Iowa Department of Human Services

Kim Reynolds
Governor

Adam Gregg
Lt. Governor

Jerry R. Foxhoven
Director

April 11, 2018

Senate Human Resources Committee
State Capitol Building
LOCAL

House of Representatives Human Resources Committee
State Capitol Building
LOCAL

Joint Appropriations Committee on Health and Human Services
State Capitol Building
LOCAL

Dear Committee Members,

Pursuant to 2016 Iowa Acts, Ch. 1139.94, the Council on Human Services, Medical Assistance Advisory Council, and the hawk-I Board are to submit minutes of their respective meetings during which the council or board addressed Medicaid managed care. The meeting minutes attached are regarding those meetings held in the 3rd quarter of SFY 2018.

Enclosed please find minutes from the following meetings:

Council on Human Services	January 10, 2018
Council on Human Services	February 14, 2018
Council on Human Services	March 14, 2018
Medical Assistance Advisory Council – Executive Committee	January 4, 2018
Medical Assistance Advisory Council – Executive Committee	February 27, 2018
Medical Assistance Advisory Council – Executive Committee	March 20, 2018
Medical Assistance Advisory Council – Full Council	February 19, 2018
Healthy and Well Kids in Iowa (hawk-i) Board	March 1, 2018

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

Sincerely,

Merea Bentrott
Policy Advisor

Attachment

Iowa Department of Human Services

Medicaid Managed Care Oversight Quarterly Meeting Minutes 3rd Quarter SFY 2018 (Jan-Mar 2018)

April 2018

COUNCIL ON HUMAN SERVICES

MINUTES

January 10, 2018
Teleconference Meeting
Held in the 1st Floor Conference Room
Hoover State Office Building, Des Moines, Iowa

COUNCIL	EX-OFFICIO LEGISLATIVE MEMBERS
Mark Anderson	Representative Joel Fry (absent)
Phyllis Hansell	Representative Lisa Heddens (absent)
Alexa Heffernan	Senator Amanda Ragan (absent)
Kim Kudej	Senator Mark Segebart (absent)
Kim Spading	
Sam Wallace	

STAFF

Jerry Foxhoven	Vern Armstrong
Nancy Freudenberg	Liz Matney
Wendy Rickman	Mikki Stier
Sandy Knudsen	Matt Highland

GUESTS

Tony Leys, Des Moines Register
Sandi Hurtado-Peters, Iowa Department of Management
Natalie Koerber, Amerigroup

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m. by teleconference on January 10, 2018, in the First Floor Conference Room of the Hoover State Office Building.

ROLL CALL

All Council members were present. All ex-officio legislative members were absent.

Anderson reported that this meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the following rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the first floor conference room of the Hoover State Office Building. Notices and agendas were sent to interested groups as well as the press advising them the meeting will be held via conference call. Minutes will be kept of the meeting.

RULES

Nancy Freudenberg, Bureau of Policy Coordination, presented the following rules for notice to Council:

N-1 Amendments to Chapter 73, Medicaid. Updates rules, specifically timelines, to reflect revised federal standards for the resolution of appeals to MCOs.

N-2 Amendments to Chapter 119, Record Checks. Adds new element to the definition of "Requesting entity." The change is required in relation to federal legislation requiring checks on any employee with access to federal tax information used for purposes of the Department.

N-3 Amendments to Chapter 167, Foster Care. Clarifies procedures for juvenile detention facilities to follow when seeking annual cost reimbursement.

Motion was made by Heffernan to approve the noticed rules and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

APPROVAL OF MINUTES

A motion was made by Wallace and seconded by Kudej to approve the minutes of December 13, 2017. MOTION CARRIED UNANIMOUSLY.

REVIEW OF MCO QUARTERLY REPORT

Liz Matney, Chief, MCO Oversight and Supports Bureau, Iowa Medicaid Enterprise, provided an overview of the "Managed Care Organization Report: SFY 2018, Quarter 1 (July-September) Performance Data Report."

- Upon suggestions from stakeholders and oversight entities, the quarterly report has changed to make it flow better and be more meaningful.

- Results from the 'Secret Shopper' process for the helplines were added to assess quality.

- The report reviews payment of claims not just for timeliness, but also in how the rates were paid and what should have been paid.

- Data results of the 'Iowa Participant Experience Survey' is reported on page 20. The survey tool was customized to make it specific to Iowa.

- Employment data (page 21) is collected twice a year - and updates will be included every other quarter.

- Approximately 6,000 health risk assessments were completed during this quarter.

- MCO's are maintaining their service levels for their helplines in this quarter. Over 37,000 value-added services were accessed by members in this quarter.

In response to a question by Anderson regarding cost savings realized by the State since changing to managed care, Foxhoven reported that savings attributable to managed care is complicated to compile due to many factors. He reported that Mike Randol, Iowa's new Medicaid Director, is working on a comprehensive review and will be reporting on the savings.

Spading asked that the Department report on the methodology used to initially estimate what the savings would be in moving to managed care and then what the actual savings are.

In response to a question from Spading, Matney reported that the word 'timely' refers to the requirement by the federal government for the 1915c waivers that means 'at least annually' - for both service plans and level of care assessments.

Spading inquired whether it would be possible to standardize the different types of grievances (page 23). Matney replied that in the past that proved to be very challenging, but she would re-visit the issue.

