Hawki
Iowa HHS

Elizabeth Matney, Medicaid Director **Healthy and Well Kids in Iowa (Hawki)**

Hawki Board Meeting Materials

Monday, April 17, 2023

1. April 17, 2023, Hawki Board Meeting Agenda
2. February 20, 2023, Hawki Board Meeting Minutes
3. MCO SFY2023 Quarter 1 Performance Report

Hawki
Iowa HHS

Elizabeth Matney, Medicaid Director **Healthy and Well Kids in Iowa (Hawki)**

AGENDA
Hawki Board Meeting
Monday, April 17, 2023
12:30 PM – 2:30 PM

Virtual Meeting via Zoom
https://www.zoomgov.com/j/1616707613
Meeting ID: 161 670 7613

12:30 PM	Roll Call – **Mary Nelle Trefz**
12:35 PM	Approval of Minutes from February 20, 2023 – **Mary Nelle Trefz**
12:40 PM	Public Comments
12:45 PM	New Business
12:50 PM	Educational Presentation: Overview of CHIP programs across the country – **Anita Cardwell and Maureen Hensley-Quinn, National Academy for State Health Policy (NASHP)**
1:20 PM	Quarter 1 MCO Report – **Kurt Behrens**
1:50 PM	MCO Engagement – Board discussion of MCO well-child visit presentations
2:10 PM	Updates – **Various Presenters** • Director's Update • MCO Updates • Clinical Advisory Committee • Children with Special Healthcare Needs Committee • Outreach Update • Communications Update
2:30 PM	Adjourn

For more information, contact John Riemenschneider at jriemen@dhs.state.ia.us or Emily Eppens at eeppens@dhs.state.ia.us.

Note: Times listed for items on the agenda are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

Hawki
Iowa HHS

Elizabeth Matney, Medicaid Director **Healthy and Well Kids in Iowa (Hawki)**

Hawki Board Meeting Minutes

Monday, February 20, 2023

Hawki Board Members	Iowa Medicaid
Mary Nelle Trefz, Chair – present	Julie Lovelady
Mary Scieszinski, Vice Chair – present	Tashina Hornaday
Angela Burke Boston – present	Joanne Bush
Jim Donoghue – present	Heather Miller
Mike Stopulos – present	Dr. William Jagiello
Angela Doyle Scar – present	
Shawn Garrington –	**Guests**
Senator Nate Boulton –	John Hedgecoth, Amerigroup
Senator Mark Costello –	Kristin Pendegraft, ITC
Representative Shannon Lundgren –	Gretchen Hageman, DDIA
	Melissa Ellis, HHS
	Lindsay Paulson, Maximus
	Mikki Stier, ChildServe
	Dr. Timothy Gutshall, Molina

CALL TO ORDER AND ROLL CALL

Hawki Board chair Mary Nelle Trefz called the meeting to order at 12:30 PM. Mary Nelle called the roll and a quorum was achieved.

APPROVAL OF MEETING MINUTES

Mary Nelle called for a motion to approve minutes from the December 19, 2022, meeting. The motion carried and the minutes were approved.

PUBLIC COMMENT

There was no public comment.

NEW BUSINESS

Mike Stopulos mentioned a letter he had received from a member and asked if other Board members had received it or were aware of it. Jim Donoghue stated that he had received it. The letter referenced an incident involving a member and a provider, and the letter's author raised concerns over the provider still seeing patients. The Board decided that the matter would best be handled through the member's managed care organization (MCO), and Mary Nelle said the Board would follow up to ensure the letter is sent through the appropriate channels.

MEMBER REASSIGNMENT

Joanne Bush, Iowa Medicaid, presented on member reassignment. The presentation focused on Molina onboarding ahead of the MCO's July 1, 2023, start date. Joanne discussed the rationale behind member reassignment and Iowa Medicaid's methodology behind successful onboarding and reassignment processes. She highlighted two goals of member reassignment: 1) Maintain continuity of care to the best extent possible, and 2) Facilitate and oversee equitable member reassignment to ensure all MCOs have the same membership proportion and no MCO shoulders the most critical populations. Approximately 67% of Medicaid members will remain with their current MCOs, and the redistribution will keep family units together. Members will have the opportunity to choose an MCO during the open enrollment period scheduled for March 1, 2023, through May 18, 2023. This includes members who were reassigned to Molina. After Molina begins offering Medicaid services on July 1, 2023, members will once again have a window of 90 days to change MCOs. Joanne then walked through a timeline from January 1, 2023, to July 1, 2023, highlighting important events and milestones, such as when key mailings will go out to members and when member redistribution will occur. Mary Nelle asked about returned mail and members who do not have current addresses on file. Joanne stated that Iowa Medicaid is working with the MCOs to update as many member addresses as possible. Angie Doyle Scar asked about the number of members who will undergo eligibility reviews, and the number of members who will be discontinued at the end of the public health emergency (PHE). Joanne said that she will reach out to eligibility for those numbers.

OVERALL HEALTH OF HAWKI MEMBERS AND HAWKI MEMBERS WITH SPECIAL HEALTHCARE NEEDS

Tashina Hornaday, Iowa Medicaid, presented on these topics. She briefly discussed Hawki members with special healthcare needs and the need to identify that population through diagnoses, while also considering current benefits and eligibility status. Appropriateness and quality of healthcare also factor in, and Iowa Medicaid continues its focus on this area with more information coming at a later date.

Tashina then presented a slide deck covering the health of Hawki members. She offered Hawki data collected during calendar year 2022, including monthly enrollment averages, overall claims, claims as individual billing codes and primary diagnosis codes, and claims by age. The data also covered diagnosis categories, claims within those categories, percentage of those claims that were reviewed, and member emergency room visits and diagnoses. Tashina also touched on Hawki dental statistics over calendar year 2022. Angie asked about the increase in teenage members utilizing Hawki services and suggested that it could be related to mental health. Jim Donoghue suggested that teenage sports physicals may contribute to the increase.

DIRECTOR'S UPDATE

Julie Lovelady, deputy Medicaid director, provided an update. She began with the end of the continuous coverage requirement which will occur on April 1, 2023. She noted that the HHS website has information regarding the end of the requirement, including an eligibility dashboard. She then offered a brief history of the continuous coverage requirement going back to March 2020. Most members will go through a redetermination process during the 12-month unwinding process. Julie stressed the importance of having correct member addresses on file and that members must respond to all requests for information. Additionally, Julie emphasized that the end of the continuous coverage requirement is not the same as the end of the PHE. Mary Nelle asked if there had been any lessons learned from members who have recently aged out of the Hawki program, and Julie reiterated that members have access to information through call centers and the HHS website should they have questions about eligibility. In addition to these resources, Iowa Medicaid will begin holding two member town hall events per month. This is to ensure continued information flow between Iowa Medicaid and members throughout the unwinding process.

Julie briefly talked about the community-based services evaluation (CBSE) report released on January 31, 2023. The report contains HHS's strengths and weaknesses in administering the Iowa Medicaid program and lays out a road map for the next phase of the waiver transformation. It also contains clear and actionable guidance for Iowa Medicaid's community-based services program. Iowa Medicaid will develop a transformational plan that will include the framework for implementation of the recommendations. Julie stated that stakeholder feedback will be critical over the next year as Iowa Medicaid works to implement the new and improved system.

Julie added that Director Matney is presenting to the HHS budget committee on the CBSE; Iowa Medicaid's plan to implement regular rate reviews; dental request for proposals (RFP); and the continuous coverage requirement unwind.

MCO UPDATES – WELL-CHILD VISITS

John Hedgecoth, Amerigroup, provided an update. John discussed Healthcare Effectiveness Data and Information Set (HEDIS) measures and how they are used to evaluate performance

in terms of clinical quality and customer service. Using HEDIS, MCOs are able to provide Iowa Medicaid with quality monthly reports. John noted some advantages and disadvantages of using the system. He then covered some well-child visit statistics as scored by certain HEDIS measures, including visits by age, lead screening, and weight assessment and counseling for nutrition and physical activity for children and adolescents (WCC). John noted that WCC statistics are generally moving in the wrong direction from year to year. Other statistics included childhood immunizations and adolescent immunizations. Additionally, John outlined Amerigroup's outreach efforts and strategies to influence children's HEDIS quality measures. Outreach includes texting and calling campaigns, and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT) outreach. Providers also receive monthly/quarterly missed opportunity reports on members eligible for services. John concluded by briefly discussing some of Amerigroup's internal efforts to enhance performance in these areas.

Kristin Pendegraft, Iowa Total Care (ITC), provided an update. She presented childhood and adolescent immunization statistics based on HEDIS measures. She noted that ITC is exceeding national averages in most vaccination categories. Kristin presented well-child visit, well-care visit, and WCC data, emphasizing that wellness exams can be performed during sick visits. She further broke down WCC visits in terms of body mass index (BMI) percentage; and physical activity and nutrition counseling. BMI percentage is determined through medical record review, while the National Committee for Quality Assurance (NCQA) requires specific medical record documentation to determine if a program is in compliance. To engage with the population, ITC focuses on partnering with providers across the state, reaching out to and educating members through text, call, and mail campaigns, and collaborating with health and wellness organizations and programs, such as the American Cancer Society, Mary Greeley Medical Center, diabetes prevention programs, and community gardens.

OUTREACH UPDATE

Melissa Ellis, HHS, introduced herself to the Board. Jean Johnson has accepted another position within the department, and Melissa will be filling the outreach coordinator position temporarily.

Meeting adjourned at 2:03 PM.
The next meeting will be Monday, April 17, 2023.

