



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:

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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.

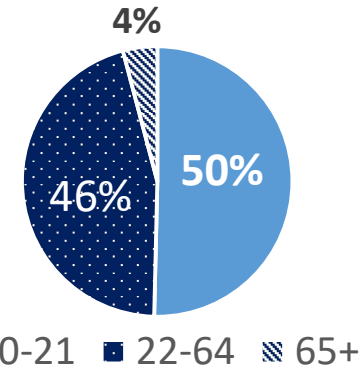
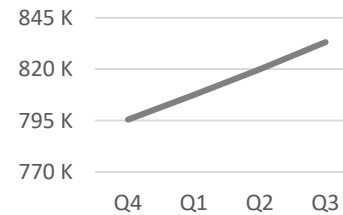
MCO Member Summary - All MCO Counts

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.

All MCO Members

833,203



+ 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 <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>	Iowa Medicaid Population		917,009		
<i>If Yes, explain:</i>						1 year distinct count	
<ul style="list-style-type: none"> o MCO Market Share > All new members are being assigned to Iowa Total Care prior to Molina implementation 							

MCO Member Summary



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



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)	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

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

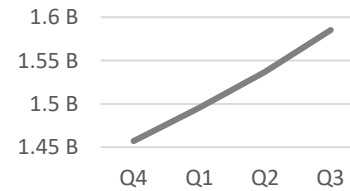
¹ Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24. ² Facility Based Services listed above only include the institutional groups where members are most likely to have an option 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.

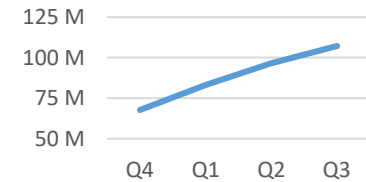
The MCOs are responsible for recovering Medicaid dollars when it is determined that other insurance coverage is available (e.g. health, auto, worker's comp, or even Medicare). This process is known as Third Party Liability (TPL). The MCO retains all recovered TPL funds: however, these funds are then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

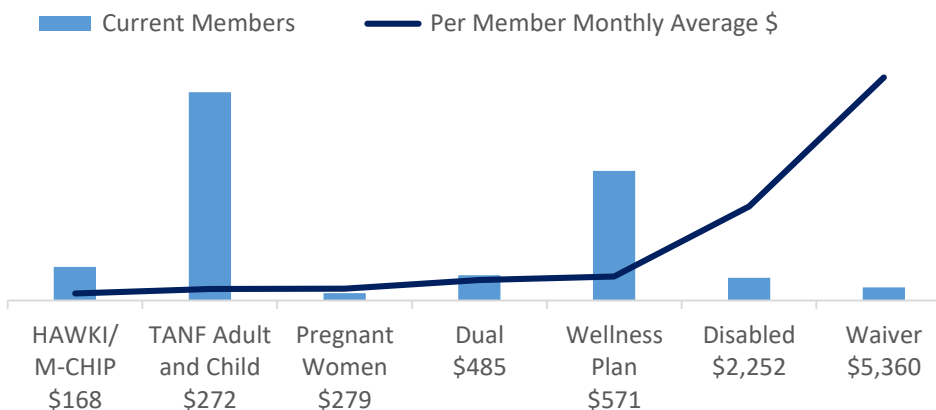
	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Financial Summary						
Capitation Payments	\$1.46 B	\$1.5 B	\$1.54 B	\$1.59 B	\$1.52 B	\$6.07 B
Third Party Liability (TPL) Recovered	\$67.7 M	\$83.1 M	\$96.4 M	\$107.3 M	\$88.6 M	\$354.5 M
Significant Change in Data? (+/-)	No	<input checked="" type="checkbox"/>	Yes	<input type="checkbox"/>		
<i>If Yes, explain:</i>						

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



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 MLR⁵		94.9%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	Y



SFY23 Q2 | SFY23 Q3

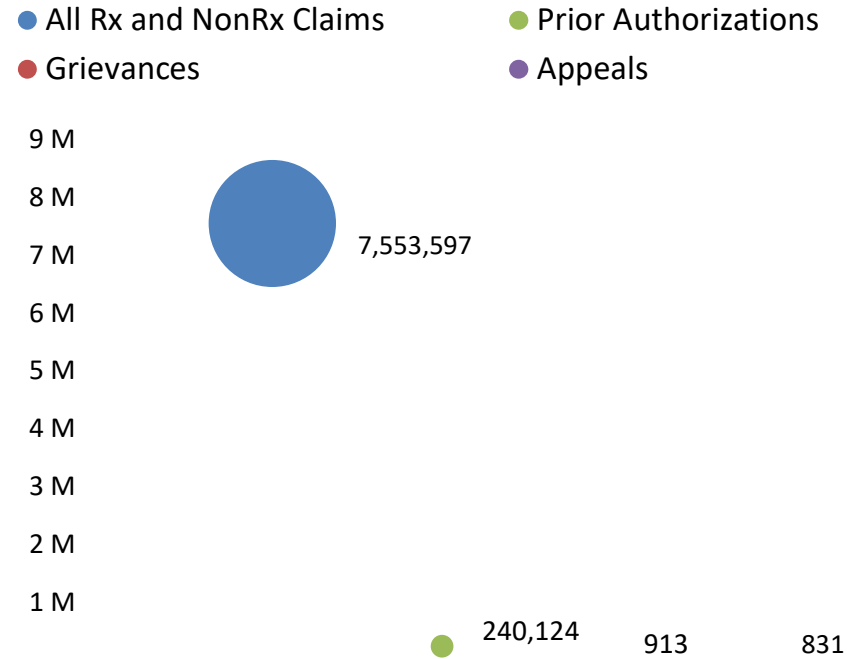
Capitation Totals	\$678.99 M	\$721.06 M
Adjustments	\$2.81 M	\$12.15 M
Current	\$647.12 M	\$671.86 M
Retro	\$29.07 M	\$37.06 M
Third Party Liability (TPL)	\$72.5 M	\$86.5 M
Financial Ratios		
Medical Loss Ratio (MLR)	97.1%	97.6%
Administrative Loss Ratio (ALR)	5.3%	5.9%
Underwriting Ratio (UR)	-2.4%	-3.5%
Unreconciled SFY MLR⁵		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

