Medical Assistance Advisory Council

MATERIALS JUNE 26, 2023

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

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	June 26, 2023 — TIME: 1:00 PM
LOCATION	Virtual (Zoom): https://www.zoomgov.com/j/1603360604

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 Quarterly Report Quarter 2 State Fiscal Year 2023	Kurt Behrens, Iowa Medicaid	30 minutes	https://hhs.iowa.gov/sites/default/files/Q2_SFY2023-Report-FINAL_3.21.2023.pdf
4. Dental Quality Strategy Report	Katie McBurney	15 minutes	
5. PHE Unwind Update	Anna Casteel and Allison Scott	10 minutes	
6. Medicaid Director's Update	Liz Matney, Medicaid Director	20 minutes	
7. Implementation Update from Molina Healthcare	Jennifer Vermeer, Molina Plan President	10 minutes	
8. Managed Care Plan (MCP) Updates	Stacie Maas, Iowa Total Care John McCalley, Amerigroup	10 minutes, each	
9. MAAC Professional and Business Entity Election 2023	Mike Kitzman, Iowa Medicaid	10 minutes	

10. Open Comment			

Medical Assistance Advisory Council

MEETING MINUTES
MARCH 23, 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 not achieved.

APPROVAL OF PREVIOUS MEETING MINUTES

Approval of the minutes from the November 17, 2022 meeting will be held until the next meeting of the council.

MANAGED CARE ORGANIZATION (MCO) QUARTERLY REPORT AND MEDICAID DASHBOARD

Kurt Behrens, Iowa Medicaid, reviewed the MCO Quarterly Report for Q1 SFY 23. Kurt stated that all the information available in the quarterly report will be available in some form in the Medicaid Dashboard on the Department's website.

Enrollment in the managed care program increased between Q4 SFY 2022 and Q1 SFY 2023 by 1.5 percent, or around 11,906 members for a total of 807,413 members. The fee-for-service (FFS) program had a similar increase of around 1.4 percent (683 members), for a total of 48,623 members in FFS. During this period the Department assigned new members to Iowa Total Care to try and balance the market share between the two MCOs in preparation for the onboarding of Molina Healthcare, Inc. later this year. When Molina enters the program officially on July 1, 2023, members will have been distributed as equally as possible between the three MCOs.

The financial summary shows an increase in population correlates to an increase in capitation payments to the MCOs. Third-party liability (TPL) funds recovered by the MCOs increased by 22.8 percent, from $67.7 million to $83.1 million. Both MCOs missed a monthly target for processing 100 percent of prior authorizations within 24 hours, each MCO missing this target for a single month by less than a percent.

Information from the Children Summary section of the report will be available on the new Outcomes page of the dashboard. The current version of the report shows a comparison of one year in the past, and the dashboard will allow multiple years of data to be compared, showing trends over time. New sections for the Children Summary show Behavioral and Mental Health Treatment and Services. Kurt said these sections will effectively have "mini" substance use disorder (SUD) and severe emotional disturbance (SED) dashboards; showing information of the first and second diagnoses, for a range of conditions, gathered from claims data.

The long-term services and supports (LTSS) section of the report shows information related to waiver services. Kurt said the Department will be adding more questions to the Iowa Participant Experience Survey (IPES) section when the report transitions into a dashboard. The LTSS areas of the dashboard

will have information on the timeliness of assessments and services used, broken down by labor. Kurt explained that this information, as it appears on the report as present illustrates the number of members utilizing the service, for example page 25 of the report shows 2,742 home delivered meals; this is the number of members utilizing this service, and not a count of individual meals delivered to members' homes.

Angie praised the report and the dashboard; stating that historically data has been the focus of the council's discussions, and that since Kurt has joined the organization the council has been able to shift its focus to other matters.

Kurt said that a lot of what is included in the report and dashboard is driven by requests from the legislature and raised the idea of the council making a formal recommendation to the legislature to officially adopt the dashboard format. Director Matney agreed with this idea, adding that the council would likely be able to provide such a recommendation to the legislature during next year's legislative session. Angie asked that agenda items be added to upcoming meetings for a thorough walkthrough of the dashboard once it launches, and a discussion of making a formal recommendation to the legislature to officially adopt the dashboard format.

Director Matney stated that while Kurt and the Bureau of Managed Care Reporting and Oversight are preparing the dashboard for launch, she is encouraging the team to think about the next update to the dashboard. Asking them to consider how the dashboard could focus on outcomes rather than processes.

Kady Reese, Iowa Medical Society, asked if there were any proposed outcome measures identified, and if these could be shared with provider networks to inform the work they do. Director Matney said that these have not yet been identified, adding that her team would appreciate feedback from this group and other stakeholders about what kind of targets they'd like to see.