Submitted by John Riemenschneider
Recording Secretary
jr

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Managed Care Organization (MCO) Quarterly Performance Report

SFY2023, Quarter 1

(July - September 2022)

Published December 2022

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:

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Executive Summary

This report is based on Quarter 1 of State Fiscal Year (SFY) 2023 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

Notes about the reported data:

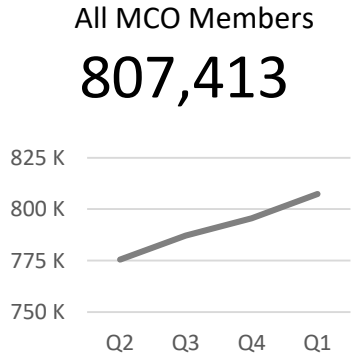
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However, based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.
- Data pulled on other dates may not reflect the same numbers due to reinstatements and eligibility changes.
- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available fee-for-service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.
- Providers and members can find more information on the IA Health Link program at: https://dhs.iowa.gov/iahealthlink

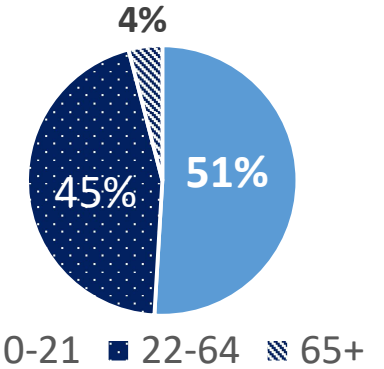
Mission/Vision Statement: Iowa Medicaid is committed to ensuring that all members have access to high quality services that promote dignity, removing barriers to increase health engagement, and improving whole person health. Our vision is operating a sustainable Medicaid program that improves the lives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

MCO Member Summary - All MCO Counts

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

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





+ 11,906 Members
1.50% Increase

All MCO Enrollment (by Age)

Data Notes: September 2022 enrollment data as of November 2022. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Distinct
MCO Member Summary - *Overall Counts*	775,507	787,187	795,507	**807,413**	791,404	**841,836**
0-21	400,213	404,569	407,098	411,121	405,750	426,544
22-64	345,001	351,867	356,845	363,817	354,383	378,779
65+	30,293	30,751	31,564	32,475	31,271	36,513
Fee-For-Service (FFS) - *Non MCO Enrollees*	46,254	46,896	47,940	**48,623**	47,428	**51,968**

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

If Yes, explain:

Iowa Medicaid Population **893,804**
1 year distinct count

- Disenrollment increased between Q4 and Q1 for each MCO because of Open Enrollment
- MCO Market Share > All new members are being assigned to Iowa Total Care prior to Molina implementation

MCO Member Summary

Amerigroup (An Anthem Company)	SFY22 Q4	SFY23 Q1
All Members - *by MCO*	455,273	455,190
Traditional Medicaid	280,403	281,794
Wellness Plan - IHAWP/Expansion	129,728	129,781
M-CHIP - Expansion	9,842	9,921
Healthy and Well Kids in Iowa (Hawki)	35,300	33,694
MCO Member Market Share	57.4%	56.4%
Disenrolled	517	1,451
Long-Term Service & Support (LTSS)	21,436	21,061
HCBS Waivers	69.0%	69.4%
Facility Based Services	31.0%	30.6%
HCBS Waivers [1]	14,785	14,624
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,651	6,437
ICF/ID [3]	849	817
Mental Health Institute (MHI)	43	29
Nursing Facilities (NF)	5,411	5,242
Nursing Facilities for Mentally Ill	59	58
Skilled	88	87
PMIC [4]	201	204

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All Members - *by MCO*	340,234	352,223
Traditional Medicaid	210,236	217,967
Wellness Plan - IHAWP/Expansion	108,181	112,810
M-CHIP - Expansion	6,779	6,977
Healthy and Well Kids in Iowa (Hawki)	15,038	14,469
MCO Member Market Share	42.8%	43.6%
Disenrolled	334	905
Long-Term Service & Support (LTSS)	14,669	14,998
HCBS Waivers	65.3%	64.9%
Facility Based Services	34.7%	35.1%
HCBS Waivers [1]	9,583	9,730
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,086	5,268
ICF/ID [3]	503	491
Mental Health Institute (MHI)	30	31
Nursing Facilities (NF)	4,339	4,531
Nursing Facilities for Mentally Ill	31	35
Skilled	67	76
PMIC [4]	116	104

[1] Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24. [2] Facility Based Services listed above only include the institutional groups where members are most likely to have an option to transition to an HCBS setting. Excluded institution types include Hospice (AGP 413; ITC 369). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

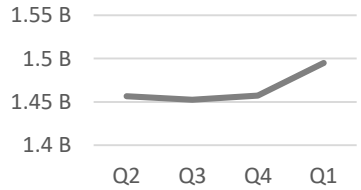
MCO Financial Summary - All MCO Counts

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

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

All Capitation Payments

$1.5 Billion

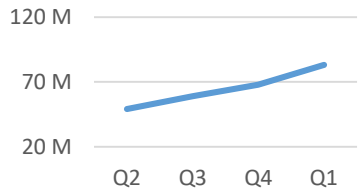


+ $38.2 Million

2.6% Increase

Third Party Liability Recovered

$83.1 Million



+ $ 15.5 Million

22.8% increase

Data Notes: September 2022 enrollment data as of November 2022. 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.

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Total
Financial Summary						
Capitation Payments	$1.46 B	$1.45 B	$1.46 B	**$1.5 B**	$1.47 B	$5.86 B
Third Party Liability (TPL) Recovered	$49.2 M	$58.9 M	$67.7 M	**$83.1 M**	$64.7 M	$258.9 M

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

If Yes, explain:

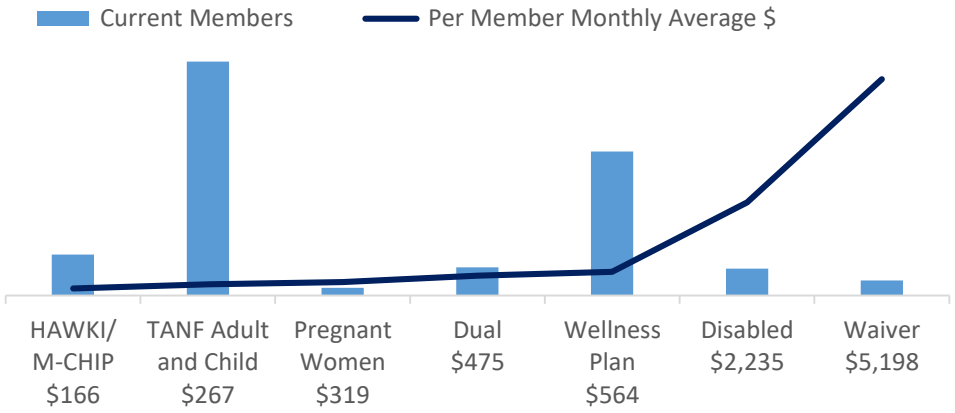
o Third Party Liability Recovered increased by 22.8% ($67.7M to $83.1M)

MCO Financial Summary

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

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

Monthly Capitation Expenditures



Amerigroup An Anthem Company

	SFY22 Q4	SFY23 Q1
Capitation Totals	$843.74 M	**$856.41 M**
Adjustments	$571 K	-$148 K
Current	$823.45 M	$840.59 M
Retro	$19.72 M	$15.97 M
Third Party Liability (TPL) Recovered	$28.2 M	**$28.3 M**
Financial Ratios		
Medical Loss Ratio (MLR)	93.9%	**87.5%**
Administrative Loss Ratio (ALR)	5.5%	5.9%
Underwriting Ratio (UR)	0.6%	6.6%
Unreconciled SFY MLR [5]		87.5%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

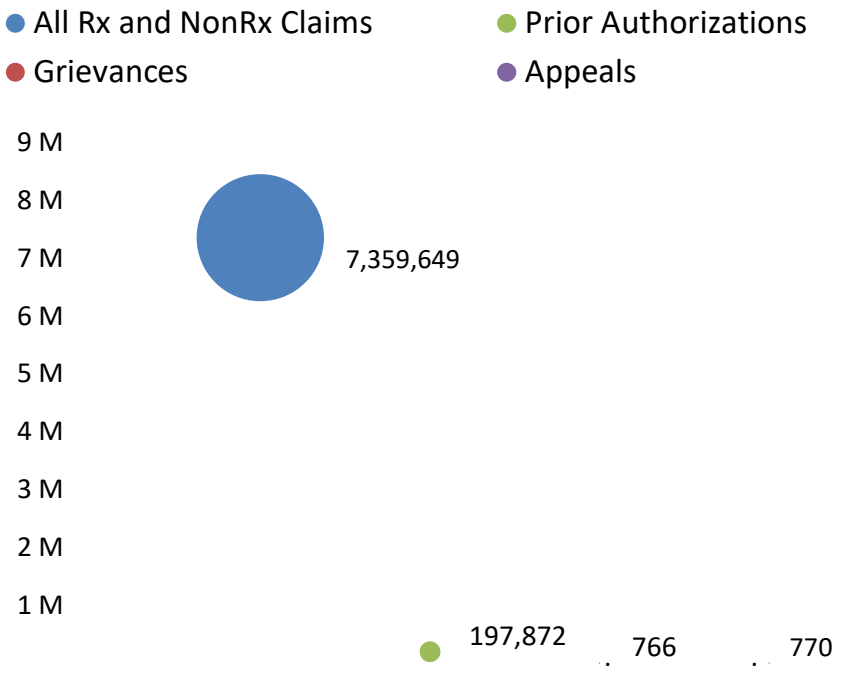
	SFY22 Q4	SFY23 Q1
Capitation Totals	**$613.33 M**	**$638.84 M**
Adjustments	-$18 K	-$56 K
Current	$594.66 M	$617.42 M
Retro	$18.68 M	$21.47 M
Third Party Liability (TPL) Recovered	$39.4 M	**$54.8 M**
Financial Ratios		
Medical Loss Ratio (MLR)	94.2%	**91.7%**
Administrative Loss Ratio (ALR)	7.6%	5.1%
Underwriting Ratio (UR)	-1.8%	3.2%
Unreconciled SFY MLR [5]		91.7%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[5] 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	2.69%
Grievances	0.01%
Appeals	0.01%