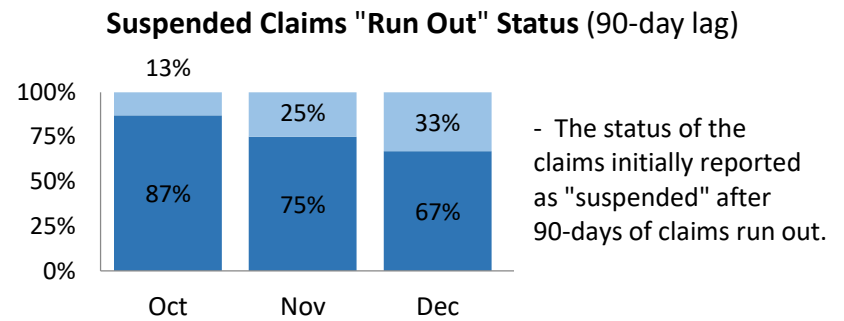
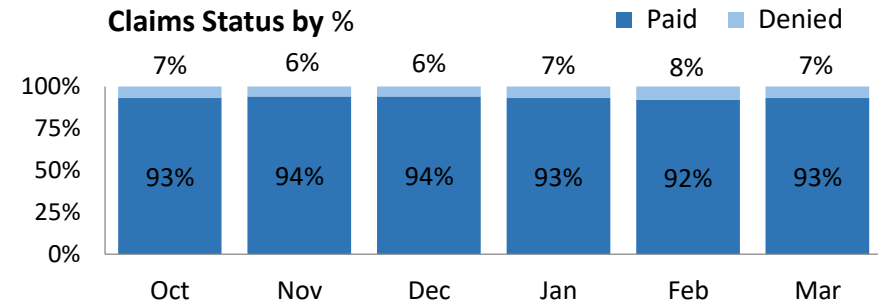
Claims Summary (Non-Pharmacy)

2.44 Million
Claims Paid & Denied



	Jan	Feb	Mar
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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%



Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
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

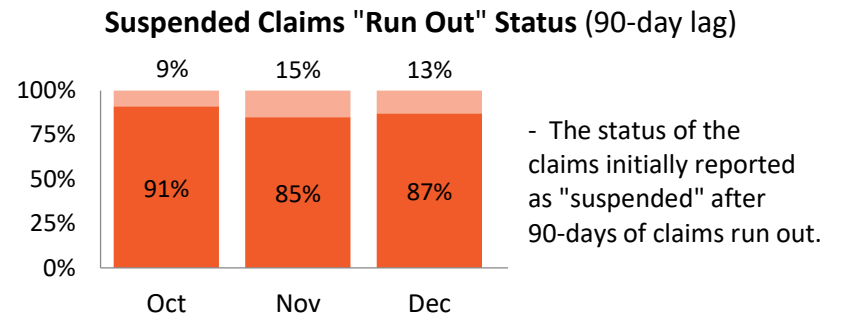
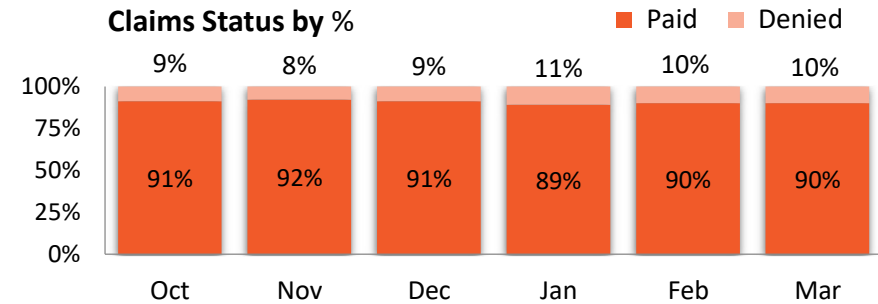
Claims Summary (Non-Pharmacy)

1.86 Million
Claims Paid & Denied



	Jan	Feb	Mar
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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%



Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
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

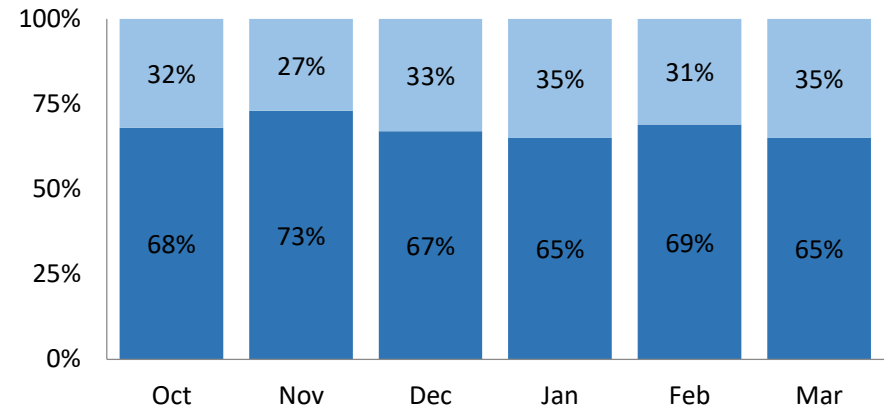
Claims Summary (Pharmacy)



