STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Managed Care Organization (MCO) Quarterly Performance Report

SFY2023, Quarter 4

(April - June 2023)

Published September 2023

Contents

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, and 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 flows as follows:

Executive Summary

This report is based on Quarter 4 of State Fiscal Year (SFY) 2023 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

Notes about the reported data:

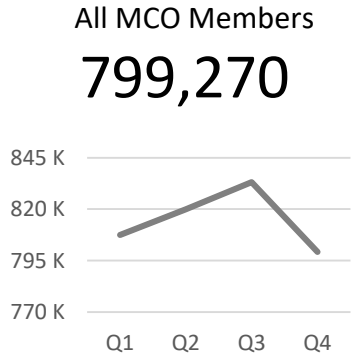
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However, based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.
- Data pulled on other dates may not reflect the same numbers due to reinstatements and eligibility changes.
- 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.
- Providers and members can find more information on the IA Health Link program at: https://hhs.iowa.gov/iahealthlink
- These reports are due to be replaced by a dashboard that is currently under development. Once completed, the dashboard will provide both medical and dental Medicaid data to the public.

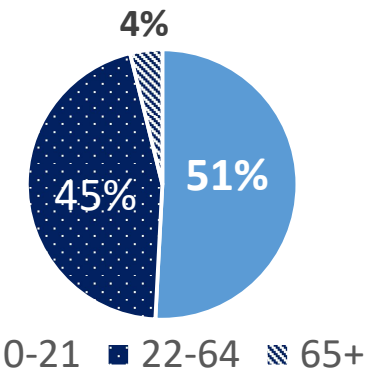
Mission/Vision Statement: Iowa Medicaid is committed to ensuring that all members have access to high quality services that promote dignity, removing barriers to increase health engagement, and improving whole person health. Our vision is operating a sustainable Medicaid program that improves the lives of its members through effective internal and external collaboration, innovative solutions to identified challenges, and data driven program improvement.

MCO Member Summary - All MCO Counts

Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

In Iowa, almost 95% of the Medicaid population is covered by an MCO. Populations not covered by MCOs are provided coverage through the state's Fee-For-Service (FFS) program.





- 33,933 Members
4.07% Decrease

All MCO Enrollment (by Age)

Data Notes: June 2023 data as of August 2023. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Distinct
MCO Member Summary - *Overall Counts*	807,413	819,852	833,203	**799,270**	814,935	**870,005**
0-21	411,121	414,784	419,670	406,070	412,911	434,067
22-64	363,817	371,787	379,544	362,543	369,423	397,667
65+	32,475	33,281	33,989	30,657	32,601	38,271
Fee-For-Service (FFS) - *Non MCO Enrollees*	47,940	49,363	50,689	**49,354**	49,337	**55,074**

Significant Change in Data? (+/-) No [ ] Yes [x]

If Yes, explain:

Iowa Medicaid Population **925,079**
1 year distinct count

This quarter there was a large increase in member disenrollments. This is due to the expiration of Medicaid guideline adjustments put into place to counteract the COVID public health emergency.

MCO Member Summary

Amerigroup (An Anthem Company)	SFY23 Q3	SFY23 Q4
All Members - *by MCO*	452,811	430,406
Traditional Medicaid	281,612	271,661
Wellness Plan - IHAWP/Expansion	129,852	120,090
M-CHIP - Expansion	9,594	9,436
Healthy and Well Kids in Iowa (Hawki)	31,753	29,219
MCO Member Market Share	54.3%	53.8%
Disenrolled	882	130,730
Long-Term Service & Support (LTSS)	21,061	20,293
HCBS Waivers	68.1%	70.9%
Facility Based Services	28.2%	29.1%
HCBS Waivers [1]	14,344	14,378
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,935	5,915
ICF/ID [3]	752	725
Mental Health Institute (MHI)	36	45
Nursing Facilities (NF)	4,808	4,814
Nursing Facilities for Mentally Ill	55	51
Skilled	89	85
PMIC [4]	195	195

iowa total care	SFY23 Q3	SFY23 Q4
All Members - *by MCO*	380,392	368,864
Traditional Medicaid	232,769	225,026
Wellness Plan - IHAWP/Expansion	126,643	118,045
M-CHIP - Expansion	7,240	7,159
Healthy and Well Kids in Iowa (Hawki)	13,740	18,634
MCO Member Market Share	45.7%	46.2%
Disenrolled	732	80,510
Long-Term Service & Support (LTSS)	15,840	15,810
HCBS Waivers	64.1%	64.4%
Facility Based Services	35.9%	35.6%
HCBS Waivers [1]	10,159	10,186
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,681	5,624
ICF/ID [3]	435	410
Mental Health Institute (MHI)	36	35
Nursing Facilities (NF)	4,953	4,928
Nursing Facilities for Mentally Ill	38	35
Skilled	77	74
PMIC [4]	142	142

[1] Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24. [2] Facility Based Services listed above only include the institutional groups where members are most likely to have an option to transition to an HCBS setting. Excluded institution types include Hospice (AGP 414; ITC 425). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

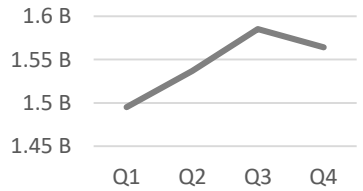
MCO Financial Summary - All MCO Counts

The MCOs receive capitation payments from the State for members' medical services. Capitation payments are made whether or not a provider files a claims with the MCO for services provided to a member.

The MCOs are responsible for recovering Medicaid dollars when it is determined that other insurance coverage is available (e.g. health, auto, worker's comp, or even Medicare). This process is known as Third Party Liability (TPL). The MCO retains all recovered TPL funds: however, these funds are then used to develop future capitation rates.

All Capitation Payments

$1.56 Billion

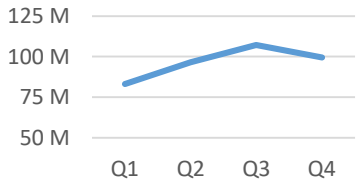


- $21.2 Million

1.34% Decrease

Third Party Liability

$99.4 Million



- $ 7.9 Million

7.4% decrease

Data Notes: June 2023 data as of August 2023. All Third Party Liability (TPL) data reported above is self-reported by MCOs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Financial Summary						
Capitation Payments	$1.5 B	$1.54 B	$1.59 B	**$1.56 B**	$1.55 B	$6.18 B
Third Party Liability (TPL) Recovered	$83.1 M	$96.4 M	$107.3 M	**$99.4 M**	$96.6 M	$386.3 M

Significant Change in Data? (+/-) No [x] Yes [ ]

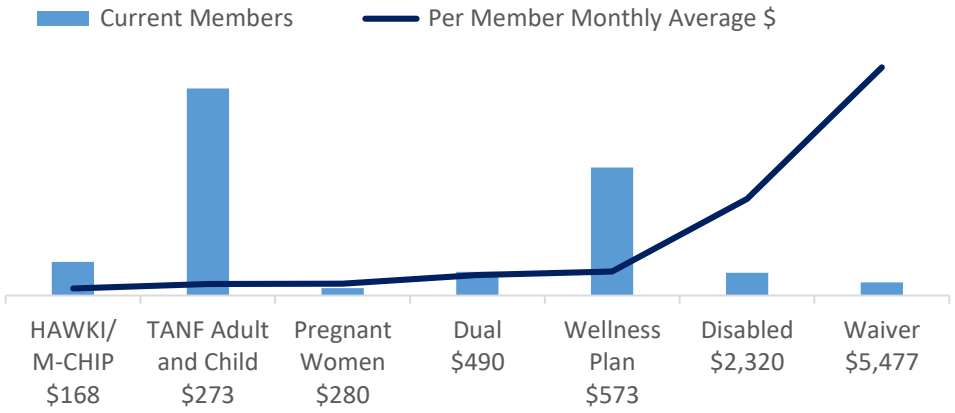
If Yes, explain:

MCO Financial Summary

Per member Medicaid capitation is determined by program eligibility. Medicaid capitation expenditures vary based on member eligibility group size and per member capitation rate. In Iowa, about 50% of all capitation expenditures are allocated to supporting the disabled & waiver eligibility groups.

Medical loss ratios (MLR) capture how much money is spent on medical claims and quality measures versus administrative expenses and profits. By contract, MCOs are required to spend a certain percentage of their capitation payments on claims annually or risk having to return the difference.

Monthly Capitation Expenditures



Amerigroup An Anthem Company

	SFY23 Q3	SFY23 Q4
Capitation Totals	$864.42 M	**$849.67 M**
Adjustments	$14.29 M	$1.52 M
Current	$839.18 M	$832.84 M
Retro	$10.95 M	$15.31 M
Third Party Liability (TPL)	$20.8 M	**$20.0 M**
Financial Ratios		
Medical Loss Ratio (MLR)	96.7%	**96.2%**
Administrative Loss Ratio (ALR)	3.6%	4.5%
Underwriting Ratio (UR)	-0.3%	-0.6%
Unreconciled SFY MLR [5]		96.5%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

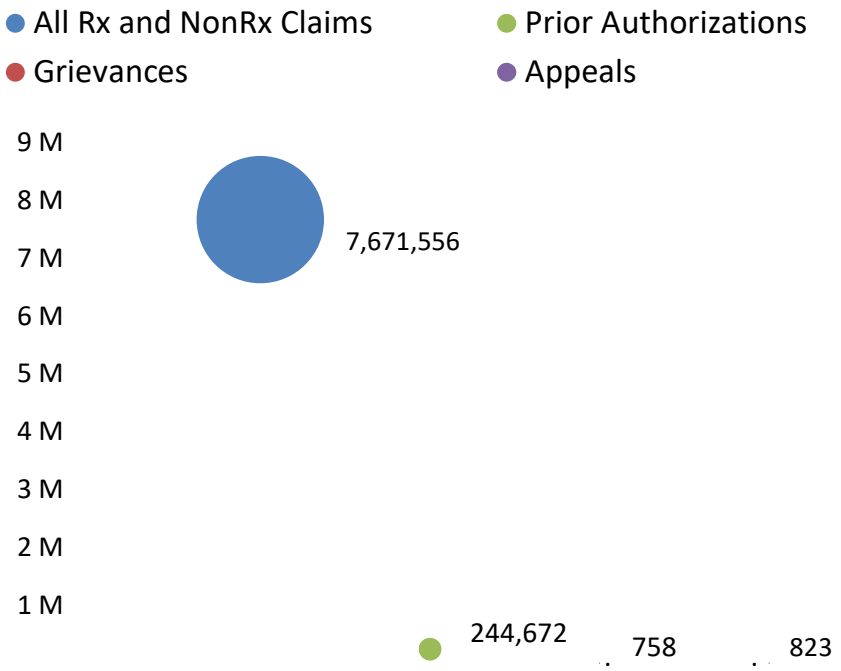
	SFY23 Q3	SFY23 Q4
Capitation Totals	$721.06 M	**$714.58 M**
Adjustments	$12.15 M	$1.25 M
Current	$671.86 M	$689.39 M
Retro	$37.06 M	$23.93 M
Third Party Liability (TPL)	$86.5 M	**$79.4 M**
Financial Ratios		
Medical Loss Ratio (MLR)	97.6%	**97.7%**
Administrative Loss Ratio (ALR)	5.9%	6.0%
Underwriting Ratio (UR)	-3.5%	-3.7%
Unreconciled SFY MLR [5]		98.2%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[5] MLR is unaudited and is now reported to include changes with additional quarters of information during the SFY. Primary drivers that influence changes in the MLR include: 1) estimates for unpaid claims liability, 2) estimates for the impact of the risk corridor and 3) financial review process that may result in expenditure reclassifications.

