Hawki Board Materials
Monday, October 19, 2020

1. Agenda of Meeting for October 19, 2020

2. August 17, 2020 Hawki Board Meeting Minutes

3. Hawki Enrollment and Financials

4. Managed Care Quarterly Report SFY 20 Quarter 4

5. Hawki Outreach Update

AGENDA
Hawki Board Meeting

Monday, October 19, 2020
Time: 12:30 – 2:30 p.m.
Virtual Meeting Via Zoom
https://zoom.us/j/91246059638?pwd=QVZzNUhRQ0xZRG8za0U2eDA4cncvQT09
Meeting ID: 912 4605 9638
Passcode: 975305

12:30 p.m.	Roll call – **Mary Nelle Trefz**
12:35 p.m.	Approval of minutes – **Mary Nelle Trefz** • August 17, 2020 – BOARD ACTION REQUIRED
12:45 p.m.	Director's Report – **Julie Lovelady** • Enrollment reports • Review and discuss finances • Medicaid Update
1:10 p.m.	Updates from the MCOs – **MCOs** • Amerigroup Iowa (10 minutes) • Iowa Total Care (10 minutes) • Delta Dental (10 minutes)
1:40 p.m.	MCO Quarterly Report SFY20, Quarter 4[1] – **Mary Stewart**
2:10 p.m.	Communications update – **Kevin Kirkpatrick**
2:15 p.m.	Outreach update – **Jean Johnson**
2:20 p.m.	Public Comment – **Mary Nelle Trefz**
2:25 p.m.	New Business – **Mary Nelle Trefz**
2:30 p.m.	Adjourn

For more information, contact Michael Kitzman at 515-974-3216 or mkitzma@dhs.state.ia.us.
Note: Times listed on agenda for specific items are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

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[1] https://dhs.iowa.gov/sites/default/files/SFY20_Q4_Report.pdf?100520201330

Hawki Board Meeting
August 17, 2020

Hawki Board Members	Department of Human Services
Angela Burke Boston – present	Julie Lovelady, Interim Medicaid Director
Mary Nelle Trefz, Chair – present	Kevin Kirkpatrick, IME
Jim Donoghue – present	Anna Ruggle, IME
Eric Kohlsdorf –	Heather Miller, IME
Dr. Bob Russell – present	Kurt Behrens, IME
Dr. Kaaren Vargas – present	**Guests**
Shawn Garrington – present	Jean Johnson, IA Department of Public Health
Senator Nate Boulton – present	Lindsay Paulson, MAXIMUS
Senator Dennis Guth –	Joe Estes, MAXIMUS
Representative John Forbes – present	Gretchen Hageman, Delta Dental Iowa
Representative Shannon Lundgren -	John Hedgecoth, Amerigroup Iowa, Inc.
	Kim Flores, Iowa Total Care
	Tia Sigworth Scott County Health Department
	Michelle Canfield, HACAP
	Amanda Johnsinger, Dubuque Visiting Nurses Association

Call to Order and Roll Call
Board Chair Mary Nelle Trefz called the meeting to order at 12:31 PM by phone. Chair Trefz conducted a roll call, and attendance is as reflected above. Chair Trefz established a quorum.

Approval of the Hawki Board Meeting Minutes
Chair Trefz called for the Board to review the minutes from the June 15, 2020, meeting and from the July 20, 2020, meeting. Chair Trefz asked for a motion to approve the minutes, and the motion carried.

Director's Report
Interim Medicaid Director Julie Lovelady gave updates on the Hawki program and Medicaid overall. Julie noted the enhanced Federal Medical Assistance Percentages (FMAP) rate Medicaid and the Hawki program have received due to the COVID-19 public health emergency (PHE). The Hawki program has seen a small decrease in enrollment, due to more families becoming eligible for Medicaid during the COVID-19 PHE. Julie continues to hold bi-weekly stakeholder calls; these calls started in March and will continue for the duration of the COVID-19 PHE. COVID-19 statistics including positive cases amongst Medicaid beneficiaries and deaths are posted to the DHS website, these statistics are updated weekly. The Department has designed a Uniform Prior Authorization (PA) form that can be used by providers to submit PAs to all Managed Care Organizations (MCOs) and the IME. Providers will be required to use the new Universal PA form beginning October 1, 2020.

Mary Nelle noting the decrease in enrollment (as a result of families moving from Hawki to Medicaid) challenged the board to reflect on ways to increase outreach to families that may be newly eligible for enrollment in the Hawki program.

Updates from the MCOs
John Hedgecoth, of Amerigroup Iowa, Inc., presented an update to the Board. Amerigroup notes that MCO enrolment is flat or is increasing 3% or less month over month. Amerigroup is not seeing the increase in enrollment they have seen in other states. Amerigroup is looking forward to the upcoming Open Choice period. Amerigroup is working on community mental health initiatives, collaborating with the State's Mental Health and Disability Services (MHDS) Regions to support: Intensive Residential Service Homes (IRSH), the Assertive Community Treatment (ACT) team, and Mental Health access centers. Within the maternal-child health space, Amerigroup continues to deploy national resources through their integrated case management team. Amerigroup has a national relationship with Count the Kicks, a non-profit working in the maternal-child health space. John turned his remarks to how Amerigroup is working to provide relief for Iowans affected by the August 10, 2020 derecho. Amerigroup has made thousands of calls to members to check on them since the storm, and is exploring how it can assist in food and durable medical equipment (DME) distribution during the disaster recovery.

Kim Flores, of Iowa Total Care (ITC), presented an update. ITC is utilizing their resource team to direct members to programs and resources available to them during the recovery from the derecho. ITC has been making contact with members to check on them following the storm. ITC staff is dispatching staff to make door-to-door contact with members who have they have not been able to reach over the phone. Similarly, ITC is contacting their network of providers to see how they can assist in the recovery process. ITC will launch their annual flu shot program, Fluvention, in September. Fluvention is a collection of provider toolkits, member outreach, and other initiatives aimed at encouraging members (especially members of vulnerable populations) to get their flu shot. ITC launched a new Telehealth vendor Babylon Health on July 1, 2020. ITC launched this new telehealth vendor to ensure members have access to their care providers during the COVID-19 PHE.

Gretchen Hageman, of Delta Dental Iowa (DDIA), gave a brief update. During the summer months, DDIA has been focused on preventative services and restorative services that school aged children need. Summer is an important time for children to get into the dentist to receive these services. DDIA is engaging in outreach efforts to remind parents and provide care coordination to get children in to their dental providers during the summer. DDIA is working with iSmile to figure out how they can support comprehensive care for children in the fall, specifically regarding schooling and coronavirus. DDIA is also focusing on expanding outreach efforts to pregnant women, noting that if pregnant women receive preventative care during their pregnancy they are more likely to seek preventative care for newborns. Gretchen reported that DDIA has seen a great response in members seeking preventative care while pregnant. Regarding the derecho, DDIA saw an increase in call volumes the day following the storm, mostly general questions not specifically related to dental care. DDIA is working with the non-profit Ethnic Minorities of Burma Advocacy and Resource Center (EMBARC) in Cedar Rapids to provide relief from the storm, specifically to provide oral hygiene supplies.

Chair Trefz asked Gretchen if DDIA has seen any change, either an increase or decrease, in children getting preventative care visits during the summer. Gretchen answered that the Hawki program has not seen much of a change overall, that the season started off slow due to coronavirus concerns, but has picked up in the past few months.

Chair Trefz, noting that all three MCOs had discussed pregnant women in their updates, asked if they are tracking pregnant women who are having coverage longer due to the suspension of disenrollments during the COVID-19 PHE, and how this extended coverage might impact the health of this population.

Kim and John stated that they would put together information on this topic for the next meeting. Gretchen noted that DDIA does not receive medical claims information and it would be very difficult for them to provide answers for these questions.

Managed Care Quarterly Report
Kurt Behrens, of the IME, presented the Managed Care Quarterly Report for State Fiscal Year (SFY) 2020 Quarter 3. Kurt noted that this report is largely a pre-coronavirus report, stating that at the start of March 2020, Iowa had 3 confirmed cases, and by the end of March 2020, Iowa had 500 cases. Enrollment increased slightly during this quarter, by around 6,000 members. Kurt reviewed data for: member grievances; Secret Shopper questions, specifically: billing, newborn enrollment, and healthy behaviors; claims data; value added services, highlighting ITC's My Health Pays program; and value based purchasing enrollment numbers.

Communications Update
Kevin Kirkpatrick provided an IME Communications update. The Member Open Choice Enrollment Period will begin on September 1, 2020, and go through October 30, 2020. The IME will not redistribute members as they did last year to balance membership between the MCOs. Members will receive information packets regarding the Open Choice Enrollment Period in coming weeks. During the COVID-19 PHE, the IME has suspended payments for Medicaid and Hawki. Some households had their monthly payments set up to automatically pay each month. Beginning September 1, 2020, the IME will no longer accept payments and will disable all online payments. The IME will notify families of this with a mailed letter. Additionally, any member with a credit on their account of $100 or more will receive a refund.

Outreach
Jean Johnson, of Iowa Department of Public Health (IDPH), gave an update on Hawki outreach. There was a large school nurse's conference held virtually in mid-July 2020. Jean shared outreach success stories. Jean then noted that outreach has been challenging during the COVID-19 PHE. Jean said outreach program's upcoming focus would be on getting into schools with programs like iSmile and to perform preventative screenings.

Chair Trefz invited the board and guests to discuss how outreach efforts could be supported, stating it is important to make sure the program can reach eligible children to enroll in the Hawki program. Michelle Canfield from the Hawkeye Area Community Action Program (HACAP), stated that her program has a long history of working closely with school nurses and that it will be critical to make sure school nurses have the technology they need to help children enroll this fall, especially as districts are exploring virtual learning. Tia Sigworth, Scott County Health Department, stated the Scott County Health Department recently held an event that handed out resources and back to school to approximately 300 families. Michelle stated that HACAP has been putting outreach materials into food boxes.

Noting that disenrollments have been suspended during the COVID-19 PHE, Chair Trefz asked Julie and Kevin if they had any thoughts on how re-enrollment would work once the PHE ends. Julie stated that she and other IME staff would put together a response to this question.

Public Comment
There were no public comments.

New Business
Chair Trefz asked board members if they would be interested in putting together onboarding materials for new Hawki Board members. Shawn Garrington and Jim Donoghue volunteered to help with this effort. Lindsay Paulson, MAXIMUS, offered to forward materials used by the Medical Assistance Advisory Council (MAAC). Chair Trefz stated she would follow up with the board members who volunteered.

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<u>Next Meeting</u>
The next meeting will be October 19, 2020.

Meeting adjourned at 1:39 PM.

Submitted by,

Michael Kitzman
Recording Secretary
mk

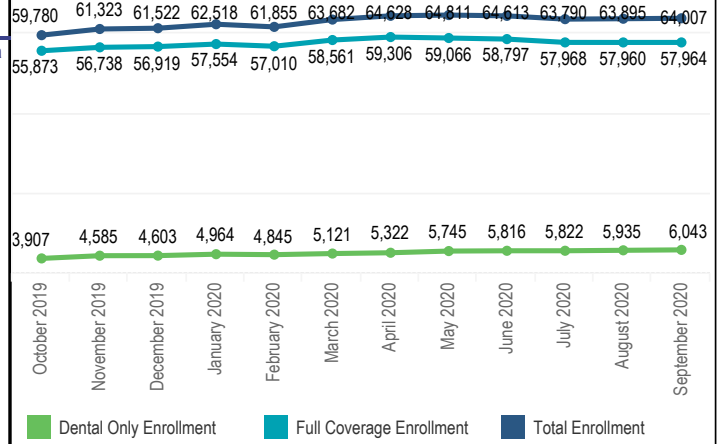# Hawk-i Dashboard

Updated 10/19/2020

Hawki Enrollment Report
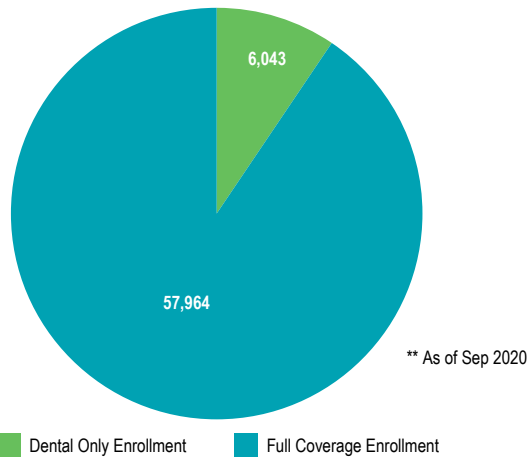
October 19, 2020

Healthy and Well Kids of Iowa

Hawki Enrollment

	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	July 2020	August 2020	September 2020
Total Enrollment	59,780	61,323	61,522	62,518	61,855	63,682	64,628	64,811	64,613	63,790	63,895	64,007
Full Coverage Enrollment	55,873	56,738	56,919	57,554	57,010	58,561	59,306	59,066	58,797	57,968	57,960	57,964
Dental Only Enrollment	3,907	4,585	4,603	4,964	4,845	5,121	5,322	5,745	5,816	5,822	5,935	6,043

Legend: Dental Only Enrollment, Full Coverage Enrollment, Total Enrollment

Full Coverage verses Dental Only

- 6,043 (Dental Only Enrollment)
- 57,964 (Full Coverage Enrollment)

** As of Sep 2020

Legend: Dental Only Enrollment, Full Coverage Enrollment

Hawki Enrollment By MCO

- Amerigroup 18,083
- Iowa Total Care 39,881

** As of Sep 2020

Legend: Amerigroup, Iowa Total Care

Hawki Data Budget vs Actual SFY21

Actual vs Initial and Updated Budget

Legend: ■ Actual ■ Budget - Initial ■ Budget - Updated

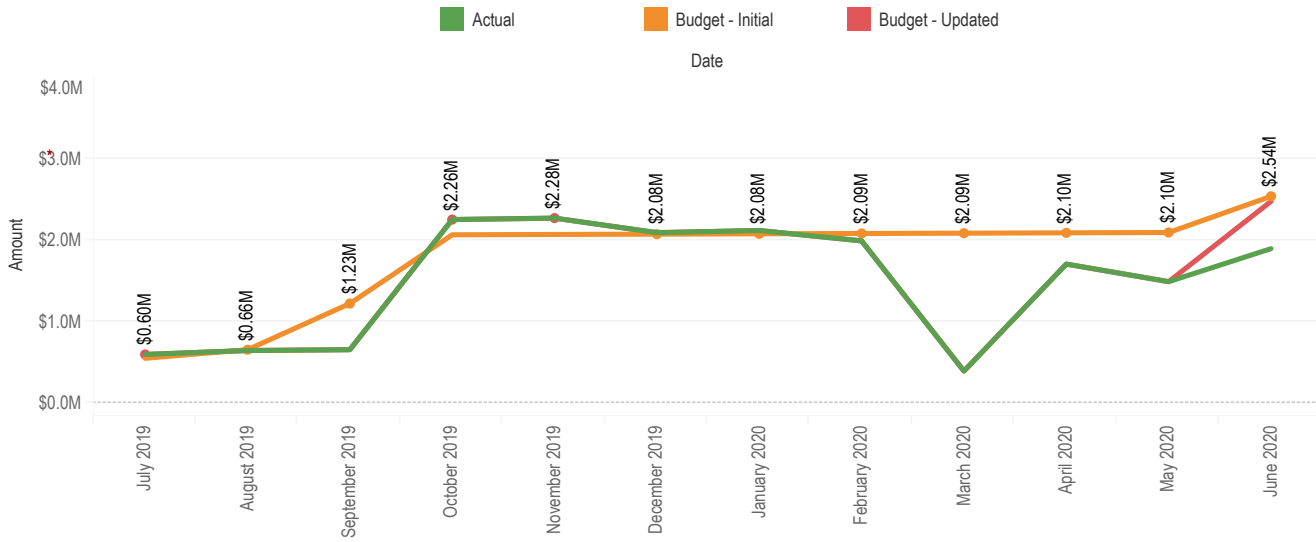|		July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	Grand Total
Admin & Outreach	Administration	$0	$1,584	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,584
	Outreach	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Medicaid Fiscal Agent Processi..	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Earned Interest	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Total	$0	$1,584	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$1,584
Capitation-State%	Hawki	$1,144,662	$1,365,541	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$2,510,202
	Medicaid CHIP	$340,967	$368,318	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$709,285
	Total	$1,485,628	$1,733,859	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,219,487
Total		$1,485,628	$1,735,443	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$3,221,071
Budget - Initial	Initial	$1,485,628	$1,828,810	$1,698,734	$3,355,643	$3,089,032	$3,419,961	$3,977,783	$3,479,554	$4,008,951	$5,626,269	$3,420,541	$3,982,793	$39,373,699
Budget - Updated	Updated	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0

For October of 2020, the FMAP decreases by 11.5 percentage points increasing state expenditures by approximately $ 18.7M.

For April of 2021, the increase in expenditures is due to the release of the 2% performance measure withhold payment and CY20 health insurer fee payments.

Hawki Data Budget vs Actual SFY20

Actual vs Initial and Updated Budget

Actual   Budget - Initial   Budget - Updated

Date

		July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	Grand Total
Admin & Outreach	Outreach	$0	$0	$0	$2,990	$0	$7,689	$13,560	$13,827	($7,438)	$71,776	$0	$108,586	$210,989
	Administration	$0	$841	$3,111	$21,737	$10,215	$27,459	$18,429	$15,278	$5,284	$6,902	$11,429	$31,767	$152,451
	Medicaid Fiscal Agent Processi..	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0	$0
	Earned Interest	$0	$0	($26,206)	($45,985)	($50,628)	($25,048)	($27,198)	($22,245)	($23,126)	($20,389)	($16,929)	($25,142)	($282,898)
	Total	$0	$841	($23,096)	($21,259)	($40,413)	$10,099	$4,790	$6,860	($25,280)	$58,289	($5,501)	$115,211	$80,542
Capitation-State%	Hawki	$433,236	$477,259	$494,241	$1,501,934	$1,821,933	$1,470,754	$1,588,073	$1,668,069	$274,815	$1,227,990	$1,292,183	$1,994,683	$14,245,168
	Medicaid CHIP	$168,534	$171,918	$189,023	$778,143	$494,867	$617,048	$531,440	$321,777	$147,952	$425,593	$209,206	$418,110	$4,473,610
	Total	$601,770	$649,177	$683,264	$2,280,076	$2,316,800	$2,087,802	$2,119,513	$1,989,847	$422,767	$1,653,582	$1,501,390	$2,412,792	$18,718,778
	Total	$601,770	$650,019	$660,168	$2,258,818	$2,276,387	$2,097,901	$2,124,303	$1,996,706	$397,487	$1,711,871	$1,495,889	$2,528,003	$18,799,320
Budget - Initial	Initial	$554,766	$659,709	$1,226,986	$2,071,743	$2,075,691	$2,079,646	$2,083,610	$2,087,581	$2,091,561	$2,095,549	$2,099,545	$2,544,178	$21,670,566
Budget - Updated	Updated	$601,770	$650,019	$660,168	$2,258,818	$2,276,387	$2,097,901	$2,124,303	$1,996,706	$397,487	$1,711,871	$1,495,889	$2,528,003	$18,799,320

In October 2019 the Federal Share of Hawki decreased from 94.95% to 84.34 % resulting in a budget increase of approximately $11.1 Million in State Share Funds for State Fiscal Year 2020.