1.76 Million
Claims Paid & Denied

Claims Status by %
■ 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)

	%	Reason
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)

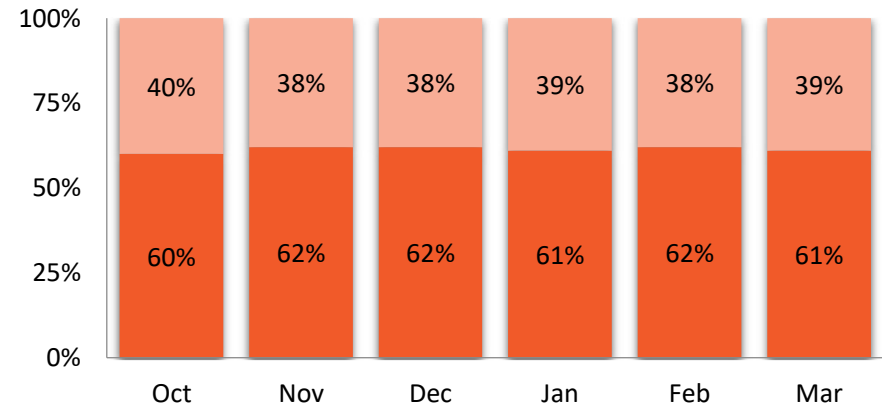


1.49 Million
Claims Paid & Denied

	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

Claims Status by %

■ Paid ■ Denied



Top 10 Reasons for Claims Denials (Pharmacy)

	%	Reason
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

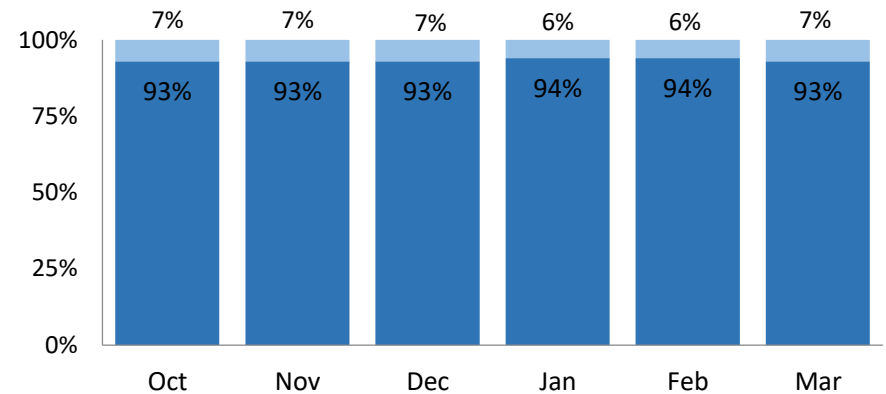
Non-Pharmacy

	Jan	Feb	Mar
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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

■ Approved ■ Modified ■ Denied



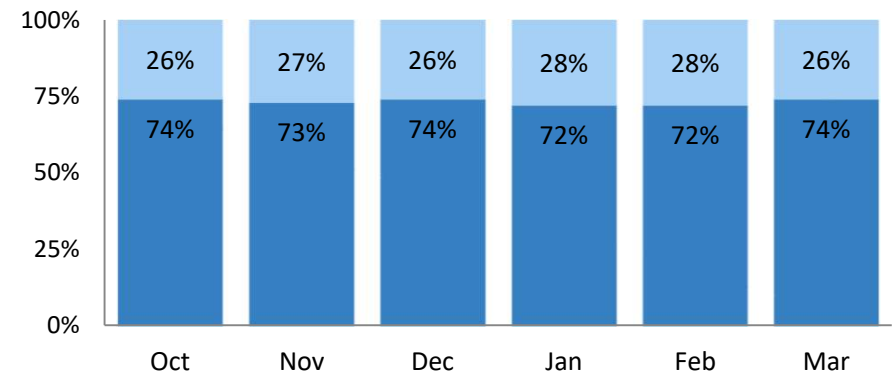
Pharmacy

	Jan	Feb	Mar
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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

■ Approved ■ Denied



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



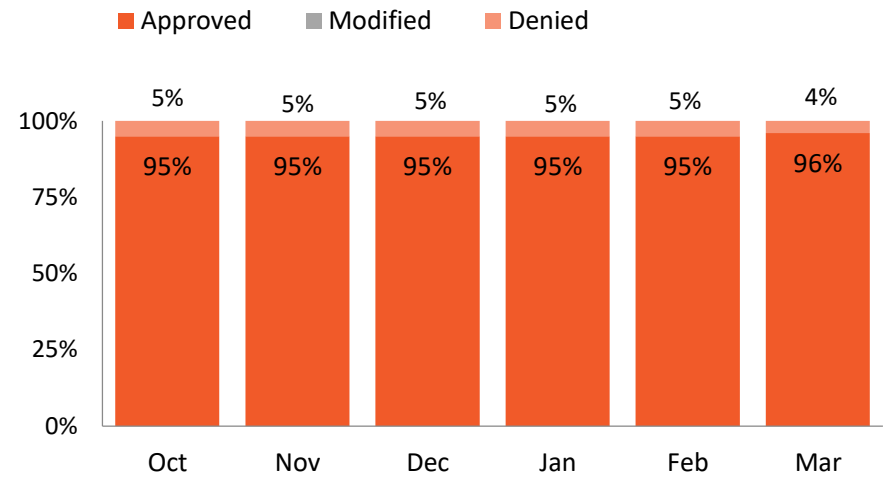
147,747

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	100%	100%	100%
in 14-days (Requirement 99%)			
Expedited PAs Completed	100%	99%	99%
in 72-hours (Requirement 99%)			