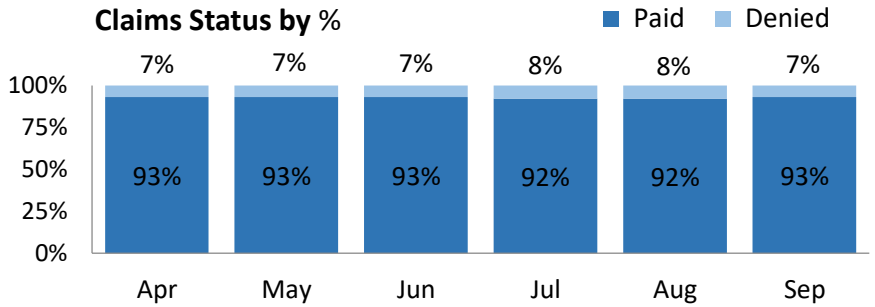
	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.4 M	7.7 M	7.4 M	**7.4 M**	7.5 M	29.9 M
Non-Pharmacy	4.5 M	4.4 M	4.4 M	4.2 M	4.4 M	17.5 M
Pharmacy	3.0 M	3.3 M	3.0 M	3.1 M	3.1 M	12.4 M
Prior Authorization Summary (p. 13-14)	169,391	186,524	193,729	**197,872**	186,879	747,516
Non-Rx - Standard PAs Submitted	124,736	134,628	142,964	146,847	137,294	549,175
Pharmacy - Standard PAs Submitted	44,655	51,896	50,765	51,025	49,585	198,341
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	720	784	761	**766**	758	3,031
Standard Appeals	574	558	752	**770**	664	2,654

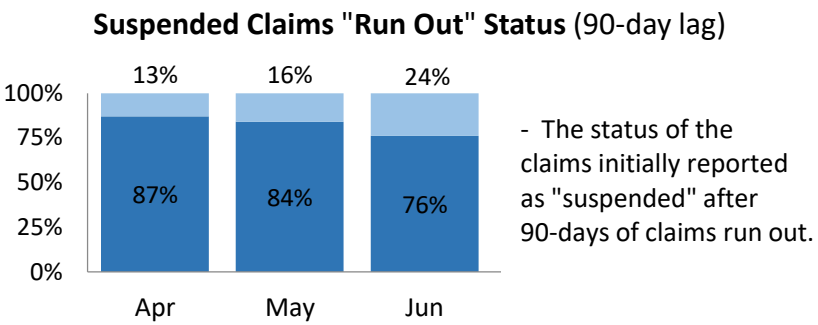
Claims Summary (Non-Pharmacy)

2.37 Million
Claims Paid & Denied

Amerigroup
An Anthem Company

	Jul	Aug	Sept
All Claims			
Paid	683,697	812,174	690,550
Denied	61,605	68,158	49,859
Suspended	206,678	190,309	255,950
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	96%	96%
in 45-days (Requirement 95%)	100%	100%	98%
Average Days to Pay	7	7	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

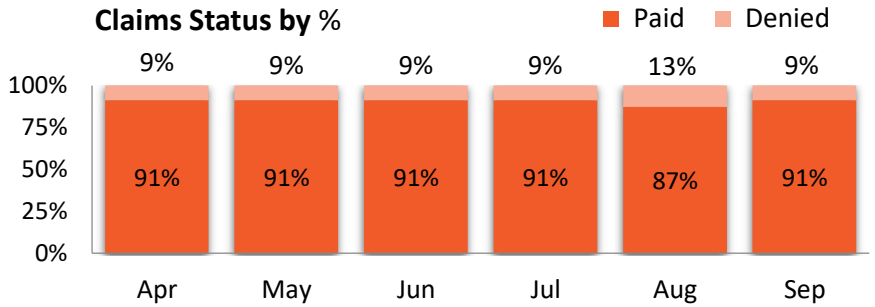
	%	
1.	14%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
2.	13%	Duplicate claim/service
3.	10%	Expenses incurred after coverage terminated
4.	8%	Service not payable per managed care contract
5.	7%	Claim/service lacks information or has submission/billing error(s) - primary payer information required
6.	6%	Precertification/authorization/notification absent
7.	6%	The impact of prior payer(s) adjudication including payments and/or adjustments.
8.	4%	Attachment/Other Documentation Required
9.	4%	At least one Remark Code must be provided
10.	3%	The time limit for filing has expired

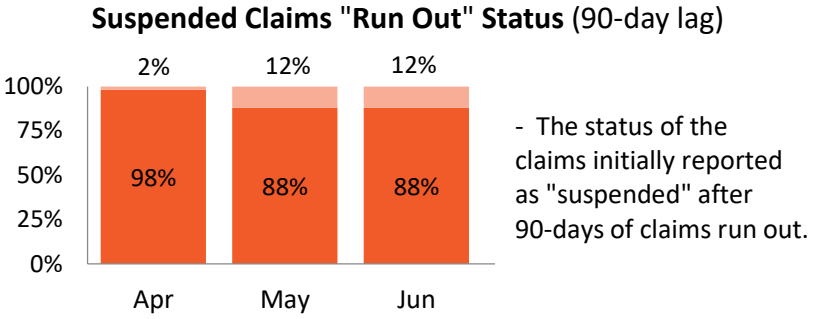
Claims Summary (Non-Pharmacy)

1.88 Million
Claims Paid & Denied

iowa total care

	Jul	Aug	Sept
All Claims			
Paid	539,464	604,871	536,436
Denied	55,693	89,074	55,948
Suspended	144,914	176,102	128,473
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	98%	99%
in 45-days (Requirement 95%)	99%	99%	100%
Average Days to Pay	9	9	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	98%	97%





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

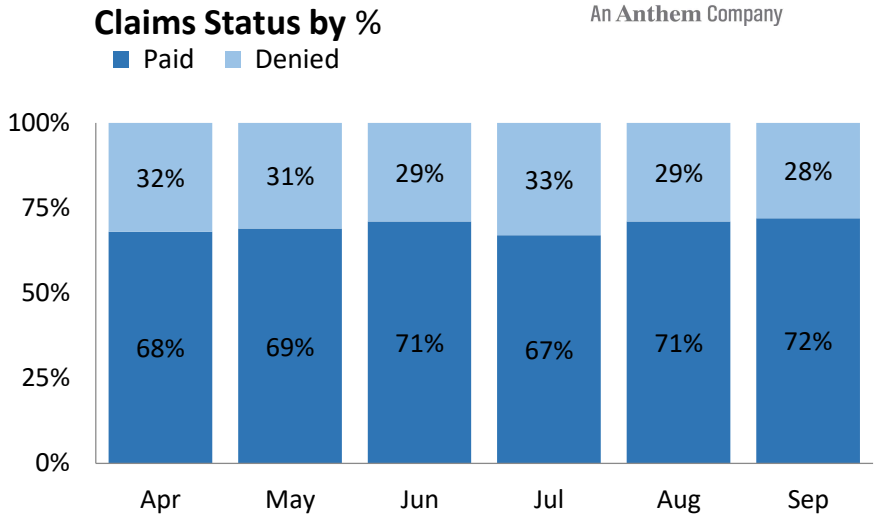
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	14%	Duplicate claim/service
2.	13%	Service can not be combined with other service on same day
3.	10%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	7%	Service is not covered
5.	7%	No authorization on file that matches service(s) billed
6.	5%	ACE claim level return to provider
7.	4%	Diagnosis code incorrectly coded per ICD10 manual
8.	3%	Void Adjustment
9.	2%	Referring Provider not registered with IA DHHS/IA Medicaid
10.	2%	Billing NPI not registered with IA DHHS/IA Medicaid

Claims Summary (Pharmacy)

1.76 Million
Claims Paid & Denied

	Jul	Aug	Sept
All Claims (Pharmacy)			
Paid	339,312	430,108	466,265
Denied	163,569	175,894	181,234
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	11



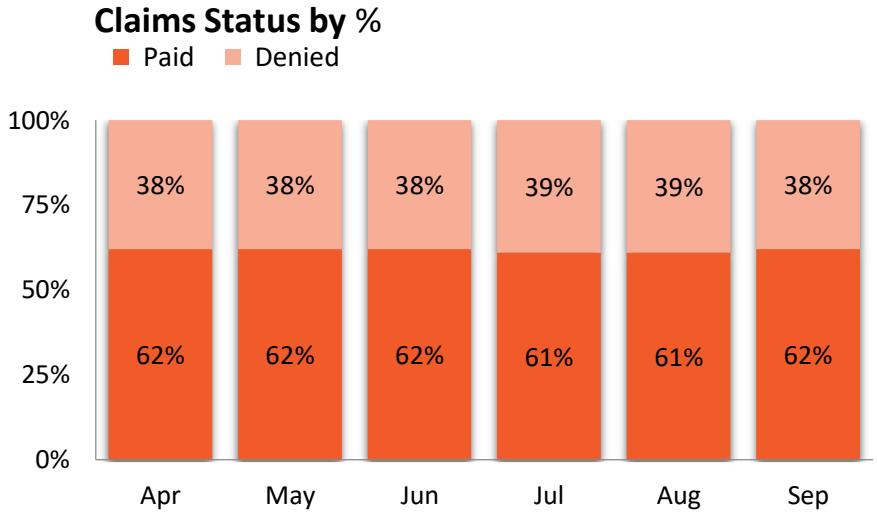
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	37%	Refill too soon
2.	16%	Prior authorization required
3.	11%	Submit bill to other processor or primary payer
4.	10%	National Drug Code (NDC) not covered
5.	7%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	3%	M/I processor control number
8.	2%	Prescriber is not enrolled in State Medicaid program
9.	2%	Filled after coverage terminated
10.	1%	Pharmacy not enrolled in State Medicaid program