March 2020 actuals differ from previous months as the Families First Corona Virus Response Act provided a 6.2% FMAP increase effective January 1, 2020 through the end of the public health emergency.
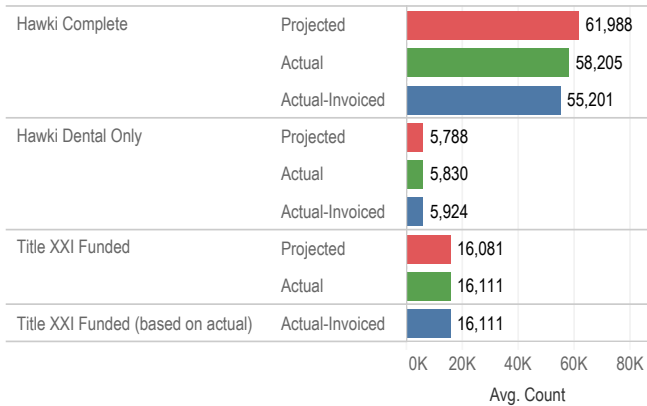
In March 2020 supplemental appropriation of $ 1,737,394 were added to cover a shortfall resulting primarily from SFY20 MCO capitation rate changes. This supplemental appropriation was issued before the increased FMAP rate became available.

April, May and June 2020 projections were updated to reflect an increase in enhanced FMAP, increased enrollment due to economic stressors, and decreased dis-enrollments due to COVID-19.
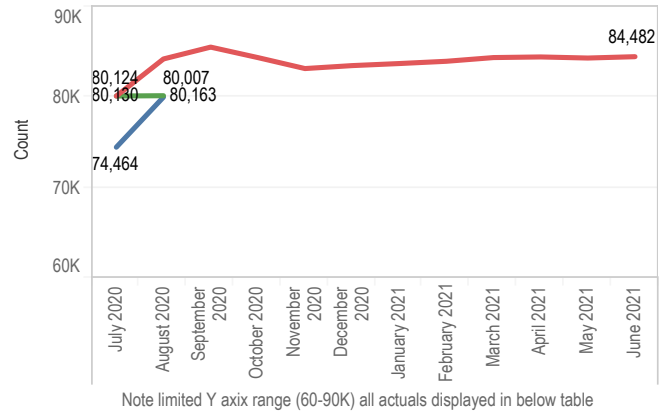
In June 2020, the enhanced FMAP rate remains at 88.68% due to the public health emergency effective January to June 2020.

Hawki Membership Counts SFY21

Average Monthly Membership

		Avg. Count
Hawki Complete	Projected	61,988
	Actual	58,205
	Actual-Invoiced	55,201
Hawki Dental Only	Projected	5,788
	Actual	5,830
	Actual-Invoiced	5,924
Title XXI Funded	Projected	16,081
	Actual	16,111
Title XXI Funded (based on actual)	Actual-Invoiced	16,111

Enrollment Trending

Note limited Y axix range (60-90K) all actuals displayed in below table

Underlying Detail
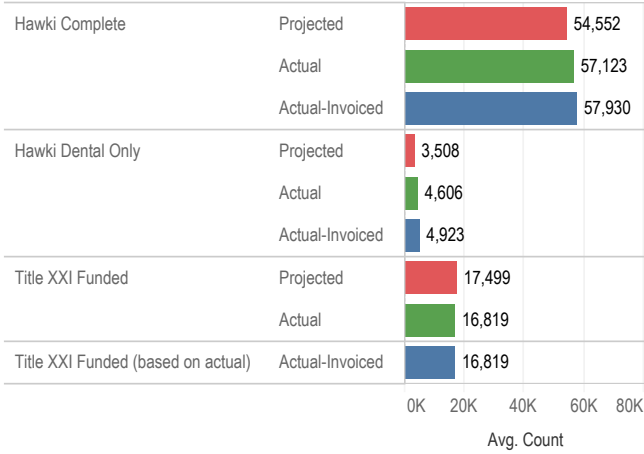
		July 2020	August 2020	September 2020	October 2020	November 2020	December 2020	January 2021	February 2021	March 2021	April 2021	May 2021	June 2021	Total
Projected	Hawki Complete	58,244	62,399	63,582	62,344	61,107	61,408	61,709	62,010	62,312	62,613	62,914	63,215	743,857
	Hawki Dental Only	5,777	5,779	5,781	5,783	5,785	5,787	5,789	5,791	5,793	5,795	5,797	5,799	69,456
	Title XXI Funded	16,103	16,052	16,179	16,256	16,275	16,299	16,224	16,172	16,280	16,046	15,622	15,468	192,976
	Total	80,124	84,231	85,541	84,383	83,167	83,494	83,723	83,973	84,384	84,453	84,333	84,482	1,006,289
Actual	Hawki Complete	58,244	58,166											116,410
	Hawki Dental Only	5,777	5,883											11,660
	Title XXI Funded	16,109	16,114											32,223
	Total	80,130	80,163											160,293
Actual-Invoiced	Hawki Complete	52,497	57,904											110,401
	Hawki Dental Only	5,858	5,989											11,847
	Title XXI Funded (ba..	16,109	16,114											32,223
	Total	74,464	80,007											154,471

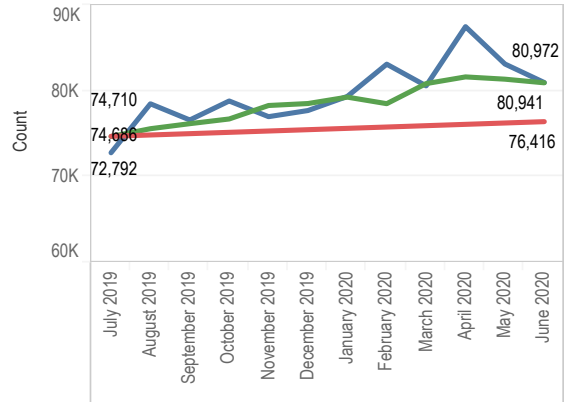Actual: represents membership counts by eligibility date subsequently updated
Actual - Invoiced: represents member counts by invoiced date based on current and prior month invoiced membership

Hawki Membership Counts SFY20

Average Monthly Membership

		Avg. Count
Hawki Complete	Projected	54,552
	Actual	57,123
	Actual-Invoiced	57,930
Hawki Dental Only	Projected	3,508
	Actual	4,606
	Actual-Invoiced	4,923
Title XXI Funded	Projected	17,499
	Actual	16,819
Title XXI Funded (based on actual)	Actual-Invoiced	16,819

Enrollment Trending

74,710
74,686
72,792
80,972
80,941
76,416

Note limited Y axix range (60-90K) all actuals displayed in below table

Underlying Detail

		July 2019	August 2019	September 2019	October 2019	November 2019	December 2019	January 2020	February 2020	March 2020	April 2020	May 2020	June 2020	Total
Projected	Hawki Complete	53,977	54,081	54,185	54,289	54,394	54,499	54,604	54,709	54,814	54,920	55,026	55,132	654,628
	Hawki Dental Only	3,434	3,447	3,461	3,474	3,488	3,501	3,515	3,529	3,542	3,556	3,570	3,584	42,101
	Title XXI Funded	17,300	17,336	17,372	17,408	17,444	17,480	17,517	17,553	17,590	17,626	17,663	17,699	209,987
	Total	74,710	74,864	75,017	75,171	75,325	75,480	75,635	75,791	75,946	76,102	76,259	76,416	906,717
Actual	Hawki Complete	54,307	55,318	55,690	55,864	56,696	56,916	57,335	56,780	58,680	59,562	59,309	59,014	685,471
	Hawki Dental Only	3,537	3,487	3,569	3,862	4,580	4,564	4,968	4,816	5,142	5,285	5,716	5,749	55,275
	Title XXI Funded	16,842	16,789	16,921	17,002	17,022	17,047	16,969	16,914	17,027	16,782	16,339	16,178	201,832
	Total	74,686	75,594	76,180	76,728	78,298	78,527	79,272	78,510	80,849	81,629	81,364	80,941	942,578
Actual-Invoiced	Hawki Complete	52,497	57,904	55,939	57,560	55,356	56,058	57,063	60,721	58,532	63,931	60,804	58,794	695,159
	Hawki Dental Only	3,453	3,801	3,751	4,260	4,619	4,607	5,324	5,477	5,028	6,771	5,990	6,000	59,081
	Title XXI Funded (ba..	16,842	16,789	16,921	17,002	17,022	17,047	16,969	16,914	17,027	16,782	16,339	16,178	201,832
	Total	72,792	78,494	76,611	78,822	76,997	77,712	79,356	83,112	80,587	87,484	83,133	80,972	956,072

Actual: represents membership counts by eligibility date subsequently updated
Actual - Invoiced: represents member counts by invoiced date based on current and prior month invoiced membership

Iowa Medicaid Enterprise (IME)

**Managed Care Organization (MCO)
Report: SFY 2020, Quarter 4**
(April-June)
Performance Data

Published September 30, 2020

CONTENTS

Legislative Requirements:
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
- 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 will flow in the following way:

- Eligibility and demographic information associated with members assigned to managed care
- Care coordination related to specific population groupings (General, Special Needs, Behavioral Health, and Elderly)
- Consumer protections and support information
- Managed care organization program information related to operations
- Network access and continuity of providers
- Financial reporting
- Program integrity actions and recoveries
- Health care outcomes for Medicaid members
- Appendices with supporting information

This report is based on Quarter 4 of State Fiscal Year (SFY) 2020 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs):

- Amerigroup Iowa, Inc. (Amerigroup, AGP)
- 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.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported annually. This will include measures associated with HEDIS®[1] and CAHPS[2].
- 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.

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[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a standardized, nationally-accepted set of performance measures that assess health plan performance and quality.
[2] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized, nationally-accepted survey that assesses health plan member satisfaction.

- 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.

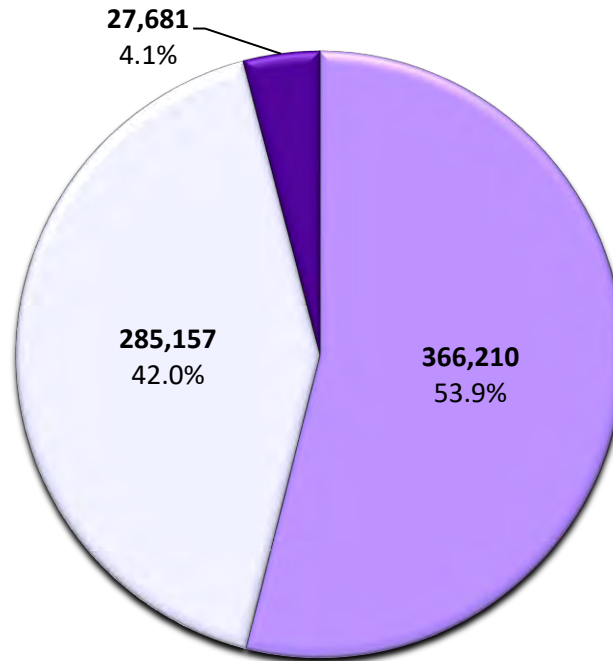More information on the move to managed care is available at
http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Providers and members can find more information on the IA Health Link program at
http://dhs.iowa.gov/iahealthlink

Managed Care Enrollment (by Age)
Total MCO Enrollment = 679,048*

■ 0-21   ⊔ 22-64   ■ 65+

27,681
4.1%

285,157
42.0%

366,210
53.9%

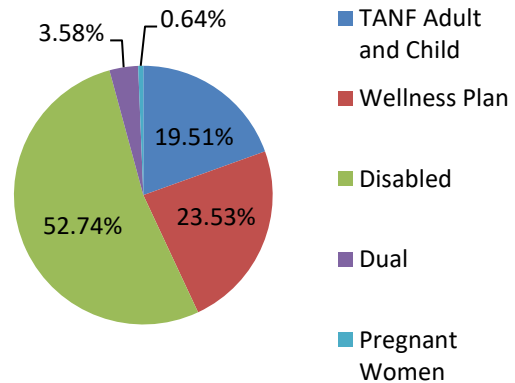*June 2020 enrollment data as of July 30, 2020. Enrollment data captures Hawki enrollees; however, excludes the 38,979 Fee-for-Service (FFS) members.

Capitated Enrollment

0.98%
5.81%
11.47%
28.94%
52.80%

■ TANF Adult and Child
■ Wellness Plan
■ Disabled
■ Dual
■ Pregnant Women
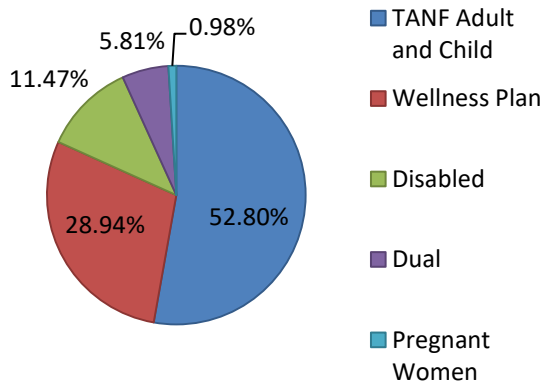
Capitation Expenditures

3.58%
0.64%
19.51%
52.74%
23.53%

■ TANF Adult and Child
■ Wellness Plan
■ Disabled
■ Dual
■ Pregnant Women

PLAN ENROLLMENT BY MANAGED CARE ORGANIZATION (MCO)

Total Plan Enrollment by MCO*

■ Amerigroup ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	387,035	386,338	386,901	400,127
Iowa Total Care	264,956	265,667	267,028	278,921
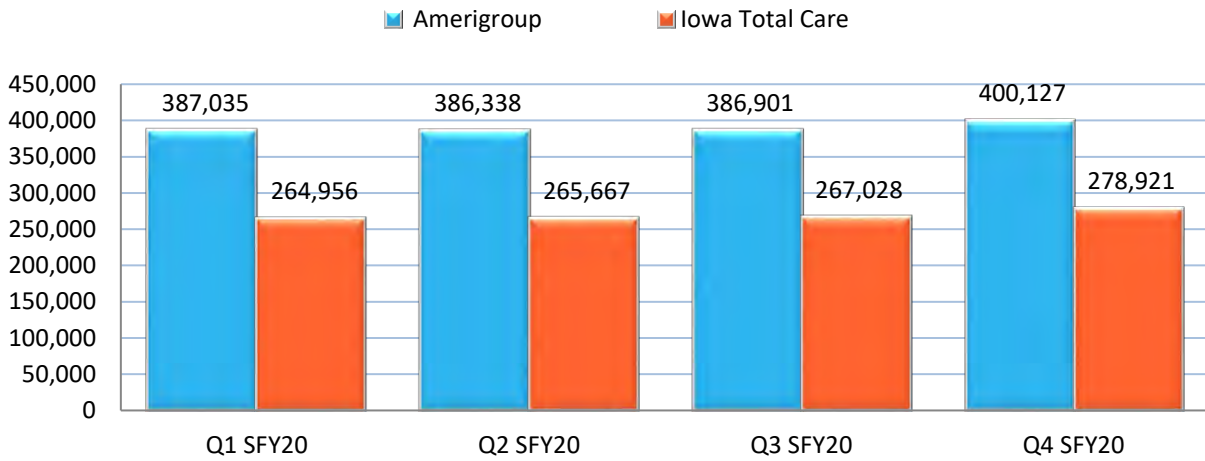
* June 2020 enrollment data as of July 30, 2020

PLAN DISENROLLMENT BY MCO

Active Member Disenrollment by MCO*

■ Amerigroup ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	3,217	462	414	0
Iowa Total Care	16,082	602	510	0
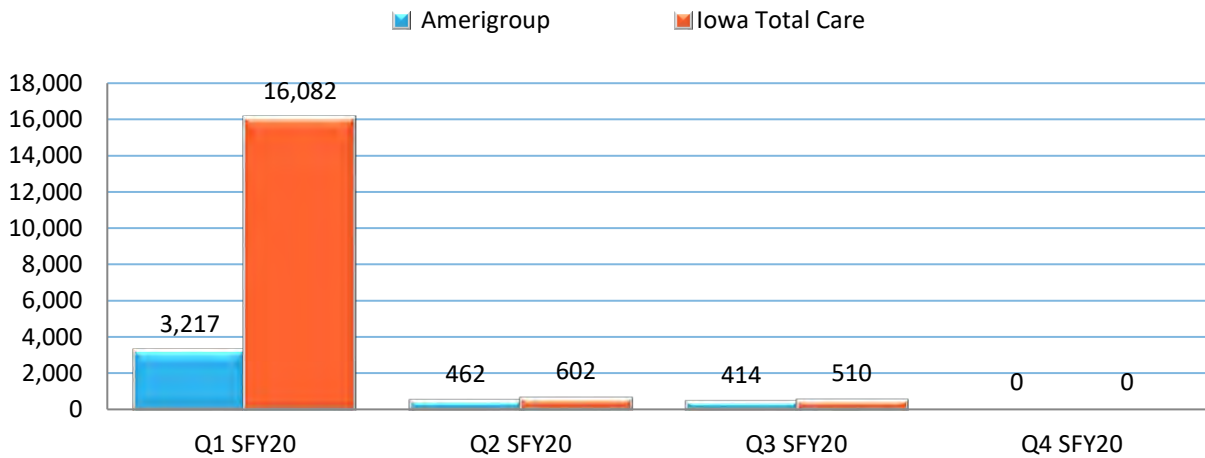
* June 2020 enrollment data as of July 30, 2020

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT

All Managed Long-Term Services and Support

■ Community-Based Services   ■ Facility-Based Services

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Facility-Based Services	36%	36%	36%	35%
Community-Based Services	64%	64%	64%	65%
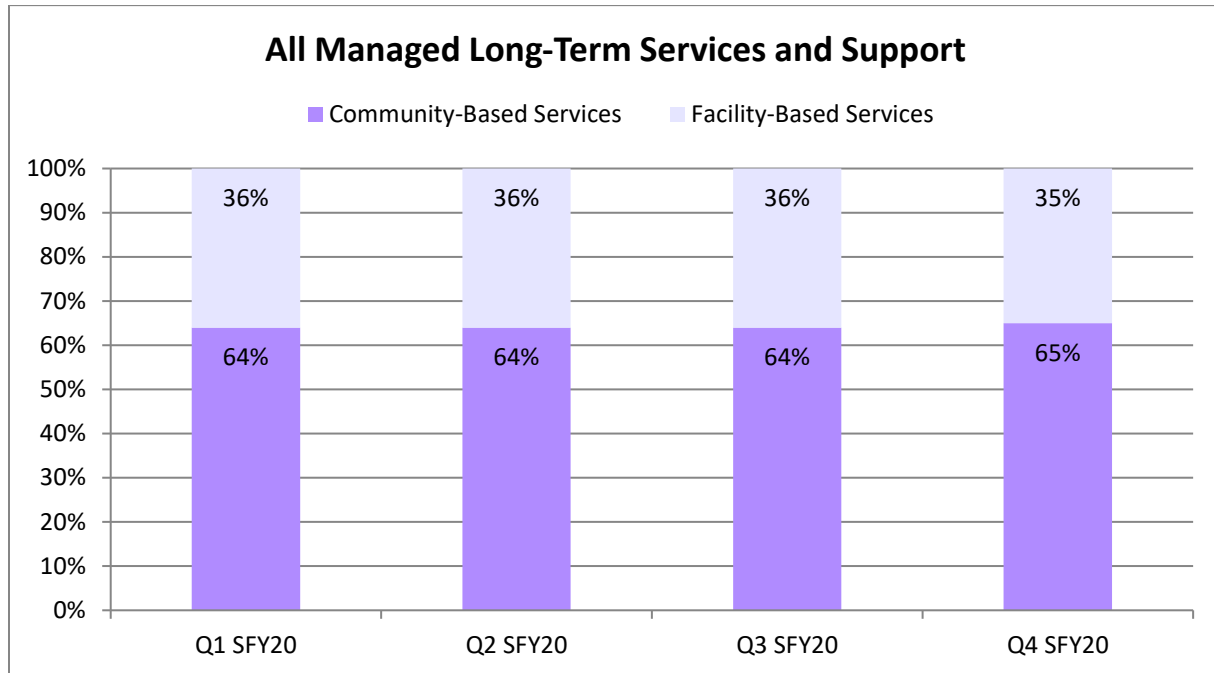
Information on individual waiver enrollment and waitlists can be found at the dedicated webpage: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

