HUMAN SERVICES DEPARTMENT [441]

Adopted and Filed

The Human Services Department hereby amends Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," and Chapter 79, "Other Policies Relating to Providers of Medical and Remedial Care," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code section 249A.4.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code section 249A.4.

Purpose and Summary

These amendments implement the Individual Placement and Support (IPS) Supported Employment (SE) evidence-based model within the Home- and Community-Based Services (HCBS) Habilitation Supported Employment services. These amendments establish the provider qualifications and implementation criteria applicable to the IPS SE providers. These amendments also implement the outcome-based reimbursement methodology for IPS SE.

IPS is a model of supported employment for people with serious mental illness. IPS SE helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS is the only evidence-based practice of supported employment.

IPS research (27 randomized controlled trials) show IPS is more effective than alternate vocational approaches regardless of a variety of client background factors (e.g., ethnicity, gender, socioeconomic status, barriers to employment).

IPS is research-based. Efficacy and effectiveness are empirically validated through a body of rigorous research, replicated in a wide range of settings by multiple investigators. IPS has standardized practice guidelines. Its critical components are well defined in a "manualized" service approach, measured via a 25-item Fidelity Scale.

IPS was developed by practitioners in the fields of employment and psychiatry, including Deborah R. Becker, M.Ed, CRC; Robert E. Drake, MD, Ph.D; and Gary Bond, Ph.D, at the Dartmouth Psychiatric Research Center of Dartmouth Medical School in the late 1980s. The Dartmouth Psychiatric Research Center is now called The IPS Center at Westat in Lebanon, New Hampshire. The IPS Center started the International Learning Collaborative (ILC) in 2001 with three sites. As of 2020, there are 24 U.S. states or territories and six countries in the ILC. Westat leads the dissemination, quality control, research, and support of IPS nationally and globally.

Iowa currently has two qualified IPS providers, which have participated in an IPS pilot project since 2018 with funding for training and technical assistance provided by their mental health disability service regions. These two IPS providers initially received reimbursement through their regions for IPS outcomes and then through the Iowa Medicaid State Plan HCBS Habilitation Services program through an exception to policy (ETP). At the same time Iowa Medicaid began reimbursing these two providers for the IPS Model through an ETP, Iowa Vocational Rehabilitation Services (IVRS) adopted an IPS funding model that reimburses equal to Iowa Medicaid.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on May 19, 2021, as ARC 5623C.

The Department received four comments from two respondents on the proposed rules. The comments and corresponding responses from the Department are divided into two topic area of provider standards and reimbursement.

<u>Provider Standards</u>

<u>1. Comment</u>

A suggested edit to paragraph 76 is "Providers shall be accredited Community Mental Health Centers (CMHCs) in good standing, and/or Employment Service Providers who are enrolled in IVRS and Medicaid Habilitation and are eligible to form an IPS Team."

In the experience of the Vera French Community Mental Health Center, part of why IPS works is the seamless integration of mental health habilitation services with the employment process. In fact, elsewhere in this document, there is a requirement that the IPS team include both vocational and mental health service providers. Yet, only those providers of vocational services under this current section are eligible. It is our belief that either half of the IPS team (mental health or vocation services) should at least be eligible to form an IPS team under this opportunity, subject to securing the partnerships necessary to meet all other conditions under this document. The Vera French Community Mental Health Center has many years of experience providing habilitation services and would be interested in forming an IPS team under this state initiative. In fact, Vera French at the end of 2019 secured over $200,000 in local and private funding to create an IPS program in Davenport. Vera French pursued IPS on behalf of our clients because it was an evidence-based practice. Yet, despite this experience and our ability to document substantial local financial support, the document as is currently written prevents Vera French from growing our IPS program with State of Iowa assistance.

<u>1. Response</u>

CMHCs wishing to deliver State Plan HCBS Habilitation Supported Employment services must be enrolled to deliver SE under the HCBS Habilitation program. The following agencies may be enrolled to provide employment services:

(1) An agency that is certified by the department to provide supported employment services under:

a. The home- and community-based services intellectual disability waiver pursuant to rule 441—77.37(249A); or

b. The home- and community-based services brain injury waiver pursuant to rule 441—77.39(249A).

(2) An agency that is accredited by the Commission on Accreditation of Rehabilitation Facilities as an organizational employment service provider or a community employment service provider.

(3) An agency that is accredited by the Council on Accreditation.

(4) An agency that is accredited by the Joint Commission.

(5) An agency that is accredited by the Council on Quality and Leadership.

(6) An agency that is accredited by the International Center for Clubhouse Development.

Currently employment support services are not identified in the CMHC Core services in Iowa Code 230A, and it is unclear that the CMHC accreditation include the review of the delivery of employment supports or how CMCHs are qualified to deliver comprehensive supported employment services. The department is willing to continue to work with DHS, MHDS division and the CMHCs to explore adding CMCH accreditation as a qualifying criteria for enrollment as a supported employment services provider.

2. Comment

Please clarify what is a sufficient level of knowledge and skill. Please clarify what CES certification is.

2. Response

"Certified employment specialist" or "CES" means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

Certified employment specialists obtain CES certification through a national accrediting body. Certification is offered through the Association Supporting People in Employment (APSE). The CESP credential is designed for employment support professionals to enhance their professional standing, wages and career advancement options, as a measure of staff competency for providers of employment services. The certification awarded designates that participants have demonstrated the requisite, work-related knowledge, skills, or competencies and met other requirements established by the certification program provider (e.g., academic degree, a specified number of years of occupational or professional experience).

3. Comment

People served in IPS are occasionally only funded under Habilitation and do not have an open file with IVRS. In those cases there would not be an IVRS counselor on the team. We would suggest changing this definition to read: "IPS team" means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, or a case manager or care coordinator.

3. Response

In cases where a member receiving IPS is not actively working with IVRS, the inclusion of the IVRS counselor on the team would not be applicable. No changes will be made to the rules at this time.

Reimbursement:

4. Comment

Under the Current IPS Exception to Policy the outcome payments are billed as follows: Outcome 1 is billed under T2015u3 for 34 units as a lump sum upon completion of the Career Plan. Outcome 2 is billed under T2018 for 30 units as a lump sum upon completion of the first day on the job. Outcome 3 is billed under T2018 for 30 units as a lump sum upon completion of 45 days on the job. Outcome 4 is billed under H2025u for 1 unit as a lump sum upon completion of 90 days on the job. Can you clarify that this will continue when these rules go into effect?

4. Response

Upon implementation of the administrative rules, IPS SE will have a dedicated procedure code and modifier for each of the four outcome payments as noted in the table below. Procedure codes and modifiers will be as follows:

Model to be implemented September 1, 2021.			
Outcome Description	IME IPS Service Code	Service Code Description	Units authorized
#1. Completed Employment Plan	T2018 U3	IPS Completed Employment Plan	1 unit
#2. 1st Day Successful Placement	T2018 U4	IPS 1st Day Successful Placement	1 unit
#3. 45 Days Successful Job Retention	T2018 U5	IPS 45 Days Successful Job Retention	1 unit
#4. 90 Days Successful Job Stabilization	T2018 U6	IPS 90 Days Successful Job Stabilization	1 unit

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on July 8, 2021.

Fiscal Impact

The purpose of these proposed amendments implement the Individual Placement and Support (IPS) Supported Employment (SE) evidenced based model. These amendments establish the provider qualifications and implementation criteria applicable to the Individual Placement and Support (IPS) evidenced based practice model for approved supported employment providers. The IME currently reimburses for the IPS SE Model through an Exception to Policy for 2 IPS certified providers. The current IPS model reimbursement methodology is consistent with how the Department reimburses for traditional SE services within the Habilitation program. This rule will change the IPS payment structure to an outcome-based reimbursement methodology and is expected to have a higher per recipient cost than the current method. The cost impact will be low initially since only current IPS recipients will be impacted, but is expected to grow over time as more providers elect to participate. The initial cost for only IPS recipients is estimated at $33,330 (total); $12,652 (state share) but could grow to $1,105,203 (total); $419,535 (state share) if all those currently receiving the traditional SE model transition to IPS. The fiscal impact cannot be determined because the degree to which providers/members will transition to IPS is not known. Based on the above, the annual state share cost is expected to be between $12,652 and $419,535, and likely closer to the low-end at initial implementation. Participation in the IPS SE Model has led to improved mental health, physical health, and overall functioning for job seekers, which in turn leads to reduced expenditures related to hospitalizations, emergency room visits, prescription drugs and other Medicaid covered services and supports. These potential savings are not incorporated in the above cost estimates.

Jobs Impact

Adoption of these rules is likely to increase the number of individuals with serious mental illness who are able to obtain and maintain employment. The adoption of these rules may also create additional certified employment specialists (CES) positions within the SE provider community.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any pursuant to 441 IAC 1.8 (17A, 217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on September 1, 2021.

The following rule-making action is adopted:

See attached.

THE FOLLOWING RULES ARE ADOPTED:

ITEM 1. Adopt the following **new** definitions of "Certified employment specialist," "Individual placement and support," "IPS 25-item supported employment fidelity scale," "IPS implementation," "IPS reviewer," "IPS team," "IPS trainer," "Prospective IPS team" and "Provisionally approved IPS team" in subrule **77.25(1)**:

"*Certified employment specialist*" or "*CES*" means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

"*Individual placement and support*" or "*IPS*" means the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.
2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.
3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.
4. Attention to worker preferences: Services are based on each person's preferences and choices, rather than providers' judgments.
5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.
6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.
7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.
8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

"*IPS 25-item supported employment fidelity scale*" means the fidelity scale published by the IPS Employment Center at Westat, resulting in scores of exemplary fidelity, good fidelity, fair fidelity, or not supported employment.

"*IPS implementation*" means the process advocated by the IPS Employment Center at Westat, which consists of the following phases:

1. Formation of IPS team steering group and one-day meeting with the IPS trainer and team members.
2. Completion of the IPS Readiness Assessment developed by the IPS Employment Center at Westat and individual review with the IPS trainer.
3. Completion of a one-day IPS kick-off team training with the IPS trainer and team members.
4. Participation in individual team training and monthly consultations as follows:
   - Two-and-a-half-day individual team training with the IPS trainer and team members.
   - Virtual training by the IPS Employment Center at Westat for at least three people per team.
   - Leadership training for two people per team at the IPS Employment Center at Westat.
   - Virtual monthly technical assistance for two hours per month per team.
5. Participation in the International Learning Collaborative, including:
   - Participation in the International Learning Collaborative annual conference by two people per state.
   - Virtual monthly technical assistance calls with the IPS Center mentor assigned to the team.
   - Participation in the prescribed data tracking and management activities.

6. Completion of one baseline fidelity review per IPS team, with two IPS reviewers on site for two days per review.

7. Evaluation and development of next steps, with an on-site half-day meeting for the IPS trainer and the team.

"IPS reviewer" means a person who is qualified to complete fidelity reviews of IPS services and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of "good" or better, has completed the IPS Employment Center at Westat's training to become an IPS reviewer, and has shadowed one or more IPS fidelity reviews;
2. An existing IPS reviewer from a state which is a member of the IPS International Learning Collaborative;
3. An IPS reviewer contracted directly from the IPS Employment Center at Westat;
4. A CES with a bachelor's degree who has completed the IPS Employment Center at Westat's training to become an IPS reviewer and has shadowed one or more IPS fidelity reviews.

"IPS team" means, at a minimum, an IPS employment specialist, a behavioral health specialist, Iowa Vocational Rehabilitation Services (IVRS) counselor, and a case manager or care coordinator.

"IPS trainer" means a person who is qualified to provide training and technical assistance for IPS implementation and is one of the following:

1. A person who has provided IPS services or has supervised an IPS team in Iowa which has obtained a fidelity score of "good" or better, and has completed the IPS Employment Center at Westat's training to become an IPS trainer;
2. An existing IPS trainer from a state which is a member of the IPS International Learning Collaborative;
3. An IPS trainer contracted directly from the IPS Employment Center at Westat;
4. A CES with a bachelor's degree who has completed the IPS Employment Center at Westat's training to become an IPS trainer.

"Prospective IPS team" means a group that is forming an IPS team to deliver IPS services but who has not yet completed implementation phase 4a.

"Provisionally approved IPS team" means a group that has (1) formed a team to deliver IPS services, (2) completed implementation phase 4a, and (3) begun to deliver IPS services.

ITEM 2. Adopt the following **new** paragraph **77.25(10)"d"**:

d. Providers qualified to offer IPS services shall meet the following requirements:

(1) Providers shall meet the provider qualifications listed in this subrule.

(2) Providers shall be accredited to provide supported employment and have provided supported employment for a minimum of two years.

(3) Providers shall demonstrate adequate funding has been secured for the training and technical assistance required for IPS implementation. Adequate funding is defined as at least the amount required for the start-up of one IPS team to complete all phases of IPS implementation. Evidence of such funding shall be made available to the department at the time of enrollment. Evidence may include a written funding agreement or other documentation from the funder.

(4) Providers shall receive training and technical assistance throughout IPS implementation froman IPS trainer. Evidence of the IPS team's agreement for such training and technical assistance shall be made available to the department at the time of enrollment.

(5) Prospective IPS teams shall complete IPS implementation as defined in subrule 77.25(1) and as outlined by the IPS Center at Westat.

(6) Prospective IPS teams are provisionally approved until the IPS team has obtained at least a "fair" score on a baseline fidelity review completed by IPS reviewers.

(7) Provisionally approved IPS teams shall complete IPS implementation phases 1 through 4a within 12 months of enrolling.

(8) Upon completion of IPS implementation phase 4a, provisionally approved IPS teams shall deliver IPS services according to the IPS outcomes model.

(9) Upon completion of IPS implementation phase 7, IPS teams are qualified to deliver IPS services, subject to the following:

1. IPS teams must obtain a baseline fidelity review score of "fair" or better within 14 months of completion of IPS implementation phase 1. The fidelity review must be completed by IPS reviewers. The fidelity reviews shall be provided to the department upon receipt by the IPS team.

2. In the event an IPS team fails to achieve a fidelity score of "fair" or better, the IPS team shall receive technical assistance to address areas recommended for improvement as identified in the fidelity review. If the subsequent fidelity review results in a score of less than "fair" fidelity, the IPS team will be provisionally approved for no more than 12 months or until the fidelity score again reaches "fair" fidelity, whichever date is earliest.

3. IPS teams who do not achieve a "fair" fidelity score within 12 months from being provisionally approved will no longer be qualified to deliver IPS services until they again reach the minimum "fair" fidelity score.

ITEM 3. Adopt the following **new** definition of "Certified employment specialist" in subrule **78.27(1)**:

"Certified employment specialist" or *"CES"* means a person who has demonstrated a sufficient level of knowledge and skill to provide integrated employment support services to a variety of client populations and has earned a CES certification through a nationally recognized accrediting body.

ITEM 4. Amend subrule **78.27(1)**, definition of "Individual placement and support," as follows:

"Individual placement and support" or *"IPS"* means ~~an evidence-based supported employment model that helps people with mental illness to seek and obtain~~ the evidence-based practice of supported employment that is guided by IPS practice principles outlined by the IPS Employment Center at Westat, and as measured by its most recently published 25-item supported employment fidelity scale available online at ipsworks.org/wp-content/uploads/2017/08/ips-fidelity-manual-3rd-edition_2-4-16.pdf. The IPS practice principles are:

1. Focus on competitive employment: Agencies providing IPS services are committed to competitive employment as an attainable goal for people with behavioral health conditions seeking employment. Mainstream education and specialized training may enhance career paths.

2. Zero exclusion criteria based on client choice: People are not excluded on the basis of readiness, diagnoses, symptoms, substance use history, psychiatric hospitalizations, homelessness, level of disability, or legal system involvement.

3. Integration of rehabilitation and mental health services: IPS programs are closely integrated with mental health treatment teams.

4. Attention to worker preferences: Services are based on each person's preferences and choices, rather than providers' judgments.

5. Personalized benefits counseling: Employment specialists help people obtain personalized, understandable, and accurate information about their social security, Medicaid, and other government entitlements.

