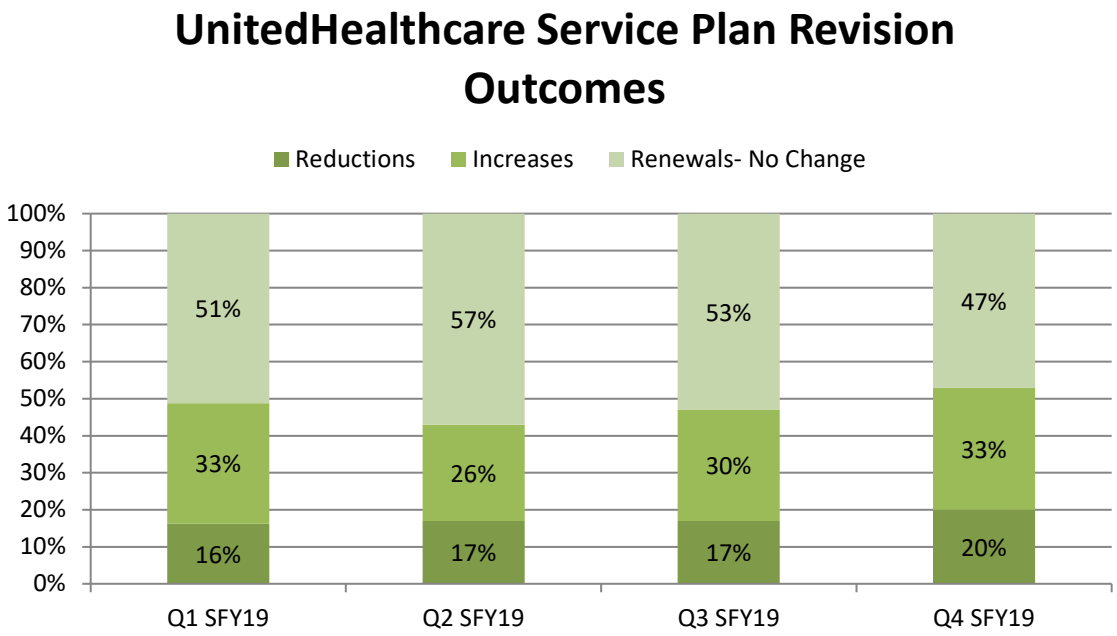
Level of Care

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



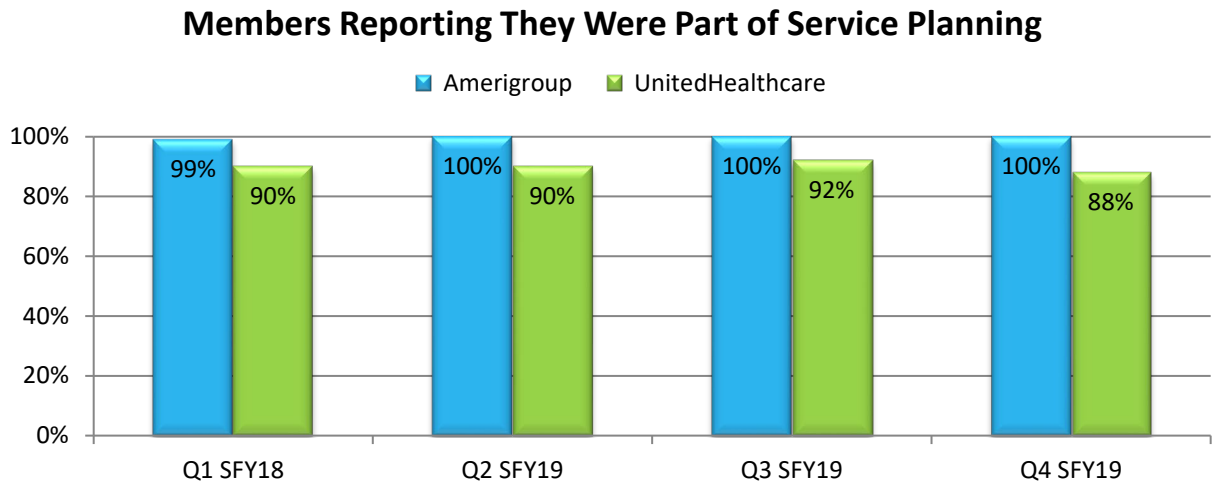
Service Plan Revision Outcomes reports how service plan authorizations are changed from year to year for members receiving Home and Community Based Services (HCBS). These are new measures for SFY 2019.

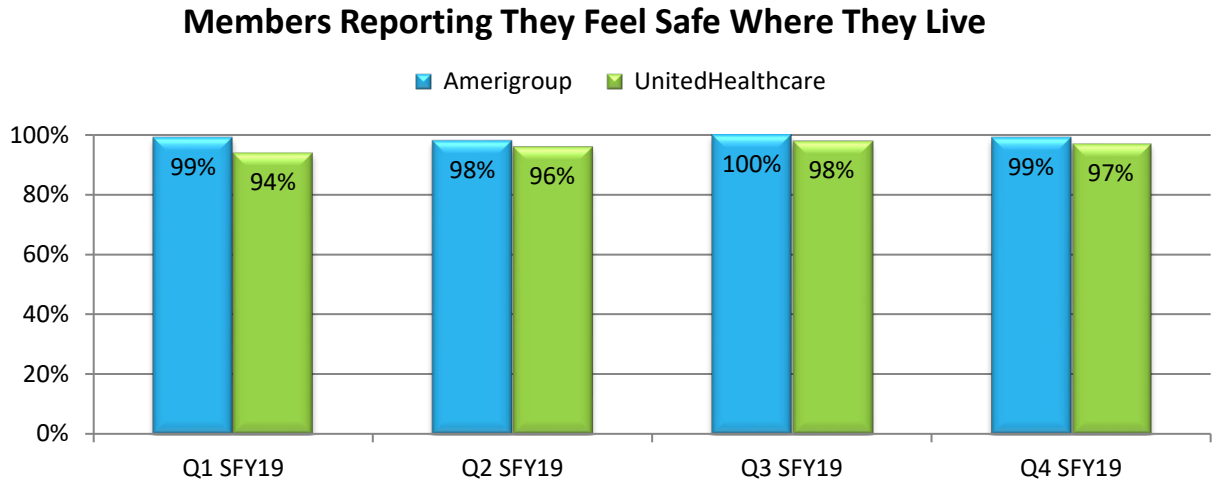


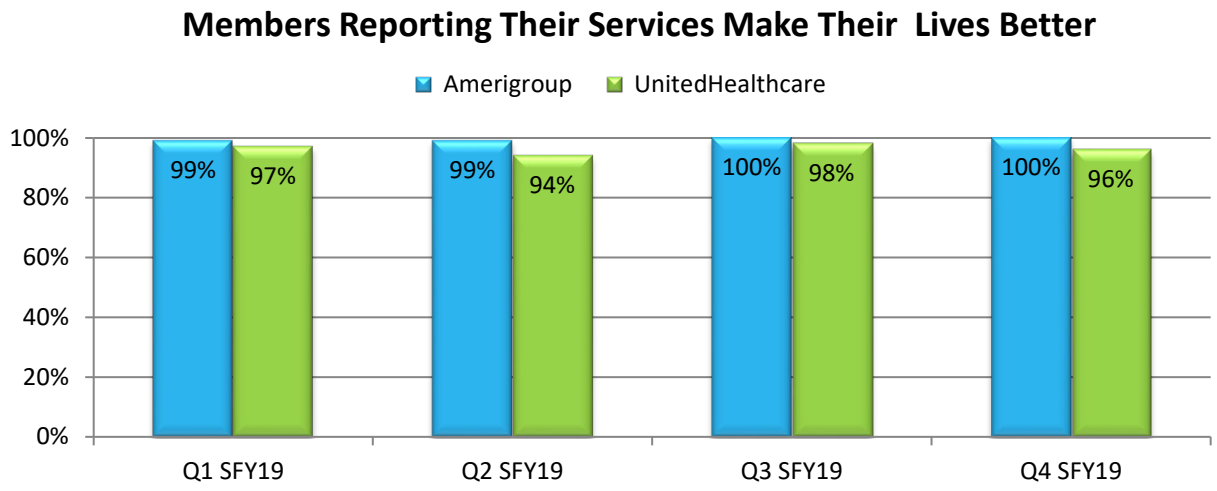

UnitedHealthcare Service Plan Revision Outcomes
Reductions
Increases
Renewals- No Change
100%
90%
80%
70%
60%
50%
40%
30%
20%
10%
0%
51%
33%
16%
57%
26%
17%
53%
30%
17%
47%
33%
20%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

Iowa Participant Experience Survey Reporting

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






Members Reporting Their Services Make Their Lives Better
Amerigroup
UnitedHealthcare
100%
80%
60%
40%
20%
0%
99%
97%
99%
94%
100%
98%
100%
96%
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 SFY19

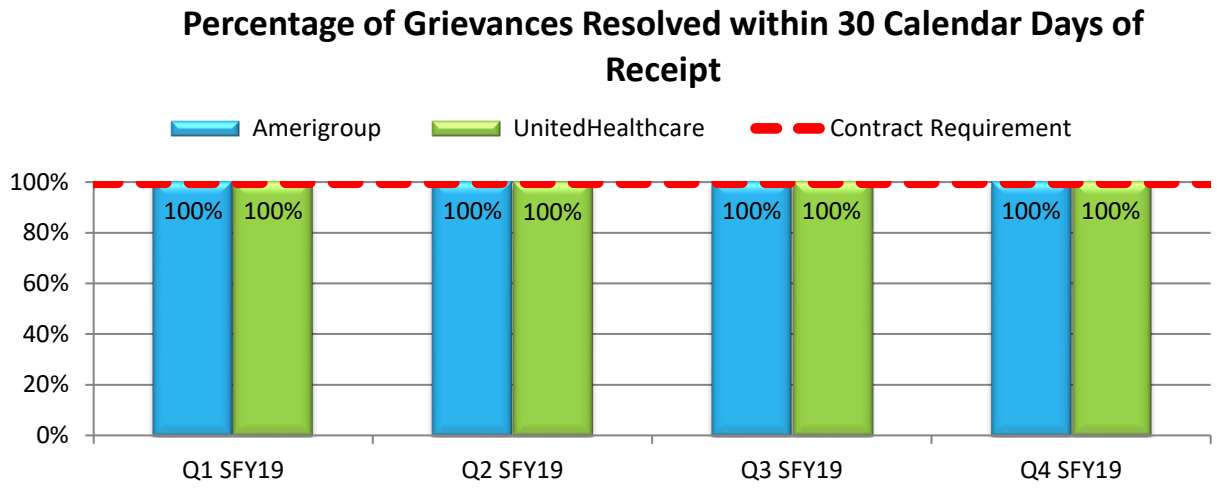
MCO Member Grievances and Appeals

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.