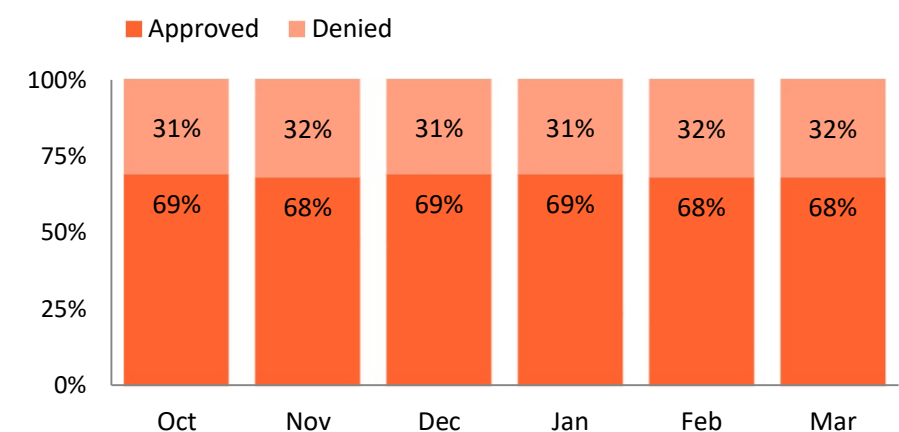
Non-Pharmacy by Percentage



Pharmacy

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

Pharmacy by Percentage



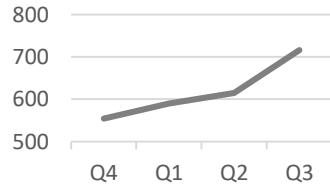
⁶ Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals



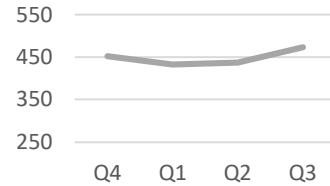
Standard Grievances

716



Standard Appeals/ 1st Level Review

473

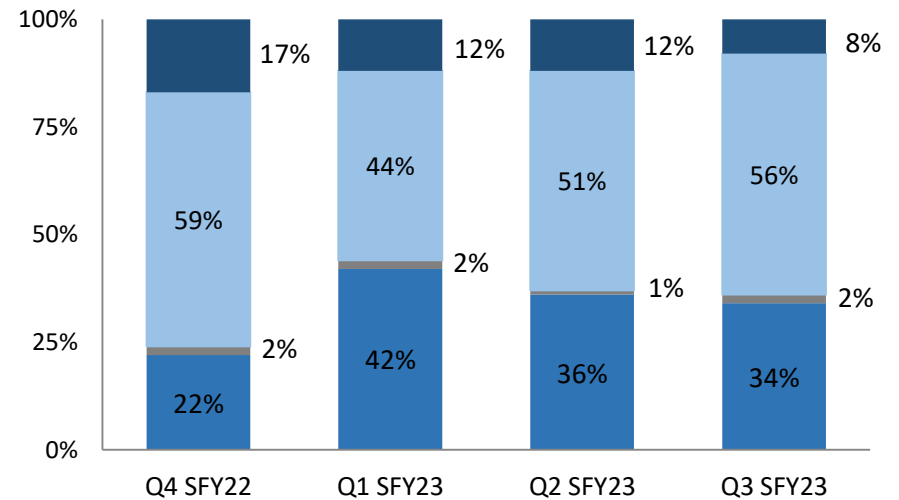


**Resolved in 30-days
100%**

**Resolved in 30-days
100%**

■ Withdrawn ■ Upheld
■ Partially Overturned ■ Overturned

Standard Appeal Outcome %



Top 10 Reasons for Grievances ⁷

	%	Reason
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

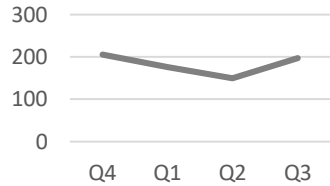
	%	Reason
	28%	Pharmacy - Non Injectable
	18%	DME
	13%	Pharmacy - Injectable
	12%	Outpatient Services - Medical
	6%	Surgery
	4%	Inpatient - Medical
	3%	Therapy OT/PT
	3%	Radiology
	3%	Pain Mgmt
	2%	BH - Inpatient