6. Rapid job search: IPS programs use a rapid job search approach to help job seekers obtain jobs directly, rather than providing lengthy preemployment assessment, training, and counseling. If further education is part of their plan, IPS specialists assist in these activities as needed.

7. Systematic job development: Employment specialists systematically visit employers, who are selected based on job seeker preferences, to learn about their business needs and hiring preferences.

8. Time-unlimited and individualized support: Job supports are individualized and continue for as long as each worker wants and needs the support.

ITEM 5. Reletter paragraphs **78.27(10)"d"** to **"f"** as **78.27(10)"e"** to **"g."**

ITEM 6. Adopt the following **new** paragraph **78.27(10)"d"**:

d. Individual placement and support (IPS).

(1) IPS shall include the following activities, which shall be described and documented in the member's employment plan:

1. Development of the career profile, including previous work experience, goals, preferences, strengths, barriers, skills, disclosure preferences, career advancement, education and plan for graduation.

2. Integration of IPS team members and the behavioral health team, including routine staffing meetings regarding IPS clients.

3. Addressing barriers to employment, which may be actual or perceived. Support may include addressing justice system involvement, a lack of work history, limited housing, child care, and transportation.

4. Rapid job search and systematic job development. CESs help members seek jobs directly, and do not provide extensive preemployment assessment and training or intermediate work experiences. The job process begins within 30 days of starting IPS services. This rapid job search is supported by CESs developing relationships with employers through multiple face-to-face meetings. CESs take time to learn about the employers' needs and the work environment while gathering information about job opportunities that might be a good fit for individuals they are working with.

5. Disclosure counseling, to assist the member in making an informed decision on disclosure of a disability to a prospective or current employer.

6. Identification and implementation of job accommodations and assistive technology supports.

7. Ongoing benefits counseling. The member must receive information on available work incentive programs, or referral to professional benefits counselors for a personalized work incentives plan for any state or federal entitlement.

8. Time-unlimited follow-along supports. These supports are planned for early in the employment process, are personalized, and follow the member for as long as the member needs support. The focus is supporting the member in becoming as independent as possible and involving family members, co-workers, and other natural supports. These supports can be provided on or off the job site and focus on the continued acquisition and development of skills needed to maintain employment.

(2) Units of service. Reimbursement is made for each outcome achieved for the member participating in the IPS supported employment model. Outcomes are as follows:

1. Outcome #1: Completed employment plan.
2. Outcome #2: First day of successful job placement.
3. Outcome #3: 45 days successful job retention.
4. Outcome #4: 90 days successful job retention.

ITEM 7. Amend subrule **79.1(2)**, provider category of "HCBS waiver service providers," paragraph 19, as follows:

Provider category	Basis of reimbursement	Upper limit
19. Supported employment:		
Individual placement and support	Fee schedule	Fee schedule in effect 7/1/21.
Individual supported employment	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
Long-term job coaching	Fee schedule	Fee schedule in effect 7/1/16. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.
Small-group supported employment (2 to 8 individuals)	Fee schedule	Fee schedule in effect 7/1/16. Maximum 160 units per week. Total monthly cost for all supported employment services not to exceed $3,059.29 per month.

Iowa Department of Human Services

Information on Proposed Rules

Name of Program Specialist	Telephone Number	Email Address
LeAnn Moskowitz	515-321-8922	lmoskow@dhs.state.ia.us

1. Give a brief purpose and summary of the rulemaking:

   These proposed amendments implement the Individual Placement and Support (IPS) Supported Employment (SE) evidenced-based model within the Home- and Community-based Services (HCBS) Habilitation Supported Employment services. These amendments establish the provider qualifications and implementation criteria applicable to the IPS SE providers. These amendments also implement the outcome-based reimbursement methodology for IPS SE.

   IPS is a model of supported employment for people with serious mental illness. IPS supported employment helps people living with behavioral health conditions work at regular jobs of their choosing. Although variations of supported employment exist, IPS is the only evidence-based practice of supported employment.

   IPS research (27 randomized controlled trials) show IPS is more effective than alternate vocational approaches regardless of a variety of client background factors (e.g., ethnicity, gender, socioeconomic status, barriers to employment).

   IPS is research-based. Efficacy and effectiveness are empirically validated through a body of rigorous research, replicated in a wide range of settings by multiple investigators. IPS has standardized practice guidelines, its critical ingredients are well defined in a “Manual-ized” service approach, measured via a 25-item Fidelity Scale.

   IPS was developed by practitioners in the fields of employment and psychiatry, Deborah R. Becker, MEd, CRC, Robert E. Drake, MD, PhD, and Gary Bond, PhD at the Dartmouth Psychiatric Research Center of Dartmouth Medical School in the late 1980s. The Dartmouth Psychiatric Research Center is now called The IPS Center at Westat in Lebanon, New Hampshire. They started the International Learning Collaborative (ILC) in 2001 with three sites. As of 2020, there are 24 US States/Regions and 6 Countries in the ILC. Westat leads the dissemination, quality control, research on, and support of IPS nationally and globally.

   Iowa currently has two qualified IPS providers that have participated in an IPS pilot project since 2018 with funding for the training and technical assistance provided by their mental health disability service regions. These two IPS providers initially received reimbursement through their Regions for IPS outcomes and then through the Iowa Medicaid State Plan HCBS Habilitation Services program through an exception to policy (ETP). At the same time IME began reimbursing these two providers for the IPS Model through an ETP, Iowa Vocational Rehabilitation Services (IVRS) adopted an IPS funding model that reimburses equal to IME.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

   Iowa Code 249A.4

3. Describe who this rulemaking will positively or adversely impact.

   There will be a positive impact on individuals who qualify for Habilitation services and are seeking employment. With IPS’ rapid engagement and the dedicated employment staff, individuals quickly find the

job they want and begin building an empowered life based on their wants and needs while also gaining a vast array of skills. This has led to improved mental health, physical health, and overall functioning as well as financial stability. IPS has been a success for many members.

The two qualified IPS providers that have been providing and being reimbursed for the IPS services through an exception to policy will no longer require an ETP to be paid for the outcome-based payments for IPS.

Formalizing the IPS SE Model into rule creates the expectation that the IPS SE model is an evidenced-based model provided with fidelity and which provides the framework for additional providers to become qualified IPS providers.

There is no adverse impact of this rule amendment.

4. Does this rule contain a waiver provision? If not, why?

   A waiver provision is not necessary. 441 -1.8(17A, 217) provides for waiver of administrative rules in exceptional circumstances.

5. What are the likely areas of public comment?

   Participation in the IPS SE Model has led to improved mental health, physical health, and overall functioning for job seekers. IPS has been a success for many individuals, and the SE providers, Regions, CMHCs and other mental health providers are looking forward to using this model to assist more individuals in obtaining and maintaining employment.

   SE providers who have not participated in the Department's IPS projects or the IPS Model training provided by the Department may question the requirements to become a qualified IPS provider. Providers that state that they provide IPS but who have not participated in the required independent fidelity reviews may object to the adoption of formal rules.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

   Adoption of these rules is likely to increase the number of individuals with serious mental illness who are able to obtain and maintain employment. The adoption of these rules may also create additional certified employment specialists (CES) positions within the SE provider community.

Administrative Rule Fiscal Impact Statement

Date: 04/08/2021

Agency: Human Services

IAC citation: 441 IAC 77.27, 78.27 , 79.1(2)

Agency contact: LeAnn Moskowitz IME Policy

Summary of the rule:

The purpose of these proposed amendments implement the Individual Placement and Support (IPS) Supported Employment (SE) evidenced based model. These amendments establish the provider qualifications and implementation criteria applicable to the Individual Placement and Support (IPS) evidenced based practice model for approved supported employment providers.

Fill in this box if the impact meets these criteria:

☐ No fiscal impact to the state.

☐ Fiscal impact of less than $100,000 annually or $500,000 over 5 years.

☒ Fiscal impact cannot be determined.

Brief explanation:

The IME currently reimburses for the IPS SE Model through an Exception to Policy for 2 IPS certified providers. The current IPS model reimbursement methodology is consistent with how the Department reimburses for traditional SE services within the Habilitation program.

This rule will change the IPS payment structure to an outcome-based reimbursement methodology and is expected to have a higher per recipient cost than the current method. The cost impact will be low initially since only current IPS recipients will be impacted, but is expected to grow over time as more providers elect to participate.

The initial cost for only IPS recipients is estimated at $33,330 (total); $12,652 (state share) but could grow to $1,105,203 (total); $419,535 (state share) if all those currently receiving the traditional SE model transition to IPS.

The fiscal impact cannot be determined because the degree to which providers/members will transition to IPS is not known. Based on the above, the annual state share cost is expected to be between $12,652 and $419,535, and likely closer to the low-end at initial implementation.

Participation in the IPS SE Model has led to improved mental health, physical health, and overall functioning for job seekers, which in turn leads to reduced expenditures related to hospitalizations, emergency room visits, prescription drugs and other Medicaid covered services and supports. These potential savings are not incorporated in the above cost estimates.

Further detail regarding assumptions and calculations are provided as an attachment.

Fill in the form below if the impact does not fit the criteria above:

☐ Fiscal impact of $100,000 annually or $500,000 over 5 years.

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2022)	Year 2 (FY 2023)
Revenue by each source:		
General fund		
Federal funds		
Other (specify):		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
Other (specify):		
TOTAL EXPENDITURES		
NET IMPACT	TBD	TBD

☐ This rule is required by state law or federal mandate.
Please identify the state or federal law:
Identify provided change fiscal persons:

☐ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

☒ Funding has not been provided for the rule.

Please explain how the agency will pay for the rule change:

Any increase in costs will need to be funded from the existing Medical Assistance appropriation.

Fiscal impact to persons affected by the rule:

IPS providers will likely see an increase in payment based on the new outcome-based reimbursement methodology.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

None anticipated.

Agency representative preparing estimate:	Soraya Miller	JH 4/12/2021, JS 4/13/21
Telephone number:	515-281-6017	

HUMAN SERVICES DEPARTMENT [441]

Adopted and Filed

Rule making related to terminology for deaf and hard of hearing.

The Human Services Department hereby amends Chapter 73, "Managed Care," Chapter 77, "Conditions of Participation for Providers of Medical and Remedial Care," Chapter 78, "Amount, Duration and Scope of Medical and Remedial Services," Chapter 81, "Nursing Facilities," Chapter 82, "Intermediate Care Facilities for Persons with an Intellectual Disability," and Chapter 113, "Licensing and Regulation of Foster Family Homes," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 249A.

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 249A.

Purpose and Summary

The proposed rule making replaces the term "deaf" with "deaf or hard of hearing" or "deaf and hard of hearing" and replaces the term "hearing-impaired" with "deaf or hard of hearing" throughout the Department's rules as a result of 2020 Iowa Acts, House File 2585. This rule making covers the Department chapters affected by the legislation.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on May 19, 2021, as ARC 5619C.

No public comments were received.

No changes from the Notice have been made.

Adoption of Rule Making

This rule making was adopted by the Human Services Department on July 8, 2021.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any pursuant to 441 IAC 1.8 (17A, 217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on September 1, 2021.

The following rule-making action is adopted:

See attached.

ADOPT THE FOLLOWING RULES:

ITEM 1. Amend subrule 73.21(2) as follows:

73.21(2) *Outreach to members with special needs.* The managed care organization shall provide enhanced outreach to members with special needs including, but not limited to, persons with psychiatric disabilities, an intellectual disability or other cognitive impairments, illiterate persons, non-English-speaking persons, and persons with visual impairments or who are deaf or hard of hearing ~~impairments~~.

ITEM 2. Amend paragraph **78.1(16)"g"** as follows:

g. The information in paragraphs *"b"* through *"f"* shall be effectively presented to a blind, deaf , hard-of-hearing, or otherwise ~~handicapped~~ disabled individual and an interpreter shall be provided when the individual to be sterilized does not understand the language used on the consent form or used by the person obtaining consent. The individual to be sterilized may have a witness of the individual's choice present when consent is obtained.

ITEM 3. Amend subparagraph **78.9(9)"c"(4)** as follows:

(4) Preexisting mental or physical disabilities such as deaf, hard of hearing, blind, hemiplegic, activity-limiting disease, sickle cell anemia, uncontrolled hypertension, uncontrolled diabetes, mental illness, or intellectual disability.

ITEM 4. Amend subparagraph **78.19(1)"d"(3)** as follows:

(3) Aural rehabilitation, the instruction given by a qualified speech pathologist in speech reading or lip reading to patients who have suffered a hearing loss or become hard of hearing (input impairment), constitutes a covered service if reasonable and necessary to the patient's illness or injury. Group treatment is not covered. Audiological services related to the use of a hearing aid are not reimbursable.

ITEM 5. Amend subparagraph **78.34(9)"b"(17)** as follows:

(17) Telecommunications device for the deaf or hard of hearing.

ITEM 6. Amend subparagraph **78.37(9)"b"(17)** as follows:

(17) Telecommunications device for the deaf or hard of hearing.

ITEM 7. Amend subparagraph **78.41(4)"b"(17)** as follows:

(17) Telecommunications device for the deaf or hard of hearing.

ITEM 8. Amend subparagraph **78.43(5)"b"(17)** as follows:

(17) Telecommunications device for the deaf or hard of hearing.

ITEM 9. Amend subparagraph **78.46(2)"b"(17)** as follows:

(17) Telecommunications device for the deaf or hard of hearing.

ITEM 10. Amend subparagraph **81.13(10)"b"(2)** as follows:

(2) By arranging for transportation to and from the office of a medical practitioner specializing in the treatment of vision ~~or hearing~~ impairment or the deaf or hard of hearing or the office of a professional specializing in the provision of vision or hearing assistive devices.

ITEM 11. Amend subparagraph **82.2(7)"a"(2)** as follows:

(2) The facility shall not segregate clients solely on the basis of their physical disabilities. It shall integrate clients who have ambulation deficits or who are deaf, hard of hearing, blind, or have seizure disorders with others of comparable social and intellectual development.

ITEM 12. Amend paragraph **113.7(1)"a"** as follows:

a. At least one UL (Underwriter's Laboratory)-approved smoke detector. On floors that are used for sleeping, the smoke detector shall be in a location where sleeping areas can be alerted. For ~~hearing-impaired~~ deaf or hard-of-hearing children, the foster parent shall install a smoke detector in the child's bedroom that will use an alternative means of waking the child.

Iowa Department of Human Services

Administrative Rule Transmittal

Subject of Rule Making Adding Hard of Hearing to the rules that reference deaf and hearing impairment.		
Administrative Code Chapters Affected 441 Chaptes 73,77, 78, 81, 82, 113	Iowa Code Section or Bill Giving Rule Making Authority 249A, 237, HF2585	
Program Specialist Anna Ruggle	Date Initiated 3-22-2021	Desired Effective Date

Are you requesting emergency rule making? ☒ No ☐ Yes

Are there grounds for emergency rule making? ☒ No

☐ Yes, because:

- ☐ The period for notice and public comment may be waived because obtaining public comment is:
  - ☐ Unnecessary. Reason:
  - ☐ Impracticable. Reason:
  - ☐ Contrary to the public interest. Reason:
- ☐ The implementation period can be waived since:
  - ☐ Legislation permits emergency rule making. Citation:
  - ☐ The rule confers a benefit on the public or removes a restriction on the public. Reason:
  - ☐ The effective date is necessary because of imminent peril to public health, safety, or welfare. Reason:

Are public hearings needed? ☒ No ☐ Yes

Are changes to a data system needed? ☒ No ☐ Yes

Will this affect appeal volume? ☒ No ☐ Yes: ☐ Increase ☐ Decrease

Is training required? ☒ No ☐ Yes, scheduled for:

Are form changes required? ☒ No ☐ Yes, to:

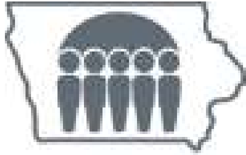
Are manual changes required? ☒ No ☐ Yes, to:

Division Sign-Off:

Signature	Date
Bureau Chief Signature (Process initiation)	Date
Division Administrator Signature (Form Content Approval)	Date
Attorney General Signature (Review)	Date
Fiscal Administrative Rules Coordinator Julie A. Shaw	Date 4/19/21
Deputy Director Signature J. Slaybaugh	Date 4/19/21

Please plan for one week turnaround and final approval before submitting.