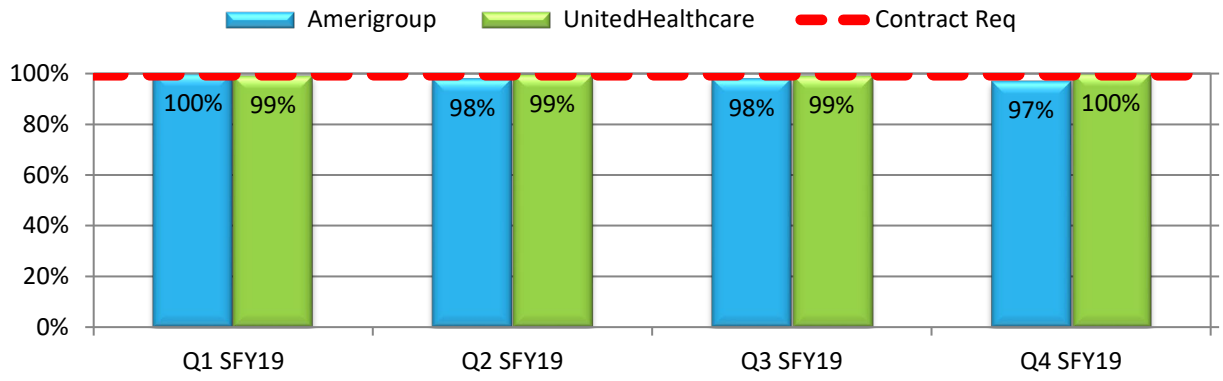
Appeal: A request for a review of an MCO's denial, reduction, suspension, termination or delay of services.

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



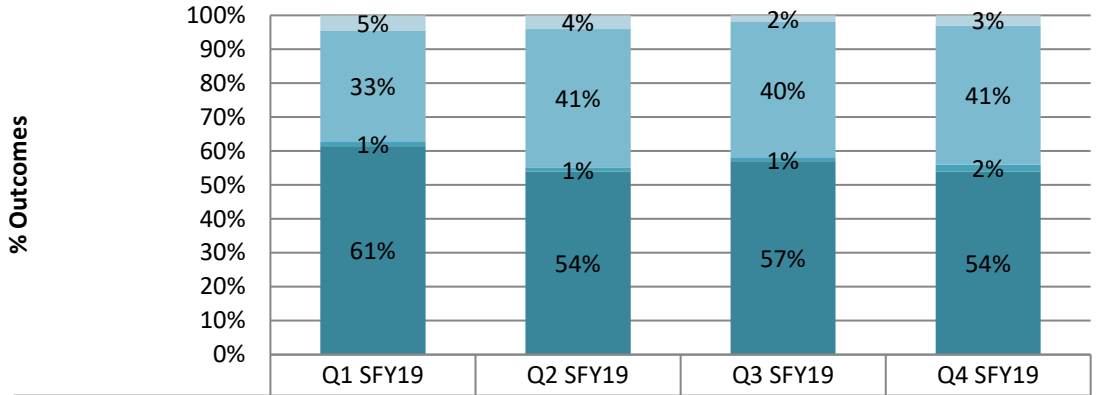
Supporting Data				
	Amerigroup		UnitedHealthcare	
Metric	**Count**	**% Pop**	**Count**	**% Pop**
Grievances Received in Q1 SFY19	228	0.10%	471	0.10%
Grievances Received in Q2 SFY19	280	0.13%	474	0.10%
Grievances Received in Q3 SFY19	314	0.14%	307	0.07%
Grievances Received in Q4 SFY19	248	0.09%	205	0.05%

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



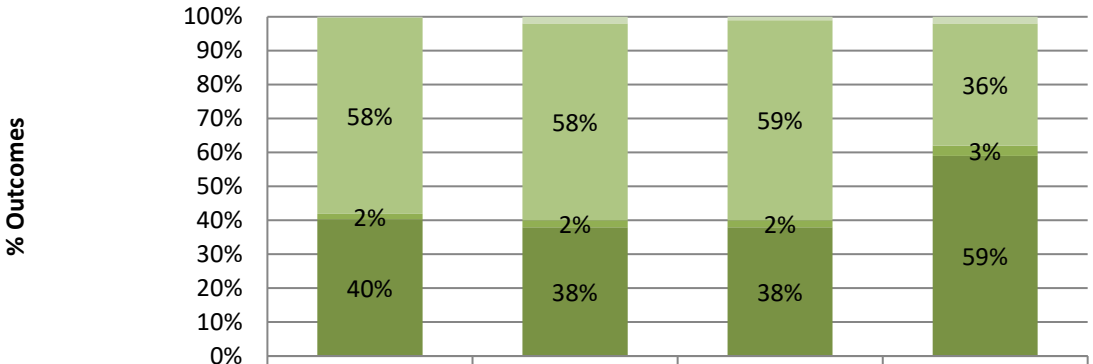
Supporting Data				
	Amerigroup		**UnitedHealthcare**	
Metric	**Count**	**% Claims**	**Count**	**% Claims**
Appeals Received in Q1 SFY19	285	0.01%	385	0.01%
Appeals Received in Q2 SFY18	239	0.01%	317	0.01%
Appeals Received in Q3 SFY19	233	0.01%	252	0.01%
Appeals Received in Q4 SFY19	211	0.01%	225	0.01%

Amerigroup Appeal Outcomes



	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	5%	4%	2%	3%
Upheld	33%	41%	40%	41%
Partially Overturned	1%	1%	1%	2%
Overturned	61%	54%	57%	54%

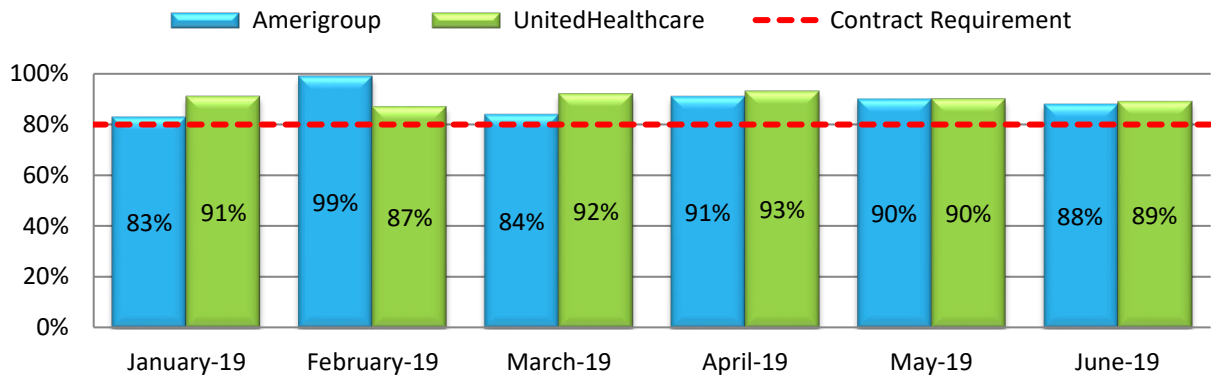
UnitedHealthcare Appeal Outcomes



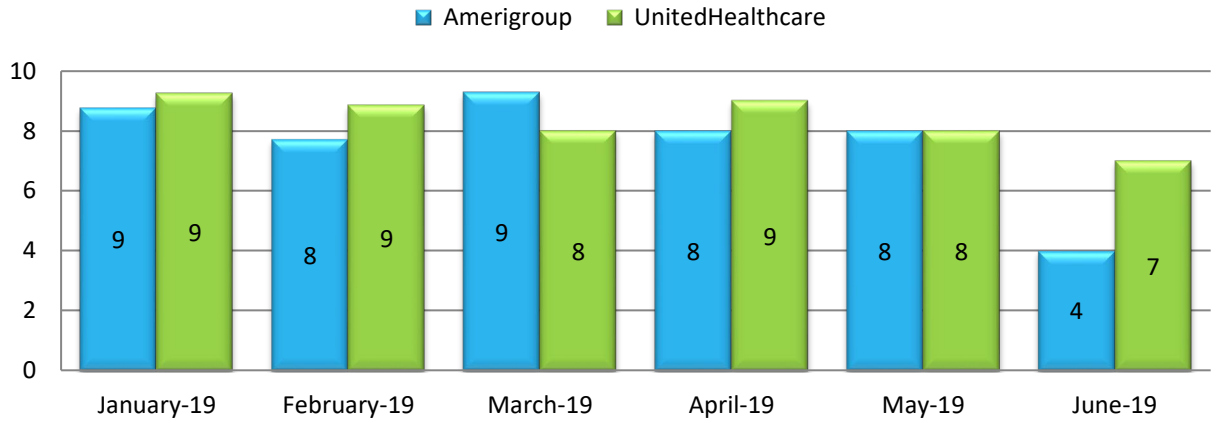
	Q1 SFY19	Q2 SFY19	Q3 SFY19	Q4 SFY19
Withdrawn	0%	2%	1%	2%
Upheld	58%	58%	59%	36%
Partially Overturned	2%	2%	2%	3%
Overturned	40%	38%	38%	59%

Member Helpline

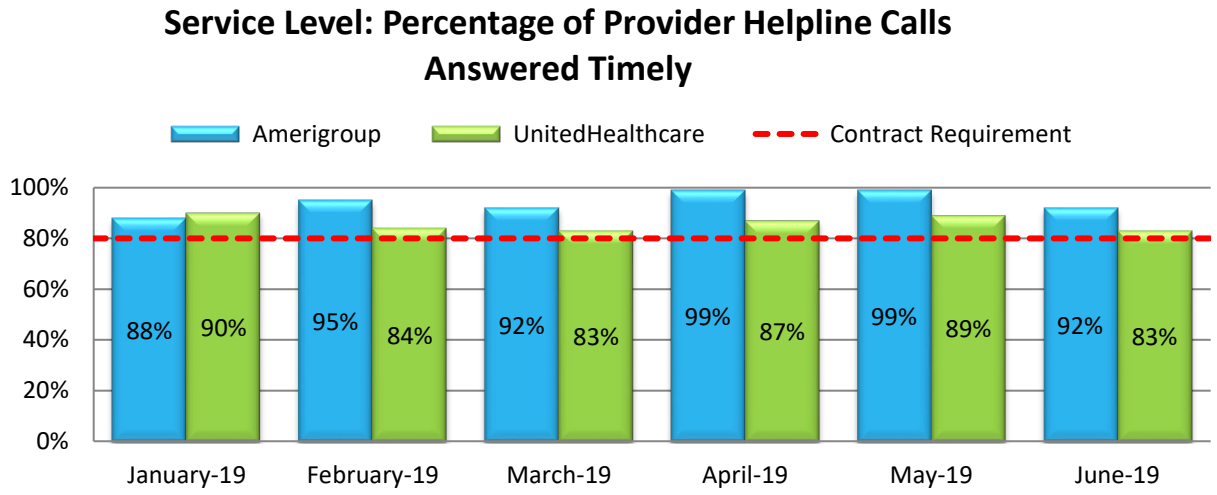
Service Level: Percentage of Member Helpline Calls Answered Timely

