Managed Care Program Annual Report (MCPAR) for Iowa: Iowa Health Link

Due date	Last edited	Edited by	Status
12/27/2023	05/06/2024	Michael Egan	In progress

Indicator	Response
Exclusion of CHIP from MCPAR Enrollees in separate CHIP programs funded under Title XXI should not be reported in the MCPAR. Please check this box if the state is unable to remove information about Separate CHIP enrollees from its reporting on this program.	Selected

Section A: Program Information

Point of Contact

Number	Indicator	Response
A1	**State name** Auto-populated from your account profile.	Iowa
A2a	**Contact name** First and last name of the contact person. States that do not wish to list a specific individual on the report are encouraged to use a department or program-wide email address that will allow anyone with questions to quickly reach someone who can provide answers.	Jennifer Steenblock
A2b	**Contact email address** Enter email address. Department or program-wide email addresses ok.	JSTEENB@dhs.state.ia.us
A3a	**Submitter name** CMS receives this data upon submission of this MCPAR report.	Kurt Behrens
A3b	**Submitter email address** CMS receives this data upon submission of this MCPAR report.	kbehren@dhs.state.ia.us
A4	**Date of report submission** CMS receives this date upon submission of this MCPAR report.	12/21/2023

Reporting Period

Number	Indicator	Response
A5a	**Reporting period start date** Auto-populated from report dashboard.	07/01/2022
A5b	**Reporting period end date** Auto-populated from report dashboard.	06/30/2023
A6	**Program name** Auto-populated from report dashboard.	Iowa Health Link

Add plans (A.7)

Enter the name of each plan that participates in the program for which the state is reporting data.

	Indicator	Response
	Plan name	Iowa Total Care, Inc. Amerigroup Iowa, Inc.

Add BSS entities (A.8)

Enter the names of Beneficiary Support System (BSS) entities that support enrollees in the program for which the state is reporting data. Learn more about BSS entities at 42 CFR 438.71. See Glossary in Excel Workbook for the definition of BSS entities.

Examples of BSS entity types include a: State or Local Government Entity, Ombudsman Program, State Health Insurance Program (SHIP), Aging and Disability Resource Network (ADRN), Center for Indepedent Living (CIL), Legal Assistance Organization, Community-based Organization, Subcontractor, Enrollment Broker, Consultant, or Academic/Research Organization.

Indicator	Response
BSS entity name	Iowa Office Of Ombudsmen
	MAXIMUS Health Services, Inc.

Section B: State-Level Indicators

Topic I. Program Characteristics and Enrollment

Number	Indicator	Response
BI.1	**Statewide Medicaid enrollment** Enter the average number of individuals enrolled in Medicaid per month during the reporting year (i.e., average member months). Include all FFS and managed care enrollees and count each person only once, regardless of the delivery system(s) in which they are enrolled.	800,852
BI.2	**Statewide Medicaid managed care enrollment** Enter the average number of individuals enrolled in any type of Medicaid managed care per month during the reporting year (i.e., average member months). Include all managed care programs and count each person only once, even if they are enrolled in multiple managed care programs or plans.	751,498

Topic III. Encounter Data Report

Number	Indicator	Response
BIII.1	**Data validation entity** Select the state agency/division or contractor tasked with evaluating the validity of encounter data submitted by MCPs. Encounter data validation includes verifying the accuracy, completeness, timeliness, and/or consistency of encounter data records submitted to the state by Medicaid managed care plans. Validation steps may include pre-acceptance edits and post-acceptance analyses. See Glossary in Excel Workbook for more information.	State Medicaid agency staff Other state agency staff EQRO Other third-party vendor Proprietary system(s)
BIII.2	**HIPAA compliance of proprietary system(s) for encounter data validation** Were the system(s) utilized fully HIPAA compliant? Select one.	Yes

Topic X: Program Integrity

Number	Indicator	Response
BX.1	**Payment risks between the state and plans** Describe service-specific or other focused PI activities that the state conducted during the past year in this managed care program. Examples include analyses focused on use of long-term services and supports (LTSS) or prescription drugs or activities that focused on specific payment issues to identify, address, and prevent fraud, waste or abuse. Consider data analytics, reviews of under/overutilization, and other activities.	In SFY2023, numerous analytic projects and work was completed and focused on the managed care programs. 1. SURS Reports – Peer to peer comparisons to identify outliers and anomalies (e.g. overutilization) of providers 2. Vulnerability Assessment – More than 100 algorithms were delivered through this FWA reporting service including algorithms addressing COVID vulnerabilities 3. Algorithms – examples listed below: a. Home Delivered Meals b. School Based Services Transportation c. Psychotropic Drug Use in Nursing Homes d. Other activities to note are: i. Continued work on encounter data quality to allow for improved monitoring in areas such as: 1. Client Participation 2. Out of Order Paid Dates 3. Therapy Services Billed During LTC Stay ii. Annual audits on the MCOs. The MCO audit topics include overpayment recovery, algorithms, and electronic visit verification.
BX.2	**Contract standard for overpayments** Does the state allow plans to retain overpayments, require the return of overpayments, or has established a hybrid system? Select one.	State has established a hybrid system
BX.3	**Location of contract provision stating overpayment standard** Describe where the overpayment standard in the previous indicator is located in plan contracts, as required by 42 CFR 438.608(d)(1)(i).	Section 12.8 Recovery of Overpayment

BX.4	**Description of overpayment contract standard** Briefly describe the overpayment standard (for example, details on whether the state allows plans to retain overpayments, requires the plans to return overpayments, or administers a hybrid system) selected in indicator B.X.2.	The managed care plans are allowed to retain any overpayments they collect as a result of their identified overpayments.
BX.5	**State overpayment reporting monitoring** Describe how the state monitors plan performance in reporting overpayments to the state, e.g. does the state track compliance with this requirement and/or timeliness of reporting? The regulations at 438.604(a)(7), 608(a)(2) and 608(a)(3) require plan reporting to the state on various overpayment pieces (whether annually or promptly). This indicator is asking the state how it monitors that reporting.	The managed care plans report overpayment recoveries on a monthly basis. The Department tracks timeliness, accuracy, performance, and completeness of report. The Department reviews the report for the identified overpayments to collect, the monthly amount collected, and the total to date collected. The Department audits the managed care plans to ensure the reported overpayments collected were reported correctly and the overpayments were collected by the managed care plans.
BX.6	**Changes in beneficiary circumstances** Describe how the state ensures timely and accurate reconciliation of enrollment files between the state and plans to ensure appropriate payments for enrollees experiencing a change in status (e.g., incarcerated, deceased, switching plans).	The Department runs a reconciliation of the managed care enrollment files with the incarceration, deceased, and HIPP files to determine if there were capitations payments made for those members. If there were capitation payments made, the Department will pull back capitation payments in the amount identified as being paid in error.
BX.7a	**Changes in provider circumstances: Monitoring plans**	Yes