In response to a question from Spading, Matney and Stier reported that the Department has a transition plan with AmeriHealth to close out the contract and any activities. AmeriHealth will be responsible for paying claims for a year following their exit and they also have a 'members services helpline' open for six months. Department staff continue to have weekly phone conferences with AmeriHealth representatives.

REVIEW OF CHILD WELFARE REPORT

Vern Armstrong, Administrator, Division of Field Operations and Wendy Rickman, Administrator, Division of Adult, Children and Family Services, provided an overview of the "Initial Child Welfare Review" report conducted by the Child Welfare Policy and Practice Group, dated December 22, 2017. The report recommendations are divided into two sections - "Tier 1", those based on the information gathered in the limited, targeted review, and "Tier 2" those recommendations for follow-up in a second phase of the review which would be conducted throughout 2018.

Armstrong reviewed the recommendations in the report for both Tiers. Recommendation highlights:

Tier 1:

- Provide accurate information on actual caseloads
- Institute competency-based learning
- Strengthen requirements for providing services to parents
- Explore avenues to secure funding to improve data system
- Form a workgroup to review timeframes for response and completion of child abuse and family assessments
- Identify and resolve barriers to extending the centralized intake system to 24 hour coverage

Tier 2:

- Work with Human Resources to review pay structure and training
- Examine workload and advocate for staff allocations
- Undertake a systemic review of FSRP services
- Review policies and practices around screening, training, and supporting foster and adoptive parents

Rickman reviewed the approach the department plans to take in response to the report. She reported that DHS has established an internal workgroup to determine the direction and to prioritize tasks. DHS also plans to convene an external stakeholder group to move the work forward.

Anderson requested that Armstrong and Rickman report to the Council with an update at next month's meeting (in writing if preferable).

COUNCIL UPDATES

Anderson reported that he met with the Waverly Exchange Club and will be meeting with the local hospital director and board of directors next week.

DIRECTOR'S REPORT

Jerry Foxhoven, Director, provided the following report:

Among many other things included in the Child Welfare Review, the report also reinforced that employees at DHS are extremely dedicated and hardworking. Iowa's turnover rate for employees, especially social workers, compared to other states is extremely low.

The Complex Service Needs Workgroup Report regarding mental health, disability, and substance use disorder services, was issued on December 15, 2017. Foxhoven noted that the report is a good road map toward a quality mental health system in Iowa that focuses on a full array of services.

In response to a question from Heffernan regarding the budget, Foxhoven responded that there will continue to be budget cuts for this current fiscal year and the Department is working with the Governor's Office and the Department of Management to minimize the impact. The Department will receive some additional funding in the next fiscal year.

ADJOURNMENT

Council adjourned at 10:52 a.m.

Submitted by,

Sandy Knudsen
Recording Secretary

COUNCIL ON HUMAN SERVICES

MINUTES

February 14, 2018

COUNCIL

Mark Anderson
Phyllis Hansell
Alexa Heffernan (Absent)
Kimberly Kudej (Via Phone)
Kim Spading
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

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

STAFF

Jerry Foxhoven
Sandy Knudsen
Nancy Freudenberg
Janee Harvey
Mikki Stier
Michael Randol
Matt Highland

GUESTS

Natalie Koerber, Amerigroup Iowa
Sandi Hurtado-Peters, Iowa Department of Management
Paige Petitt, UnitedHealthCare
Flora A. Schmidt, IBHA
Zita Cashen

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 10:00 a.m.

ROLL CALL

All Council members were present with the exception of Alexa Heffernan. All Ex-officio legislative members were absent.

RULES

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

R-1. Amendments to Chapter 73, Medicaid. Updates rules, specifically timelines, to reflect revised federal standards for the resolution of appeals to MCOs.

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

R-2. Amendments to Chapter 119, Record Checks. Adds new element to the definition of "Requesting entity." The change is required in relation to federal legislation requiring checks on any employee with access to federal tax information used for purposes of the Department

Motion was made by Wallace to approve and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

R-3. Amendments to Chapter 167, Foster Care. Clarifies procedures for juvenile detention facilities to follow when seeking annual cost reimbursement.

Motion was made by Wallace to approve and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

Notices of Intended Action

N-1. Amendments to Chapters 51 and 52, SSA COLA. Implements the January 1, 2018 cost of living adjustments to income limits and benefit amounts for several SSA categories. These amendments were already Adopted and Filed Emergency at the December 13, 2017 meeting of the Council on Human Services. Due to administrative delay, these amendments were required to be refiled in the Legislative Service Agency's Rules Management System.

N-2. Amendments to Chapters 78, 79, and 83, Medicaid. Day Habilitation and Adult Day Care service rates will be changed to a fee schedule using tiered rates. These amendments were Adopted and Filed Emergency at the November 8, 2017 meeting of the Council on Human Services. These amendments were filed to allow for public comment. The Department received 60 comments during the public comment period requesting that Public Hearings be held to allow for interested parties to provide comments to the Department. This amended Notice of Intended Action establishes two public hearings to accommodate the requests received by the Department in the previous comment period.

N-3. Amendments to Chapter 79, Medicaid. These amendments further clarify services covered and provide standards for operation of Medicaid crisis response service providers. These amendments correct inadvertent errors in a previous rule making, in addition to providing updates requested by the Iowa Medicaid Enterprise.

N-4. Amendments to Chapter 81, Medicaid. Adds the use of online course curricula to meet the required minimum of 30 hours of classroom instruction for nurse aide training. Allows a veteran to be deemed to satisfy training requirements for nurse aide training based upon the veteran's service-related training and experience.