MCO Claims Universe - All MCO Counts

This illustration provides context to the volume of the following actions in comparison to the overall claims universe:

- Some benefits may require **Prior Authorization** before service
- Members may elect to file a **Grievance** to express general plan dissatisfaction
- Members or Providers may **Appeal** a filed claim based on a reduction in benefits or an outright rejection



	% of Claims Universe
Prior Authorizations	3.19%
Grievances	0.01%
Appeals	0.01%

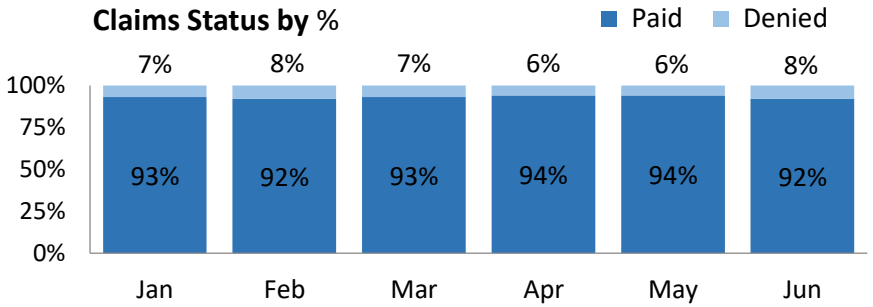
	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.4 M	7.5 M	7.6 M	**7.7 M**	7.5 M	30.1 M
Non-Pharmacy	4.2 M	4.3 M	4.3 M	4.4 M	4.3 M	17.3 M
Pharmacy	3.1 M	3.1 M	3.3 M	3.3 M	3.2 M	12.8 M
Prior Authorization Summary (p. 13-14)	197,872	222,695	240,124	**244,672**	226,341	905,363
Non-Rx - Standard PAs Submitted	146,847	169,055	179,963	182,649	169,629	678,514
Pharmacy - Standard PAs Submitted	51,025	53,640	60,161	62,023	56,712	226,849
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	766	765	913	**758**	801	3,202
Standard Appeals	770	772	831	**823**	799	3,196

Claims Summary (Non-Pharmacy)

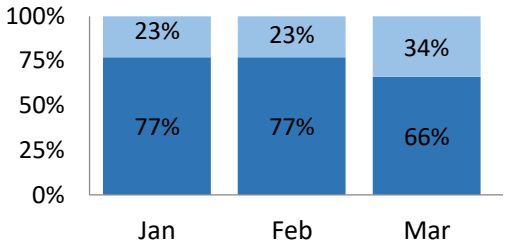
2.42 Million
Claims Paid & Denied

Amerigroup
An Anthem Company

	Apr	May	Jun
All Claims			
Paid	720,361	850,969	690,813
Denied	48,589	55,993	56,816
Suspended	220,353	149,817	183,277
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	97%	97%
in 45-days (Requirement 95%)	98%	99%	98%
Average Days to Pay	7	7	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%



Suspended Claims "Run Out" Status (90-day lag)



- The status of the claims initially reported as "suspended" after 90-days of claims run out.

Top 10 Reasons for Claims Denials (Non-Pharmacy)

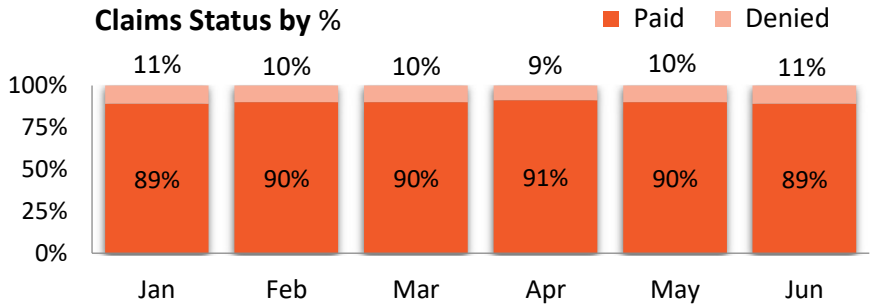
	%	
1.	12%	Duplicate claim/service
2.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	9%	Expenses incurred after coverage terminated
4.	9%	The impact of prior payer(s) adjudication including payments and/or adjustments.
5.	9%	Claim/service lacks information or has submission/billing error(s) - primary payer information required
6.	8%	Attachment/Other Documentation Required
7.	7%	Precertification/authorization/notification absent
8.	5%	Service not payable per managed care contract
9.	3%	Time limt for filing has expired
10.	2%	Incomplete/invalid support data for claim

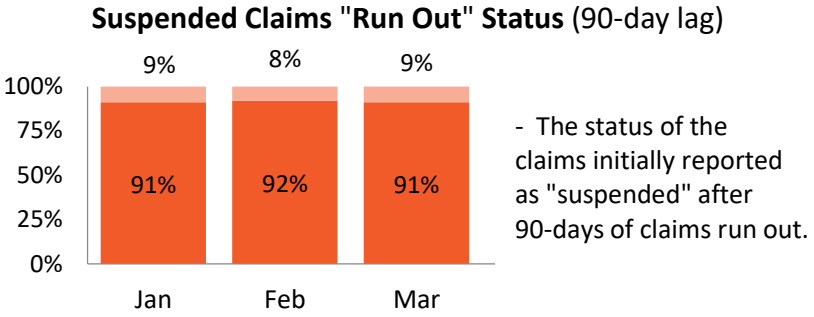
Claims Summary (Non-Pharmacy)

1.98 Million
Claims Paid & Denied

iowa total care

	Apr	May	Jun
All Claims			
Paid	540,070	656,128	580,289
Denied	55,905	76,408	69,699
Suspended	147,968	195,749	125,693
Clean Claims Processed			
in 30-days (Requirement 90%)	98%	98%	97%
in 45-days (Requirement 95%)	99%	100%	99%
Average Days to Pay	9	8	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	100%	99%





- The status of the claims initially reported as "suspended" after 90-days of claims run out.

Top 10 Reasons for Claims Denials (Non-Pharmacy)

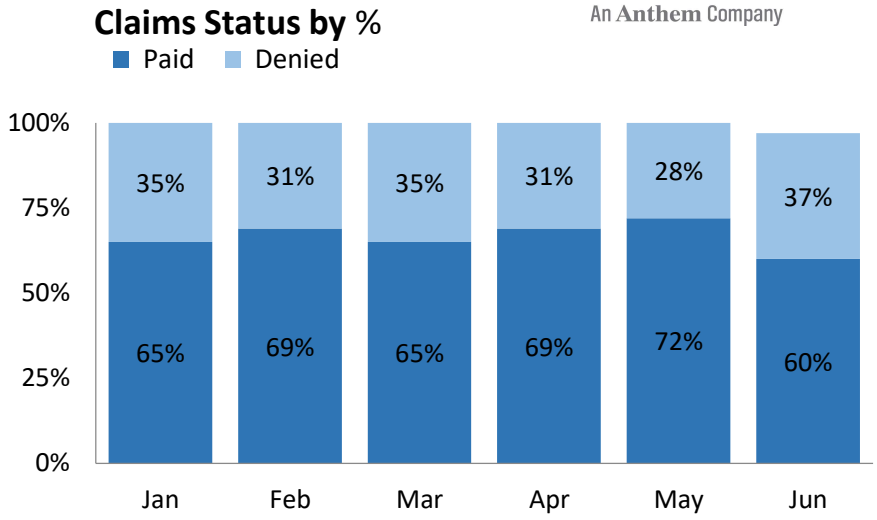
	%	
1.	17%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
2.	11%	Duplicate claim/service
3.	9%	Service can not be combined with other service on same day
4.	6%	No authorization on file that matches service(s) billed
5.	5%	Service is not covered
6.	3%	Void Adjustment
7.	3%	Diagnosis code incorrectly coded per ICD10 manual
8.	2%	Ace Claim level return to provider
9.	2%	Billing NPI not registered with IA DHHS/IA Medicaid
10.	2%	Referring Provider not registered with IA DHHS/ IA Medicaid

Claims Summary (Pharmacy)

1.75 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	366,282	455,391	352,922
Denied	164,425	179,017	233,569
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	11	10