	Does the state monitor whether plans report provider “for cause” terminations in a timely manner under 42 CFR 438.608(a)(4)? Select one.	
BX.7b	**Changes in provider circumstances: Metrics** Does the state use a metric or indicator to assess plan reporting performance? Select one.	Yes
BX.7c	**Changes in provider circumstances: Describe metric** Describe the metric or indicator that the state uses.	The managed care plans are required to report on a monthly basis through the PI reporting their provider actions, which include "for cause" actions.
BX.8a	**Federal database checks: Excluded person or entities** During the state's federal database checks, did the state find any person or entity excluded? Select one. Consistent with the requirements at 42 CFR 455.436 and 438.602, the State must confirm the identity and determine the exclusion status of the MCO, PIHP, PAHP, PCCM or PCCM entity, any subcontractor, as well as any person with an ownership or control interest, or who is an agent or managing employee of the MCO, PIHP, PAHP, PCCM or PCCM entity through routine checks of Federal databases.	No
BX.9a	**Website posting of 5 percent or more ownership control** Does the state post on its website the names of	No

	individuals and entities with 5% or more ownership or control interest in MCOs, PIHPs, PAHPs, PCCMs and PCCM entities and subcontractors? Refer to §455.104 and required by 42 CFR 438.602(g)(3).	
BX.10	**Periodic audits** If the state conducted any audits during the contract year to determine the accuracy, truthfulness, and completeness of the encounter and financial data submitted by the plans, what is the link(s) to the audit results? Refer to 42 CFR 438.602(e).	https://hhs.iowa.gov/programs/welcome-iowa-medicaid/medicaid-news/resources-and-reports/annual-reports MLR Audit will be posted when available

Section C: Program-Level Indicators

Topic I: Program Characteristics

Number	Indicator	Response
C1I.1	**Program contract** Enter the title of the contract between the state and plans participating in the managed care program.	Iowa Health Link - Amerigroup Iowa contract effective date is 4/1/2016; Iowa Health Link - Iowa Total Care contract effective date 7/1/2019
N/A	Enter the date of the contract between the state and plans participating in the managed care program.	04/01/2016
C1I.2	**Contract URL** Provide the hyperlink to the model contract or landing page for executed contracts for the program reported in this program.	https://hhs.iowa.gov/programs/welcome-iowa-medicaid/medicaid-contracts
C1I.3	**Program type** What is the type of MCPs that contract with the state to provide the services covered under the program? Select one.	Managed Care Organization (MCO)
C1I.4a	**Special program benefits** Are any of the four special benefit types covered by the managed care program: (1) behavioral health, (2) long-term services and supports, (3) dental, and (4) transportation, or (5) none of the above? Select one or more. Only list the benefit type if it is a covered service as specified in a contract between the state and managed care plans participating in the program. Benefits available to eligible program enrollees via fee-for-	Behavioral health Long-term services and supports (LTSS) Transportation

	service should not be listed here.	
C1I.4b	**Variation in special benefits** What are any variations in the availability of special benefits within the program (e.g. by service area or population)? Enter "N/A" if not applicable.	N/A
C1I.5	**Program enrollment** Enter the average number of individuals enrolled in this managed care program per month during the reporting year (i.e., average member months).	751,498
C1I.6	**Changes to enrollment or benefits** Briefly explain any major changes to the population enrolled in or benefits provided by the managed care program during the reporting year.	Due to PHE, continuous eligibility was still in place for SFY23.

Topic III: Encounter Data Report

Number	Indicator	Response
C1III.1	**Uses of encounter data** For what purposes does the state use encounter data collected from managed care plans (MCPs)? Select one or more. Federal regulations require that states, through their contracts with MCPs, collect and maintain sufficient enrollee encounter data to identify the provider who delivers any item(s) or service(s) to enrollees (42 CFR 438.242(c)(1)).	Rate setting Quality/performance measurement Monitoring and reporting Contract oversight Program integrity Policy making and decision support
C1III.2	**Criteria/measures to evaluate MCP performance** What types of measures are used by the state to evaluate managed care plan performance in encounter data submission and correction? Select one or more. Federal regulations also require that states validate that submitted enrollee encounter data they receive is a complete and accurate representation of the services provided to enrollees under the contract between the state and the MCO, PIHP, or PAHP. 42 CFR 438.242(d).	Timeliness of initial data submissions Use of correct file formats Provider ID field complete Overall data accuracy (as determined through data validation) Other, specify – EQR Study Reports are conducted. In addition, ad hoc analysis of the encounter data is performed to identify data quality issues which are remediated with the MCP
C1III.3	**Encounter data performance criteria contract language** Provide reference(s) to the contract section(s) that describe the criteria by which managed care plan performance on encounter data submission and correction will be measured. Use contract	13.1 c 1-4, 13.1.1.19, 13.5, 15.1.1.16

	section references, not page numbers.	
C1III.4	**Financial penalties contract language** Provide reference(s) to the contract section(s) that describes any financial penalties the state may impose on plans for the types of failures to meet encounter data submission and quality standards. Use contract section references, not page numbers.	Exhibit E, Table E1
C1III.5	**Incentives for encounter data quality** Describe the types of incentives that may be awarded to managed care plans for encounter data quality. Reply with "N/A" if the plan does not use incentives to award encounter data quality.	N/A
C1III.6	**Barriers to collecting/validating encounter data** Describe any barriers to collecting and/or validating managed care plan encounter data that the state has experienced during the reporting period.	A key barrier to validating encounter data are related to manual validation processes.

