Iowa Medicaid
IOWA HHS

Medical Assistance Advisory Council

MATERIALS AUGUST 17, 2023

1. Agenda of Meeting for August 17, 2023
2. June 26, 2023 Council Meeting Minutes
3. MCO Quarterly Report SFY 23 Quarter 3

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

MEETING AGENDA			
DIVISION	Iowa Department of Health and Human Services		
MEETING TITLE	Medical Assistance Advisory Council		
FACILITATOR	Angie Doyle-Scar & Jason Haglund		
DATE	August 17, 2023	TIME	1:00 PM
LOCATION	Virtual (Zoom): https://www.zoomgov.com/j/1613704516		

MEETING OBJECTIVES

To review the performance and operation of Iowa's Medical Assistance programs; in order to advise the director about health and medical care services under the medical assistance program.

AGENDA TOPIC	Presenter	Time Allotted	Items
1. Call Meeting To Order and Roll Call 2. Approval of Previous Meeting Minutes	Angie Doyle-Scar & Jason Haglund, Co-Chairs	10 minutes	
3. Managed Care Dashboard Demonstration	Kurt Behrens, Iowa Medicaid	45 minutes	https://hhs.iowa.gov/sites/default/files/Dashboard-Release_v1%20MAAC.pdf
4. PHE Unwind Update	Anna Casteel and Allison Scott	10 minutes	
5. Medicaid Director's Update	Liz Matney, Medicaid Director	20 minutes	
6. Managed Care Plan (MCP) Updates	Stacie Maas, Iowa Total Care John McCalley, Amerigroup Jennifer Vermeer, Molina Healthcare	10 minutes, each	
7. Open Comment			

Iowa Medicaid
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Medical Assistance Advisory Council

MEETING MINUTES
JUNE 26, 2023

CALL TO ORDER AND ROLL CALL

MAAC Chair Angie Doyle Scar, Division of Public Health, called the meeting to order at 1:00 p.m. Angie called the roll, attendance is reflected in the separate roll call sheet and a quorum was achieved.

APPROVAL OF PREVIOUS MEETING MINUTES

The minutes from the November 17, 2022 meeting and March 23, 2023 meeting were approved by the council.

MANAGED CARE ORGANIZATION (MCO) QUARTERLY REPORT: QUARTER 2 STATE FISCAL YEAR (Q 2 SFY) 2023

Kurt Behrens, Iowa Medicaid, reviewed the MCO Quarterly Report for Q2 SFY 23. All information available in the quarterly report will be available in some form in the Medicaid Dashboard on the Department's website.

Kurt previewed the transition from a PDF quarterly report to the interactive Medicaid Dashboard. While the Q2 SFY 2023 report is over 40 pages, the dashboard is about 89 pages. The Medicaid Dashboard will include all types of data found in the previous PDF quarterly reports such as MCO data, fee-for-service (FFS) data, and dental data.

Enrollment in the managed care (MC) program increased between Q1 SFY 2023 and Q2 SFY 2023 from 807,413 to 819,852 members, representing a 1.5 percent increase or 12,439 new members. The FFS program had an increase of around 3.0 percent (1,423 members), for a total of 49,363 members in FFS.

Between Q1 SFY 2023 and Q2 SFY 2023, Amerigroup Iowa, Inc. (AGP) and Iowa Total Care's (ITC) market share changed from 57.4 and 43.6 percent to 55.3 and 44.7 percent, respectively. There have been efforts to equal out AGP and ITC's shares as Molina Healthcare, Inc. continues to be onboarded. Therefore, almost all new members have been directed into ITC.

Both AGP and ITC's Medical Loss Ratio (MLR) were above the 89.0 percent for contract standards. Both MCOs missed a monthly target for processing 100.0 percent of prior authorizations (PAs) within 24 hours, each MCO missing this target for more than one month by less than a percent.

Kurt highlighted several Medicaid Dashboard revamps. A user will be able to search and sort by medical type and category in the Grievances and Appeals sections. The MCO Care Quality and Outcomes section will be more detailed in the dashboard, being capable of showing the full Value-Based Purchasing (VBP) Agreement lists instead of just the top five. In the MCO Children Summary section, the age range will be from zero to 21. Additionally, an emergency room indicator will be added. About 14, instead of three, iPad survey questions will be included in the Long-Term Services and Supports (LTSS) section. Users will also be able to search for specific waivers in this section. The Provider Network Access Summary section is being translated over to the dashboard, however, it is still a work in progress. How network standard data will be displayed will be improved in the dashboard as well.

Lastly, Kurt previewed what the new Medicaid Dashboard will look like, starting with the landing page. The landing page will display the fluctuations in claims counts, PAs, grievances, appeals, and state fair hearings between quarters. The landing page will also have a tab that directs users to the National Quality Scores & Measures webpage. This webpage includes these sections: NCQA Health Plan Ratings, CMS Core Set Measures, the Iowa Medicaid Scorecard, Healthcare Effectiveness Data and Information Set (HEDIS), and the Consumer Assessment of Healthcare Providers & Systems (CAHPS). Using the Zoom chat feature, Dr. Amy Shriver, public member, praised how user-friendly the dashboard was.

Brandon Hagen, Iowa Health Care Association, asked to be reminded of what the suspended claims were. Kurt explained that a suspended claim is a claim that cannot be adjudicated until additional data is processed. Liz Matney, Iowa Medicaid Director, jumped in to further explain what type of additional data might need to be collected to process a claim, for example, PAs. Liz also noted that the paid and denied suspended claims were being monitored. Stacie Maass, ITC, said she would be in contact with ITC's claims team to address Brandon's questions regarding the MCOs' suspended claims. Sabrina Johnson, MCNA Dental, explained that when MCNA suspends a claim, it is because the claim requires clinical review and that the claim usually processes in the next reporting period.

Angie expressed excitement over the progress of the Medicaid Dashboard, and thanked Kurt for his hard work and presentation.

PUBLIC HEALTH EMERGENCY (PHE) UNWIND UPDATES

Anna Casteel, Iowa Department of Health and Human Services (HHS), assisted by Allison Scott, HHS, briefly reviewed the background surrounding the ending of the continuous coverage requirement. This requirement was put in place due to the COVID-19 pandemic and required maintaining Medicaid eligibility for individuals. The continuous coverage requirement ended on March 31, 2023. Anna's team started the Unwind process in February 2023, which involved sending renewal forms to members and discontinuing coverage for those who no longer meet eligibility criteria. Procedural reasons, such as not returning renewal forms or requested information, were common reasons for discontinuance. Anna's team is using various tools and strategies to reach out to members, including checking address databases, regular communication, town halls, and online resources. Her team is also analyzing data and

reporting metrics to the Centers for Medicare and Medicaid Services (CMS). They are working to ensure members have correct information and maintain their eligibility.

Prompted by a question in the Zoom chat from Ben Shuberg, Iowa Association of Community Providers, about how many discontinuances there were, Liz requested that Anna elaborate on the availability and understanding of disenrollment numbers in relation to the Medicaid Dashboard and CMS reports. Anna clarified that the dashboard displays total enrollment data, requiring calculations to determine actual disenrollment numbers. On the other hand, according to Anna, CMS reports are point-in-time and involve initiated renewals that may not accurately reflect final outcomes due to the time needed for renewal processing. Anna highlighted that the discrepancy between initiation and outcome dates could cause confusion. CMS also instructed reporting in two buckets: denials leading to the marketplace or procedural denials. This method lacked nuance, as some ineligible individuals do not fit these categories. There are ongoing efforts to provide a more complete picture of Unwind's impact, analyzing procedural reasons and individual cases. Anna also mentioned upcoming updates to the dashboard to provide clearer enrollment information.

After confirming there were no more questions or comments about Unwind, Angie thanked Anna for presenting and answering questions.

DENTAL QUALITY STRATEGY REPORT

Katie McBurney, Iowa Medicaid, discussed what she, the dental policy team, internal, and external stakeholders have been collaborating on. Katie also noted that she would post their findings for public comment.

One of their goals is to renew or update the MC plan to include children. However, the four main goals of the Dental Quality Strategy Report are as follows:

- Improve Network Adequacy and Availability of Services
    - Increase the number of general dentists who actively participate in the dental program
    - Increase the number of members who access dental care
    - Improve timely access of network providers
- Improve Prevention and Recall Services
    - Members who received preventive dental care
    - Continued preventive utilization
    - Members who received two topical fluoride applications
    - Members who received a dental sealant
- Improve Oral Health
    - Monitor dental access by race, ethnicity, age, and gender
    - Increase race, ethnicity, and social determinants of health reporting among Dental Wellness Plan (DWP) population
    - Increase benefit utilization for special populations
    - Increase access for special populations

- Improve Care Coordination and Continuity of Care Between MCOs and Dental Pre-Paid Ambulatory Health Plan (PAHPs)
    - Decrease use of the Emergency Department for non-traumatic and/or oral health disease (MCO)
    - Increase the number of child and adult members who receive a follow up dental visit following an ED visit for dental related causes (PAHP)
    - Increase members who receive a topical fluoride application during a well-child visit (MCO)

Katie indicated that the report will be available for public comment for 30 days, encouraging feedback and suggestions to improve the above initiatives.

Once Katie finished presenting, Liz congratulated Katie on her recent promotion within Medicaid to a product owner role in the provider enrollment sphere.

MEDICAID DIRECTOR'S UPDATE

Liz praised Anna's thorough Unwind presentation which addressed eligibility and continuous coverage efforts. According to Liz, there are ongoing conversations with CMS to address their concerns and how their concerns can be alleviated with additional data and context.

Liz emphasized that, while there have been significant Medicaid dis-enrollments, this was expected due to adjustments made in response to the COVID-19 pandemic. Additionally, she emphasized that many dis-enrolled individuals already had other major medical health insurance and that losing Medicaid does not mean losing all health insurance.

Liz discussed updates from a recent town hall meeting. A $7 million state share was allocated for mental health (MH) therapy rates, which, with federal matching, totals about $16.5 million. This reflects a substantial 56.0 percent increase for different MH therapy codes, addressing the growing demand that exceeds capacity. An additional $3 million was allocated for substance use treatment, resulting in approximately $14.5 million due to federal matching, equating to a 96.0 percent increase from current payment levels. MH therapy and substance use providers have not received rate increases for over a decade. The large increase is due to the prolonged absence of raises. The remaining $3 million will be invested in P mech rate increases to address the high demand for Children's Psychiatric Residential Services. The aim is to reimburse at a higher rate to accommodate increased behavioral health (BH) needs among children. Liz acknowledged long waitlists and her aims to prevent rejections by increasing reimbursement rates.