ALL MCO HOME AND COMMUNITY-BASED SERVICE (HCBS) WAIVER ENROLLMENT

MCO Waiver Enrollment by Program
Total Waivers = 33,017

- AIDS/HIV — 31
- Brain Injury — 1,365
- Children's Mental Health — 1,245
- Elderly — 8,219
- Habilitation — 7,218
- Health & Disability — 2,056
- Intellectual Disability — 11,687
- Physical Disability — 1,196
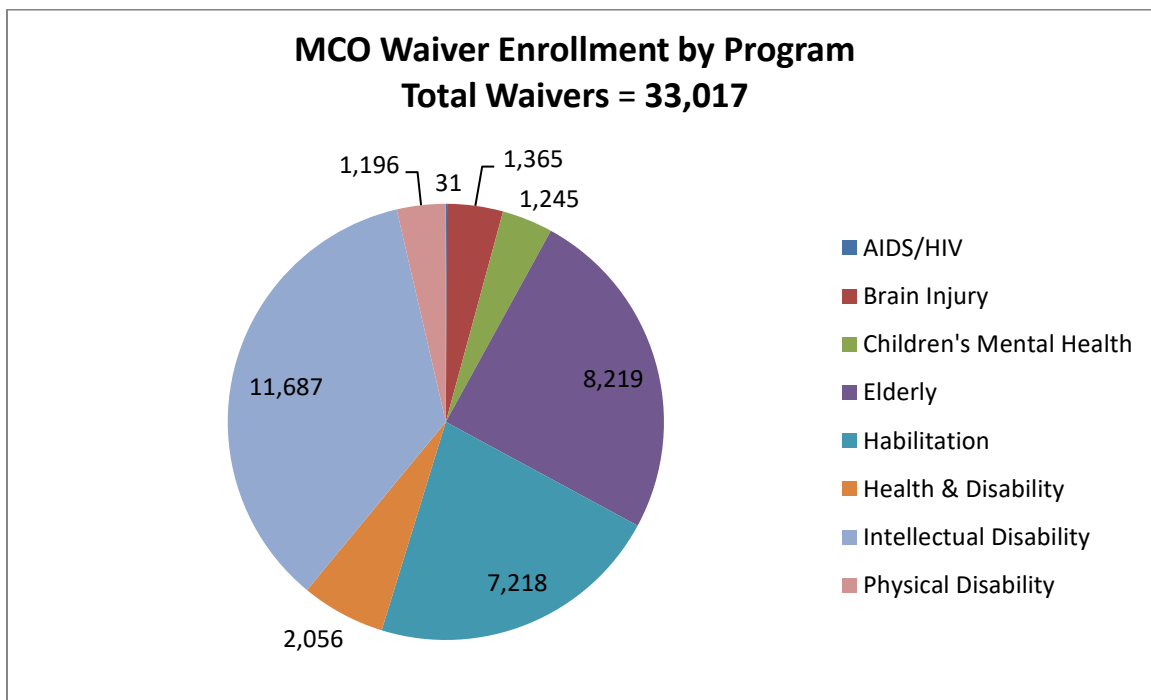
Care Coordination and Case Management

Average Number of Contacts		
Data Reported as of June 30, 2020	Amerigroup	Iowa Total Care
Average Number of Care Coordinator Contacts per Member per Month	0.9	0.8
Average Number of Community-Based Case Manager Contacts per Member per Month	1.3	1.0

Member to Coordinator Ratios		
Data Reported as of June 30, 2020	Amerigroup	Iowa Total Care
Ratio of Members to Care Coordinators	14	75
Ratio of HCBS Members to Community-Based Case Managers	65	38

Level of Care (LOC) Reassessments

Must be updated annually or as a member's needs change.

Percentage of Level of Care (LOC) Reassessments Completed Timely

Legend: Amerigroup | Iowa Total Care | Contract Requirement: 95%

Month	Amerigroup	Iowa Total Care
Jan-2020	97%	96%
Feb-2020	98%	97%
Mar-2020	98%	97%
Apr-2020	100%	99%
May-2020	100%	98%
Jun-2020	100%	99%
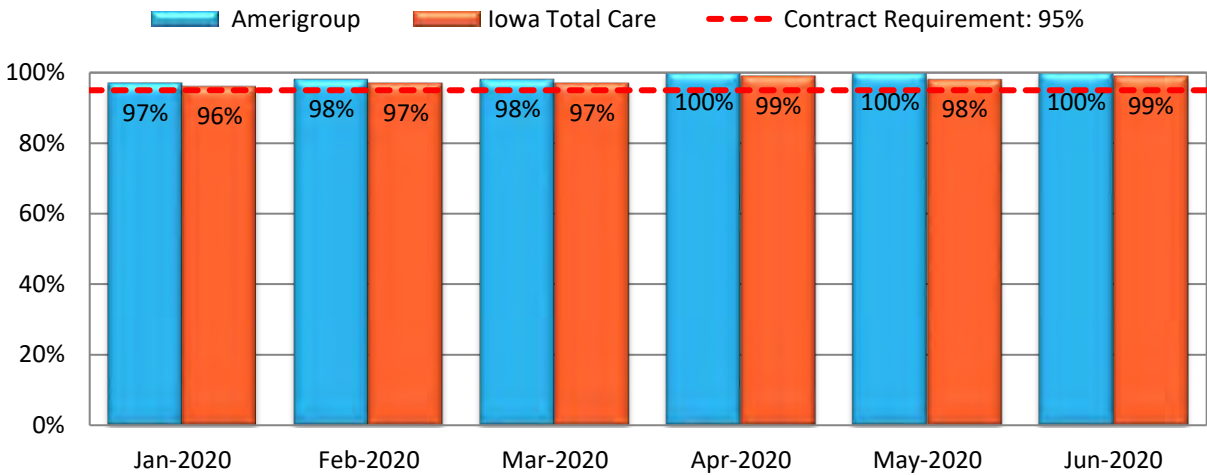
The data illustrated below reflects the status of the annual service plan reviews for members receiving HCBS.

Amerigroup
Service Plan Revision Outcomes

Legend: ■ Reductions ■ Increases ■ Renewals - No Change

Quarter	Reductions	Increases	Renewals - No Change
Q1 SFY20	6%	6%	88%
Q2 SFY20	7%	8%	84%
Q3 SFY20	42%	35%	23%
Q4 SFY20	13%	22%	65%
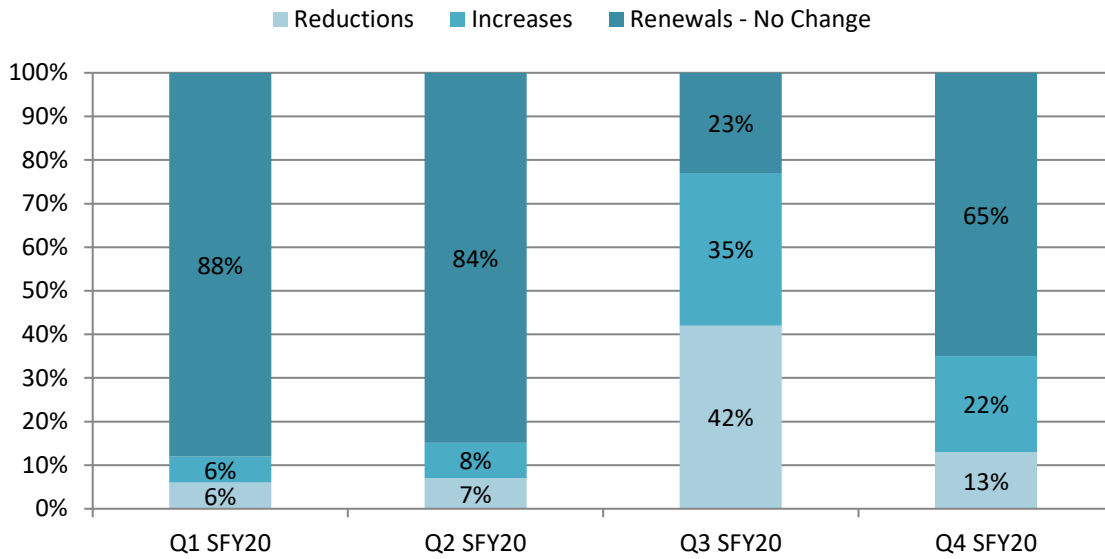
Iowa Total Care
Service Plan Revision Outcomes

Legend: ■ Reductions ■ Increases ■ Renewals - No Change

Quarter	Reductions	Increases	Renewals - No Change
Q1 SFY20	7%	27%	66%
Q2 SFY20	9%	18%	73%
Q3 SFY20	15%	25%	61%
Q4 SFY20	13%	19%	68%
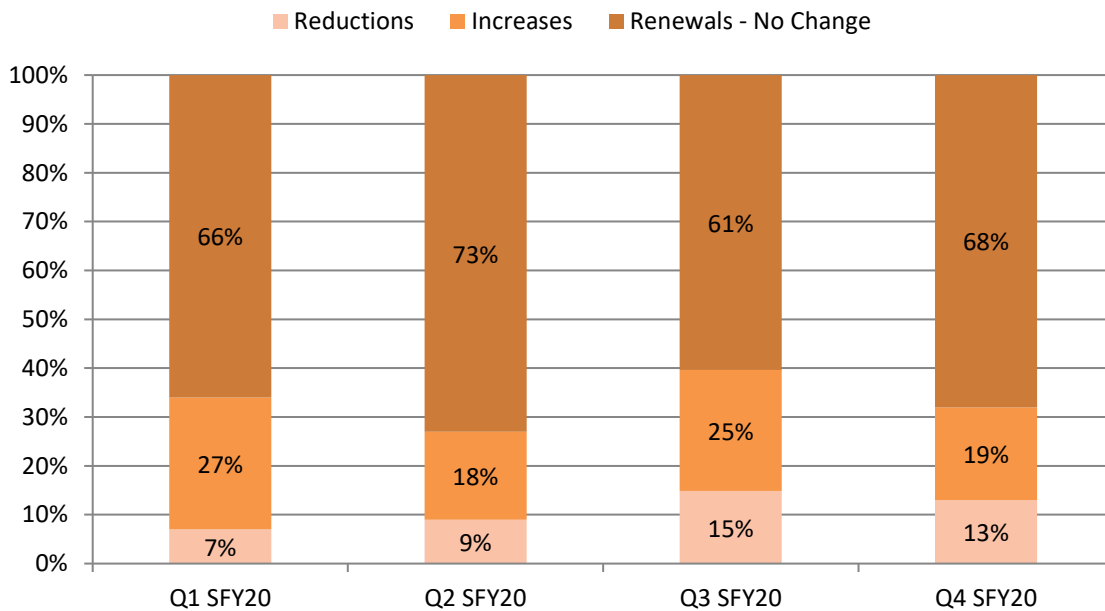
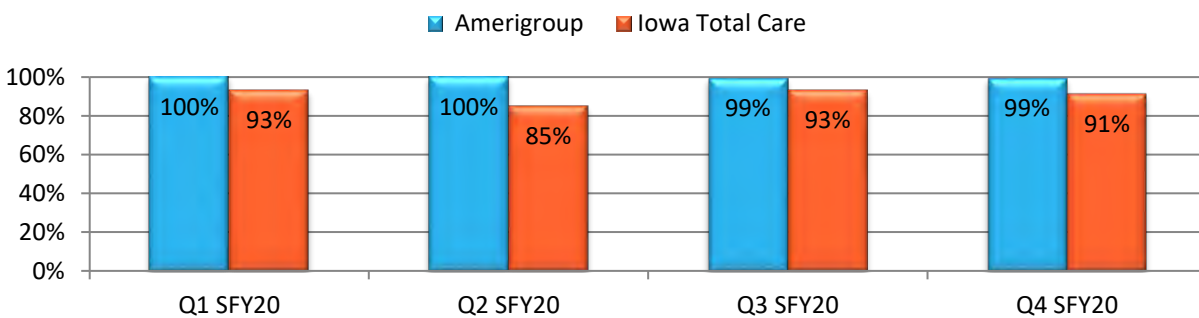# Iowa Participant Experience Survey (IPES) Reporting

Iowa Participant Experience Survey (IPES) results are one component of the Department's HCBS quality strategy. Surveys are conducted to achieve a statistically significant representative sample by waiver with a 95% confidence level and a 5% error rate. Percentages below reflect the number of survey responses in the quarter from all applicable waivers indicating "yes". Other valid survey responses include "no," "I don't know," "I don't remember," and "no/unclear."

Members Reporting: They Were Part of Service Planning

Legend: ■ Amerigroup ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	100%	100%	100%	100%
Iowa Total Care	66%	61%	93%	93%
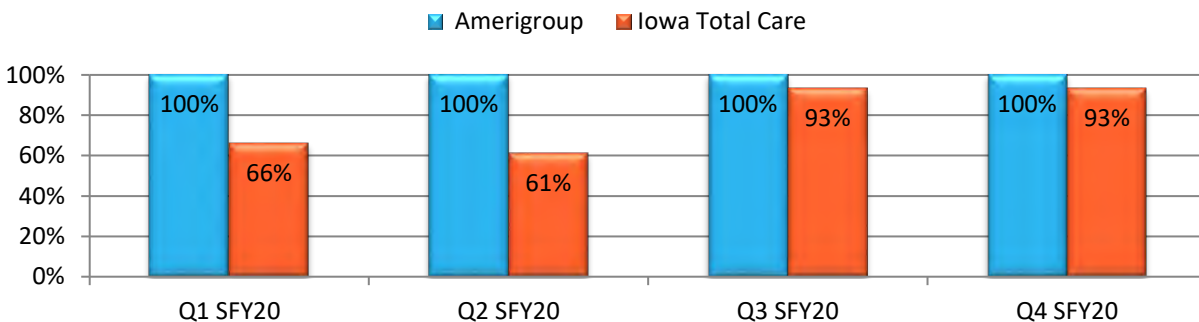
Members Reporting: They Feel Safe Where They Live

Legend: ■ Amerigroup ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	100%	100%	99%	99%
Iowa Total Care	93%	85%	93%	91%

Members Reporting: Their Services Make Their Lives Better

Legend: ■ Amerigroup ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	100%	100%	99%	99%
Iowa Total Care	99%	74%	91%	94%
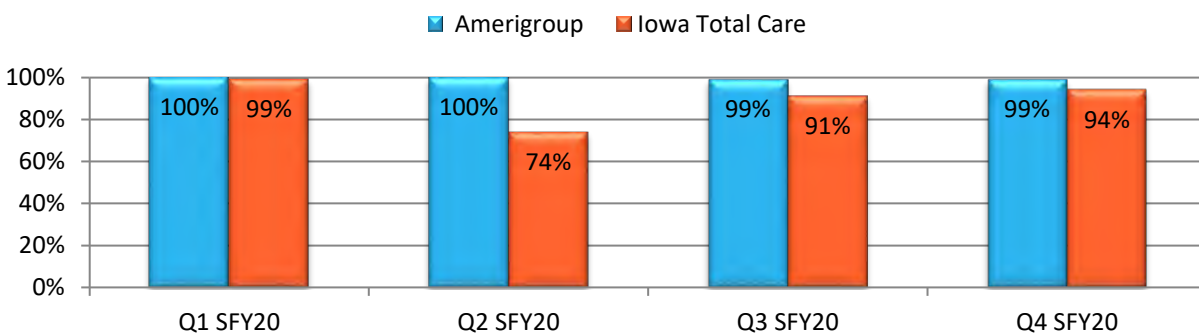
MCO Member Grievances

The grievances resolved data below demonstrates the level to which the member is receiving timely and adequate levels of service. A grievance is considered resolved once it has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Grievances Resolved within 30 Calendar Days of Receipt

	Amerigroup		Iowa Total Care	
Quarter	Count	% Pop	Count	% Pop
Q1 SFY20	286	0.07%	155	0.05%
Q2 SFY20	784	0.19%	282	0.10%
Q3 SFY20	706	0.19%	230	0.08%
Q4 SFY20	322	0.09%	100	0.03%
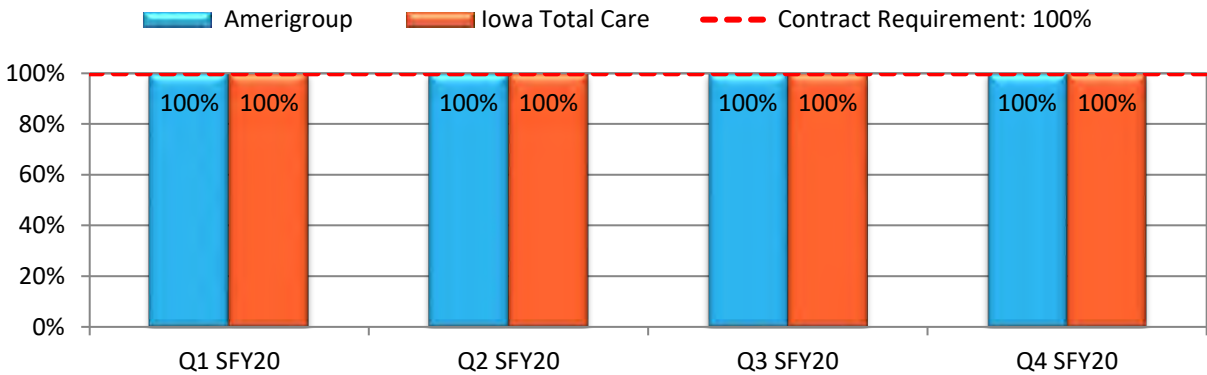
Grievances Received Supporting Data

Top 10 Reasons for Grievances
**As of the end of the reporting period

#	Amerigroup	%	Iowa Total Care	%
	Reason	%	Reason	%
1.	Voluntary Disenrollment	28%	Access to Care - Network Availability	42%
2.	Provider Balance Billed	14%	Unhappy with Benefits	19%
3.	Provider Attitude/Rudeness	8%	Transportation - General Complaint Vendor	8%
4.	Adequacy of treatment record keeping	6%	Claim Dispute	3%
5.	Transportation – Driver No-Show	6%	Lack of Caring/Concern	3%
6.	Transportation – Driver Delay	5%	Provider - Interpersonal	3%
7.	Termination of Eligibility	5%	Transportation – Missed Appointment	2%
8.	Availability of appointments	4%	Transportation – General Complaint Vendor/CSR	2%
9.	Effective Dates of Coverage	2%	Customer Service – Health Plan Staff	2%
10.	Treatment Dissatisfaction	2%	Inappropriate Behavior – Office Staff - Interpersonal	1%

MCO Member Appeals

The appeals resolved data below demonstrates the level to which the member is receiving adequate and timely and levels of service. An appeal is considered resolved once it has been through the process and a disposition has been communicated to the member and member representative.