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

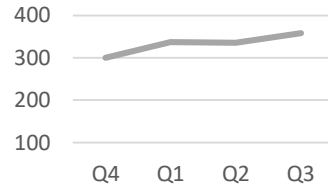


Resolved in 30-days

99%

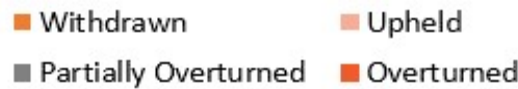
Standard Appeals/ 1st Level Review

358

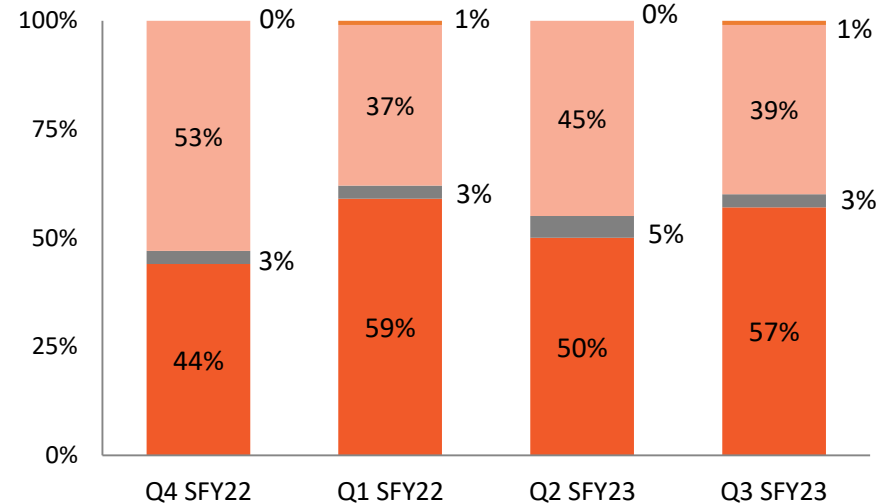


Resolved in 30-days

100%



Standard Appeal Outcome %



Top 10 Reasons for Grievances ⁷

	%	Reason
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

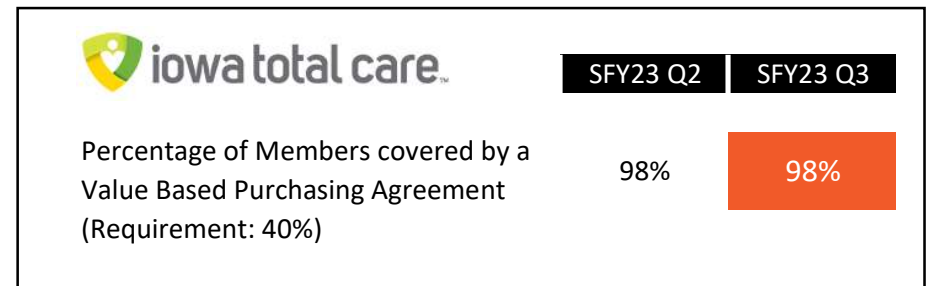
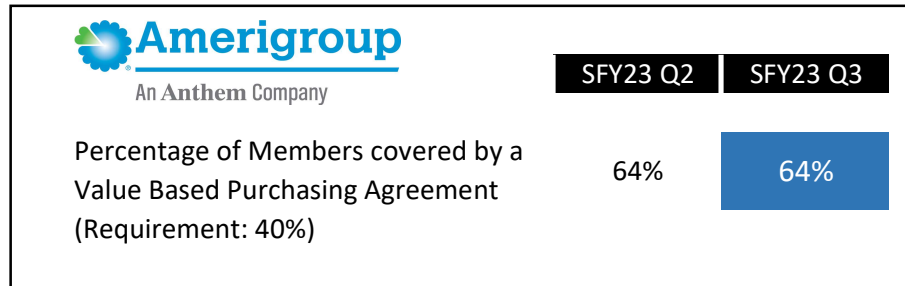
	%	Reason
	26%	RX - Does Not Meet Prior Auth Guidelines
	6%	DME - Wheelchair - Not Medically Necessary
	5%	Rehabilitation/Therapy - Physical Therapy
	3%	Injection - Self Injectibles - Not Medically Necessary
	2%	Therapy - Occupational Therapy - Not Medically Necessary
	2%	Diagnostic - MRI - Not Medically 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.

MCO Care Quality and Outcomes

Value Based Purchasing (VBP) Agreement

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



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

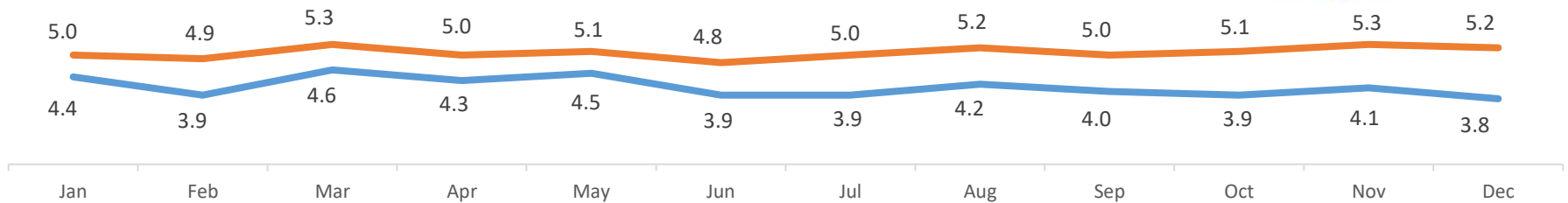
	SFY23 Q2	SFY23 Q3
Healthy Rewards	6,574	10,158
Taking Care of Baby and Me	2,145	2,130
Community Resource Link	1,977	1,587
SafeLink Mobile Phone	2,613	1,050
Dental Hygiene Kit	514	568

iowa total care.