Topic IV. Appeals, State Fair Hearings & Grievances

Number	Indicator	Response
C1IV.1	**State's definition of "critical incident," as used for reporting purposes in its MLTSS program** If this report is being completed for a managed care program that covers LTSS, what is the definition that the state uses for "critical incidents" within the managed care program? Respond with "N/A" if the managed care program does not cover LTSS.	Iowa Code 441-77.46(1)d(1) identifies a "Major Incident" a means an occurrence involving a member enrolled in HCBS waiver or Habilitation services that: 1. Results in a physical injury to or by the member that requires a physician's treatment or admission to a hospital; 2. Results in the death of any person; 3. Requires emergency mental health treatment for the member; 4. Requires the intervention of law enforcement; 5. Requires a report of child abuse pursuant to Iowa Code section 232.69 or a report of dependent adult abuse pursuant to Iowa Code section 235B.3; 6. Constitutes a prescription medication error or a pattern of medication errors that leads to the outcome in paragraph "1," "2," or "3"; or 7. Involves a member's location being unknown by provider staff who are assigned protective oversight. A Major Incident is synonymous with "Critical Incident".
C1IV.2	**State definition of "timely" resolution for standard appeals** Provide the state's definition of timely resolution for standard appeals in the managed care program. Per 42 CFR §438.408(b)(2), states must establish a timeframe for timely resolution of standard appeals that is no longer than 30 calendar days from the day the MCO, PIHP or PAHP receives the appeal.	8.15.4 (2) Standard resolution of appeals. For standard resolution of an appeal, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this subsection.
C1IV.3	**State definition of "timely" resolution for expedited appeals**	8.15.4 (3) Expedited resolution of appeals. For expedited resolution of an appeal, the Contractor shall resolve and provide notice to

	Provide the state's definition of timely resolution for expedited appeals in the managed care program. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal.	affected parties within 72 hours after the Contractor receives the appeal. This timeframe may be extended under paragraph (c) of this section.
C1IV.4	**State definition of "timely" resolution for grievances** Provide the state's definition of timely resolution for grievances in the managed care program. Per 42 CFR §438.408(b)(1), states must establish a timeframe for timely resolution of grievances that is no longer than 90 calendar days from the day the MCO, PIHP or PAHP receives the grievance.	8.15.4 (b) Specific timeframes—(1) Standard resolution of grievances. For standard resolution of a grievance, the Contractor shall resolve and provide notice to the affected parties within 30 calendar days from the day Contractor receives the grievance.

Topic V. Availability, Accessibility and Network Adequacy

Network Adequacy

Number	Indicator	Response
C1V.1	**Gaps/challenges in network adequacy** What are the state's biggest challenges? Describe any challenges MCPs have maintaining adequate networks and meeting standards.	MCOs met adequacy standards with some exceptions granted. The biggest challenge is identifying specialty providers in rural areas.
C1V.2	**State response to gaps in network adequacy** How does the state work with MCPs to address gaps in network adequacy?	The state provides exceptions to the standard when there are no Medicaid providers enrolled. As a result of stakeholder feedback, we encourage our managed care partners to leverage value-based purchasing arrangements to improve provider reimbursement rates. This creates an opportunity to retain and expand network adequacy.

Access Measures

Describe the measures the state uses to monitor availability, accessibility, and network adequacy. Report at the program level.

Revisions to the Medicaid managed care regulations in 2016 and 2020 built on existing requirements that managed care plans maintain provider networks sufficient to ensure adequate access to covered services by: (1) requiring states to develop quantitative network adequacy standards for at least eight specified provider types if covered under the contract, and to make these standards available online; (2) strengthening network adequacy monitoring requirements; and (3) addressing the needs of people with long-term care service needs (42 CFR 438.66; 42 CFR 438.68).

42 CFR 438.66(e) specifies that the MCPAR must provide information on and an assessment of the availability and accessibility of covered services within the MCO, PHIP, or PAHP contracts, including network adequacy standards for each managed care program.

Access measure total count: 8

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

1 / 8

C2.V.2 Measure standard

60 minutes or miles for 75% of Population 90 minutes or miles for 100% of Population

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Specialty Care	All regions	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

2 / 8

C2.V.2 Measure standard

Inpatient Urban - 60 minutes or miles for Urban Population Inpatient Rural - 90 minutes or miles for Rural Population Outpatient - 30 minutes or miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population

Behavioral health	All regions	Adult and pediatric

C2.V.7 Monitoring Methods

Review of grievances related to access, Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard

3 / 8

C2.V.2 Measure standard

30 minutes or miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Hospital	All regions	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

4 / 8

C2.V.2 Measure standard

2 Providers per County

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-personal care assistant	All regions	MLTSS

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

5 / 8

C2.V.2 Measure standard

Urban: 30 min/ 30 mile Rural: 60 min/ 60 mile 2 per County

C2.V.3 Standard type

Maximum time or distance & Minimum number of network providers.

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-adult day care	All regions	MLTSS

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: provider travels to the enrollee

6 / 8

C2.V.2 Measure standard

2 per County

C2.V.3 Standard type

Minimum number of network providers

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS assistive technology	All regions	MLTSS

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: LTSS-related standard: enrollee travels to the provider

7 / 8

C2.V.2 Measure standard

Urban: 30 min/ 30 mile Rural: 60 min/ 60 mile

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
LTSS-SNF	All regions	MLTSS

C2.V.7 Monitoring Methods

Geomapping, Review of grievances related to access

C2.V.8 Frequency of oversight methods

Quarterly

Complete

C2.V.1 General category: General quantitative availability and accessibility standard 8 / 8

C2.V.2 Measure standard

30 minutes or 30 miles

C2.V.3 Standard type

Maximum time or distance

C2.V.4 Provider	C2.V.5 Region	C2.V.6 Population
Primary care	All Regions	Adult and pediatric

C2.V.7 Monitoring Methods

Geomapping

C2.V.8 Frequency of oversight methods

Quarterly

Topic IX: Beneficiary Support System (BSS)

Number	Indicator	Response
C1IX.1	**BSS website** List the website(s) and/or email address that beneficiaries use to seek assistance from the BSS through electronic means. Separate entries with commas.	Iowa Medicaid Member Services provides enrollment broker and choice counseling services. Information is provided at the following website: https://dhs.iowa.gov/iahealthlink/resources/member-specific Ombudsman: Beneficiaries are able to access services to the Managed Care Ombudsman program through the website and email address provided below. https://iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program ManagedCareOmbudsman@iowa.gov
C1IX.2	**BSS auxiliary aids and services** How do BSS entities offer services in a manner that is accessible to all beneficiaries who need their services, including beneficiaries with disabilities, as required by 42 CFR 438.71(b)(2))? CFR 438.71 requires that the beneficiary support system be accessible in multiple ways including phone, Internet, in-person, and via auxiliary aids and services when requested.	Iowa Medicaid Member Services: Inquiries can be made by contacting Member Services call center by phone, mail or email. Iowa Medicaid Member Services (Monday to Friday from 8 a.m. to 5 p.m.) 1-800-338-8366 (Toll Free) 515-256-4606 (Des Moines Area) 515-725-1351 (Fax) Email: IMEMemberServices@dhs.state.ia.us For telephone accessibility assistance if you are deaf, hard-of-hearing, deaf-blind, or have difficulty speaking, call Relay Iowa TTY at 1-800-735-2942. Ombudsman: Inquires can be made by contacting the Managed Care Ombudsman's office and representatives are available to beneficiaries, even those with disabilities, in person or via-mail to our Des Moines location, via phone, the internet or through our Managed Care Ombudsman email inbox that goes directly to a representative. Beneficiaries can also directly file a complaint or concern with their Managed Care Organization and submit it online: https://iowaaging.gov/state-long-term-care-ombudsman/filing-complaint See contact information below. Managed Care Ombudsman 510 E 12th St., Ste. 2 Des Moines,