470-4673 (Rev. 09/18)



Iowa Department of Human Services

Information on Proposed Rules

Name of Program Specialist	Telephone Number	Email Address
Anna Ruggle	515-201-4713	aruggle@dhs.state.ia.us

1. Give a brief purpose and summary of the rulemaking:

   The legislation updates current disability language. It changes hearing impaired to hard of hearing and adds hard of hearing wherever the term deaf appears.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

   HF2585, 249A and 237

3. Describe who this rulemaking will positively or adversely impact.

   This will positively impact those that are hard of hearing but are not considered deaf.

4. Does this rule contain a waiver provision? If not, why?

   The amendments do not contain waiver provisions because they are being required by the State Legislation to update current disability terminology. If needed, the department has an established procedure for considering exceptions to policy. A waiver of any of the Iowa Administrative Code rules may be granted through that process.

5. What are the likely areas of public comment?

   Public comment will likely be supportive of the change.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

   There is no impact on private-sector jobs and employment opportunities in Iowa.

Administrative Rule Fiscal Impact Statement

Date: April 19, 2021

Agency: Human Services

IAC citation: 441 IAC 73, 78, 81.82,113

Agency contact: Anna Ruggle

Summary of the rule:

This rule updates disability terminology to add hard of hearing and remove hearing impairment.

Fill in this box if the impact meets these criteria:

☒ No fiscal impact to the state.

☐ Fiscal impact of less than $100,000 annually or $500,000 over 5 years.

☐ Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

The rule updates current disability language. It changes hearing impaired to hard of hearing and adds hard of hearing wherever the term deaf appears.

Fill in the form below if the impact does not fit the criteria above:

☐ Fiscal impact of $100,000 annually or $500,000 over 5 years.

Assumptions:

Describe how estimates were derived:

Estimated Impact to the State by Fiscal Year		
	Year 1 (FY 2021)	**Year 2 (FY 2022)**
Revenue by each source:		
General fund		
Federal funds		
Other (specify):		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
Other (specify):		
TOTAL EXPENDITURES		
NET IMPACT		

☒ This rule is required by state law or federal mandate.
Please identify the state or federal law:
Identify provided change fiscal persons:
HF2585 (2020 Iowa Acts Ch. 1102)

☐ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

☒ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
There is no fiscal impact.

Fiscal impact to persons affected by the rule:
No fiscal impact identified.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):
There is no fiscal impact.

Agency representative preparing estimate: Soraya Miller JH 4/19/21, JS 4/19/21

Telephone number: 515-281-6017

HUMAN SERVICES DEPARTMENT[441]

Adopted and Filed

The Human Services Department hereby amends Chapter 7, "Appeals And Hearings," Iowa Administrative Code.

Legal Authority for Rule Making

This rule making is adopted under the authority provided in Iowa Code chapter 17A, Iowa Code section 217.6, and the Code of Federal Regulations 7 CFR.16(f).

State or Federal Law Implemented

This rule making implements, in whole or in part, Iowa Code chapter 17A and Iowa Code section 217.6, and the Code of Federal Regulations 7 CFR 16(f).

Purpose and Summary

The Department has changed the formal name of Iowa's food assistance program from Food Assistance to the Supplemental Nutrition Assistance Program (SNAP) to be consistent with the name of the federal program and to alleviate confusion around food benefits that are available.

Federal regulations give states the option of establishing procedures to allow an individual accused of an intentional SNAP violation to waive the individual's right to an administrative disqualification hearing. With the recommendation of the United States Department of Agriculture (USDA) Food and Nutrition Service (FNS), the Department has decided to take advantage of this option. The Department is responsible for investigating any case of alleged intentional program violation. The Department will notify a SNAP household when the Department submits a referral to determine whether an individual of that household intentionally violated SNAP rules. Currently, the Department's only options to ensure appropriate cases are acted upon are through an administrative disqualification hearing or through criminal prosecution by a court of an appropriate jurisdiction.

The amendments give an individual who is suspected of an intentional program violation an opportunity to waive the individual's right to an administrative disqualification hearing, if the individual so chooses, on Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

If the individual chooses to sign the form, the member will be disqualified from participating in SNAP for a specified time and agrees to repay any overpayment associated with the violation. No administrative disqualification hearing will be held. The same disqualification penalty will be imposed if the individual chooses to give up the right to an administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

No further administrative appeal procedure exists after an individual waives the individual's right to an administrative disqualification hearing and a disqualification penalty has been imposed.

Public Comment and Changes to Rule Making

Notice of Intended Action for this rule making was published in the Iowa Administrative Bulletin on April 7, 2021, as ARC 5549C.

One organization provided written comments on the proposed rule changes.

COMMENT 1:
The respondent believes the proposed change inadequately incorporates the directives in the Code of Federal Regulations (CFR) Chapter 7 Section 273.16 that are meant to provide protection to participants from erroneous deprivation of critical benefits.

RESPONSE 1:
The respondent requests the regulation explicitly incorporate language from 7 CFR 273.16. Rule 7.2(17A) already indicates to the extent that federal law related to a specific program is more specific than the rules in Chapter 7, the program-specific federal or state law shall control and provides a reference to the federal code citation for the SNAP program. However, to protect clients and their fundamental human need to access basic nutrition, Item 5, rule 7.19(17A) will be amended as follows:
441—7.19(17A) Supplemental Nutrition Assistance Program (SNAP) administrative disqualification hearings. The department acts on alleged intentional program violations either through an administrative disqualification hearing or referral to a court of appropriate jurisdiction. An individual accused of an intentional program violation may waive the individual's right to an administrative disqualification hearing in accordance with the procedures outlined in this rule and in 7 CFR 273.16(e) and (f).

COMMENT 2:
Proposed rule 7.19(17A) mentions form 470-5530, Waiver of Right to an Administrative Disqualification Hearing. However, the respondent notes the rule does not contain any information about what states are required to include in such a form, or under which circumstances the Department can issue such a notice to a Supplemental Assistance Nutrition Program (SNAP) participant.

The respondent requests the proposed rule makes it entirely clear that the Department is required to provide all of the criteria required by 7 CFR 273.16(e) and (f) in the waiver form. Respondent also suggested the rules provide that the form say, prominently and in bold, that the form need not be returned in order to get a hearing on the allegations of fraud.

RESPONSE 2:
Federal regulations at 7 CFR 273.16(f)(1) provide the requirements of what must be in the written notification sent to the individual to inform the individual of the possibility of waiving the administrative disqualification hearing. It is not necessary to repeat the requirements within the proposed rules and is covered by existing rule 7.2(17A) that indicates the program-specific federal law shall control and provides a reference to the federal code citation for the SNAP program. Also, the USDA Food and Nutrition Service has reviewed Iowa's form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, and has approved the form as it met the stated federal requirements.

No change will be made based on this comment.

COMMENT 3:
The respondent requests a statement be added to the rules indicating the Department must ensure that the evidence against the household member is reviewed by someone other than the eligibility worker assigned to the accused individual's household and it is determined such evidence warrants scheduling a disqualification hearing. This review must be conducted prior to the appeals section issuing form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

RESPONSE 3:
The Department already utilizes an established procedure where a referral for an administrative disqualification hearing is reviewed by someone other than the eligibility worker prior to submission to the appeals section. This practice already exists and the Department does not include procedural processes in the rules. No change will be made based on this comment.

COMMENT 4:

Federal regulations require intentional program violation waivers be sent by mail to prevent a situation where a fraud investigator could meet with an individual in person and pressure the individual to sign the waiver. The respondent suggests the rules explicitly provide form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, will be sent be mail only.

RESPONSE 4:

Based on the respondent's comment, Item 5, subrule 7.19(1), is amended as follows:

7.19(1) When a case is referred for an administrative disqualification hearing, the appeals section shall ~~provide~~ mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

COMMENTS ON FORM 470-5530:

When the respondent provided comments on the rules, the respondent had not yet reviewed form 470-5530, Waiver of Right to an Administrative Disqualification Hearing. Some of the comments related to the content of the form itself and not specifically to the context of the rules. A copy of the form and the form's instructions were shared with respondent and subsequent comments were provided by the on the form. The department has made additional changes to the form itself based on those additional commments

Changes made to the administrative rules are listed above.

Adoption of Rule Making

This rule making was adopted by the Council on Human Services on July 8, 2021.

Fiscal Impact

This rule making has no fiscal impact to the State of Iowa.

Jobs Impact

After analysis and review of this rule making, no impact on jobs has been found.

Waivers

Any person who believes that the application of the discretionary provisions of this rule making would result in hardship or injustice to that person may petition the Department for a waiver of the discretionary provisions, if any, pursuant to 441 IAC 1.8 (17A, 217).

Review by Administrative Rules Review Committee

The Administrative Rules Review Committee, a bipartisan legislative committee which oversees rule making by executive branch agencies, may, on its own motion or on written request by any individual or group, review this rule making at its regular monthly meeting or at a special meeting. The Committee's meetings are open to the public, and interested persons may be heard as provided in Iowa Code section 17A.8(6).

Effective Date

This rule making will become effective on September 1, 2021.

The following rule-making action is adopted:

THE FOLLOWING RULES ARE ADOPTED:

ITEM 1. Amend rule **441—7.1(17A)**, definitions of "Assistance program," "Good cause" and "Intentional program violation," as follows:

"Assistance program" means a program administered by the department or on the department's behalf through which qualifying individuals receive benefits or services. Assistance programs include, but are not necessarily limited to, ~~food assistance~~ the Supplemental Nutrition Assistance Program (SNAP), Medicaid, the family investment program, refugee cash assistance, child care assistance, emergency assistance, the family planning program, the family self-sufficiency grant, PROMISE JOBS, state supplementary assistance, the healthy and well kids in Iowa (hawki) program, foster care, adoption, and aftercare services.

"Good cause" means an intervening cause, not attributable to the negligence of a party, reasonably resulting in a delay or ~~in attendance~~ failure to attend, for purposes of subrules 7.4(3) and 7.9(2).

"Intentional program violation" means deliberately making a false or misleading statement; or misrepresenting, concealing, or withholding facts; or committing any act that is a violation of the ~~Food and Nutrition Act of 2008~~ Supplemental Nutrition Assistance Program (SNAP), ~~food assistance program~~ SNAP regulations, or any state law relating to the use, presentation, transfer, acquisition, receipt, possession, or trafficking of SNAP benefits or an electronic benefit transfer (EBT) card. An intentional program violation is determined through a ~~food assistance~~ SNAP administrative disqualification hearing~~. The hearing~~, a court conviction, or when an individual signs and returns Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, which may result in a period of ineligibility for the program, a claim for overpayment of benefits, or both.

ITEM 2. Amend rule 441—7.2(17A) as follows:

441—7.2(17A) Governing law and regulations. In the absence of an applicable rule in this chapter, the DIA rules found at 481—Chapter 10 govern department appeals. Notwithstanding the foregoing and the rules contained in this chapter, to the extent that federal or state law (including regulations and rules) related to a specific program is more specific than or contradicts these rules or the applicable DIA rules, the program-specific federal or state law shall control. For example, ~~food assistance~~ Supplemental Nutrition Assistance Program (SNAP) appeals shall be conducted in accordance with 7 CFR 273.15 and 7 CFR 273.16, and medical assistance appeals shall be conducted in accordance with 42 CFR Part 431, subpart E, and Part 438, subpart F.

ITEM 3. Amend paragraph **7.4(3)"a"** as follows:

a. ~~Food assistance~~ Supplemental Nutrition Assistance Program (SNAP), Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, family planning program and autism support program. For appeals pertaining to ~~food assistance~~ Supplemental Nutrition Assistance Program (SNAP), Medicaid eligibility, healthy and well kids in Iowa (hawki), fee-for-service Medicaid coverage, the family planning program or the autism support program, the appellant must appeal on or before the ninetieth day following the date of notice of an adverse benefit determination.

ITEM 4. Amend paragraph **7.4(3)"i"** as follows:

i. Assistance program overpayments. For appeals pertaining to the family investment program, refugee cash assistance, PROMISE JOBS, child care assistance, medical assistance, healthy and well kids in Iowa (hawki), family planning program or ~~food assistance~~ Supplemental Nutrition Assistance Program (SNAP) overpayments, the party-in-interest's right to appeal the existence, computation and amount of the overissuance or overpayment begins when the department sends the first notice informing the party-in-interest of the overissuance or overpayment.

ITEM 5. Adopt the following **new** rule 441—7.19(17A):

441—7.19(17A) Supplemental Nutrition Assistance Program (SNAP) administrative disqualification hearings. The department acts on alleged intentional program violations either through an administrative disqualification hearing or referral to a court of appropriate jurisdiction. An individual accused of an intentional

program violation may waive the individual's right to an administrative disqualification hearing in accordance with the procedures outlined in this rule and in 7 CFR 273.16 (e) and (f).

7.19(1) When a case is referred for an administrative disqualification hearing, the appeals section shall ~~provide~~ mail written notification to the individual that the individual can waive the right to an administrative disqualification hearing by signing and returning Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

7.19(2) By signing Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, the individual:

a. Waives the right to an administrative disqualification hearing;

b. Consents to the SNAP disqualification period designated on Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, and a reduction of benefits for the period of disqualification; and

c. Acknowledges that remaining household members, if any, may be held responsible for repayment of the resulting claim.

7.19(3) An administrative disqualification hearing shall be scheduled if the individual does not sign and mail or fax Form 470-5530, Waiver of Right to an Administrative Disqualification Hearing, to the appeals section within ten days of receipt of the written notification stating the individual can waive the right to an administrative disqualification hearing. The date on which the written notification is received is considered to be five days after the date on the notification, unless the individual shows the notification was not received within the five-day period.

7.19(4) An individual who waives the right to an administrative disqualification hearing will be subject to the same penalties as an individual found to have committed an intentional program violation in an administrative disqualification hearing.

7.19(5) No further administrative appeal procedure exists after an individual waives the individual's right to an administrative disqualification hearing and a disqualification penalty has been imposed. The disqualification penalty shall not be changed by a subsequent fair hearing decision.

Iowa Department of Human Services

Information on Proposed Rules

Name of Program Specialist	Telephone Number	Email Address
Denise Dutton	515-242-6302	ddutton@dhs.state.ia.us

1. Give a brief purpose and summary of the rulemaking:

   The Department of Human Services has changed the formal name of Iowa's food program from Food Assistance to the Supplemental Nutrition Assistance Program (SNAP) to be consistent with the name of the federal program and to alleviate confusion around food benefits that are available.

   Federal regulations give states the option of establishing procedures to allow individuals accused of an intentional SNAP violation to waive their right to an administrative disqualification hearing. With the recommendation of the USDA Food and Nutrition Service (FNS), the Department has decided to take advantage of this option.

   The Department is responsible for investigating any case of alleged intentional program violation. The Department will notify a SNAP household when the Department submits a referral to determine if an individual of that household intentionally violated SNAP program rules. Currently, the Department's only options to ensure appropriate cases are acted upon are through an administrative disqualification hearing or through criminal prosecution by a court of an appropriate jurisdiction.

   The amendments give individuals who are suspected of an intentional program violation an opportunity to waive their right to an administrative disqualification hearing, if the individual so chooses, on form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

   If the individual chooses to sign the form, the member will be disqualified from participating in the SNAP Program for a specified time and agrees to repay any overpayment associated with the violation. No administrative disqualification hearing will be held. The same disqualification penalty will be imposed if the individual chooses to give up the right to an administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

   No further administrative appeal procedure exists after an individual waives the individual's right to an administrative disqualification hearing and a disqualification penalty has been imposed.

2. What is the legal basis for the change? (Cite the authorizing state and federal statutes and federal regulations):

   Iowa Code 17A, Iowa Code 217.6 and 7 CFR 273.16(f)

3. Describe who this rulemaking will positively or adversely impact.

   Changing the formal name of Iowa's food program from Food Assistance to the Supplemental Nutrition Assistance Program (SNAP) will make the program name consistent with the name of the federal program and to alleviate confusion around food benefits that are available.