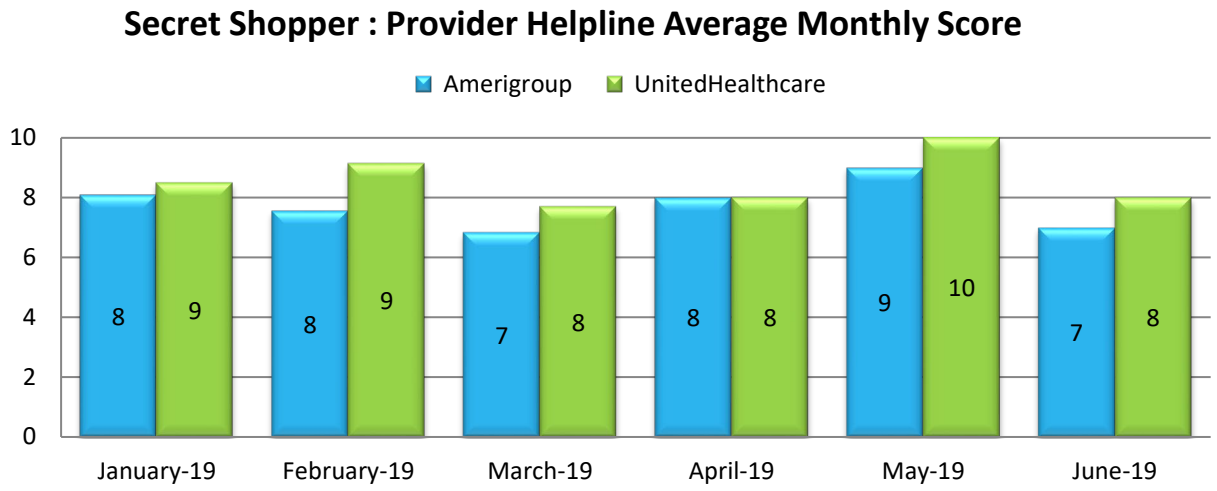


Secret Shopper: Member Helpline Average Monthly Score

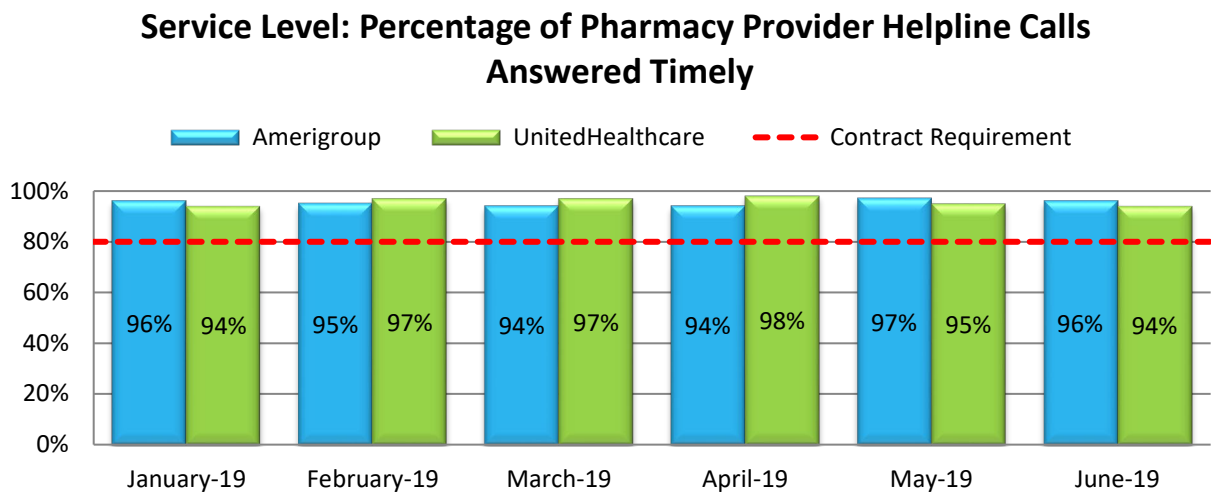


Provider Helpline





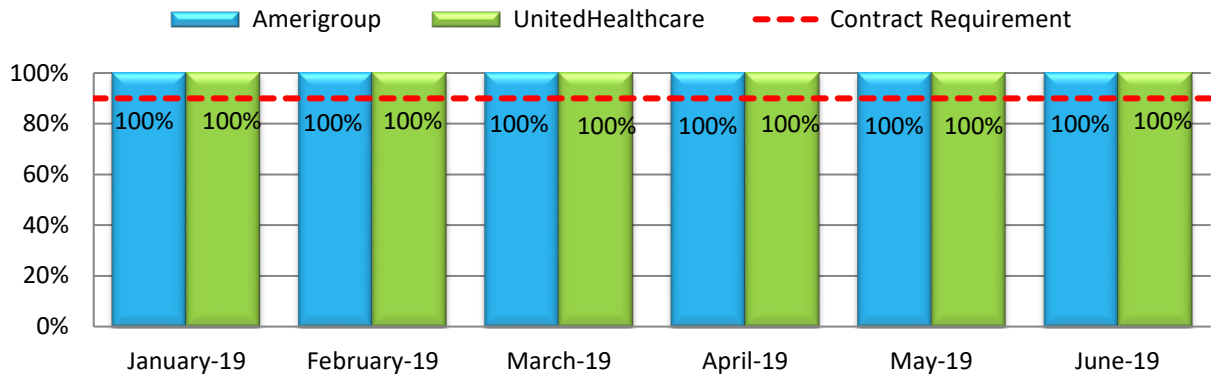
Pharmacy Services Helpline



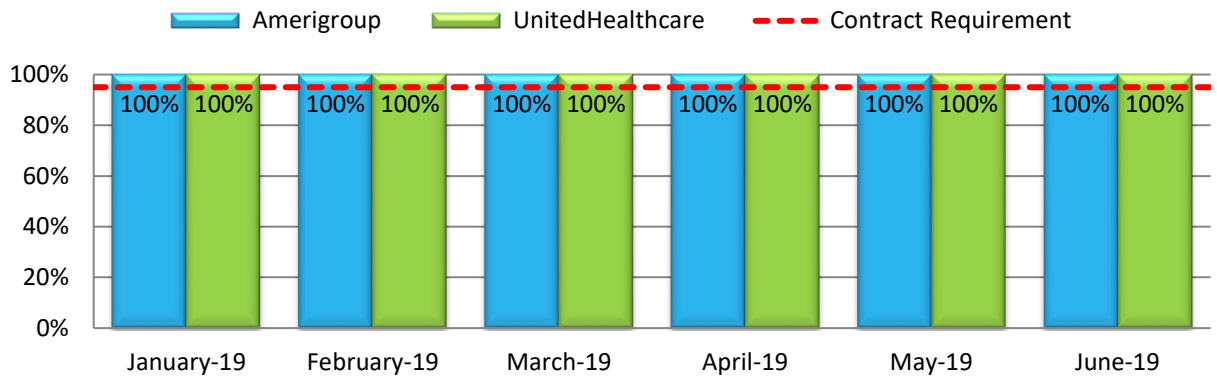
Non-Pharmacy Claims Payment

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

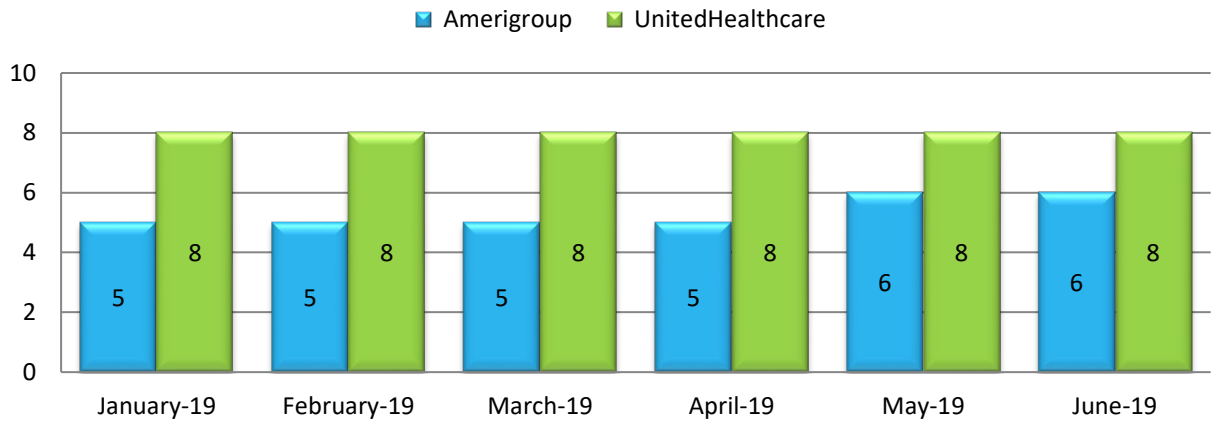
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days