MEDICAID DIRECTOR'S UPDATE

Director Matney reminded the council of town halls will be held immediately following the council's meeting. Town halls for members occur every two weeks, providers have a town hall once a month. The cadence of these town halls is working well, especially with the big events going on at Medicaid, the onboarding of Molina Healthcare and the end of the federal public health emergency (PHE).

There have been reports of some providers sending notices to members saying their Medicaid coverage will end on April 1, 2023; Director Matney said that this is not the intent of the end of the continuous coverage requirement and the PHE unwind. Members do need to go through a redetermination process, but this does not necessarily mean they will lose their Medicaid coverage, and coverage for individuals will not automatically end on April 1, 2023. Liz asked the council to make sure their fellow providers and stakeholders amplified accurate information to the public.

In previous meetings Dr. Beeman raised concerns about the composition of the council. The Department is working with necessary entities including entities that are appointing members to the board. Director Matney stated that she would be following up with Dr. Beeman to discuss issues with

pecuniary interest. Some positions on the council will be opening for appointment later this calendar year.

Director Matney discussed work the Department has been undertaking to review provider reimbursement rates and communicate recommended rate increases to the legislature. This rate review has three main components: medical provider rates, residential substance use provider rates, and dental rates. Benchmarks for rates included Medicare and Medicaid programs in surrounding states. Liz cited Mental and Behavioral Health as areas of specific interest in the rate review.

IMPLEMENTATION UPDATE FROM MOLINA HEALTHCARE

Jennifer Vermeer, Plan President Molina Healthcare (Molina), gave an update on the implementation of Molina Healthcare. Jennifer gave some background on Molina as a company, starting as a neighborhood clinic, the company has managed care contracts in 20 states, Medicaid accounts for about 85 percent of Molina's business. Molina has already completed one phase of provider claims testing and will shortly begin a second phase.

Jennifer said that most of her leadership team has been in place since October of 2022, and they have been busy building out the infrastructure for Molina's plan since then. Jennifer said the plan is paying particularly close attention to their claim's configuration. Molina is working hard to build out their network of providers; Jennifer says she believes most providers in Iowa should have received a contract packet from Molina and asked anyone on the call who has not received a packet to contact her.

MANAGED CARE PLAN (MCP) UPDATES

Delta Dental of Iowa (DDIA)

Nicole Miller, DDIA, provided an update, starting by noting DDIA's access rate for Dental Wellness Plan (DWP) adults is 24 percent; and DDIA's access rate for DWP kids is 46 percent; DDIA's access rate for Hawki kids is 57 percent. DDIA is sending dental kits to 19- and 20-year-old members enrolled in the DWP. The kit includes a toothbrush and toothpaste, as well as general information about oral health. The information in the kit also includes instructions for finding a dentist and contacting DDIA if the member needs assistance finding a provider or coordinating care. DDIA has a second project for children in the DWP and Hawki programs, with the intent to increase fluoride treatments in this population. DDIA is working with a tele-dentistry company, starting by sending a dental kit very similar to the first one mentioned. The kit includes a QR code to schedule an appointment once a fluoride kit has been sent to the member's house. The member and parents or guardians will meet virtually with a licensed dentist and apply the fluoride on the call with the dentist.

The DDIA Foundation provides educational loan repayment assistance to dentists through their program Fulfilling Iowa's Need for Dentists (FIND). Nicole highlighted a recent recipient of this assistance: Dr. Daniel Binkowski in Story City, IA. Dr. Binkowski will receive $125,000 in return for a five-year commitment to serve the patients in his local community. The DDIA Foundation has also provide a $150,000 grant to Center Associates in Marshalltown, IA. Center Associates provides high quality and comprehensive mental health services to the residents of Marshall and Hardin counties.

MCNA

Kendra Aracena, MCNA Dental, provided an update. MCNA has updated their fee schedules to a minimum of 110 percent of the state Medicaid fee schedule for all services for dates of service starting October 1, 2022. Additionally, MCNA wants to target preventive services, so these services now reimburse at 120 percent of the state Medicaid fee schedule.

Kendra then addressed MCNA's value-based payment programs. The first program pays providers a ten-dollar incentive for ensuring continuity of care through timely recall visits. Providers receive an additional ten dollars when they see an MCNA patient between 175 and 235 days from the members first exam. The second value-based payment rewards providers for establishing a dental home. MCNA's data analysis shows that many members seek episodic oral health care and do not return for routine periodic care. MCNA wants to recognize and reward providers for establishing a dental home for these members. Providers who conduct a comprehensive patient exam or a comprehensive periodontal exam receive a 20-dollar reward from MCNA.