N-5. Amendments to Chapters 81 and 166, Medicaid. Aligns rules with federal regulations regarding the use of civil money penalties (CMP) imposed by the Centers for Medicare and Medicaid Services (CMS). Also updates the Department's process in how and when applications for grant proposals are requested.

N-6. Amendments to Chapters 95 and 99, Child Support. Aligns CSRU rules with federal regulations. Removes references to voluntary reduction of income as a factor when CSRU modifies child support obligations.

N-7. Amendments to Chapter 100, Child Support. Replaces the current chapter on Child Support Parental Obligation Pilot Projects. Renames the program and clarifies incentives within the program.

Motion was made by Wallace to approve the noticed rules and seconded by Spading. MOTION CARRIED UNANIMOUSLY.

APPROVAL OF MINUTES

A motion was made by Spading and seconded by Wallace to approve the minutes of January 10, 2018. MOTION CARRIED UNANIMOUSLY.

OVERSIGHT OF MANAGED CARE UPDATE

Mike Randol, Director, Iowa Medicaid Enterprise, provided the following updates:

- The first meeting of the 'Process Improvement Work Group' will be held on February 22. The meetings are designed to get a cross-section of providers together to identify issues they have experienced with managed care. After the issues are identified, the work group will be broken down into subgroups based on category. In response to questions from Spading, Randol reported that the work group meeting is not public, but he will report to the Council, Legislature and the MAAC on the outcomes. The providers were chosen with input from several of the provider associations and IME staff.

- The Department is reviewing Integrated Health Homes with the MCO's to give the department an opportunity to re-look at the health home programs overall. Randol has concerns about the provision of the chronic conditions services within that program.

- IME continues to work with Amerigroup regarding their capacity. Effective March 1, 2018, Amerigroup will work to enroll the 10,000 members that were moved temporarily to fee-for-service program.

- Randol continues to meet with providers and various stakeholders and feels it is important for them to have the opportunity to communicate with him directly.

- The Department is currently working through the Request for Proposal (RFP) process to obtain a new Managed Care Organization that will be effective July 1, 2019.

In response to a question from Hansell, Randol reported that the Milliman actuarial firm continues to have a relationship with the Department until their contract expires on June 30, 2018 and will be completing several projects. An RFP will be proposed for a new actuarial firm that will begin in about 9 months, but it is important to have another actuarial firm (in place currently) so the Department could move forward with the commitment to review rates and be on track to have those rates negotiated soon.

Randol noted that since providers have 365 days to file a claim it is difficult to make decisions based on that analysis without complete data. It is important that States wait six months after the end of the year when claims have been filed before they can start seeing the complete data. Fee-for-Service data is not the same thing in Managed Care - it is not the same utilization trend or the same patterns for those populations. Iowa now has 22 months of experience and with that lag the Department can start doing some of the detailed analysis.

Spading questioned the proposed legislation that appears to be reducing the amount of reporting required of the MCOs. Randol responded that the legislation does not reduce oversight but rather strikes some data elements that were superfluous and allowed more flexibility with reporting. Spading stated that she would like to review the proposed legislation and continue seeing the MCO report every quarter so the Council could see trends. Randol stressed the importance of complete and accurate encounter data.

Spading stated that she would like to get a handle on how much "we missed by" and would like to maintain transparency in seeing the true savings from managed care.

CHILD WELFARE REPORT UPDATE

Janee Harvey, Chief, Bureau of Child Welfare and Community Services, Division of Adult, Children and Family Services provided the Council with an update on proposed strategies in response to the Child Welfare Policy & Practice Group's (CWPPG) report.

Harvey reviewed the nine themes for strategically improving child welfare:

- Intake and Assessment
- Training for staff and contractors
- Documentation efficiency
- Contracted services
- Development of a Child Welfare Information System (CWIS)
- Caseloads - reporting and hiring
- Practice
- Dependent adults
- Other

Hansell noted that she appreciates hearing about other state's experiences and that the Council is mindful of the need for funding.

LEGISLATIVE UPDATE

Director Foxhoven reported that bills are pending in both the House and Senate that incorporate the "Complex Service Needs Workgroup Report" into legislation. Foxhoven sees this as one of the biggest initiatives on the expansion and improvement of services for individuals with mental health, disability and substance abuse needs in many years.

Stier reported on the following legislation that the Department is tracking on:

HSB626 (Passed out of the House) - Child Sexual Abuse as Result of Adult in Home
HSB627 (Passed out of the House) - Custody Transfer for Youth at Boys State Training School
HSB638 (Passed out of the House) - Eldora State Training School/establishing a diagnosis and evaluation center and other units
HSB630 (Passed out of the House Sub, waiting to pass full) - Child Abuse, Reporters and Employment Background Checks
HSB641 (Passed House Sub; scheduled to go through full) - Child Abuse and Registered Sex Offender Access
HSB631 (Amended and Passed House) - Human Services Department Technical Changes, Support of Mentally Ill
HSB629 (Amended and Passed out of the House) - Child Support, Medical Support
HSB632 (Amended; Needs to go through House Full Committee) - Medicaid Efficiency - Multiple Technical Clean-up

DIRECTOR'S REPORT

Director Foxhoven reported on his outreach to department staff and his efforts to improve staff morale.

COUNCIL UPDATES

Spading and Hansell shared that they were disappointed that data is being pulled out of the quarterly managed care reporting and didn't think that lent itself to transparency. Anderson noted that the Council can request reports and specify what they would like to see in those reports.