Percentage of Appeals Resolved within 30 Calendar Days of Receipt

Legend: Amerigroup | Iowa Total Care | Contract Requirement: 100%

Bar chart values:
- Q1 SFY20: Amerigroup 99%, Iowa Total Care 98%
- Q2 SFY20: Amerigroup 100%, Iowa Total Care 100%
- Q3 SFY20: Amerigroup 99%, Iowa Total Care 100%
- Q4 SFY20: Amerigroup 100%, Iowa Total Care 100%
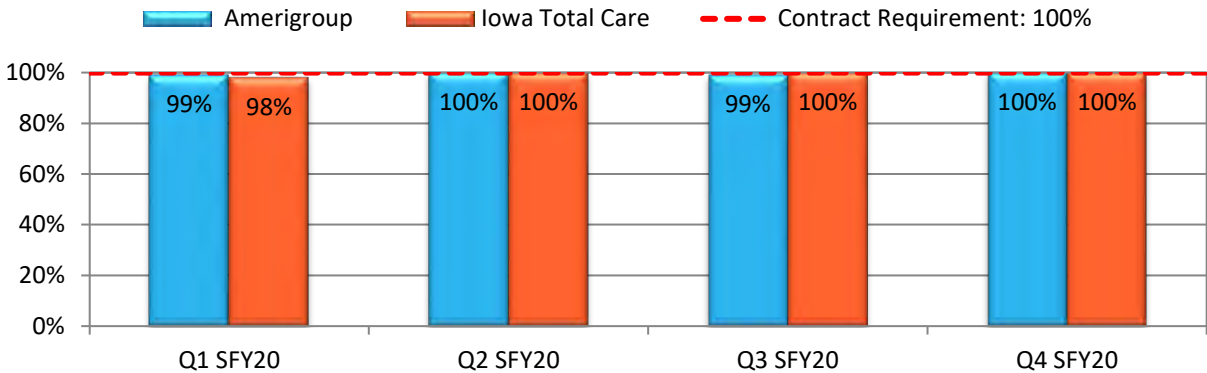
Appeals Received Supporting Data				
	Amerigroup		Iowa Total Care	
Quarter	Count	% Claims	Count	% Claims
Q1 SFY20	244	0.01%	89	0.01%
Q2 SFY20	355	0.01%	199	0.01%
Q3 SFY20	433	0.01%	179	< 0.01%
Q4 SFY20	372	0.01%	205	< 0.01%

Top 10 Reasons for Appeals **As of the end of the reporting period				
#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
1.	DME	27%	Other – Mental Health Service	36%
2.	Pharmacy – Non-Injectable	22%	RX – Does Not Meet Prior Auth Guidelines	15%
3.	BH – Op Service	9%	DME - Other	8%
4.	Personal Care Services Self Directed	8%	DME - Wheelchair	6%

Top 10 Reasons for Appeals
**As of the end of the reporting period

#	Amerigroup		Iowa Total Care	
	Reason	%	Reason	%
5.	Pharmacy - Injectable	7%	DME – Orthopedic Devices	3%
6.	Radiology	6%	DME – Pneumatic Compressor/Appliance	3%
7.	Surgery	5%	DME – Blood Glucose Monitor	2%
8.	BH - Inpatient	5%	DME – Motorized Wheelchair	2%
9.	Other	5%	DME – Wheelchair Accessories	2%
10.	Pain Mgmt.	4%	Injections – Epidural Injections	2%

Amerigroup
Appeal Outcome Percentages

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
■ Withdrawn	4%	3%	3%	1%
■ Upheld	38%	47%	48%	57%
■ Partially Overturned	2%	1%	1%	1%
■ Overturned	56%	49%	48%	42%
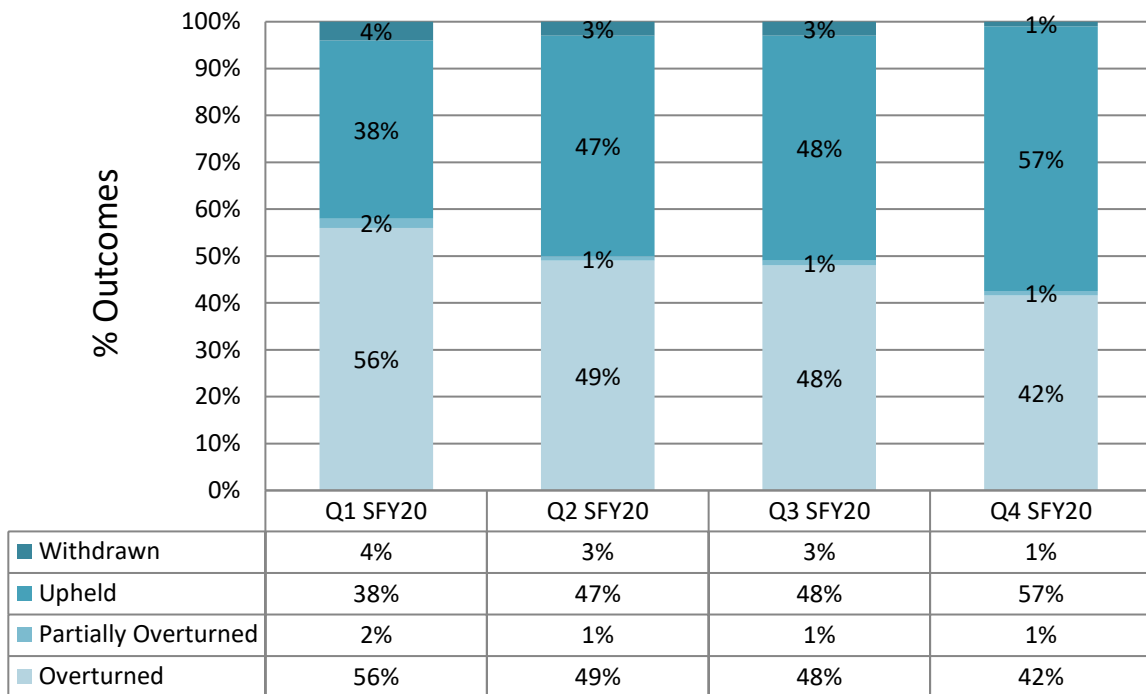
Iowa Total Care
Appeal Outcome Percentages
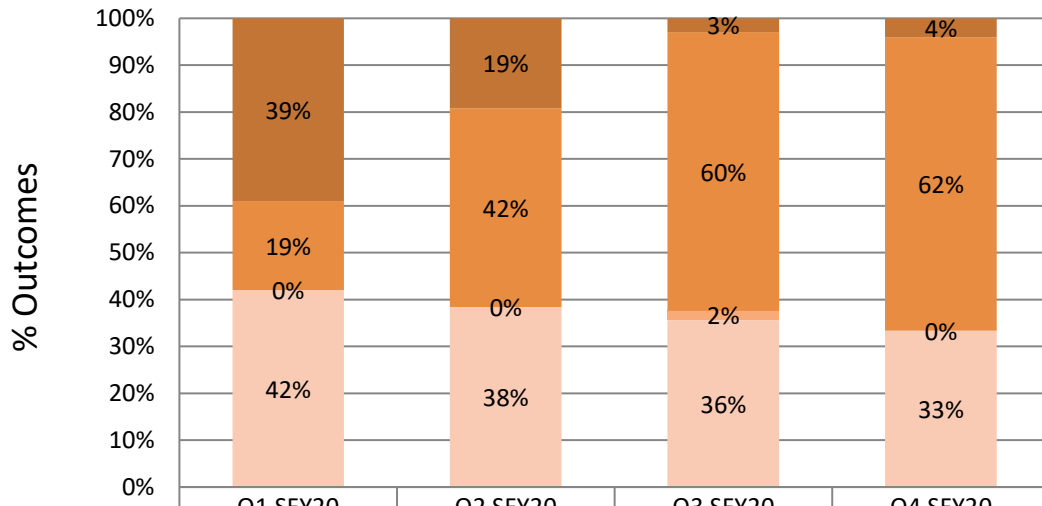
	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
■ Withdrawn	39%	19%	3%	4%
■ Upheld	19%	42%	60%	62%
■ Partially Overturned	0%	0%	2%	0%
■ Overturned	42%	38%	36%	33%

Member Helpline

Service Level
Percentage of Member Helpline Calls Answered Timely

Legend: Amerigroup | Iowa Total Care | Contract Requirement: 80%

Month	Amerigroup	Iowa Total Care
Jan-20	87%	91%
Feb-20	90%	86%
Mar-20	95%	84%
Apr-20	98%	94%
May-20	98%	93%
Jun-20	90%	88%
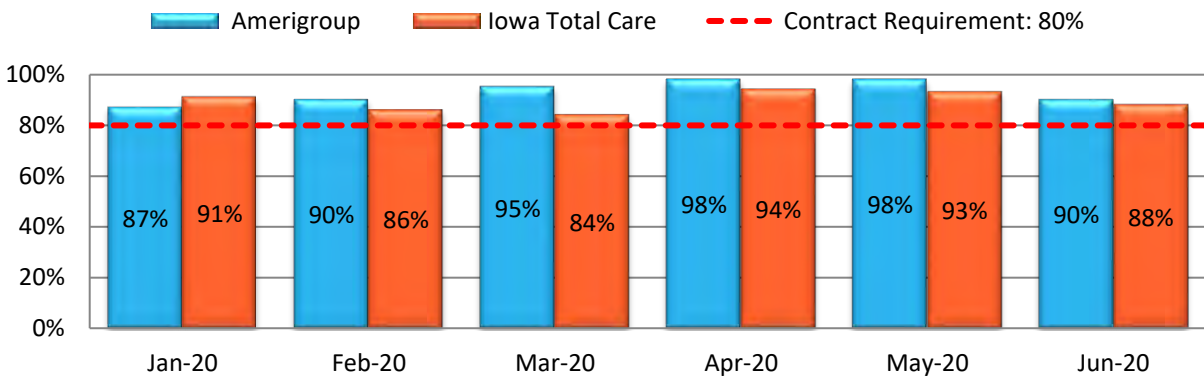
Secret Shopper
Member Helpline Average Monthly Score

Legend: Amerigroup | Iowa Total Care

Month	Amerigroup	Iowa Total Care
Jan-20	9	8
Feb-20	9	9
Mar-20	7	9
Apr-20	8	8
May-20	6	7
Jun-20	8	8
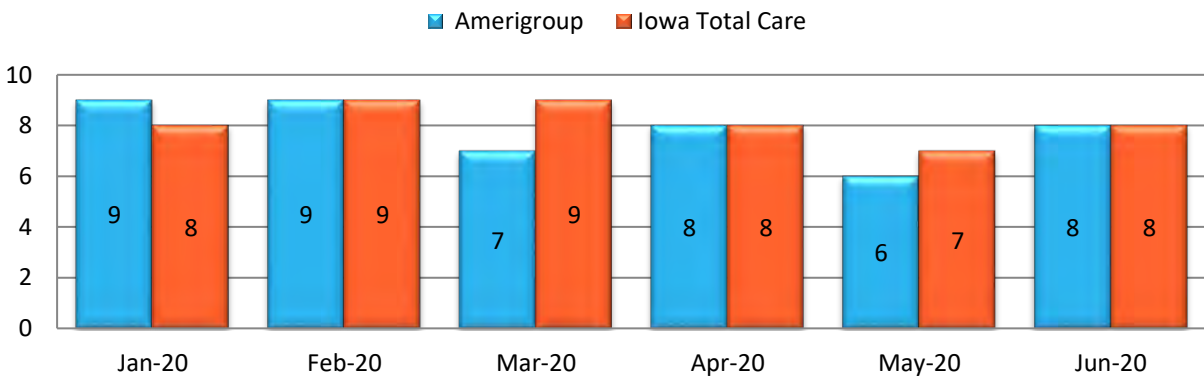
Provider Helpline

Service Level
Percentage of Provider Helpline Calls Answered Timely

Legend: ▬ Amerigroup ▬ Iowa Total Care ▬ ▬ Contract Requirement: 80%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	84%	88%	94%	96%	96%	89%
Iowa Total Care	85%	88%	86%	93%	95%	88%
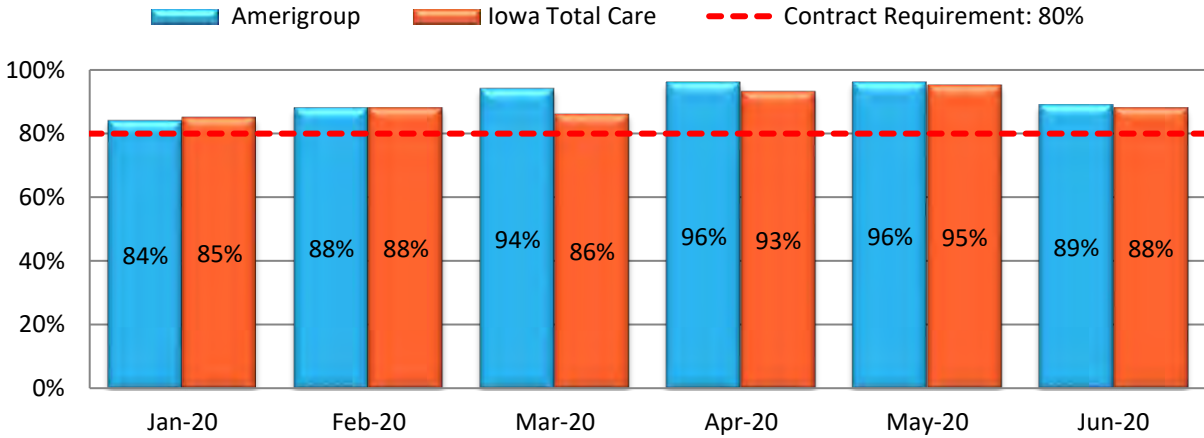
Secret Shopper
Provider Helpline Average Monthly Score

Legend: ▪ Amerigroup ▪ Iowa Total Care

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	6	7	6	5	7	8
Iowa Total Care	9	9	6	7	6	8
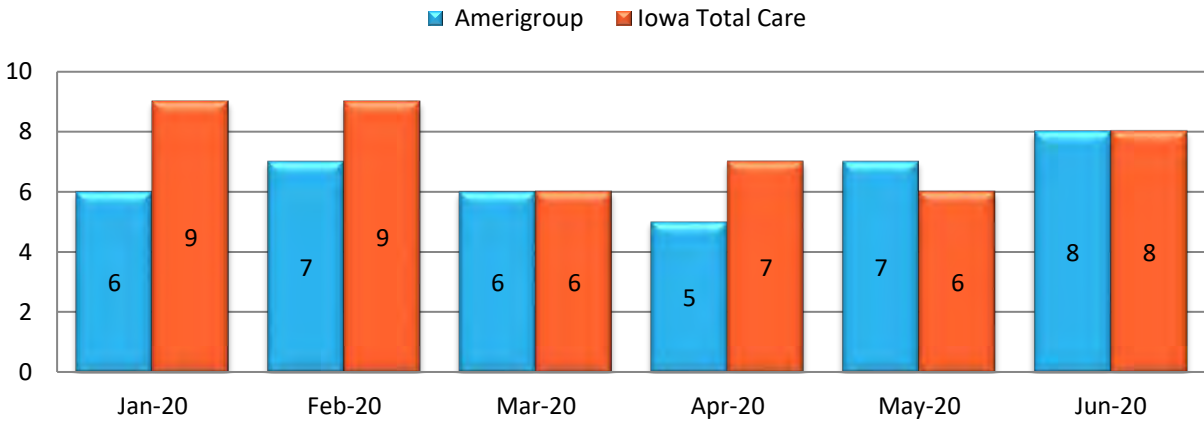
Service Level
Percentage of Pharmacy Provider Helpline Calls
Answered Timely
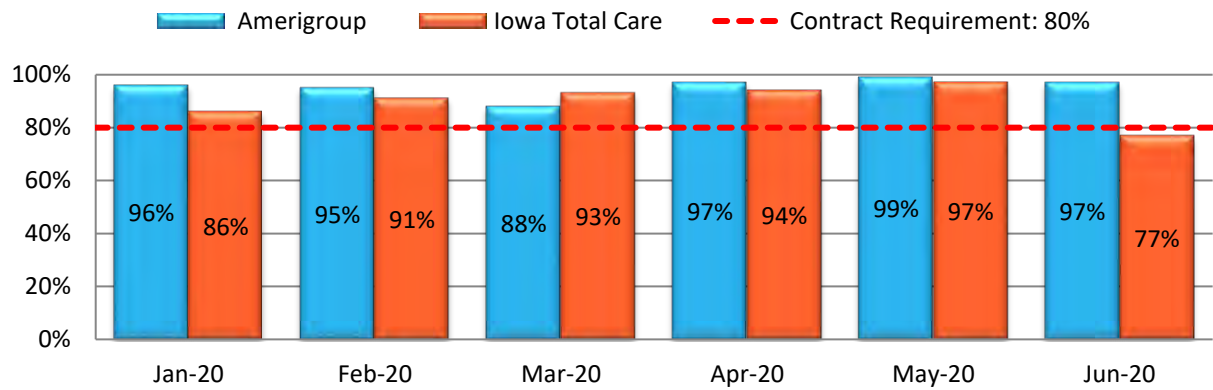
Legend: Amerigroup | Iowa Total Care | Contract Requirement: 80%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	96%	95%	88%	97%	99%	97%
Iowa Total Care	86%	91%	93%	94%	97%	77%

Non-Pharmacy Claims Payments

Amerigroup
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days

Legend: Amerigroup — Contract Requirement: 90%

Month	Amerigroup
Jan-20	99%
Feb-20	100%
Mar-20	99%
Apr-20	100%
May-20	99%
Jun-20	98%

Iowa Total Care
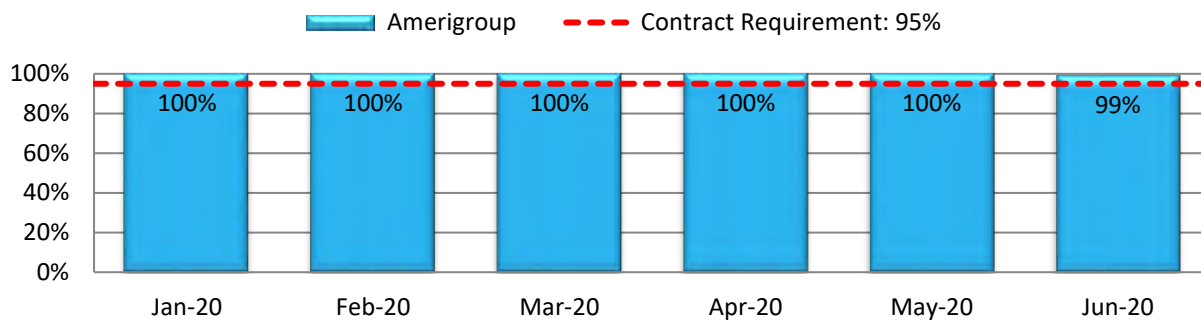### Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 30 Calendar Days