   Any individual who is investigated and referred for an administrative disqualification hearing for an intentional program violation will be affected by this rulemaking. Currently, the Department's only options to ensure appropriate cases are acted upon is through an administrative disqualification hearing or through criminal prosecution by a court of an appropriate jurisdiction. The amendments give individuals

who are suspected of an intentional program violation an opportunity to waive their right to an administrative disqualification hearing if they so choose.

If the Waiver of Right to an Administrative Disqualification Hearing form is signed, the individual is disqualified from participating in SNAP for a specified time and agrees to repay any overpayment associated with the violation. No administrative disqualification hearing will be held and no further administrative appeal procedure exists after an individual waives their right to an administrative disqualification hearing and a disqualification penalty has been imposed.

There are no requirements that an individual sign the Waiver of Right to an Administrative Disqualification Hearing form. This is optional for the individual who has been referred for an intentional program violation. If the form is not signed, an administrative disqualification hearing will be pursued.

The same disqualification penalty will be imposed if the individual chooses to give up the administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

4. Does this rule contain a waiver provision? If not, why?

   These amendments do not include waiver provisions because they confer benefits on those affected and are pursuant to federal law that does not provide for waivers, given that the process is optional. Individuals may request a waiver under the Department's general rule on exceptions at Iowa Admin. Code 441—1.8.

5. What are the likely areas of public comment?

   There are no requirements that an individual sign the Waiver of Right to an Administrative Disqualification Hearing form. This is optional for an individual who may have intentionally broken SNAP rules. If the form is not signed, an administrative disqualification hearing will be pursued.

   The same disqualification penalty will be imposed if the individual chooses to give up the administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

   As there are no additional penalties involved and the waiver of an individual's right to an administrative disqualification hearing is optional, it is anticipated that there will be no public comments made.

   Also, this rule making was previously adopted effective December 1, 2018, but was subsequently removed effective April 15, 2020 as the Department had not received written approval from the USDA Food and Nutrition Service (FNS) to implement. The Department has now received written approval to implement.

6. Do these rules have an impact on private-sector jobs and employment opportunities in Iowa? (If yes, describe nature of impact, categories and number of jobs affected, state regions affected, costs to employer per employee.)

   These rule changes have no impact on private-sector jobs and employment opportunities in Iowa.

Administrative Rule Fiscal Impact Statement

Date: January 29, 2021

Agency: Human Services

IAC citation: 441 IAC Chapter 7

Agency contact: Denise Dutton

Summary of the rule:

The Department of Human Services has changed the formal name of Iowa's food program from Food Assistance to the Supplemental Nutrition Assistance Program (SNAP) to be consistent with the name of the federal program and to alleviate confusion around food benefits that are available.

Federal regulations give states the option of establishing procedures to allow individuals accused of an intentional SNAP violation to waive their right to an administrative disqualification hearing. With the recommendation of the USDA Food and Nutrition Service (FNS), the Department has decided to take advantage of this option.

The Department is responsible for investigating any case of alleged intentional program violation. The Department will notify a SNAP household when the Department submits a referral to determine if an individual of that household intentionally violated SNAP program rules. Currently, the Department's only options to ensure appropriate cases are acted upon are through an administrative disqualification hearing or through criminal prosecution by a court of an appropriate jurisdiction.

The amendments give individuals who are suspected of an intentional program violation an opportunity to waive their right to an administrative disqualification hearing, if the individual so chooses, on form 470-5530, Waiver of Right to an Administrative Disqualification Hearing.

If the individual chooses to sign the form, the member will be disqualified from participating in the SNAP Program for a specified time and agrees to repay any overpayment associated with the violation. No administrative disqualification hearing will be held. The same disqualification penalty will be imposed if the individual chooses to give up the right to an administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

No further administrative appeal procedure exists after an individual waives the individual's right to an administrative disqualification hearing and a disqualification penalty has been imposed.

Fill in this box if the impact meets these criteria:

- [x] No fiscal impact to the state.
- [ ] Fiscal impact of less than $100,000 annually or $500,000 over 5 years.
- [ ] Fiscal impact cannot be determined.

Brief explanation:

Budget Analysts must complete this section for ALL fiscal impact statements.

There is no fiscal impact to the state. No additional costs to the regulated community or State of Iowa as a whole are anticipated.

Fill in the form below if the impact does not fit the criteria above:

☐ Fiscal impact of $100,000 annually or $500,000 over 5 years.

Assumptions:

There is no fiscal impact to the state.

Describe how estimates were derived:

There are no potential costs estimated for this rule.

Estimated Impact to the State by Fiscal Year

	Year 1 (FY 2021)	Year 2 (FY 2022)
Revenue by each source:		
General fund		
Federal funds		
Other (specify):		
TOTAL REVENUE		
Expenditures:		
General fund		
Federal funds		
Other (specify):		
TOTAL EXPENDITURES		
NET IMPACT		

☐ This rule is required by state law or federal mandate.
Please identify the state or federal law:
Identify provided change fiscal persons:

☐ Funding has been provided for the rule change.
Please identify the amount provided and the funding source:

☒ Funding has not been provided for the rule.
Please explain how the agency will pay for the rule change:
There is no fiscal impact to the state.

Fiscal impact to persons affected by the rule:

There is no fiscal impact. Changing the formal name of Iowa's food program from Food Assistance to the Supplemental Nutrition Assistance Program (SNAP) will make the program name consistent with the name of the federal program and to alleviate confusion around food benefits that are available.

Any individual who is investigated and referred for an administrative disqualification hearing for an intentional program violation will be affected by this rulemaking. Currently, the Department's only options to ensure appropriate cases are acted upon is through an administrative disqualification hearing or through criminal prosecution by a court of an appropriate jurisdiction. The amendments give individuals who are suspected of an intentional program violation an opportunity to waive their right to an administrative disqualification hearing if they so choose.

If the Waiver of Right to an Administrative Disqualification Hearing form is signed, the individual is disqualified from participating in SNAP for a specified time and agrees to repay any overpayment associated with the violation. No administrative disqualification hearing will be held and no further administrative appeal procedure exists after an individual waives their right to an administrative disqualification hearing and a disqualification penalty has been imposed.

There are no requirements that an individual sign the Waiver of Right to an Administrative Disqualification Hearing form. This is optional for the individual who has been referred for an intentional program violation. If the form is not signed, an administrative disqualification hearing will be pursued.

The same disqualification penalty will be imposed if the individual chooses to give up the administrative disqualification hearing and signs the waiver form or if the individual participates in the hearing and is found to have committed an intentional program violation by an administrative law judge.

Fiscal impact to counties or other local governments (required by Iowa Code 25B.6):

There is no expected impact on private sector jobs or employment in Iowa.

Agency representative preparing estimate:	Rob Beran	JH – 02/25/21, JS 2/26/21
Telephone number:	281-6188	

Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 2

(October - December 2020)

Performance Data

Published March 2021

Department of
HUMAN SERVICES

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 3
Managed Care Organization (MCO) Member Summary 4
MCO Financial Summary 6
Claims Universe 8
Claims Summary (Non-Pharmacy) 9
Claims Summary (Pharmacy) 11
Prior Authorizations 13
Grievances and Appeals 15
MCO Care Quality and Outcomes 17
MCO Children Summary 19
Long Term Services - Care Quality and Outcomes 21
Call Center Performance Metrics 25
Provider Network Access 27
MCO Program Integrity 29
MCO COVID-19 Summary 30
Appendix: Glossary 31

Executive Summary

This report is based on Quarter 2 of State Fiscal Year (SFY) 2021 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However, based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.
- Data pulled on other dates may not reflect the same numbers due to reinstatements and eligibility changes.
- All encounter data is provided "as is". The IME takes measures to attempt to ensure the accuracy, completeness, and reliability of the data. However, users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.
- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available fee-for-service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.
- Providers and members can find more information on the IA Health Link program at: http://dhs.iowa.gov/iahealthlink

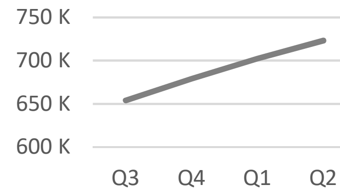
MCO Member Summary - All MCO Counts

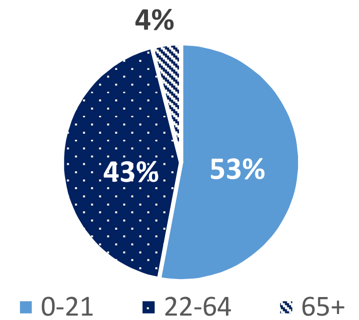
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

All MCO Members

723,211





+ 20,779 Members
2.96% Increase

All MCO Enrollment
(by Age)

Data Notes: December 2020 enrollment data as of February 9, 2020. The "Average" column below represents a four-quarter rolling average while the "Distinct" column represents the total number of unique individuals appearing within populations at least once during the past four-quarters.

	SFY20 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Distinct
MCO Member Summary	653,929	679,048	702,432	**723,211**	689,655	**727,293**
0-21	353,122	366,686	375,723	383,041	369,643	384,577
22-64	274,650	285,200	298,168	311,554	292,393	312,711
65+	26,157	27,162	28,541	28,616	27,619	30,005
Fee-For-Service (FFS) - Non MCO Enrollees	38,172	38,979	40,370	**41,375**	39,724	**42,911**

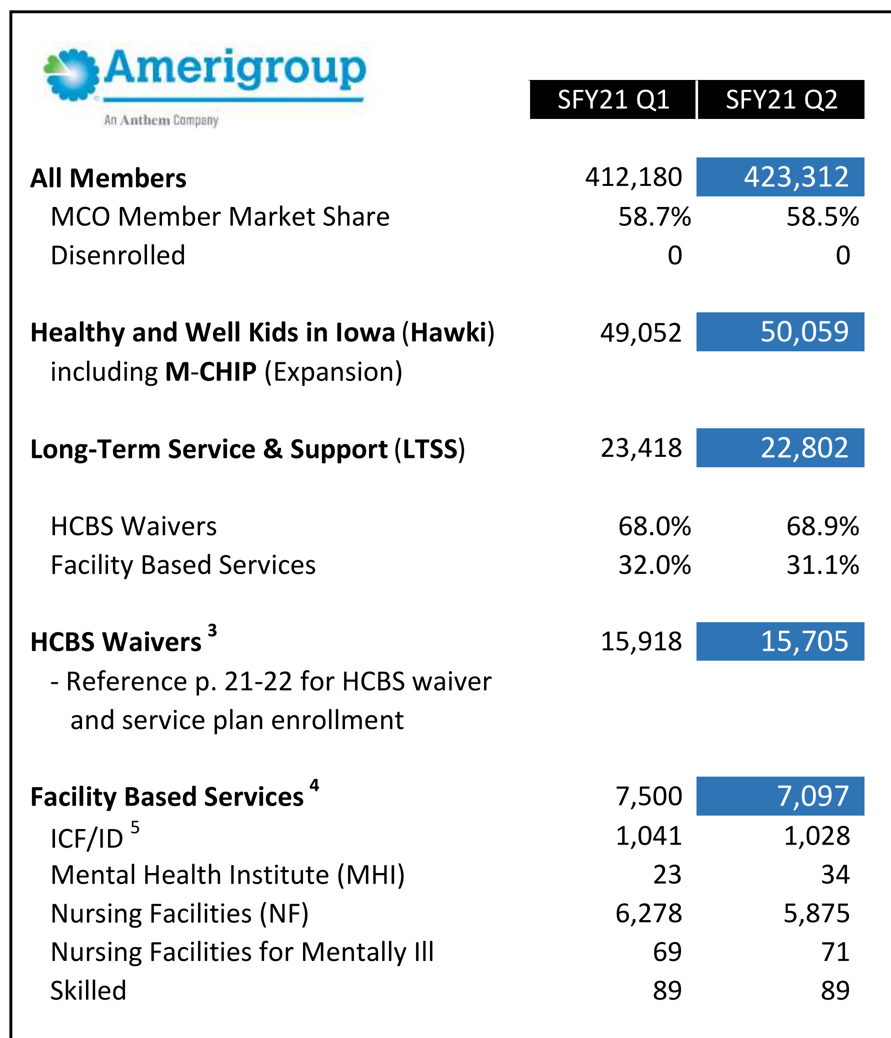
Significant Change in Data? (+/-) No [ ] Yes [X]

If Yes, explain:

Iowa Medicaid Population **770,204**
1 year distinct count

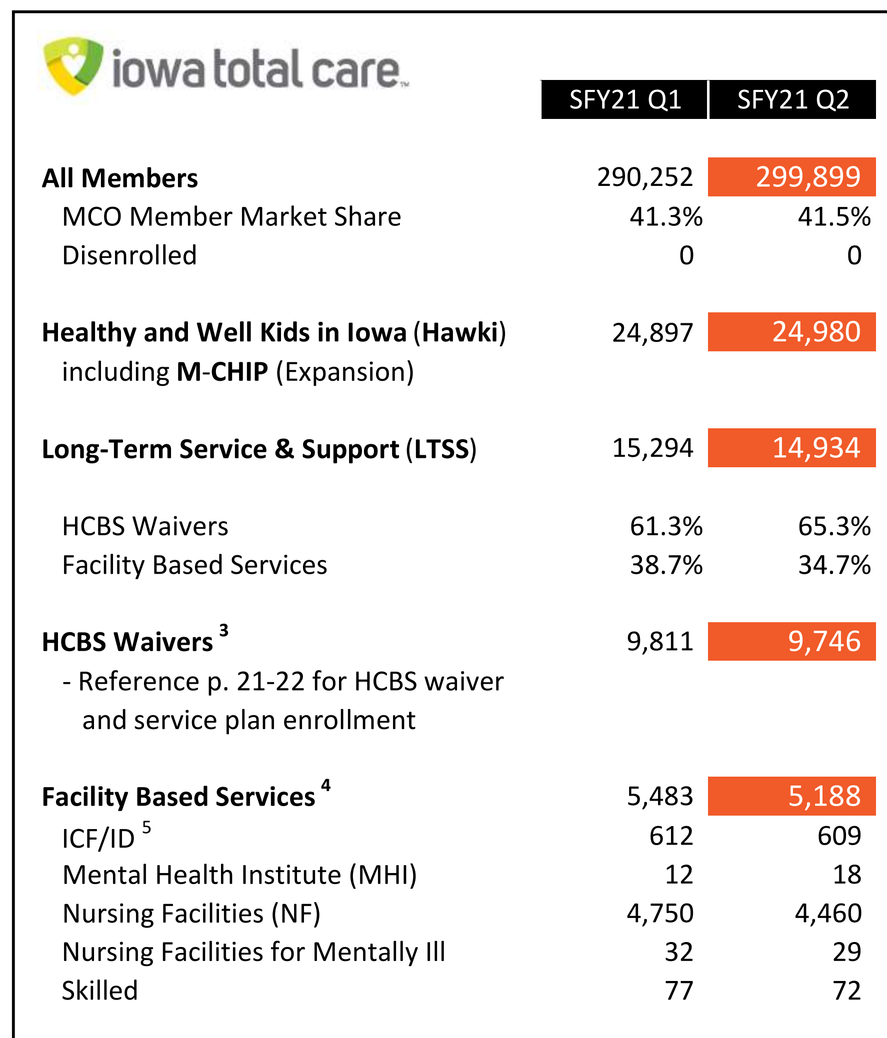
o MCO enrollment increased by 20,779 members (or 2.96% increase)
o Since March 2020, all MCO disenrollment has been suspended because of COVID-19

MCO Member Summary



Amerigroup
An Anthem Company

	SFY21 Q1	SFY21 Q2
All Members	412,180	423,312
MCO Member Market Share	58.7%	58.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (**Hawki**) including **M-CHIP** (Expansion)	49,052	50,059
Long-Term Service & Support (**LTSS**)	23,418	22,802
HCBS Waivers	68.0%	68.9%
Facility Based Services	32.0%	31.1%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	15,918	15,705
Facility Based Services [4]	7,500	7,097
ICF/ID [5]	1,041	1,028
Mental Health Institute (MHI)	23	34
Nursing Facilities (NF)	6,278	5,875
Nursing Facilities for Mentally Ill	69	71
Skilled	89	89



iowa total care

	SFY21 Q1	SFY21 Q2
All Members	290,252	299,899
MCO Member Market Share	41.3%	41.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (**Hawki**) including **M-CHIP** (Expansion)	24,897	24,980
Long-Term Service & Support (**LTSS**)	15,294	14,934
HCBS Waivers	61.3%	65.3%
Facility Based Services	38.7%	34.7%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	9,811	9,746
Facility Based Services [4]	5,483	5,188
ICF/ID [5]	612	609
Mental Health Institute (MHI)	12	18
Nursing Facilities (NF)	4,750	4,460
Nursing Facilities for Mentally Ill	32	29
Skilled	77	72

[3] Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24.