Amerigroup
An Anthem Company



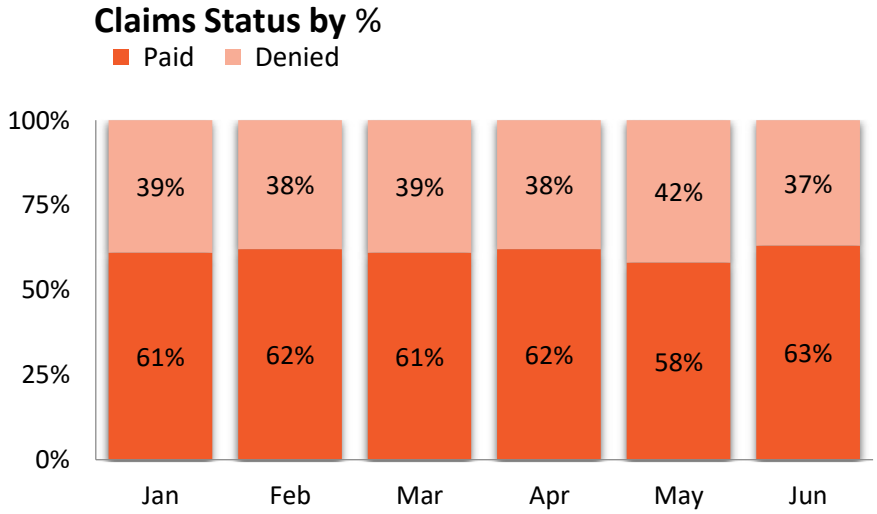
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	29%	Refill too soon
2.	17%	Plan limitations exceeded
3.	12%	Prior authorization required
4.	11%	M/I other coverage code
5.	8%	Submit bill to other processor or primary payer
6.	6%	Filled after coverage terminated
7.	6%	National Drug Code (NDC) not covered
8.	3%	M/I other payer reject code
9.	2%	M/I processor control number
10.	1%	Prescriber is not enrolled in State Medicaid program

Claims Summary (Pharmacy)

1.52 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	297,184	318,097	309,262
Denied	182,548	228,434	182,385
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	10	10	10



Top 10 Reasons for Claims Denials (Pharmacy)

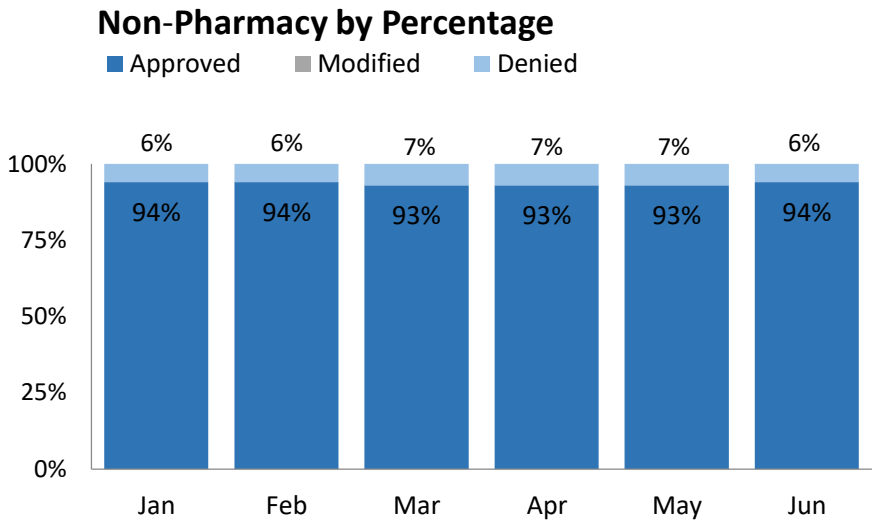
	%	
1.	20%	Plan limitations exceeded
2.	19%	Refill too soon
3.	8%	Prior authorization required
4.	5%	National Drug Code (NDC) not covered
5.	5%	Filled after coverage terminated
6.	4%	Submit bill to other processor or primary payer
7.	2%	Product not covered - non-participating manufacturer
8.	2%	Discrepancy - other coverage code & other payer amount paid
9.	2%	Drug Utilization Review (DUR) reject error
10.	1%	M/I group number

Prior Authorization Summary

93,129
All PAs Submitted [6]

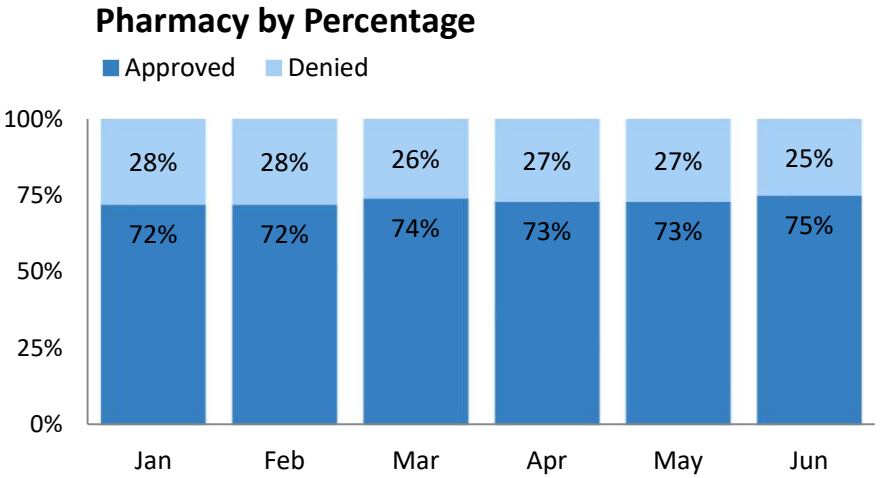
Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	18,325	19,638	18,410
Denied	1,390	1,450	1,261
Modified	0	0	0
Average Days to Process	3	3	3
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	7,793	8,285	7,957
Denied	2,864	3,008	2,722
PAs Completed in 24-hours (Requirement 100%)	100.0%	100.0%	100.0%



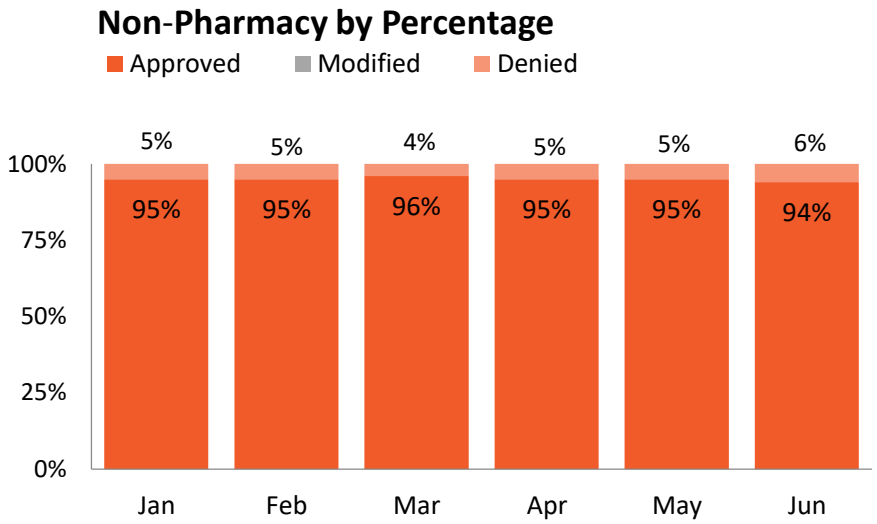
[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

151,543
All PAs Submitted [6]

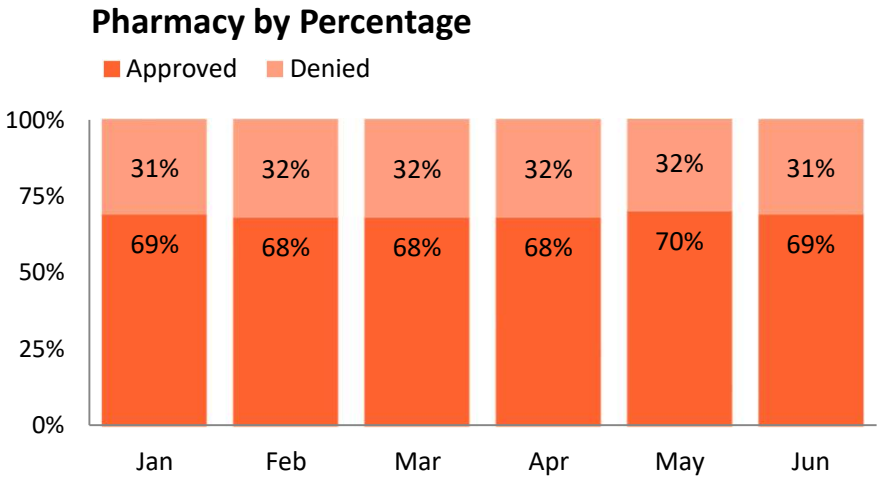
Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	37,950	42,949	36,445
Denied	1,890	2,229	2,215
Modified	0	0	0
Average Days to Process	2	2	2
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	99%	100%



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	5,929	6,531	6,189
Denied	2,747	2,750	2,775
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	100.0%

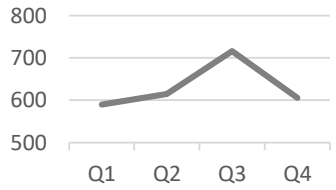


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

Standard Grievances

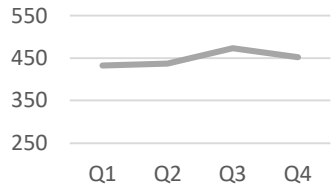
606



Resolved in 30-days
100%

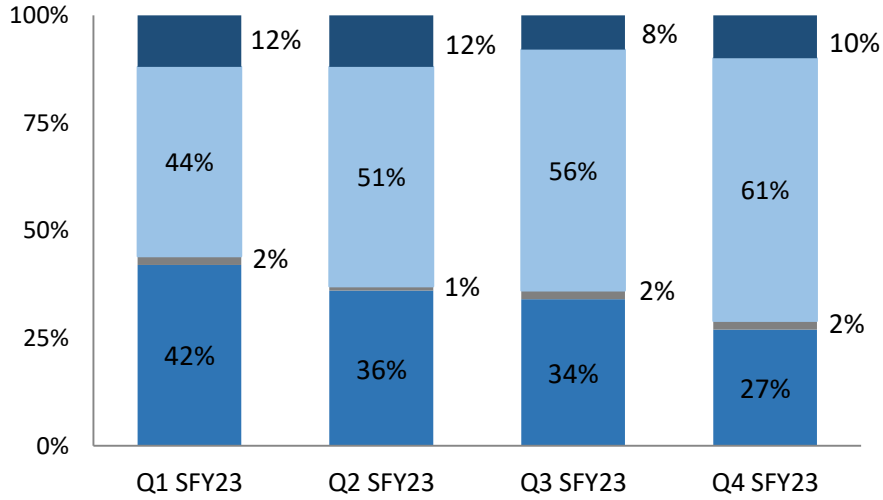
Standard Appeals/ 1st Level Review

452



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	25%	Voluntary Disenrollment
2.	23%	Provider balance billed
3.	5%	Provider Dissatisfaction
4.	5%	Treatment Dissatisfaction
5.	4%	Inadequate benefit access
6.	4%	Transportation - Unsafe Driving
7.	4%	Access to Case Management
8.	3%	Effective Dates of Coverage
9.	3%	Couldn't Obtain Prescription
10.	3%	Poor Customer Service