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

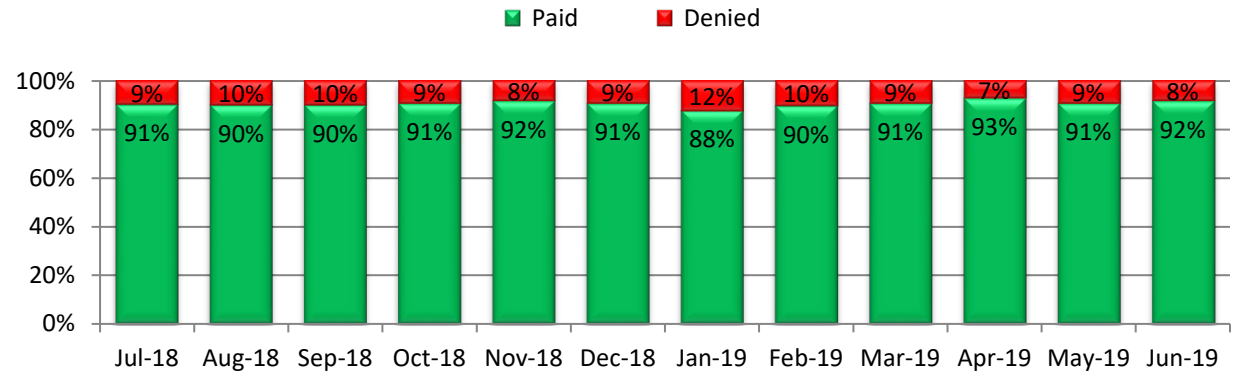


Average Days for Non-Pharmacy Claims Payment



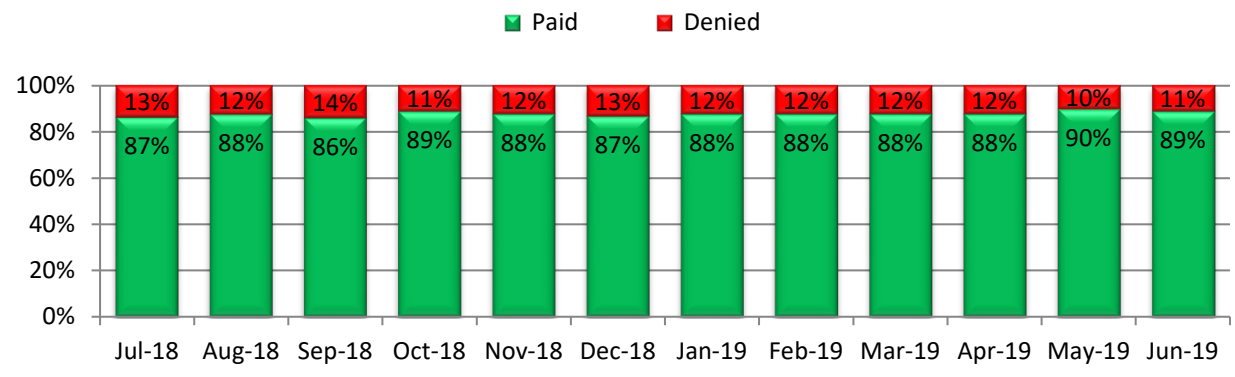
Amerigroup Non-Pharmacy Claims Status

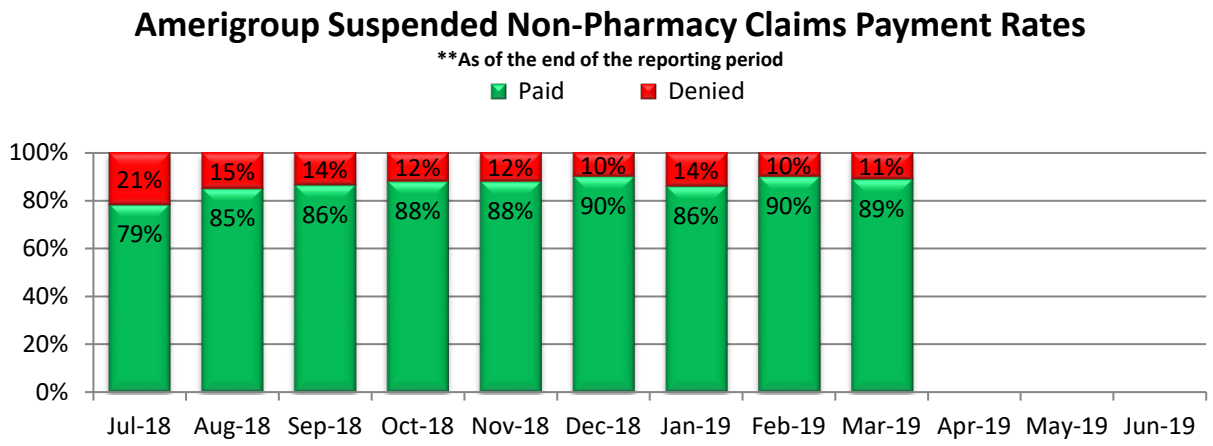
**As of the end of the reporting period

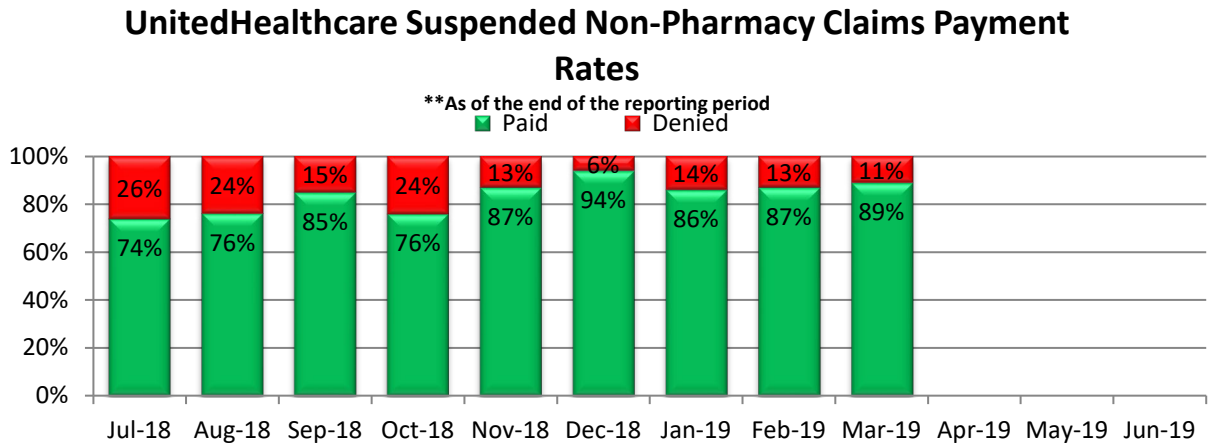


UnitedHealthcare Non-Pharmacy Claims Status

**As of the end of the reporting period







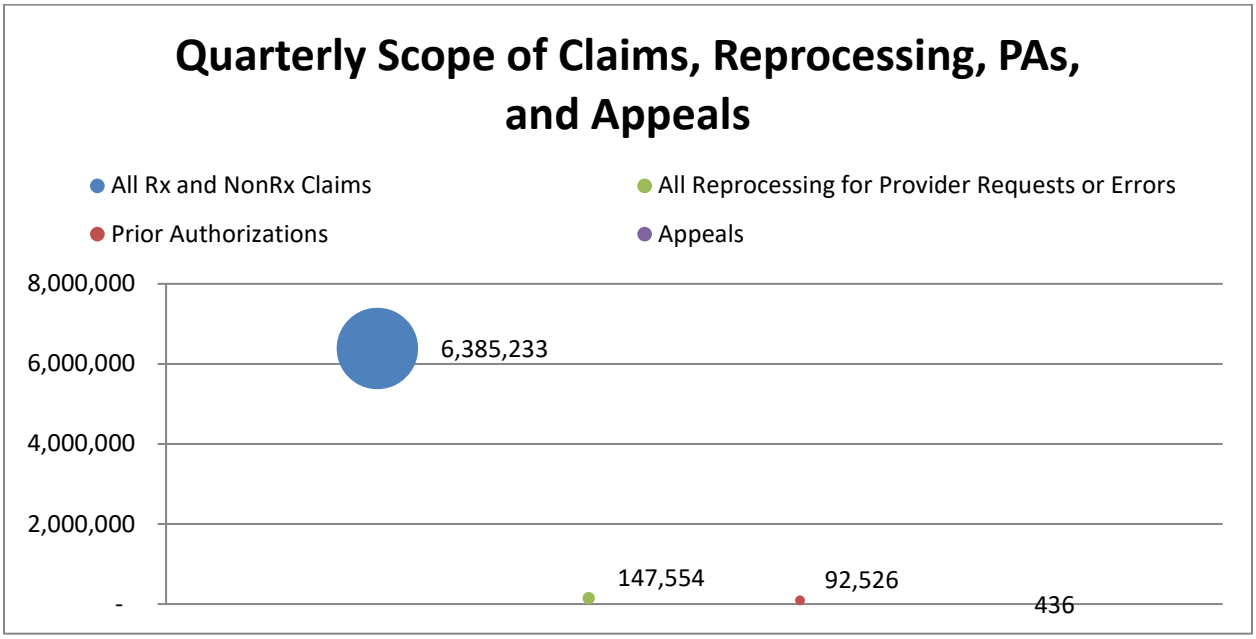
Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires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

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

Top Ten Reasons for Non-Pharmacy Claims Denial as of End of Reporting Period				
CARC and RARC are defined below table				
#	Amerigroup		UnitedHealthcare	
	Reason	%	Reason	%
			they are considered components of the same procedure. Separate payment is not allowed.	
9.	97-The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present N432-Alert: Adjustment based on a Recovery Audit	3%	CARC-23 The impact of prior payer(s) adjudication including payments and/or adjustments.	2%
10.	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 MA130-Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information	1%	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.	2%

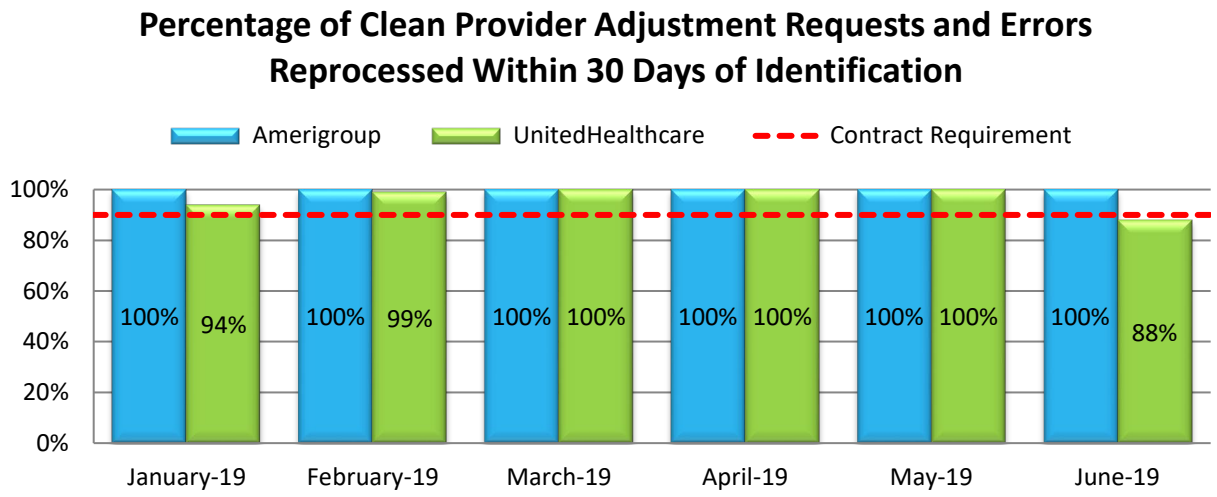
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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



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

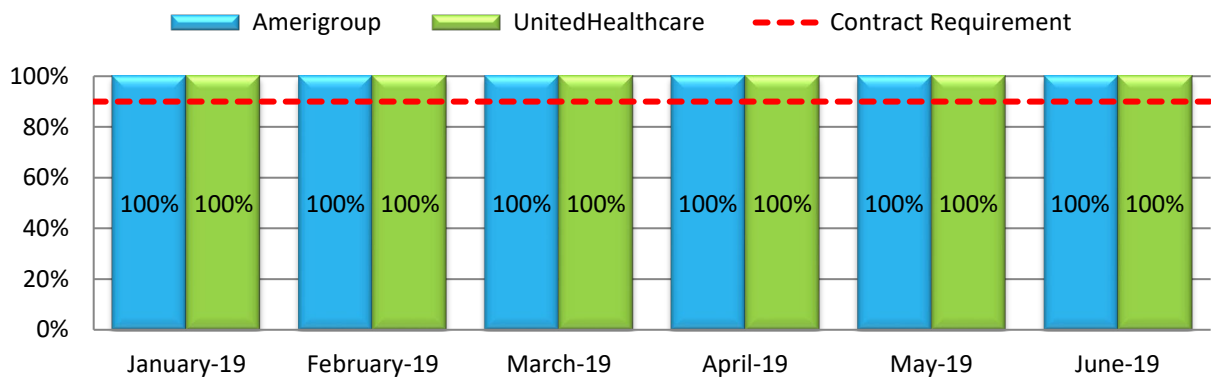
Supporting Data		
All Rx and NonRx Claims	6,385,233	**% of Claims Universe**
All Rx and NonRx Reprocessing for Provider Requests or Errors	147,554	2.31%
All Rx and NonRx Prior Authorizations	92,526	1.45%
Appeals	436	0.01%


Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification
Amerigroup
UnitedHealthcare
Contract Requirement
100%
80%
60%
40%
20%
0%
100%
94%
100%
99%
100%
100%
100%
100%
100%
100%
100%
88%
January-19
February-19
March-19
April-19
May-19
June-19