Liz noted a decline in emergency department and inpatient rates and an increase in therapy services. Liz also mentioned ongoing efforts to enhance nursing facility rate increases, addressing the challenges of staggered cost reports and timing issues for the new rates. While the new rates might not be ready by the effective date, Liz planned to share rate range estimates with providers. If there's a delay in updating

the claims systems with the new rates, the reprocessing will ensure providers receive the correct payments retrospectively.

IMPLEMENTATION UPDATE FROM MOLINA HEALTHCARE, INC.

Jennifer Vermeer, Plan President Molina Healthcare (Molina), provided an update on Molina which was previously shared during a town hall. Jennifer expressed confidence in Molina's readiness to go live July 1, 2023. Molina's staffing is nearly complete with a 98.0 percent fill rate. Additionally, all of Molina's staff are either fully trained or almost fully trained. Case managers, in particular, have undergone extensive training.

Jennifer also highlighted Molina's member outreach efforts:

- Mailing members welcome postcards, ID cards, and welcome kits
- Ongoing email and text campaigns
- Posting to social media
- Calling to welcome members

Molina's call center has been operational since June 1, 2023, with extended weekend hours for the first two weekends of July 2023.

Molina has been collaborating and exchanging information with other MCOs to support a smooth transition or "warm handoff" that focuses on a continuation of services and supports risk mitigation for transitioning members. To further support a smooth transition, approved PAs will be honored for the initial 90 days, and providers will be able to confirm these PAs using the provider portal. Additionally, PAs will be waived for most new services during the first three months.

Jennifer emphasized the importance of timely and accurate claims processing, with a focus on mirroring Iowa's benefits and services. In addition, claims testing with providers, which began in February 2023, was comprehensive and valuable. Provider outreach involved orientations, office hours, and meetings with provider groups. Jennifer's key message to providers was to begin billing early and to reach out for support as needed.

Providers may call the call center during specified hours or use the provider portal's tools for secure claims messaging and inquiry. If further assistance is needed, providers may reach out to their provider services representative or escalate to Iowa plan leadership. Member escalation steps involve contacting Molina's member services call center, and member advocates are available to help those struggling with inquiries. This information is also accessible on the Medicaid town hall website.

For Electronic Visit Verification (EVV), Molina will be partnering with CareBridge, the same vendor the two existing MCOs use. To make the process easier for providers, Molina's EVV process will be the exact same as the preexisting MCOs'.

Using the Zoom chat feature, Ben asked if LTSS was excluded from the waiving of new PAs for 90 days. Jennifer confirmed that, as has been the case historically, LTSS is excluded and will continue to have to go through the plan of care process. Jennifer also noted that there was an authorization FAQ and that it could be shared with providers.

Amy stated that about 51.0 percent of Medicaid members are children. She also expressed her interest in connecting with Jennifer or Molina leadership more broadly to discuss how to better serve this population going forward.

Jennifer thanked everyone participating in the meeting for their time, and expressed how she and Molina look forward to continue working with HHS.

MANAGED CARE PLAN (MCP) UPDATES

Iowa Total Care (ITC)

Stacie Maass, Vice President of legislative government affairs ITC, provided a brief update on ITC's recent activities.

Stacie brought up the recent work done in response to the COVID-19 outbreak which led to changes in coverage requirements and continuous collaboration with Iowa Medicaid. She praised the proactive approach to communicate with providers and members beyond sending informational letters (IL), such as conducting frequent town halls and utilizing texting for outreach.

ITC continues to use data analysis and engagement strategies to ensure they are meeting their members' needs in their health plans, taking things such as health access, housing, and safety into consideration. Additionally, this data and these engagement strategies improve ITC's pay for performance programs, which involves around 25,000 providers. ITC provider engagement teams work on best practices, gap identification, and quality enhancements.

Special mention was given to the Home-and Community-Based Services (HCBS) Provider Incentive Program, aimed at reducing homelessness, supporting new and continuous employment, and driving follow up care after hospitalization.

ITC partnered with Corinthian Baptist Church in Downtown Des Moines to host a community health fair in late March 2023. There were about 100 volunteers at the fair and 25 Des Moines and state partners.

Seven months ago, ITC launched its pilot doula program. The program has about 50 members and is focusing on the counties with the highest lowest-weight births. The program has been very successful, only one of 20 births in the pilot program being a low-weight birth.

Stacie ended by thanking Iowa Medicaid workers, the other MCOs, and Iowa Medicaid stakeholders for their continued efforts to help Medicaid members.

Amerigroup Iowa, Inc (AGP)

John McCalley, Health Equity Director AGP, stated that AGP has been working toward many of the same goals as ITC and Molina. One of AGP's priorities at this time, similar to the other MCOs, is to continue to unwind the continuous enrollment policy that was set in place during the COVID-19

pandemic. AGP has also been engaged in member and provider outreach, via phone, mail, and in-person, trying to reach members who are at risk of losing Medicaid coverage. Additionally, AGP is supporting the onboarding of Molina by sharing their data and collaborating with them.

LTSS case management team has helped to increase the transition work capacity given the anticipated increased demand of individuals seeking to leave facility-based care in favor of community-based care. AGP continues to offer community-based service and provider enhancement grants which will continue through 2023.

From 2022 to 2023, AGP expanded its quality incentive programs. AGP is coordinating with providers, mainly hospitals, in regards to their newest program, its substance-use disorder emergency department quality incentive program. AGP plans to implement this program in 2024.

AGP is working to increase case management capacity for LTSS to lower caseloads for case managers to improve the quality of the work being done.

The Champ Housing Stability Initiative has served almost 930 individuals who were either facing eviction or transitioning from homelessness. AGP plans to continue to expand this program this summer, with a particular focus further on maternal child health.

AGP's health worker, continuing education, training partnership with Iowa Chronic Care Consortium is expected to be rolled out in July 2023. Additionally, AGP's partnership with the University of Iowa for excellence in disability and development training is anticipated to be rolled out in September 2023.

This fall, AGP plans to launch programs meant to prevent homelessness and suicide among individuals who have aged out of the foster care system. AGP plans to implement strategies and tactics to improve the HPV vaccination rate among children ages nine to 13 this fall as well.

Lastly, former AGP Plan President Jeff Jones, following his promotion, was replaced by Teresa Hursey. John congratulated Jeff and Teresa on their respective promotions. John stated that Teresa has extensive experience in Medicaid and will be a good fit with AGP.

MAAC PROFESSIONAL AND BUSINESS ENTITY ELECTION 2023

Mike Kitzman, Communications Specialist Iowa Medicaid, stated that everyone who represents a professional business entity should have received an email from him with a link to a web form regarding the 2023 election.

Mike relayed the results of the election: the Iowa Medical Society and Iowa Association of Community Professionals incumbents both won re-election by a large margin.

Mike said that the three seats that were not voted on during this election would be voted on next year.

Kady Reese, Iowa Medical Society, requested modifying next year's election forms to make the language clearer. Mike said that could be done.

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OPEN DISCUSSION

Ben re-introduced himself and thanked everyone on the call again for their time and hard work.

Marcie Strouse, public member, expressed her appreciation of the recent communication efforts. She also relayed how she felt the transition for individuals from private insurance to an MCO is easier than the transition from an MCO to private insurance, drawing on her own personal experience and the knowledge of her case manager. She expressed interest in improving the later transition for individuals. Liz thanked Marcie for her feedback.

Kady shared how providers appreciate the previously discussed PA policies given the prior administrative burdens of the PA process.

ADJOURNMENT

Meeting adjourned at 2:53 p.m.

Submitted by,
Emma Nutter
Recording Secretary
en

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Managed Care Organization (MCO) Quarterly Performance Report

SFY2023, Quarter 3

(January - March 2023)

Published June 2023

Contents

This report is based on requirements of **2016 Iowa Acts Section 1139**. The legislature grouped these reports into three main categories: Consumer Protection, Outcome Achievement, and Program Integrity.

The Department grouped the managed care reported data in this publication as closely as possible to **House File 2460** categories but has made some alterations to ease content flow and data comparison. This publication content flows as follows:

Executive Summary 3
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Claims Summary (Pharmacy) 11
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Executive Summary

This report is based on Quarter 3 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:

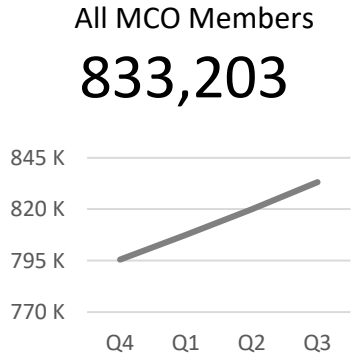
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period 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://hhs.iowa.gov/iahealthlink
- These reports are due to be replaced by a dashboard that is currently under development. Once completed, the dashboard will provide both medical and dental Medicaid data to the public.

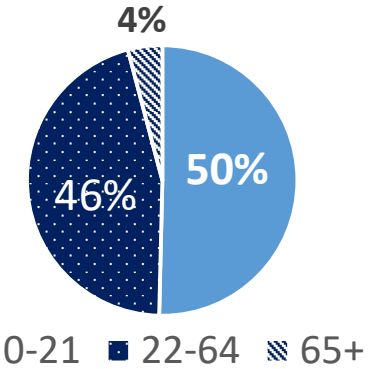
Mission/Vision Statement: Iowa Medicaid is committed to ensuring that all members have access to high quality services that promote dignity, removing barriers to increase health engagement, and improving whole person health. Our vision is operating a sustainable Medicaid program that improves the lives 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.