Iowa Total Care

Stacie Maass gave an update for ITC. Stacie began by discussing the end of continuous coverage requirements as part of the PHE. Ending these requirements is a big project requiring intensive collaboration between ITC, Iowa Medicaid, Amerigroup, MCNA, DDIA and Molina. Stacie turned to discussing ITC programs addressing social determinants of health (SDOH). ITC has developed a data dashboard showing analysis of information related to SDOH: mental health access, medical access, domestic abuse, housing, employment, food safety. ITC is trying to track these needs in their member population and assess what programs they can implement to address these issues outside the regular Medicaid program. ITC has resource specialists that help locate housing and employment resources for members.   highlighting the ongoing work to plan the transition out of the PHE. ITC is working on implementing the rate increases passed during the spring legislative session. ITC is collaborating with Iowa Medicaid to distribute American Rescue Plan Act (ARPA) funds to providers. ITC continues to participate in regular meetings discussing operational and strategic ways to improve the Medicaid program, address work force issues and members access to services. Stacie discussed the work of ITC's quality team, both internally and in public facing settings. A major goal of the quality team is to improve member health outcomes. Part of this work is ITC's focus on health equities and SDOH. ITC is analyzing the impact of existing programs and searching for new ways to connect with members.

ITC has a large pay for performance program with 25,000 providers participating. ITC's provider engagement team meets with providers participating in the program to develop reporting specific to each provider to help them match some of the care gaps of the providers membership. Following up on some of these meetings, ITC has developed incentives for home- and community-based service (HCBS) providers. These HCBS incentives launched last year, and they incentivize providers to actively address factors to reduce homelessness, support employment and follow up hospitalization and mental illness. Stacie finished her update on ITC efforts in the area of SDOH by highlighting a community health fair held at Corinthian Baptist Church. The event was held on Saturday, March 25, 2023 from 11:00 AM to 3:00 PM. The first thousand households will be given a free bag of produce. ITC is one of several entities

partnering on the event, including Broadlawns, Hy-Vee, and 25 other community partners. The community health fair

Stacie previously reported that ITC applied for a health equity accreditation from the National Committee for Quality Assurance (NCQA). ITC was awarded this accreditation in February.

Stacie finished her report by updating the council on ITC's doula pilot program. ITC looked at zip codes that had a higher-than-average maternal rates and unfavorable maternal health rates. ITC identified three counties with the highest negative early birth rates: Muscatine, Polk, and Johnson Counties. The program includes three visits pre-birth educational visits, in person birthing support, three visits after birth, and breastfeeding support on twenty-four hour call up until 37 weeks after birth. So far, the program has 24 members, eight births, all healthy.

Amerigroup Iowa, Inc.

John McCalley, Amerigroup, began his update by noting the ongoing work collaborative efforts between Amerigroup and Iowa Medicaid to prepare for the end of the PHE.

Last August, Amerigroup was awarded a new contract with Iowa Medicaid's managed care program. The new contract period will begin July 1, 2023. Ahead of this new contract period, Amerigroup is updating their value-added benefits to align with their Health Equity Plan. Amerigroup is expanding their Quality Incentive Programs (QIP) to identify what more can be done within their provider network to address SDOH. The first such incentive program is the obstetrics QIP, previously reported with two providers, now has eleven members and is expected to grow even further in coming months. Amerigroup is launching food provider and housing provider incentive programs, contracting this year and implementing in 2024. Finally, in preparation for the new contract, Amerigroup has launched an upgraded case management platform for care coordinators, to lower caseloads for long-term services and supports (LTSS) case managers.

Amerigroup is preparing outreach measures for Iowa Medicaid members as part of the PHE unwind and the end of the continuous coverage requirement. In March, Amerigroup sent postcards to members advising them to watch their mail and encouraging members to be alert for changes in the program and to open letters that Iowa Medicaid sends to them.

Amerigroup is supporting the onboarding of Molina by monitoring the membership realignment and preparing to share LTSS care plans for LTSS members that may transfer from Amerigroup to different MCOs.

Amerigroup has a few initiatives tied to their health equity plan, including a doula program, which just launched a second pilot project in rural southwest Iowa. Additionally, Amerigroup is building a new prevention and vaccination health equity initiative, informed by their experience with vaccination rates as they were tracked through the PHE.

Amerigroup continues its work on social determinants of health (SDOH): their Champ Housing Stability Initiative has now helped 906 Amerigroup members transition from homelessness to safe affordable housing or avoid eviction. Amerigroup has partnered with the Iowa Chronic Care Consortium; they are finalizing the production of five new online community health worker continues education modules and

expect the first module to launch in the second quarter of 2023. Building on this experience Amerigroup has partnered with the University of Iowa Center for Excellence in Developmental Disabilities (UCEDD) to build a health equity training webinar platform specifically for LTSS stakeholders, this platform should launch in the third quarter of 2023.

Amerigroup continues to work on the transition of members from the Glenwood Resource Center into community settings. Amerigroup's work on this is done in collaboration with the Glenwood Resource clinical teams, ITC's clinical teams, the Department's clinical teams and local providers. Part of this work is funding community transformation grants. Providers can apply for these grants if they are looking to expand capacity to make room for members transitioning from Glenwood Resource Center.