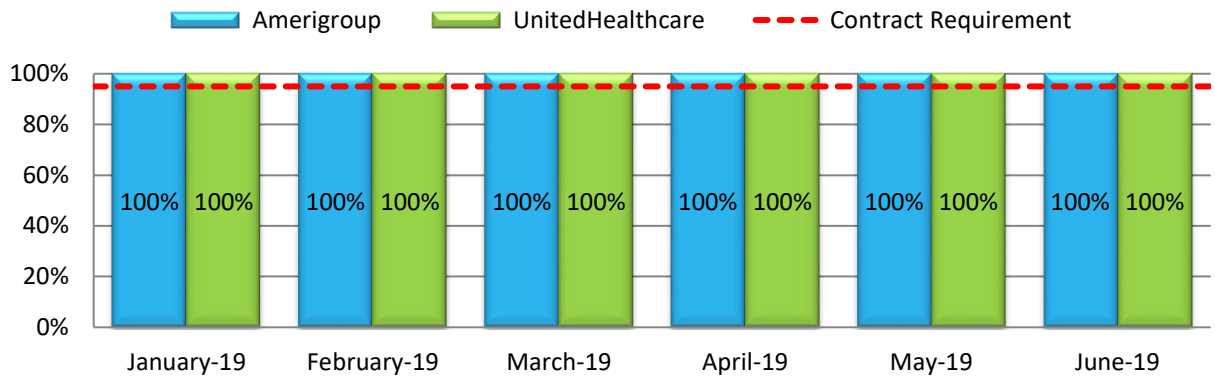
Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

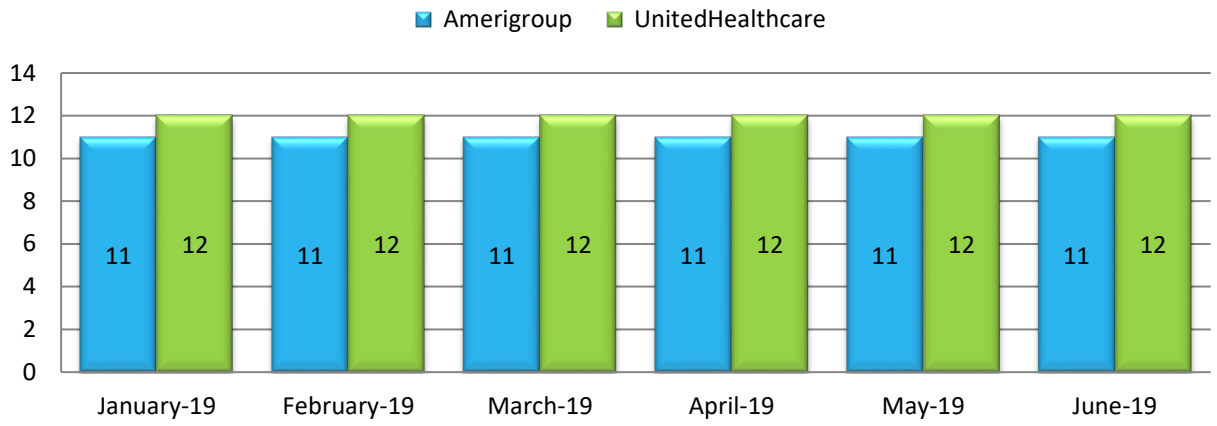
Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days



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

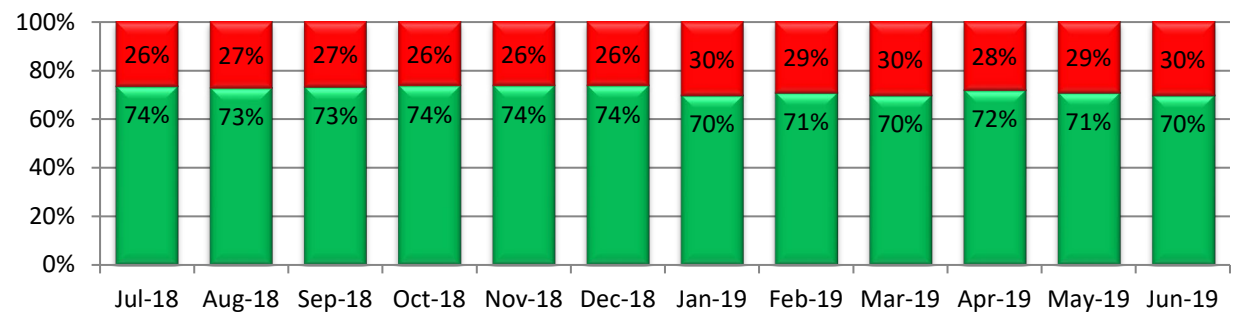


Average Days for Pharmacy Claims Payment



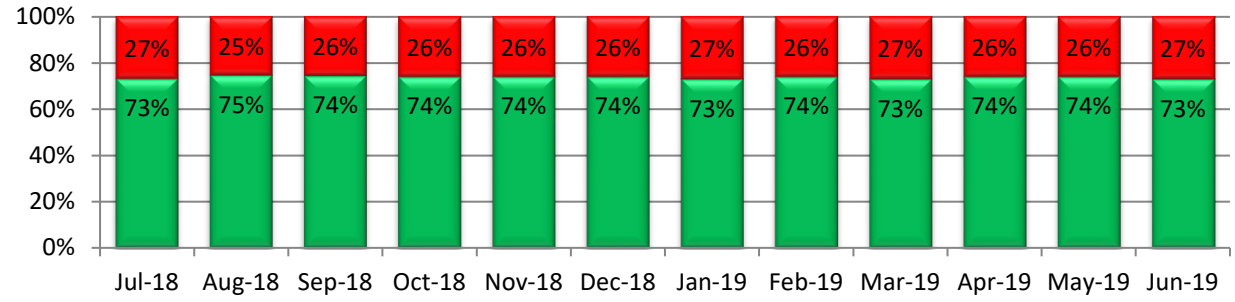
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



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

Utilization of Value Added Services Reported Count of Members

MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q4 SFY19 Data	UnitedHealthcare
Baby Blocks	2,985
School/Camp/Sports Physicals	48
Non Emergent Transportation	932
Weight Watchers	105

Utilization of Value Added Services Reported Count of Members

MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

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

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

Provider Network Access

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

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

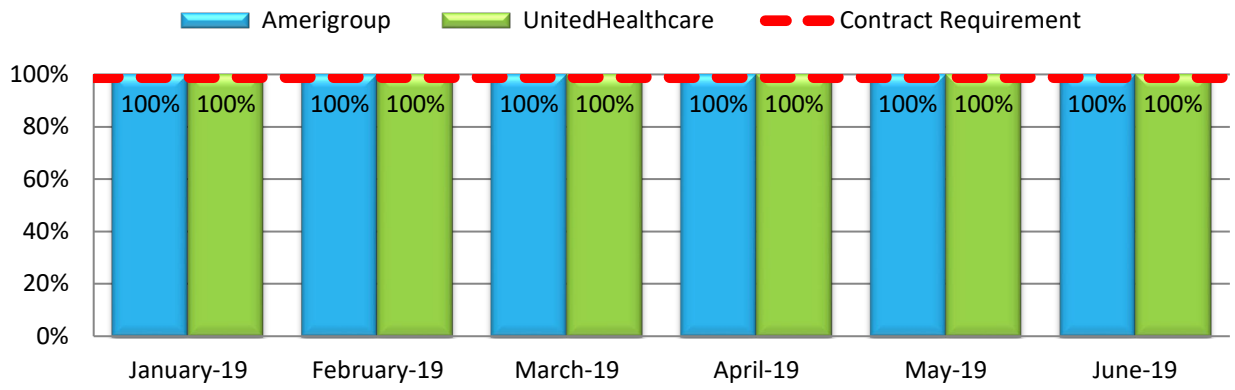
As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the Department when the MCO clearly demonstrates that:

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

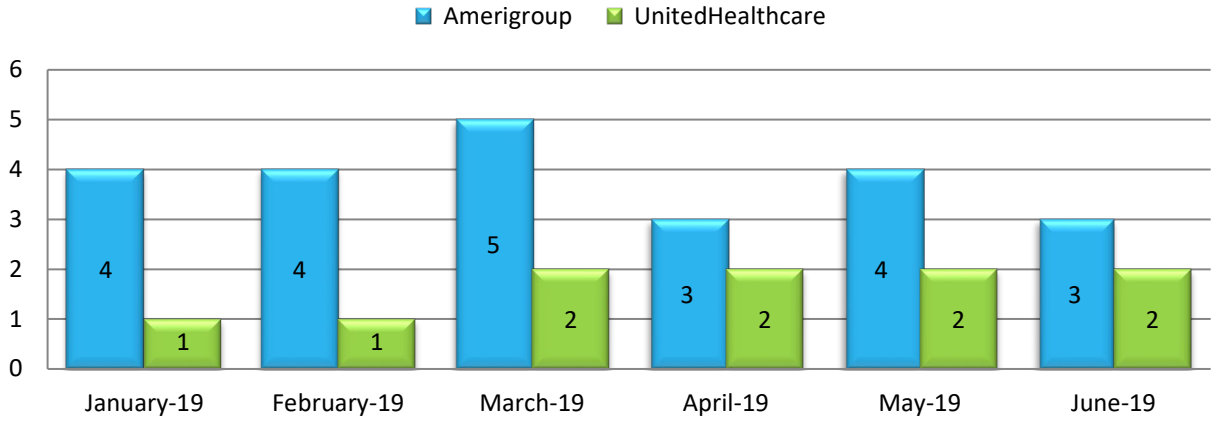
Links to time and distance reports can be found at: https://dhs.iowa.gov/ime/about/performance-data-GeoAccess.