Legend: Processed in 30 Days — Held — — Contract Requirement: 90%

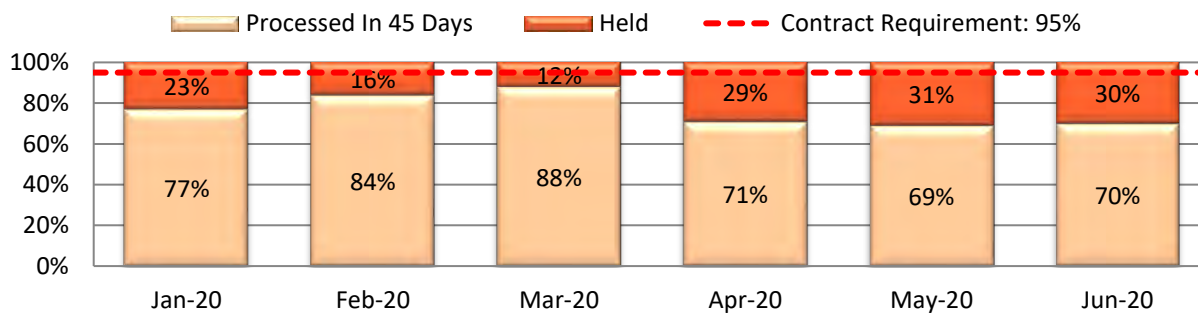| Month	Held	Processed in 30 Days
Jan-20	25%	75%
Feb-20	20%	80%
Mar-20	23%	77%
Apr-20	32%	68%
May-20	35%	65%
Jun-20	33%	67%
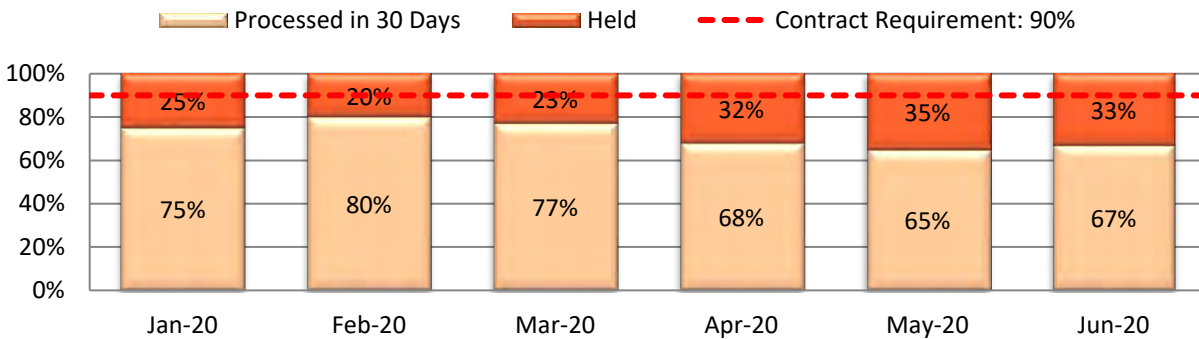
This measure is being reported separately for ITC at this time due to significant number of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as those processed within 30 calendar days. There is potential for some clean claims withheld by ITC due to payment system configuration issues to have been processed within 30 or 45 days. However, there is not a count of such claims available at this time.

Amerigroup
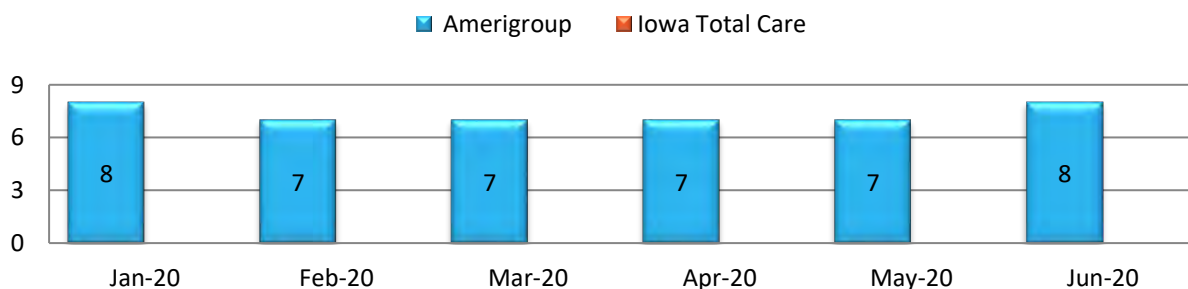### Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 45 Calendar Days

Legend: Amerigroup — — — Contract Requirement: 95%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	100%	100%	100%	100%	100%	99%

Iowa Total Care
Percentage of Clean Non-Pharmacy Claims Paid or Denied Within 45 Calendar Days

Legend: Processed In 45 Days — Held — — — Contract Requirement: 95%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Held	23%	16%	12%	29%	31%	30%
Processed In 45 Days	77%	84%	88%	71%	69%	70%

This measure is being reported separately for ITC at this time due to significant number of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as those processed within 45 calendar days. There is potential for some clean claims withheld by ITC due to payment system configuration issues to have been processed within 30 or 45 days. However, there is not a count of such claims available at this time.

Average Days for Non-Pharmacy Claims Payment

Legend: Amerigroup ■ Iowa Total Care

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	8	7	7	7	7	8

Due to significant numbers of clean claims that have been withheld from processing by ITC due to payment system configuration issues, it is not possible to accurately reflect this measure for ITC for this quarter.
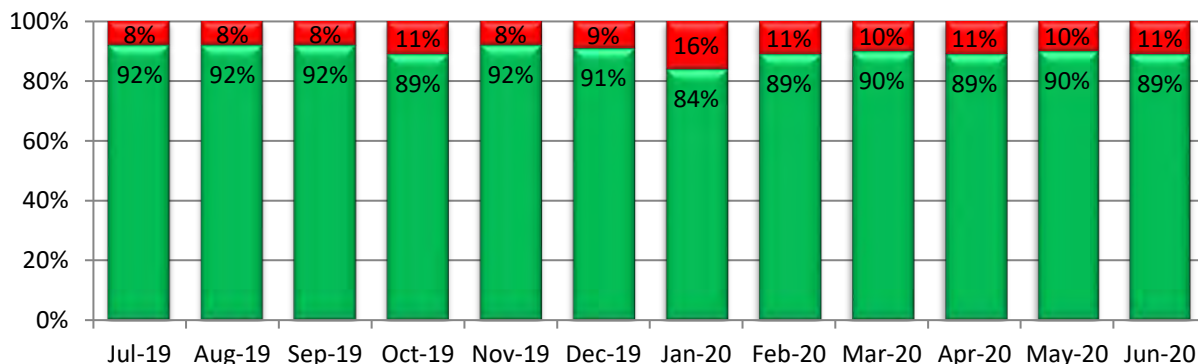

Non-Pharmacy Claims Payments

Amerigroup
Non-Pharmacy Claims Status
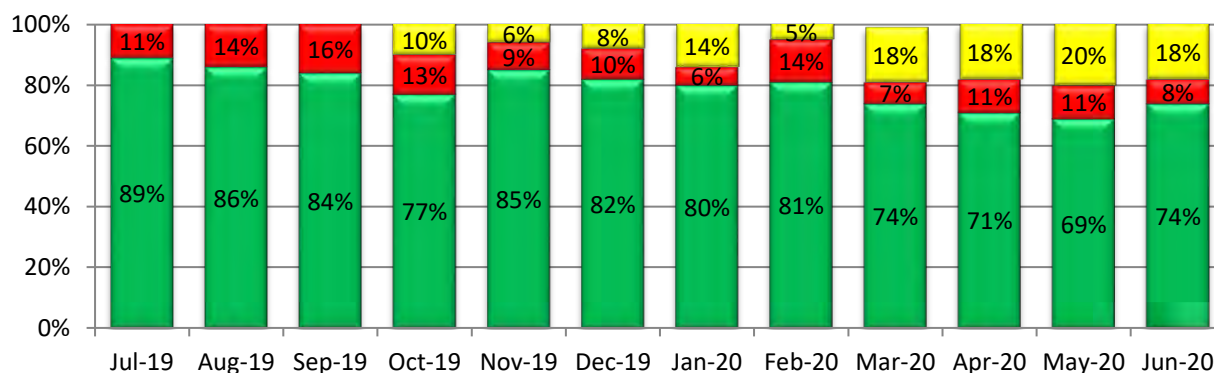**As of the end of the reporting period

Legend: Paid (green), Denied (red)

Month	Paid	Denied
Jul-19	92%	8%
Aug-19	92%	8%
Sep-19	92%	8%
Oct-19	89%	11%
Nov-19	92%	8%
Dec-19	91%	9%
Jan-20	84%	16%
Feb-20	89%	11%
Mar-20	90%	10%
Apr-20	89%	11%
May-20	90%	10%
Jun-20	89%	11%

Iowa Total Care
Non-Pharmacy Claims Status
**As of the end of the reporting period

Legend: Paid (green), Denied (red), Held (yellow)

| Month	Paid	Denied	Held
Jul-19	89%	11%	
Aug-19	86%	14%	
Sep-19	84%	16%	
Oct-19	77%	13%	10%
Nov-19	85%	9%	6%
Dec-19	82%	10%	8%
Jan-20	80%	6%	14%
Feb-20	81%	14%	5%
Mar-20	74%	7%	18%
Apr-20	71%	11%	18%
May-20	69%	11%	20%
Jun-20	74%	8%	18%

This measure is being reported differently for ITC at this time due to significant number of clean claims that have been withheld from processing by ITC due to payment system configuration issues. The chart above reflects the percentage of those clean claims that have been withheld from processing as well as all claims paid and denied.

Non-Pharmacy Claims Payments

Amerigroup
Suspended Non-Pharmacy Claims Payment Rates (90-day lag)
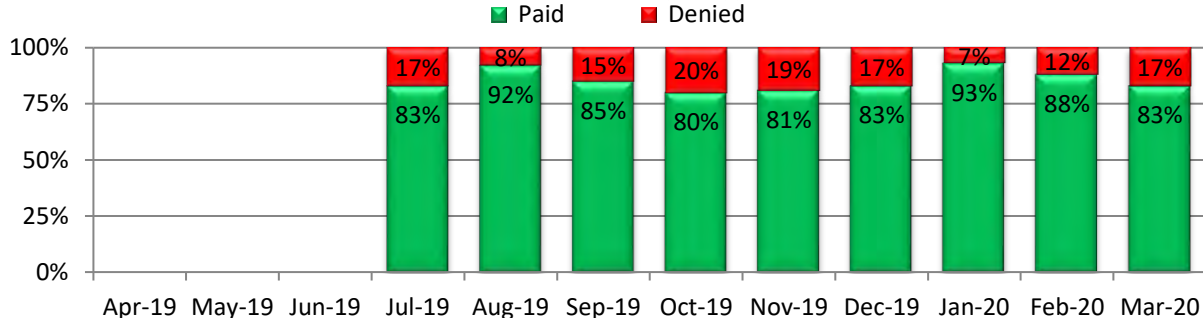**As of the end of the reporting period**

■ Paid ■ Denied
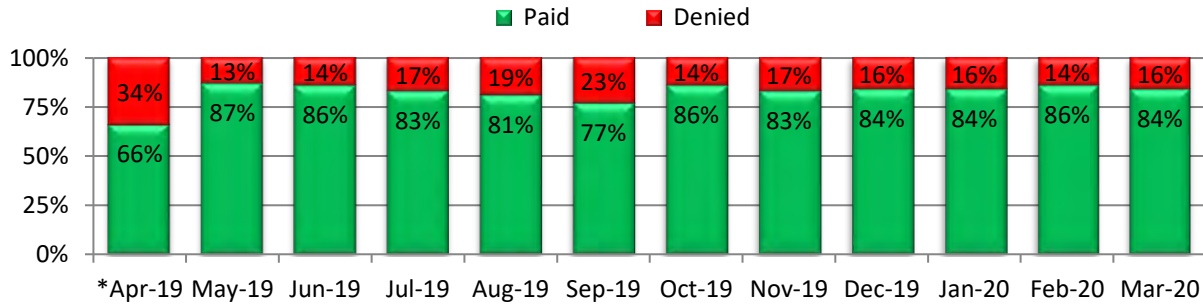
After the final Q1 SFY20 report was completed, Amerigroup identified an error in their calculation of the Suspended Non-Pharmacy Claims Payment Rates for April 2019. Their corrected rates for April 2019 are 84% paid and 16% denied.
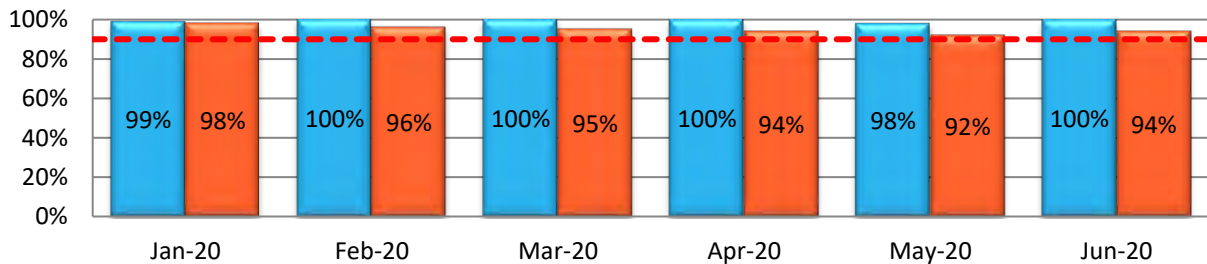
Iowa Total Care
Suspended Non-Pharmacy Claims Payment Rates (90-day lag)
As of the end of the reporting period

■ Paid ■ Denied

Percentage of Clean Provider Adjustment Requests and Errors Reprocessed Within 30 Days of Identification

■ Amerigroup ■ Iowa Total Care – – – Contract Requirement: 90%

Top 10 Reasons for Non-Pharmacy Claims Denial
**As of the end of the reporting period

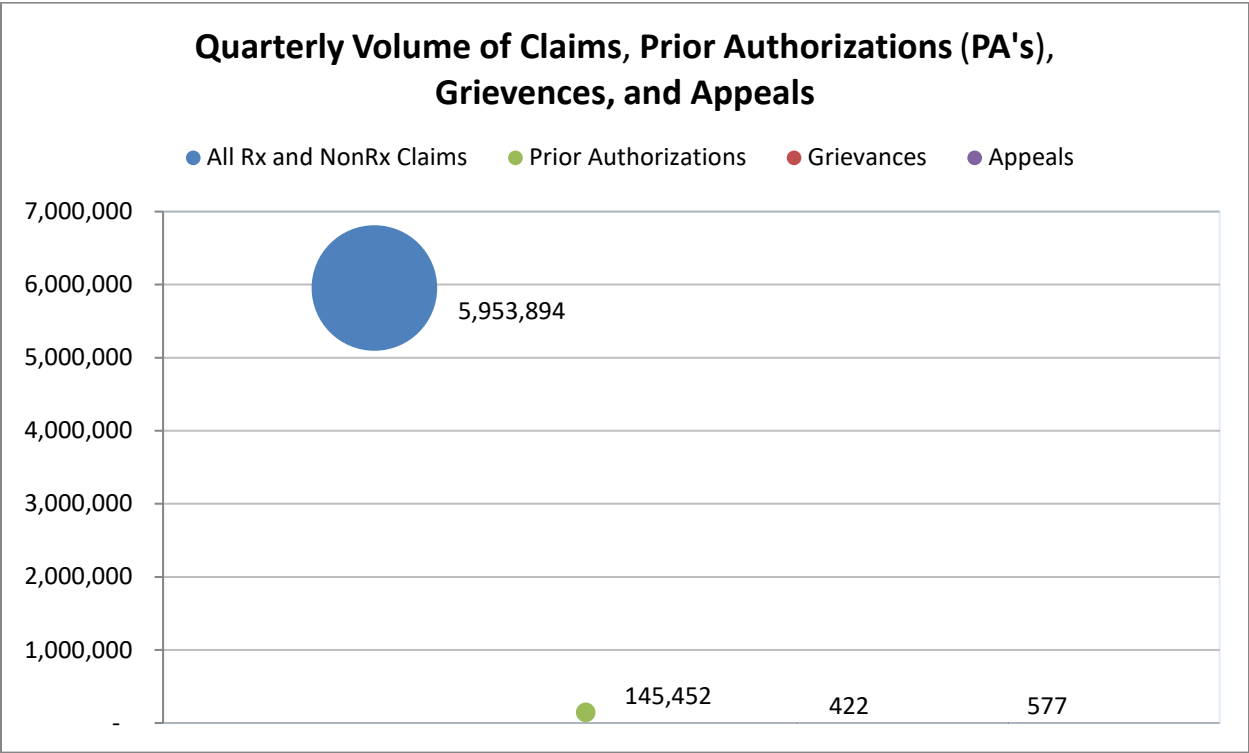| #	Amerigroup	%	Iowa Total Care	%
	Reason	%	Reason	%
1.	18-Exact duplicate claim/service	30%	18: DENY: DUPLICATE CLAIM SERVICE	27%
2.	27-Expenses incurred after coverage terminated	9%	18: DENY: DUPLICATE SUBMISSION-ORIGINAL CLAIM STILL IN PEND STATUS	5%
3.	45-Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges	8%	A1: ACE CLAIM LEVEL RETURN TO PROVIDER (REVIEW CLAIM REMARKS)	5%
4.	16-Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.	8%	A1: ACE LINE ITEM DENIAL	5%
5.	256-Service not payable per managed care contract	7%	23: ADJUSTMENT TO PREVIOUSLY SUBMITTED CLAIM	5%
6.	29-The time limit for filing has expired	6%	A1: DENY : PROCEDURE COVERAGE NOT DEFINED BY MEDICAID – PROVIDER TO RESUBMIT	4%
7.	197-Precertification/authorization/ notification absent	5%	236: DENY: CMS MEDICAID NCCI UNBUNDLING	3%
8.	23-The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	4%	A1: PROVIDER MEDICAID ID REQUIRED FROM MEMBER STATE; OBTAIN ID & RESUBMIT	3%
9.	252-An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be	4%	A1: DENY: NDC MISSING/INVALID OR NOT APPROPRIATE FOR PROCEDURE	3%

#	Top 10 Reasons for Non-Pharmacy Claims Denial **As of the end of the reporting period			
	Amerigroup		**Iowa Total Care**	
	Reason	%	Reason	%
	provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). N479-Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer)			
10	97 – The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present N432 – Alert: Adjustment based on a Recovery Audit	3%	96: DENY SERVICE REVIEWED AND IS NOT COVERED BY IOWA MEDICAID	3%

Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

Quarterly Volume of Claims, Prior Authorizations (PA's), Grievences, and Appeals

● All Rx and NonRx Claims   ● Prior Authorizations   ● Grievances   ● Appeals

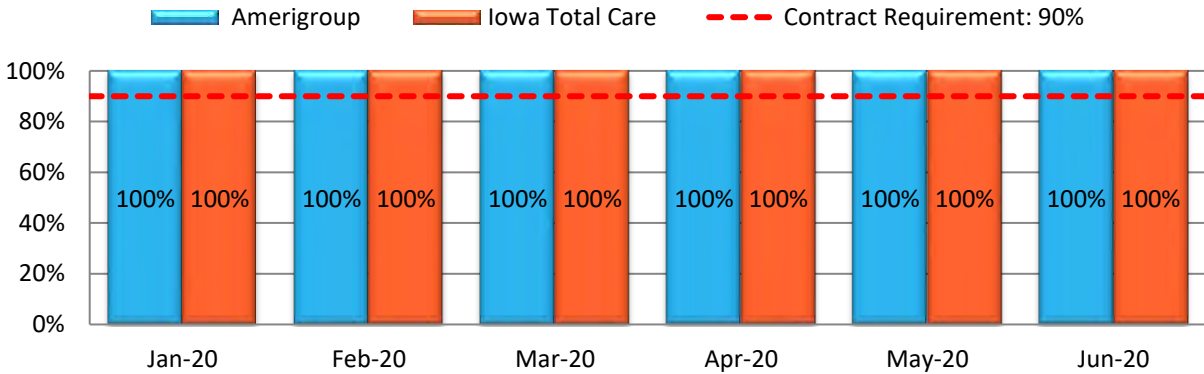|	
7,000,000	
6,000,000	5,953,894
5,000,000	
4,000,000	
3,000,000	
2,000,000	
1,000,000	
-	145,452 422 577

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

- 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
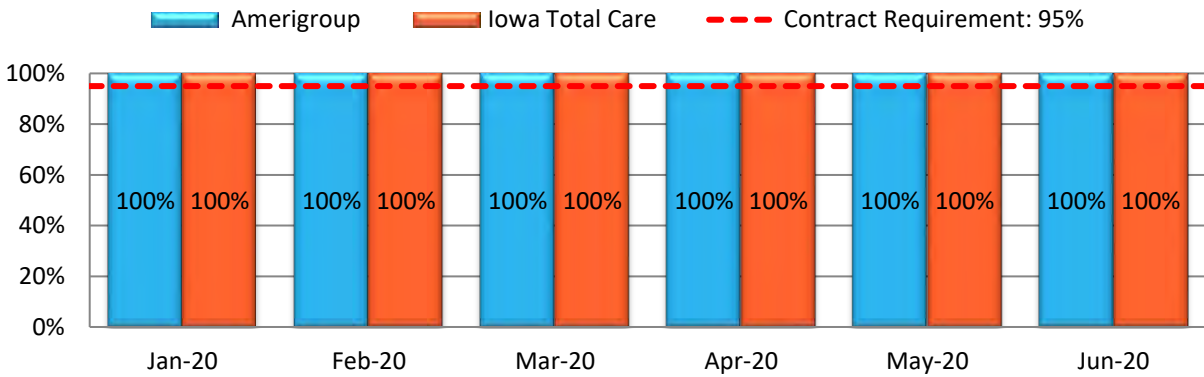
Supporting Data		
All Rx and NonRx Claims	**5.953,894**	**% of Claims Universe**
Prior Authorizations	145,452	2.44%
Grievances	422	0.01%
Appeals	577	0.01%

Pharmacy Claims Payment

Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days

Legend: Amerigroup — Iowa Total Care — Contract Requirement: 90%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	100%	100%	100%	100%	100%	100%
Iowa Total Care	100%	100%	100%	100%	100%	100%

Percentage of Clean Pharmacy Claims Paid or Denied Within 45 Calendar Days

Legend: Amerigroup — Iowa Total Care — Contract Requirement: 95%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	100%	100%	100%	100%	100%	100%
Iowa Total Care	100%	100%	100%	100%	100%	100%

Average Days for Pharmacy Claims Payment

Legend: Amerigroup — Iowa Total Care

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	11	11	11	12	12	11
Iowa Total Care	4	4	4	3	3	4
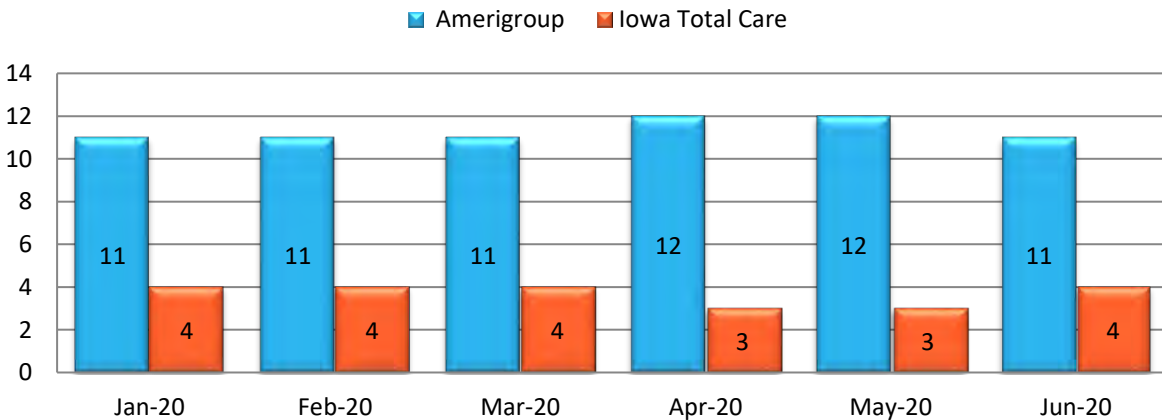
Pharmacy Claims Payment

Amerigroup
Pharmacy Claims Status
**As of the end of the reporting period

Legend: ■ Paid ■ Denied

Month	Paid	Denied
Jul-19	68%	32%
Aug-19	70%	30%
Sep-19	71%	29%
Oct-19	55%	45%
Nov-19	65%	35%
Dec-19	69%	31%
Jan-20	72%	28%
Feb-20	71%	29%
Mar-20	67%	33%
Apr-20	76%	24%
May-20	72%	28%
Jun-20	70%	30%
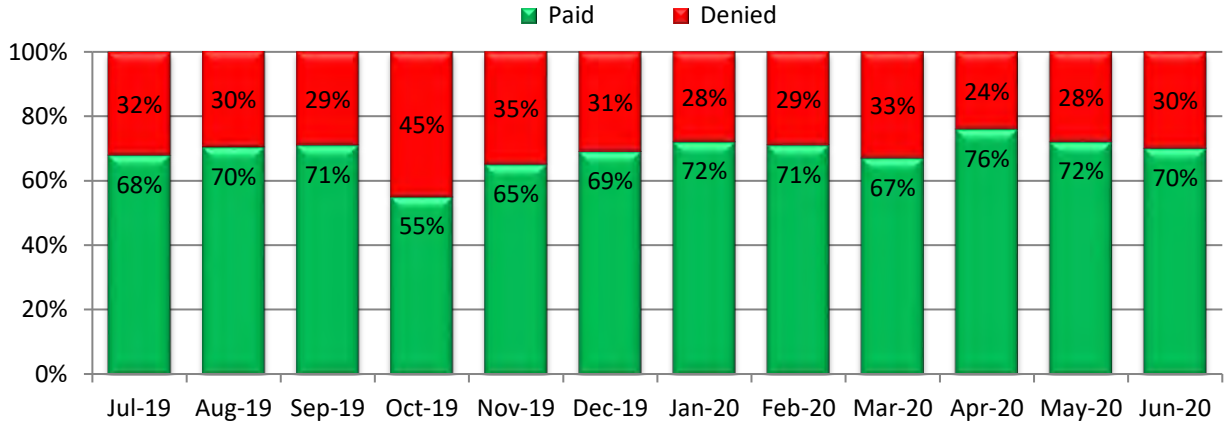
Iowa Total Care
Pharmacy Claims Status
**As of the end of the reporting period

Legend: ■ Paid ■ Denied

Month	Paid	Denied
Jul-19	73%	27%
Aug-19	75%	25%
Sep-19	68%	32%
Oct-19	55%	45%
Nov-19	60%	40%
Dec-19	69%	31%
Jan-20	61%	39%
Feb-20	61%	39%
Mar-20	62%	38%
Apr-20	65%	35%
May-20	66%	34%
Jun-20	67%	33%
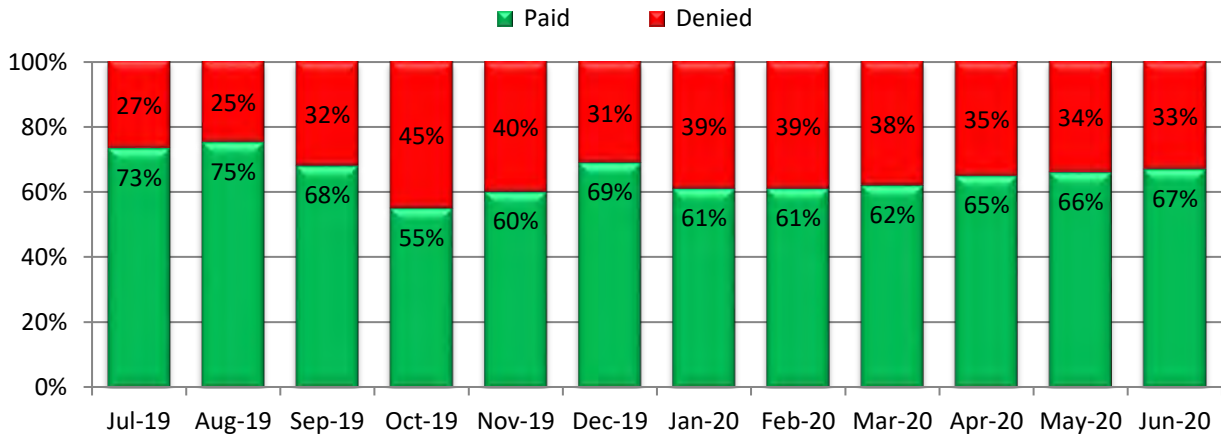
Top 10 Reasons for Pharmacy Claims Denial
**As of the end of the reporting period

#	Amerigroup	%	Iowa Total Care	%
	Reason	%	Reason	%
1.	79 - REFILL TOO SOON	46%	79 - REFILL TOO SOON	30%
2.	41 – SBMT BILL TO OTHER PROCSR	15%	75 - PRIOR AUTHORIZATION REQUIRED	10%
3.	75 – PRIOR AUTHORIZATION REQRD	12%	AG - Days' Supply Limitation For Product/Service	5%
4.	70 - NDC NOT COVERED	9%	85 – CLAIM NOT PROCESSED	3%
5.	76 – PLAN LIMITATIONS EXCEEDED	5%	MR – Product Not On Formulary	3%
6.	69 – FILLED AFTER COVERAGE TRM	2%	9G – Quantity Dispensed Exceeds Maximum Allowed	3%
7.	6E – M/I OTH PAYER REJECT CODE	2%	41 - SUBMIT BILL TO OTHER PROCESSOR OR PRIMARY PAYOR	2%
8.	56 – NON-MATCHED PRESCRIBER ID	2%	88 - DUR REJECT ERROR	2%
9.	7M – DISCREPANCY B/W OCC&OPPR	1%	68 – FILLED AFTER COVERAGE EXPIRED	2%
10.	77 – DISCONTINUED NDC NUMBER	1%	70 – NDC NOT COVERED	2%

Utilization of Value Added Services
Reported Count of Members

The MCOs may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q4 SFY20 Data	Iowa Total Care
My Health Pays Program	13,421
The Flu Program	1,517
Start Smart for Your Baby	1,417
Member Connections Program	110
Mobile App	349
Tobacco Cessation	90
Q4 SFY20 Data	Amerigroup
Weight Watchers	853
Exercise Kit	79
Dental Hygiene Kit	80
Comfort Item	3
SafeLink Mobile Phone	652
Healthy Families Program	14
Community Resource Link	715
Live Health Online	135
Healthy Rewards	1,765
Taking Care of Baby and Me	2,754
Personal Care Attendant	1
Home Delivered Meals	50

Provider Network Access

There are two major methods used to determine adequacy of network in the contract between the Department and the MCOs:

- Member and provider ratios by provider type and by region
- Geographic access by time and distance

As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the Department when the MCO clearly demonstrates that:
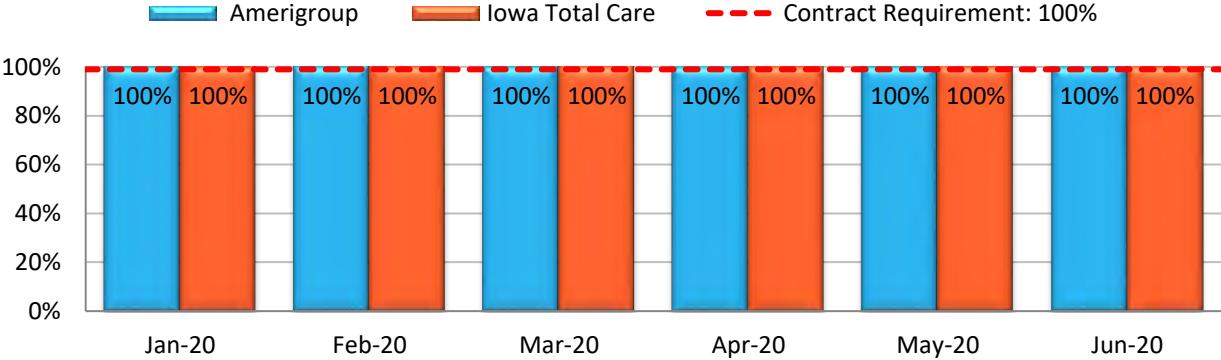
- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

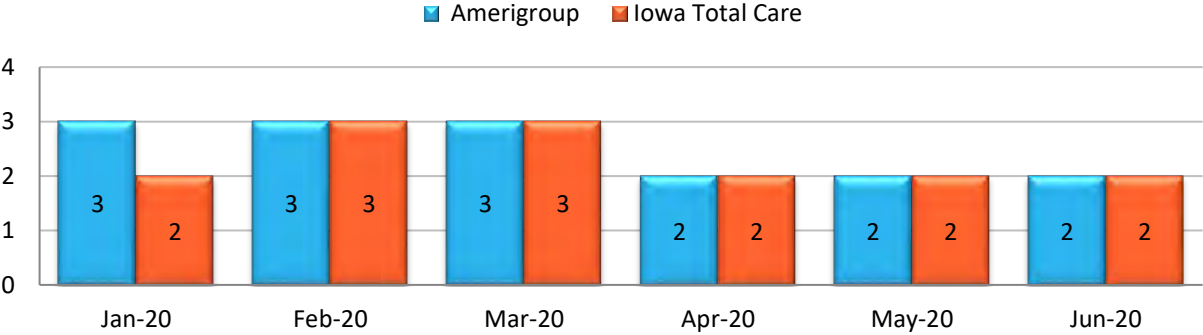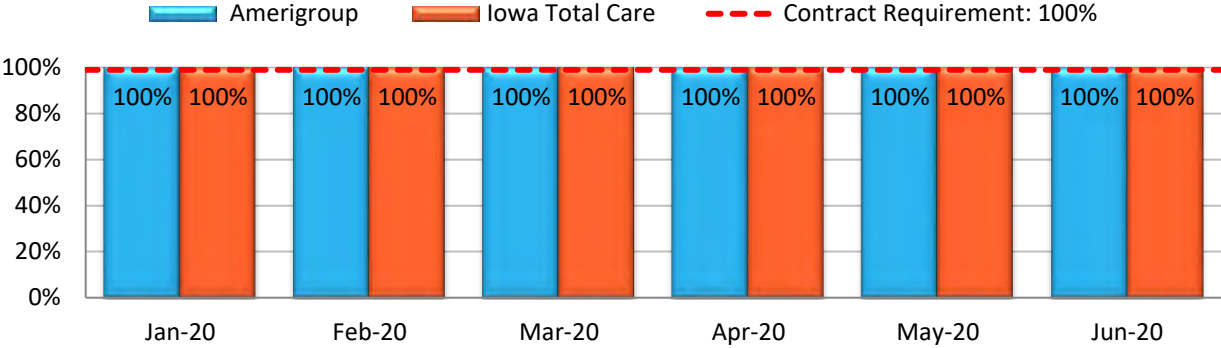Links to time and distance reports can be found at:
https://dhs.iowa.gov/ime/about/performance-data-GeoAccess

Non-Pharmacy Prior Authorizations (PA's)

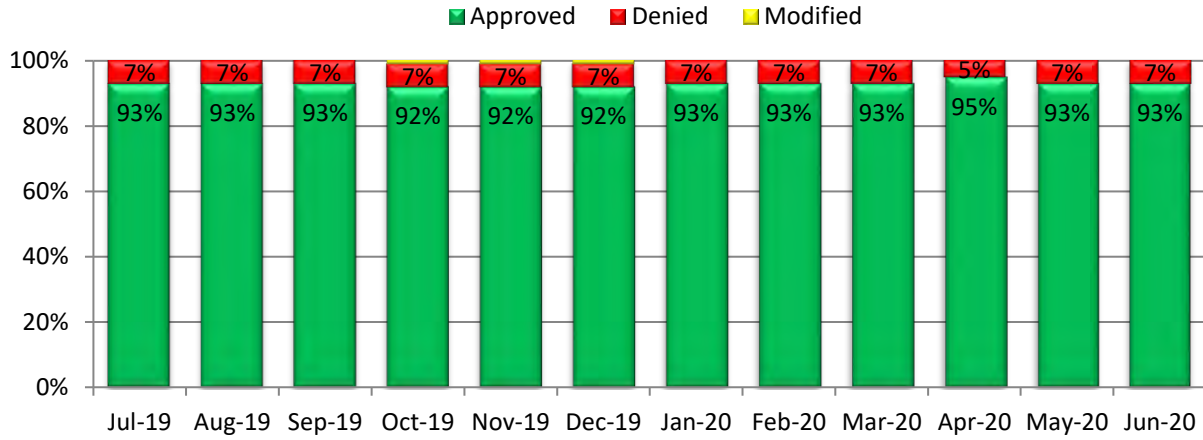## Percentage of Regular PAs Completed Within 14 Calendar Days of Request

Legend: ■ Amerigroup ■ Iowa Total Care --- Contract Requirement: 100%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	100%	100%	100%	100%	100%	100%
Iowa Total Care	100%	100%	100%	100%	100%	100%

Average Days for Regular PA Processing

Legend: ■ Amerigroup ■ Iowa Total Care

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	3	3	3	2	2	2
Iowa Total Care	2	3	3	2	2	2

Percentage of Expedited PAs Completed Within 72 Hours of Request

Legend: ■ Amerigroup ■ Iowa Total Care --- Contract Requirement: 100%

	Jan-20	Feb-20	Mar-20	Apr-20	May-20	Jun-20
Amerigroup	100%	100%	100%	100%	100%	100%
Iowa Total Care	100%	100%	100%	100%	100%	100%

Non-Pharmacy Prior Authorizations (PAs)

Amerigroup
Non-Pharmacy PAs Status
**As of the end of the reporting period

■ Approved ■ Denied ■ Modified

Month	Denied	Approved
Jul-19	7%	93%
Aug-19	7%	93%
Sep-19	7%	93%
Oct-19	7%	92%
Nov-19	7%	92%
Dec-19	7%	92%
Jan-20	7%	93%
Feb-20	7%	93%
Mar-20	7%	93%
Apr-20	5%	95%
May-20	7%	93%
Jun-20	7%	93%