[4] Facility Based Services listed above only include the institutional groups where members are most likely to have an option to transition to an HCBS setting. Excluded institution types include Hospice and Psychiatric Medical Institutions for Children (PMICs).

[5] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

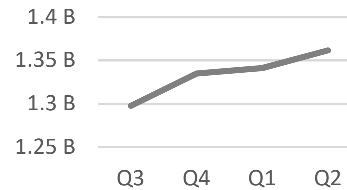
MCO Financial Summary - All MCO Counts

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

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

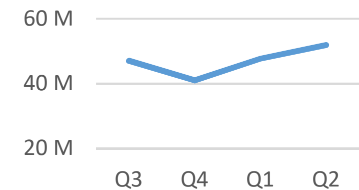
All Capitation Payments

$1.36 Billion



Third Party Liability Recovered

$ 51.91 Million



+ $20.3 Million
1.51% Increase

+ $ 4.3 Million
8.94% increase

Data Notes: December 2020 capitation data as of February 5, 2020. All Third Party Liability (TPL) data reported above is self-reported by MCOs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

	SFY20 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Financial Summary						
Capitation Payments	$1.3 B	$1.33 B	$1.34 B	**$1.36 B**	$1.33 B	$5.34 B
Third Party Liability (TPL) Recovered	$46.41 M	$41.63 M	$47.65 M	**$51.91 M**	$46.90 M	$187.60 M

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

If Yes, explain:

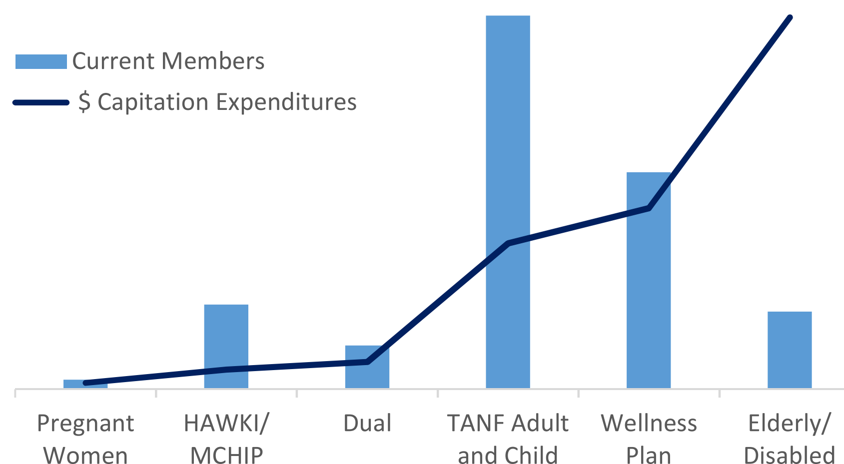
o Medical Loss Ratio (MLR) - The MLR is contractually set at 89% for the time period of July 1, 2020 through December 31, 2020.

o In Q3 SFY2020, the Department withheld $44M from ITC due to internal claims payments issues. As of the end of Q2 SFY21, this amount has still not been released.

MCO Financial Summary

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

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



	SFY21 Q1	SFY21 Q2
Capitation Totals	$802.56 M	**$811.95 M**
Adjustments	-$2.2 M	-$2.3 M
Current	$783.29 M	$793.35 M
Retro	$21.48 M	$20.9 M
Third Party Liability (TPL) Recovered	$23.26 M	**$22.40 M**
Financial Ratios		
Medical Loss Ratio (MLR)	86.2%	**88.8%**
Administrative Loss Ratio (ALR)	6.7%	6.3%
Underwriting Ratio (UR)	7.1%	5.8%
Annual MLR [6]		87.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

	SFY21 Q1	SFY21 Q2
Capitation Totals	$538.8 M	**$549.7 M**
Adjustments	-$2.04 M	-$1.34 M
Current	$520.41 M	$531.3 M
Retro	$20.44 M	$19.74 M
Third Party Liability (TPL) Recovered	$24.40 M	**$29.52 M**
Financial Ratios		
Medical Loss Ratio (MLR)	94.8%	**88.8%**
Administrative Loss Ratio (ALR)	5.1%	5.5%
Underwriting Ratio (UR)	0.1%	5.7%
Annual MLR [6]		91.7%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

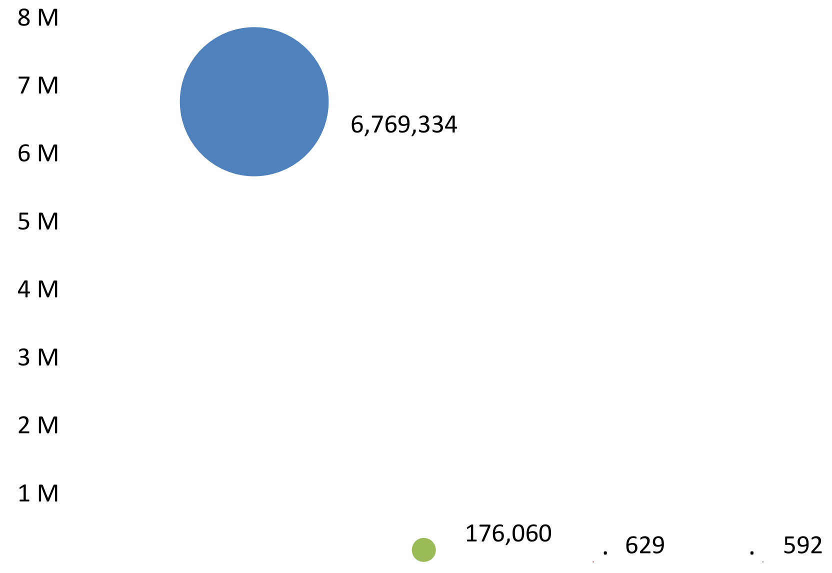
[6] Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

MCO Claims Universe - All MCO Counts

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

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

	% of Claims Universe
Prior Authorizations	2.60%
Grievances	0.01%
Appeals	0.01%

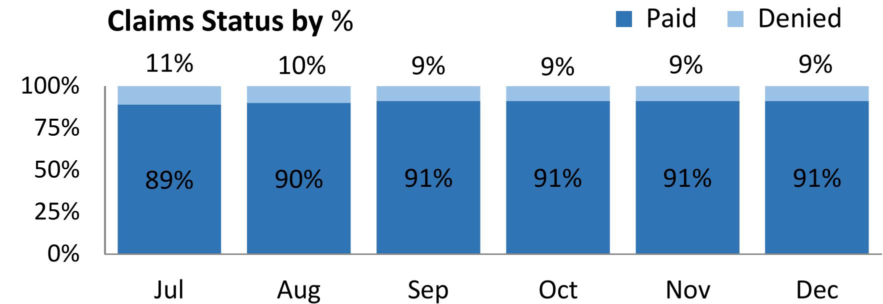


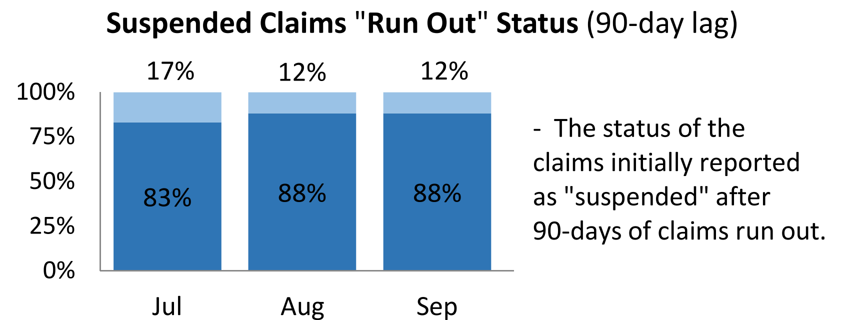
	SFY20 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Claim Counts - All Paid & Denied (p. 9-12)	7.79 M	5.95 M	7.02 M	**6.77 M**	6.88 M	27.54 M
Non-Pharmacy	4.62 M	3.17 M	4.02 M	3.96 M	3.94 M	15.77 M
Pharmacy	3.17 M	2.79 M	3.00 M	2.81 M	2.94 M	11.77 M
Prior Authorization Summary (p. 13-14)	178,919	145,452	172,937	**176,060**	168,342	673,368
Non-Pharmacy - All PAs Submitted	137,044	115,665	133,417	133,643	129,942	519,769
Pharmacy - All PAs Submitted	41,875	29,787	39,520	42,417	38,400	153,599
Grievances & Appeals Summary (p. 15-16)						
Grievances	936	422	718	**629**	676	2,705
Appeals	612	577	613	**592**	599	2,394

Claims Summary (Non-Pharmacy)

2.14 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	658,610	602,325	686,521
Denied	63,876	62,327	65,588
Suspended	139,459	151,215	115,585
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	99%	99%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	7	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	100%	97%





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

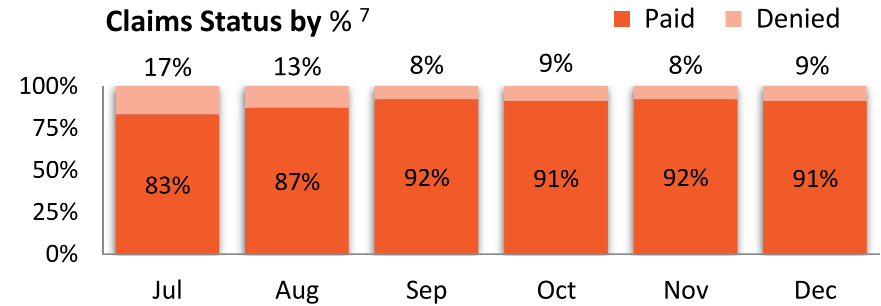
	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	33%	Duplicate claim service
2.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Claim/service lacks information or has submission/billing error(s)
4.	5%	Precertification/authorization/notification absent
5.	5%	Service not payable per managed care contract
6.	5%	An attachment/other documentation is required to adjudicate this claim/service.
7.	5%	The time limit for filing has expired
8.	3%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	3%	Claim/Service denied. At least one Remark Code must be provided
10.	2%	Expenses incurred after coverage terminated

Claims Summary (Non-Pharmacy)

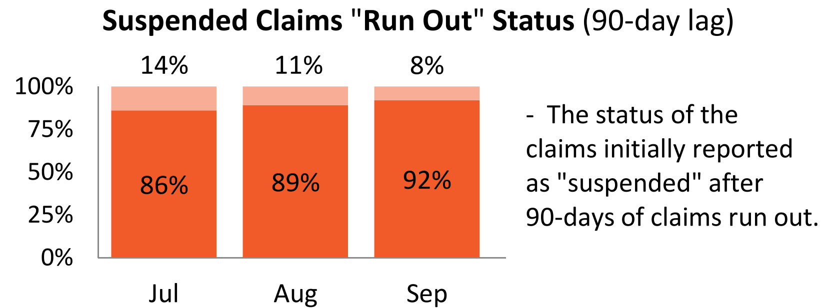
1.82 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	503,711	576,638	584,590
Denied	52,838	47,853	57,720
Suspended	173,513	218,331	82,791
Clean Claims Processed [7]			
in 30-days (Requirement 90%)	98%	97%	98%
in 45-days (Requirement 95%)	99%	99%	99%
Average Days to Pay [7]	10	10	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	100%	100%

Claims Status by % [7]



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



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

	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	15%	Duplicate claim service
2.	10%	National Drug Code (NDC) missing/invalid or not appropriate for procedure
3.	9%	Service can not be combined with other service on same day
4.	8%	No authorization on file that matches service(s) billed
5.	7%	Advanced claim edits (ACE) claim level return to provider
6.	7%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
7.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
8.	4%	Procedure coverage not defined by Medicaid; Provider to resubmit
9.	3%	Provider Medicaid ID required
10.	3%	ACE line item denial

[7] In SFY20, **Clean Claims Processed**, **Average Days to Pay**, and **Claims Status by %** were reported separately because of system configuration issues.

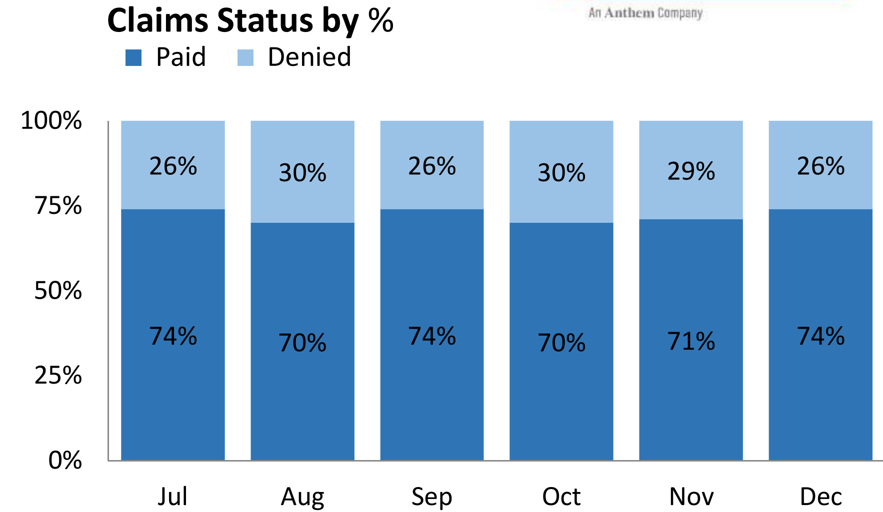
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **October**: 9,680
- **November**: 5,232
- **December**: 11,576

Claims Summary (Pharmacy)

1.6 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	357,245	353,842	437,935
Denied	153,240	142,138	151,481
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	11	12

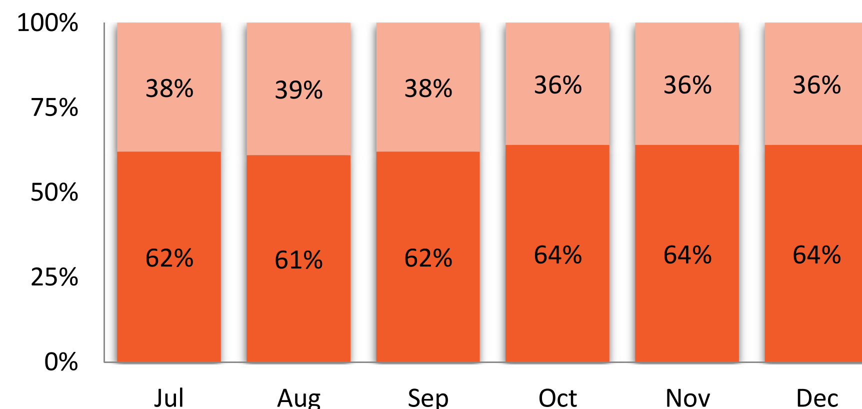


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	45%	Refill too soon
2.	15%	Prior authorization required
3.	14%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	3%	M/I other payer reject code
7.	2%	Filled after coverage terminated
8.	2%	Non matched prescriber ID
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	Discrepancy between other coverage code and other coverage information on file

Claims Summary (Pharmacy)

1.21 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	264,239	249,688	260,731
Denied	150,970	141,568	143,660
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	3	3	4