		IA 50319 (866) 236-1430 ManagedCareOmbudsman@iowa.gov
C1IX.3	**BSS LTSS program data** How do BSS entities assist the state with identifying, remediating, and resolving systemic issues based on a review of LTSS program data such as grievances and appeals or critical incident data? Refer to 42 CFR 438.71(d)(4).	Reports can be found at this link: https://iowaaging.gov/state-long-term-care-ombudsman/managed-care-ombudsman-program ManagedCareOmbudsman@iowa.gov
C1IX.4	**State evaluation of BSS entity performance** What are steps taken by the state to evaluate the quality, effectiveness, and efficiency of the BSS entities' performance?	Enrollment Broker: Information and Choice Counseling, enrollment, disenrollment, RFI, maintain data, escalate member issues, are monitored by the state contract manager. The Managed Care Ombudsman program is established in state legislation and is an independent, separate entity from the state Medicaid agency.

Topic X: Program Integrity

Number	Indicator	Response
C1X.3	**Prohibited affiliation disclosure** Did any plans disclose prohibited affiliations? If the state took action, enter those actions under D: Plan-level Indicators, Section VIII - Sanctions (Corresponds with Tab D3 in the Excel Workbook). Refer to 42 CFR 438.610(d).	No

Section D: Plan-Level Indicators

Topic I. Program Characteristics & Enrollment

Number	Indicator	Response
D1I.1	**Plan enrollment** Enter the average number of individuals enrolled in the plan per month during the reporting year (i.e., average member months).	**Iowa Total Care, Inc.** 350,271 **Amerigroup Iowa, Inc.** 401,227
D1I.2	**Plan share of Medicaid** What is the plan enrollment (within the specific program) as a percentage of the state's total Medicaid enrollment? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid enrollment (B.I.1)	**Iowa Total Care, Inc.** 43.7% **Amerigroup Iowa, Inc.** 50.1%
D1I.3	**Plan share of any Medicaid managed care** What is the plan enrollment (regardless of program) as a percentage of total Medicaid enrollment in any type of managed care? • Numerator: Plan enrollment (D1.I.1) • Denominator: Statewide Medicaid managed care enrollment (B.I.2)	**Iowa Total Care, Inc.** 46.6% **Amerigroup Iowa, Inc.** 53.4%

Topic II. Financial Performance

Number	Indicator	Response
D1II.1a	**Medical Loss Ratio (MLR)** What is the MLR percentage? Per 42 CFR 438.66(e)(2)(i), the Managed Care Program Annual Report must provide information on the Financial performance of each MCO, PIHP, and PAHP, including MLR experience. If MLR data are not available for this reporting period due to data lags, enter the MLR calculated for the most recently available reporting period and indicate the reporting period in item D1.II.3 below. See Glossary in Excel Workbook for the regulatory definition of MLR.	**Iowa Total Care, Inc.** 92.8% **Amerigroup Iowa, Inc.** 92.6%
D1II.1b	**Level of aggregation** What is the aggregation level that best describes the MLR being reported in the previous indicator? Select one. As permitted under 42 CFR 438.8(i), states are allowed to aggregate data for reporting purposes across programs and populations.	**Iowa Total Care, Inc.** Statewide all programs & populations **Amerigroup Iowa, Inc.** Statewide all programs & populations
D1II.2	**Population specific MLR description** Does the state require plans to submit separate MLR calculations for specific populations served within this program, for example, MLTSS or Group VIII expansion enrollees? If so, describe the populations here. Enter "N/A" if not applicable. See glossary for the regulatory definition of MLR.	**Iowa Total Care, Inc.** N/A **Amerigroup Iowa, Inc.** N/A

D1II.3	**MLR reporting period discrepancies** Does the data reported in item D1.II.1a cover a different time period than the MCPAR report?	**Iowa Total Care, Inc.** Yes **Amerigroup Iowa, Inc.** Yes
N/A	Enter the start date.	**Iowa Total Care, Inc.** 07/01/2021 **Amerigroup Iowa, Inc.** 07/01/2021
N/A	Enter the end date.	**Iowa Total Care, Inc.** 06/30/2022 **Amerigroup Iowa, Inc.** 06/30/2022

Topic III. Encounter Data

Number	Indicator	Response
D1III.1	**Definition of timely encounter data submissions** Describe the state's standard for timely encounter data submissions used in this program. If reporting frequencies and standards differ by type of encounter within this program, please explain.	**Iowa Total Care, Inc.** The Contractor shall submit encounter claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic claims submission standards. The Agency will have all of the remedies provided to it under the Contract, including liquidated damages, for failure to comply with these requirements. Drug encounter data shall be submitted by the Contractor once every other week for adjudicated claims in support of the IME's drug rebate invoicing process identified in section 3.2.6.11. Ninety-nine percent (99%) of encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. The remaining one percent (1%) must be submitted by the 20th of the following month. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data cannot exceed one percent (1%). The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and quality sixty (60) days prior to implementation. **Amerigroup Iowa, Inc.** The Contractor shall submit encounter claims in an electronic format that adheres to the data Specifications set forth by the Agency and in any State or federally mandated electronic claims submission standards. The Agency will

		have all of the remedies provided to it under the Contract, including liquidated damages, for failure to comply with these requirements. Drug encounter data shall be submitted by the Contractor once every other week for adjudicated claims in support of the IME's drug rebate invoicing process identified in section 3.2.6.11. Ninety-nine percent (99%) of encounter data shall be submitted by the 20th of the month subsequent to the month for which data are reflected. The remaining one percent (1%) must be submitted by the 20th of the following month. All corrections to the monthly encounter data submission shall be finalized within forty-five (45) days from the date the initial error report for the month was sent to the Contractor or fifty-nine (59) days from the date the initial encounter data were due. The error rate for encounter data cannot exceed one percent (1%). The Agency will notify the Contractor of changes made to calculate encounter data timeliness, accuracy, and quality sixty (60) days prior to implementation.
D1III.2	**Share of encounter data submissions that met state's timely submission requirements** What percent of the plan's encounter data file submissions (submitted during the reporting period) met state requirements for timely submission? If the state has not yet received any encounter data file submissions for the entire contract period when it submits this report, the state should enter here the percentage of encounter data submissions that were compliant out of the file submissions it has received	**Iowa Total Care, Inc.** 98% **Amerigroup Iowa, Inc.** 98%

	from the managed care plan for the reporting period.	
D1III.3	**Share of encounter data submissions that were HIPAA compliant** What percent of the plan's encounter data submissions (submitted during the reporting period) met state requirements for HIPAA compliance? If the state has not yet received encounter data submissions for the entire contract period when it submits this report, enter here percentage of encounter data submissions that were compliant out of the proportion received from the managed care plan for the reporting period.	**Iowa Total Care, Inc.** 100% **Amerigroup Iowa, Inc.** 100%