Claims Summary (Pharmacy)

1.36 Million
Claims Paid & Denied

	Jul	Aug	Sept
All Claims (Pharmacy)			
Paid	260,611	288,640	281,927
Denied	166,875	182,759	174,926
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	10	10	10



Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	26%	Refill too soon
2.	11%	Prior authorization required
3.	9%	National Drug Code (NDC) not covered
4.	6%	Submit bill to other processor or primary payer
5.	5%	Plan limitations exceeded
6.	2%	Product not covered - non-participating manufacturer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Discrepancy - other coverage code & other payer amount paid
9.	2%	Pharmacy not enrolled in State Medicaid program
10.	1%	Drug not covered for patient age

Prior Authorization Summary

88,689
All PAs Submitted [6]

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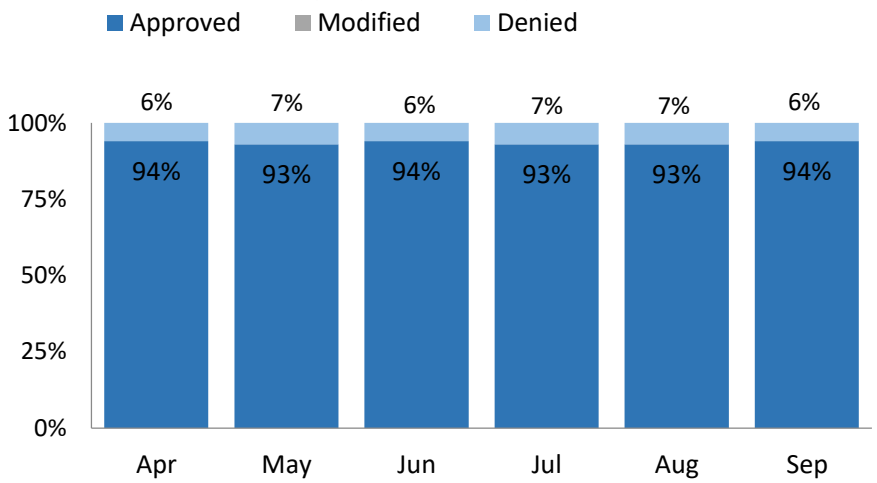
Non-Pharmacy

	Jul	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	17,417	20,248	18,925
Denied	1,241	1,427	1,315
Modified	0	0	0
Average Days to Process	4	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

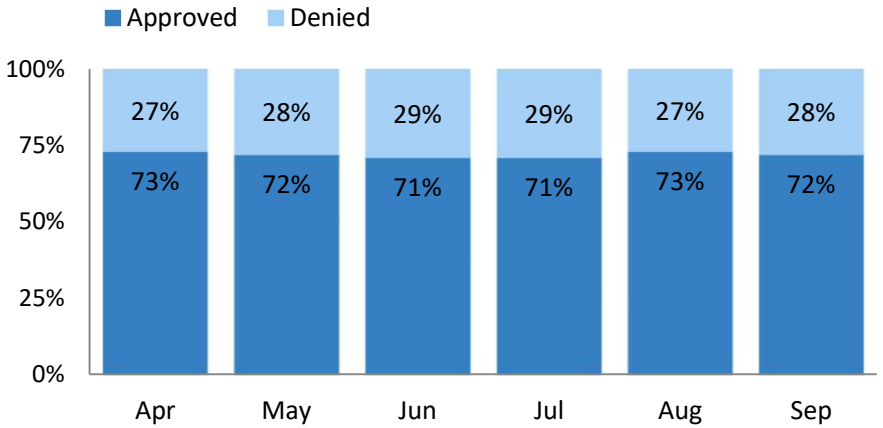
Non-Pharmacy by Percentage



Pharmacy

	Jul	Aug	Sept
Prior Authorizations			
Approved	5,763	7,520	6,853
Denied	2,347	2,845	2,630
PAs Completed in 24-hours (Requirement 100%)	100.0%	99.9%	100.0%

Pharmacy by Percentage



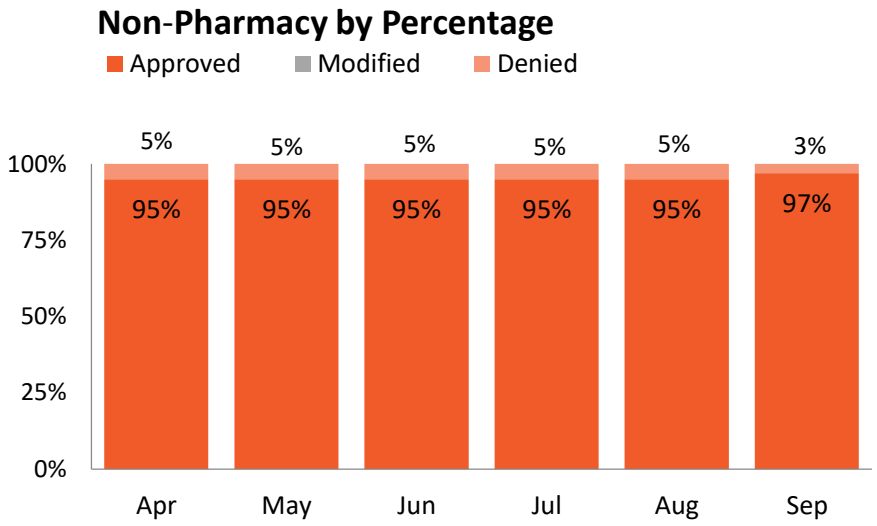
[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

109,183
All PAs Submitted [6]

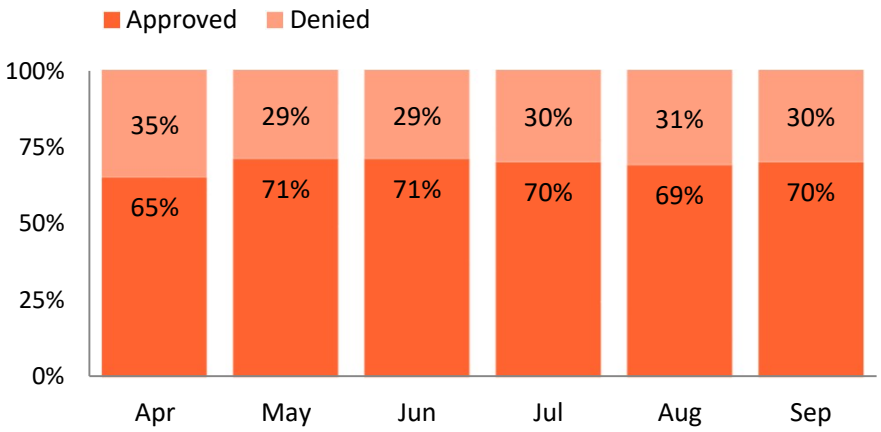
Non-Pharmacy

	Jul	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	21,941	26,465	34,422
Denied	1,253	1,252	1,182
Modified	0	0	0
Average Days to Process	2	2	1
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Jul	Aug	Sept
Prior Authorizations			
Approved	4,461	5,246	4,801
Denied	1,902	2,330	2,034
PAs Completed in 24-hours (Requirement 100%)	99.9%	100.0%	100.0%

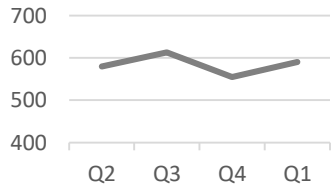


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

Standard Grievances

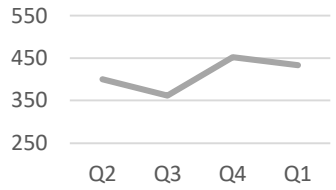
590



Resolved in 30-days
100%

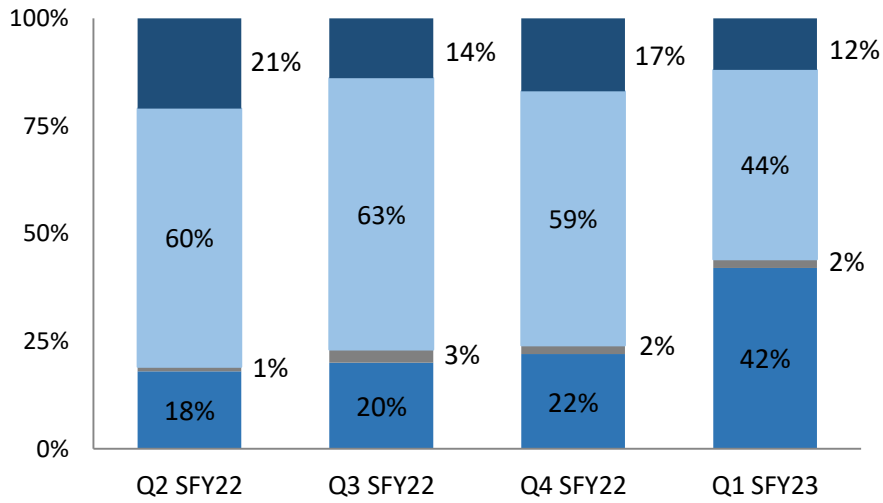
Standard Appeals/ 1st Level Review

433



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	25%	Voluntary disenrollment
2.	15%	Provider balance billed
3.	6%	Transportation - No Show
4.	5%	Provider Dissatisfaction
5.	4%	Treatment Dissatisfaction
6.	3%	Continuity of Care
7.	3%	Routine Appointments
8.	3%	Transportation - Driver Delay
9.	2%	Transportation Delay
10.	2%	Provider refusal to treat