+ 13,351 Members
1.63% Increase

All MCO Enrollment (by Age)

Data Notes: March 2023 data as of May 2023. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Distinct
MCO Member Summary - *Overall Counts*	795,507	807,413	819,852	**833,203**	813,994	**863,190**
0-21	407,098	411,121	414,784	419,670	413,168	432,907
22-64	356,845	363,817	371,787	379,544	367,998	392,399
65+	31,564	32,475	33,281	33,989	32,827	37,884
Fee-For-Service (FFS) - *Non MCO Enrollees*	46,896	47,940	49,363	**50,689**	48,722	**53,819**

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

If Yes, explain:

Iowa Medicaid Population **917,009**
1 year distinct count

o MCO Market Share > All new members are being assigned to Iowa Total Care prior to Molina implementation

MCO Member Summary

Amerigroup (An Anthem Company)	SFY23 Q2	SFY23 Q3
All Members - *by MCO*	453,029	452,811
Traditional Medicaid	281,378	281,612
Wellness Plan - IHAWP/Expansion	129,484	129,852
M-CHIP - Expansion	9,649	9,594
Healthy and Well Kids in Iowa (Hawki)	32,518	31,753
MCO Member Market Share	55.3%	54.3%
Disenrolled	925	882
Long-Term Service & Support (LTSS)	21,061	20,279
HCBS Waivers	68.5%	70.7%
Facility Based Services	28.8%	29.3%
HCBS Waivers [1]	14,431	14,344
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,068	5,935
ICF/ID [3]	776	752
Mental Health Institute (MHI)	34	36
Nursing Facilities (NF)	4,924	4,808
Nursing Facilities for Mentally Ill	57	55
Skilled	87	89
PMIC [4]	190	195

iowa total care	SFY23 Q2	SFY23 Q3
All Members - *by MCO*	366,823	380,392
Traditional Medicaid	225,474	232,769
Wellness Plan - IHAWP/Expansion	120,162	126,643
M-CHIP - Expansion	7,097	7,240
Healthy and Well Kids in Iowa (Hawki)	14,090	13,740
MCO Member Market Share	44.7%	45.7%
Disenrolled	731	732
Long-Term Service & Support (LTSS)	15,328	15,840
HCBS Waivers	64.8%	64.1%
Facility Based Services	35.2%	35.9%
HCBS Waivers [1]	9,937	10,159
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,391	5,681
ICF/ID [3]	447	435
Mental Health Institute (MHI)	26	36
Nursing Facilities (NF)	4,696	4,953
Nursing Facilities for Mentally Ill	34	38
Skilled	66	77
PMIC [4]	122	142

[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 431; ITC 426). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

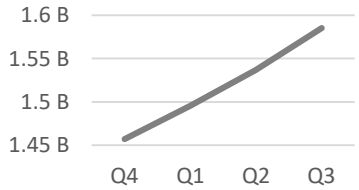
MCO Financial Summary - All MCO Counts

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

$1.59 Billion

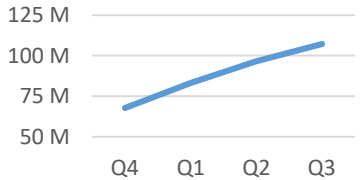


+ $48.8 Million

3.17% Increase

Third Party Liability

$107.3 Million



+ $ 10.9 Million

11.3% increase

Data Notes: March 2023 data as of May 2023. 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 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Financial Summary						
Capitation Payments	$1.46 B	$1.5 B	$1.54 B	**$1.59 B**	$1.52 B	$6.07 B
Third Party Liability (TPL) Recovered	$67.7 M	$83.1 M	$96.4 M	**$107.3 M**	$88.6 M	$354.5 M

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

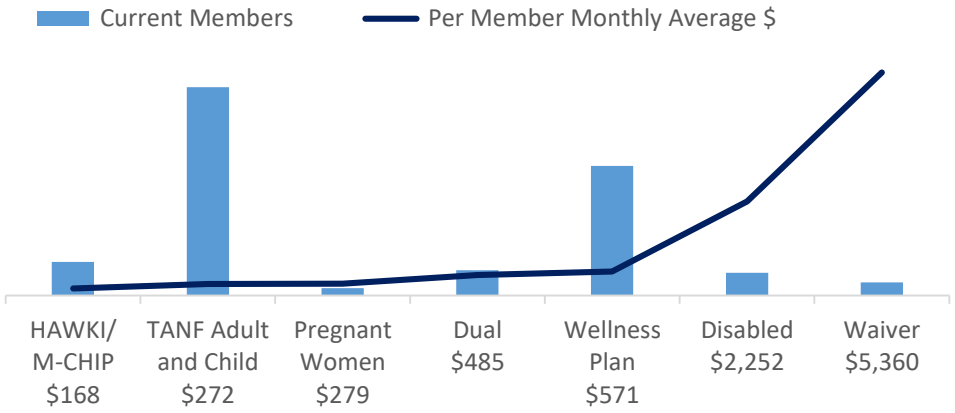
If Yes, explain:

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

	SFY23 Q2	SFY23 Q3
Capitation Totals	$857.74 M	**$864.42 M**
Adjustments	$1.74 M	$14.29 M
Current	$845.29 M	$839.18 M
Retro	$10.71 M	$10.95 M
Third Party Liability (TPL)	$23.9 M	**$20.8 M**
Financial Ratios		
Medical Loss Ratio (MLR)	95.2%	**96.7%**
Administrative Loss Ratio (ALR)	6.1%	3.6%
Underwriting Ratio (UR)	-1.3%	-0.3%
Unreconciled SFY MLR [5]		94.9%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

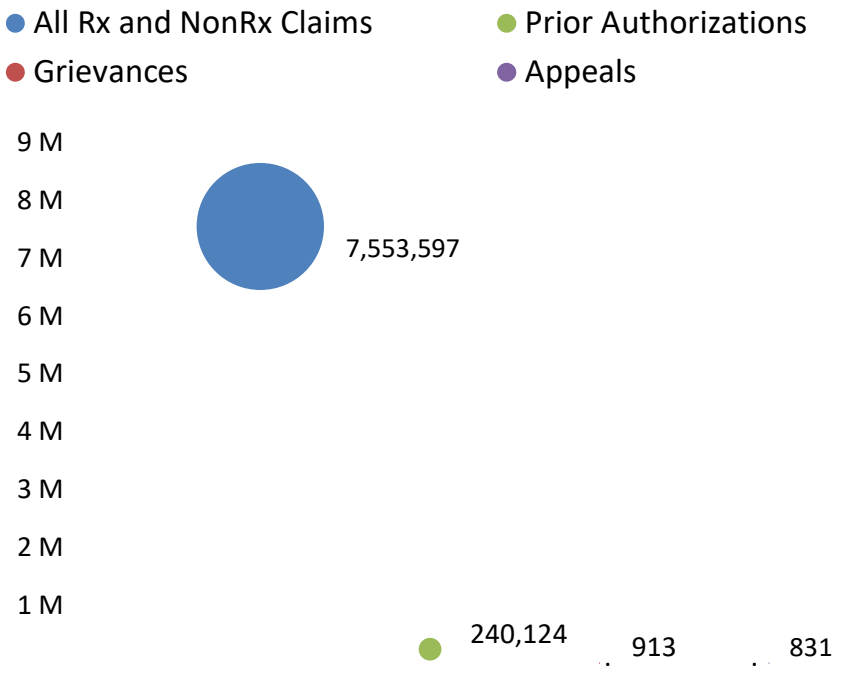
	SFY23 Q2	SFY23 Q3
Capitation Totals	$678.99 M	**$721.06 M**
Adjustments	$2.81 M	$12.15 M
Current	$647.12 M	$671.86 M
Retro	$29.07 M	$37.06 M
Third Party Liability (TPL)	$72.5 M	**$86.5 M**
Financial Ratios		
Medical Loss Ratio (MLR)	97.1%	**97.6%**
Administrative Loss Ratio (ALR)	5.3%	5.9%
Underwriting Ratio (UR)	-2.4%	-3.5%
Unreconciled SFY MLR [5]		96.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[5] MLR is unaudited and is now reported to include changes with additional quarters of information during the SFY. Primary drivers that influence changes in the MLR include: 1) estimates for unpaid claims liability, 2) estimates for the impact of the risk corridor and 3) financial review process that may result in expenditure reclassifications.

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	3.18%
Grievances	0.01%
Appeals	0.01%

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.4 M	7.4 M	7.5 M	**7.6 M**	7.5 M	29.8 M
Non-Pharmacy	4.4 M	4.2 M	4.3 M	4.3 M	4.3 M	17.3 M
Pharmacy	3.0 M	3.1 M	3.1 M	3.3 M	3.1 M	12.5 M
Prior Authorization Summary (p. 13-14)	193,729	197,872	222,695	**240,124**	213,605	854,420
Non-Rx - Standard PAs Submitted	142,964	146,847	169,055	179,963	159,707	638,829
Pharmacy - Standard PAs Submitted	50,765	51,025	53,640	60,161	53,898	215,591
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	761	766	765	**913**	801	3,205
Standard Appeals	752	770	772	**831**	781	3,125

Claims Summary (Non-Pharmacy)

2.44 Million
Claims Paid & Denied

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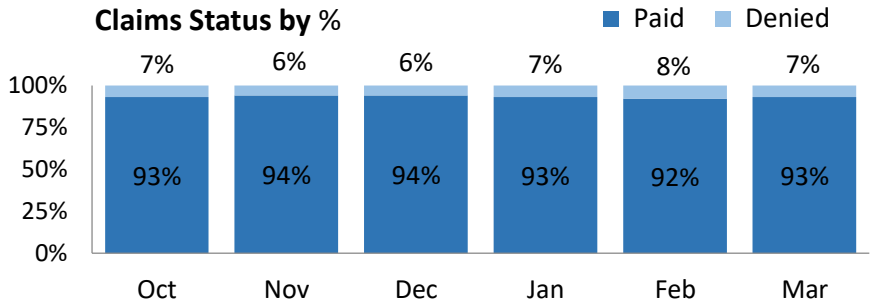
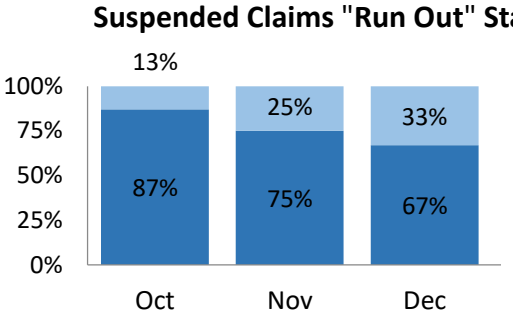
	Jan	Feb	Mar
All Claims			
Paid	775,646	728,554	766,743
Denied	56,150	61,532	55,046
Suspended	186,852	181,396	183,762
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	97%	95%
in 45-days (Requirement 95%)	98%	97%	96%
Average Days to Pay	8	8	8
Provider Adjustment Requests & Errors Reprocessed 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)

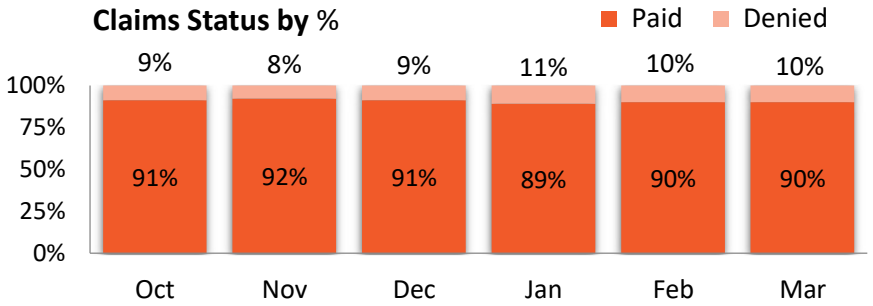
	%	
1.	13%	Duplicate claim/service
2.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	9%	The impact of prior payer(s) adjudication including payments and/or adjustments.
4.	8%	Expenses incurred after coverage terminated
5.	8%	Claim/service lacks information or has submission/billing error(s) - primary payer information required
6.	7%	Service not payable per managed care contract
7.	6%	Attachment/Other Documentation Required
8.	5%	Precertification/authorization/notification absent
9.	5%	Missing/incomplete/invalid type of bill
10.	4%	Prior Processing information appears incorrect