MEDICAID UNWIND STRATEGIES

Anna Casteel, Iowa Department of Health and Human Services, gave an update on unwinding the federal PHE, specifically on efforts to unwind the continuous coverage requirement. Anna provided the council with some background, noting that to receive enhanced federal funds during the federal PHE, there was a requirement that Medicaid programs maintain member's eligibility during the PHE. This was known as the continuous coverage requirement. On December 29, 2022 congress passed the Consolidated Appropriations Act (CEA), which disconnects the continuous coverage requirement from the federal PHE and sets an end date for the continuous coverage requirement on March 31, 2023. The CEA also made some changes to the structure of the enhanced funding that states are receiving as part of maintaining Medicaid eligibility and implemented strict reporting guidelines with financial sanctions if the guidelines aren't followed. Additionally, the CEA included significant requirements around returned mail before states can terminate members coverage.

The federal PHE will end officially on May 11, 2023. The Department is continuing to work on releasing additional information and guidance on which flexibilities implemented during the PHE will stay in place, and which flexibilities will be unwound. Flexibilities anticipated to stay in place include telehealth, COVID-19 testing, and some expanded services for some members.

The Centers for Medicare and Medicaid Services (CMS) is requiring states to complete a full renewal of eligibility for most members at the end of the continuous coverage requirement, on March 31, 2023. Iowa Medicaid has 12 months to issue these renewals to members and 14 months to complete the review of these renewals. This will be a large effort due to the growth in Iowa Medicaid's enrollment in the past three years. The Department has spent considerable time and effort planning how these renewals will be sent and processed.

The Department has distributed the caseload of Medicaid renewals across a 12-month period, which means that most members will have a different renewal date this year than they did last year. This is done to ensure the Department complies with CMS's rules about when renewals can be sent, and to ensure the Department's income maintenance workers and field staff have an equal workload across months in future years.

CMS provided states with three options for when the 12-month renewal review period could begin, and Iowa selected the option that would allow us to start the earliest. Iowa's continuous coverage requirement unwinding began in February when we initiated the ex parte or the passive removal process

for renewals due in the month of April. Some of these members received renewal forms in February, but most of them received their forms in early March, this group all had a printed due date on their forms of April 5, 2023. This pattern will repeat each month, with passive renewal beginning and paper forms being sent to members in advance of their renewal due date. The Department anticipates about 50,000 cases going through redetermination each month over the next year. Anna highlighted this number of 50,000 cases each month saying that she has seen some inaccurate messaging sent to members by providers stating all members must complete their renewal by a given date in April.

The Department has carefully planned work and has a developed several strategies to complete it, including overtime hours, shifting staffing resources based on specialization and need, and distributing renewals to be worked by staff across the state. The MCPs have begun assisting the Department with outreach campaigns to members. The Department has begun comparing addresses on file with the National Change of Address (NCOA) database maintained by the United States Postal Service (USPS). The Department has developed member and stakeholder toolkits, available online, and is increasing the use of social media and other forms of outreach to connect with members.

Once a member has completed and returned their renewal form to the Department a notice of decision or a notice of action will be sent to the member. These notices are required to be sent regardless of the outcome of the eligibility determination. In cases where the eligibility review results in a reduction or end to Medicaid benefits notices will be issued ten days prior to the effective date of the change in benefits. The earliest a Medicaid member may see their coverage end is May 1, 2023.

There is an eligibility dashboard on the Department's website showing enrollment data going back to 2019, and data related to the continuous coverage requirement unwind. The dashboard shows renewals received and processed by the Department as well as other workload metrics.

Lisa Rockhill, Northwest Iowa Care Connections, said that in her work with the Sioux Rivers Mental Health and Disability Services (MHDS) Region they are seeing members have some difficulty receiving and completing renewal packets, stating there is some delay in mail leaving Polk County and arriving in Lyon County. Anna said that one of the things the Department has asked of its field staff is to be lenient with regards to due dates during this unwinding period. CMS is closely monitoring members losing their benefits due to a failure to complete paperwork, or procedural denials.

Branden Hagen, Iowa Health Care Association, asked if there were any pattern to provider groups being unwound more quickly than others, or if the pattern would be random, or generic. Anna answered that the Department did try to think strategically issuing renewal packets, and that members for whom the Department has received some indication they may no longer be eligible for Medicaid would receive their packets first. For example, if the Department had received a report that a member was now over the program's income limits, they would be likely to receive a renewal packet earlier in the process than later. Branden then asked about cases where providers have been submitting renewal information on behalf of members in the past 12 months. Anna said that cases where members have recently renewed their eligibility, they will be more likely to be issued their renewal packets later in the unwind process. Branden asked if providers would be able to review members upcoming renewal dates in the Iowa Medicaid Portal Access (IMPA) platform. Anna said that yes, this capability would remain in place.