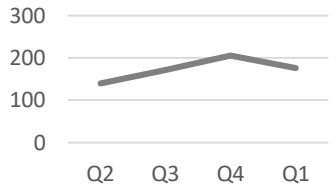
%	Top 10 Reasons for Appeals [7]
36%	Pharmacy - Non Injectable
19%	DME
10%	Pharmacy - Injectable
9%	Outpatient Services - Medical
4%	Surgery
4%	Radiology
4%	Pain Management
4%	Inpatient - Medical
1%	Skilled Nursing
1%	Personal Care Services Self Directed

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

Grievances and Appeals

Standard Grievances

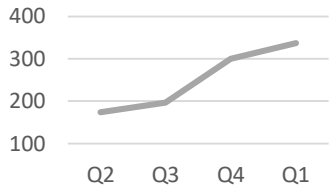
176



Resolved in 30-days
100%

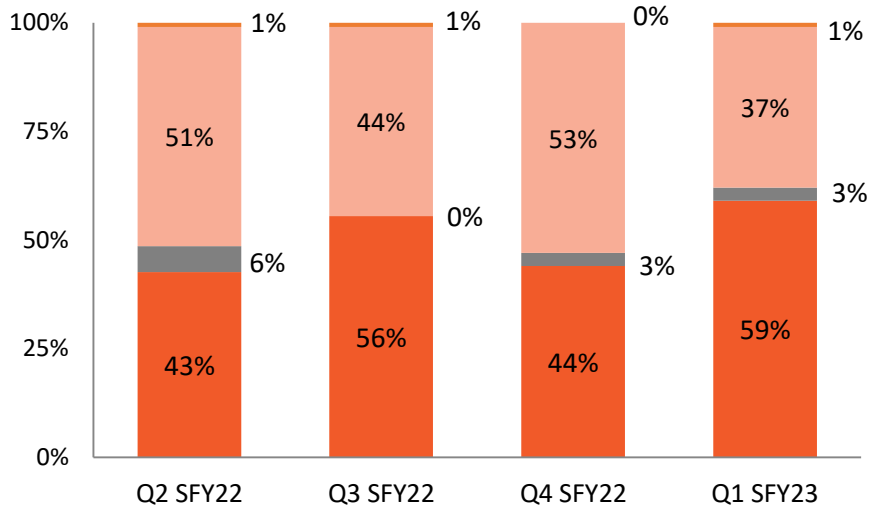
Standard Appeals/ 1st Level Review

337



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	13%	Provider Not in Network
2.	13%	Transportation - General Complaint Vendor
3.	12%	Transportation - Driver did not show
4.	8%	Transportation - Missed Appointment
5.	8%	Unhappy with Benefits
6.	7%	Lack of Caring/Concern
7.	6%	Transportation - Late Appointment
8.	4%	Transportation - Unsafe Driving
9.	3%	Provider
10.	3%	Transportation - General Complaint Vendor/CSR

%	Top 10 Reasons for Appeals [7]
26%	RX - Does Not Meet Prior AuthGuidelines
15%	Therapy - Speech Therapy
8%	Therapy - Physical Therapy
6%	Therapy - Occupational Therapy
5%	Injections - Epidural Injections
4%	DME - Other
3%	DME - Wheelchair
3%	Outpatient - Procedure
3%	Diagnostic - MRI
2%	Diagnostic - CAT Scan

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

MCO Care Quality and Outcomes

Value Based Purchasing (VBP) Agreement

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

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	SFY22 Q4	SFY23 Q1
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	64%

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	SFY22 Q4	SFY23 Q1
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	100%	99%

Top 5 - Value Added Services (VAS)

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

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	SFY22 Q4	SFY23 Q1
Healthy Rewards	3,295	4,544
Community Resource Link	1,242	1,426
SafeLink Mobile Phone	928	1,351
Taking Care of Baby and Me	2,661	1,226
Breast Pump	543	503

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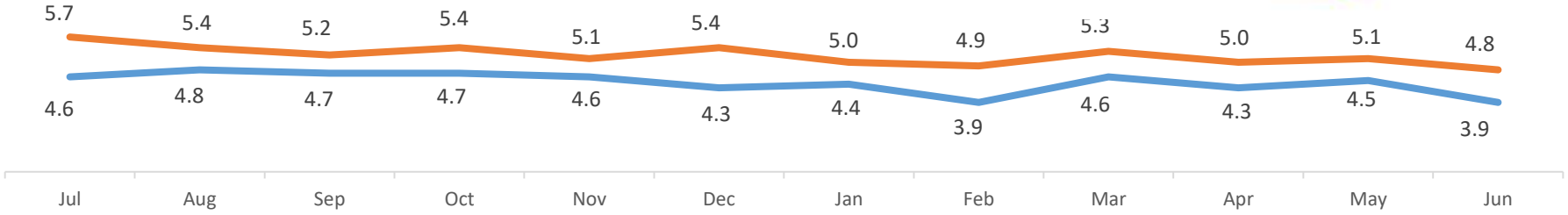
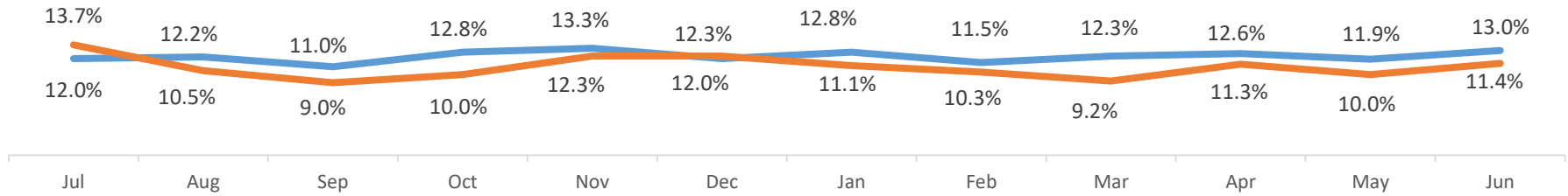
	SFY22 Q4	SFY23 Q1
My Health Pays Program	7,400	10,346
Start Smart for Your Baby	1,638	1,698
Mobile App	1,148	1,448
The Flu Program	885	610
Breast Pump	564	571

MCO Care Quality and Outcomes

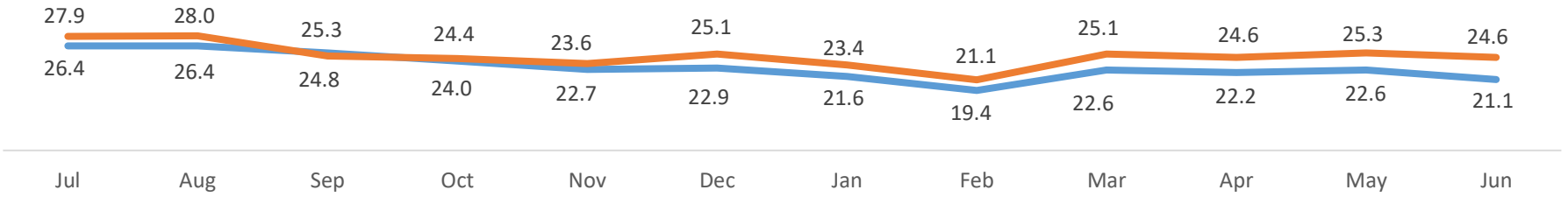
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



[8] *This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.*

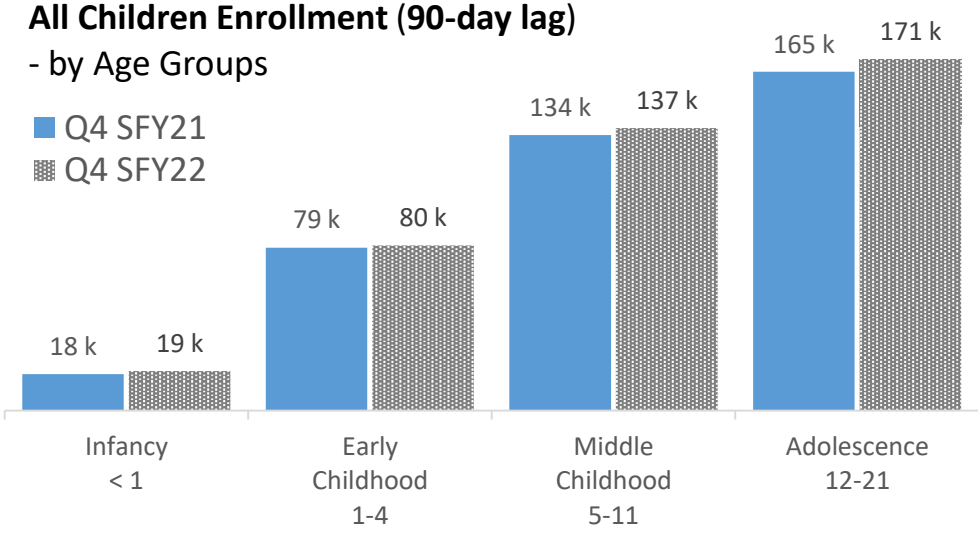
[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

MCO Children Summary

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

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

All Children Enrollment (90-day lag)
- by Age Groups



Amerigroup An Anthem Company

	SFY21 Q4	SFY22 Q4
Member Enrollment	236,807	240,170
Infancy < 1	9,176	9,767
Early Childhood 1 - 4	47,242	46,052
Middle Childhood 5 - 11	80,950	82,236
Adolescence 12 - 21	99,439	102,115
Well Child Exams (Preventive Visits)	36,804	37,348
Infancy < 1	11,392	11,021
Early Childhood 1 - 4	11,986	11,807
Middle Childhood 5 - 11	7,078	7,780
Adolescence 12 - 21	6,348	6,740
Lead Screenings	4,651	5,024
Infancy < 1	136	165
Early Childhood 1 - 4	4,174	4,466
Middle Childhood 5 - 11	295	359
Adolescence 12 - 21	46	34