ADJOURNMENT

Meeting adjourned at 1:15 p.m.

Submitted by Sandy Knudsen, Recording Secretary

COUNCIL ON HUMAN SERVICES

MINUTES

March 7, 2018
Teleconference Meeting
Held in the Director's Conference Room - 5th Floor
Hoover State Office Building, Des Moines, Iowa

COUNCIL

Mark Anderson
Phyllis Hansell
Alexa Heffernan
Kim Kudej
Kim Spading
Sam Wallace

EX-OFFICIO LEGISLATIVE MEMBERS

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

STAFF

Jerry Foxhoven
Nancy Freudenberg
Mikki Stier
Mike Randol
Matt Highland
Sandy Knudsen

GUESTS

Tony Leys, Des Moines Register
Natalie Koerber, Amerigroup

CALL TO ORDER

Mark Anderson, Chair, called the Council meeting to order at 11:00 a.m. by teleconference on March 7, 2018, in the DHS Director's Conference Room in the Hoover State Office Building.

ROLL CALL

All Council members were present. All ex-officio legislative members were absent.

Anderson reported that this meeting of the Iowa Council on Human Services is being held in accord with Section 21.8 of the Code of Iowa entitled "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances are such that a meeting in person is impossible or impractical, or if the governmental body complies with the following rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in the director's conference room of the Hoover State Office Building. Notices and agendas were sent to interested groups as well as the press advising them the meeting will be held via conference call. Minutes will be kept of the meeting.

RULES

Nancy Freudenberg, Bureau of Policy Coordination, presented the following rules :

R-1. Amendments to Chapters 51 and 52, SSA COLA. Implements the January 1, 2018 cost of living adjustments to income limits and benefit amounts for several SSA categories. These amendments were already Adopted and Filed Emergency at the December 13, 2017 meeting of the Council on Human Services. Due to administrative delay, these amendments were required to be refiled in the Legislative Service Agency's Rules Management System.

Motion was made by Heffernan to approve and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

R-2. Amendments to Chapter 78, 79, and 83, Medicaid. Day Habilitation and Adult Day Care service rates will be changed to a fee schedule using tiered rates. These amendments were Adopted and Filed Emergency at the November 8, 2017 meeting of the Council on Human Services. These amendments were filed to allow for public comment. The Department received 60 comments during the public comment period requesting that Public Hearings be held to allow for interested parties to provide comments to the Department. This amended Notice of Intended Action establishes two public hearings to accommodate the requests received by the Department in the previous comment period.

Motion was made by Spading to approve and seconded by Heffernan. MOTION CARRIED UNANIMOUSLY.

R-3. Amendments to Chapter 79, Medicaid. These amendments further clarify services covered and provide standards for operation of Medicaid crisis response service providers. These amendments correct inadvertent errors in a previous rule making, in addition to providing updates requested by the Iowa Medicaid Enterprise.

Motion was made by Wallace to approve and seconded by Kudej. MOTION CARRIED UNANIMOUSLY.

R-4. Amendments to Chapter 81, Medicaid. Adds the use of online course curricula to meet the required minimum of 30 hours of classroom instruction for nurse aide training. Allows a veteran to be deemed to satisfy training requirements for nurse aide training based upon the veteran's service-related training and experience.

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

R-5. Amendments to Chapters 81 and 166, Medicaid. Aligns rules with federal regulations regarding the use of civil money penalties (CMP) imposed by the Centers for Medicare and Medicaid Services (CMS). Also updates the Department's process in how and when applications for grant proposals are requested.

Motion was made by Hansel to approve and seconded by Kudej. MOTION CARRIED UNANIMOUSLY.

R-6. Amendments to Chapters 95 and 99, Child Support. Aligns CSRU rules with federal regulations. Removes references to voluntary reduction of income as a factor when CSRU modifies child support obligations.

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

R-7. Amendments to Chapter 100, Child Support. Replaces the current chapter on Child Support Parental Obligation Pilot Projects. Renames the program and clarifies incentives within the program.

Motion was made by Hansell to approve and seconded by Wallace. MOTION CARRIED UNANIMOUSLY.

The following amendments to rules are presented as Notices of Intended Action for review by the Council:

N-1. Amendments to Chapter 7, Appeals. Implements new federal guidelines extending the period to appeal decisions for state fair hearings from 90 days to 120 days. Also changes effectuation of a reversed appeal resolution for MCO appeals.

N-2. Amendments to Chapter 77, Medicaid and Mental Health and Disability Services. Requires hospitals providing inpatient psychiatric services, including the state mental health institutes (MHI) to update the inpatient psychiatric bed tracking system at least two times per day with number of available, staffed beds by gender, child, adult, and geriatric.

N-3. Amendments to Chapter 170, Child Care Assistance. Revises the child care assistance (CCA) fee chart based on the new federal poverty levels (FPL).

Updates rules regarding temporary lapse policy and adds a wait list exemption for homeless families.

Motion was made by Spading to approve the noticed rules and seconded by Hansell. MOTION CARRIED UNANIMOUSLY.

Hansell requested a tutorial at a future meeting on how the federal poverty level is determined.

APPROVAL OF MINUTES

A motion was made by Wallace and seconded by Kudej to approve the minutes of February 14, 2018. MOTION CARRIED WITH HEFFERNAN ABSTAINING.