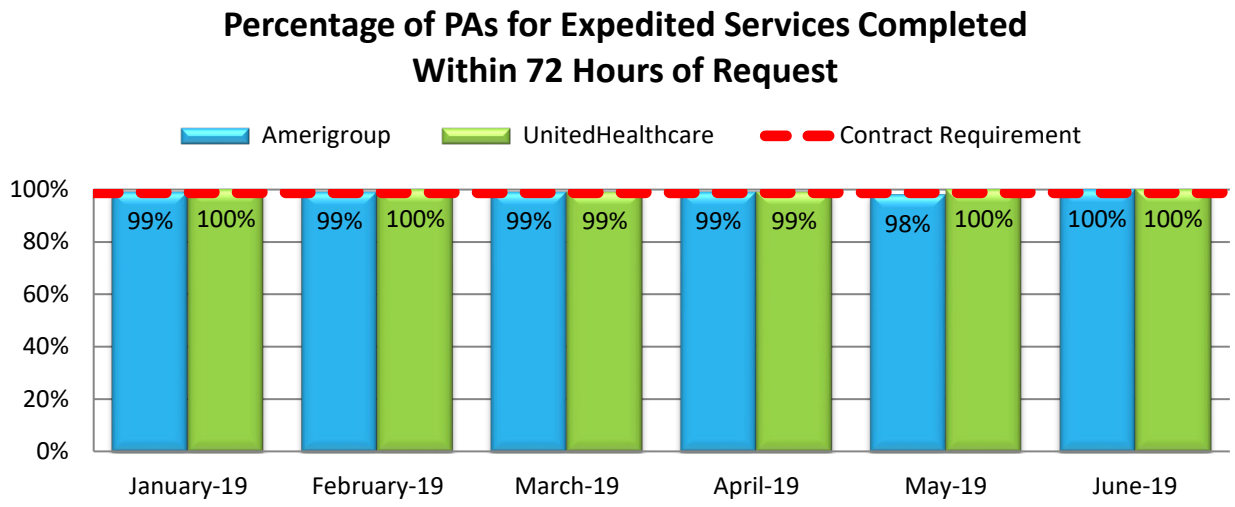
Non-Pharmacy Prior Authorization

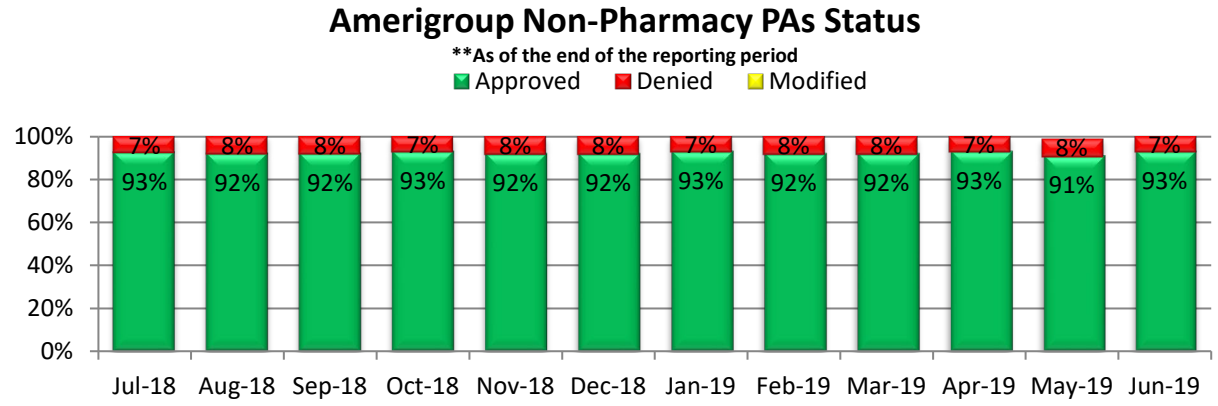
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request

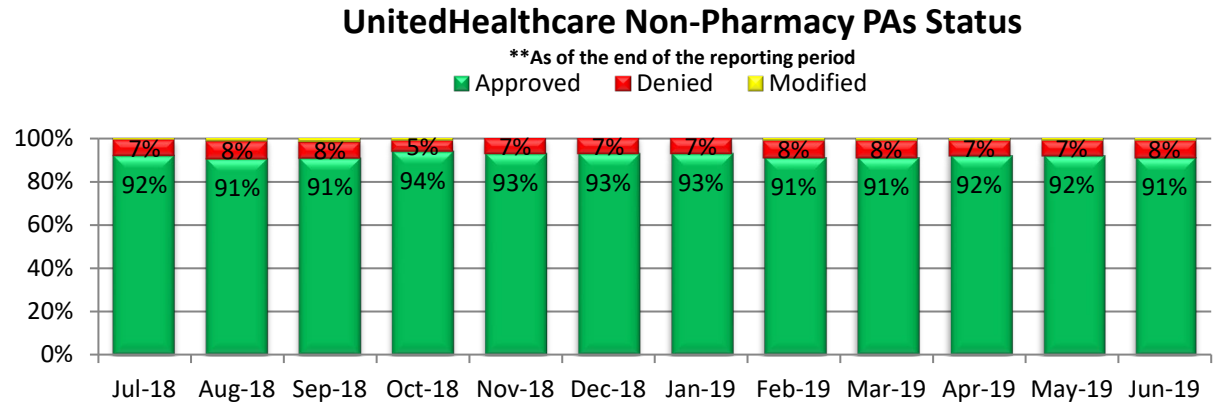


Average Days for Regular PA Processing



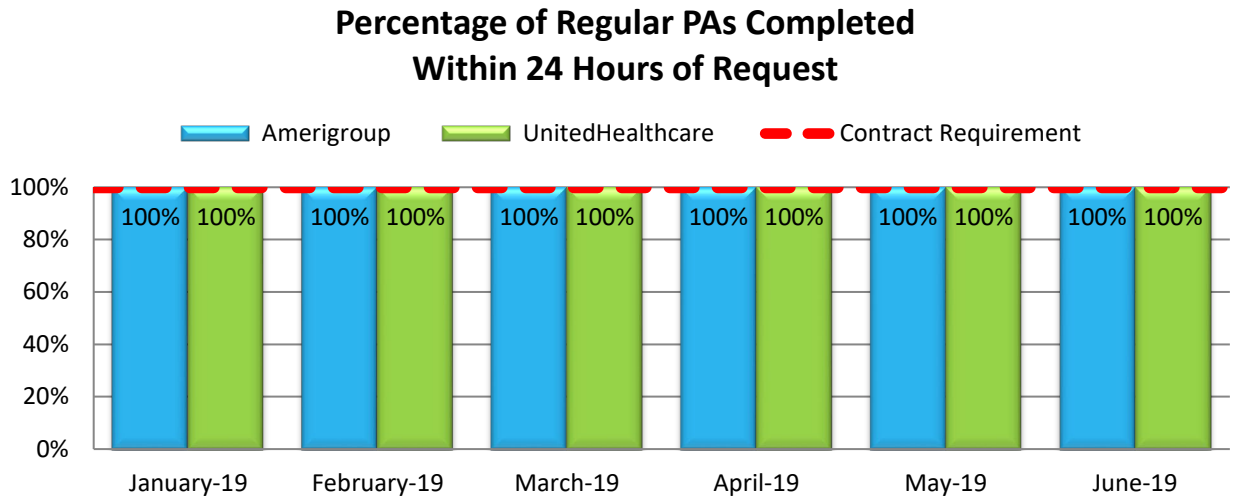




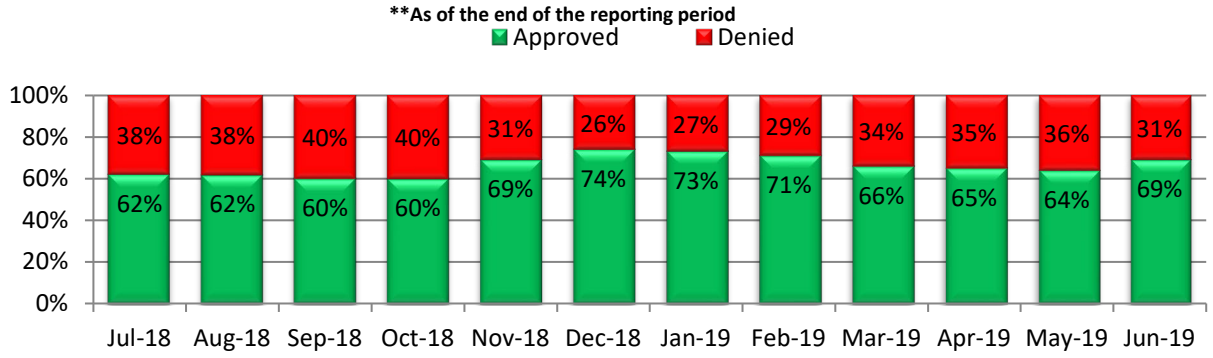


The Department has found and corrected an error in reporting percentages for Non-Pharmacy PA Status from October 2018 – March 2019. The graphs above contain the correct percentages.

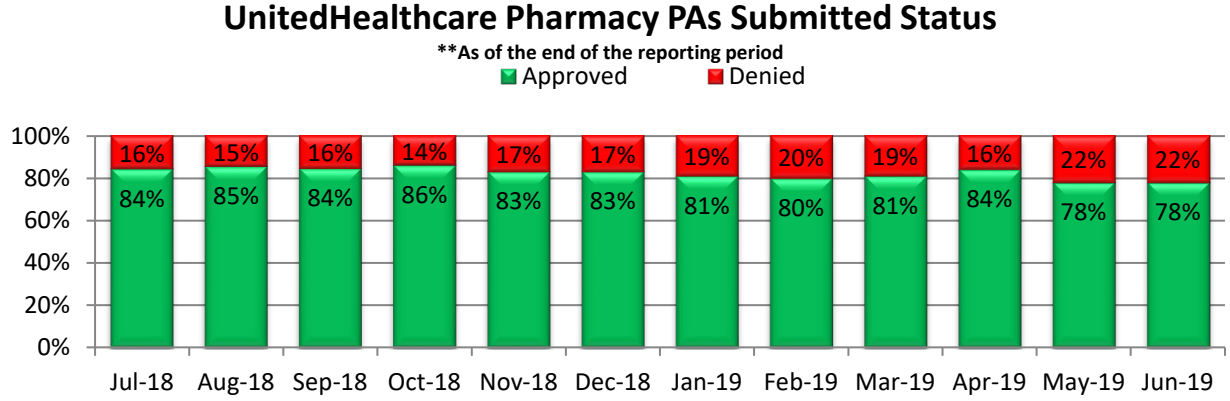
Prior Authorization - Pharmacy



Amerigroup Pharmacy PAs Submitted Status



UnitedHealthcare Pharmacy PAs Submitted Status



Encounter Data Reporting

Encounter Data are records of medically-related services rendered by a provider to a member. The Department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

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

Value Based Purchasing Enrollment

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

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

MLR/ALR/Underwriting

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

- Medical loss ratio (MLR) reflects the percentage of capitation payments used to pay medical expenses.
- Administrative loss ratio (ALR) reflects the percentage of capitation payments used to pay administrative expenses.
- Underwriting ratio reflects profit or loss.

A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

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

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

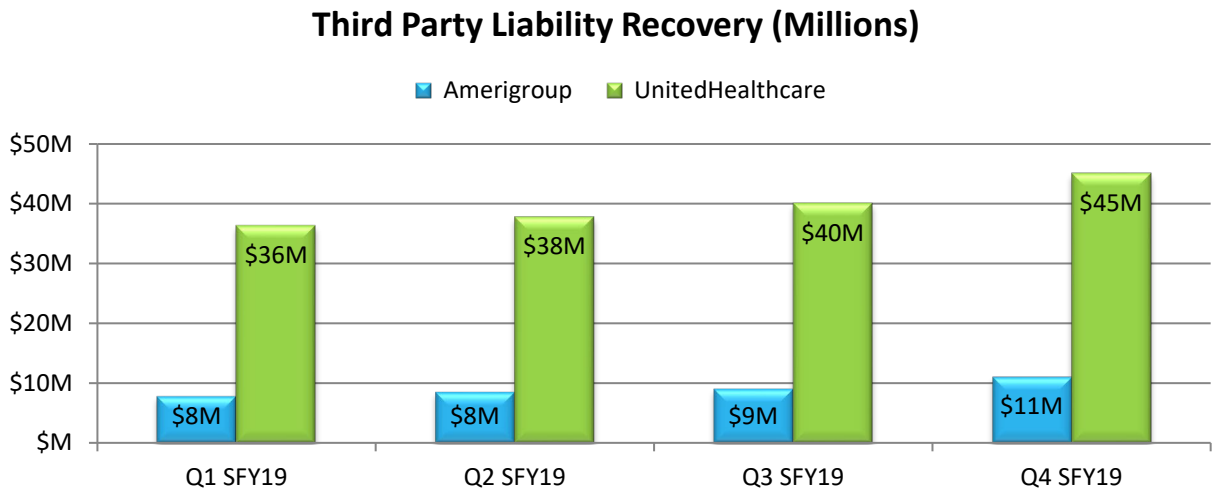
Capitation Payments Made to the Managed Care Organizations

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

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

Managed Care Organization Reported Reserves

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


Third Party Liability Recovery (Millions)
Amerigroup
UnitedHealthcare
$50M
$40M
$30M
$20M
$10M
$M
$8M
$36M
$8M
$38M
$9M
$40M
$11M
$45M
Q1 SFY19
Q2 SFY19
Q3 SFY19
Q4 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.