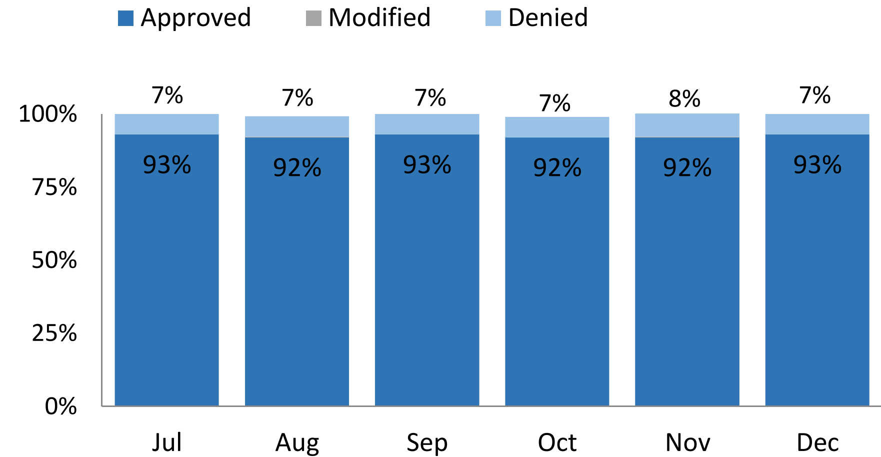
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	31%	Refill too soon
2.	10%	Prior authorization required
3.	4%	Quantity dispensed exceeds maximum allowed
4.	3%	Claim not processed
5.	3%	Product not on formulary
6.	3%	Submit bill to other processor or primary payer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Drug not covered for patient age
9.	2%	Filled after coverage expired
10.	2%	National Drug Code (NDC) not covered

Prior Authorization Summary

81,521
All PAs Submitted [8]

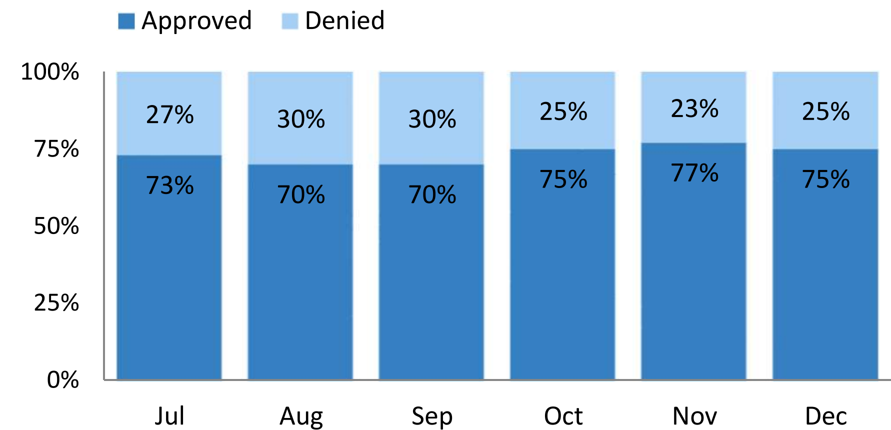
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	18,750	16,279	17,911
Denied	1,481	1,324	1,273
Modified	47	34	48
Average Days to Process	5	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	6,921	5,940	5,490
Denied	2,354	1,773	1,873
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	99.9%



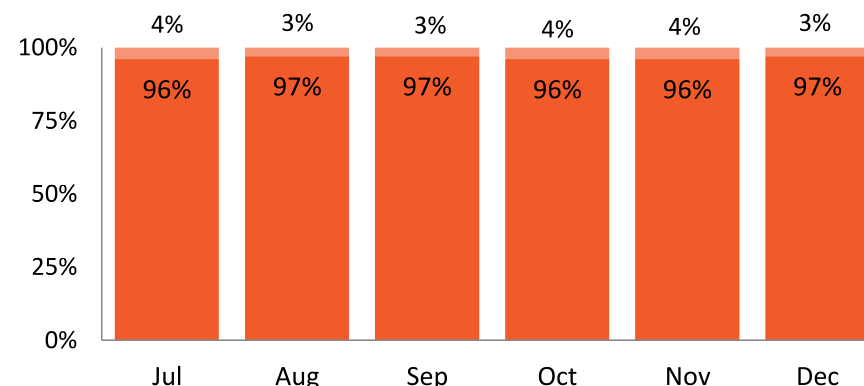
[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

94,539
All PAs Submitted [8]

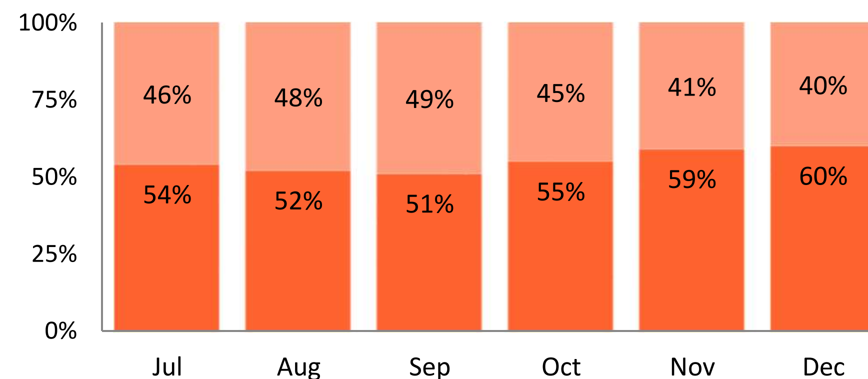
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	24,444	21,508	26,148
Denied	1,055	903	947
Modified	0	0	0
Average Days to Process	3	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	3,024	3,087	3,258
Denied	2,459	2,122	2,200
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	99.9%

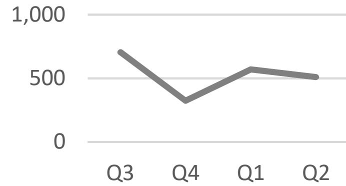


[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

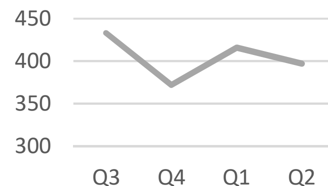
Grievances

510



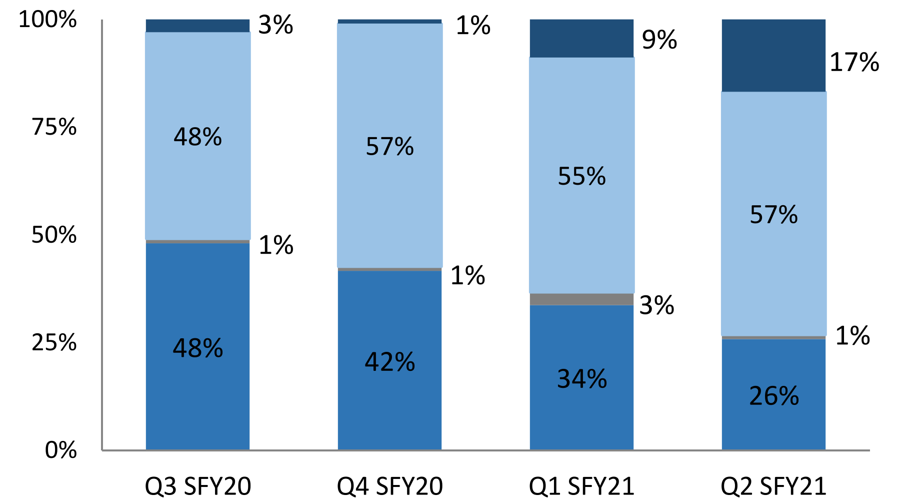
Appeals

397



Resolved in 30-days 100%	Resolved in 30-days 100%

Appeal Outcome Percentages



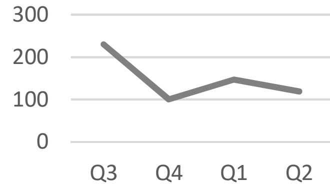
	%	Top 10 Reasons for Grievances
1.	39%	Voluntary Disenrollment
2.	18%	Provider balance billed
3.	7%	Adequacy of treatment record keeping
4.	6%	Transportation - Driver no-show
5.	4%	Availability of appointments
6.	4%	Transportation - Driver Delay
7.	4%	Treatment Dissatisfaction
8.	4%	Provider attitude/rudeness
9.	3%	Delay in Treatment
10.	3%	Inadequate benefit access

%	Top 10 Reasons for Appeals
20%	Pharmacy - Non Injectable
18%	Durable Medical Equipment (DME)
10%	Radiology
9%	Surgery
8%	Therapy - Physical Therapy
8%	Pharmacy - Injectable
4%	Inpatient Services - Medical
4%	Laboratory
3%	Behavioral Health (BH) - Op Service
3%	Behavioral Health (BH) - Inpatient

Grievances and Appeals

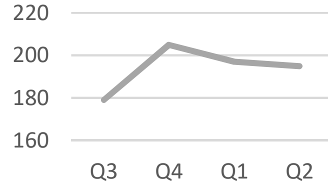
Grievances

119



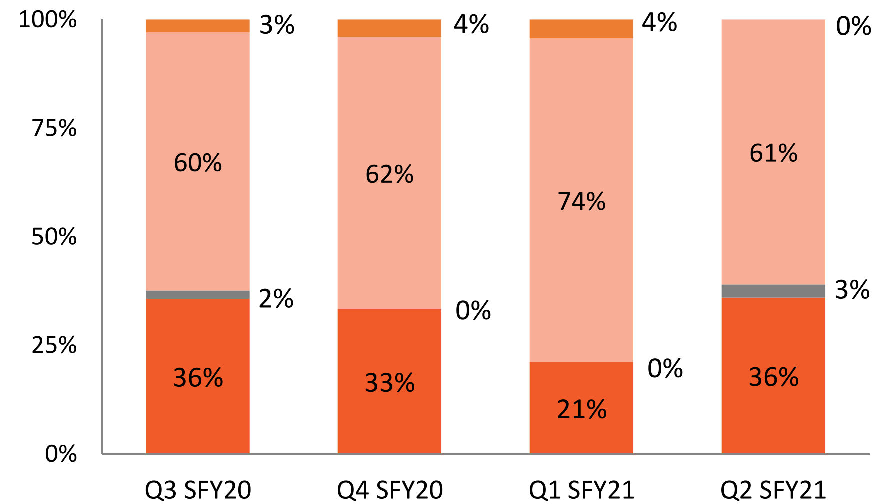
Appeals

195



Resolved in 30-days	Resolved in 30-days
100%	100%

Appeal Outcome Percentages

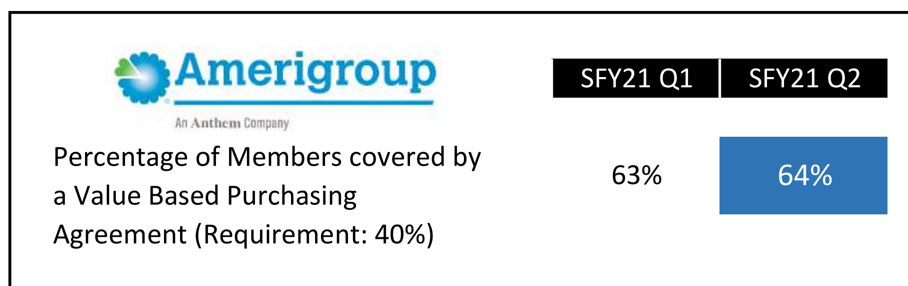


	%	Top 10 Reasons for Grievances
1.	27%	Access to Care - Network Availability
2.	17%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	5%	Transportation - Missed Appointment
5.	4%	Provider
6.	4%	Transportation - Late Appointment
7.	3%	Lack of Caring/Concern
8.	3%	Health Plan Staff
9.	3%	Claim Dispute
10.	2%	Transportation - Unsafe Driving

%	Top 10 Reasons for Appeals
39%	RX - Does Not Meet Prior AuthGuidelines
17%	Other - Mental Health Service
5%	Diagnostic - CAT Scan
3%	Diagnostic - MRI
3%	DME - Wheelchair
2%	DME - Other
2%	Injections - Epidural
2%	DME - Orthopedic Devices
2%	Outpatient - Home Health Visits
1%	DME - CPAP Machine

Value Based Purchasing (VBP) Agreement

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



Amerigroup	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	64%

Iowa Total Care	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	84%	84%

Top 5 - Value Added Services (VAS)

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

Amerigroup
An Anthem Company

Amerigroup	SFY21 Q1	SFY21 Q2
Community Resource Link	841	2,989
Taking Care of Baby and Me	2,095	2,482
Healthy Rewards[9]	1,678	1,408
Dental Hygiene Kit	683	711
SafeLink Mobile Phone	723	581

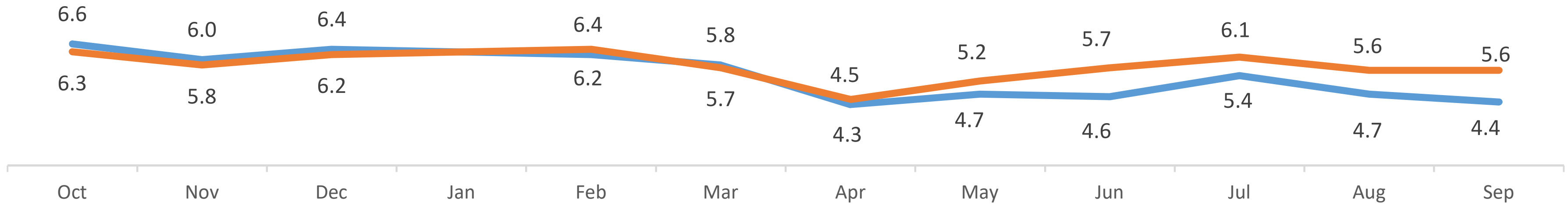
iowa total care

Iowa Total Care	SFY21 Q1	SFY21 Q2
My Health Pays Program	8,755	13,222
The Flu Program	2,689	3,427
Start Smart for Your Baby	1,558	1,215
Mobile App	544	989
myStrength.com	28	428

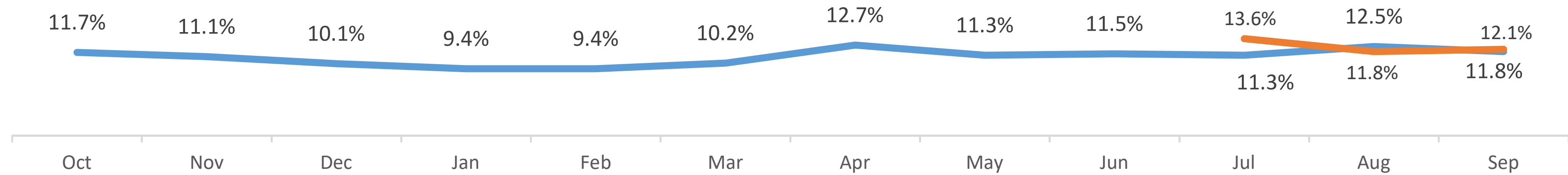
[9] *Amerigroup is reporting the total number of members who received an award in quarter (not the total enrolled in program).*

MCO Care Quality and Outcomes

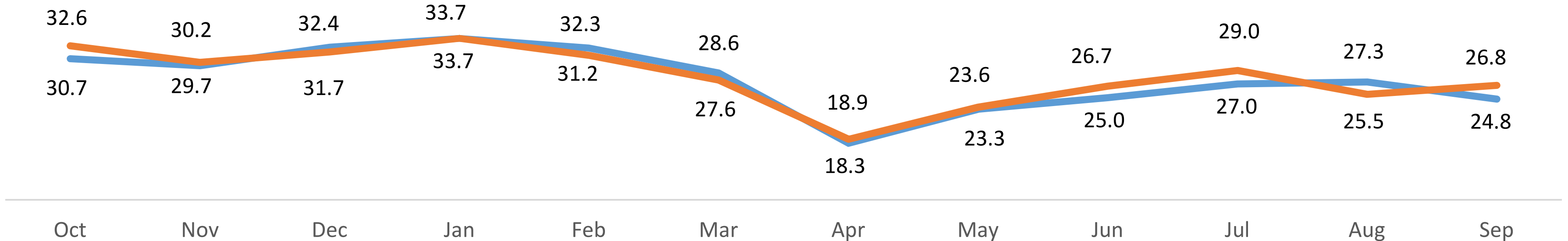
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [10]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [11]



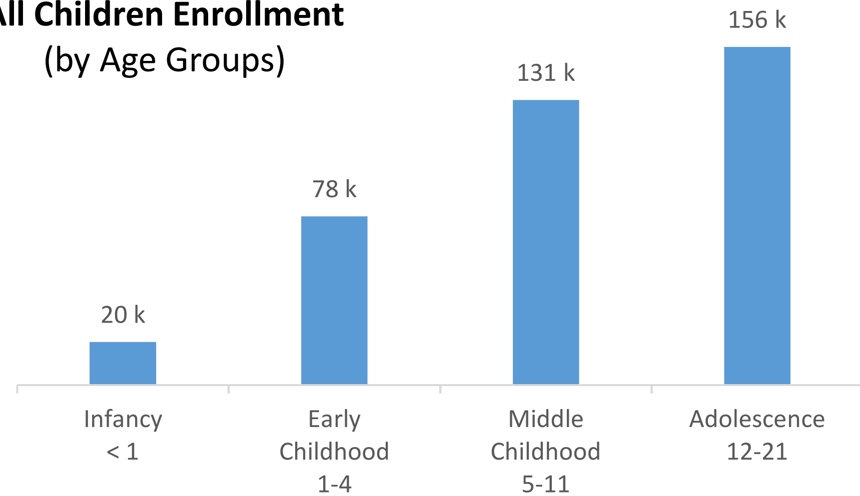
[10] *This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.*
[11] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

MCO Children Summary

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

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

Data Note: MCO Enrollment, Well Child Exams, Screenings, and Immunizations are compared using the same quarter 1-year apart.