Iowa Total Care
Non-Pharmacy PAs Status
**As of the end of the reporting period

■ Approved ■ Denied ■ Modified

Month	Denied	Approved
Jul-19	0%	100%
Aug-19	0%	100%
Sep-19	0%	100%
Oct-19	1%	99%
Nov-19	1%	99%
Dec-19	1%	99%
Jan-20	2%	98%
Feb-20	2%	98%
Mar-20	2%	98%
Apr-20	2%	98%
May-20	2%	98%
Jun-20	2%	98%
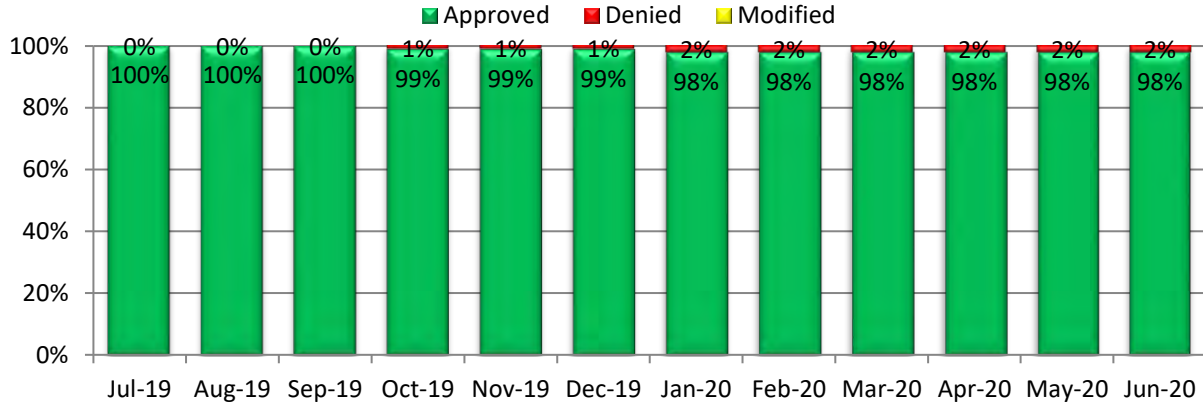
Pharmacy Prior Authorizations (PAs)

Percentage of Regular PAs Completed
Within 24 Hours of Request

Legend: ▬ Amerigroup ▬ Iowa Total Care - - - Contract Requirement: 100%

Month	Amerigroup	Iowa Total Care
Jan-20	100.0%	99.6%
Feb-20	100.0%	100.0%
Mar-20	100.0%	99.9%
Apr-20	100.0%	99.9%
May-20	100.0%	100.0%
Jun-20	100.0%	100.0%
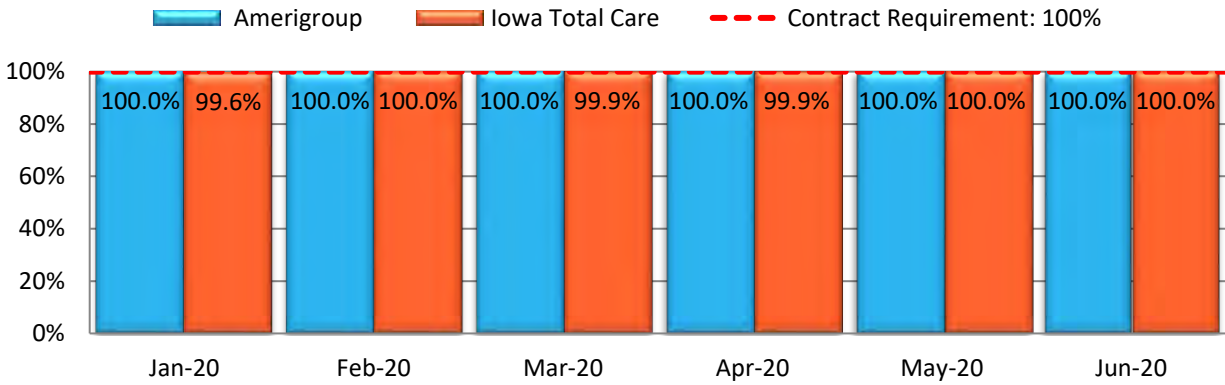
Pharmacy Prior Authorizations (PAs)

Amerigroup
Pharmacy PAs Submitted Status
**As of the end of the reporting period

■ Approved ■ Denied

Month	Approved	Denied
Jul-19	68%	32%
Aug-19	69%	31%
Sep-19	69%	31%
Oct-19	73%	27%
Nov-19	64%	36%
Dec-19	63%	37%
Jan-20	67%	33%
Feb-20	62%	38%
Mar-20	64%	36%
Apr-20	65%	35%
May-20	64%	36%
Jun-20	66%	34%
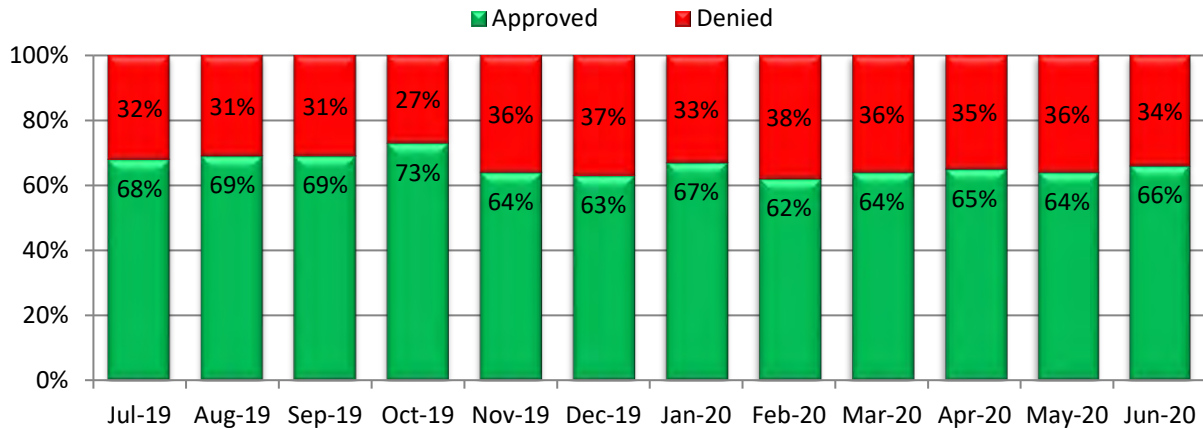
Iowa Total Care
Pharmacy PAs Submitted Status
**As of the end of the reporting period

■ Approved ■ Denied

Month	Approved	Denied
Jul-19	94%	6%
Aug-19	86%	14%
Sep-19	79%	21%
Oct-19	71%	29%
Nov-19	63%	37%
Dec-19	58%	42%
Jan-20	57%	43%
Feb-20	59%	41%
Mar-20	55%	45%
Apr-20	55%	45%
May-20	58%	42%
Jun-20	56%	44%
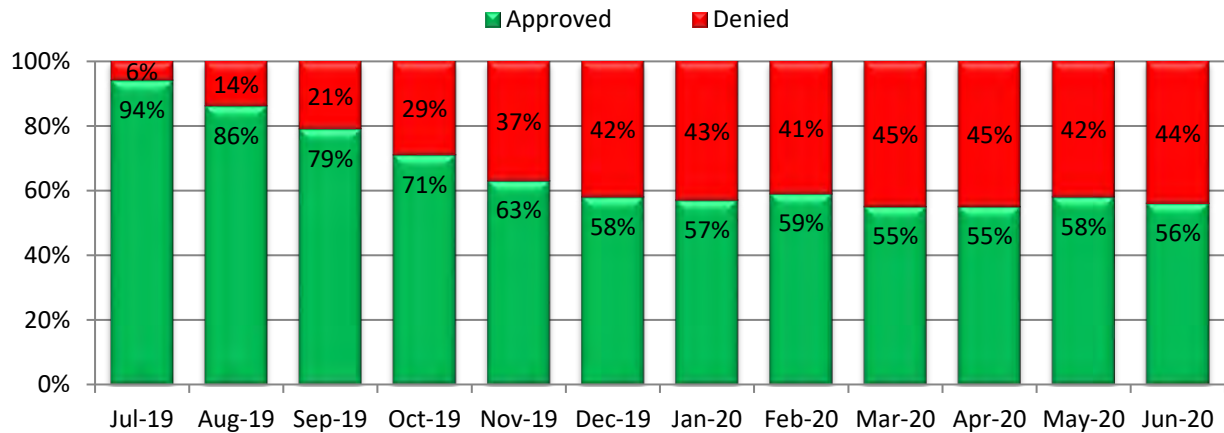
Encounter Data Reporting

Encounter Data are records of medically-related services rendered by a provider to a member. The Department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

Measure	Amerigroup			Iowa Total Care		
	Jan	Feb	Mar	Jan	Feb	Mar
Encounter Data Submitted By 20th of the Month	Y	Y	Y	Y	Y	Y

Value Based Purchasing Enrollment

The MCOs are expected to have 40% of their population covered by a value-based purchasing agreement.

Data as of March 2020	Amerigroup	Iowa Total Care
% of Members Covered by a Value-Based Purchasing Agreement Meeting State Standards	63%	32%

Financial Ratios

Each MCO is required to meet a minimum Medical Loss Ratio (MLR) of 88% per the contract between the Department and the MCOs.

- **Medical Loss Ratio** (**MLR**): Reflects the percentage of capitation payments used to pay medical expenses.
- **Administrative Loss Ratio (ALR**): Reflects the percentage of capitation payments used to pay administrative expenses.
- **Underwriting Ratio** (**UR**): Reflects either profit or loss

A minimum MLR protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. It also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

Q4 SFY20 Data	Amerigroup	Iowa Total Care
MLR	80.5%	90.8%
ALR	5.7%	5.0%
UR	13.8%	4.2%

These measurements may be subject to change after the end of the reporting quarter due to out-of-period adjustments made by the MCOs.

Capitation Payments

Capitation payments include payments made for the reported quarter's enrollment, adjustments, and member reinstatements and retroactive eligibility. Quarterly Performance Reports in previous fiscal years only included payments for the current quarter's enrollment, which is why previous quarters are not provided.

Amerigroup	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Total	**$776,896,261**	**$770,541,008**	**$780,177,202**	**$801,008,868**
Adjustments	$6,430,230	($318,472)	($561,917)	(-$709,161)
Current	$746,007,181	$741,757,464	$737,725,943	$765,456,683
Member Reinstatements and Retroactive Eligibility	$24,458,850	$29,102,016	$43,013,176	$36,261,345
Iowa Total Care	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Total	**$490,980,587**	**$515,932,803**	**$517,576,251**	**$533,865,563**
Adjustments	($2,210,078)	($738,123)	($269,855)	(-$985,520)
Current	$472,574,570	$477,277,865	$482,489,315	$505,021,654
Member Reinstatements and Retroactive Eligibility	$20,616,095	$39,393,061	$35,356,790	$29,829,430

Reported Reserves

Data reported	Amerigroup	Iowa Total Care
Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*	Y	Y

Third Party Liability (TPL)

TPL Recovery (Millions)

■ Amerigroup   ■ Iowa Total Care

	Q1 SFY20	Q2 SFY20	Q3 SFY20	Q4 SFY20
Amerigroup	$15M	$15M	$16M	$15M
Iowa Total Care	$13M	$18M	$31M	$26M
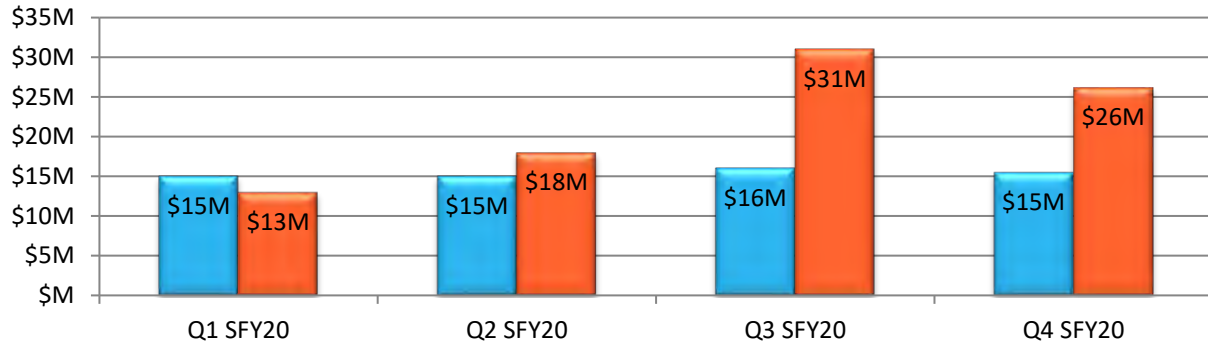
Program Integrity (PI)

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.

Fraud, Waste and Abuse

Program integrity activity data demonstrates the MCO's ability to identify, investigate, and prevent fraud, waste, and abuse.

Q4 SFY20 Data	Amerigroup	Iowa Total Care
Investigations Opened During the Quarter	72	6
Overpayments Identified During the Quarter	14	2
Cases Referred to the Medicaid Fraud Control Unit (MFCU) During the Quarter	4	3
Member Concerns Referred to IME	5	4

The plans have initiated 130 investigations in the third quarter and referred seven cases to the Medicaid Fraud Control Unit (MFCU). 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, would not occur until there is sufficient evidence to implement.

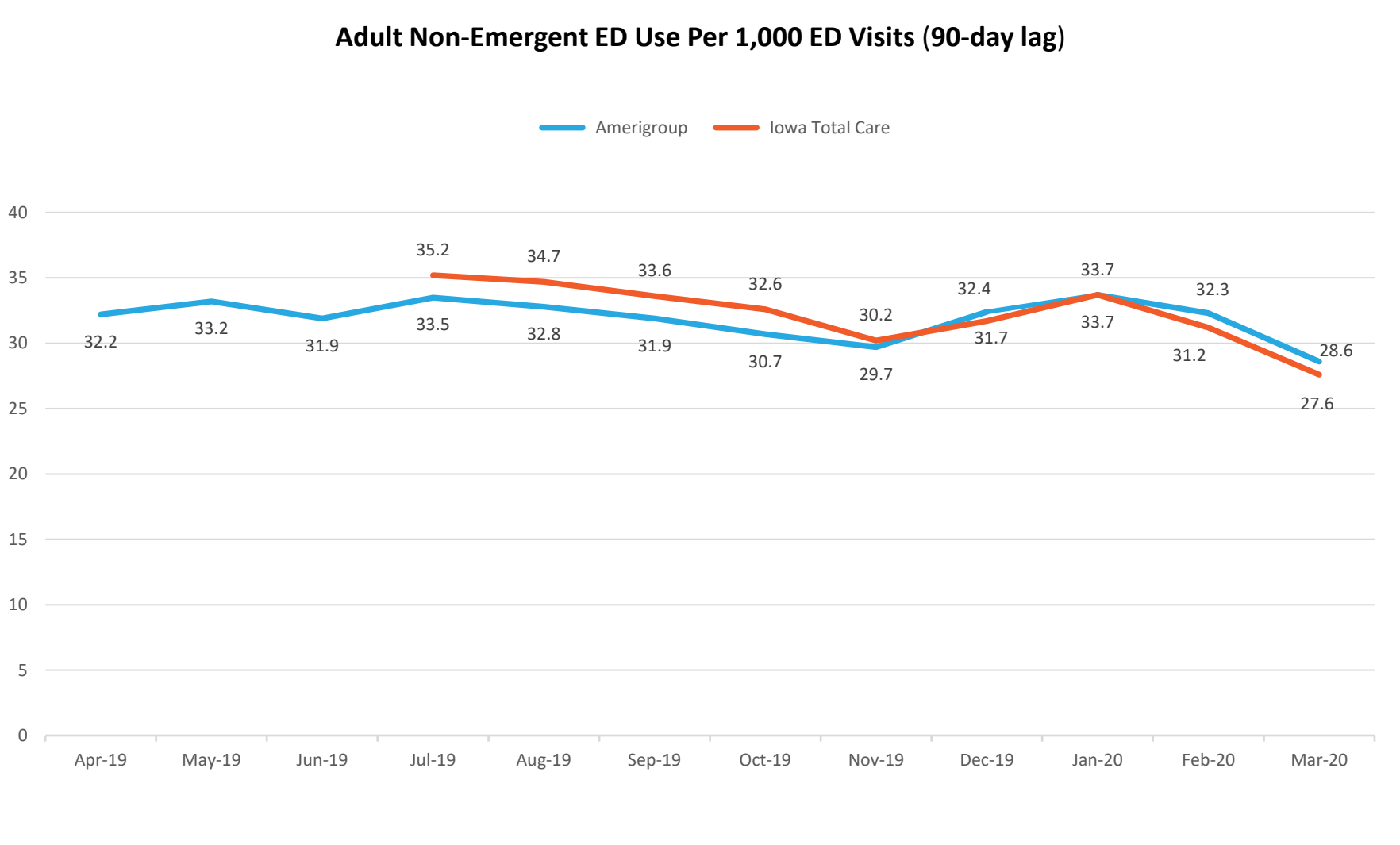Inpatient Admissions per 1,000 Members Per Month (90-day lag)
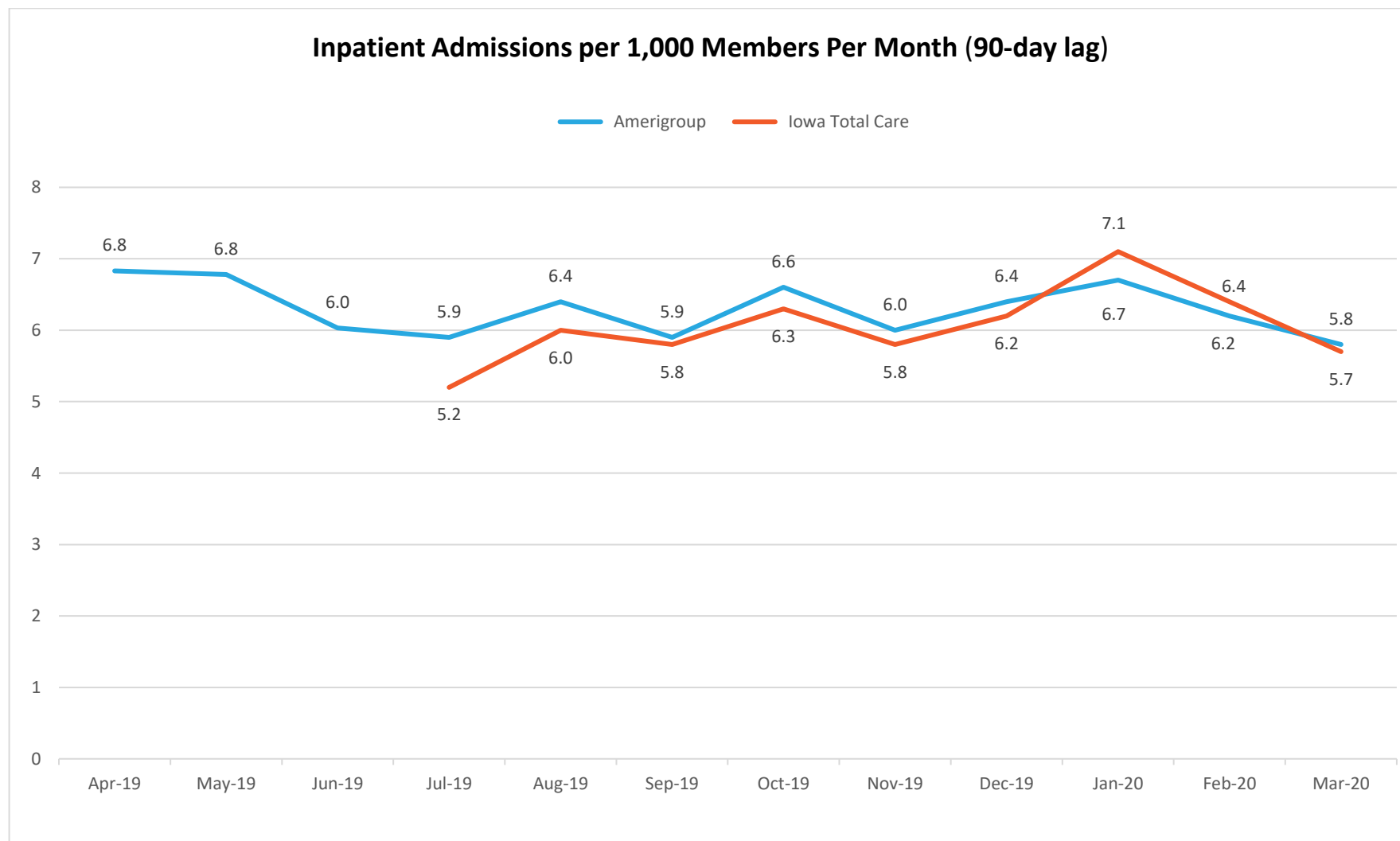
All Cause Readmissions within 30 Days (90-day lag)