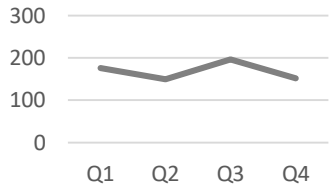
%	Top 10 Reasons for Appeals [7]
25%	Pharmacy - Non Injectable
16%	Pharmacy - Injectable
15%	DME
10%	Outpatient Services - Medical
6%	Radiology
4%	Surgery
4%	Inpatient - Medical
3%	Therapy OT/PT
3%	Pain Mgmt
2%	DME - New Wheelchair

[7] Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Grievances and Appeals

Standard Grievances

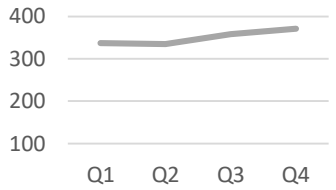
152



Resolved in 30-days
100%

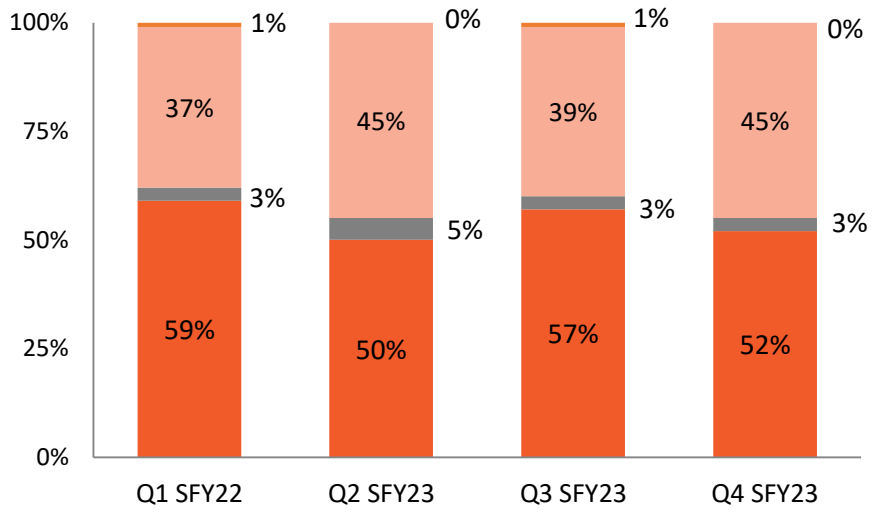
Standard Appeals/ 1st Level Review

371



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	22%	General Complaint Vendor
2.	10%	Unhappy with Benefits
3.	10%	Transportation - Driver did not show
4.	9%	Transportation - Missed Appointment
5.	9%	Lack of Caring/Concern
6.	5%	Provider Not in Network
7.	4%	Transportation - Unsafe Driving
8.	3%	Transportation - Late Appointment
9.	3%	Other
10.	3%	Case Management Complaint

%	Top 10 Reasons for Appeals [7]
19%	RX - Does Not Meet Prior Auth Guidelines
6%	Rehabilitation/Therapy - Physical Therapy
5%	Therapy - Occupational Therapy
4%	LTSS - CDAC
4%	DME - Other - Not Medically Necessary
4%	DME - Wheelchair - Not Medically Necessary
2%	LTSS - Respite
2%	LTSS - SCL
2%	MHN -Outpatient -MHN- Mental Health (Over 18 Years Old)
2%	Diagnostic - MRI - Not Medically Necessary

[7] Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Value Based Purchasing (VBP) Agreement

Value Based Purchasing (VBP) Agreement: An agreement that holds health care providers accountable for both the cost and quality of care they provide by providing payment to improved performance.

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	SFY23 Q3	SFY23 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	64%	74%

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	SFY23 Q3	SFY23 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	98%	96%

Top 5 - Value Added Services (VAS)

Value Added Services (VAS) are optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

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	SFY23 Q3	SFY23 Q4
Healthy Rewards	10,158	8,973
Taking Care of Baby and Me	2,130	1,909
Community Resource Link	1,587	1,539
SafeLink Mobile Phone	1,050	1,261
Dental Hygiene Kit	568	565

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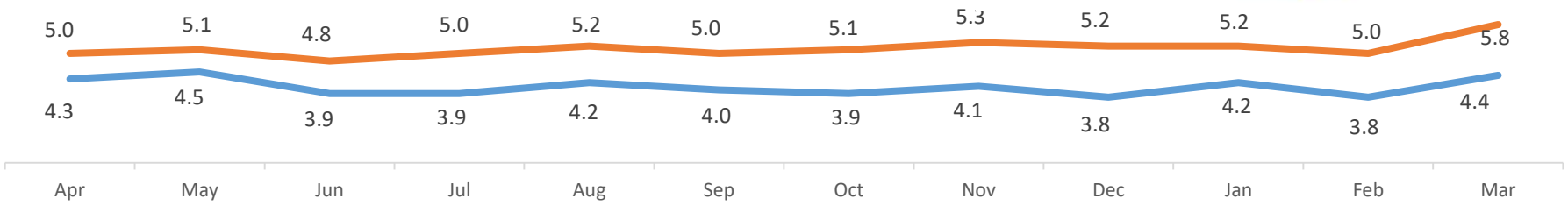
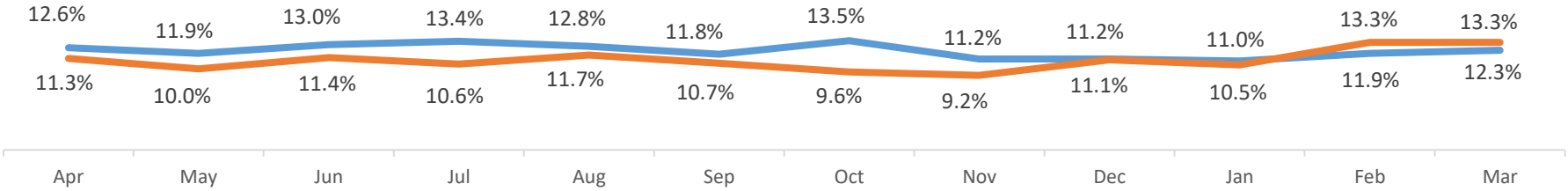
	SFY23 Q3	SFY23 Q4
My Health Pays Program	9,596	7,310
Start Smart for Your Baby	2,000	1,911
Mobile App	2,080	1,745
SafeLink Phones	1,198	1,236
The Flu Program	6,132	760

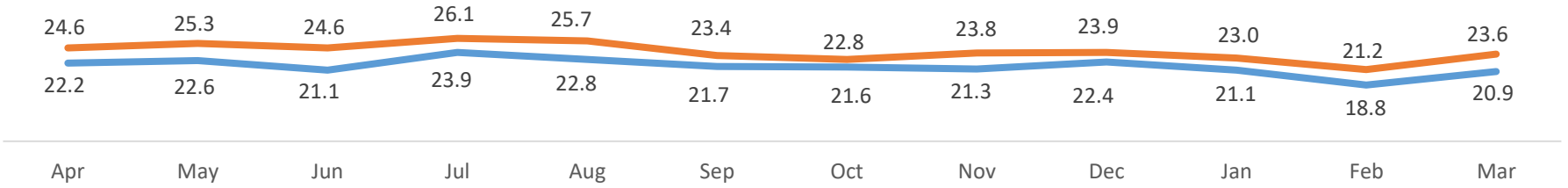
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [8]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [9]



[8] *This measure requires 12 months of continuous enrollment with the MCO.*

[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

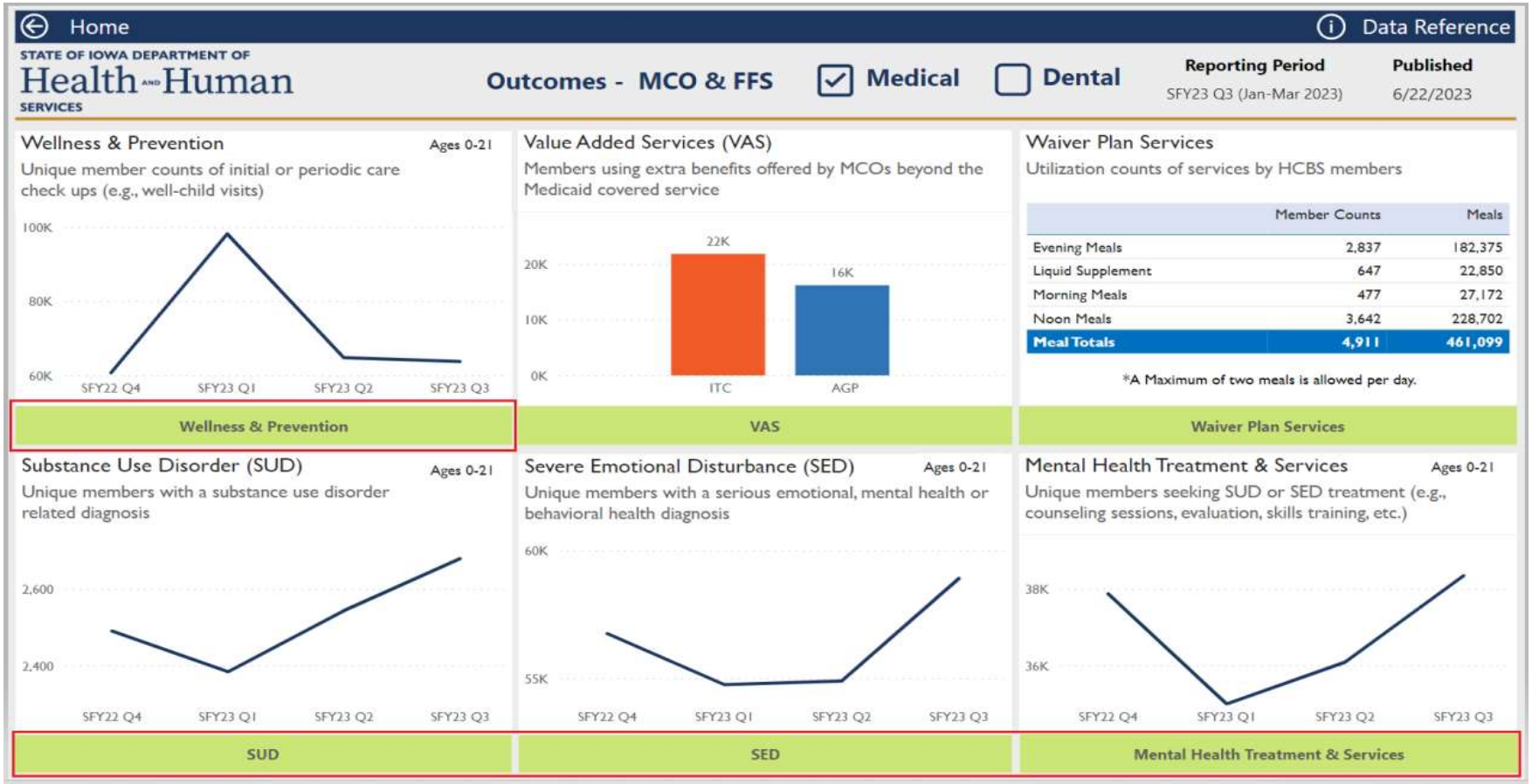
MCO Children Summary

Medicaid-eligible children either qualify for Traditional Medicaid or CHIP (Children's Health Insurance Program). Which eligibility group children qualify for is based on household income status and other factors. In Iowa, CHIP is offered through the Healthy and Well Kids in Iowa (Hawki) program or M-CHIP (Medicaid expansion for kids).