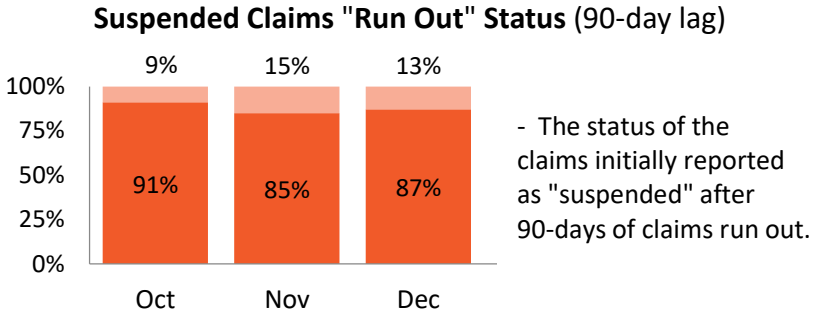
Claims Summary (Non-Pharmacy)

1.86 Million
Claims Paid & Denied

iowa total care

	Jan	Feb	Mar
All Claims			
Paid	486,754	474,842	710,163
Denied	59,794	51,036	76,163
Suspended	150,469	188,721	114,121
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	99%	98%
in 45-days (Requirement 95%)	98%	100%	100%
Average Days to Pay	8	9	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	100%	100%





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

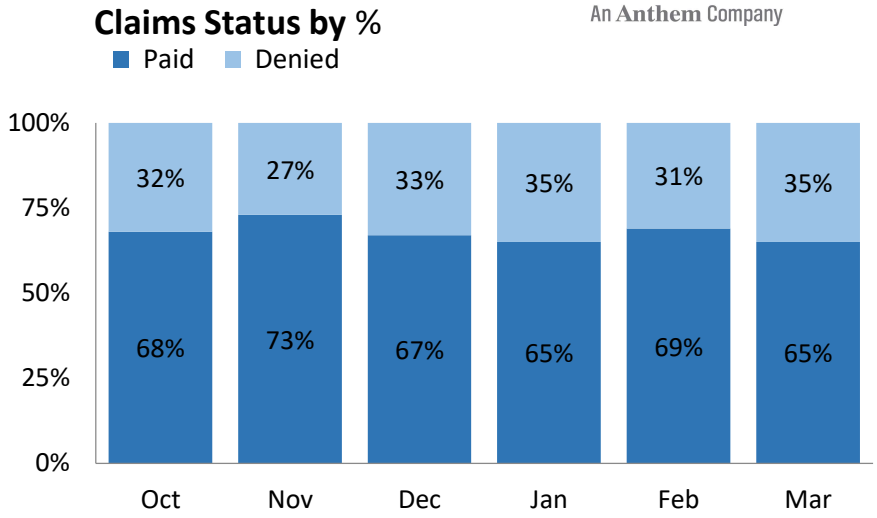
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	16%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
2.	10%	Duplicate claim/service can not be combined with other service on same day
3.	9%	Service can not be combined with other service on same day Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	5%	Service is not covered
5.	5%	No authorization on file that matches service(s) billed
6.	4%	Billing NPI not registered with IA DHHS/IA Medicaid
7.	3%	ECI diagnosis invalid or requires additional digit
8.	3%	Void Adjustment
9.	3%	Diagnosis code incorrectly coded per ICD10 manual
10.	2%	Time Frame for filing a Claim reconsideration has expired

Claims Summary (Pharmacy)

1.76 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	343,268	366,868	460,028
Denied	187,713	162,916	243,504
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	10	11	11



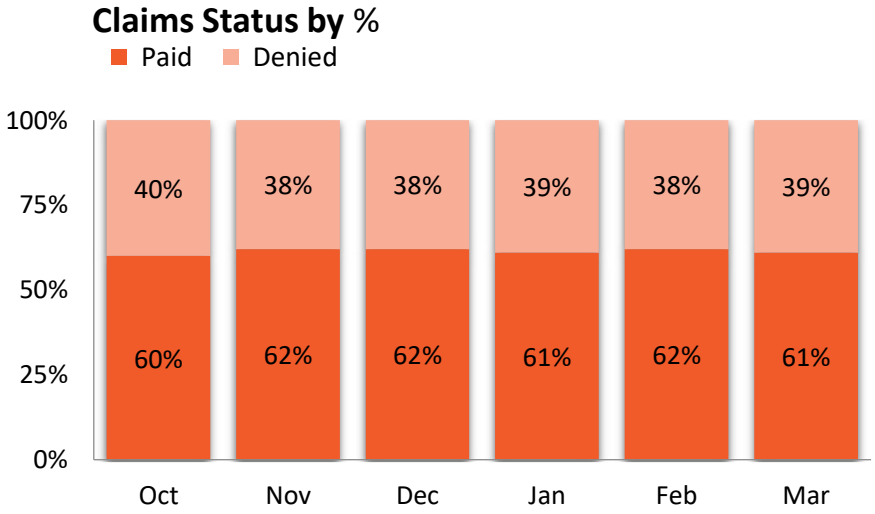
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	31%	Refill too soon
2.	20%	M/I other coverage code
3.	12%	Prior authorization required
4.	11%	Submit bill to other processor or primary payer
5.	6%	National Drug Code (NDC) not covered
6.	6%	Plan limitations exceeded
7.	3%	M/I other payer reject code
8.	3%	M/I processor control number
9.	1%	Prescriber is not enrolled in State Medicaid program
10.	1%	Filled after coverage terminated

Claims Summary (Pharmacy)

1.49 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	306,638	283,621	322,738
Denied	193,490	175,568	204,822
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.	27%	Refill too soon
2.	12%	Prior authorization required
3.	8%	National Drug Code (NDC) not covered
4.	5%	Submit bill to other processor or primary payer
5.	5%	Plan limitations exceeded
6.	2%	Product not covered - non-participating manufacturer
7.	2%	Discrepancy - other coverage code & other payer amount paid
8.	2%	Drug Utilization Review (DUR) reject error
9.	2%	Drug not covered for patient age
10.	1%	Prescriber is not enrolled in State Medicaid program

Prior Authorization Summary

92,377
All PAs Submitted [6]

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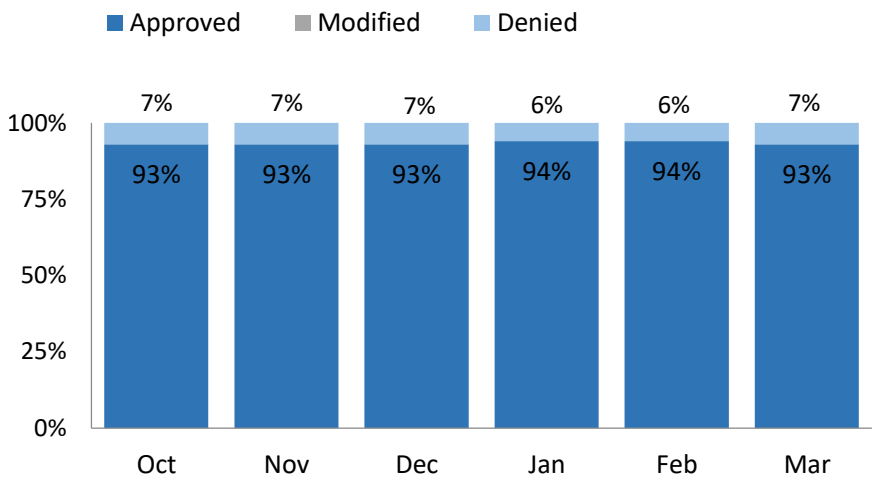
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	17,048	18,349	21,758
Denied	1,125	1,204	1,592
Modified	0	0	0
Average Days to Process	3	4	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

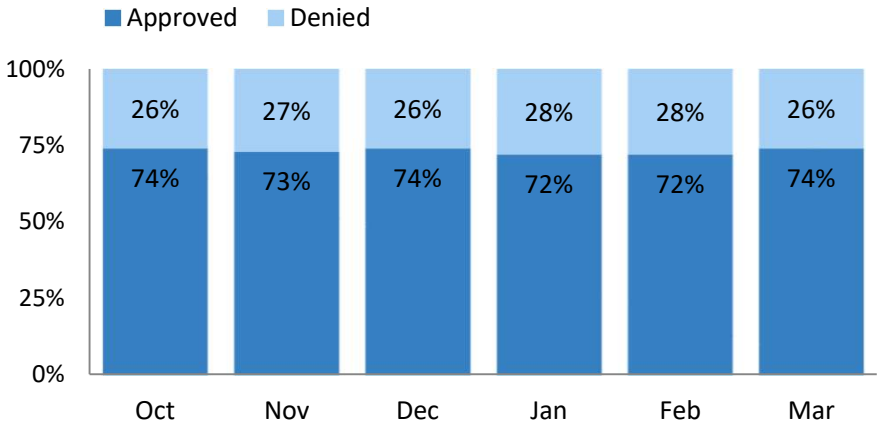
Non-Pharmacy by Percentage



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	7,726	6,797	8,161
Denied	2,986	2,673	2,918
PAs Completed in 24-hours (Requirement 100%)	100.0%	99.9%	100.0%

Pharmacy by Percentage



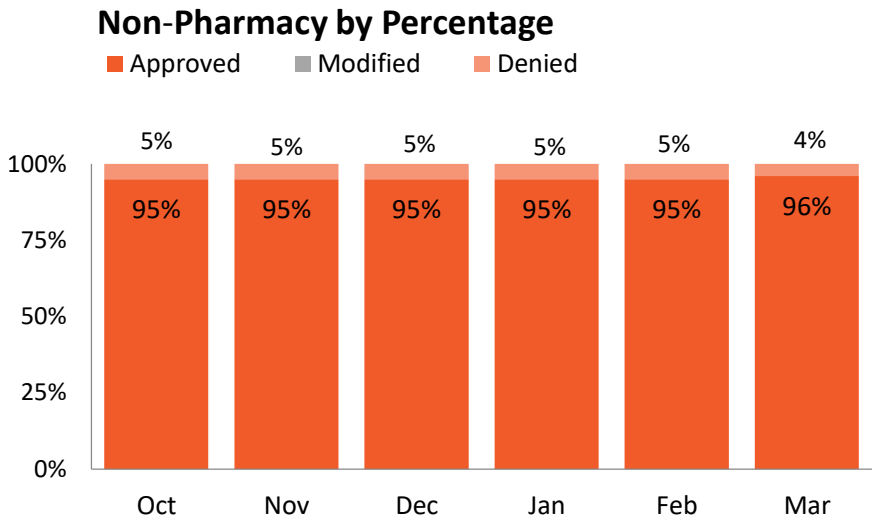
[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