DENTAL REQUEST FOR PROPOSAL (RFP)

Katie McBurney, Iowa Medicaid, gave an update on the upcoming RFP for a third dental Pre-Ambulatory Health Plan (PAHP) and discussing Iowa Medicaid's dental strategy. Over the last six months the Department has been working with a diverse group of stakeholders to discuss issues and concerns within the Medicaid dental program, particularly related to access to care. A stakeholder workgroup was held, in person, in September of 2022; since then, five more stakeholder sessions have been held. Katie and her colleague Heather Miller have begun working through the feedback from these sessions. Additionally, the Department has released an RFP for State Fiscal Year 2025 for a third PAHP.

Dental reimbursement is one of the first things staff are looking at adjusting, particularly for adult members. Katie said they are looking at the dental benefit package and looking at adjusting reduce administrative burden and increase reimbursement for services that are typically harder to get. Some of these services are preventive, and others are medically necessary, such as tooth extractions. Another area that's being looked at is orthodontia benefits, making it easier for providers and members to understand when they qualify for orthodontia. The Department is looking at expanding on programs that have been successful, such as the ISmile program. Another area of focus is access to anesthesia and oral surgery facilities.

Information related to the upcoming RFP can be found on the Department's website.

OPEN DISCUSSION

There were no comments.

ADJOURNMENT

Meeting adjourned at 3:17 PM.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Managed Care Organization (MCO) Quarterly Performance Report

SFY2023, Quarter 2

(October - December 2022)

Published March 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 2 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.

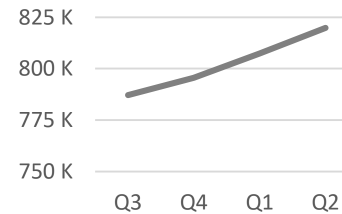
MCO Member Summary - All MCO Counts

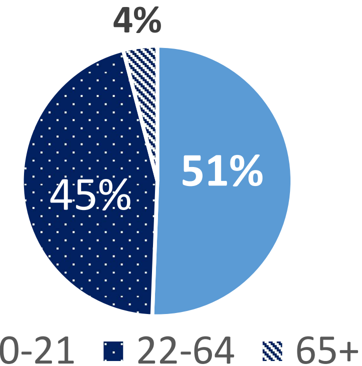
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

819,852





+ 12,439 Members
1.54% Increase

All MCO Enrollment
(by Age)

Data Notes: December 2022 data as of February 2023. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Distinct
MCO Member Summary - *Overall Counts*	787,187	795,507	807,413	**819,852**	802,490	**851,687**
0-21	404,569	407,098	411,121	414,784	409,393	429,275
22-64	351,867	356,845	363,817	371,787	361,079	385,394
65+	30,751	31,564	32,475	33,281	32,018	37,018
Fee-For-Service (FFS) - *Non MCO Enrollees*	46,254	46,896	47,940	**49,363**	47,613	**52,403**

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

If Yes, explain:

Iowa Medicaid Population **904,090**
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

	SFY23 Q1	SFY23 Q2
All Members - *by MCO*	455,190	453,029
Traditional Medicaid	281,794	281,378
Wellness Plan - IHAWP/Expansion	129,781	129,484
M-CHIP - Expansion	9,921	9,649
Healthy and Well Kids in Iowa (Hawki)	33,694	32,518
MCO Member Market Share	57.4%	55.3%
Disenrolled	1,451	925

	SFY23 Q1	SFY23 Q2
Long-Term Service & Support (LTSS)	21,061	20,499
HCBS Waivers	69.4%	70.4%
Facility Based Services	30.6%	29.6%
HCBS Waivers [1]	14,624	14,431
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,437	6,068
ICF/ID [3]	817	776
Mental Health Institute (MHI)	29	34
Nursing Facilities (NF)	5,242	4,924
Nursing Facilities for Mentally Ill	58	57
Skilled	87	87
PMIC [4]	204	190

	SFY23 Q1	SFY23 Q2
All Members - *by MCO*	352,223	366,823
Traditional Medicaid	217,967	225,474
Wellness Plan - IHAWP/Expansion	112,810	120,162
M-CHIP - Expansion	6,977	7,097
Healthy and Well Kids in Iowa (Hawki)	14,469	14,090
MCO Member Market Share	43.6%	44.7%
Disenrolled	905	731

	SFY23 Q1	SFY23 Q2
Long-Term Service & Support (LTSS)	14,998	15,328
HCBS Waivers	64.9%	64.8%
Facility Based Services	35.1%	35.2%
HCBS Waivers [1]	9,730	9,937
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,268	5,391
ICF/ID [3]	491	447
Mental Health Institute (MHI)	31	26
Nursing Facilities (NF)	4,531	4,696
Nursing Facilities for Mentally Ill	35	34
Skilled	76	66
PMIC [4]	104	122

[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 387; ITC 375). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