	SFY20 Q2	SFY21 Q2
Member Enrollment	**225,398**	**231,588**
Infancy < 1	13,684	10,159
Early Childhood 1 - 4	46,178	47,354
Middle Childhood 5 - 11	78,030	79,742
Adolescence 12 - 21	87,506	94,333
Well Child Exams (Preventive Visits)	46,157	43,306
Infancy < 1	15,136	11,524
Early Childhood 1 - 4	13,674	12,993
Middle Childhood 5 - 11	9,270	9,947
Adolescence 12 - 21	8,077	8,842
Lead Screenings	5,386	4,313
Infancy < 1	228	98
Early Childhood 1 - 4	4,777	3,853
Middle Childhood 5 - 11	343	323
Adolescence 12 - 21	38	39

	SFY20 Q2	SFY21 Q2
Member Enrollment	**150,165**	**154,855**
Infancy < 1	8,547	9,615
Early Childhood 1 - 4	30,611	30,738
Middle Childhood 5 - 11	52,051	52,334
Adolescence 12 - 21	58,956	62,168
Well Child Exams (Preventive Visits)	32,242	30,439
Infancy < 1	10,652	10,480
Early Childhood 1 - 4	9,048	7,949
Middle Childhood 5 - 11	6,801	6,423
Adolescence 12 - 21	5,741	5,587
Lead Screenings	3,921	2,961
Infancy < 1	136	69
Early Childhood 1 - 4	3,476	2,661
Middle Childhood 5 - 11	284	217
Adolescence 12 - 21	25	14

MCO Children Summary

	SFY20 Q2	SFY21 Q2
Hearing Screenings	2,810	1,872
Infancy < 1	225	113
Early Childhood 1 - 4	1,236	830
Middle Childhood 5 - 11	1,009	654
Adolescence 12 - 21	340	275
Vision Screenings	974	901
Infancy < 1	65	10
Early Childhood 1 - 4	476	374
Middle Childhood 5 - 11	276	343
Adolescence 12 - 21	157	174

Immunization Summary - Vaccines for Children (VFC)

	SFY20 Q2	SFY21 Q2
Vaccination Totals	104,285	91,072
DTaP (Diphtheria, Tetanus, Pertussis)	11,737	10,124
Influenza (FLU)	46,228	40,164
HepA (Hepatitis A)	5,353	4,956
HepB (Hepatitis B)	2,489	951
Haemophilus Influenza Type B (Hib)	6,169	5,238
Human Papillomavirus (HPV)	3,243	3,092
Meningococcal ACWY (MenACWY)	2,614	3,103
Meningococcal B - (MenB)	1,423	1,430
MMR (Measles, Mumps, Rubella)	4,607	4,389
Pneumococcal (PCV13)	9,284	7,727
Pneumococcal (PPSV23)	104	72
Polio (IPV)	362	297
RV (Rotavirus)	5,968	4,874
Tetanus and diphtheria (Td)	68	43
TDAP (Tetanus, Diphtheria, Pertussis)	2,093	2,247
Varicella Virus Vaccine (VAR)	2,543	2,365

	SFY20 Q2	SFY21 Q2
Hearing Screenings	1,452	1,072
Infancy < 1	97	83
Early Childhood 1 - 4	614	420
Middle Childhood 5 - 11	502	391
Adolescence 12 - 21	239	178
Vision Screenings	660	669
Infancy < 1	23	19
Early Childhood 1 - 4	314	281
Middle Childhood 5 - 11	212	245
Adolescence 12 - 21	111	124

Immunization Summary - Vaccines for Children (VFC)

	SFY20 Q2	SFY21 Q2
Vaccination Totals	70,828	62,721
DTaP (Diphtheria, Tetanus, Pertussis)	8,076	7,639
Influenza (FLU)	29,211	24,481
HepA (Hepatitis A)	3,797	3,049
HepB (Hepatitis B)	4,895	4,576
Haemophilus Influenza Type B (Hib)	2,842	2,606
Human Papillomavirus (HPV)	2,467	2,066
Meningococcal ACWY (MenACWY)	1,921	1,913
Meningococcal B - (MenB)	26	14
MMR (Measles, Mumps, Rubella)	3,021	2,909
Pneumococcal (PCV13)	6,539	6,110
Pneumococcal (PPSV23)	0	0
Polio (IPV)	342	216
RV (Rotavirus)	4,292	4,019
Tetanus and diphtheria (Td)	51	14
TDAP (Tetanus, Diphtheria, Pertussis)	1,653	1,431
Varicella Virus Vaccine (VAR)	1,695	1,678

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

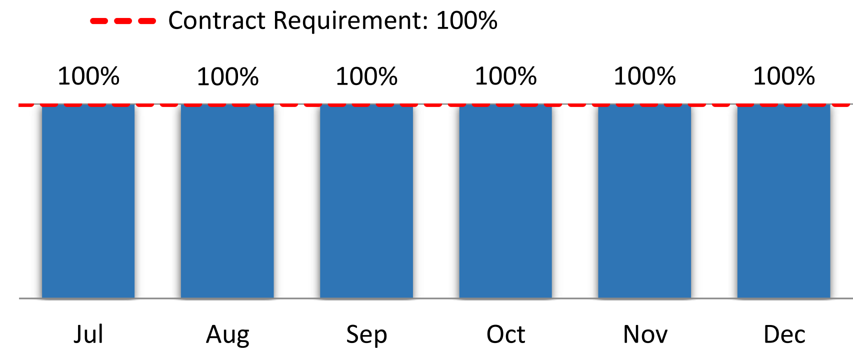
Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	16	**24**
HCBS Members to Case Managers	65	**65**

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

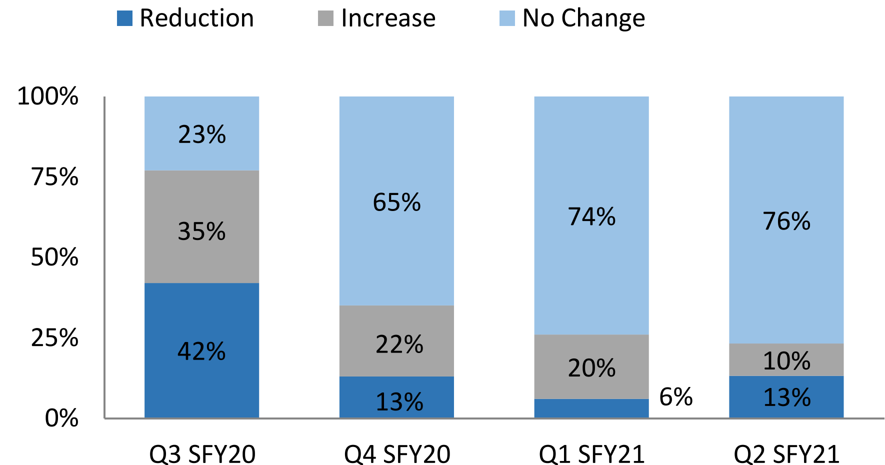
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.6%
	Yes	99.7%	99.4%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.7%	100.0%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

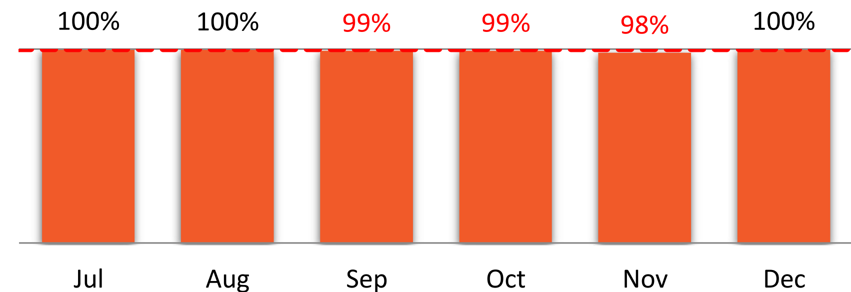
Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	36	**20**
HCBS Members to Case Managers	38	**41**

Iowa Participant Experience Survey (IPES)

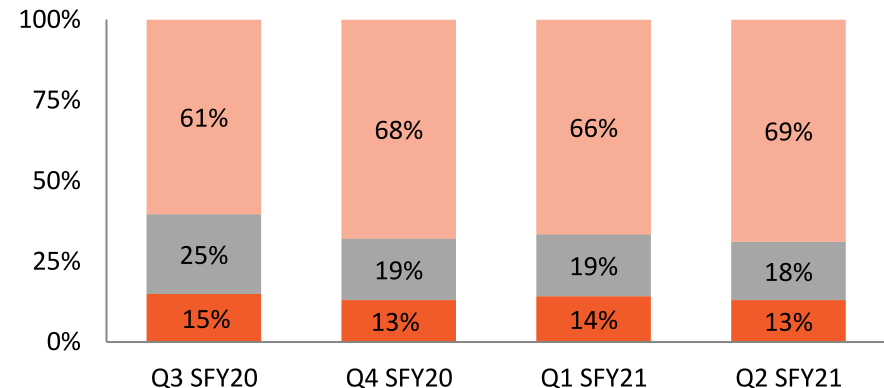
Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.4%	0.4%
	No	5.2%	1.1%
	Sometimes	1.1%	1.9%
	Yes	93.3%	96.7%
They feel safe where they live.	I don't know	0.8%	0.4%
	No	2.3%	0.4%
	Sometimes	1.9%	1.5%
	Yes	95.1%	97.8%
Their services make their lives better.	I don't know	1.1%	0.0%
	No	1.9%	0.7%
	Sometimes	2.6%	2.6%
	Yes	94.4%	96.7%

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

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services
- by Member Usage

	SFY21 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	16	16
CDAC (individual) by 15 minute units	0	3
Supported Community Living (daily)	1	1
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	0	1
Brain Injury (BI) Waivers	831	821
Financial Management Services	236	239
Supported Community Living (by unit)	224	210
Respite (by 15 minute units)	174	170
Personal Emergency Response	162	163
Supported Community Living (daily)	107	107
Children's Mental Health (CMH)	879	876
Respite (by 15 minute units)	441	453
Family and Community Support	271	240
Respite (Hos/NF) - 15 minute units	245	232
Respite (Resident Camp) by units	18	14
Home Delivered Meals	8	8
Elderly Waivers	4,886	4,795
Home Delivered Meals	3,213	3,089
Personal Emergency Response	3,144	3,056
Assisted Living Services	437	412
CDAC (agency) by 15 minute units	319	349
Personal Emergency Response (install)	343	319

	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	4,786	4,696
Home-based Habilitation	3,816	3,991
Long Term Job Coaching	403	375
Day Habilitation (units by day)	213	319
Day Habilitation (by 15 minute units)	593	282
Individual Supported Employment	184	196
Health & Disability (HD)	1,394	1,359
Financial Management Services	374	361
Home Delivered Meals	364	356
Respite (by 15 minute units)	370	350
Personal Emergency Response	363	349
Respite (Hos/NF) - 15 minute units	67	67
Intellectual Disability (ID)	7,150	7,111
Supported Community Living (by unit)	1,886	1,848
Supported Community Living (daily)	1,965	1,586
Day Habilitation (units by day)	1,551	1,498
Financial Management Services	1,376	1,385
Supported Community Living (RCF)	966	1,107
Physical Disability (PD)	759	724
Personal Emergency Response	402	384
CDAC (agency) by 15 minute units	70	72
Personal Emergency Response (install)	75	63
Home-based Habilitation	60	52
Home Delivered Meals	55	51

Long Term Services - Waiver Service Plan Participation

All eligible members receive service coordination and a customized individual service plan. For additional information on the HCBS waiver program including a full list of available services reference our dedicated webpage: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services
- by Member Usage

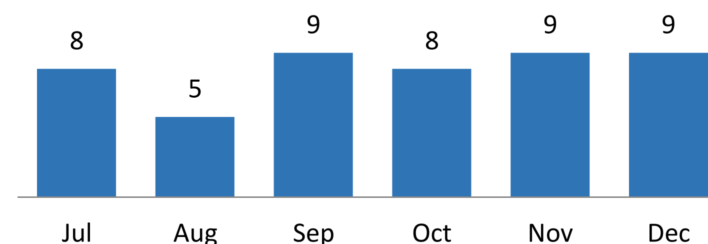
	SFY21 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	13	11
Home Delivered Meals	7	7
CDAC (individual) by 15 minute units	6	5
Homemaker (by 15 minute units)	2	3
Supported Community Living (daily)	2	2
Day Habilitation (units by day)	1	1
Brain Injury (BI) Waivers	531	532
Supported Community Living (by unit)	233	234
Respite (by 15 minute units)	157	153
Personal Emergency Response	127	130
Supported Community Living (daily)	119	117
Transportation (1-way trip)	92	93
Children's Mental Health (CMH)	351	351
Respite (by 15 minute units)	173	192
Respite (Hos/NF) - 15 minute units	96	113
Family and Community Support	85	89
Mental Health Service	5	16
Respite (Resident Camp) by units	7	6
Elderly Waivers	3,336	3,310
Home Delivered Meals	2,548	2,610
Personal Emergency Response	2,451	2,526
CDAC (agency) by 15 minute units	1,285	1,330
Homemaker (by 15 minute units)	914	928
CDAC (individual) by 15 minute units	778	762

	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	2,395	2,416
Home-based Habilitation	1,787	1,800
Day Habilitation (by 15 minute units)	370	350
Day Habilitation (units by day)	283	270
Long Term Job Coaching	225	240
Individual Supported Employment	145	153
Health & Disability (HD)	645	631
Respite (by 15 minute units)	297	292
Home Delivered Meals	203	190
Personal Emergency Response	180	176
CDAC (individual) by 15 minute units	130	130
CDAC (agency) by 15 minute units	111	109
Intellectual Disability (ID)	4,524	4,512
Supported Community Living (by unit)	1,949	1,939
Day Habilitation (by 15 minute units)	1,912	1,899
Day Habilitation (units by day)	1,778	1,769
Supported Community Living (RCF)	1,490	1,440
Respite (by 15 minute units)	1,075	1,079
Physical Disability (PD)	411	399
Personal Emergency Response	244	236
CDAC (agency) by 15 minute units	204	197
CDAC (individual) by 15 minute units	144	148
Transportation (1-way trip)	56	54
Personal Emergency Response (install)	40	28