147,747
All PAs Submitted [6]

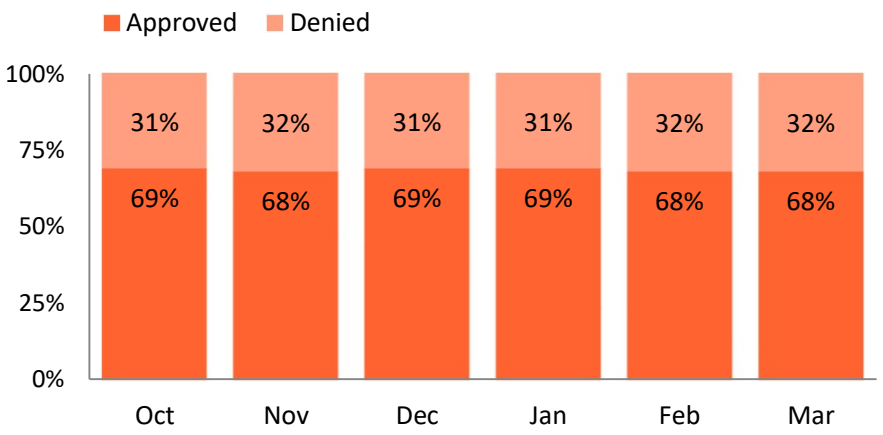
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	35,466	35,279	41,886
Denied	1,849	2,021	1,763
Modified	0	0	0
Average Days to Process	2	2	2
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	99%	99%



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	5,838	5,530	6,569
Denied	2,632	2,629	3,035
PAs Completed in 24-hours (Requirement 100%)	100.0%	100.0%	99.9%

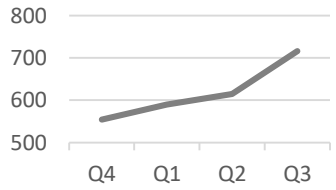


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

Standard Grievances

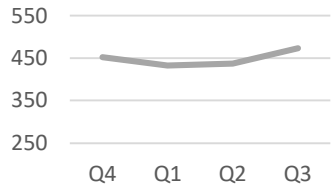
716



Resolved in 30-days
100%

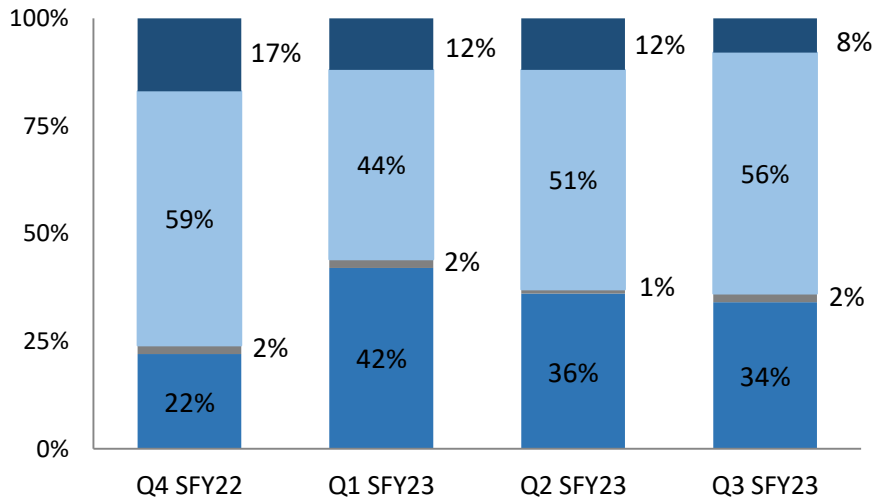
Standard Appeals/ 1st Level Review

473



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	26%	Voluntary Disenrollment
2.	17%	Provider balance billed
3.	8%	Provider Dissatisfaction
4.	5%	Treatment Dissatisfaction
5.	4%	Transportation - Driver Delay
6.	3%	Inadequate benefit access
7.	2%	Continuity of Care
8.	2%	Inadequate member materials
9.	2%	Provider refusal to treat
10.	2%	Too many phone inquiries

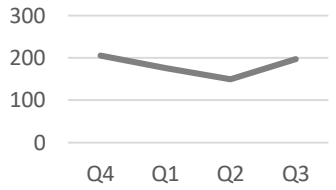
%	Top 10 Reasons for Appeals [7]
28%	Pharmacy - Non Injectable
18%	DME
13%	Pharmacy - Injectable
12%	Outpatient Services - Medical
6%	Surgery
4%	Inpatient - Medical
3%	Therapy OT/PT
3%	Radiology
3%	Pain Mgmt
2%	BH - Inpatient

[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

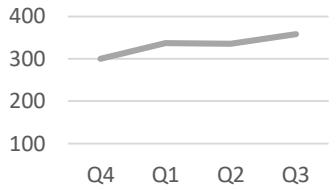
197



Resolved in 30-days
99%

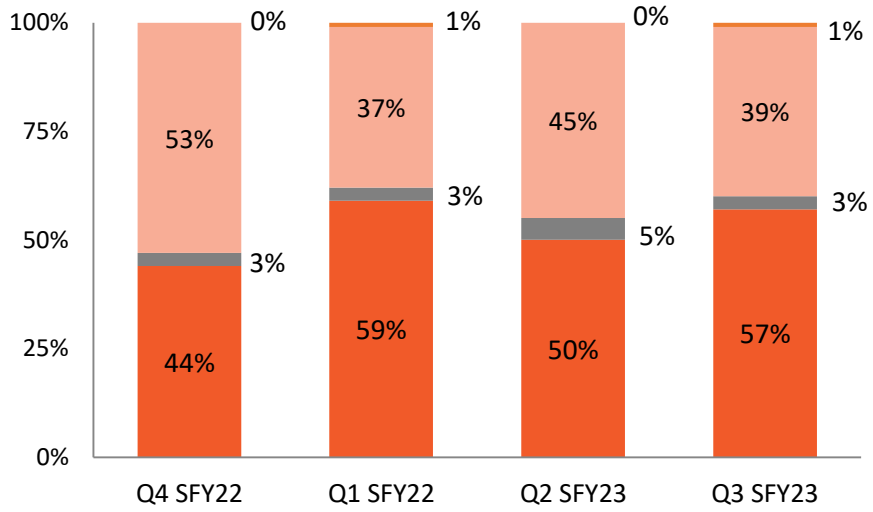
Standard Appeals/ 1st Level Review

358



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	15%	Provider Not in Network
2.	14%	Transportation - General Complaint Vendor
3.	12%	Unhappy with Benefits
4.	11%	Transportation - Driver did not show
5.	6%	Transportation - Missed Appointment
6.	6%	Lack of Caring/Concern
7.	5%	Transportation - Late Appointment
8.	4%	Transportation - General Complaint Vendor CSR
9.	3%	Transportation - Other
10.	3%	Inappropriate Payment Demand(par)

%	Top 10 Reasons for Appeals [7]
26%	RX - Does Not Meet Prior Auth Guidelines
6%	DME - Wheelchair - NotMedically Necessary
5%	Rehabilitation/Therapy - Physical Therapy
3%	Injection - Self Injectibles - Not Medically Necessary
2%	Therapy - Occupational Therapy - Not Medically Necessary
2%	Diagnostic - MRI - Not Medically Necessary
2%	DME - Other - Not Medically Necessary
2%	Other - Mental Health Service
2%	Injections - Epidural Injections -Not Medically Necessary
1%	DME - Blood Glucose Monitor - Not Medically Necessary

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

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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	SFY23 Q2	SFY23 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	64%	64%

iowa total care

	SFY23 Q2	SFY23 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	98%	98%

Top 5 - Value Added Services (VAS)

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

Amerigroup An Anthem Company

	SFY23 Q2	SFY23 Q3
Healthy Rewards	6,574	10,158
Taking Care of Baby and Me	2,145	2,130
Community Resource Link	1,977	1,587
SafeLink Mobile Phone	2,613	1,050
Dental Hygiene Kit	514	568

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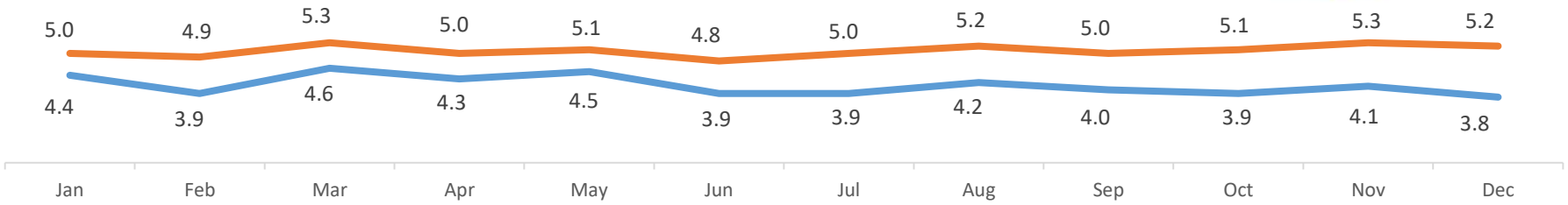
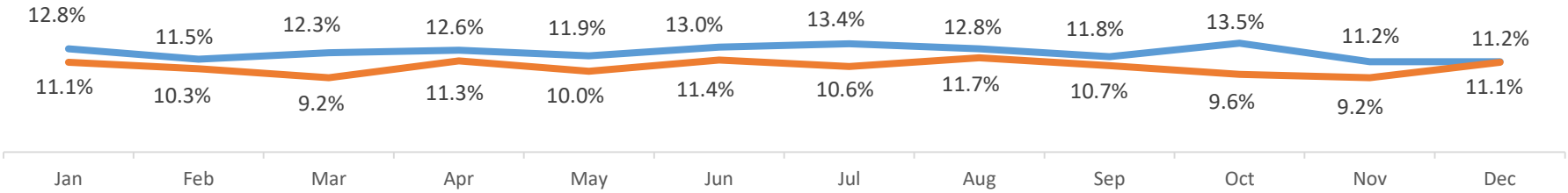
	SFY23 Q2	SFY23 Q3
My Health Pays Program	12,676	9,596
The Flu Program	14,212	6,132
Mobile App	1,831	2,080
Start Smart for Your Baby	1,743	2,000
SafeLink Phones	662	1,198