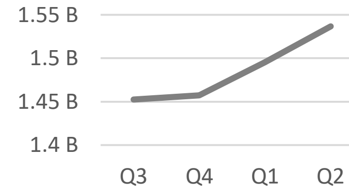
MCO Financial Summary - All MCO Counts

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

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

All Capitation Payments

$1.5 Billion

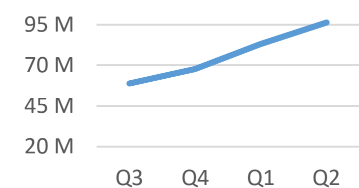


+ $41.5 Million

2.8% Increase

Third Party Liability Recovered

$96.4 Million



+ $ 13.3 Million

16.0% increase

Data Notes: December 2022 data as of February 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 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Total
Financial Summary						
Capitation Payments	$1.45 B	$1.46 B	$1.5 B	**$1.54 B**	$1.49 B	$5.94 B
Third Party Liability (TPL) Recovered	$58.9 M	$67.7 M	$83.1 M	**$96.4 M**	$76.5 M	$306.2 M

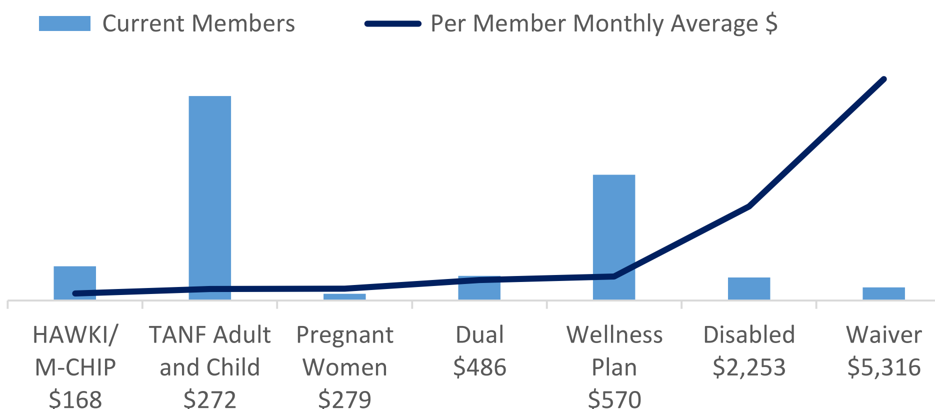
Significant Change in Data? (+/-) No [x] Yes [ ]

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.



	SFY23 Q1	SFY23 Q2
Capitation Totals	$856.41 M	**$857.74 M**
Adjustments	-$148 K	$1.74 M
Current	$840.59 M	$845.29 M
Retro	$15.97 M	$10.71 M
Third Party Liability (TPL)	$28.3 M	**$23.9 M**
Financial Ratios		
Medical Loss Ratio (MLR)	92.1%	**95.2%**
Administrative Loss Ratio (ALR)	5.7%	6.1%
Underwriting Ratio (UR)	2.2%	-1.3%
Unreconciled SFY MLR [5]		93.6%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

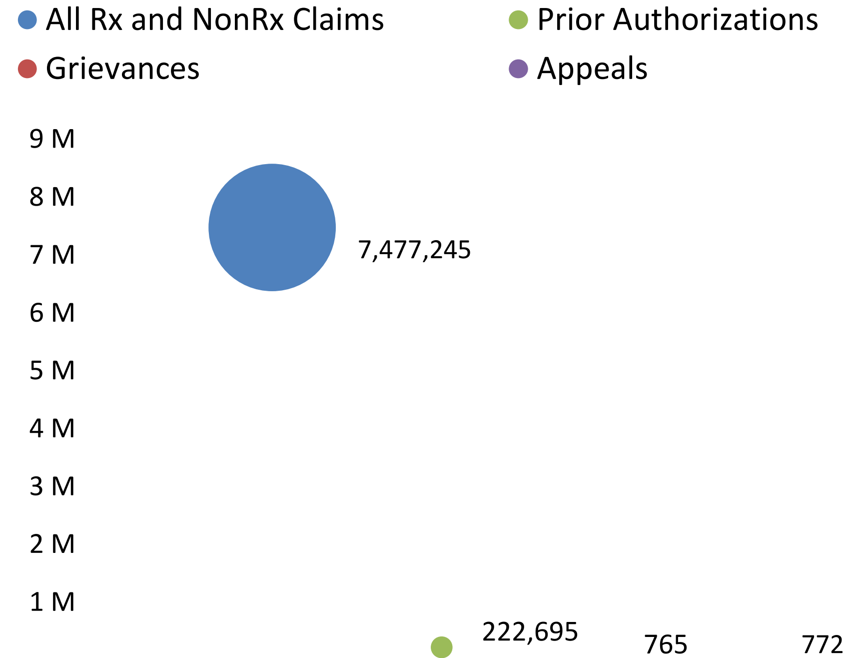
	SFY23 Q1	SFY23 Q2
Capitation Totals	$638.84 M	**$678.99 M**
Adjustments	-$56 K	$2.81 M
Current	$617.42 M	$647.12 M
Retro	$21.47 M	$29.07 M
Third Party Liability (TPL)	$54.8 M	**$72.5 M**
Financial Ratios		
Medical Loss Ratio (MLR)	95.5%	**97.1%**
Administrative Loss Ratio (ALR)	6.0%	5.3%
Underwriting Ratio (UR)	-1.4%	-2.4%
Unreconciled SFY MLR [5]		96.3%
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