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	SFY21 Q4	SFY22 Q4
Member Enrollment	158,536	166,928
Infancy < 1	8,480	9,300
Early Childhood 1 - 4	31,936	34,185
Middle Childhood 5 - 11	52,915	55,058
Adolescence 12 - 21	65,205	68,385
Well Child Exams (Preventive Visits)	30,301	32,445
Infancy < 1	11,394	11,570
Early Childhood 1 - 4	9,111	9,926
Middle Childhood 5 - 11	5,090	5,886
Adolescence 12 - 21	4,706	5,063
Lead Screenings	3,785	4,269
Infancy < 1	145	185
Early Childhood 1 - 4	3,331	3,791
Middle Childhood 5 - 11	285	246
Adolescence 12 - 21	24	47

MCO Children Summary

Amerigroup An Anthem Company	SFY21 Q4	SFY22 Q4
Hearing Screenings	1,779	2,448
Infancy < 1	140	185
Early Childhood 1 - 4	810	1,215
Middle Childhood 5 - 11	556	791
Adolescence 12 - 21	273	257
Vision Screenings	1,565	2,232
Infancy < 1	34	61
Early Childhood 1 - 4	865	1,041
Middle Childhood 5 - 11	452	755
Adolescence 12 - 21	214	375
Vaccination Totals	63,672	46,784
COVID-19 Dose 1	8,969	122
COVID-19 Dose 2	7,447	139
COVID-19 Single-Dose	209	572
DTaP (Diphtheria, Tetanus, Pertussis)	9,377	9,173
Influenza (FLU)	778	1,060
HepA (Hepatitis A)	4,497	4,115
HepB (Hepatitis B)	882	755
Haemophilus Influenza Type B (Hib)	5,007	4,745
Human Papillomavirus (HPV)	2,653	2,557
Meningococcal ACWY (MenACWY)	2,476	2,399
Meningococcal B - (MenB)	994	1,057
MMR (Measles, Mumps, Rubella)	3,682	3,808
Pneumococcal (PCV13)	7,423	7,253
Pneumococcal (PPSV23)	56	41
Polio (IPV)	225	214
RV (Rotavirus)	4,811	4,653
Tetanus and diphtheria (Td)	31	38
TDAP (Tetanus, Diphtheria, Pertussis)	2,171	2,154
Varicella Virus Vaccine (VAR)	1,984	1,929

iowa total care	SFY21 Q4	SFY22 Q4
Hearing Screenings	1,144	1,661
Infancy < 1	126	177
Early Childhood 1 - 4	500	830
Middle Childhood 5 - 11	349	484
Adolescence 12 - 21	169	170
Vision Screenings	1,097	1,498
Infancy < 1	32	44
Early Childhood 1 - 4	594	739
Middle Childhood 5 - 11	355	487
Adolescence 12 - 21	116	228
Vaccination Totals	48,636	41,243
COVID-19 Dose 1	5,503	731
COVID-19 Dose 2	4,751	694
COVID-19 Single-Dose	170	464
DTaP (Diphtheria, Tetanus, Pertussis)	7,828	7,976
Influenza (FLU)	698	894
HepA (Hepatitis A)	3,373	3,559
HepB (Hepatitis B)	793	749
Haemophilus Influenza Type B (Hib)	4,387	4,234
Human Papillomavirus (HPV)	1,860	1,823
Meningococcal ACWY (MenACWY)	1,595	1,715
Meningococcal B - (MenB)	640	712
MMR (Measles, Mumps, Rubella)	2,814	3,055
Pneumococcal (PCV13)	6,518	6,631
Pneumococcal (PPSV23)	34	31
Polio (IPV)	147	229
RV (Rotavirus)	4,297	4,376
Tetanus and diphtheria (Td)	19	29
TDAP (Tetanus, Diphtheria, Pertussis)	1,467	1,624
Varicella Virus Vaccine (VAR)	1,742	1,717

MCO Children Summary - Behavioral/Mental Health Treatment & Services

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Substance Use Disorder (SUD) Summary	SFY21 Q4	SFY22 Q4
Total Visits - *As 1st or 2nd Diagnosis*	7,031	6,235
Alcohol	1,393	1,333
Cannabis	2,873	2,746
Cocaine	56	39
Nicotine	772	581
Opioid	444	576
Other	77	31
Other Psychoactive	478	425
Other Stimulant	809	390
Sedative	129	114

iowa total care

Substance Use Disorder (SUD) Summary	SFY21 Q4	SFY22 Q4
Total Visits - *As 1st or 2nd Diagnosis*	3,911	4,078
Alcohol	734	912
Cannabis	1,688	1,883
Cocaine	29	23
Nicotine	129	87
Opioid	482	405
Other	37	28
Other Psychoactive	234	218
Other Stimulant	387	463
Sedative	191	59

Severe Emotional Disturbance (SED) for Children Summary	SFY21 Q4	SFY22 Q4
Total Visits - *As 1st or 2nd Diagnosis*	235,508	209,533
ADHD [10]	51,916	45,006
Anxiety	41,824	40,543
Bipolar	3,908	3,063
Conduct Disorder	24,499	20,922
Depression	33,663	29,877
Obsessive Compulsive Disorder	899	723
Other	17,671	14,356
Post-traumatic Stress Disorder	60,511	54,602
Tourette Syndrome	617	441

Severe Emotional Disturbance (SED) for Children Summary	SFY21 Q4	SFY22 Q4
Total Visits - *As 1st or 2nd Diagnosis*	122,271	118,847
ADHD [10]	24,188	22,923
Anxiety	23,327	23,600
Bipolar	1,712	1,668
Conduct Disorder	12,153	11,603
Depression	18,223	17,580
Obsessive Compulsive Disorder	475	409
Other	8,396	7,923
Post-traumatic Stress Disorder	33,581	32,929
Tourette Syndrome	216	212

Data Notes: All counts listed above reflect claims activity with a 90-day lag. Counts are populated every time a claim is identified as having a 1st or 2nd SUD or SED diagnosis reason for children ages 5 to 21. [10] Attention Deficit/Hyperactivity Disorder (ADHD)

MCO Children Summary - Behavioral/Mental Health Treatment & Services

Amerigroup An Anthem Company	SFY21 Q4	SFY22 Q4
Mental Health Assessments	9,910	9,098
Middle Childhood 5 - 11	3,438	3,318
Adolescence 12 - 21	6,472	5,780
Therapy/Counseling - Individual	79,894	73,308
Middle Childhood 5 - 11	31,950	28,528
Adolescence 12 - 21	47,944	44,780
Therapy/Counseling - Group & Family	11,987	9,124
Middle Childhood 5 - 11	4,579	3,317
Adolescence 12 - 21	7,408	5,807
Behavioral Intervention Services	22,615	21,591
Middle Childhood 5 - 11	13,543	12,887
Adolescence 12 - 21	9,072	8,704
Applied Behavior Analysis (ABA)	4,470	3,708
Middle Childhood 5 - 11	3,948	3,182
Adolescence 12 - 21	522	526
Residential Treatment	1,097	521
Middle Childhood 5 - 11	222	133
Adolescence 12 - 21	875	388
M/H & Substance Abuse B3 Services [11]	6,144	5,217
Middle Childhood 5 - 11	1,639	1,523
Adolescence 12 - 21	4,505	3,694

iowa total care	SFY21 Q4	SFY22 Q4
Mental Health Assessments	5,829	5,585
Middle Childhood 5 - 11	2,019	2,112
Adolescence 12 - 21	3,810	3,473
Therapy/Counseling - Individual	45,344	44,819
Middle Childhood 5 - 11	19,351	18,183
Adolescence 12 - 21	25,993	26,636
Therapy/Counseling - Group & Family	6,060	5,708
Middle Childhood 5 - 11	2,557	2,309
Adolescence 12 - 21	3,503	3,399
Behavioral Intervention Services	12,262	12,253
Middle Childhood 5 - 11	7,615	7,468
Adolescence 12 - 21	4,647	4,785
Applied Behavior Analysis (ABA)	1,057	1,067
Middle Childhood 5 - 11	923	923
Adolescence 12 - 21	134	144
Residential Treatment	523	321
Middle Childhood 5 - 11	165	73
Adolescence 12 - 21	358	248
M/H & Substance Abuse B3 Services [11]	3,135	2,993
Middle Childhood 5 - 11	1,026	866
Adolescence 12 - 21	2,109	2,127

Data Notes: All claims data is reported on a 90-day lag. Quarters listed by MCO compare same quarter 1-year apart (e.g., SFY21 Q1 vs. SFY22 Q2).

[11] *"B3" services are mental health and substance abuse services available to MCO members.*

Non-LTSS Care Coordination and HCBS Case Management

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An Anthem Company

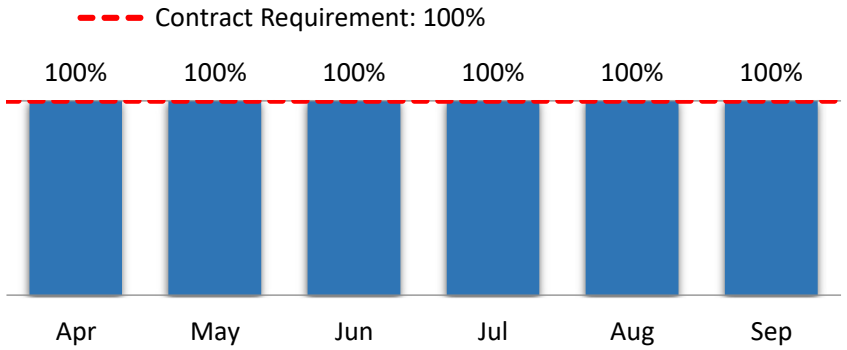
Average Number of Contacts Per Month	SFY22 Q4	SFY23 Q1
by Care Coordinators	2.2	**2.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	16	**15**
HCBS Members to Case Managers	62	**69**

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.