Topic IV. Appeals, State Fair Hearings & Grievances

Appeals Overview

Number	Indicator	Response
D1IV.1	**Appeals resolved (at the plan level)** Enter the total number of appeals resolved during the reporting year. An appeal is "resolved" at the plan level when the plan has issued a decision, regardless of whether the decision was wholly or partially favorable or adverse to the beneficiary, and regardless of whether the beneficiary (or the beneficiary's representative) chooses to file a request for a State Fair Hearing or External Medical Review.	**Iowa Total Care, Inc.** 1,453 **Amerigroup Iowa, Inc.** 1,659
D1IV.2	**Active appeals** Enter the total number of appeals still pending or in process (not yet resolved) as of the end of the reporting year.	**Iowa Total Care, Inc.** 69 **Amerigroup Iowa, Inc.** 206
D1IV.3	**Appeals filed on behalf of LTSS users** Enter the total number of appeals filed during the reporting year by or on behalf of LTSS users. Enter “N/A” if not applicable. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was	**Iowa Total Care, Inc.** 239 **Amerigroup Iowa, Inc.** 227

	actively receiving LTSS at the time that the appeal was filed).	
D1IV.4	**Number of critical incidents filed during the reporting period by (or on behalf of) an LTSS user who previously filed an appeal** For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed appeals in the reporting year. If the managed care plan does not cover LTSS, enter “N/A”. Also, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, enter “N/A”. The appeal and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the appeal need to have been filed in relation to delivery of LTSS — they may have been filed for any reason, related to any service received (or desired) by an LTSS user. To calculate this number, states or managed care plans should first identify the LTSS users for whom critical incidents were filed during the reporting year,	**Iowa Total Care, Inc.** 35 **Amerigroup Iowa, Inc.** 56

	then determine whether those enrollees had filed an appeal during the reporting year, and whether the filing of the appeal preceded the filing of the critical incident.	
D1IV.5a	**Standard appeals for which timely resolution was provided** Enter the total number of standard appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(2) for requirements related to timely resolution of standard appeals.	**Iowa Total Care, Inc.** 1,410 **Amerigroup Iowa, Inc.** 1,659
D1IV.5b	**Expedited appeals for which timely resolution was provided** Enter the total number of expedited appeals for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(3) for requirements related to timely resolution of standard appeals.	**Iowa Total Care, Inc.** 42 **Amerigroup Iowa, Inc.** 35
D1IV.6a	**Resolved appeals related to denial of authorization or limited authorization of a service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of authorization for a service not yet rendered or limited authorization of a service. (Appeals related to denial of payment for a service already	**Iowa Total Care, Inc.** 1,399 **Amerigroup Iowa, Inc.** 1,689

	rendered should be counted in indicator D1.IV.6c).	
D1IV.6b	**Resolved appeals related to reduction, suspension, or termination of a previously authorized service** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's reduction, suspension, or termination of a previously authorized service.	**Iowa Total Care, Inc.** 54 **Amerigroup Iowa, Inc.** 30
D1IV.6c	**Resolved appeals related to payment denial** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial, in whole or in part, of payment for a service that was already rendered.	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 0
D1IV.6d	**Resolved appeals related to service timeliness** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to provide services in a timely manner (as defined by the state).	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 0
D1IV.6e	**Resolved appeals related to lack of timely plan response to an appeal or grievance** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's failure to act within the timeframes provided at 42 CFR	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 0

	§438.408(b)(1) and (2) regarding the standard resolution of grievances and appeals.	
D1IV.6f	**Resolved appeals related to plan denial of an enrollee's right to request out-of-network care** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to exercise their right, under 42 CFR §438.52(b)(2)(ii), to obtain services outside the network (only applicable to residents of rural areas with only one MCO).	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 2
D1IV.6g	**Resolved appeals related to denial of an enrollee's request to dispute financial liability** Enter the total number of appeals resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request to dispute a financial liability.	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 0

Appeals by Service

Number of appeals resolved during the reporting period related to various services. Note: A single appeal may be related to multiple service types and may therefore be counted in multiple categories.

Number	Indicator	Response
D1IV.7a	**Resolved appeals related to general inpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include appeals related to inpatient behavioral health services – those should be included in indicator D1.IV.7c. If the managed care plan does not cover general inpatient services, enter "N/A".	**Iowa Total Care, Inc.** 9 **Amerigroup Iowa, Inc.** 67
D1IV.7b	**Resolved appeals related to general outpatient services** Enter the total number of appeals resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Please do not include appeals related to outpatient behavioral health services – those should be included in indicator D1.IV.7d. If the managed care plan does not cover general outpatient services, enter "N/A".	**Iowa Total Care, Inc.** 881 **Amerigroup Iowa, Inc.** 173
D1IV.7c	**Resolved appeals related to inpatient behavioral health services** Enter the total number of appeals resolved by the plan	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.**

	during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover inpatient behavioral health services, enter "N/A".	42
D1IV.7d	**Resolved appeals related to outpatient behavioral health services** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover outpatient behavioral health services, enter "N/A".	**Iowa Total Care, Inc.** 28 **Amerigroup Iowa, Inc.** 25
D1IV.7e	**Resolved appeals related to covered outpatient prescription drugs** Enter the total number of appeals resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover outpatient prescription drugs, enter "N/A".	**Iowa Total Care, Inc.** 476 **Amerigroup Iowa, Inc.** 481
D1IV.7f	**Resolved appeals related to skilled nursing facility (SNF) services** Enter the total number of appeals resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover skilled nursing services, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 15