— Amerigroup   — *Iowa Total Care

Month	Value
Apr-19	9.0%
May-19	12.5%
Jun-19	11.2%
Jul-19	10.7%
Aug-19	9.8%
Sep-19	13.1%
Oct-19	11.7%
Nov-19	11.1%
Dec-19	10.1%
Jan-20	9.4%
Feb-20	9.4%
Mar-20	10.2%
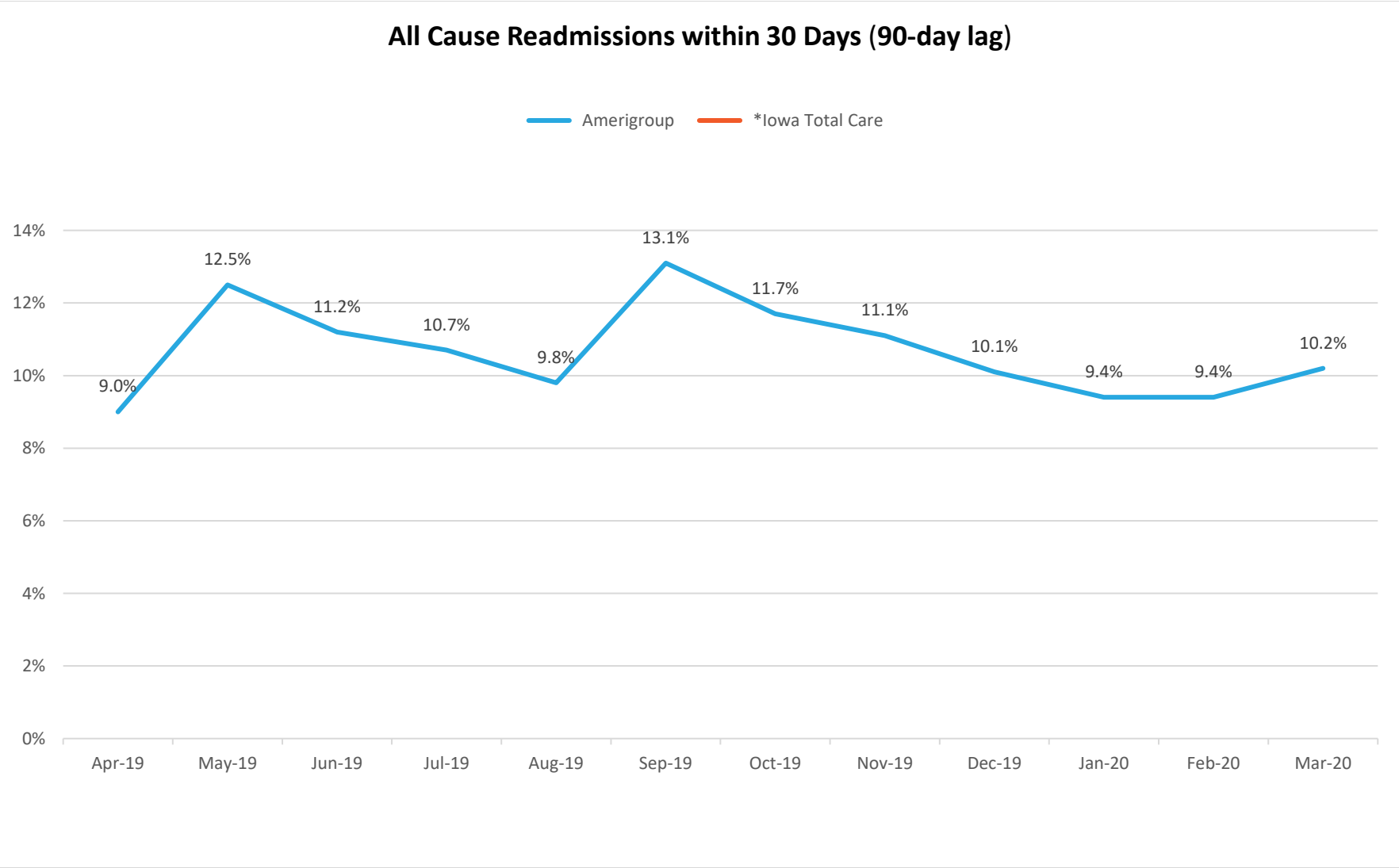
This measure requires 12 months of continuous enrollment with the MCO. Since ITC does not have members with 12 months of continuous enrollment, and since this measure is reported using a 90 day lag, there will not be results for ITC for this measure until Q2 SFY2021.

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

Amerigroup ——— Iowa Total Care ———

Amerigroup: 32.2, 33.2, 31.9, 33.5, 32.8, 31.9, 30.7, 29.7, 31.7, 33.7, 32.3, 28.6

Iowa Total Care: 35.2, 34.7, 33.6, 32.6, 30.2, 32.4, 33.7, 31.2, 27.6

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

MCO COVID-19 Summary

Total Individuals Tested	Total Tested Positive	Total COVID Deaths	Total COVID Inpatient Stays[1]
19,857	**481**	**120**	**1,867**

1 of 34	2.4%	0.02%	2.05%
MCO Members Tested	% Tested Positive	% of MCO Population	% of Total Inpatient stays
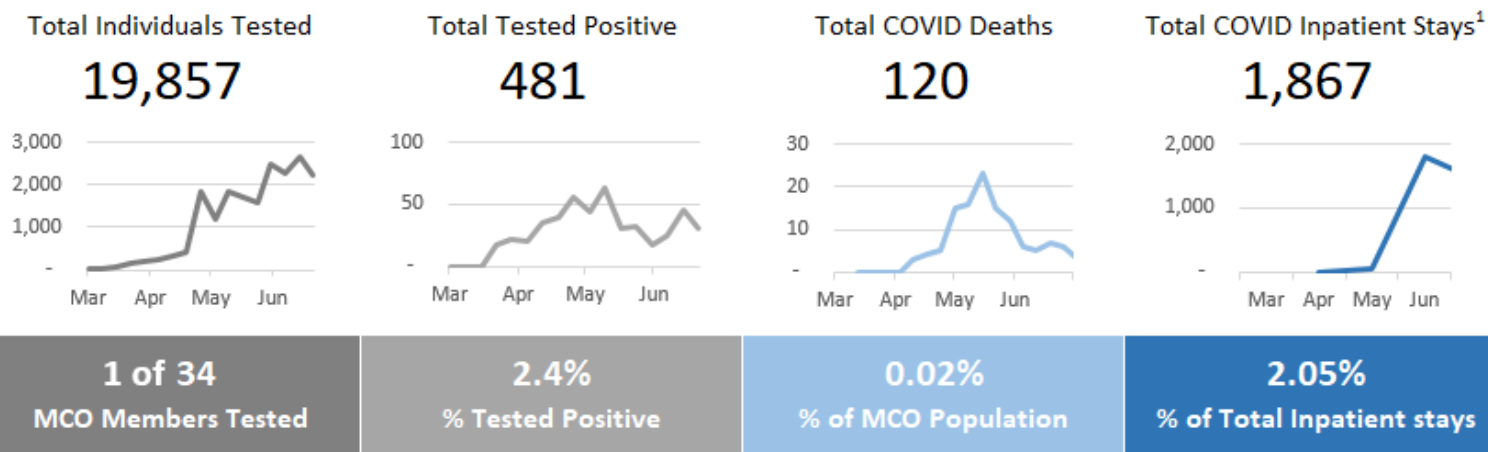
COVID-19 testing and treatment is a covered benefit for Medicaid members. Total test counts reflect multiple tests for some individuals. [1] Reported counts include patients initially hospitalized as "expected positive", but may have never tested positive.

Claims Activity During COVID-19

MCO Total Counts	Q3	Q4
ER Visits - Counts	253,024	**200,760**
Amount Paid	$36.34 M	$39.96 M
Telehealth Services - Counts	9,386	**185,205**
Amount Paid	$650 k	$15.02 M
Transportation Claims - Counts	90,007	**64,341**
Amount Paid	$4.38 M	$3.96 M
Home Maker Services - Counts	6,357	**6,265**
Amount Paid	$984 k	$941 k
COVID Testing - Counts	839	**19,018**
Amount Paid	$62 k	$1273 k
Meals - Counts	18,644	**20,948**
Amount Paid	$4.17 M	$4.57 M

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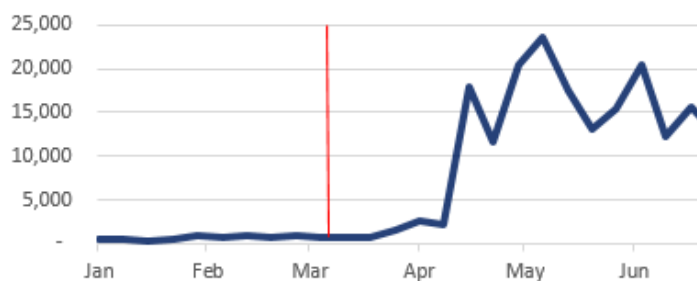
o In March, IL 2115-MC-FFS and IL 2119-MC-FFS authorized the expansion of telehealth services in Iowa.

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

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.
ITC: Iowa Total Care

Glossary Terms:

Administrative Loss Ratio (**ALR**): The percent of capitated rate payment or premium spent on administrative costs.

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 the Department of Human Services (DHS) or they may ask to ask for a state fair hearing.

Appeal process: The MCO process for handling of appeals, which complies with:

- The procedures for a member to file an appeal,
- The process to resolve the appeal,
- The right to access a state fair hearing, and
- The timing and manner of required notices.

Calls Abandoned: Member terminates the call before a representative is connected.

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

CARC: Claim Adjustment Reason Code. An explanation of why a claim or service line was paid differently than it was billed. A **RARC** – Readjustment Advice Remark Code provides further information.

Care Management: Care Management helps members manage their complex health care needs. It may include helping member get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

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.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing home or home supports.

Community-Based Case Management (**CBCM**): Community-Based Case Management helps Long-Term Services and Supports (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. Community-Based Care managers (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**): Consumer-Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able. CDAC services include:

- Bathing.
- Grocery Shopping.
- Medication Management.
- Household Chores.

Critical Incidents: When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to the HCBS member's MCO in a clear, legible manner, providing as much information as possible regarding the incident.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

DHS: Iowa Department of Human Services.

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

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

ED: Emergency Department.

Emergency Medical Condition: An Emergency Medical Condition is any condition that the member believes endangers their life or would cause permanent disability if not treated immediately. A physical or behavioral condition or medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy.
- Serious impairment to bodily function.
- Serious dysfunction of any bodily organ or body part.

If a member has a serious or disabling emergency, they do not need to call their provider or MCO. They should go directly to the nearest hospital emergency room or call an ambulance. The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services.
- Needed to assess and stabilize an emergency medical condition.

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Fee-for-Service (FFS): The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through fee-for-service Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: Members may request to change their MCO during their 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason. Some examples of Good Cause for disenrollment include:

- A member's provider is not in the MCO's network.
- A member needs related services to be performed at the same time. Not all related services are available within the MCO's provider network. The member's primary care provider or another provider determined that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- The member's provider has been terminated or no longer participates with the MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by the member's MCO.
- The MCO plan does not cover the services the member needs due to moral or religious objections.

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:

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

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

HCBS: Home- and Community-Based Services, waiver services. Home- and Community-Based Services (HCBS) provide supports to keep Long Term Services and Supports (LTSS) members in their homes and communities.

Hawki*: A program that provides coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the Federal Poverty Level (FPL) based on Modified Adjusted Gross Income (MAGI) methodology.

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

Health Risk Assessment (**HRA**): A Health Risk Assessment (HRA) is a short survey with questions about the member's health.

Historical Utilization: A measure of the percentage of assigned members whose current providers are part of the managed-care network for a particular service or provider type based on claims history.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides, and therapists.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery, or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services.
- Observation services.
- Outpatient surgery.
- Lab tests.
- X-rays.

ICF/ID: Intermediate Care Facility for Individuals with Intellectual Disabilities.

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

IID: Iowa Insurance Division.

IME: Iowa Medicaid Enterprise.

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

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):
Long Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.

Long Term Care Services:

- Home- and Community-Based Services (HCBS).
- Intermediate Care Facilities for Persons with Intellectual Disabilities.
- Nursing Facilities and Skilled Nursing Facilities.

MCO: Managed Care Organization.

Medicaid Fraud Control Unit (**MFCU**) - **Iowa Department of Inspections** & **Appeals**:
The Medicaid Fraud Control Unit's (MFCU) 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**): The percent of capitated rate payment or premium spent on claims and expenses that improve health care quality.

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: 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.

NF: Nursing Facility.

PA: Prior Authorization. Some services or prescriptions require approval from the MCO to be covered. This must be done before the member gets that service or fills that prescription.

PCP: Primary Care Provider. A Primary Care Provider (PCP) is either 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.

PDL: Preferred Drug List.

Person-centered Plan: A Person-centered Plan is a written individual plan based on the member's needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP), or individual education plan (IEP).

PMIC: Psychiatric Medical Institute for Children.

Rejected Claims: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

SMI: Serious Mental Illness.

Serious Emotional Disturbance (**SED**): A mental, behavioral, or emotional disturbance which impacts children. An SED may last a long time and interferes with family, school, or community activities. SED does not include Neurodevelopmental or substance-related disorders.

Service Plan: A Service Plan is a 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: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. The member must be medically and financially eligible. If the member's care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding their care, then a skilled level of care is assigned.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Suspended Claims: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

Third-Party Liability (**TPL**): This is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: A health plan accepts responsibility for paying for the health care services of covered individuals in exchange for dollars, which are usually referred to as premiums. This practice is known as underwriting. When a health insurer collects more premiums than it pays in expense for those treatments (claim costs) and the expense to run its business (administrative expenses), an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs.

Hawki Board Report – Hawki Grassroots Outreach Report
__October 2020__

<mark>Major activities: Hawki Outreach</mark>

- State Hawki Outreach Coordinator continues working with local Hawki Outreach Coordinators to provide them with information in their outreach "tool box" during this COVID-19 pandemic.

- New Hawki Outreach Coordinator, Alesia Houser, American Home Finding Association in Ottumwa, Iowa.

- Hawki Outreach Coordinators will hold a *Virtual Fall Conference on November 18 with Hawki Outreach Coordinators*. Guest speakers include MaryNelle Trefz, Common Good Iowa; DHS/IME staff: Anna Ruggle, Joe Estes and Teresa Booker

Local Outreach Success Stories/Activities:

<mark>*Webster County Health Department - Fort Dodge, IA*</mark>

Webster County Health Department received a call from a mother who needed assistance. Mom had been diagnosed with breast cancer. Her husband, a truck driver, had injured his back and they had lost their insurance for the family. This was right after the shut down due to COVID-19. The Hawki Outreach Coordinator did an application for health insurance for the entire family through the DHS portal over the phone. The entire family was approved for Presumptive Eligibility. The HOC met with the mother outside the health agency to have her sign the form and get a copy of the approval to take to the doctor's appointment they had that day. Upon meeting the mother, she was emotional and said they normally

would not have needed the help, but she was so thankful and appreciative of the service.

In September, the Waukee School District Social Worker for PE Medicaid application assistance and some extra support for the family referred a mother to EveryStep. The mother was dealing with an impactful incident that occurred with one of her children, working full time, and trying to keep up with children's appointments. Two of her three children lost health insurance coverage and were due for their physical and dental exams. The Hawki Outreach Coordinator assisted mom with a PE Medicaid application and the children were approved, and information was explained to mom that the children would eventually be approved for Hawki.

American Home Finding Association - Ottumwa, IA
The Hawki Outreach Coordinator met with area school leadership for face-to-face meetings in Wapello, Mahaska and Keokuk counties. Information regarding the Medicaid/Hawki programs and income guidelines were presents to school administration and school nurses. Ease of PE application processing by the HOC for immediate qualification for children in need and application assistance was highlighted. Information was then posted on **school websites**, **Facebook**, **Twitter** and other **social media platforms** with HOC contact informing for question or help with applying. Advertisements for the program and information through online both in Spanish and English. AHFA looks to expand advertising more in FY20.

Words of Alesia Houser, MCAH Coordinator:

It is hard to pinpoint one success story as I feel that anytime we can help take the medical/dental payments off struggling families is a success in my book. Through these unprecedented times with COVID-19, AHFA has experienced an increase in services needed. Families who once did not qualify for MCAH/WIC are contacting our agency because one or both parents have been put out of work. It's very convenient being housed in the MCAH/WIC office, gives me the unique opportunity to work alongside the MCAH/WIC staff and assist families in need by providing them access to free or low cost health/dental insurance. One success story that comes to mind is a family that just arrived here from Democratic

Republic of Congo and had very limited in English. Their children ages 2, 6, and 9 had never seen a dentist, were behind on vaccinations and were unsure of medical/dental providers in the area. Because dad just started working, the family did not qualify for insurance through his employment. While in clinic for MCAH/WIC, I met with the family to discussed insurance option through Medicaid and Hawki. PE application was complete for the children on site. I also provided then with information regarding medical and dental providers in the area. Once the family selected medical/dental homes, they requested assistance with scheduling appointments. I was able to obtain appointments for all three kids for both medical and dental. I instructed the family about DHS follow-up and the possibility of them needing to send more information for continued coverage. The family returned two weeks later with their letter from DHS and with their information they requested for assistance with sending it to DHS. The children qualified for Medicaid insurance. From FY19 to FY 20 AHFA provided a 358 child PE applications that is up 20 from FY19.