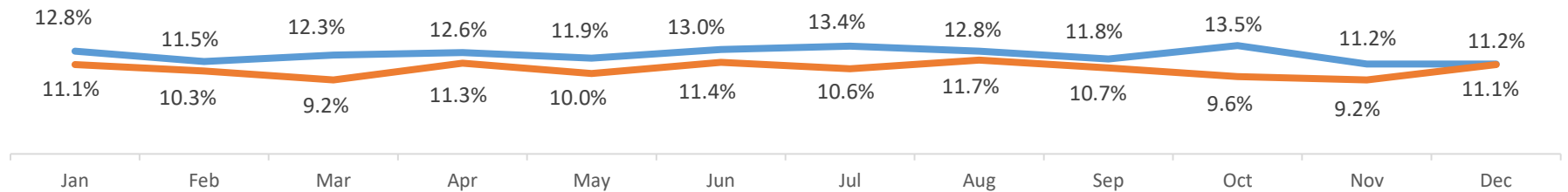
	SFY23 Q2	SFY23 Q3
My Health Pays Program	12,676	9,596
The Flu Program	14,212	6,132
Mobile App	1,831	2,080
Start Smart for Your Baby	1,743	2,000
SafeLink Phones	662	1,198

MCO Care Quality and Outcomes

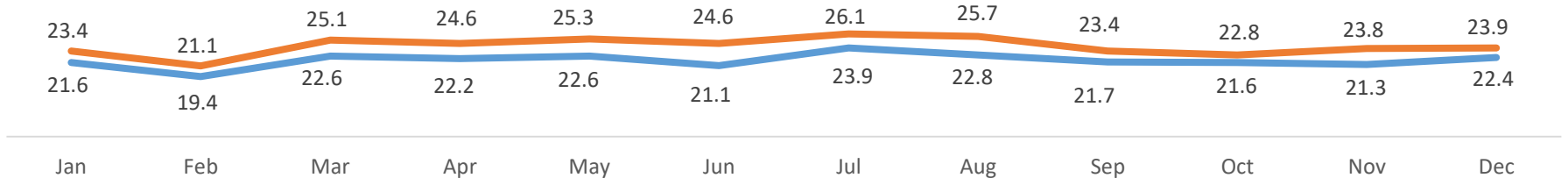
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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).

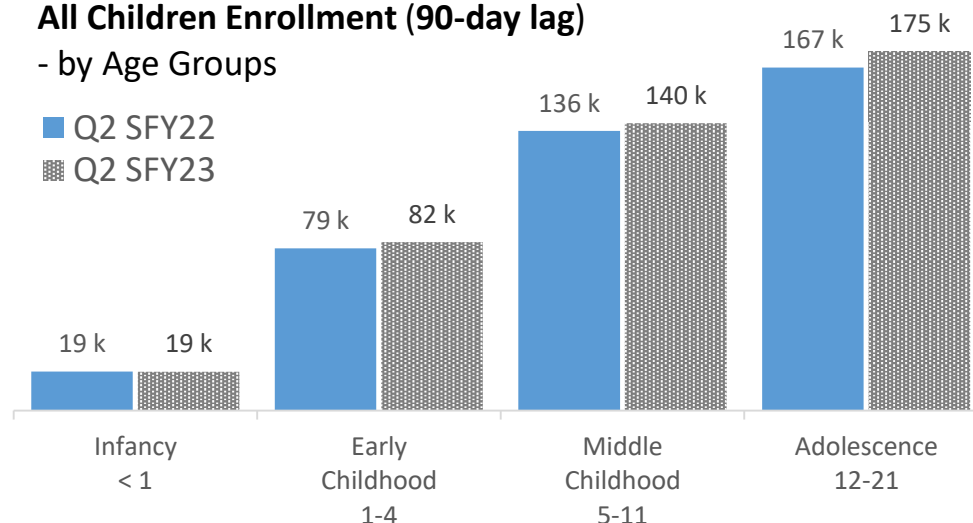


SFY22 Q2 **SFY23 Q2**

	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

All Children Enrollment (90-day lag)

- by Age Groups



SFY22 Q2 **SFY23 Q2**

	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



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



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



Substance Use Disorder (SUD) Summary

SFY22 Q2 **SFY23 Q2**

	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



Substance Use Disorder (SUD) Summary

SFY22 Q2 **SFY23 Q2**

	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**

	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

Severe Emotional Disturbance (SED) for Children Summary

SFY22 Q2 **SFY23 Q2**

	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



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 Services¹¹	5,632	5,415
Middle Childhood 5 - 11	1,502	1,530
Adolescence 12 - 21	4,130	3,885



SFY22 Q2 SFY23 Q2

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 Services¹¹	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.

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management



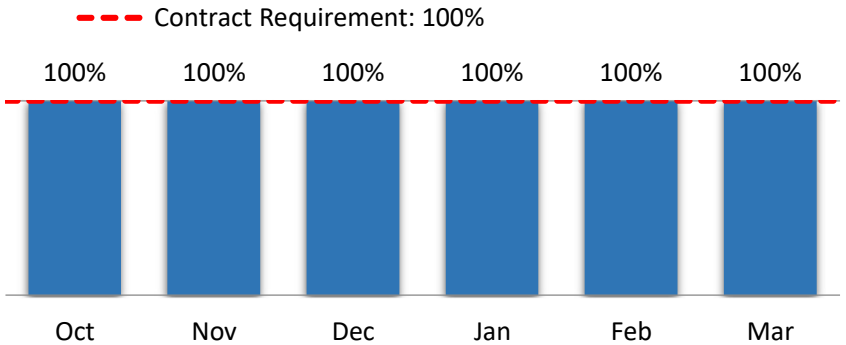
Average Number of Contacts Per Month	SFY23 Q2	SFY23 Q3
by Care Coordinators	2.0	2.0
by Case Managers	1.0	1.0
"Members to" Ratios		
Members to Care Coordinators	12	15
HCBS Members to Case Managers	76	67

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.