MCO Care Quality and Outcomes

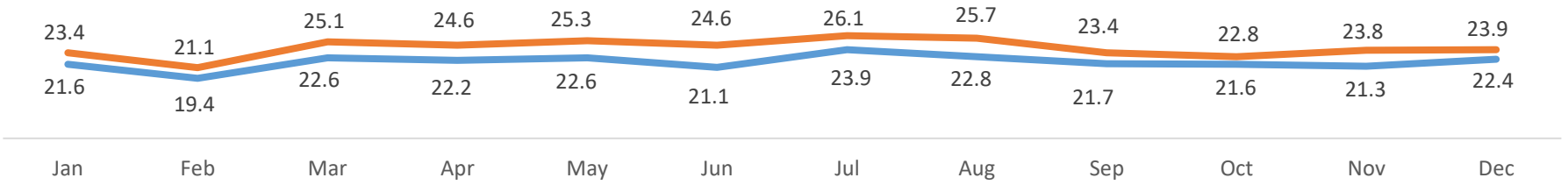
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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.*

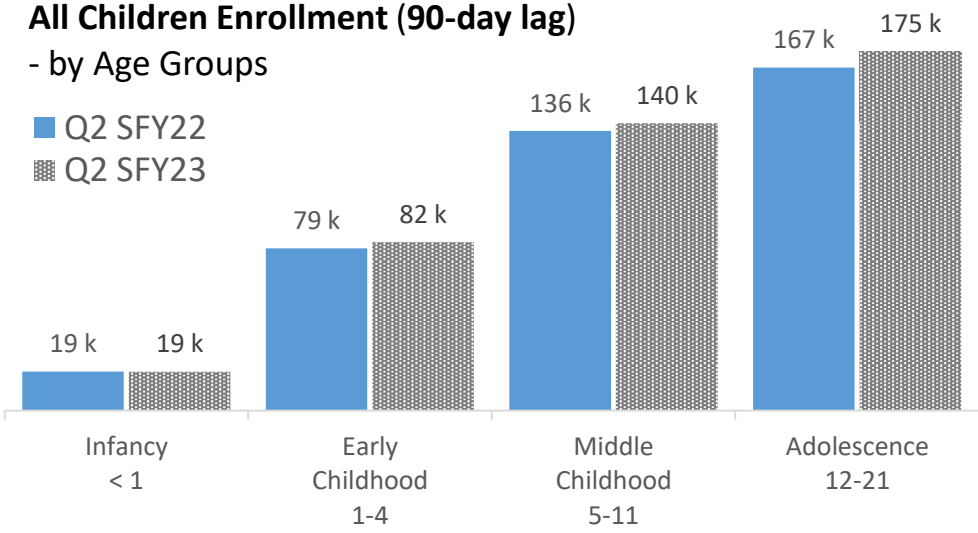
[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

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

	SFY22 Q2	SFY23 Q2
Member Enrollment	237,998	238,257
Infancy < 1	9,842	8,810
Early Childhood 1 - 4	46,275	45,215
Middle Childhood 5 - 11	81,778	81,767
Adolescence 12 - 21	100,103	102,465
Well Child Exams (Preventive Visits)	39,572	43,034
Infancy < 1	11,043	11,232
Early Childhood 1 - 4	11,242	12,037
Middle Childhood 5 - 11	8,865	10,298
Adolescence 12 - 21	8,422	9,467
Lead Screenings	3,445	3,771
Infancy < 1	77	129
Early Childhood 1 - 4	3,059	3,348
Middle Childhood 5 - 11	269	251
Adolescence 12 - 21	40	43

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	SFY22 Q2	SFY23 Q2
Member Enrollment	162,215	176,527
Infancy < 1	9,062	9,974
Early Childhood 1 - 4	32,560	36,469
Middle Childhood 5 - 11	54,062	57,849
Adolescence 12 - 21	66,531	72,235
Well Child Exams (Preventive Visits)	35,030	36,532
Infancy < 1	11,829	12,504
Early Childhood 1 - 4	9,811	10,348
Middle Childhood 5 - 11	7,064	7,022
Adolescence 12 - 21	6,326	6,658
Lead Screenings	3,264	3,741
Infancy < 1	123	147
Early Childhood 1 - 4	2,847	3,283
Middle Childhood 5 - 11	258	263
Adolescence 12 - 21	36	48

MCO Children Summary

Amerigroup An Anthem Company	SFY22 Q2	SFY23 Q2
Hearing Screenings	2,200	2,165
Infancy < 1	172	162
Early Childhood 1 - 4	1,111	1,048
Middle Childhood 5 - 11	660	676
Adolescence 12 - 21	257	279
Vision Screenings	1,871	2,358
Infancy < 1	47	13
Early Childhood 1 - 4	854	838
Middle Childhood 5 - 11	626	948
Adolescence 12 - 21	344	559
Vaccination Totals	80,580	70,221
COVID-19 Dose 1	2,212	513
COVID-19 Dose 2 or Single-Dose (J&J)	2,031	447
DTaP (Diphtheria, Tetanus, Pertussis)	9,220	8,248
Influenza (FLU)	31,194	27,677
HepA (Hepatitis A)	4,027	3,763
HepB (Hepatitis B)	878	466
Haemophilus Influenza Type B (Hib)	4,786	4,090
Human Papillomavirus (HPV)	2,656	2,635
Meningococcal ACWY (MenACWY)	2,714	2,666
Meningococcal B - (MenB)	1,216	1,273
MMR (Measles, Mumps, Rubella)	3,687	3,658
Pneumococcal (PCV13)	7,090	6,540
Pneumococcal (PPSV23)	57	45
Polio (IPV)	239	291
RV (Rotavirus)	4,696	4,151
Tetanus and diphtheria (Td)	29	26
TDAP (Tetanus, Diphtheria, Pertussis)	1,949	1,889
Varicella Virus Vaccine (VAR)	1,899	1,843

iowa total care	SFY22 Q2	SFY23 Q2
Hearing Screenings	1,377	1,526
Infancy < 1	172	150
Early Childhood 1 - 4	664	761
Middle Childhood 5 - 11	388	437
Adolescence 12 - 21	153	178
Vision Screenings	1,450	1,720
Infancy < 1	40	9
Early Childhood 1 - 4	732	639
Middle Childhood 5 - 11	491	672
Adolescence 12 - 21	187	400
Vaccination Totals	64,089	59,488
COVID-19 Dose 1	1,823	14
COVID-19 Dose 2 or Single-Dose (J&J)	1,723	454
DTaP (Diphtheria, Tetanus, Pertussis)	8,050	7,830
Influenza (FLU)	22,087	19,904
HepA (Hepatitis A)	3,328	3,537
HepB (Hepatitis B)	769	574
Haemophilus Influenza Type B (Hib)	4,399	4,141
Human Papillomavirus (HPV)	1,911	1,970
Meningococcal ACWY (MenACWY)	1,853	1,990
Meningococcal B - (MenB)	801	868
MMR (Measles, Mumps, Rubella)	3,088	3,054
Pneumococcal (PCV13)	6,455	6,722
Pneumococcal (PPSV23)	66	39
Polio (IPV)	204	446
RV (Rotavirus)	4,338	4,507
Tetanus and diphtheria (Td)	35	30
TDAP (Tetanus, Diphtheria, Pertussis)	1,430	1,609
Varicella Virus Vaccine (VAR)	1,729	1,799

MCO Children Summary - Behavioral/Mental Health Treatment & Services

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Substance Use Disorder (SUD) Summary	SFY22 Q2	SFY23 Q2
Total Visits - *As 1st or 2nd Diagnosis*	6,530	6,489
Alcohol	1,263	1,300
Cannabis	2,810	2,958
Cocaine	60	108
Nicotine	712	774
Opioid	515	442
Other	64	40
Other Psychoactive	305	333
Other Stimulant	476	449
Sedative	325	85

Severe Emotional Disturbance (SED) for Children Summary	SFY22 Q2	SFY23 Q2
Total Visits - *As 1st or 2nd Diagnosis*	208,917	197,251
ADHD [10]	46,141	44,528
Anxiety	38,611	38,593
Bipolar	3,231	2,938
Conduct Disorder	20,894	19,795
Depression	29,504	27,237
Obsessive Compulsive Disorder	765	717
Other	14,964	13,098
Post-traumatic Stress Disorder	54,357	50,036
Tourette Syndrome	450	309

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Substance Use Disorder (SUD) Summary	SFY22 Q2	SFY23 Q2
Total Visits - *As 1st or 2nd Diagnosis*	4,019	4,272
Alcohol	752	1,009
Cannabis	2,051	1,951
Cocaine	40	36
Nicotine	66	132
Opioid	339	376
Other	43	15
Other Psychoactive	210	268
Other Stimulant	457	417
Sedative	61	68

Severe Emotional Disturbance (SED) for Children Summary	SFY22 Q2	SFY23 Q2
Total Visits - *As 1st or 2nd Diagnosis*	113,801	114,460
ADHD [10]	22,782	22,930
Anxiety	21,866	23,241
Bipolar	1,590	1,690
Conduct Disorder	11,703	10,707
Depression	16,633	16,197
Obsessive Compulsive Disorder	419	338
Other	7,355	7,655
Post-traumatic Stress Disorder	31,263	31,504
Tourette Syndrome	190	198

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	SFY22 Q2	SFY23 Q2
Mental Health Assessments	10,438	8,957
Middle Childhood 5 - 11	3,660	3,435
Adolescence 12 - 21	6,778	5,522
Therapy/Counseling - Individual	74,462	69,149
Middle Childhood 5 - 11	30,738	28,412
Adolescence 12 - 21	43,724	40,737
Therapy/Counseling - Group & Family	8,917	7,985
Middle Childhood 5 - 11	3,134	2,871
Adolescence 12 - 21	5,783	5,114
Behavioral Intervention Services	18,922	19,629
Middle Childhood 5 - 11	11,430	11,877
Adolescence 12 - 21	7,492	7,752
Applied Behavior Analysis (ABA)	4,059	3,651
Middle Childhood 5 - 11	3,642	3,121
Adolescence 12 - 21	417	530
Residential Treatment	666	484
Middle Childhood 5 - 11	221	111
Adolescence 12 - 21	445	373
M/H & Substance Abuse B3 Services [11]	5,632	5,415
Middle Childhood 5 - 11	1,502	1,530
Adolescence 12 - 21	4,130	3,885