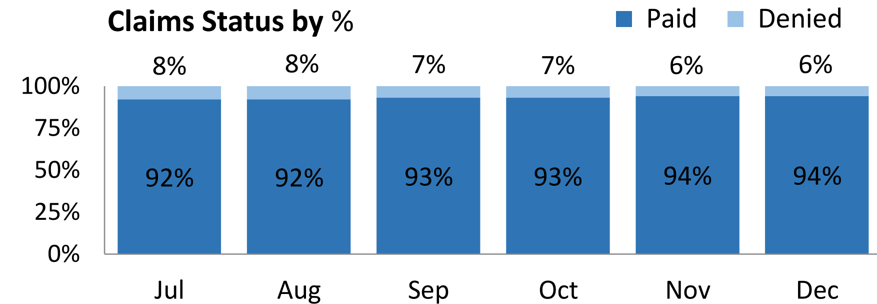
	% of Claims Universe
Prior Authorizations	2.98%
Grievances	0.01%
Appeals	0.01%

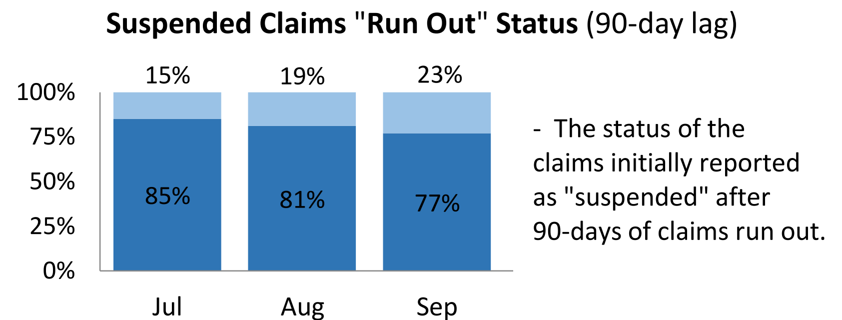
	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.7 M	7.4 M	7.4 M	**7.5 M**	7.5 M	30.0 M
Non-Pharmacy	4.4 M	4.4 M	4.2 M	4.3 M	4.3 M	17.4 M
Pharmacy	3.3 M	3.0 M	3.1 M	3.1 M	3.1 M	12.6 M
Prior Authorization Summary (p. 13-14)	186,524	193,729	197,872	**222,695**	200,205	800,820
Non-Rx - Standard PAs Submitted	134,628	142,964	146,847	169,055	148,374	593,494
Pharmacy - Standard PAs Submitted	51,896	50,765	51,025	53,640	51,832	207,326
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	784	761	766	**765**	769	3,076
Standard Appeals	558	752	770	**772**	713	2,852

Claims Summary (Non-Pharmacy)

2.5 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	738,330	864,038	740,166
Denied	57,762	54,403	48,224
Suspended	250,024	172,626	208,296
Clean Claims Processed			
in 30-days (Requirement 90%)	94%	93%	95%
in 45-days (Requirement 95%)	96%	99%	98%
Average Days to Pay	9	8	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





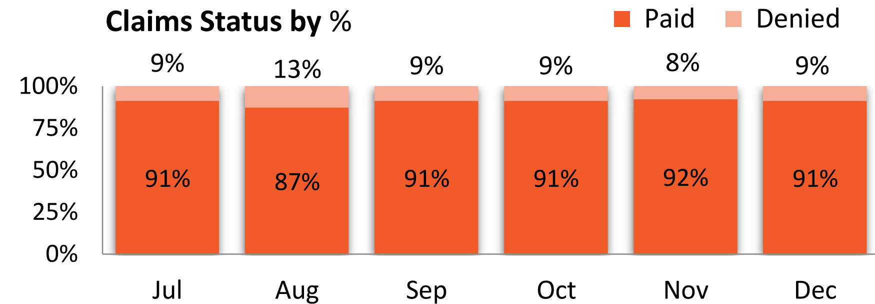
- The status of the claims initially reported as "suspended" after 90-days of claims run out.