D1IV.7g	**Resolved appeals related to long-term services and supports (LTSS)** Enter the total number of appeals resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover LTSS services, enter "N/A".	**Iowa Total Care, Inc.** 55 **Amerigroup Iowa, Inc.** 44
D1IV.7h	**Resolved appeals related to dental services** Enter the total number of appeals resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover dental services, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 0
D1IV.7i	**Resolved appeals related to non-emergency medical transportation (NEMT)** Enter the total number of appeals resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover NEMT, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 2
D1IV.7j	**Resolved appeals related to other service types** Enter the total number of appeals resolved by the plan during the reporting year that were related to services that do	**Iowa Total Care, Inc.** 4 **Amerigroup Iowa, Inc.**

	not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.7a-i, enter "N/A".	860

State Fair Hearings

Number	Indicator	Response
D1IV.8a	**State Fair Hearing requests** Enter the total number of State Fair Hearing requests filed during the reporting year with the plan that issued an adverse benefit determination.	**Iowa Total Care, Inc.** 57 **Amerigroup Iowa, Inc.** 82
D1IV.8b	**State Fair Hearings resulting in a favorable decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were partially or fully favorable to the enrollee.	**Iowa Total Care, Inc.** 6 **Amerigroup Iowa, Inc.** 13
D1IV.8c	**State Fair Hearings resulting in an adverse decision for the enrollee** Enter the total number of State Fair Hearing decisions rendered during the reporting year that were adverse for the enrollee.	**Iowa Total Care, Inc.** 10 **Amerigroup Iowa, Inc.** 48
D1IV.8d	**State Fair Hearings retracted prior to reaching a decision** Enter the total number of State Fair Hearing decisions retracted (by the enrollee or the representative who filed a State Fair Hearing request on behalf of the enrollee) during the reporting year prior to reaching a decision.	**Iowa Total Care, Inc.** 36 **Amerigroup Iowa, Inc.** 21
D1IV.9a	**External Medical Reviews resulting in a favorable**	**Iowa Total Care, Inc.**

	decision for the enrollee If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were partially or fully favorable to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	N/A **Amerigroup Iowa, Inc.** N/A
D1IV.9b	**External Medical Reviews resulting in an adverse decision for the enrollee** If your state does offer an external medical review process, enter the total number of external medical review decisions rendered during the reporting year that were adverse to the enrollee. If your state does not offer an external medical review process, enter "N/A". External medical review is defined and described at 42 CFR §438.402(c)(i)(B).	**Iowa Total Care, Inc.** N/A **Amerigroup Iowa, Inc.** N/A

Grievances Overview

Number	Indicator	Response
D1IV.10	**Grievances resolved** Enter the total number of grievances resolved by the plan during the reporting year. A grievance is "resolved" when it has reached completion and been closed by the plan.	**Iowa Total Care, Inc.** 958 **Amerigroup Iowa, Inc.** 2,672
D1IV.11	**Active grievances** Enter the total number of grievances still pending or in process (not yet resolved) as of the end of the reporting year.	**Iowa Total Care, Inc.** 14 **Amerigroup Iowa, Inc.** 314
D1IV.12	**Grievances filed on behalf of LTSS users** Enter the total number of grievances filed during the reporting year by or on behalf of LTSS users. An LTSS user is an enrollee who received at least one LTSS service at any point during the reporting year (regardless of whether the enrollee was actively receiving LTSS at the time that the grievance was filed). If this does not apply, enter N/A.	**Iowa Total Care, Inc.** 199 **Amerigroup Iowa, Inc.** 367
D1IV.13	**Number of critical incidents filed during the reporting period by (or on behalf of) an**	**Iowa Total Care, Inc.** 73

LTSS user who previously filed a grievance

For managed care plans that cover LTSS, enter the number of critical incidents filed within the reporting period by (or on behalf of) LTSS users who previously filed grievances in the reporting year. The grievance and critical incident do not have to have been "related" to the same issue - they only need to have been filed by (or on behalf of) the same enrollee. Neither the critical incident nor the grievance need to have been filed in relation to delivery of LTSS - they may have been filed for any reason, related to any service received (or desired) by an LTSS user.
If the managed care plan does not cover LTSS, the state should enter "N/A" in this field.
Additionally, if the state already submitted this data for the reporting year via the CMS readiness review appeal and grievance report (because the managed care program or plan were new or serving new populations during the reporting year), and the readiness review tool was submitted for at least 6 months of the reporting year, the state can enter "N/A" in this field.
To calculate this number, states or managed care plans should

Amerigroup Iowa, Inc.

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	first identify the LTSS users for whom critical incidents were filed during the reporting year, then determine whether those enrollees had filed a grievance during the reporting year, and whether the filing of the grievance preceded the filing of the critical incident.	
D1IV.14	**Number of grievances for which timely resolution was provided** Enter the number of grievances for which timely resolution was provided by plan during the reporting period. See 42 CFR §438.408(b)(1) for requirements related to the timely resolution of grievances.	**Iowa Total Care, Inc.** 956 **Amerigroup Iowa, Inc.** 2,661

Grievances by Service

Report the number of grievances resolved by plan during the reporting period by service.

Number	Indicator	Response
D1IV.15a	**Resolved grievances related to general inpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general inpatient care, including diagnostic and laboratory services. Do not include grievances related to inpatient behavioral health services — those should be included in indicator D1.IV.15c. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 174
D1IV.15b	**Resolved grievances related to general outpatient services** Enter the total number of grievances resolved by the plan during the reporting year that were related to general outpatient care, including diagnostic and laboratory services. Do not include grievances related to outpatient behavioral health services — those should be included in indicator D1.IV.15d. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 311

D1IV.15c	**Resolved grievances related to inpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to inpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 13
D1IV.15d	**Resolved grievances related to outpatient behavioral health services** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient mental health and/or substance use services. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 11
D1IV.15e	**Resolved grievances related to coverage of outpatient prescription drugs** Enter the total number of grievances resolved by the plan during the reporting year that were related to outpatient prescription drugs covered by the managed care plan. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 4 **Amerigroup Iowa, Inc.** 205
D1IV.15f	**Resolved grievances related to skilled nursing facility (SNF) services**	**Iowa Total Care, Inc.** 0

	Enter the total number of grievances resolved by the plan during the reporting year that were related to SNF services. If the managed care plan does not cover this type of service, enter "N/A".	**Amerigroup Iowa, Inc.** 0
D1IV.15g	**Resolved grievances related to long-term services and supports (LTSS)** Enter the total number of grievances resolved by the plan during the reporting year that were related to institutional LTSS or LTSS provided through home and community-based (HCBS) services, including personal care and self-directed services. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 1 **Amerigroup Iowa, Inc.** 9
D1IV.15h	**Resolved grievances related to dental services** Enter the total number of grievances resolved by the plan during the reporting year that were related to dental services. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 74
D1IV.15i	**Resolved grievances related to non-emergency medical transportation (NEMT)** Enter the total number of grievances resolved by the plan during the reporting year that were related to NEMT. If the managed care plan does not cover this type of service, enter "N/A".	**Iowa Total Care, Inc.** 410 **Amerigroup Iowa, Inc.** 620

D1IV.15j	**Resolved grievances related to other service types** Enter the total number of grievances resolved by the plan during the reporting year that were related to services that do not fit into one of the categories listed above. If the managed care plan does not cover services other than those in items D1.IV.15a-i, enter "N/A".	**Iowa Total Care, Inc.** 543 **Amerigroup Iowa, Inc.** 1,320

Grievances by Reason

Report the number of grievances resolved by plan during the reporting period by reason.