Children (ages 0-21) make up over half of the enrolled MCO population. Of this population, 80% of children are Traditional Medicaid eligible. 20% of MCO enrolled children are CHIP eligible (Hawki/M-CHIP).

Starting in **August 2023**, MCO Children's Summary measures can be found within the Iowa Medicaid Dashboard, located at the Iowa HHS website:

https://hhs.iowa.gov/Iowa-Medicaid-dashboard > Select **Outcomes** > Select **Wellness & Prevention**; **SUD**; **SED**; or **MH Treatment**



Non-LTSS Care Coordination and HCBS Case Management

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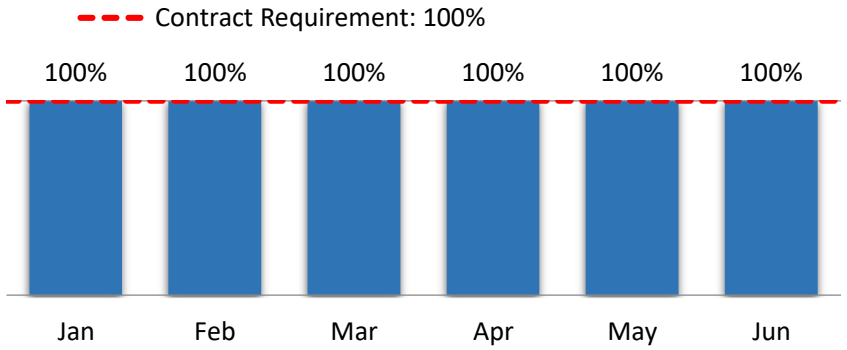
Average Number of Contacts Per Month	SFY23 Q3	SFY23 Q4
by Care Coordinators	2.0	**2.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	15	**14**
HCBS Members to Case Managers	67	**63**

There are no current MCO contract standards for ratios of members to care coordinators or community based case managers. However, MCO contracts do state that members are to be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least 60 days between visits.

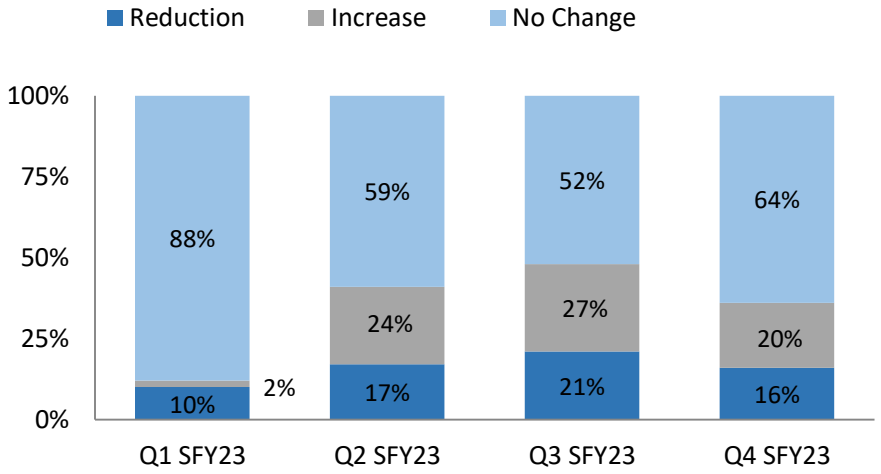
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY23 Q3	SFY23 Q4
They were part of service planning.	I don't know	0.5%	0.5%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.5%	99.5%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	1.0%	0.5%
	No	0.0%	0.5%
	Sometimes	1.4%	1.4%
	Yes	97.6%	97.6%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

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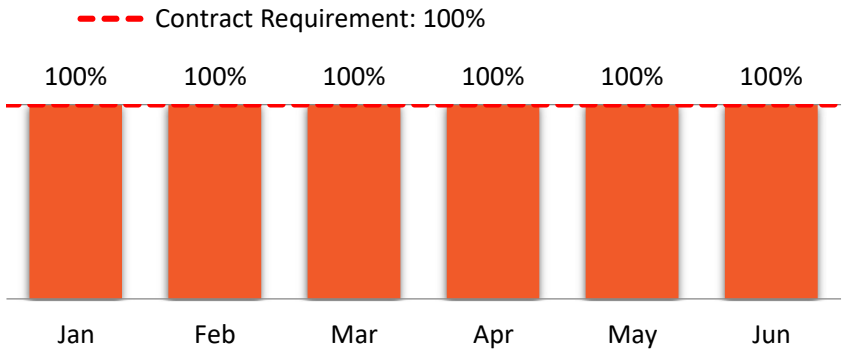
Average Number of Contacts Per Month	SFY23 Q3	SFY23 Q4
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	44	**53**
HCBS Members to Case Managers	44	**48**

MCO contracts also state that community based case managers shall contact HCBS waiver members either at least monthly in person or by telephone with an interval of at least 14 calendar days between contacts. All Level of Care (LOC) and functional need assessments must be updated annually or as a member's needs change

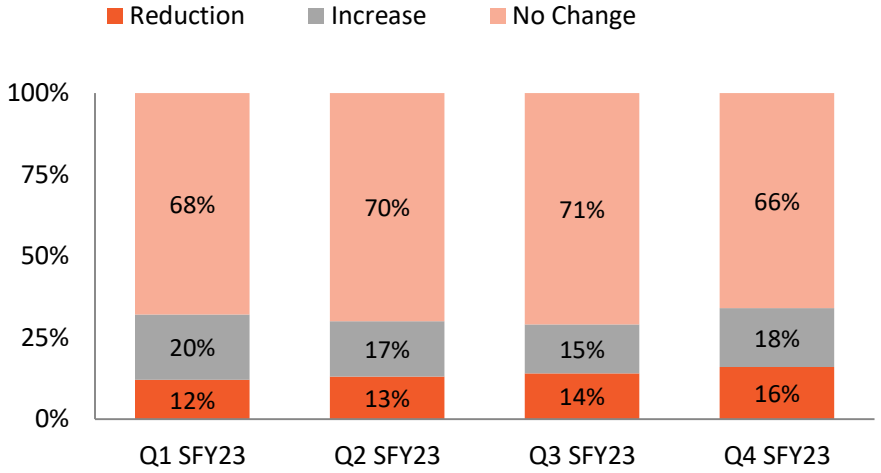
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY23 Q3	SFY23 Q4
They were part of service planning.	I don't know	1.4%	2.7%
	No	0.0%	4.7%
	Sometimes	2.8%	2.7%
	Yes	95.8%	90.7%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	5.6%	1.3%
	Sometimes	2.8%	1.3%
	Yes	91.7%	97.3%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	4.2%	1.3%
	Sometimes	1.4%	2.7%
	Yes	94.4%	96.0%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

Home- and Community-Based Services (HCBS) programs are available for eligible members with disabilities or older Iowans that would otherwise require care in a medical institution. The following information captures the Top 5 services used by members with "active" waiver service plans.

Top 5 Waiver Services

- by Member Usage

	SFY23 Q3	SFY23 Q4
AIDS/HIV - Waiver Member Count	26	27
Home Delivered Meals	18	19
CDAC (agency) by 15 minute units	2	2
Financial Management Services	2	2
Adult Day Care Services - full day	2	1
CDAC (individual) by 15 minute units	1	1
Brain Injury (BI) Waivers	755	759
Supported Community Living (by unit)	205	205
Financial Management Services	200	198
Personal Emergency Response	171	173
Respite (by 15 minute units)	153	151
Supported Community Living (daily)	119	121
Children's Mental Health (CMH)	797	773
Respite (by 15 minute units)	456	441
Respite (Hos/NF) - 15 minute units	235	225
Family and Community Support	187	173
Respite (Resident Camp) by units	19	26
Respite (Resident Camp) by day	0	7
Elderly Waivers	3,925	3,935
Personal Emergency Response	2,692	2,593
Home Delivered Meals	2,627	2,513
CDAC (agency) by 15 minute units	334	409
Assisted Living Services	316	311
CDAC (individual) by 15 minutes	213	248

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	SFY23 Q3	SFY23 Q4
Habilitation (Hab)	4,148	4,150
Home-based Habilitation	3,389	3,418
Long Term Job Coaching	389	387
Day Habilitation (units by day)	326	321
Individual Supported Employment	122	152
Day Habilitation (by 15 minute units)	161	146
Health & Disability (HD)	1,349	1,347
Respite (by 15 minute units)	419	440
Financial Management Services	338	320
Personal Emergency Response	322	306
Home Delivered Meals	308	289
CDAC (individual) by 15 minute units	61	72
Intellectual Disability (ID)	6,930	6,996
Supported Community Living (by unit)	1,855	1,912
Supported Community Living (RCF)	1,525	1,563
Day Habilitation (units by day)	1,322	1,400
Supported Community Living (daily)	1,211	1,250
Long Term Job Coaching	1,080	1,124
Physical Disability (PD)	562	545
Personal Emergency Response	314	312
CDAC (agency) by 15 minute units	53	96
CDAC (individual) by 15 minute units	58	53
Personal Emergency Response (install)	29	35
Home Delivered Meals	22	34