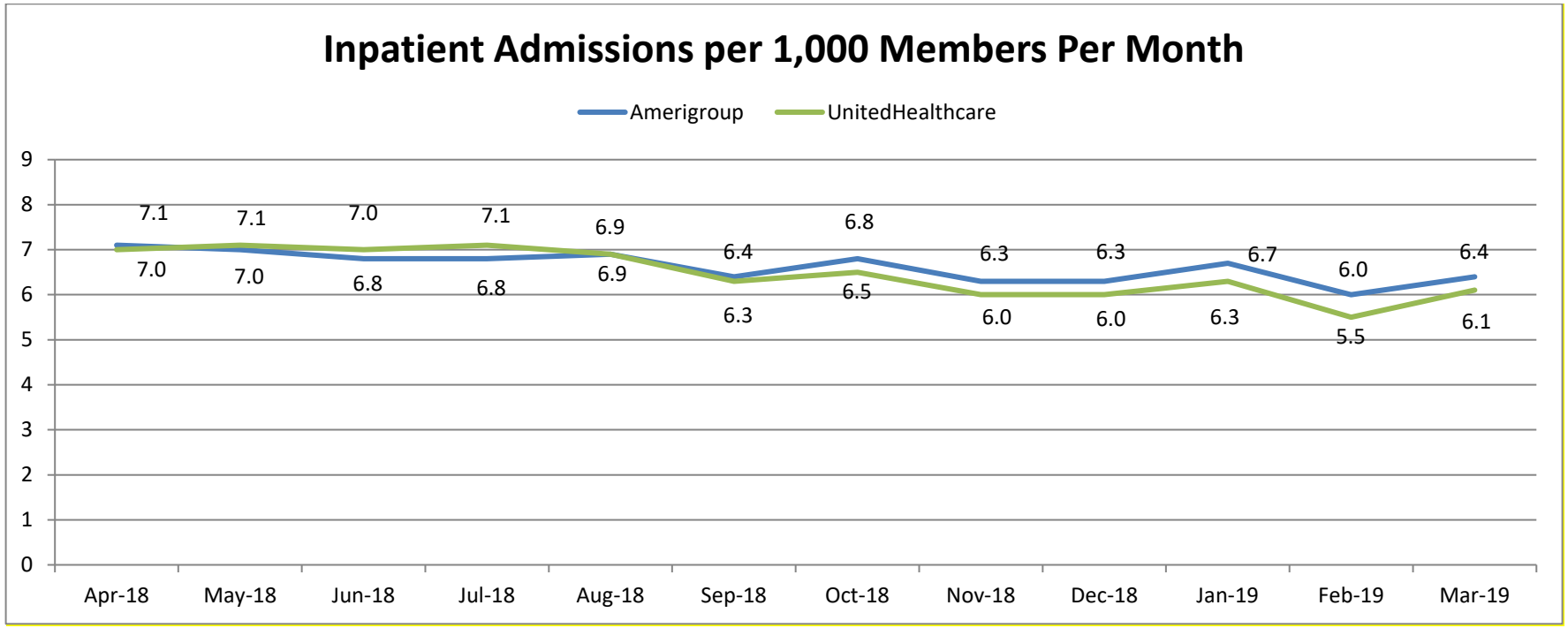
Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

Fraud, Waste and Abuse

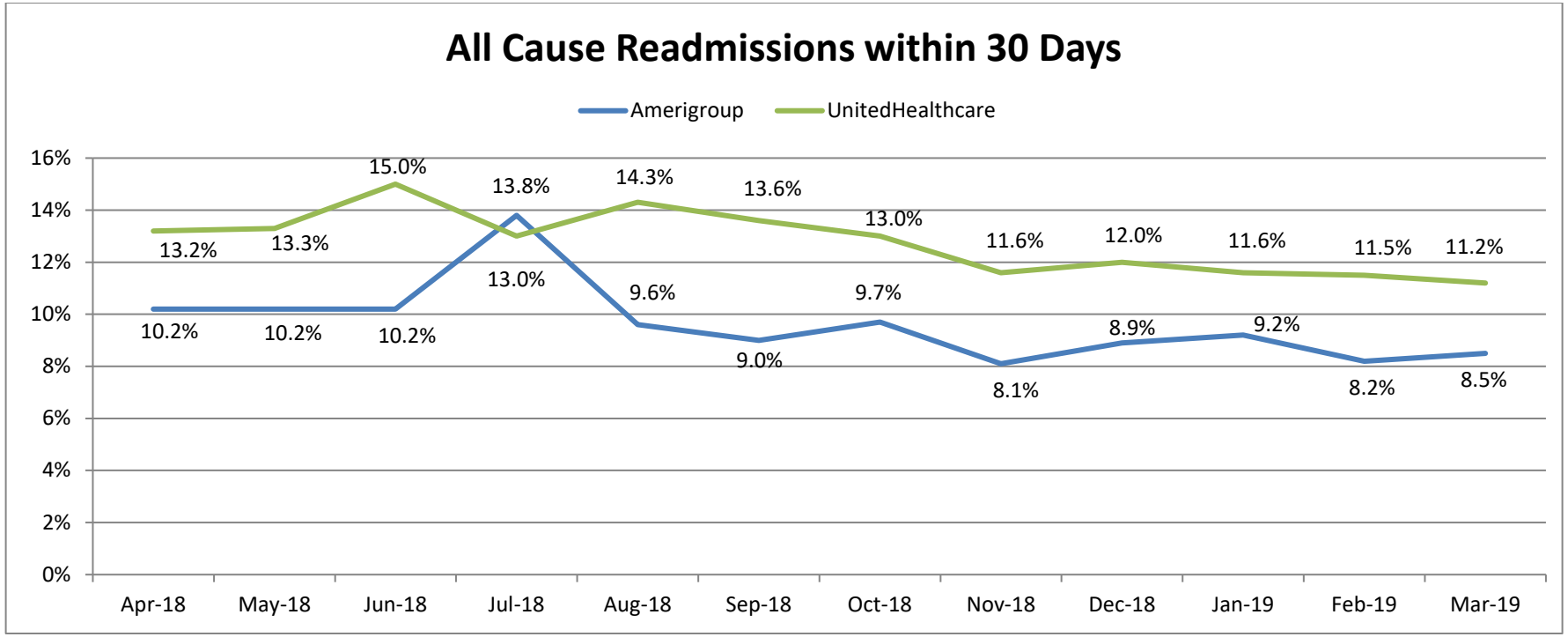
Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.

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

In prior reports, dollars recovered through program integrity efforts were reported on a quarterly basis. However, the MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The plans have initiated 42 investigations in the fourth quarter and referred 31 cases to MFCU. The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse; therefore, MCO investigations, overpayment recovery, and referrals to MFCU would not occur until there is sufficient evidence to implement.



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



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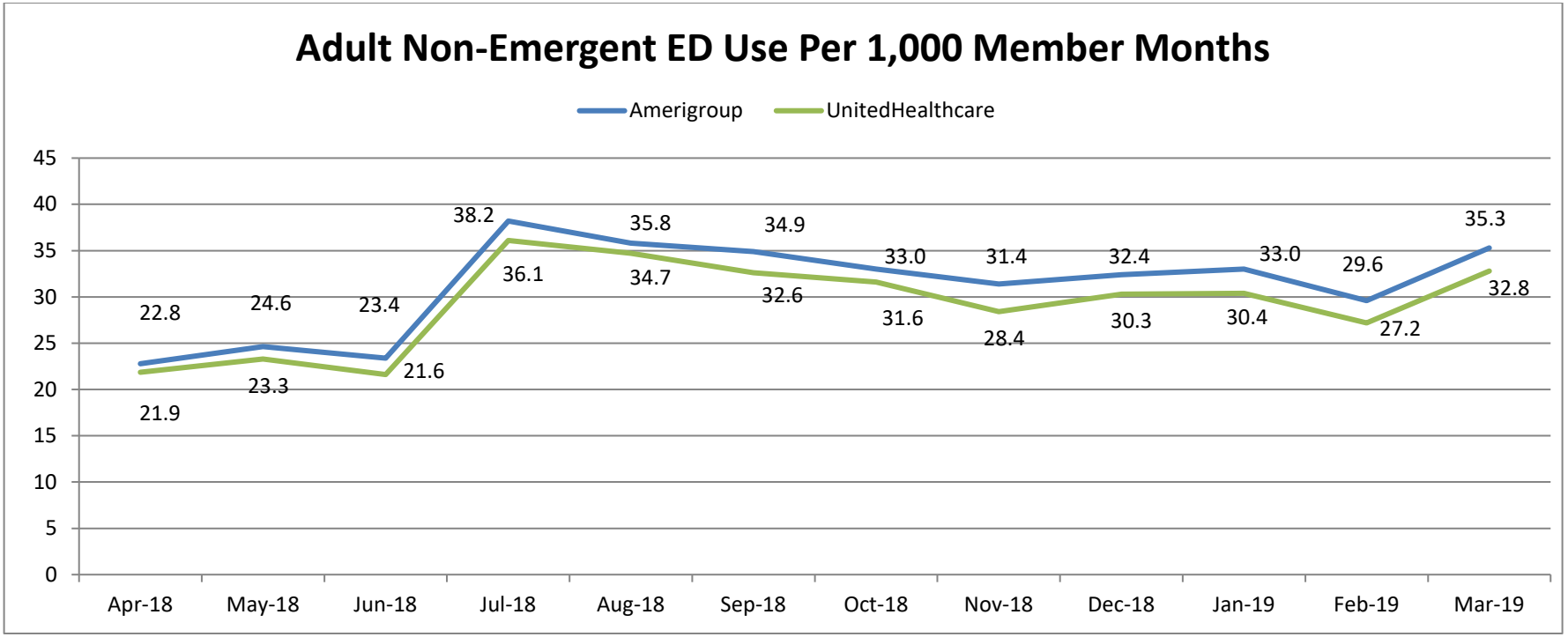

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As of July 1, 2018, the list of emergent diagnosis codes used to determine this measure was updated, as described in Informational Letter No. 1901-MC-FFS. Due to the decrease in appropriate emergent diagnosis codes, it was anticipated that the number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

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

APPENDIX

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 the service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

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

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

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

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

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

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

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

DHS: Iowa Department of Human Services

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

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

ED: Emergency department

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

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

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

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

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

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

Emergency Services: Covered inpatient or outpatient services that are:

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

IID: Iowa Insurance Division.

IME: Iowa Medicaid Enterprise.

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

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

Long-Term Services and Supports (LTSS): Long-Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.
Long Term Care Services:
• Home and Community Based Services (HCBS)
• Intermediate Care Facilities for Persons with Intellectual Disabilities
• Nursing Facilities and Skilled Nursing Facilities

MCO: Managed Care Organization.