COUNCIL UPDATES

Kudej noted that at the April meeting she would like to discuss 'Tiered Rates' and the Department's proposed legislation regarding the Eldora State Training School.

Following discussion, Anderson suggested that if Council members are contacted by constituents with questions, they could share the questions/concerns via email with the other Council members or forward to Sandy Knudsen in the Director's Office to forward to the entire Council. The Council may request that certain topics and issues be placed on the Council's agenda at any time. Also if Council members wish, they could submit questions needing response from DHS to Sandy Knudsen to disseminate to staff.

DIRECTOR'S REPORT

Mikki Stier, Deputy Director, reported that DHS staff continue to work with the department's legislative liaison and legislators on various bills. The Mental Health Complex Work Group's legislation is moving through both houses and is receiving positive responses.

ADJOURNMENT

A motion was made by Heffernan and seconded by Hansel to adjourn. MOTION CARRIED UNANIMOUSLY. Council adjourned at11:35 a.m.

Submitted by,

Sandy Knudsen
Recording Secretary

Executive Committee
Summary of Meeting Minutes
January 4, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler – **present**	Matt Highland - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski - **present**
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch – **present**	Alisha Timmerman -
Julie Fugenschuh – **present**	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was met.

Approval of the Executive Committee Meeting Minutes of December 19, 2017
Minutes of the Executive Committee meeting of December 19, 2017 was approved.

Long Term Services and Supports Presentation (LTSS)
Deb Johnson handed out copies of the document, "Medicaid Home-and Community-Based Services (HCBS) Program Comparison Chart" which outlines the various services under LTSS.

She stated that LTSS consists of Home- and Community-Based Services (HCBS) Waivers and Institutional Care:

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

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

Quarterly Report Data Presentation

The Q1 SFY18 report was made available in the materials packet. Liz stated that all members that receive community services or are in a waiver program have an assigned care coordinator or case manager but not all members in facilities have assigned care coordinators or case managers. Liz reviewed HCBS-specific data and case management ratios of MCOs for members receiving community-based services, and discussed surveys. Liz stated she would provide additional information regarding annual state savings at a future meeting.

Care Coordination and Conflict-Free Case Management

1. **UnitedHealthcare**
   Kellyann Light-McCoroary, stated that UnitedHealthcare's Case Managers (CMs) focus on person-centered planning while ensuring compliance with state and federal regulations. UnitedHealthcare CMs are nurses as well as social workers and they have extensive training in LTSS. Upon hiring, CMs are put through training in LTSS and each CM hired is paired with a mentor. She stated that UnitedHealthcare follows conflict of interest requirements as outlined in the Code of Federal Regulations. She stated that all states are required to separate case management person-centered service planning development from service delivery. She stated that for assessments, UnitedHealthcare utilizes inter RAI and the SIS as required by the State. Assessors are certified and carry out case reviews, ride-alongs, and peer reviews.

2. **Amerigroup**
   Kelly Espeland stated that Amerigroup has assessments teams that do assessments with the members and are facilitators of those assessments. In regards to the SIS assessment, the CM is a facilitator and does not determine the score or the member's needs as this is carried out by the team. Assessors are trained by AAIDE and assesors are reviewed and certified annually by AAIDE. The information then goes to the CM, the team reviews the information, and the CM provides the service coordination to develop the member's person-center plan based on identified needs. She stated that the UM team looks at the assessment and care plan that has been developed, and a determination is then made regarding services. She stated that oversight within their organization consists of: member appeals rights available if they disagree with a decision; contractual requirements and guidelines, and; External Quality Review (EQR) audits.

   Member advocacy during appeals hearings was discussed. It was clarified that the CM facilitates the service planning meeting and the member selects their care team. Kim Foltz stated that conflict-free case management means that the provider cannot be the assessor, care planner, and the delivery/service provider. It was stated that the contract between the State and the MCOs is a risk-based arrangement.

Medicaid Director's Update

The Action Items document was made available in the materials packet. Update postponed to February 27, 2018, Executive Committee meeting.

Mobile Applications
Matt Highland to discuss at February 27, 2018, Executive Committee meeting.

Open Discussion

There was no open discussion due to lack of time.

Adjourn

4:45 P.M.

Executive Committee
Summary of Meeting Minutes
February 27, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh – **present**	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney -
Shelly Chandler –	Kevin Kirkpatrick - **present**
Cindy Baddeloo – **present**	Lindsay Paulson -
Casey Ficek –	Sean Bagniewski -
Lori Allen –	Luisito Cabrera - **present**
Richard Crouch –	Alisha Timmerman - **present**
Julie Fugenschuh –	
Jodi Tomlonovic – **present**	

Introduction
Gerd called the meeting to order and performed the roll call. Executive Committee attendance is as reflected above and quorum was not met.

Approval of the Executive Committee Meeting Minutes of January 4, 2018
Minutes of the Executive Committee meeting of January 4, 2018, were not approved as quorum was not met.

Long Term Services and Supports Presentation (LTSS)
Long Term Services and Supports
Deb Johnson discussed and defined the Program of All Inclusive Care for the Elderly (PACE) program, Hospice Services, Targeted Case Management (TCM), Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs), Residential Care Facilities (RCFs), Nursing Facilities, and Skilled Nursing Facilities as outlined on the Long Term Care webpage[1].