Long Term Services - Waiver Service Plan Participation

All eligible members receive service coordination and a customized individual service plan. For additional information on the HCBS waiver program to include wait list information and a full list of available services, reference: https://hhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services

- by Member Usage

	SFY23 Q3	SFY23 Q4
AIDS/HIV - Waiver Member Count	8	7
Home Delivered Meals	7	7
CDAC (agency) by 15 minute units	3	3
CDAC (individual) by 15 minute units	1	1
Brain Injury (BI) Waivers	529	541
Supported Community Living (by unit)	199	204
Personal Emergency Response	143	141
Supported Community Living (daily)	120	121
Transportation (1-way trip)	91	95
CDAC (agency) by 15 minute units	80	82
Children's Mental Health (CMH)	388	404
Respite (by 15 minute units)	255	272
Respite (Hos/NF) - 15 minute units	159	169
Family and Community Support	106	110
Mental Health Service	46	45
Respite (Resident Camp) by units	13	13
Elderly Waivers	3,687	3,644
Personal Emergency Response	2,723	2,733
Home Delivered Meals	2,718	2,730
CDAC (agency) by 15 minute units	1,404	1,446
Homemaker (by 15 minute units)	727	709
Assisted Living Services	635	659

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	SFY23 Q3	SFY23 Q4
Habilitation (Hab)	2,500	2,536
Home-based Habilitation	1,936	1,955
Day Habilitation (by 15 minute units)	394	418
Day Habilitation (units by day)	311	329
Long Term Job Coaching	275	281
Individual Supported Employment	132	152
Health & Disability (HD)	597	608
Respite (by 15 minute units)	196	196
Home Delivered Meals	158	155
Personal Emergency Response	144	140
CDAC (individual) by 15 minute units	100	96
CDAC (agency) by 15 minute units	94	96
Intellectual Disability (ID)	4,527	4,561
Day Habilitation (by 15 minute units)	1,695	1,724
Supported Community Living (by unit)	1,676	1,669
Day Habilitation (units by day)	1,541	1,562
Supported Community Living (RCF)	1,200	1,210
Supported Community Living	930	958
Physical Disability (PD)	423	423
Personal Emergency Response	231	233
CDAC (agency) by 15 minute units	175	179
CDAC (individual) by 15 minute units	129	127
Transportation (1-way trip)	48	51
Personal Emergency Response (install)	33	30

Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	95.82%	92.94%	95.00%
Abandonment Rate - Must be 5% or less	0.37%	0.93%	0.39%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.79%	99.81%	99.82%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	89.93%	87.46%	86.73%
Abandonment Rate - Must be 5% or less	0.54%	0.68%	0.89%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	94.98%	94.44%	96.16%
Abandonment Rate - Must be 5% or less	0.00%	0.20%	0.07%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	84.34%	85.49%	95.88%
Abandonment Rate - Must be 5% or less	2.63%	2.78%	0.58%

Secret Shopper Scores
- Member Helpline

Secret Shopper Surveys were put on hold in December.

Jan Feb Mar Apr May Jun

Secret Shopper Scores
- Provider Helpline

Secret Shopper Surveys were put on hold in December.

Jan Feb Mar Apr May Jun

Data Notes: Top 5 Call Reasons are captured during the last month of the reporting period.

	Top 5 Call Reasons (Member Helpline)	Top 5 Call Reasons (Provider Helpline)
1.	Benefit Inquiry	Benefit Inquiry
2.	Enrollment Information	Claim Status
3.	Recertification	Authorization Status
4.	ID Card Request or Inquiry	Claim Payment Question or Dispute
5.	Transportation Inquiry	Enrollment Inquiry

Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	95.84%	95.89%	95.68%
Abandonment Rate - Must be 5% or less	1.98%	1.28%	1.27%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	91.46%	97.06%	95.21%
Abandonment Rate - Must be 5% or less	1.43%	0.58%	1.88%
Provider Helpline			
Service Level (Requirement 80%)	94.45%	98.32%	97.47%
Abandonment Rate - Must be 5% or less	0.73%	0.31%	0.37%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	94.52%	94.49%	90.18%
Abandonment Rate - Must be 5% or less	0.15%	0.15%	0.41%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	85.06%	86.56%	96.22%
Abandonment Rate - Must be 5% or less	1.81%	1.98%	0.48%

Secret Shopper Scores
- Member Helpline

Secret Shopper Surveys were put on hold in December.

Jan Feb Mar Apr May Jun

Secret Shopper Scores
- Provider Helpline

Secret Shopper Surveys were put on hold in December.

Jan Feb Mar Apr May Jun

Data Notes: Top 5 Call Reasons are captured during the last month of the reporting period.

	Top 5 Call Reasons (Member Helpline)	Top 5 Call Reasons (Provider Helpline)
1.	Benefits and Eligibility for Member	Benefits and Eligibility for Provider
2.	Coordination Of Benefits for Member	Coordination Of Benefits
3.	Update Preference for Member	Claims Inquiry
4.	Member Rewards for Member	Medical Authorization Inquiry
5.	Materials Fulfillment	Care Authorization for Provider

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4
Adults PCP				
Provider Count	7,093	7,374	6,966	7,603
Members with Access	238,093	237,553	237,034	224,822
Average Distance (Miles)	1.8	1.8	2.0	1.8
Pediatric PCP				
Provider Count	7,124	7,405	6,997	7,638
Members with Access	213,457	212,349	211,612	201,777
Average Distance (Miles)	1.9	1.9	2.2	1.9

Specialty Care & Behavioral Health (BH)

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4
OB/GYN Adult				
Provider Count	440	462	487	468
Members with Access	154,298	154,103	154,071	149,785
Average Distance (Miles)	5.5	5.4	5.3	5.6
Outpatient - Behavioral Health				
Provider Count	4,679	4,880	5,314	5,112
Members with Access	451,550	449,902	448,646	426,599
Average Distance (Miles)	2.2	2.2	1.9	2.0
Inpatient - Behavioral Health				
Provider Count	53	56	56	56
Rural Members				
Members with Access	184,040	183,139	182,392	173,187
Average Distance (Miles)	18.8	18.8	26.4	26.4
Urban Members				
Members with Access	267,510	266,763	266,254	253,412
Average Distance (Miles)	5.7	5.5	5.7	5.5

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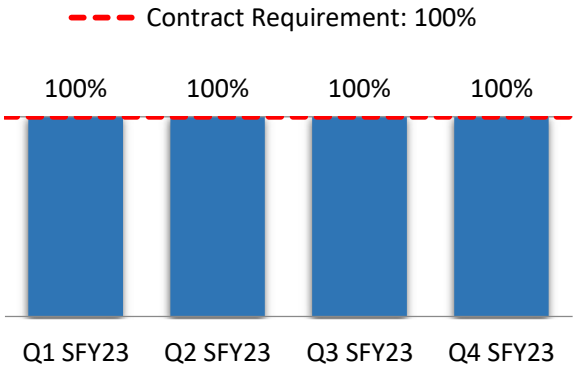
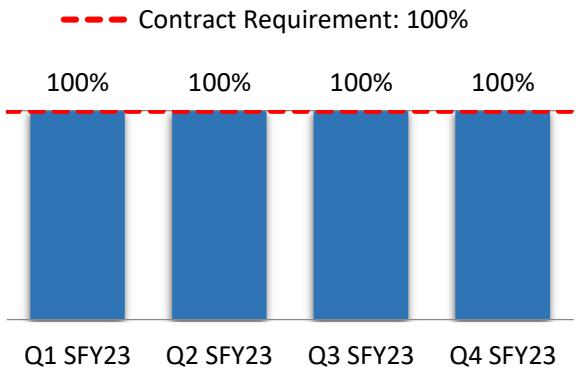
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

https://hhs.iowa.gov/ime/about/performance-data-geoaccess

Provider Network Access Summary

Primary Care Providers (PCP)

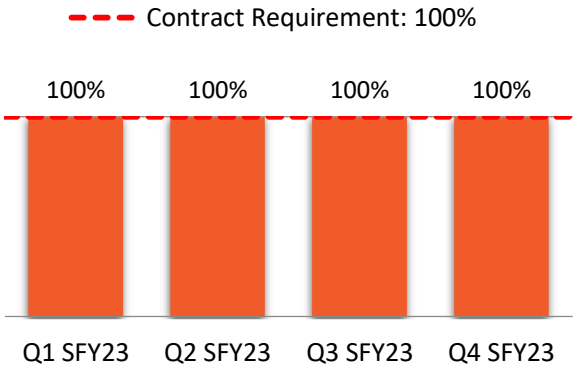
	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4
Adults PCP				
Provider Count	9,894	9,894	7,771	8,048
Members with Access	196,756	206,246	216,380	216,380
Average Distance (Miles)	2.0	2.0	2.2	2.1
Pediatric PCP				
Provider Count	10,658	10,658	8,375	8,663
Members with Access	151,411	155,500	160,395	160,395
Average Distance (Miles)	2.1	2.1	2.3	2.3

Specialty Care & Behavioral Health (BH)

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4
OB/GYN Adult				
Provider Count	1,298	1,298	751	790
Members with Access	127,515	133,013	138,628	138,628
Average Distance (Miles)	5.3	5.3	6.1	6.0
Outpatient - Behavioral Health				
Provider Count	9,688	9,688	5,114	5,362
Members with Access	348,179	361,746	376,790	376,790
Average Distance (Miles)	2.5	2.4	3.0	3.0
Inpatient - Behavioral Health				
Provider Count	36	36	26	25
Rural Members				
Members with Access	249,950	259,591	270,380	270,380
Average Distance (Miles)	24.4	24.4	21.9	24.0
Urban Members				
Members with Access	98,229	102,155	106,410	106,410
Average Distance (Miles)	8.4	8.4	3.6	3.5

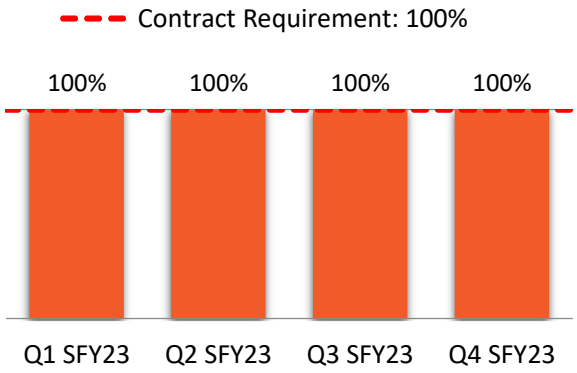
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

https://hhs.iowa.gov/ime/about/performance-data-geoaccess

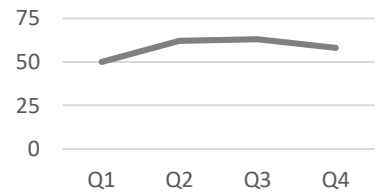
MCO Program Integrity

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.

