STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Prepaid Ambulatory Health Plan (PAHP)
Healthy and Well Kids in Iowa (Hawki)
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

Oral disease, including tooth decay and gum disease, is the most common, chronic disease among children in Iowa. Prevention and treatment of oral disease are key to improving overall health outcomes and reducing the cost of dental and medical care. The Dental Dashboard monitors the services provided to Iowa Hawki recipients, reviewing utilization, performance, network adequacy, among other metrics to assure quality service and dental care for Iowa Hawki members.

Delivery System: The Hawki dental fee schedule is determined and administrated by Delta Dental of Iowa, as are any rate increases. The Hawki or CHIP dental plan is much smaller than the adult and other children population and covers over 60,000 members.

Background: Federal and state requirements for dental benefits vary by age and eligibility. The Hawki program for children was implemented in 1999, as part of Medicaid expansion for children and covers Medicaid members that qualify for the Children's Health Insurance Program (CHIP). Hawki provides health and dental insurance coverage to children with family incomes higher than traditional Medicaid but under 302% of the federal poverty level. The plan is comprehensive and designed more like a commercial dental plan, with a $1,000 annual benefit maximum. In 2010, the Hawki Dental-Only program was implemented to assist children that fell within the income guidelines for CHIP with active health insurance coverage but without dental coverage. Hawki and Hawki Dental-Only members are charged a premium depending on income, between $10-$40 a month, to receive dental benefits. The Hawki dental benefit is administered solely through Delta Dental of Iowa.

Monitoring and Oversight: Iowa's Hawki program must comply with all applicable federal program requirements. In addition to meeting requirements, states are granted considerable flexibility to tailor their CHIP to meet the specific priorities, demographics and constraints they face. Performance monitoring and data analysis are critical components in assessing how well the PAHP is improving the quality of care delivered to members. Delta Dental of Iowa submits monthly and quarterly data reports, which provide a snapshot of information on major contract compliance areas and member enrollment. Iowa Medicaid reviews and analyzes this data, monitoring performance and compliance of the dental plan. Iowa Medicaid conducts further analysis and works toward quality improvement with the PAHP as issues are identified.

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.

Additional program related information can be found at https://hhs.iowa.gov/dental-wellness-plan/who-qualifies

PAHP Member Summary - Hawki

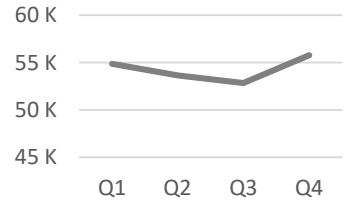
Dental Prepaid Ambulatory Health Plans (PAHP) offer dental insurance benefits for those children in the Healthy and Well Kids in Iowa (Hawki) program. Currently and historically Delta Dental of Iowa is the sole administrator of the dental Hawki program.

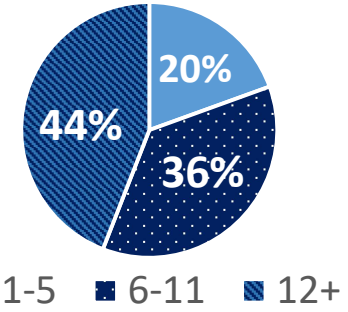
In Iowa, 100% of Hawki members are covered by a PAHP.

M-CHIP members are assigned to PAHPs and managed under the Dental Wellness Plan (DWP).

All Hawki Members

55,799





+ 2,966 Members
5.61% Increase

Hawki Enrollment
(by Age)

Data Notes: June 2023 enrollment data as of August 2023. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters. Because of the capitation structure, M-CHIP is categorized under DWP.

DELTA DENTAL

	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Distinct
Healthy and Well Kids in Iowa (Hawki) - *Total*	54,854	53,636	52,833	55,799	54,281	**55,799**
Dental Only Members	6,691	7,028	7,340	7,946	7,251	7,946
Medical and Dental Members	48,163	46,608	45,493	47,853	47,029	47,853

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

If Yes, explain:

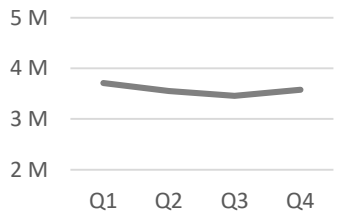
Financial Summary - Hawki

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

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

All Capitation Payments

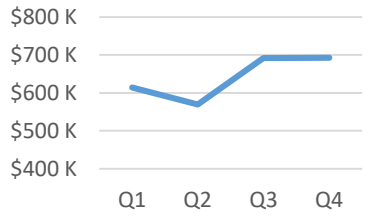
$3.58 Million



+ $115 Thousand
3.3% Increase

Third Party Liability Recovered

$692Thousand



- $.4 Thousand
0.1% Decrease

Data Notes: June 2023 capitation data as of August 2023. All Third Party Liability (TPL) data reported above is self-reported by PAHPs. 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	$3.71 M	$3.55 M	$3.46 M	**$3.58 M**	$3.57 M	$14.30 M
Third Party Liability (TPL) Recovered	$614 K	$570 K	$692 K	**$692 K**	$642 K	$2.57 M

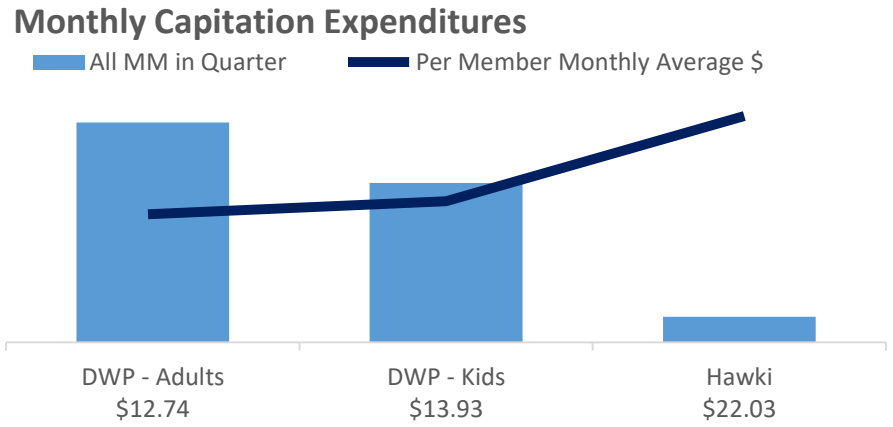
Significant Change in Data? (+/-) No [x] Yes [ ]

If Yes, explain:

Financial Summary - Hawki

Per member Medicaid capitation is determined by the members eligibility group, the applicable provider fee schedule and annual benefit maximums (ABM).

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



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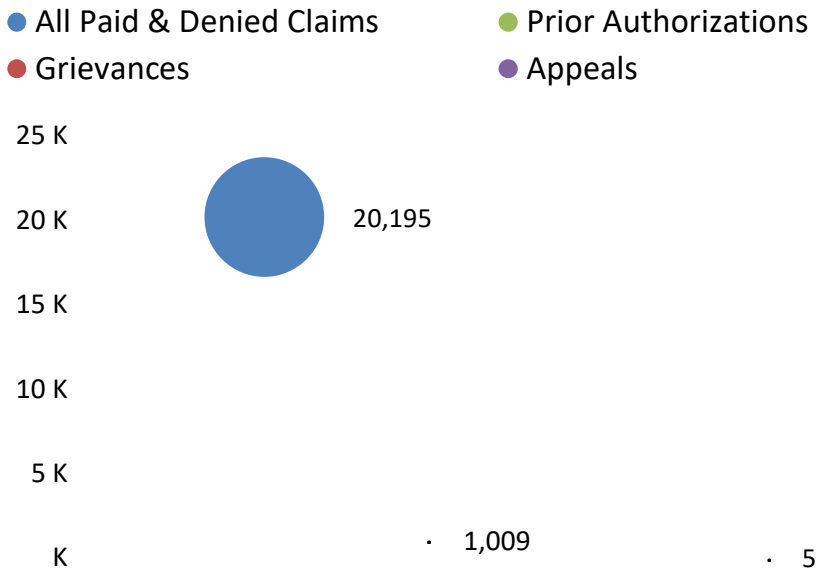
	SFY23 Q3	SFY23 Q4
Capitation Totals	$3.46 M	**$3.57 M**
Adjustments	-$93 K	-$24 K
Current	$3.51 M	$3.58 M
Retro	$40 K	$16 K
Third Party Liability (TPL) Recovered	$692 K	**$692 K**
Financial Ratios		
Medical Loss Ratio (MLR)	86.7%	**86.8%**
Administrative Loss Ratio (ALR)	12.4%	13.6%
Underwriting Ratio (UR)	0.9%	-0.3%
Unreconciled SFY MLR [2]		87.6%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[2] 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.