Home- and Community-Based Services (HCBS) Waivers
Deb Johnson advised that the link to the HCBS Waiver Program webpage[2] was provided in the agenda and reviewed the Medicaid Home and Community Based Services (HCBS) Program Comparison Chart[3]. Deb clarified that Medicaid pays for Consumer Directed Attendant Care (CDAC) supervising nurse costs under the Medicaid State Plan. Deb also explained that members residing in

[1] https://dhs.iowa.gov/ime/members/medicaid-a-to-z/long-term-care
[2] http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers
[3] https://dhs.iowa.gov/sites/default/files/Medicaid_HCBS_Program_Comparison_Chart.pdf

ICF/IDs are enrolled in managed care and may access some additional medical services outside of the ICF/ID; such as x-rays for a broken arm. It was also identified that the case manager and Interdisciplinary Team (IDT) assist the member in person-centered planning to determine which HCBS services are best suited for the member. Deb stated that some of the available services under the HCBS programs are currently underutilized due to a limited number of providers available to provide the services and lack of member demand. To determine which programs may be available to individuals, members may contact the Area Agency on Aging, LifeLong Links, their local DHS office, the Iowa Department of Public Health (IDPH), or access the Compass website. Deb acknowledged that prior to receiving HCBS services individuals must first be determined Medicaid eligible and then meet LOC for the services; however, prior to receiving HCBS services the member is eligible for State Plan benefits.

Medicaid Director's Update

The Action Items document was made available in the materials packet. Mike Randol stated that on March 1, 2018, former AmeriHealth Caritas members who temporarily transitioned to Fee-for-Service (FFS) will be moved to Amerigroup. Requests for Proposals (RFPs) for potential MCOs are due on March 6, 2018, and the new MCO contract will be awarded in April 2018; information regarding RFP submissions will be made available in the next couple of weeks. Mike stated that issues were identified in the February 22, 2018, Process Improvement Workgroup and Medicaid staff will be categorizing the issues to determine subgroups. He indicated that report will be created providing outcomes from the Process Improvement subgroups and workgroup. Mike acknowledged that cost avoidance estimates will no longer be available in the quarterly reports as there is a six month lag in claims data which makes the information inaccurate and difficult to compare.

Mobile Applications

Kevin Kirkpatrick stated that both Amerigroup and UnitedHealthcare have mobile applications available for download on Google Play and iTunes. Some functions available on the applications are: member ID cards; emailing to Member Services; provider look-up; English and Spanish versions of the applications, and; claims history. In the future, the application download options are to be made available on the DHS website.

Q2 SFY18 Recommendations Subcommittee

It was decided that a subcommittee be created to discuss Q2 SFY18 recommendations. The individuals below will be on the subcommittee and an email is to be sent to Executive Committee members requesting additional persons participate in the subcommittee.

- David Hudson
- Dennis Tibben
- Dan Royer

Open Discussion

David solicited comments. No comments were made.

Adjourn

4:30 P.M.

Executive Committee
Summary of Meeting Minutes
March 20, 2018

EXECUTIVE COMMITTEE MEMBERS	DEPARTMENT OF HUMAN SERVICES
Gerd Clabaugh –	Jerry Foxhoven -
David Hudson – **present**	Michael Randol - **present**
Dennis Tibben –	Deb Johnson - **present**
Dan Royer – **present**	Liz Matney - **present**
Shelly Chandler –	Kevin Kirkpatrick - **present**
Cindy Baddeloo – **present**	Lindsay Paulson - **present**
Casey Ficek – **present**	Sean Bagniewski -
Lori Allen – **present**	Luisito Cabrera - **present**
Richard Crouch –	Alisha Timmerman -
Julie Fugenschuh –	
Jodi Tomlonovic –	

Introduction
David called the roll call. Executive Committee attendance is as reflected above and quorum was not met.

Approval of the Executive Committee Meeting Minutes of February 27, 2018
Minutes of the Executive Committee meeting of February 27, 2018 were not approved because quorum was not met. David asked that an electronic vote be initiated for Executive Committee members to approve the minutes of the January 4 and February 27 Executive Committee meetings.

Recommendations Discussion
Q2 SFY18 Recommendations Subcommittee Update
David referred to the draft of the Q2 SFY18 recommendations document and gave an update from the March 8, 2018 subcommittee meeting. He stated that the aim is to get the recommendations to Director Foxhoven by the April 11, 2018 Executive Committee meeting and to share them at the next Full Council meeting on May 3, 2018. Lindsay explained that the current recommendations are for Q2 SFY18 IA Health Link public comment meetings and, as the meetings have concluded, no further recommendations for the meetings are required per legislation. The MAAC may continue to make general recommendations at any time. David invited feedback from the Committee on the draft recommendations. Dan Royer suggested more clarification on data regarding claims that are suspended versus denied and Cindy suggested that dollar amounts for items such as inpatient and outpatient claims paid be provided by the Department. David referenced the March 9, 2018, email from Dan Royer that had been distributed to Executive Committee members regarding how Medicaid and MCO operations are impacting hospitals and health systems. He stated that he would like to include some of the relevant recommendations from his document in the Q2 SFY18 recommendations. David suggested discussing Dan's ideas at the March 30, 2018, recommendations subcommittee meeting.