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 listed in this chart would be considered pending until final determinations are made.

Total Investigations Opened in SFY23 Q4

58



6 Total Cases
Referred to MFCU Q4

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	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Investigations opened	36	41	47	46	43	170
Overpayments identified	14	8	25	9	14	56
Member concerns referred to IME	2	2	3	2	2	9
Cases referred to the Medicaid Fraud Control Unit (MFCU)	3	9	6	2	5	20

iowa total care

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Investigations opened	14	21	16	12	16	63
Overpayments identified	19	21	5	6	13	51
Member concerns referred to IME	4	4	3	8	5	19
Cases referred to the Medicaid Fraud Control Unit (MFCU)	2	6	0	4	3	12

Appendix: Glossary

Abandonment Rate: Percentage of unanswered calls abandoned by the caller after 30 seconds of the call entering the queue. (E.g., caller hangs up before speaking to anyone after waiting more than 30 seconds in a queue.)

Administrative Loss Ratio (**ALR**): See Financial Ratios

Adult Day Care: An organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care setting.

All Cause Readmissions: This measure looks at the rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among beneficiaries assigned.

AIDS/HIV Waiver: A HCBS waiver that offers services for those who have been diagnosed with AIDS or HIV.

Appeal: An appeal is a request for a review of an adverse benefit determination. 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

A member or a member's authorized representative (e.g., provider or lawyer) may file an appeal directly with the MCO (a.k.a. first level review) or with the department (HHS). If filed with the MCO, the MCO has 30-days to try and resolve. If the member and/or provider is not happy with the outcome of the first level review, they may request a State Fair Hearing. See https://hhs.iowa.gov/appeals

Brain Injury (**BI**) **Waiver**: A HCBS waiver that offers services for those who have been diagnosed with a brain injury due to an accident or an illness.

Capitation Expenditures: Medicaid payments the Department makes on a monthly basis to the 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.

- **Adjustments**: Monetary only payments/adjustments that can occur within the paid month for same month or prior months. Example: Program Integrity requests recoupments/adjustments based on their data pulls (date of death, incarceration based on DOC file, etc.). Those requests would process through MMIS and would either make the pay-out amounts higher or lower depending on if they were recoupments or adjustments.

Capitation Expenditures (continued...):

- **Current**: Payments that occur within the paid month for same month
- **Retro**: Monthly mass adjustment processes look at the last 12 months and adjust capitation claims based on any eligibility changes (gender, DOB, MCO removal, Cap group changes) the member had in that timeframe. Capitation would either be adjusted or recouped and that would make the pay-out amounts higher or lower depending on if they were recoupments or adjustments.

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

Case Manager: See Community Based Case Management (CBCM)

Centers for Medicare and Medicaid Service (**CMS**): A federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid standards.

Children's Mental Health (**CMH**) **Waiver**: A HCBS waiver that offers services for children up to age 18, who have been diagnosed with a serious emotional disturbance.

Children's Health Insurance Program (**CHIP**): A federal program administered by state governments to provide health care coverage for children and families whose income is too high to qualify for Medicaid, but too low to afford individual or work-provided health care.

Claims: What providers submit to the MCOs or the Department in order to receive payment for services rendered.

- **Paid**: Claim is received and the provider is reimbursed for the service rendered
- **Denied**: Claim is received and services are not covered benefits, duplicate, or other substantial issues that prevent payment
- **Suspended**: Pending internal review for medical necessity and/or additional information must be submitted for processing
- **Run Out**: Additional time for providers to submit claims for services rendered
- **Provider Adjustment Requests and Errors Reprocessed**:
    - Claims where the provider may request a reopening to fix clerical errors or billing errors
    - Claims identified by the MCOs as erroneously paid or denied which are corrected

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

Community: A natural setting where people live, learn, work, and socialize.

Community Based Case Management (**CBCM**): Helps 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. 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**): Helps people do things that they normally would for themselves if they were able. CDAC services may include unskilled tasks such as bathing, grocery shopping, household chores or skilled tasks such as medication management, tube feeding, recording vital signs. CDAC providers are available through an agency or from an individual such as a family member, friend, or neighbor that meets eligibility requirements.

Denied Claims: See Claims

Department of Human Services (**DHS**): See Health and Human Services (HHS)

Disabled: Group descriptions include: Age Blind Disabled (ABD), Residential Care Facility (RFC), Nursing Facility (NF), Hospice, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), State Mental Health Hospital, and Children in Psychiatric Mental Institutions (PMIC).

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

Dual: Members who have both Medicare and Medicaid benefits.

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

Elderly Waiver: A HCBS waiver that offers services for elderly persons. An applicant must be at least 65 years of age.

Financial Ratios: The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for MCOs is contractually set at 88%.

- **Administrative Loss Ratio** (**ALR**): The percent of capitated rate payments an MCO spends on administrative costs.
- **Medical Loss Ratio** (**MLR**): The percent of capitated rate payments an MCO spends on claims and expenses that improve health care quality of Medicaid members.
- **Underwriting Ratio** (**UR**): If total expenses exceed capitated rate payments, an underwriting loss occurs. If total capitated rate payments exceed total expenses, an underwriting profit occurs.

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:

- Member is unhappy with the quality of your care
- Doctor who the member wants to see is not in the MCO's network
- Member is not able to receive culturally competent care
- Member got a bill from a provider for a service that should be covered by the MCO

Grievance (continued…):

- Rights and dignity
- Any other access to care issues

Habilitation (Hab) Services: A program that provides HCBS for Iowans with the functional impairments typically associated with chronic mental illnesses.

Health & **Disability** (**HD**) **Waiver**: A HCBS waiver that offers services for those persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver.

Healthy and Well Kids in Iowa (**Hawki**): In Iowa, CHIP is offered through the Hawki program. Hawki offers health coverage, through a MCO, for uninsured children of working families. A family who qualifies for Hawki may have to pay a monthly premium.

Health and Human Services (**HHS**): On June 14, 2022, House File 2578 was signed by Iowa Governor Reynolds, creating a Department of Health and Human Services by merging Public Health (IDPH) and Human Services (DHS) into one, single, department.

Home Delivered Meals: Meals that are prepared outside of the member's home and delivered to the member.

Homemaker Services: Services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to essential shopping, limited house cleaning, and meal preparation.

Home and Community Based Services (**HCBS**): Types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.

Inpatient Admissions: A member has formally been admitted to a hospital to receive care.

Intellectual Disability (**ID**) **Waiver**: A HCBS waiver that offers services for persons who have been diagnosed with an intellectual disability.

Intermediate Care Facilities for the Intellectually Disabled (**ICF/ID**): The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify for Medicaid assistance financially.

Iowa Health and Wellness Plan (**IHAWP**): The 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 or Medicaid expansion.

Iowa Insurance Division (**IID**): The state regulator which supervises all insurance business transacted in the state of Iowa.

Iowa Medicaid: The division of Health and Human Services (HHS) that administers the Iowa Medicaid Program.

Iowa Participant Experience Survey (**IPES**): A survey tool developed for use with HCBS programs that asks members about the services they receive, and where the service is provided.

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**): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money.

M-CHIP: Refers to Medicaid CHIP, or Medicaid expansion. M-CHIP provides coverage to children ages 6-18 whose family income is between 122 and 167 percent of the Federal Poverty Level (FPL), and infants whose family income is between 240 and 375 percent of the FPL.

Managed Care Organization (**MCO**): A health plan contracted with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and LTSS.

Medicaid: Provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. Also known as Title XIX under the Social Security Act.

Medicaid Expansion: See Iowa Health and Wellness Plan (IHAWP) and/or M-CHIP

Medicaid Fraud Control Unit (**MFCU**): A division within the Iowa Department of Inspections & Appeals whose primary goal is to prevent abuse of taxpayer resources through professional investigation of criminal activity. MFCU staffs experienced criminal investigators, auditors, and attorneys to achieve this goal.

Medical Loss Ratio (**MLR**): See Financial Ratios

Mental Health Institute (**MHI**): Provide short term psychiatric treatment and care for severe symptoms of mental illness. Iowa has two MHIs located in **Cherokee** and **Independence**. The services at each MHI vary.

Monthly Capitation Expenditures: See Capitation Expenditures

Nursing Facility (**NF**): Provide 24-hour care for individuals who need nursing or skilled nursing care.

Non-Emergent Use: Illnesses or injuries that are generally not life-threatening and do not need immediate treatment at an Emergency Department.

Non-Emergency Medical Transportation (**NEMT**): Services are for members with full Medicaid benefits, who need travel reimbursement or a ride to get to their medical appointments.

Physical Disability (**PD**) **Waiver**: A HCBS waiver that offers services for persons who are physically disabled. An applicant must be at least 18 years of age, but less than 65 years of age.

Prior Authorization (**PA**): 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. Prior Authorizations for pharmaceuticals are becoming more complex and may require more specific data for approval.

Primary Care Provider (**PCP**): 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.

Program Integrity (**PI**): Program Integrity (PI) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Provider Adjustment Requests and Errors Reprocessed: See Claims

Provider Network Access: 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.

Psychiatric Medical Institute for Children (**PMIC**): Institutions which provide more than 24-hours of continuous care involving long-term psychiatric services to three or more children in residence. The expected periods of stay for diagnosis and evaluation are fourteen days or more and for treatment the expected period of stay is 90-days or more.

Reported Reserves: Refer to an MCO's ability to pay their bills and the amount of cash they have on hand to do so.

Service Level (**SL**): In relation to call centers, service level is defined as the percentage of calls answered within a predefined amount of time.

Service Plan: 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: See Nursing Facility

Suspended Claims: See Claims

Temporary Assistance for Needy Families (**TANF**) **Adult and Child**: A program to help needy families achieve self-sufficiency.