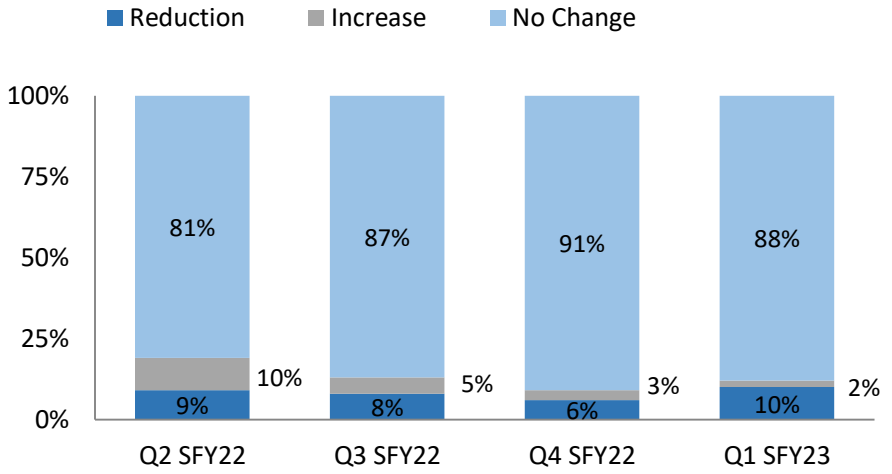
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY22 Q4	SFY23 Q1
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	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	1.0%	0.5%
	No	0.0%	0.5%
	Sometimes	0.5%	0.5%
	Yes	98.5%	98.5%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

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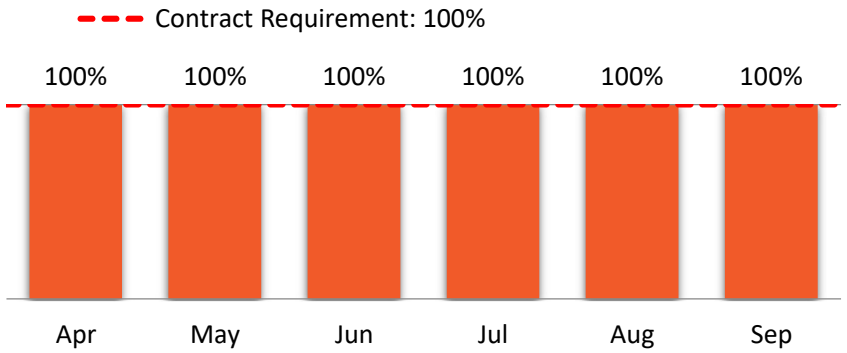
Average Number of Contacts Per Month	SFY22 Q4	SFY23 Q1
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	50	**47**
HCBS Members to Case Managers	41	**42**

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

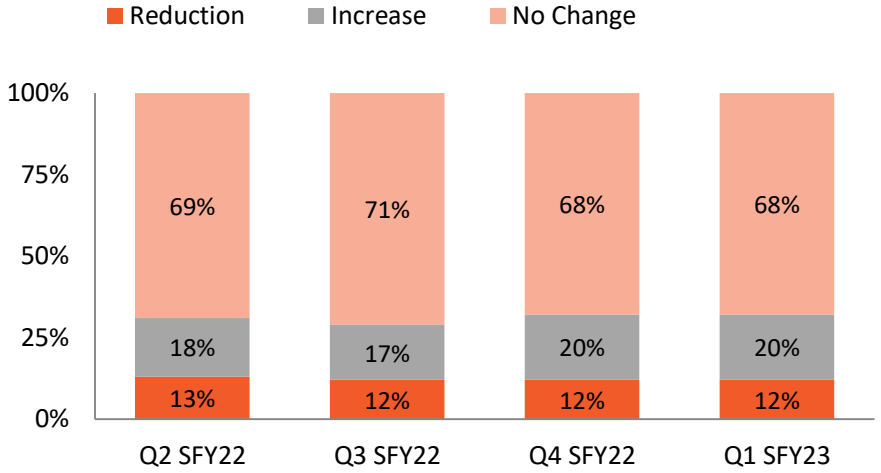
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY22 Q4	SFY23 Q1
They were part of service planning.	I don't know	1.9%	1.1%
	No	6.4%	2.6%
	Sometimes	3.4%	2.2%
	Yes	88.4%	94.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	2.2%	2.6%
	Sometimes	4.5%	3.0%
	Yes	93.3%	94.4%
Their services make their lives better.	I don't know	0.4%	0.0%
	No	3.4%	1.5%
	Sometimes	3.4%	3.4%
	Yes	92.9%	95.1%

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

	SFY22 Q4	SFY23 Q1
AIDS/HIV - Unique Service Plans	22	23
Home Delivered Meals	14	16
CDAC (individual) by 15 minute units	0	4
Financial Management Services	1	1
Brain Injury (BI) Waivers	769	764
Financial Management Services	226	209
Supported Community Living (by unit)	193	190
Respite (by 15 minute units)	164	166
Personal Emergency Response	160	166
Supported Community Living (daily)	109	111
Children's Mental Health (CMH)	783	810
Respite (by 15 minute units)	418	443
Respite (Hos/NF) - 15 minute units	216	244
Family and Community Support	185	193
Respite (Resident Camp) by units	19	24
Respite (Resident Camp) by day	3	4
Elderly Waivers	4,342	4,191
Personal Emergency Response	2,741	2,771
Home Delivered Meals	2,742	2,767
CDAC (agency) by 15 minute units	478	422
Assisted Living Services	330	322
Personal Emergency Response (install)	301	302

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	SFY22 Q4	SFY23 Q1
Habilitation (Hab)	4,201	4,102
Home-based Habilitation	3,448	3,361
Long Term Job Coaching	406	391
Day Habilitation (units by day)	354	331
Individual Supported Employment	141	160
Day Habilitation (by 15 minute units)	138	139
Health & Disability (HD)	1,345	1,347
Respite (by 15 minute units)	377	397
Financial Management Services	363	366
Personal Emergency Response	314	313
Home Delivered Meals	296	307
CDAC (individual) by 15 minute units	62	62
Intellectual Disability (ID)	6,923	6,898
Supported Community Living (by unit)	1,794	1,797
Supported Community Living (RCF)	1,489	1,492
Day Habilitation (units by day)	1,378	1,338
Financial Management Services	1,343	1,264
Supported Community Living (daily)	1,183	1,170
Physical Disability (PD)	601	591
Personal Emergency Response	327	321
CDAC (agency) by 15 minute units	84	57
CDAC (individual) by 15 minute units	63	47
Financial Management Services	35	30
Personal Emergency Response (install)	27	28

Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

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	SFY22 Q4	SFY23 Q1
AIDS/HIV - Unique Service Plans	8	8
Home Delivered Meals	8	8
CDAC (individual) by 15 minute units	1	1
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	1	0
Brain Injury (BI) Waivers	515	524
Supported Community Living (by unit)	216	215
Personal Emergency Response	139	141
Respite (by 15 minute units)	125	126
Supported Community Living (daily)	122	119
Transportation (1-way trip)	93	96
Children's Mental Health (CMH)	374	385
Respite (by 15 minute units)	215	227
Respite (Hos/NF) - 15 minute units	145	159
Family and Community Support	106	110
Mental Health Service	42	37
Respite (Resident Camp) by units	12	16
Elderly Waivers	3,277	3,404
Personal Emergency Response	2,542	2,576
Home Delivered Meals	2,477	2,554
CDAC (agency) by 15 minute units	1,303	1,331
Homemaker (by 15 minute units)	708	719
CDAC (individual) by 15 minute units	648	648

	SFY22 Q4	SFY23 Q1
Habilitation (Hab)	2,371	2,335
Home-based Habilitation	1,954	1,914
Day Habilitation (by 15 minute units)	329	354
Day Habilitation (units by day)	277	290
Long Term Job Coaching	273	271
Individual Supported Employment	126	132
Health & Disability (HD)	590	588
Respite (by 15 minute units)	276	277
Home Delivered Meals	149	151
Personal Emergency Response	152	150
CDAC (individual) by 15 minute units	95	98
CDAC (agency) by 15 minute units	100	97
Intellectual Disability (ID)	4,435	4,427
Supported Community Living (by unit)	1,751	1,750
Day Habilitation (by 15 minute units)	1,693	1,693
Day Habilitation (units by day)	1,559	1,546
Supported Community Living (RCF)	1,214	1,202
Supported Community Living	951	964
Physical Disability (PD)	384	394
Personal Emergency Response	213	216
CDAC (agency) by 15 minute units	161	169
CDAC (individual) by 15 minute units	114	119
Transportation (1-way trip)	41	44
Personal Emergency Response (install)	26	28

Call Center Performance Metrics

	Jul	Aug	Sep
Member Helpline			
Service Level (Requirement 80%)	93.65%	96.36%	90.33%
Abandonment Rate - Must be 5% or less	0.28%	0.22%	0.51%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.90%	99.74%	99.90%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	88.76%	94.22%	84.13%
Abandonment Rate - Must be 5% or less	0.39%	0.14%	0.57%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.00%	94.24%	96.55%
Abandonment Rate - Must be 5% or less	0.23%	0.21%	0.32%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	89.74%	86.89%	86.29%
Abandonment Rate - Must be 5% or less	1.29%	1.55%	1.53%

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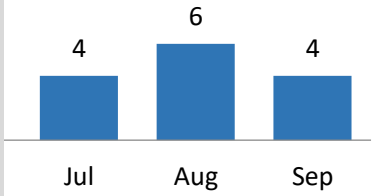
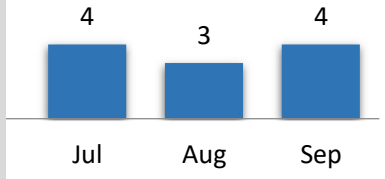
Secret Shopper Scores
- Member Helpline

Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.