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Mental Health Assessments	6,165	5,865
Middle Childhood 5 - 11	2,215	2,203
Adolescence 12 - 21	3,950	3,662
Therapy/Counseling - Individual	42,933	43,865
Middle Childhood 5 - 11	18,721	18,380
Adolescence 12 - 21	24,212	25,485
Therapy/Counseling - Group & Family	5,085	5,521
Middle Childhood 5 - 11	2,005	2,294
Adolescence 12 - 21	3,080	3,227
Behavioral Intervention Services	10,704	10,906
Middle Childhood 5 - 11	6,651	6,543
Adolescence 12 - 21	4,053	4,363
Applied Behavior Analysis (ABA)	971	1,078
Middle Childhood 5 - 11	839	942
Adolescence 12 - 21	132	136
Residential Treatment	375	506
Middle Childhood 5 - 11	101	181
Adolescence 12 - 21	274	325
M/H & Substance Abuse B3 Services [11]	3,087	3,126
Middle Childhood 5 - 11	940	847
Adolescence 12 - 21	2,147	2,279

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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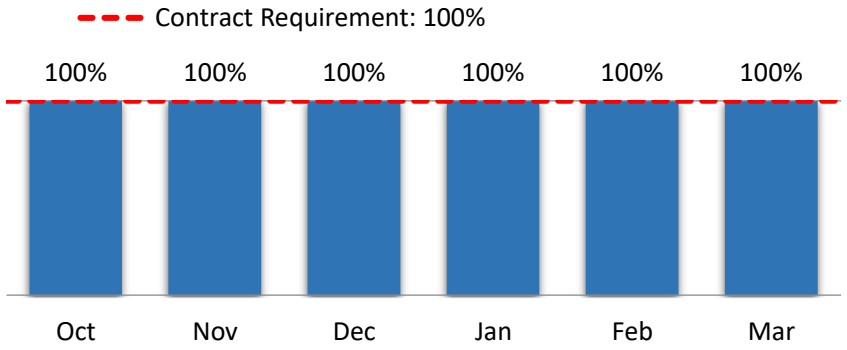
Average Number of Contacts Per Month	SFY23 Q2	SFY23 Q3
by Care Coordinators	2.0	**2.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	12	**15**
HCBS Members to Case Managers	76	**67**

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.

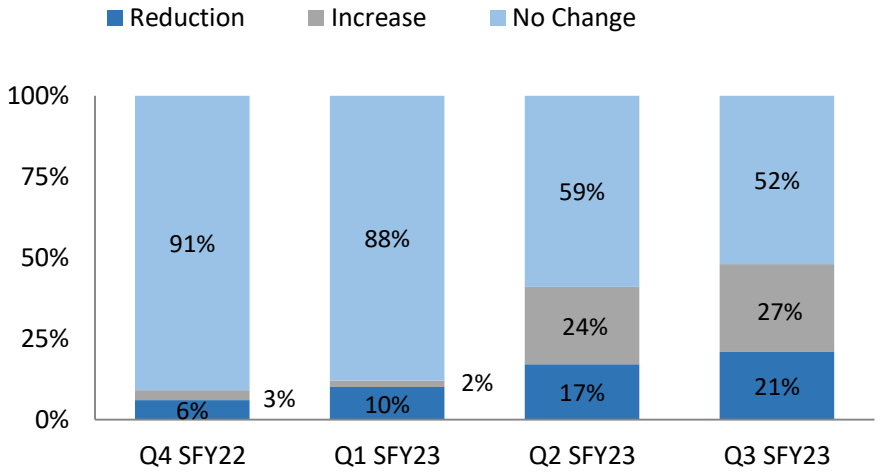
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY23 Q2	SFY23 Q3
They were part of service planning.	I don't know	0.0%	0.5%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	99.5%
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	0.0%	1.0%
	No	0.0%	0.0%
	Sometimes	0.0%	1.4%
	Yes	100.0%	97.6%

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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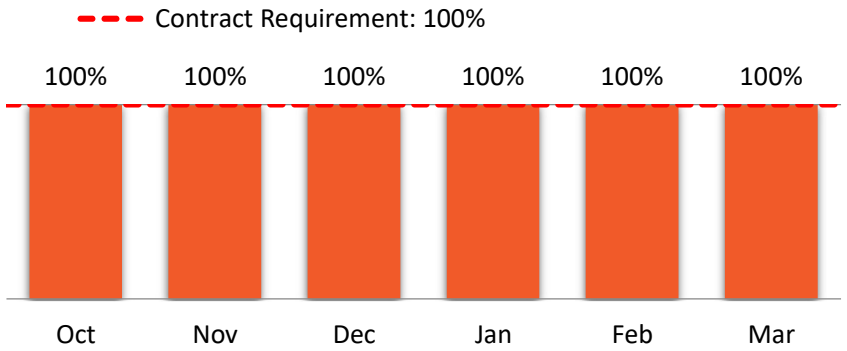
Average Number of Contacts Per Month	SFY23 Q2	SFY23 Q3
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	44	**51**
HCBS Members to Case Managers	44	**46**

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

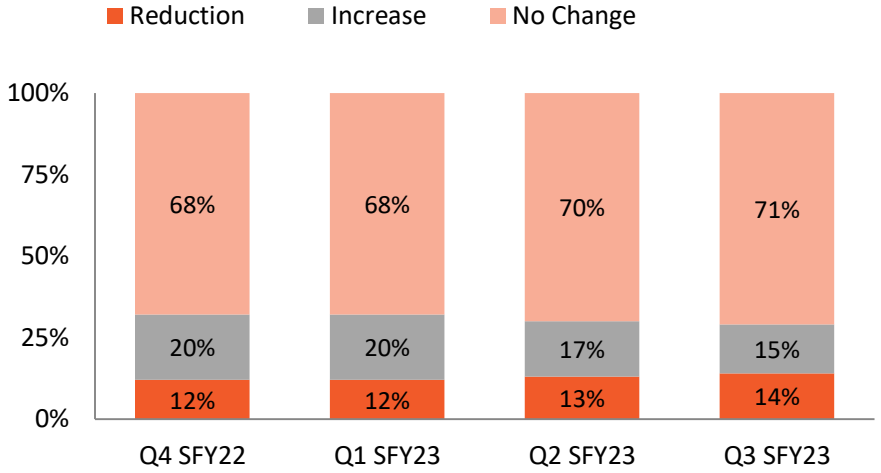
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY23 Q2	SFY23 Q3
They were part of service planning.	I don't know	2.1%	1.4%
	No	3.5%	0.0%
	Sometimes	1.1%	2.8%
	Yes	92.2%	95.8%
They feel safe where they live.	I don't know	0.4%	0.0%
	No	5.7%	5.6%
	Sometimes	2.1%	2.8%
	Yes	91.5%	91.7%
Their services make their lives better.	I don't know	1.8%	0.0%
	No	3.5%	4.2%
	Sometimes	4.2%	1.4%
	Yes	90.1%	94.4%

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

	SFY23 Q2	SFY23 Q3
AIDS/HIV - Waiver Member Count	25	26
Home Delivered Meals	18	18
CDAC (agency) by 15 minute units	1	2
Financial Management Services	2	2
Adult Day Care Services - full day	1	2
CDAC (individual) by 15 minute units	3	1
Brain Injury (BI) Waivers	755	755
Supported Community Living (by unit)	199	205
Financial Management Services	199	200
Personal Emergency Response	171	171
Respite (by 15 minute units)	151	153
Supported Community Living (daily)	115	119
Children's Mental Health (CMH)	799	797
Respite (by 15 minute units)	445	456
Respite (Hos/NF) - 15 minute units	236	235
Family and Community Support	193	187
Respite (Resident Camp) by units	21	19
Home Delivered Meals	2	3
Elderly Waivers	4,027	3,925
Personal Emergency Response	2,746	2,692
Home Delivered Meals	2,724	2,627
CDAC (agency) by 15 minute units	345	334
Assisted Living Services	317	316
Personal Emergency Response (install)	251	221

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	SFY23 Q2	SFY23 Q3
Habilitation (Hab)	4,076	4,148
Home-based Habilitation	3,381	3,389
Long Term Job Coaching	386	389
Day Habilitation (units by day)	333	326
Day Habilitation (by 15 minute units)	157	161
Individual Supported Employment	204	122
Health & Disability (HD)	1,357	1,349
Respite (by 15 minute units)	397	419
Financial Management Services	347	338
Personal Emergency Response	321	322
Home Delivered Meals	312	308
Respite (Hos/NF) - 15 minute units	57	61
Intellectual Disability (ID)	6,899	6,930
Supported Community Living (by unit)	1,822	1,855
Supported Community Living (RCF)	1,514	1,525
Day Habilitation (units by day)	1,321	1,322
Supported Community Living (daily)	1,193	1,211
Financial Management Services	1,150	1,115
Physical Disability (PD)	569	562
Personal Emergency Response	320	314
CDAC (individual) by 15 minute units	37	58
CDAC (agency) by 15 minute units	42	53
Personal Emergency Response (install)	29	29
Financial Management Services	30	25

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://hhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services

- by Member Usage

	SFY23 Q2	SFY23 Q3
AIDS/HIV - Waiver Member Count	8	8
Home Delivered Meals	8	7
CDAC (agency) by 15 minute units	3	3
CDAC (individual) by 15 minute units	0	1
Brain Injury (BI) Waivers	519	529
Supported Community Living (by unit)	214	199
Personal Emergency Response	150	143
Supported Community Living (daily)	121	120
Transportation (1-way trip)	87	91
Respite (by 15 minute units)	87	85
Children's Mental Health (CMH)	385	388
Respite (by 15 minute units)	243	255
Respite (Hos/NF) - 15 minute units	163	159
Family and Community Support	113	106
Mental Health Service	0	46
Respite (Resident Camp) by units	14	13
Elderly Waivers	3,569	3,687
Personal Emergency Response	2,650	2,723
Home Delivered Meals	2,621	2,718
CDAC (agency) by 15 minute units	1,343	1,404
Homemaker (by 15 minute units)	720	727
CDAC (individual) by 15 minute units	612	652