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

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

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

NF: Nursing Facility.

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

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

PDL: Preferred Drug List.

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

PMIC: Psychiatric Medical Institute for Children.

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

SMI: Serious mental illness.

SED: Serious emotional disturbance. Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.
SED does not include:

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

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

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

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

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

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

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

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

SFY2020 Medical Assistance Advisory Council Membership

House File (HF) 776 Updates on MAAC Membership
HF 776 updates Iowa Code to specify that the Medical Assistance Advisory Council's (MAAC) voting membership is changed to allow five (5) professional and business entities and five (5) public members, appointed by the Governor's Office of Boards and Commissions. The five professional and business entities are to be selected from the list of previously designated voting members of MAAC.

Voting Member vs. Entity
HF 776 designates 41 entities that are eligible for election as voting members of the MAAC. All eligible entities also are able to participate and cast a ballot in the election of the five voting members.

After the election of the voting members is complete, only those five entities (and the five public members) may formally vote on matters beyond the initial election. This would include approval of minutes, resolutions, recommendations and other business of the council.

The remaining 36 entities may attend all council meetings and cast a ballot in future voting for member elections. The participating entities may not vote on minutes, resolutions, recommendations and other business of the council.

Non-voting Members
HF 776 also designates non-voting members of the council. These individuals are not eligible to become voting members or participate in the voting member election process, but will be designated as council members. Nonvoting members include: designee of the department of public health; designee of the department on aging; designee of the long-term care ombudsman; designee of Des Moines University; designee of the University of Iowa College of Medicine; member of the Hawki board; four members of the General Assembly (two members of the House of Representatives and two members of the Senate). These members will be seated at the table during meetings, and are able to fully participate in discussions of the council, but will not vote on matters before the MAAC.

Roll Call in Council Meetings
At the beginning of each quarterly meeting, roll call will be taken for both voting and non-voting members and then for participating entities. Roll call will begin with voting members, as quorum is counted only by voting members present. After the completion of roll call for voting members, a roll call will be taken for non-voting members and participating entities.

Comments and Questions in Council Meetings
Comments and questions throughout council meetings will be permitted from voting and non-voting members and participating entities. **Priority will be given to voting and non-voting members, and voting and non-voting members will be permitted to comment first.** After voting and non-voting members have commented or asked questions, comments and questions will be accepted from participating entities. The co-chairs reserve the right to limit comments and questions from participating entities in order to maintain the council meeting's agenda and time schedule.

Council Membership: Voting and Non-voting Members

Formal council membership, after the July 2019 election was completed and includes:
Co-Chair: Director's designee from the Department of Public Health (Sarah Reisetter)
Co-Chair: Public Member, Jason Haglund

Voting Members	
Iowa Medical Society	Iowa Hospital Association
Iowa Association of Community Providers	Iowa Health Care Association
Iowa Pharmacy Association	Amy Shriver (Public Member)
Thomas Broeker (Public Member)	Jason Haglund (Public Member & Co-Chair)
John Dooley (Public Member)	Marcie Strouse (Public Member)
Non-voting Members	
Department of Public Health	Department on Aging
Long-term Care Ombudsman	Des Moines University
University of Iowa College of Medicine	Hawki Board Member
Representative Heather Matson	Representative Ann Meyer
Senator Joe Bolkcom	Senator Mark Costello

Participating Entities

The following professional and business entities are eligible to become voting members in the case of a vacancy and are eligible to participate in the election of voting members.

Iowa Osteopathic Medical Association	Iowa Academy of Family Physicians
Iowa Chapter of the American Academy of Pediatrics	Iowa Physical Therapy Association
Iowa Dental Association	Iowa Nurses Association
Iowa Podiatric Medical Association	Iowa Optometric Association
Iowa Psychological Association	Iowa Psychiatric Society
Iowa Chapter of the National Association of Social Workers	Coalition for Family and Children's Services in Iowa
Iowa Association of Rural Health Clinics	Iowa Primary Care Association
Free Clinics of Iowa	Opticians' Association of Iowa
Iowa Association of Hearing Health Professionals	Iowa Speech and Hearing Association
Iowa Association of Area Agencies on Aging	AARP
Iowa Caregivers Association	Leading Age Iowa
Iowa Association for Home Care	Iowa Council of Health Care Centers
Iowa Physician Assistant Society	Iowa Association of Nurse Practitioners
Iowa Nurse Practitioner Society	Iowa Occupational Therapy Association
ARC of Iowa	National Alliance on Mental Illness
Iowa State Association of Counties	Iowa Developmental Disabilities Council
Iowa Chiropractic Society	Iowa Academy of Nutrition and Dietetics
Iowa Behavioral Health Association	Midwest Association for Medical Equipment Services

Updates to Administrative Rules

The Iowa Department of Human Services proposed updates to the Administrative Rules that govern the MAAC at the August 2019 meeting. The council voted to table approval of the proposed rules until the November 2019 meeting of the MAAC. Pending approval by the MAAC, rules will proceed through the standard approval process and once formally approved and adopted, notice will be provided to all council members, including participating professional and business entities.

Proposed Administrative Rules

441—79.7 (249A) Medical assistance advisory council.

79.7(1) *Officers*.

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019 will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the Council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.
2. Requests from the director of human services.
3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership*. The membership of the council and shall be as prescribed at Iowa Code 249A.4B

a. Council membership.

(1) Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A. Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

1. An initial election in SFY20 of five business and professional members shall be held. From this initial election of five members: three members with the most votes shall serve a three year term and the other two members shall serve a two year term. Once these members have served their initial term the length of term for all following elected members shall be two years.
2. Elections shall be organized along the following guidelines.

a. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

b. The entities that receive the most votes shall serve on the council.

3. Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

4. If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification the voting entities seat will be considered vacant and will be filled as outlined in 79.7(2)(a)(1)"3".

(2) Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public members will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

(3) A member of the Hawki board, created in Iowa Code section 514I.5, selected by the members of the Hawki board, shall be a member of the council. The Hawki board member representative will be a non-voting member of the council.

(4) Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

1. Partner agency and medical school representatives will be nonvoting members of the council.

2. If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

3. Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

(5) The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

1. Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

2. Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate.

79.7(3) *Responsibilities, duties and meetings*. The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services.

a. *Recommendations.* Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be disturbed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (5 persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present voting council members.

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council.

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council.

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[ARC 8263B , IAB 11/4/09, effective 12/9/09; ARC 3006C , IAB 3/29/17]

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Explanation of MCO Financials

During the August 6, 2019 meeting of the Medical Assistance Advisory Council (MAAC), there were questions regarding the Managed Care Organization (MCO) Report for SFY2019, Quarter 3 Performance Data published on June 14, 2019. Members requested explanation to clarify the calculations for Medical Loss Ratio (MLR), Administrative Loss Ratio (ALR) and Underwriting Ratio (UR) found on page 35 of the MCQ Quarterly Performance Data Report. The report can be found at: https://dhs.iowa.gov/sites/default/files/SFY19_Q3_Report.pdf?070220191710.

The Iowa Medicaid Enterprise (IME) developed a reporting template for the MCOs to provide the Department with this information. The MCOs follow the measure definition and formula provided below. They use this information and report to IME their MLR, ALR and UR percentage each quarter.

MEASURE	FORMULA
MLR (Medical Loss Ratio)	= [Hospital and Medical Claims] / [Revenues]
ALR (Administrative Loss Ratio)	= ([Claims Adjustment Expenses] + [General Administrative Expenses]) / [Revenues]
UR (Underwriting Ratio)	= [Net Underwriting Gain (Loss)] / [Revenues]

There are instances where the calendar year (CY) quarter financial needs to be restated (as noted on Page 35 of the quarterly report). These are referred to as “Out of Period Adjustments”. For example with Amerigroup these adjustments resulted in a change from the 91.6% MLR noted in the quarterly report to a 95.1% MLR once the adjustment was made. Although the definitions in the MLR template are fairly straightforward and rely on data the MCOs include in their National Association of Insurance Commissioners (NAIC) reporting, this does not necessarily mean that the MCOs would agree that the reported figures accurately reflect their experience for a given time period.

It should also be noted that accuracy for the measures of the financial ratios cannot be complete until 6 months after the reporting period to account for claims run-out.

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Executive Summary

Medicaid Director
August 6, 2019

Transition of Managed Care Organizations (MCOs)

- UnitedHealthcare left the Iowa Medicaid market on June 30, 2019.
- Iowa Total Care went live July 1, 2019.
- We utilized the best practices from past transitions and tried to minimize member and provider disruption as much as possible.
- There have been a few bumps along the way, which is expected when you're transitioning thousands of members and providers, but no wide spread issues or concerns to date.
- We distributed the entire Medicaid population about 50-50 between Amerigroup and Iowa Total Care, but after member choice (as of August 1, 2019):
    - Amerigroup has about 345,000 members, and
    - Iowa Total Care has about 250,000 members.
- Member Open Choice Period ends September 30, 2019.

New Contracts Signed

- The Department of Human Services (DHS) has received signed contracts from Amerigroup Iowa and Iowa Total Care for State Fiscal Year 2020 (SFY20).
- Along with updating rates to reflect actual experience, the new contracts fund important legislative requirements and policy changes.
- Program and policy changes account for $83.1M, or 1.98%, of the SFY20 rate increase. These changes include Hepatitis C coverage and rate rebasing for certain providers.
- House File (HF766) from this past legislative session included increased rates for nursing facilities and providers, as well as funding for mental health. The increased legislative spending accounts for 2.66% of the SFY20 contract rate increase.
- More information can be found on the DHS website[1].

Mandatory Electronic Billing

- DHS implemented a mandatory electronic billing requirement for Medicaid providers on August 1, 2019.
- This applies to both Fee-for-Service claims and claims submitted to the MCOs.
    - Individual CDAC providers are excluded.
    - This requirement will be mandatory for dental providers starting in February 2020.
- By going to an electronic requirement for submitting claims, claims processing time should be faster, which means providers should be paid faster going forward.

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[1] https://dhs.iowa.gov/sites/default/files/IAHealthLink_ContractSummary_July2019.pdf

Department of HUMAN SERVICES

Michael Randol, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Medicaid Director Executive Summary

November 7, 2019

Transition of Managed Care Organizations (MCOs)

- Open Choice Period for members ended September 30, 2019.
- Going forward, members may change MCOs during annual choice period or for reasons of good cause.
- Membership numbers today:
  - Amerigroup: 350,000
  - Iowa Total Care: 240,000
- Coming soon: List of current system issues/claims projects will be posted on MCOs' and DHS websites.

Ground Emergency Medical Transportation (GEMT)

- Voluntary program that allows ambulance transportation providers to be reimbursed for their average uncompensated care cost per transport.
- Effective July 1, 2019.
- For Fee-for-Service and MCO claims.
- Publicly owned or operated GEMT providers can participate.
- Details are currently on the Department of Human Services (DHS) website and will be included in an upcoming Informational Letter.

Hawki Payment System Upgrade

- DHS recently implemented a new online payment system for Hawki members to pay their premiums online.
  - This change was communicated to members several months in advance.
- New system helps ensure members are paying the right amount to the right account and should help eliminate bad payments.