Number	Indicator	Response
D1IV.16a	**Resolved grievances related to plan or provider customer service** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider customer service. Customer service grievances include complaints about interactions with the plan's Member Services department, provider offices or facilities, plan marketing agents, or any other plan or provider representatives.	**Iowa Total Care, Inc.** 417 **Amerigroup Iowa, Inc.** 291
D1IV.16b	**Resolved grievances related to plan or provider care management/case management** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan or provider care management/case management. Care management/case management grievances include complaints about the timeliness of an assessment or complaints about the plan or provider care or case management process.	**Iowa Total Care, Inc.** 5 **Amerigroup Iowa, Inc.** 62

D1IV.16c	**Resolved grievances related to access to care/services from plan or provider** Enter the total number of grievances resolved by the plan during the reporting year that were related to access to care. Access to care grievances include complaints about difficulties finding qualified in-network providers, excessive travel or wait times, or other access issues.	**Iowa Total Care, Inc.** 145 **Amerigroup Iowa, Inc.** 662
D1IV.16d	**Resolved grievances related to quality of care** Enter the total number of grievances resolved by the plan during the reporting year that were related to quality of care. Quality of care grievances include complaints about the effectiveness, efficiency, equity, patient-centeredness, safety, and/or acceptability of care provided by a provider or the plan.	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 134
D1IV.16e	**Resolved grievances related to plan communications** Enter the total number of grievances resolved by the plan during the reporting year that were related to plan communications. Plan communication grievances include grievances related to the clarity or accuracy of enrollee materials or other plan communications or to an	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 96

	enrollee's access to or the accessibility of enrollee materials or plan communications.	
D1IV.16f	**Resolved grievances related to payment or billing issues** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason related to payment or billing issues.	**Iowa Total Care, Inc.** 27 **Amerigroup Iowa, Inc.** 431
D1IV.16g	**Resolved grievances related to suspected fraud** Enter the total number of grievances resolved by the plan during the reporting year that were related to suspected fraud. Suspected fraud grievances include suspected cases of financial/payment fraud perpetuated by a provider, payer, or other entity. Note: grievances reported in this row should only include grievances submitted to the managed care plan, not grievances submitted to another entity, such as a state Ombudsman or Office of the Inspector General.	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 20
D1IV.16h	**Resolved grievances related to abuse, neglect or exploitation** Enter the total number of grievances resolved by the plan during the reporting year that	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.**

	were related to abuse, neglect or exploitation. Abuse/neglect/exploitation grievances include cases involving potential or actual patient harm.	0
D1IV.16i	**Resolved grievances related to lack of timely plan response to a service authorization or appeal (including requests to expedite or extend appeals)** Enter the total number of grievances resolved by the plan during the reporting year that were filed due to a lack of timely plan response to a service authorization or appeal request (including requests to expedite or extend appeals).	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 37
D1IV.16j	**Resolved grievances related to plan denial of expedited appeal** Enter the total number of grievances resolved by the plan during the reporting year that were related to the plan's denial of an enrollee's request for an expedited appeal. Per 42 CFR §438.408(b)(3), states must establish a timeframe for timely resolution of expedited appeals that is no longer than 72 hours after the MCO, PIHP or PAHP receives the appeal. If a plan denies a request for an expedited appeal, the enrollee or their	**Iowa Total Care, Inc.** 0 **Amerigroup Iowa, Inc.** 3

	representative have the right to file a grievance.	
D1IV.16k	**Resolved grievances filed for other reasons** Enter the total number of grievances resolved by the plan during the reporting year that were filed for a reason other than the reasons listed above.	**Iowa Total Care, Inc.** 364 **Amerigroup Iowa, Inc.** 1,004

Topic VII: Quality & Performance Measures

Report on individual measures in each of the following eight domains: (1) Primary care access and preventive care, (2) Maternal and perinatal health, (3) Care of acute and chronic conditions, (4) Behavioral health care, (5) Dental and oral health services, (6) Health plan enrollee experience of care, (7) Long-term services and supports, and (8) Other. For composite measures, be sure to include each individual sub-measure component.

Quality & performance measure total count: 4

Complete

D2.VII.1 Measure Name: Cervical Cancer Screening (CCS) 21-64

1 / 4

D2.VII.2 Measure Domain

Primary care access and preventative care

D2.VII.3 National Quality Forum (NQF) number

CCS

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Traditional Medicaid, Iowa Health and Wellness Plan

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Iowa Total Care, Inc.

57%

Amerigroup Iowa, Inc.

62%

Complete

D2.VII.1 Measure Name: Prenatal and Postpartum Care (PPC) - Postpartum Care

2 / 4

D2.VII.2 Measure Domain

Maternal and perinatal health

D2.VII.3 National Quality Forum (NQF) number

PPC

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Traditional Medicaid, Iowa Health and Wellness, Hawki (CHIP)

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Iowa Total Care, Inc.

78%

Amerigroup Iowa, Inc.

83%

Complete

D2.VII.1 Measure Name: Asthma Medication Ratio (AMR) - Total All Ages

3 / 4

D2.VII.2 Measure Domain

Care of acute and chronic conditions

D2.VII.3 National Quality Forum (NQF) number

AMR

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Traditional Medicaid, Iowa Health and Wellness, Hawki (CHIP)

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Iowa Total Care, Inc.

66%

Amerigroup Iowa, Inc.

68%

Complete

D2.VII.1 Measure Name: Follow-Up After Hospitalization For Mental Illness (FUH) - 30 days (Total)

4 / 4

D2.VII.2 Measure Domain

Behavioral health care

D2.VII.3 National Quality Forum (NQF) number

FUH

D2.VII.4 Measure Reporting and D2.VII.5 Programs

Cross-program rate: Traditional Medicaid, Iowa Health and Wellness, Hawki (CHIP)

D2.VII.6 Measure Set

HEDIS

D2.VII.7a Reporting Period and D2.VII.7b Reporting period: Date range

No, 01/01/2022 - 12/31/2022

D2.VII.8 Measure Description

N/A

Measure results

Iowa Total Care, Inc.

71%

Amerigroup Iowa, Inc.

79%

Topic VIII. Sanctions

Describe sanctions that the state has issued for each plan. Report all known actions across the following domains: sanctions, administrative penalties, corrective action plans, other. Include any pending or unresolved actions.