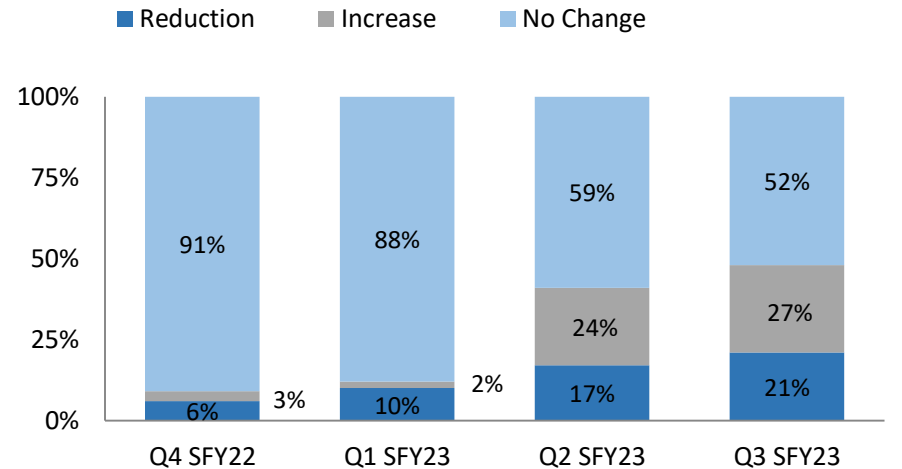
Iowa Participant Experience Survey (IPES)

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



Long Term Services - Care Quality and Outcomes

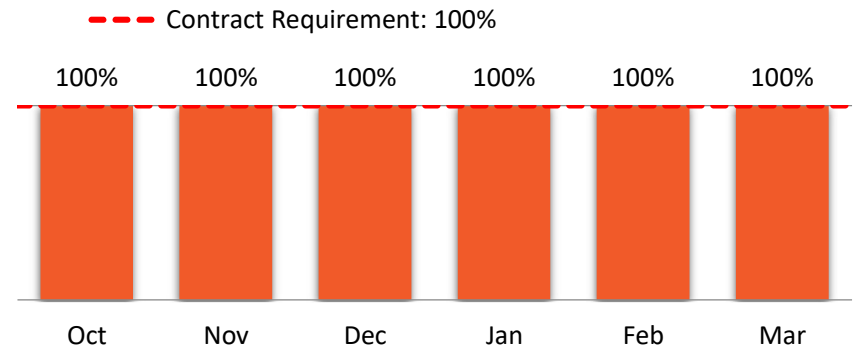
Non-LTSS Care Coordination and HCBS Case Management



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

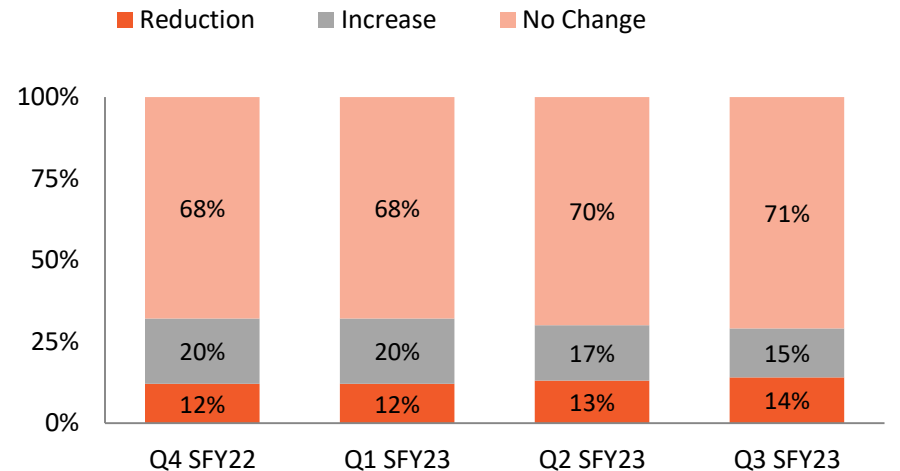
Percentage of Level of Care (LOC) Reassessments Completed Timely



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%

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		SFY23 Q2	SFY23 Q3
AIDS/HIV - Waiver Member Count	25	26	Habilitation (Hab)	4,076	4,148
Home Delivered Meals	18	18	Home-based Habilitation	3,381	3,389
CDAC (agency) by 15 minute units	1	2	Long Term Job Coaching	386	389
Financial Management Services	2	2	Day Habilitation (units by day)	333	326
Adult Day Care Services - full day	1	2	Day Habilitation (by 15 minute units)	157	161
CDAC (individual) by 15 minute units	3	1	Individual Supported Employment	204	122
Brain Injury (BI) Waivers	755	755	Health & Disability (HD)	1,357	1,349
Supported Community Living (by unit)	199	205	Respite (by 15 minute units)	397	419
Financial Management Services	199	200	Financial Management Services	347	338
Personal Emergency Response	171	171	Personal Emergency Response	321	322
Respite (by 15 minute units)	151	153	Home Delivered Meals	312	308
Supported Community Living (daily)	115	119	Respite (Hos/NF) - 15 minute units	57	61
Children's Mental Health (CMH)	799	797	Intellectual Disability (ID)	6,899	6,930
Respite (by 15 minute units)	445	456	Supported Community Living (by unit)	1,822	1,855
Respite (Hos/NF) - 15 minute units	236	235	Supported Community Living (RCF)	1,514	1,525
Family and Community Support	193	187	Day Habilitation (units by day)	1,321	1,322
Respite (Resident Camp) by units	21	19	Supported Community Living (daily)	1,193	1,211
Home Delivered Meals	2	3	Financial Management Services	1,150	1,115
Elderly Waivers	4,027	3,925	Physical Disability (PD)	569	562
Personal Emergency Response	2,746	2,692	Personal Emergency Response	320	314
Home Delivered Meals	2,724	2,627	CDAC (individual) by 15 minute units	37	58
CDAC (agency) by 15 minute units	345	334	CDAC (agency) by 15 minute units	42	53
Assisted Living Services	317	316	Personal Emergency Response (install)	29	29
Personal Emergency Response (install)	251	221	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