Third-Party Liability (**TPL**) **Recovered**: Third party payments include recoveries from health insurance coverage, settlements or court awards for casualty/tort (accident) claims, product liability claims (global settlements), medical malpractice, worker's compensation claims, etc. This means all other available TPL resources must meet their legal obligation to pay claims for the care of an individual eligible for Medicaid. By law, Medicaid is generally the payer of last resort, meaning that Medicaid only pays claims for covered items and services if there are no other liable payers.

Underwriting Ratio (**UR**): See Financial Ratios

Value Added Services (**VAS**): Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can also be found here: https://hhs.iowa.gov/sites/default/files/Comm504.pdf

- **Taking Care of Baby and Me®** (**AGP**): It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

- **My Health Pays** (**ITC**): This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

Value Based Purchasing (**VBP**) **Agreement**: An agreement that holds health care providers accountable for both the cost and quality of care they provide by providing payment to improved performance.

Waivers: See Home and Community Based Services (HCBS) or reference by individual waiver descriptions (Elderly, Physical Disability, Health and Disability, AIDS/HIV, Brian Injury, Intellectual Disability, or Children's Mental Health)

Waiver Service Plan: See Service Plan

Appendix: Oversight Entities - Healthy and Well Kids in Iowa (Hawki) Board

The Hawki Board is a group of people and directors of other state agencies who are appointed by the Governor or who are members of the Legislature. The Hawki Board was established to provide direction to the Iowa Department of Health and Human Services (HHS) on the development, implementation, and ongoing administration of the Hawki program. The Hawki Board is required by law to meet at least six times per year and usually meets on the third Monday of every other month. Anyone may attend and observe a Board meeting. During the meeting, there is time for the public to make comments and ask questions.

See DHS website for all future and historical meeting information: https://hhs.iowa.gov/hawki/hawkiboard

Hawki Board of Directors Member List

Public Members
- MaryNelle Trefz, Chair
- Mary Scieszinski, Vice Chair
- Shawn Garrington
- Mike Stopulos

Statutory Members

Iowa Insurance Division
- Doug Ommen - Commissioner
- Angela Burke Boston - Designee

Iowa Department of Education
- Dr. Ann Lebo - Director
- Jim Donoghue - Designee

Iowa Department of Health and Human Services (HHS)
- Kelly Garcia - Director
- Angie Doyle Scar - Designee

Iowa Medicaid
- Elizabeth (Liz) Matney - Director

Legislative Members - Ex Officio
- Senator Nate Boulton
- Senator Mark Costello
- Representative Shannon Lundgren

Appendix: Oversight Entities - Medical Assistance Advisory Council (MAAC)

The purpose of the Medical Assistance Advisory Council (MAAC) is to "Advise the Director about health and medical care services under the medical assistance program." The Council is mandated by federal law and further established in Iowa Code. MAAC meets quarterly.

See DHS website for all future and historical meeting information: https://hhs.iowa.gov/ime/about/advisory_groups/maac

MAAC Council Member List

Co-Chairpersons
Angela Doyle-Scar, Health and Human Services (HHS)
Jason Haglund, Voting Public Member

Voting Members: Public Representatives
John Dooley, Public Member
Dee Sandquist, Public Member
Amy Shriver, Public Member
Marcie Strouse, Public Member

Voting Members: Professional and Business Entities
Casey Ficek, Iowa Pharmacy Association
Erin Cubit, Iowa Hospital Association
Brandon Hagen, Iowa Health Care Association
Shelly Chandler, Iowa Association of Community Providers
Dennis Tibben, Iowa Medical Society

Members of the General Assembly
Senator Bolkcom
Senator Mark Costello
Representative John Forbes
Representative Ann Meyer

Professional and Business Entities
Angela Van Pelt, Iowa Department of Aging
Cynthia Pedersen, Long-Term Care Ombudsman
Jennifer Harbison, University of Iowa College of Medicine
VACANT, Des Moines University-Osteopathic Medical Center
Anthony Carroll, AARP
Doug Cunningham, the ARC of Iowa
Kristie Oliver, Coalition for Family and Children's Services in Iowa
Wendy Gray, Free Clinics of Iowa
Mary Nelle Trefz, Hawki Board
David Carlyle, Iowa Academy of Family Physicians
Patricia Hildebrand, Iowa Academy of Nutrition and Dietetics
Maria Jordan, Iowa Adult Day Services Association
Dan Royer, Iowa Alliance in Home Care
Helen Royer, Iowa Hearing Association
Cheryll Jones, Iowa Association of Nurse Practitioners
Edward Friedmann, Iowa Association of Rural Health Clinics
Di Findley, Iowa CareGivers
Flora Schmidt, Iowa Behavioral Health Association
Tom Scholz, Iowa Chapter of the American Academy of Pediatrics
Denise Rathman, Iowa Chapter of the National Association of Social Workers
Continued…

MAAC Council Member List continued...

Professional and Business Entities

Molly Lopez, Iowa Chiropractic Society
Laurie Traetow, Iowa Dental Association
Carlyn Crowe (or Brooke Lovelace - back-up), Iowa Developmental Disabilities Council
Sue Whitty, Iowa Nurses Association
Sherry Buske, Iowa Nurse Practitioner Society
Steve Bowen, Iowa Occupational Therapy Association
Gary Ellis, Iowa Optometric Association
Leah McWilliams, Iowa Osteopathic Medical Association
Kate Walton, Iowa Physical Therapy Association
Kevin Kruse, Iowa Podiatric Medical Society
Aaron Todd, Iowa Primary Care Association
Sara Stramel Brewer, Iowa Psychiatric Society
Dave Beeman, Iowa Psychological Association
Barbara Nebel, Iowa Speech-Language-Hearing Association
Deb Eckerman Slack, Iowa State Association of Counties
Matt Blake, Leading Age Iowa
Matt Flatt, Midwest Association for Medical Equipment Services
Peggy Huppert, National Alliance on Mental Illness
Joe Sample, Iowa Association of Area Agencies on Aging
VACANT, Opticians Association of Iowa
VACANT, Iowa Coalition of HCBS for Seniors
VACANT, Iowa Council of Health Care Centers
Marc Doobay, Iowa Physician Assistant Society

Appendix: Oversight Entities - Council on Human Services

There is created within the Department of Human Services a council on human services which shall act in a policymaking and advisory capacity on matters within the jurisdiction of the department. The council shall consist of seven voting members appointed by the governor subject to confirmation by the senate. Appointments shall be made on the basis of interest in public affairs, good judgement, and knowledge and ability in the field of human services. Appointments shall be made to provide a diversity of interest and point of view in the membership and without regard to religious opinions or affiliations. The voting members of the council shall serve for six-year staggered terms.

See DHS website for all future and historical meeting information: https://hhs.iowa.gov/about/dhs-council

Council on Human Services Member List

Iowa Council on Human Services Members

Rebecca Peterson, Clive - Chair
Kimberly Kudej, Swisher - Vice Chair
Sam Wallace, Des Moines
Skylar Mayberry-Mayes, Des Moines
John (Jack) Willey, Maquoketa
Kay Fisk, Mt. Vernon, IA
Monika Jindal, Tiffin, IA

Legislative Members - Ex Officio

Senator Amanda Ragan
Senator Mark Costello
Representative Joel Fry
Representative Timi Brown-Powers

Appendix: Oversight Entities - IA Mental Health & Disability Services (MHDS) Commission

The Iowa Mental Health and Disability Services (MHDS) Commission is the state policy-making body for the provision of services to persons with mental illness, intellectual disabilities or other developmental disabilities, or brain injury. It is authorized by Section 225C.5 of the Code of Iowa.

The Commission currently consists of eighteen voting members appointed by the Governor and confirmed by a two-thirds vote of the Senate. Commission members are appointed on the basis of interest and experience in the fields of mental health, intellectual disabilities or other developmental disabilities, and brain injury, and to ensure adequate representation from persons with disabilities and individuals who have knowledge concerning disability services. The Commission is required to meet at least four times year. Meetings are open to the public.

See MHDS Commission website for all future and historical meeting information: https://hhs.iowa.gov/about/mhds-advisory-groups/commission

MHDS Commission Member List

Voting Members:

Sarah Berndt, CPC Administrator
Teresa Daubitz, Service Advocate (Unity Point)
Sue Gehling, Provider of Children's MHDD Services
Janee Harvey, DHS Director's Nominee
Don Kass, County Supervisor
June Klein-Bacon, Advocate – Brain Injury
Jack Seward, County Supervisor
Jeff Sorensen, County Supervisor
Cory Turner, DHS Director's Nominee
Dr. Kenneth Wayne, Veterans
Russell Wood, Regional Administrator
Richard Whitaker, Community Mental Health Center (Vera French)
Lorrie Young, Substance Abuse Service Provider; Behavioral Health Association
Betsy Akin , Parent or Guardian of an Individual Residing at a State Resource Center
Diane Brecht, ID/DD Providers – Iowa Association of Community Providers

Non-Voting Members:

Senator Jeff Edler, Senate Majority Leader
Representative Dennis Bush, Speaker of the House
Senator Sarah Trone Garriott, Senate Minority Leader
Representative Lindsay James, House Minority Leader

Appendix: Oversight Entities - Office of the State Long-Term Care Ombudsman (OSLTCO)

The Office of the State Long-Term Care Ombudsman (OSLTCO) is an independent entity of the **Iowa Department on Aging**. Its mission is to protect the health, safety, welfare, and rights of individuals residing in long-term care by investigating complaints, seeking resolutions to problems, and providing advocacy with the goal of enhancing quality of life and care.

Operating within the Long-Term Care Ombudsman is a specific **Managed Care Ombudsman Program** (**MCOP**). The MCOP advocates for the rights and needs of Medicaid managed care members in Iowa who live or receive care in a health care facility, assisted living program or elder group home, as well as members enrolled in one of Medicaid's seven home and community-based services (HCBS) waiver programs (AIDS/HIV, Brain Injury, Children's Mental Health, Elderly, Health and Disability, Intellectual Disability and Physical Disability).

Unlike other oversite entities the MCOP does not hold public board or council meetings; however, the program does publish reports and executive summaries highlighting high-level complaint case data received from managed care members (e.g., opened cases by complaint type: access to services, member rights, etc.). See https://iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program

For more information, contact:

Managed Care Ombudsman
510 E 12th St., Ste. 2
Des Moines, IA 50319
(866) 236-1430
ManagedCareOmbudsman@iowa.gov