PAHP Claims Universe - All Hawki 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	5.00%
Grievances	0.00%
Appeals	0.02%

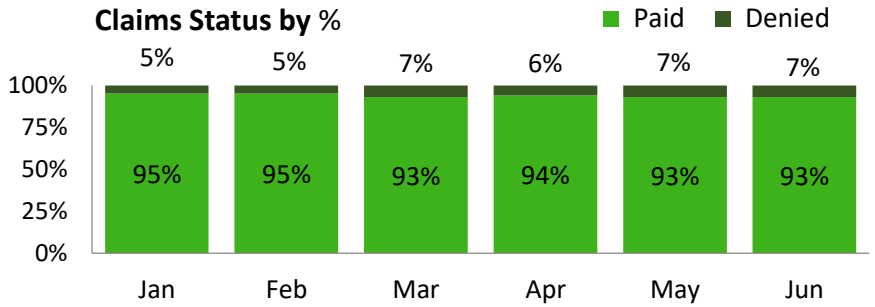
	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Claim Counts - All Paid & **Denied** (p. 9)	21,475	20,417	20,120	**20,195**	20,552	82,207
Prior Authorization Summary (p. 10)	1,173	989	1,000	**1,009**	1,043	4,171
Grievances (p. 11)	0	0	0	**0**	0	0
Appeals Summary (p. 11)	6	7	3	**5**	5	21

Claims Summary - Hawki Counts

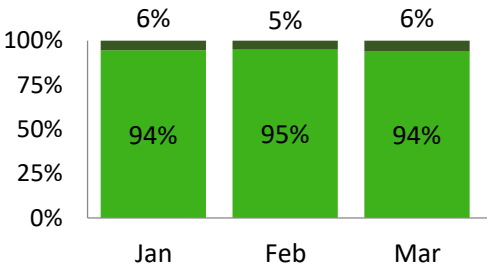
20,195
Claims Paid & Denied

DELTA DENTAL

	Apr	May	Jun
All Claims			
Paid	5,894	7,387	5,612
Denied	355	555	392
Suspended	156	218	142
Clean Claims Processed			
in 14-days (Requirement 90%)	100%	100%	100%
in 21-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	0	0	0
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.

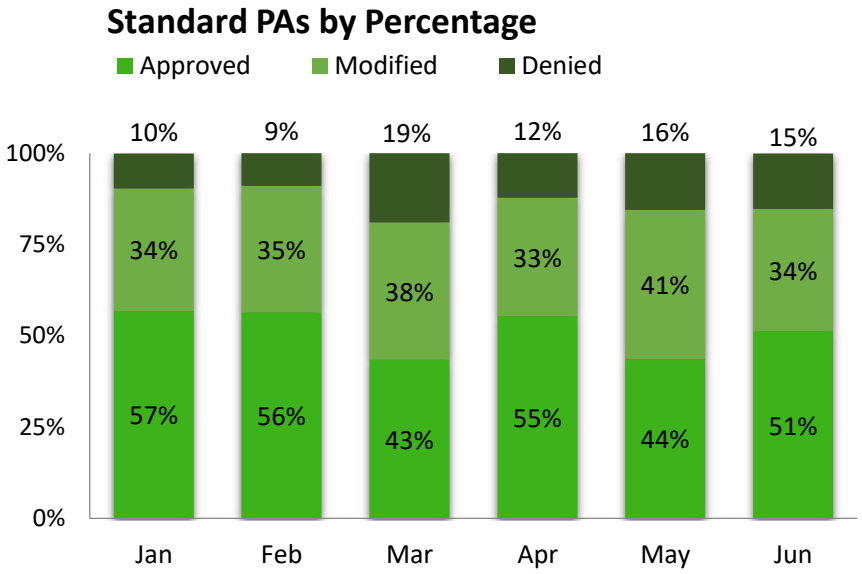
Top 10 Reasons for Claims Denials

	%	
1.	36%	Information submitted does not support this many/frequency of services
2.	33%	Program Guidelines not met
3.	13%	Services not provided by network/primary care providers
4.	9%	Exact duplicate
5.	6%	Benefit for this service is included for another service
6.	3%	Expenses incurred after coverage termination
7.		
8.		
9.		
10.		