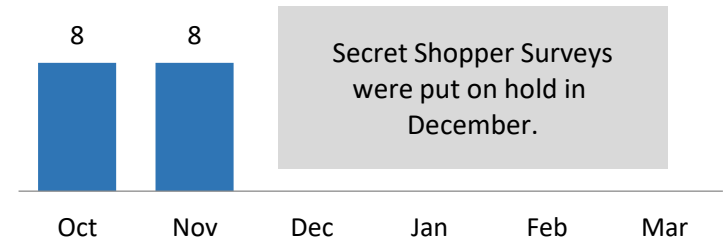
	SFY23 Q2	SFY23 Q3
Habilitation (Hab)	2,410	2,500
Home-based Habilitation	1,908	1,936
Day Habilitation (by 15 minute units)	373	394
Day Habilitation (units by day)	298	311
Long Term Job Coaching	271	275
Individual Supported Employment	134	132
Health & Disability (HD)	587	597
Respite (by 15 minute units)	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



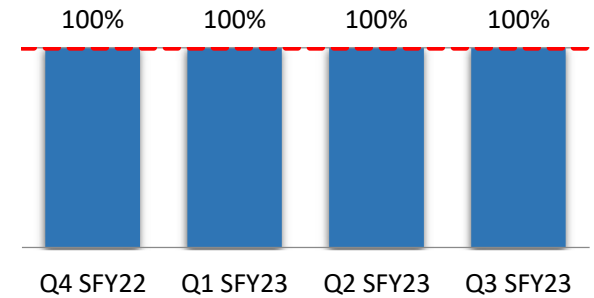
Primary Care Providers (PCP)

	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

Adult PCP - Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



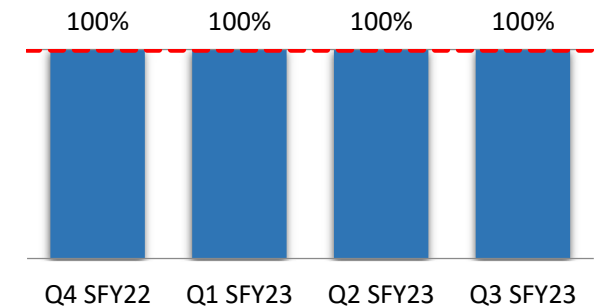
Specialty Care & Behavioral Health (BH)

	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

Pediatric PCP - Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



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

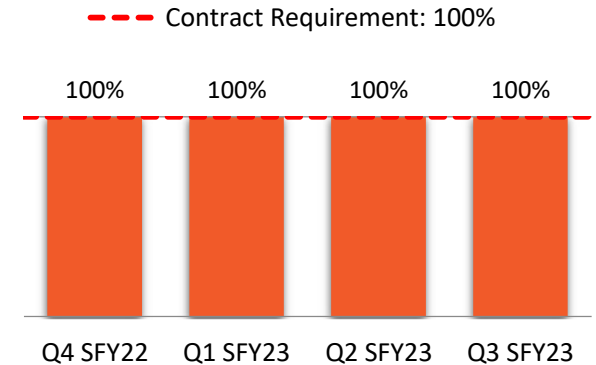
Specialty Care & Behavioral Health (BH)

	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



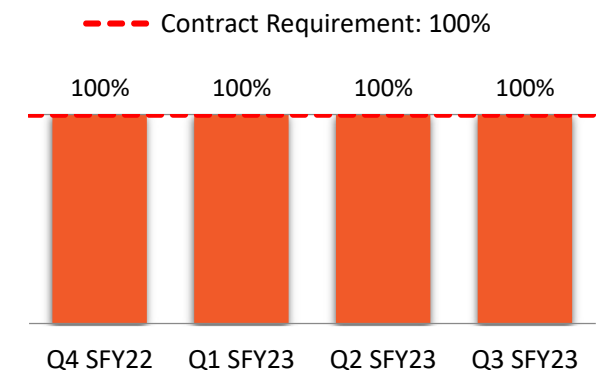
Adult PCP - Standards

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>

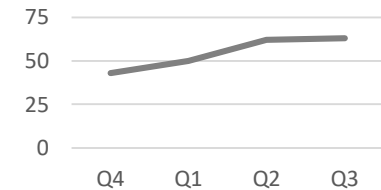
MCO Program Integrity

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



	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



	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:**
 - o Claims where the provider may request a reopening to fix clerical errors or billing errors
 - o 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 lowans 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, Brain 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 Bolcom
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 oversight 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:

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