Long Term Services and Supports Presentation (LTSS)

Deb Johnson reviewed the Home- and Community-Based (HCBS) Waiver application process. Applicants can be self-referred, referred by schools, referred by local DHS offices, MCOs, and many other avenues. Income Maintenance Workers (IMWs) assist with the Waiver application and the applicant has to choose between institutional or community services. If determined financially eligible for Medicaid and HCBS services, the IMW requests a waiver slot. If a waiver slot is not available, the applicant will be put on a waiting list and a Notice of Decision will be sent to the applicant. If a waiver slot is available, the next step is completion of a Level of Care (LOC) assessment. An LOC determination is then made upon review of the individual's needs as identified in the assessment. An LOC is not an approval of services but rather a determination of HCBS eligibility. The approval process for HCBS applicants can take several months to complete, depending upon how quickly the assessment can be scheduled and completed, and whether all necessary information is submitted timely for the LOC decision. If approved for LOC and HCBS services, it is determined whether the member is eligible to enroll with an MCO to receive services or receive services under the Fee-for-Service (FFS) program. Once the applicant has been determined eligible for HCBS and Medicaid coverage, either a case manager from the member's selected MCO, or a FFS case manager will develop a service plan with the member and the member's Interdisciplinary Team (IDT). The service plan can change in accordance with the member's needs and the LOC, Medicaid eligibility, and service plan is re-evaluated annually. Deb clarified that service plans are authorized by the state or the MCO; not the case manager. Deb stated that the provider manual details this process and that she will develop a work flow chart on the waiver application process for distribution at the April Executive Committee. Deb stated that a member can have additional services provided either by utilizing state plan or by paying for it themselves with the agreement of the member.

Consumer Assessment of Healthcare Providers and Systems (CAHPS)

Liz stated that CAHPS is intended to measure consumer experience within the healthcare system, not consumer satisfaction. She stated that the Department requires the MCOs to perform areas that are specific to the healthcare delivery systems. She indicated that there are surveys for both adults and children that look at the member's experience with their insurance provider and provider network. The surveys contain questions regarding four main areas: Getting needed care; Getting care quickly; How well doctors communicate; and Health plan information and customer service. She stated that the MCOs use independent contractors to conduct these surveys and the MCOs are required to report the CAHPS data to the Department. She stated that in the 2017 metrics, all MCOs scored above the national median in adult surveys although one area of the children surveys was below the national median; 'The customer services always or are usually helpful'. Liz indicated that CAHPS data is in the quarterly reports. She indicated that the department conducts a variety of surveys and is currently reviewing existing surveys to ensure collection of meaningful data. She mentioned that CAHPS and Healthcare Effectiveness Data and Information Set (HEDIS) data are a part of National Committee for Quality Assurance (NCQA) ratings.

Medicaid Director's Update

Process Improvement Workgroup:
Mike stated that the workgroup was to meet on March 23, 2018, and that feedback is being reviewed so that sub-workgroups may be formed to address the feedback before moving forward.

Amerigroup Transition:
Mike confirmed there are no known issues with the transition of the 10,000 members to Amerigroup. He stated that the IME and the MCOs continue to work closely to ensure a smooth transition and transfer of members and member data. Effective May 1, 2018, Amerigroup will begin accepting new members.

New MCO RFP Process:
He stated that two organizations submitted responses and they were received on March 6, 2018. He stated that the department is currently evaluating the RFPs that were received with the intent to select the new MCO by the end of April 2018 with contract negotiations and a readiness timeline for a July 1, 2019 start.

Mike stated that in adding new MCO(s), an algorithm-based methodology will be developed for distributing membership equitably across the MCOs but that all members will have choice.

Open Discussion

David stated that a provider had informed him that there were a number of people being audited by AmeriHealth Caritas in an effort to collect funds that had been lost. Cindy stated that providers receive

letters stating that the MCO is auditing claims, or there are special projects that they are reviewing. Mike stated that he would review the information and documentation.

David asked if the MCO contracts provide for a definition of “medical necessity” as he did not see it defined clearly in the Amerigroup contract; asking within the context of denial of a service deemed to not be medically necessary. Mike offered to address this by stating that the complex nature of the Medicaid member population groups and their various needs make defining the term medical necessity difficult however, there are however clinical guidelines that define medical necessity. Mike stated that medical necessity is not determined by a case manager it is determined by clinicians in the specified area. Liz stated that there is an outline that is consistent with the federal program for Medicaid and Medicare. In the glossary there is a definition of medical necessity and the contractor uses their Utilization Management guidelines to determine medical necessity.

David inquired about House File (HF) 2292 and HF 2462. Mike offered to sit down privately with David about his questions regarding these bills but that a legislative update will be provided at the next Executive Committee meeting in April.

Flora Schmidt asked that the Department provide an update on the Department’s Health Home reviews. Mike stated that the Health Home contractor will be providing an update that includes a project timeline within the next two weeks and once completed, he would like to commence department and stakeholder/provider engagement to develop a robust and comprehensive communications plan on Health Homes.

Agenda Item:

- Legislative update by Mike Randol for the April Executive Committee meeting.

Adjourn
4:19 P.M.

Full Council
Summary of Meeting Minutes
February 19 2018

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

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

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

Recommendations Update
Q4 SFY17 Director Foxhoven Reply
Gerd gave a brief background regarding the questions posed to the Director and a copy of the reply was made available in the materials packet.
Q1 SFY18 Letter
Gerd stated that this letter is currently awaiting response from Director Foxhoven but that the items on the recommendation are already being addressed.

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

collected but that the reports should be able to meaningfully answer questions that are being asked. Mike stated that there is now a process improvement working group and one of the sub-groups is data transparency dashboards which can help in answering questions about the data. Mike also reviewed the action items document and provided an update on the status of each item.