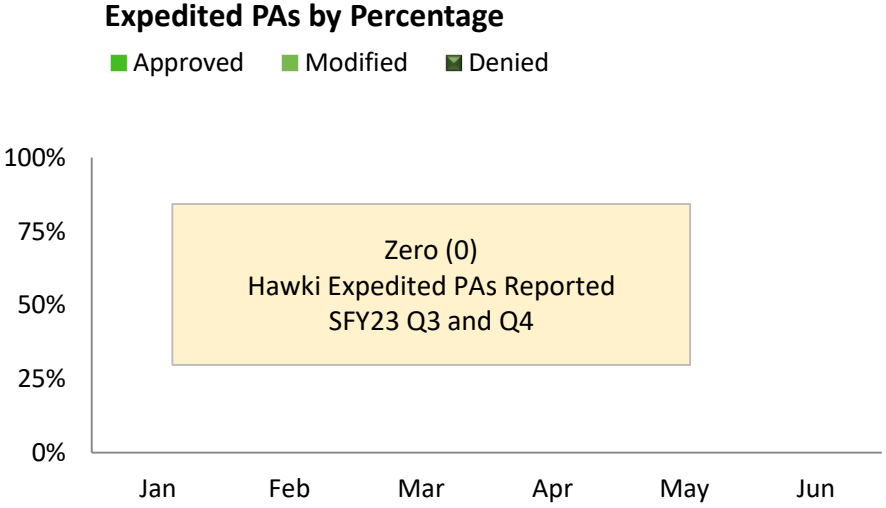
Prior Authorization Summary - Hawki Counts

1,009
All PAs Submitted

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	199	140	168
Denied	44	50	60
Modified	117	131	110
Average Days to Process	1	1	1
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%



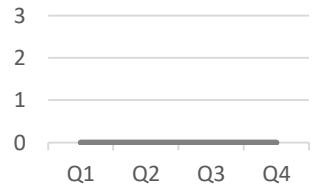
	Apr	May	Jun
Expedited Prior Authorizations (PAs)			
Approved	0	0	0
Denied	0	0	0
Modified	0	0	0
Expedited PAs Completed in 72-hours (Requirement 99%)			



Grievances and Appeals - Hawki Counts

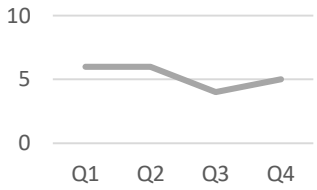
Grievances

0



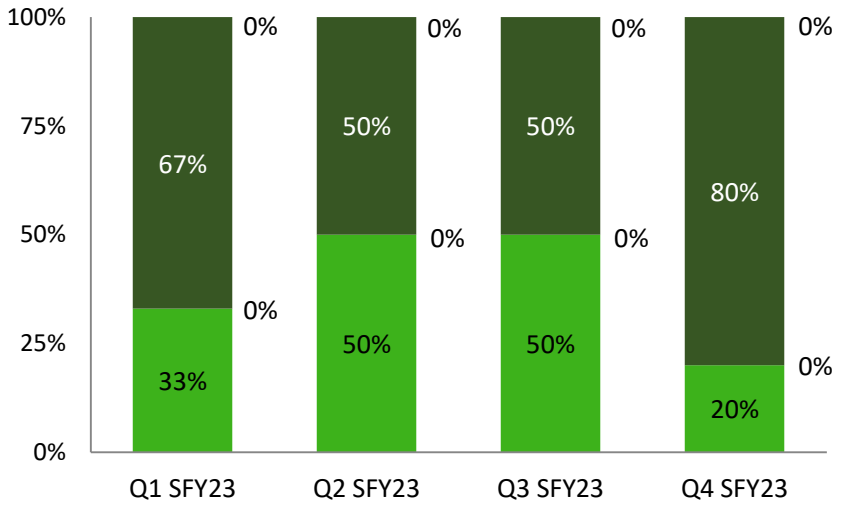
Appeals/ 1st Level Review

5



Resolved in 30-days	Resolved in 30-days
-	80%

Appeal Outcome %



Withdrawn
Partially Overturned
Upheld
Overturned

	%	Top Reasons for Grievances
1.		
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Zero (0)
Hawki Grievances Reported
SFY23 Q3