42 CFR 438.66(e)(2)(viii) specifies that the MCPAR include the results of any sanctions or corrective action plans imposed by the State or other formal or informal intervention with a contracted MCO, PIHP, PAHP, or PCCM entity to improve performance.

Sanction total count: 5

Complete

D3.VIII.1 Intervention type: Corrective action plan and Liquidated damages

1 / 5

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Iowa Total Care, Inc.

D3.VIII.4 Reason for intervention

Approval timeline for Pharmacy PA's below threshold

Sanction details

D3.VIII.5 Instances of non-compliance

14

D3.VIII.6 Sanction amount

$7,588

D3.VIII.7 Date assessed

01/26/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan and Liquidated damages

2 / 5

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Iowa Total Care, Inc.

D3.VIII.4 Reason for intervention

Member/Provider Helpline Response below threshold

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

$796

D3.VIII.7 Date assessed

05/05/2023

D3.VIII.8 Remediation date non-compliance was corrected

Yes, remediated 05/15/2023

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Liquidated damages

3 / 5

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Iowa Total Care, Inc.

D3.VIII.4 Reason for intervention

Daily LD for Non- Compliance with Pharmacy PA CAP

Sanction details

D3.VIII.5 Instances of non-compliance

65

D3.VIII.6 Sanction amount

$18,460

D3.VIII.7 Date assessed

09/20/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

4 / 5

D3.VIII.2 Intervention topic

Reporting

D3.VIII.3 Plan name

Amerigroup Iowa, Inc.

D3.VIII.4 Reason for intervention

Late or inaccurate reports

Sanction details

D3.VIII.5 Instances of non-compliance

1

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

05/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Complete

D3.VIII.1 Intervention type: Corrective action plan

5 / 5

D3.VIII.2 Intervention topic

Performance improvement

D3.VIII.3 Plan name

Amerigroup Iowa, Inc.

D3.VIII.4 Reason for intervention

Encounter Data Submission

Sanction details

D3.VIII.5 Instances of non-compliance

5

D3.VIII.6 Sanction amount

N/A

D3.VIII.7 Date assessed

09/19/2023

D3.VIII.8 Remediation date non-compliance was corrected

Remediation in progress

D3.VIII.9 Corrective action plan

Yes

Topic X. Program Integrity

Number	Indicator	Response
D1X.1	**Dedicated program integrity staff** Report or enter the number of dedicated program integrity staff for routine internal monitoring and compliance risks. Refer to 42 CFR 438.608(a)(1)(vii).	**Iowa Total Care, Inc.** 4 **Amerigroup Iowa, Inc.** 8
D1X.2	**Count of opened program integrity investigations** How many program integrity investigations were opened by the plan during the reporting year?	**Iowa Total Care, Inc.** 63 **Amerigroup Iowa, Inc.** 174
D1X.3	**Ratio of opened program integrity investigations to enrollees** What is the ratio of program integrity investigations opened by the plan in the past year per 1,000 beneficiaries enrolled in the plan on the first day of the last month of the reporting year?	**Iowa Total Care, Inc.** 2:100 **Amerigroup Iowa, Inc.** 4:10
D1X.4	**Count of resolved program integrity investigations** How many program integrity investigations were resolved by the plan during the reporting year?	**Iowa Total Care, Inc.** 78 **Amerigroup Iowa, Inc.** 96
D1X.5	**Ratio of resolved program integrity investigations to**	**Iowa Total Care, Inc.**

	enrollees What is the ratio of program integrity investigations resolved by the plan in the past year per 1,000 beneficiaries enrolled in the plan at the beginning of the reporting year?	2:100 **Amerigroup Iowa, Inc.** 21:100
D1X.6	**Referral path for program integrity referrals to the state** What is the referral path that the plan uses to make program integrity referrals to the state? Select one.	**Iowa Total Care, Inc.** Makes some referrals to the SMA and others directly to the MFCU **Amerigroup Iowa, Inc.** Makes referrals to the State Medicaid Agency (SMA) and MFCU concurrently
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Iowa Total Care, Inc.** Not applicable **Amerigroup Iowa, Inc.** 20
D1X.7	**Count of program integrity referrals to the state** Enter the total number of program integrity referrals made during the reporting year.	**Iowa Total Care, Inc.** 12 **Amerigroup Iowa, Inc.** Not applicable
D1X.8	**Ratio of program integrity referral to the state** What is the ratio of program integrity referral listed in the previous indicator made to the state in the past year per 1,000	**Iowa Total Care, Inc.** 3:1,000 **Amerigroup Iowa, Inc.**

	beneficiaries, using the plan's total enrollment as of the first day of the last month of the reporting year (reported in indicator D1.I.1) as the denominator.	5:100
D1X.9	**Plan overpayment reporting to the state** Describe the plan's latest annual overpayment recovery report submitted to the state as required under 42 CFR 438.608(d)(3). Include, at minimum, the following information: • The date of the report (rating period or calendar year). • The dollar amount of overpayments recovered. • The ratio of the dollar amount of overpayments recovered as a percent of premium revenue as defined in MLR reporting under 42 CFR 438.8(f)(2).	**Iowa Total Care, Inc.** July 31st, 2023 $288,344.13 .009% **Amerigroup Iowa, Inc.** June 2023 Report $361,688.09 0.01%
D1X.10	**Changes in beneficiary circumstances** Select the frequency the plan reports changes in beneficiary circumstances to the state.	**Iowa Total Care, Inc.** Weekly **Amerigroup Iowa, Inc.** Weekly

Section E: BSS Entity Indicators

Topic IX. Beneficiary Support System (BSS) Entities

Per 42 CFR 438.66(e)(2)(ix), the Managed Care Program Annual Report must provide information on and an assessment of the operation of the managed care program including activities and performance of the beneficiary support system. Information on how BSS entities support program-level functions is on the Program-Level BSS page.

Number	Indicator	Response
EIX.1	**BSS entity type** What type of entity was contracted to perform each BSS activity? Check all that apply. Refer to 42 CFR 438.71(b).	**Iowa Office Of Ombudsmen** Ombudsman Program **MAXIMUS Health Services, Inc.** Enrollment Broker
EIX.2	**BSS entity role** What are the roles performed by the BSS entity? Check all that apply. Refer to 42 CFR 438.71(b).	**Iowa Office Of Ombudsmen** Beneficiary Outreach LTSS Complaint Access Point LTSS Grievance/Appeals Education LTSS Grievance/Appeals Assistance Review/Oversight of LTSS Data **MAXIMUS Health Services, Inc.** Enrollment Broker/Choice Counseling Other, specify – Enrollment, disenrollment, RFI, Maintain Data, Escalate Member Issues.