Secret Shopper Scores
- Provider Helpline

Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.



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.	Over the Counter
3.	ID Card Request or Inquiry
4.	Enrollment Information
5.	Transportation Inquiry

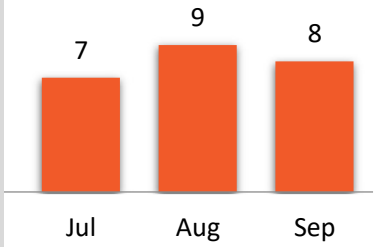
Top 5 Call Reasons (Provider Helpline)
Benefit Inquiry
Claim Status
Authorization Status
Claim Payment Question or Dispute
Enrollment Inquiry

Call Center Performance Metrics

	Jul	Aug	Sep
Member Helpline			
Service Level (Requirement 80%)	83.79%	84.14%	88.16%
Abandonment Rate - Must be 5% or less	4.15%	4.37%	4.88%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	86.52%	91.35%	88.99%
Abandonment Rate - Must be 5% or less	1.80%	0.65%	1.51%
Provider Helpline			
Service Level (Requirement 80%)	85.60%	85.40%	84.10%
Abandonment Rate - Must be 5% or less	1.28%	1.19%	1.77%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	94.47%	98.14%	97.57%
Abandonment Rate - Must be 5% or less	0.88%	0.46%	0.20%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	90.54%	86.32%	85.31%
Abandonment Rate - Must be 5% or less	0.86%	1.33%	1.05%

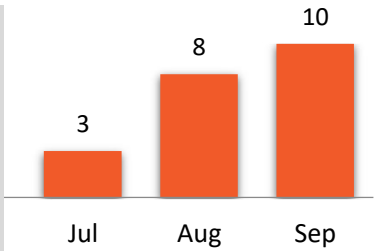
Secret Shopper Scores - Member Helpline

Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.



Secret Shopper Scores - Provider Helpline

Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.



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.	Coordination Of Benefits for Member
3.	Update Preference for Member
4.	Member Rewards for Member
5.	Update PCP

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

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1
Adults PCP				
Provider Count	6,688	6,768	6,893	7,093
Members with Access	231,146	230,958	237,584	238,093
Average Distance (Miles)	1.8	1.8	1.8	1.8
Pediatric PCP				
Provider Count	6,719	6,798	6,924	7,124
Members with Access	212,453	214,637	214,390	213,457
Average Distance (Miles)	1.9	1.9	1.9	1.9

Specialty Care & Behavioral Health (BH)

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1
OB/GYN Adult				
Provider Count	405	409	423	440
Members with Access	150,083	150,019	154,186	154,298
Average Distance (Miles)	5.6	5.5	5.5	5.5
Outpatient - Behavioral Health				
Provider Count	4,456	4,503	4,543	4,679
Members with Access	443,599	445,595	451,974	451,550
Average Distance (Miles)	2.2	2.2	2.2	2.2
Inpatient - Behavioral Health				
Provider Count	51	51	51	53
Rural Members				
Members with Access	181,008	181,707	184,359	184,040
Average Distance (Miles)	18.5	18.3	21.0	18.8
Urban Members				
Members with Access	262,591	263,888	267,615	267,510
Average Distance (Miles)	5.8	5.8	5.8	5.7

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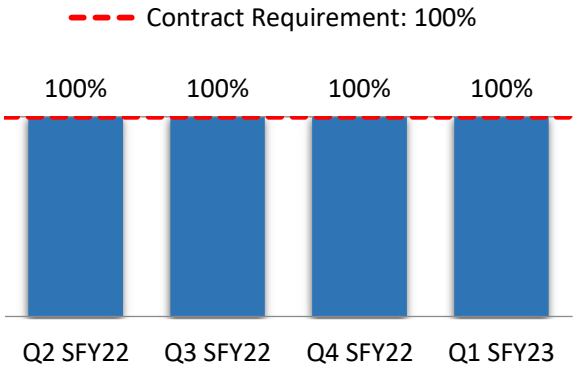
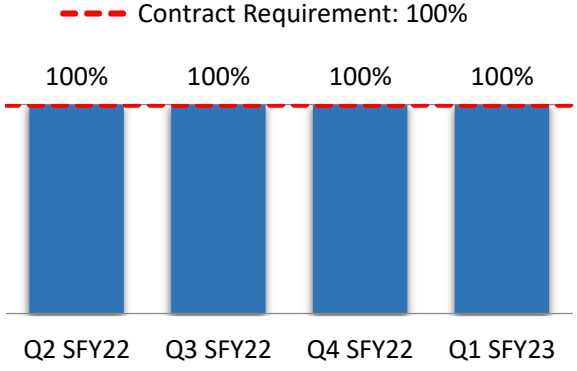
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

Provider Network Access Summary

Primary Care Providers (PCP)

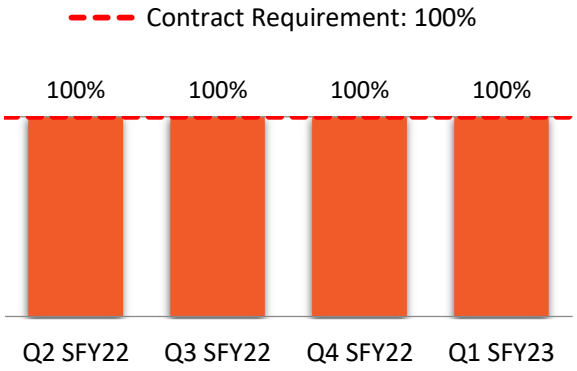
	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1
Adults PCP				
Provider Count	9,894	9,894	9,894	9,894
Members with Access	180,087	186,041	189,029	196,756
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	10,658	10,658	10,658	10,658
Members with Access	143,484	146,338	147,665	151,411
Average Distance (Miles)	2.1	2.1	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1
OB/GYN Adult				
Provider Count	1,298	1,298	1,298	1,298
Members with Access	118,135	121,417	123,122	127,515
Average Distance (Miles)	5.4	5.3	5.4	5.3
Outpatient - Behavioral Health				
Provider Count	9,688	9,688	9,688	9,688
Members with Access	323,571	332,379	336,694	348,179
Average Distance (Miles)	2.4	2.4	2.5	2.5
Inpatient - Behavioral Health				
Provider Count	36	36	36	36
Rural Members				
Members with Access	231,823	238,027	241,452	249,950
Average Distance (Miles)	24.5	24.5	24.5	24.4
Urban Members				
Members with Access	91,748	94,352	95,242	98,229
Average Distance (Miles)	8.4	8.4	8.4	8.4

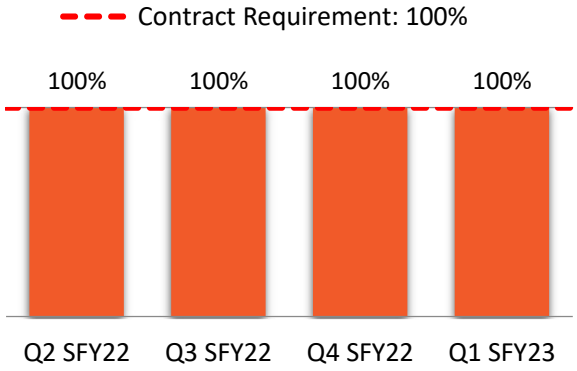
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



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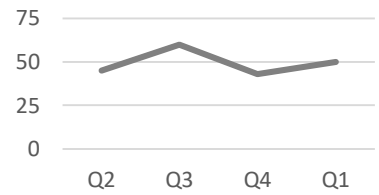
MCO Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems, which have a series of edits that reject inaccurate or duplicate claims. Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

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

Total Investigations Opened in SFY23 Q1

50



5 Total Cases
Referred to MFCU Q1

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	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Total
Investigations opened	31	44	25	36	34	136
Overpayments identified	25	28	10	14	19	77
Member concerns referred to IME	5	0	4	2	3	11
Cases referred to the Medicaid Fraud Control Unit (MFCU)	4	3	2	3	3	12

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	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Total
Investigations opened	12	16	18	14	15	60
Overpayments identified	17	9	6	19	13	51
Member concerns referred to IME	5	6	4	4	5	19
Cases referred to the Medicaid Fraud Control Unit (MFCU)	3	3	0	2	2	8

Appendix: Glossary

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

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

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

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

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

Appeal: An appeal is a request for a review of an adverse benefit determination. Actions that a member may choose to appeal:

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

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

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

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

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

Capitation Expenditures (continued...):

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

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

Case Manager: See Community Based Case Management (CBCM)

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

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

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

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

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

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

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

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

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

Denied Claims: See Claims

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

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

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

Dual: Members who have both Medicare and Medicaid benefits.

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

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

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

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

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

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

Grievance (continued…):

- Rights and dignity
- Any other access to care issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Monthly Capitation Expenditures: See Capitation Expenditures

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

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

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

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

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

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

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

Provider Adjustment Requests and Errors Reprocessed: See Claims

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

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

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

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

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

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

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

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

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

Value Added Services (**VAS**): Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can also be found here: https://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 reference by individual waiver descriptions (Elderly, Physical Disability, Health and Disability, AIDS/HIV, Brian Injury, Intellectual Disability, or Children's Mental Health)

Waiver Service Plan: See Service Plan

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

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

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

Hawki Board of Directors Member List

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

Statutory Members

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

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

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

Iowa Medicaid
- Elizabeth (Liz) Matney - Director

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

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

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

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

MAAC Council Member List

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

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

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

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

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

Continued…

MAAC Council Member List continued...

Professional and Business Entities

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

Appendix: Oversight Entities - Council on Human Services

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

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

Council on Human Services Member List

Iowa Council on Human Services Members

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

Legislative Members - Ex Officio

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

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

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

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

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

MHDS Commission Member List

Voting Members:

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

Non-Voting Members:

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

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

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

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

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

For more information, contact:

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