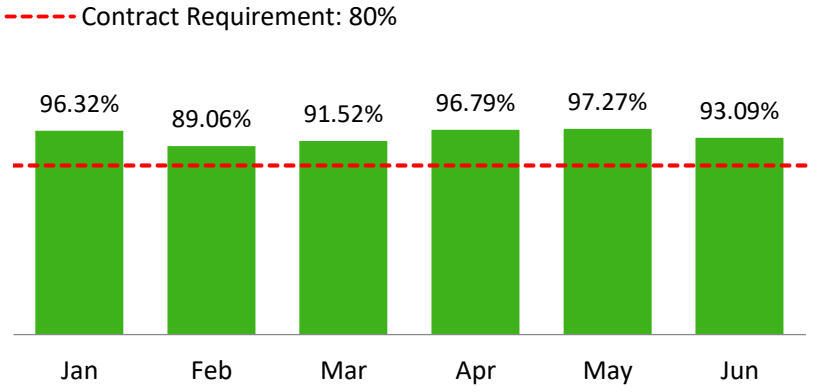
	%	Top Reasons for Appeals
1.	100%	Medical necessity: Orthodontia
2.		
3.		
4.		
5.		
6.		
7.		
8.		
9.		
10.		

Call Center Performance Metrics - Hawki Counts

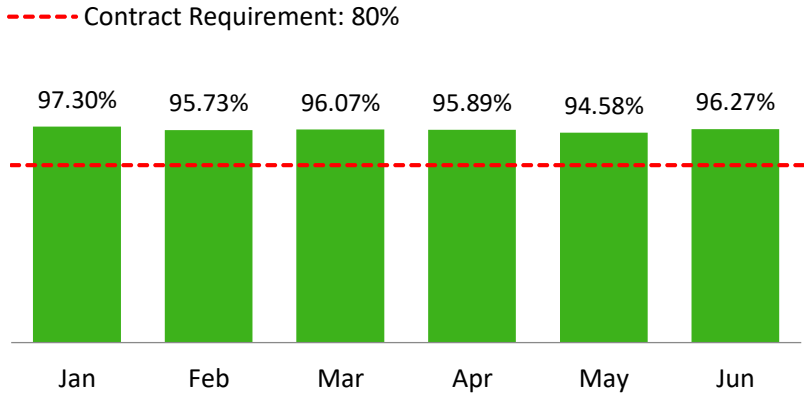
DELTA DENTAL

	Jan	Feb	Mar	Apr	May	Jun
Member Helpline						
Service Level (Requirement 80%)	96.32%	89.06%	91.52%	96.79%	97.27%	93.09%
Abandonment Rate - Must be 5% or less	0.84%	1.16%	0.00%	0.00%	0.00%	0.27%
Provider Helpline						
Service Level (Requirement 80%)	97.30%	95.73%	96.07%	95.89%	94.58%	96.27%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%	0.00%	0.43%	0.00%

Member Helpline - Service Level



Provider Helpline - Service Level



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

	Top 5 Call Reasons (Member Helpline) [5]	Top 5 Call Reasons (Provider Helpline) [5]
1.	Benefit Inquiry	Benefit Inquiry
2.	Claims Related	Claims Related
3.	Eligibility Inquiry	Eligibility Inquiry
4.	ID Card Related	
5.	Provider Related	

[5] Delta's call center does not track calls answered via voice recognition.

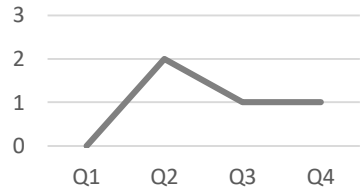
Program Integrity - Hawki Counts

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 Dental Plans, 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 Dental Plan 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