Action Item:

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

Long-Term Care Services and Support (LTSS) Presentation

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

Home- and Community-Based Services (HCBS) Waivers

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

Institutional Care: Nursing Facilities (NFs), Skilled Nursing Facilities (SNFs), Intermediate Care Facilities (ICFs), and Intermediate Care Facilities for the Intellectually Disabled (ICF/IDs)

Deb stated that members receiving these services need to meet the same Level of Care and income guidelines as in waiver programs. There are monthly maximums or caps on the financial amount for services in each program and this is important in determining the aggregate for cost neutrality. She added that cost-effectiveness of services is determined on an individual basis and is based on a variety of variables. Deb provided clarification on the distinction and relationships between Level of Care, service plan, and care coordination.

Care-Coordination and Conflict-Free Case Management

Amerigroup Iowa, Inc.

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

UnitedHealthcare Plan of the River Valley, Inc.

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

Amerigroup Iowa, Inc. Updates

Transition Update

Natalie Kerber stated that when AmeriHealth exited the market, Amerigroup determined that in order to serve a large but unidentified influx of new members, the organization would need to build more

capacity. Since that time, Amerigroup has been working closely with the IME in building said capacity. As of March 1, 2018, Amerigroup will begin accepting the members who were temporarily transitioned to Fee-for-Service and as of May 1, 2018, they will begin accepting new and choice members.

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

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

UnitedHealthcare Plan of the River Valley Updates

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

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

Quarterly Data Report Update

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

Secret Shopper Methods and Metrics

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

Open Comment (Open Comment Opportunity for Members)

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

Marsha Fisher also stated that she does not agree with the requirement to prove that the services requested are a true need. Marsha noted that the needs are seen by the Care Coordinator, there is an assessment, and there are many persons working with the individual during their care planning

although when it goes to the Utilization Management team, the member and their team are required to prove that the services are a true need; to prove beyond the information that is provided to the Utilization Management team that the services requested are needed.

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

Potential Topics for Future Recommendations:

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

Adjourn
4:02 P.M.

BOARD MEETING MINUTES
March 1, 2018

BOARD MEMBERS

Angela Burke Boston
Jim Donoghue
Eric Kohlsdorf
Dr. Bob Russell
Dr. Jonathan Crosbie (absent)
Dr. Kaaren Vargas

EX-OFFICIO LEGISLATIVE MEMBERS

Representative John Forbes (absent)
Senator Nate Boulton
Representative Shannon Lundgren (absent)
Senator Dennis Guth

Staff

Debbie Johnson
Anna Ruggle
Mike Randol
Kevin Kirkpatrick
Nick Peters

Guests

Natalie Koerber, Amerigroup
Jean Johnson, Department of Public Health-Outreach
Mary Nelle Trefz, Child and Family Policy Center
Joe Estes, MAXIMUS
Jane Brown, UnitedHealthcare
Katie McNamee, VNS
Barbara Neble, Iowa Speech-Language-Hearing Association
Kim Proctor, American Home
Jamie Powell, UnitedHealthcare

CALL TO ORDER

Eric Kohlsdorf called the meeting to order at 3:08 p.m.

The Chair read the following statement:

"This meeting of the hawk-i Board is being held in accord with Section 21.8 of the Code of Iowa entitled "electronic meeting." The Code states that a governmental body may conduct a meeting by electronic means if circumstances

are such that a meeting in person is impossible or impractical or if the governmental body complies with the rules. The rules essentially state that access must be provided to the public. The meeting is being held on a speaker phone in Conference Room 129 of the Iowa Medicaid Enterprise Office Building. An agenda was sent to interested groups as well as the press advising them the meeting will be held via conference call. Minutes will be kept of the meeting."

ROLL CALL

A quorum was present.

APPROVAL OF MINUTES

Motion to approve minutes of the December 18,2017 meeting, made by Angela Burke Boston, second by Kaaren Vargas. MOTION PASSED

DIRECTOR'S REPORT

Director's report was given by Mike Randol and Debbie Johnson. Johnson stated that the enrollment numbers are stable for the most part, and that the finances are on pace for the year. Randol talked about his activities with the legislature and legislative committees.

Kohlsdorf inquired about the federal dollars that will be available for the Children's Health Insurance Program (CHIP) and questioned the amount that is available for the rest of this year. Johnson explained that federal CHIP monies were reallocated for this year, Iowa may receive fewer federal dollars in matching funds but the situation will be monitored closely.

hawk-i Outreach Report

Jean Johnson, Iowa Department of Public Health ***hawk-i*** coordinator, highlighted the success stories she compiled. She encouraged the Board members to read and enjoy the stories.

COMMUNICATIONS UPDATE

Kevin Kirkpatrick reported that a new hawk-i brochure was being designed.

PUBLIC COMMENT

Kohlsdorf asked if there had been in change in speech therapy coverage. Comments were made from the public in attendance about coverage for habiltative/rehabilitative speech services from the MCOs.

Kohlsdorf asked for more history on the coverage for Speech Therapy services. He asked for a detailed report at the next board meeting that includes how much it would

cost to include Speech Therapy for all ***hawk-i*** participants, actuarial support on what the cost would do to benefits, any UnitedHealthcare benchmarks and if there has been a decline in the number of participants receiving speech therapy.

NEW BUSINESS

There was no new business

NEXT MEETING

The next meeting will be May 21, 2018.

ADJOURNMENT

Meeting adjourned at 3:35 p.m.

Submitted by,

Nick Peters, Recorder of Minutes