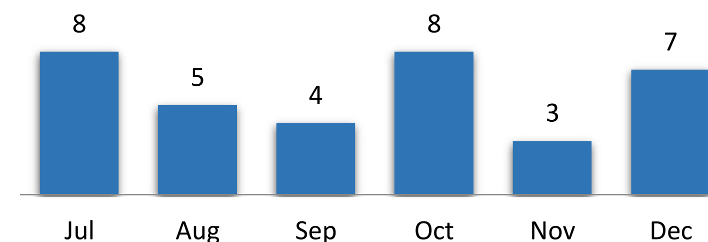
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	96.30%	96.77%	97.06%
Abandonment Rate - Must be 5% or less	1.08%	0.38%	0.50%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	90.51%	92.20%	94.57%
Abandonment Rate - Must be 5% or less	0.07%	0.07%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	90.98%	94.25%	91.36%
Abandonment Rate - Must be 5% or less	0.69%	0.19%	0.22%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	78.63%	90.80%	92.59%
Abandonment Rate - Must be 5% or less	3.25%	0.44%	0.80%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	76.62%	81.23%	94.60%
Abandonment Rate - Must be 5% or less	1.77%	1.29%	0.90%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

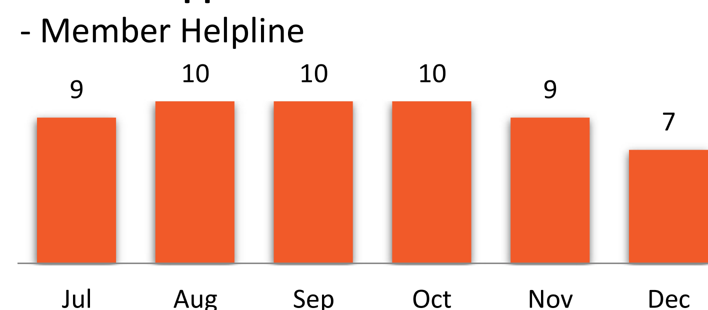
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Transportation Inquiry
5.	Claim Inquiry

Top 5 Call Reasons (Provider Helpline)
Authorization Status
Claim Status
Benefit Inquiry
Authorization New
Enrollment Inquiry

Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	81.00%	72.93%	80.91%
Abandonment Rate - Must be 5% or less	4.35%	4.54%	2.87%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	89.70%	71.87%	90.18%
Abandonment Rate - Must be 5% or less	3.74%	4.92%	4.62%
Provider Helpline			
Service Level (Requirement 80%)	83.70%	79.11%	82.38%
Abandonment Rate - Must be 5% or less	2.75%	2.51%	2.95%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	92.41%	91.43%	92.33%
Abandonment Rate - Must be 5% or less	0.43%	0.22%	0.13%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	70.29%	77.73%	94.03%
Abandonment Rate - Must be 5% or less	2.01%	1.45%	1.20%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline

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

	Top 5 Call Reasons (Member Helpline)
1.	Benefits and Eligibility for Member
2.	Update PCP/PPG for Member
3.	Member Rewards for Member
4.	Coordination Of Benefits for Member
5.	Order ID card

Top 5 Call Reasons (Provider Helpline)
Medical Claims Inquiry for Provider
Coordination Of Benefits for Provider
Benefits and Eligibility for Provider
View Authorization for Provider
Provider Outreach for Provider

Provider Network Access Summary

Primary Care Providers (PCP)

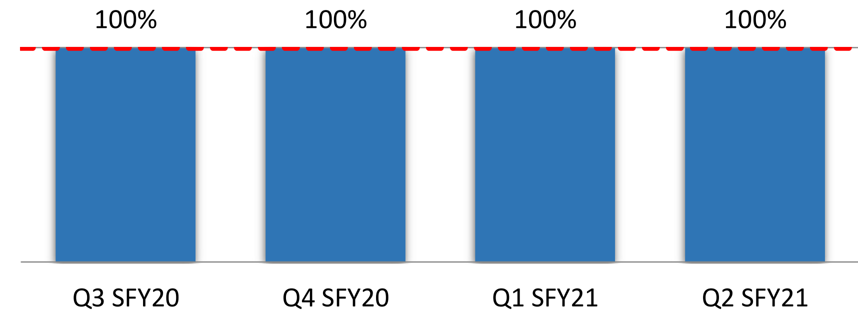
	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	6,591	6,641
Members with Access	204,945	210,795
Average Distance (Miles)	2	1.5
Pediatric PCP		
Provider Count	6,634	6,677
Members with Access	204,867	203,169
Average Distance (Miles)	2	1.6

Specialty Care & Behavioral Health (BH)

	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	400	399
Members with Access	134,256	137,341
Average Distance (Miles)	5.7	5.6
Outpatient - Behavioral Health		
Provider Count	4,000	4,043
Members with Access	409,812	413,964
Average Distance (Miles)	2	2.1
Inpatient - Behavioral Health		
Provider Count	49	48
Rural Members		
Members with Access	168,321	169,705
Average Distance (Miles)	21	21.6
Urban Members		
Members with Access	241,491	244,259
Average Distance (Miles)	6	5.7

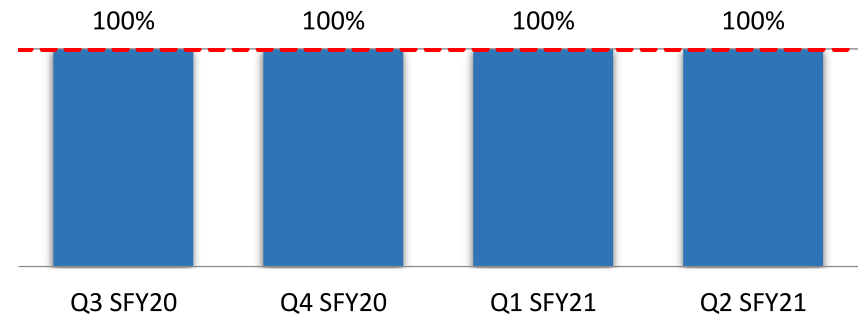
Adult PCP - Time Standards

30 minutes or 30 miles



Pediatric PCP - Time Standards

30 minutes or 30 miles



Link to Geo Access Reports:
https://dhs.iowa.gov/ime/about/performance-data-geoaccess

Provider Network Access Summary

Primary Care Providers (PCP)

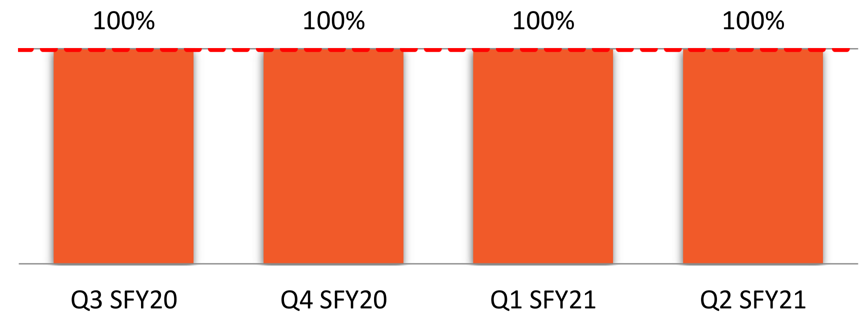
	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	8,301	8,548
Members with Access	153,137	160,490
Average Distance (Miles)	2.0	2.0
Pediatric PCP		
Provider Count	8,986	9,262
Members with Access	133,933	136,490
Average Distance (Miles)	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	1,183	1,207
Members with Access	102,412	106,694
Average Distance (Miles)	5.4	5.4
Outpatient - Behavioral Health		
Provider Count	7,842	8,251
Members with Access	287,070	296,980
Average Distance (Miles)	2.6	2.5
Inpatient - Behavioral Health		
Provider Count	35	35
Rural Members		
Members with Access	205,468	212,426
Average Distance (Miles)	25	24.7
Urban Members		
Members with Access	81,602	84,554
Average Distance (Miles)	8	8.4

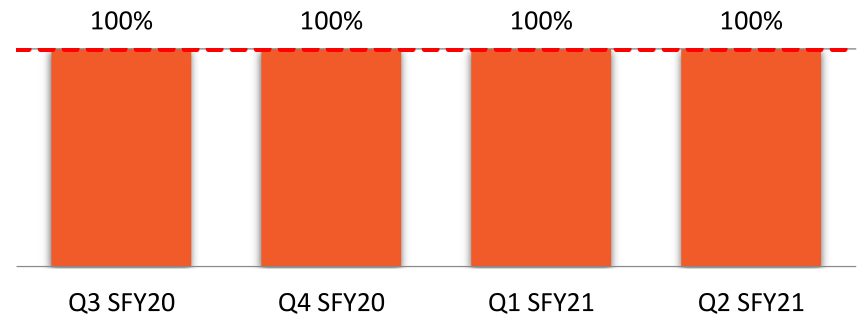
Adult PCP - Time Standards

30 minutes or 30 miles



Pediatric PCP - Time Standards

30 minutes or 30 miles



Link to Geo Access Reports:
https://dhs.iowa.gov/ime/about/performance-data-geoaccess

MCO Program Integrity

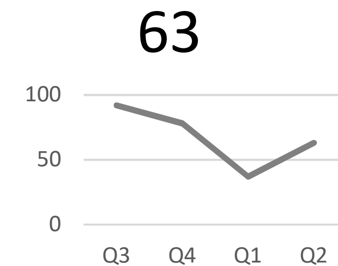
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems, which have a series of edits that reject inaccurate or duplicate claims.

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

The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse. Therefore MCO investigations, overpayment recovery, and referrals to MFCU listed in this chart would be considered pending until final determinations are made.

Total Investigations Opened - SFY21 Q2

63



9 Total Cases
Referred to MCFU

Program Integrity
- Fraud, Waste, & Abuse

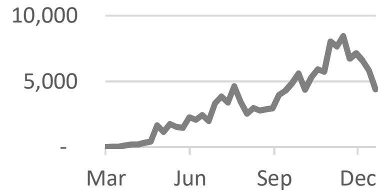
	SFY21 Q1	SFY21 Q2
Investigations opened	28	34
Overpayments identified	23	23
Member concerns referred to IME	6	3
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	6

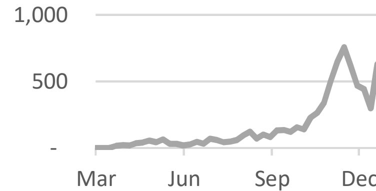
Program Integrity
- Fraud, Waste, & Abuse

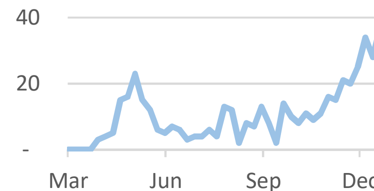
	SFY21 Q1	SFY21 Q2
Investigations opened	9	29
Overpayments identified	0	1
Member concerns referred to IME	8	4
Cases referred to the Medicaid Fraud Control Unit (MCFU)	1	3

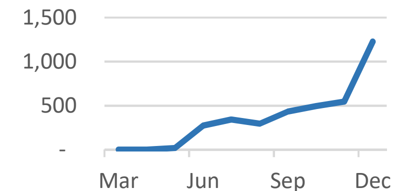
MCO COVID-19 Summary

Total Individuals Tested	Total Tested Positive	Total COVID Deaths	Total COVID Inpatient Stays [12]
146,288	7,098	462	3,625









81,802 tested in Q2	4.9%	0.06%	1.38%
78% Increase	% Tested Positive	% of MCO Population	% of Total Inpatient stays

COVID-19 testing and treatment is a covered benefit for Medicaid members. Total test counts reflect multiple tests for some individuals. In Q2, ITC updated logic used to evaluate inpatient stays which lead to the adjustment of previously reported COVID Inpatient Stays. [12]

Claims Activity During COVID-19

MCO Total Counts	Q1 SFY21	Q2 SFY21
ER Visits - Counts	**298,300**	**255,268**
Amount Paid	$63.77 M	$64.17 M
Telehealth Services - Counts	**156,254**	**162,046**
Amount Paid	$14.08 M	$14.42 M
Transportation - Counts	**200,464**	**213,932**
Amount Paid	$9.35 M	$9.61 M
Home Maker Services - Counts	**6,283**	**7,921**
Amount Paid	$1.18 M	$1.26 M
COVID Testing - Counts	**46,040**	**81,802**
Amount Paid	$6.02 M	$9.72 M
Meals - Counts	**12,817**	**12,594**
Amount Paid	$6.44 M	$6.05 M

Telehealth Services - All MCO Counts

o In March, IL 2115-MC-FFS and IL 2119-MC-FFS authorized the expansion of telehealth services in Iowa.

o Since March, the Managed Care Organizations have reported a significant increase in telehealth services.

o IME is currently reviewing the continuation of telehealth service expansion once the public health emergency is lifted.

Appendix: Glossary

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

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

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

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

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

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO. Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required time-frames.
- For a resident of a rural area with only one MCO, the denial of services outside the network

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

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

Capitation Expenditures: Medicaid payments the Department makes on a monthly basis to the MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member's eligibility.

- **Adjustments**: Monetary only payments/adjustments that can occur within the paid month for same month or prior months
  - Example - Recoup and repay when rate changes occur
- **Current**: Payments that occur within the paid month for same month

Capitation Expenditures (continued...):

- **Retro**: Payments for months prior to the current month for member months not previously paid for
  - o Member months are counted if request is to provide member months within a specific date range for more than one month
  - o Data is not pulled by paid date, but by eligibility month

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

Case Manager: See Community Based Case Management (CBCM)

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

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

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

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

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

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

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

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

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

Denied Claims: See Claims

Department of Human Services (**DHS**): The state's health and social services agency.

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

Dual: Members who have both Medicare and Medicaid benefits.

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

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

Financial Ratios: The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for MCOs is contractually set at 89%.

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

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

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

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

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

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

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

Home Health Aide: Medical services that provide direct personal care. This may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompanying member to medical services, transporting member to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

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

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

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

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

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

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

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

Iowa Medicaid Enterprise (**IME**): The division of DHS that administers the Iowa Medicaid Program.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Prior Authorization (**PA**): Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription. Prior Authorizations for pharmaceuticals are becoming more complex and may require more specific data for approval.

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

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

Provider Adjustment Requests and Errors Reprocessed: See Claims

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

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

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

Run Out: See Claims

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

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

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

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

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

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

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

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

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

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

Waivers: See Home and Community Based Services (HCBS) or specific waivers listed above.

Waiver Service Plan: See Service Plan

NORTHEASTERN IOWA SYNOD
EVANGELICAL LUTHERAN CHURCH IN AMERICA
Office of the Bishop
201 20th Street SW, P.O. Box 804, Waverly, Iowa 50677-0804 319/352-1414 FAX 319/352-1416

COPY

June 17, 2021

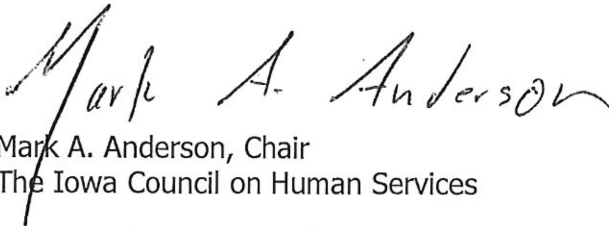
The Honorable Kim Reynolds
Governor of the State of Iowa
State Capitol
1007 East Grand Ave.
Des Moines, IA 50319

Dear Governor Reynolds,

Thank you for giving me the honor and privilege of serving on the Iowa Council on Human Services. Over the last several years, I have learned a great deal about the department and those who serve there. I have the deepest respect for all four of the directors I have worked with but none more than our current director. I believe that bringing Director Garcia to lead DHS is the best think your administration has done for the citizens of our great state.

It is with genuine sadness that I must offer my immediate resignation from the council. Other circumstances have made it impossible for me to give the work of the council the attention it deserves. The council members give generously of their time in both attending and being prepared for our meetings. I do not want to dishonor their contribution by not meeting the expectations of this important role.

Sincerely,



Mark A. Anderson, Chair
The Iowa Council on Human Services

cc: Director Kelly Garcia