1



0 Total Cases
Referred to MFCU Q4

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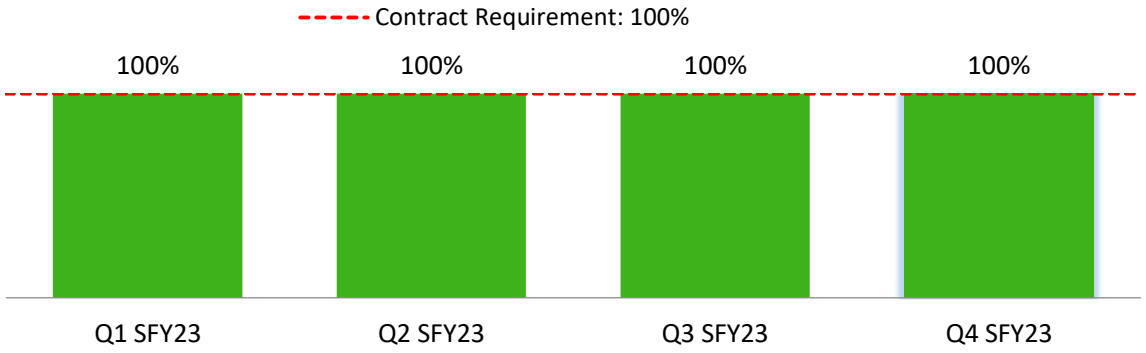
	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4	Average	Total
Investigations opened	0	2	1	1	1	4
Overpayments identified	-	1	-	1	1	2
Member concerns referred to IME	0	0	-	0	0	0
Cases referred to the Medicaid Fraud Control Unit (MCFU)	0	1	-	0	0	1

Provider Network Access Summary - Hawki Counts

Access Primary Care Dentist	SFY23 Q1	SFY23 Q2	SFY23 Q3	SFY23 Q4
Hawki				
Members with Access	54,755	53,524	52,667	55,512
Primary Care Dentists	1,092	1,085	1,081	1,123

General Dentist Time and Distance Standards

60 minutes or 60 miles



Link to Geo Access Reports:

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

Annual Benefit Maximum

A $ 1,000 Annual Benefit Maximum (ABM) applies to the **Hawki** population. On a State-Fiscal-Year-To-Date (SFYTD) basis, the state monitors the cumulative count of members that have reached the ABM.

	SFYTD	
DELTA DENTAL	Count	% of Total
The total number of members that have met their ABM during SFY.	2,358	4.23%

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

Annual Benefit Maximum (**ABM**): A $1,000 maximum state fiscal year (July 1 to June 30) benefit limit that applies to every adult Medicaid member, age 21 and older, as well as the Hawki population. By program design, certain services are excluded from the ABM calculation including emergency dental services.

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 PAHP to act within required time-frames.
- For a resident of a rural area with only one PAHP, 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 PAHP (a.k.a. first level review) or with the department (HHS). If filed with the PAHP, the PAHP 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

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.

- **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.

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 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 PAHP 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 PAHP 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.

Delta Dental of Iowa (**Delta**): An Iowa licensed dental insurance carrier utilized by the Department of Health and Human Services to administer assigned Dental Wellness Plan and Hawki members.

Denied Claims: See Claims

Dental Plan: see PAHP

Dental Wellness Plan (**DWP**): Medicaid Dental Coverage that is not Hawki split into

- DWP-Adults (DWP-A) those non-Hawki members 19+ and older
- DWP-Kids (DWP-K) those non-Hawki members 18 and older

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 PAHP to an alternate PAHP.

Financial Ratios: Affordable Care Act requires insurance companies to spend a certain percentage of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for PAHPs is contractually set between 89.1 and 89.5% depending on PAHP and product (Dental Wellness Plan or Hawki).

- **Administrative Loss Ratio** (**ALR**): The percent of capitated rate payments an PAHP spends on administrative costs.

- **Medical Loss Ratio** (**MLR**): The percent of capitated rate payments an PAHP 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 PAHP. 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 PAHP'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 PAHP
- Rights and dignity
- Any other access to care issues

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.

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

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.

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 of North America (**MCNA**): An Iowa licensed dental insurance carrier utilized by the Department of Health and Human Services to administer assigned Dental Wellness Plan Members.

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

Monthly Capitation Expenditures: See Capitation Expenditures

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

Prepaid Ambulatory Health Plan (**PAHP**): A dental health insurance company retained to manage care for a segment of the population and adjudicate claims funded through capitation

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

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 PAHP has a network of providers across Iowa who their members may see for care. Members don't need to call their PAHP before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the PAHP network. There may be times when a member needs to get services outside of the PAHP 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.

Reported Reserves: Refers to an PAHPs 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.

Suspended Claims: See Claims

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 PAHP outside of the standard Medicaid benefit package. PAHPs use value added services as an incentive to attract members to their plan. Historically, dental value added services have been in the form of gift cards toward dental hygiene items.