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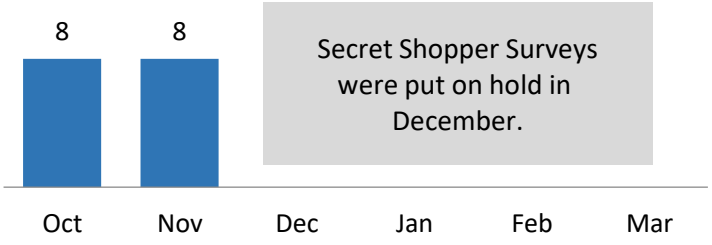
	SFY23 Q2	SFY23 Q3
Habilitation (Hab)	2,410	2,500
Home-based Habilitation	1,908	1,936
Day Habilitation (by 15 minute units)	373	394
Day Habilitation (units by day)	298	311
Long Term Job Coaching	271	275
Individual Supported Employment	134	132
Health & Disability (HD)	587	597
Respite (by 15 minute units)	201	196
Home Delivered Meals	152	158
Personal Emergency Response	139	144
CDAC (individual) by 15 minute units	97	100
CDAC (agency) by 15 minute units	96	94
Intellectual Disability (ID)	4,466	4,527
Day Habilitation (by 15 minute units)	1,691	1,695
Supported Community Living (by unit)	1,716	1,676
Day Habilitation (units by day)	1,550	1,541
Supported Community Living (RCF)	1,195	1,200
Supported Community Living	942	930
Physical Disability (PD)	403	423
Personal Emergency Response	225	231
CDAC (agency) by 15 minute units	176	175
CDAC (individual) by 15 minute units	126	129
Transportation (1-way trip)	42	48
Personal Emergency Response (install)	30	33

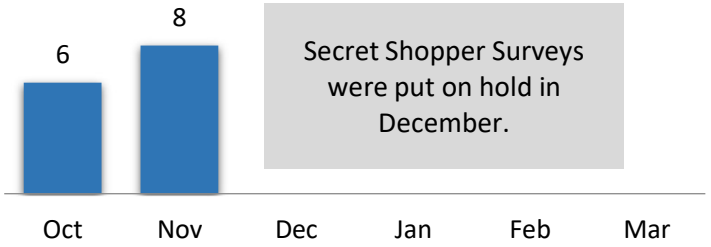
Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	99.36%	98.68%	95.55%
Abandonment Rate - Must be 5% or less	0.20%	0.31%	0.28%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	97.29%	97.42%	99.63%
Abandonment Rate - Must be 5% or less	0.08%	0.30%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	98.15%	95.25%	89.36%
Abandonment Rate - Must be 5% or less	0.12%	0.17%	0.52%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	94.60%	93.60%	92.94%
Abandonment Rate - Must be 5% or less	0.06%	0.15%	0.43%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	82.28%	86.51%	89.22%
Abandonment Rate - Must be 5% or less	2.76%	0.85%	0.77%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

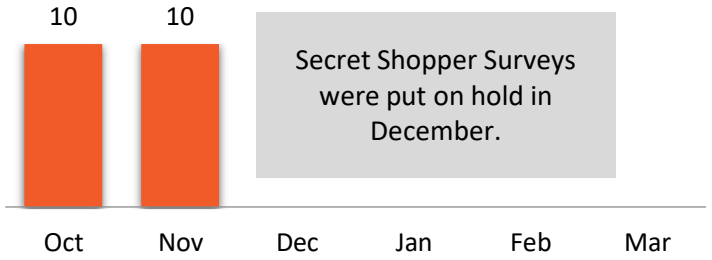
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Transportation Inquiry
5.	Claim Inquiry

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

Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	91.56%	92.48%	90.96%
Abandonment Rate - Must be 5% or less	3.06%	3.05%	3.57%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	86.48%	91.62%	90.63%
Abandonment Rate - Must be 5% or less	0.89%	1.36%	0.98%
Provider Helpline			
Service Level (Requirement 80%)	90.68%	92.41%	92.70%
Abandonment Rate - Must be 5% or less	0.82%	0.84%	0.79%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	91.65%	90.36%	91.28%
Abandonment Rate - Must be 5% or less	0.50%	0.47%	0.51%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	84.30%	91.84%	90.02%
Abandonment Rate - Must be 5% or less	1.39%	0.57%	0.59%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline

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

	Top 5 Call Reasons (Member Helpline)
1.	Benefits and Eligibility for Member
2.	Update Preference for Member
3.	Coordination Of Benefits for Member
4.	Update PCP
5.	Member Rewards for Member

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

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
Adults PCP				
Provider Count	6,893	7,093	7,374	6,966
Members with Access	237,584	238,093	237,553	237,034
Average Distance (Miles)	1.8	1.8	1.8	2.0
Pediatric PCP				
Provider Count	6,924	7,124	7,405	6,997
Members with Access	214,390	213,457	212,349	211,612
Average Distance (Miles)	1.9	1.9	1.9	2.2

Specialty Care & Behavioral Health (BH)

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
OB/GYN Adult				
Provider Count	423	440	462	487
Members with Access	154,186	154,298	154,103	154,071
Average Distance (Miles)	5.5	5.5	5.4	5.3
Outpatient - Behavioral Health				
Provider Count	4,543	4,679	4,880	5,314
Members with Access	451,974	451,550	449,902	448,646
Average Distance (Miles)	2.2	2.2	2.2	1.9
Inpatient - Behavioral Health				
Provider Count	51	53	56	56
Rural Members				
Members with Access	184,359	184,040	183,139	182,392
Average Distance (Miles)	21.0	18.8	18.8	26.4
Urban Members				
Members with Access	267,615	267,510	266,763	266,254
Average Distance (Miles)	5.8	5.7	5.5	5.7

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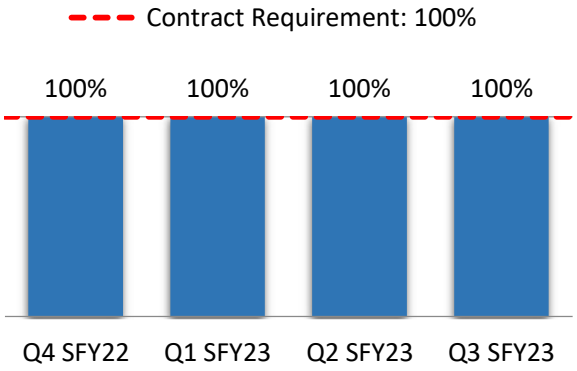
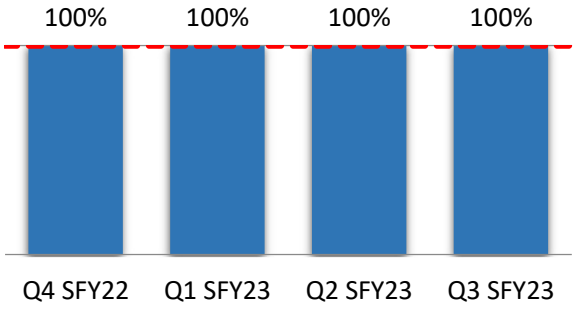
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

Provider Network Access Summary

Primary Care Providers (PCP)

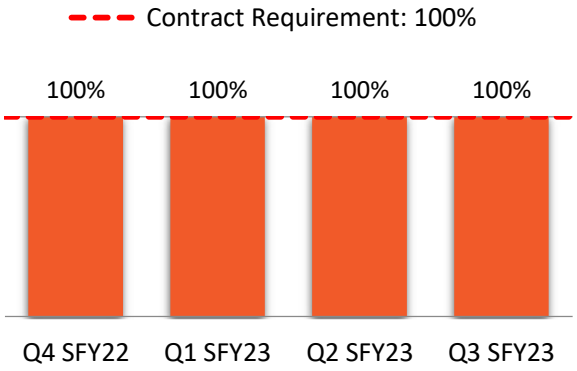
	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
Adults PCP				
Provider Count	9,894	9,894	9,894	7,771
Members with Access	189,029	196,756	206,246	216,380
Average Distance (Miles)	2.0	2.0	2.0	2.2
Pediatric PCP				
Provider Count	10,658	10,658	10,658	8,375
Members with Access	147,665	151,411	155,500	160,395
Average Distance (Miles)	2.1	2.1	2.1	2.3

Specialty Care & Behavioral Health (BH)

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
OB/GYN Adult				
Provider Count	1,298	1,298	1,298	751
Members with Access	123,122	127,515	133,013	138,628
Average Distance (Miles)	5.4	5.3	5.3	6.1
Outpatient - Behavioral Health				
Provider Count	9,688	9,688	9,688	5,114
Members with Access	336,694	348,179	361,746	376,790
Average Distance (Miles)	2.5	2.5	2.4	3.0
Inpatient - Behavioral Health				
Provider Count	36	36	36	26
Rural Members				
Members with Access	241,452	249,950	259,591	270,380
Average Distance (Miles)	24.5	24.4	24.4	21.9
Urban Members				
Members with Access	95,242	98,229	102,155	106,410
Average Distance (Miles)	8.4	8.4	8.4	3.6

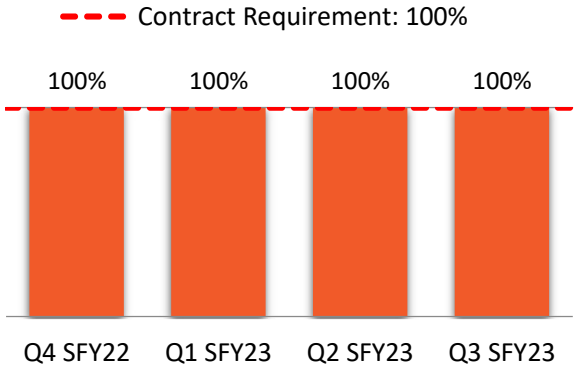
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

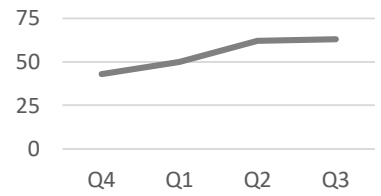
MCO Program Integrity

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

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

Total Investigations Opened in SFY23 Q3

63



6 Total Cases
Referred to MFCU Q3

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	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Investigations opened	25	36	41	47	37	149
Overpayments identified	10	14	8	25	14	57
Member concerns referred to IME	4	2	2	3	3	11
Cases referred to the Medicaid Fraud Control Unit (MFCU)	2	3	9	6	5	20

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	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Investigations opened	18	14	21	16	17	69
Overpayments identified	6	19	21	5	13	51
Member concerns referred to IME	4	4	4	3	4	15
Cases referred to the Medicaid Fraud Control Unit (MFCU)	0	2	6	0	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://hhs.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://hhs.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://hhs.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://hhs.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
Brandon Hagen, 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
Mary Nelle Trefz, 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…

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

MAAC Council Member List continued...

Professional and Business Entities

Molly Lopez, Iowa Chiropractic Society
Laurie Traetow, Iowa Dental Association
Carlyn Crowe (or Brooke Lovelace - back-up), 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://hhs.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://hhs.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