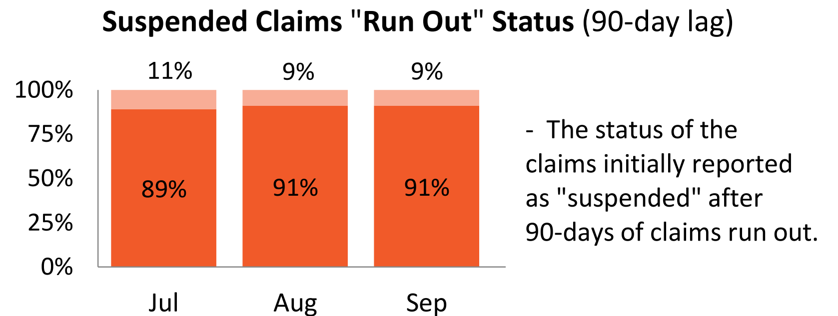
	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	12%	Duplicate claim/service
2.	12%	The impact of prior payer(s) adjudication including payments and/or adjustments.
3.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
4.	8%	Claim/service lacks information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

Claims Summary (Non-Pharmacy)

1.83 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	524,852	621,456	527,461
Denied	49,347	54,484	51,838
Suspended	140,268	97,276	139,934
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	99%	99%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	9	11	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	97%	99%	100%





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

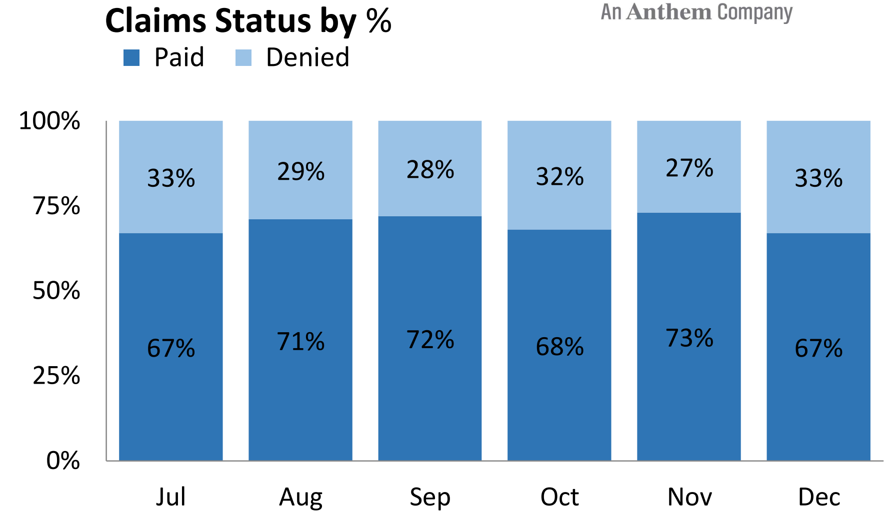
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
1.	18%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
2.	14%	Duplicate claim/service can not be combined with other service on same day
3.	11%	Service can not be combined with other service on same day Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	6%	Service is not covered
5.	6%	No authorization on file that matches service(s) billed
6.	4%	Diagnosis code incorrectly coded per ICD10 manual
7.	3%	ACE claim level return to provider Diagnosis code incorrectly coded per ICD10 manual
8.	3%	Void Adjustment
9.	2%	Billing NPI not registered with IA DHHS/IA Medicaid Referring Provider not registered with IA DHHS/IA Medicaid
10.	2%	Insufficient info for processing

Claims Summary (Pharmacy)

1.71 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	363,917	458,989	370,637
Denied	168,839	171,284	180,339
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	12	11



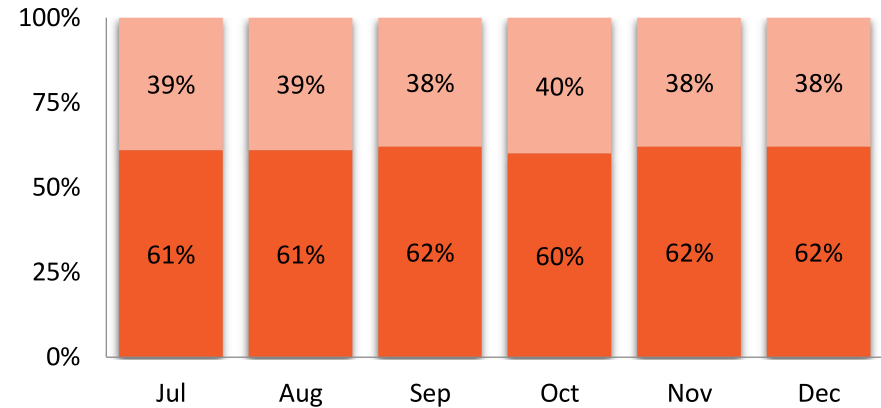
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	38%	Refill too soon
2.	16%	Prior authorization required
3.	12%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	7%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	3%	M/I processor control number
8.	2%	Filled after coverage terminated
9.	2%	Prescriber is not enrolled in State Medicaid program
10.	1%	Pharmacy not enrolled in State Medicaid program

Claims Summary (Pharmacy)

1.43 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	289,045	293,462	292,759
Denied	194,640	181,396	179,577
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	9	10	9

Claims Status by %



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

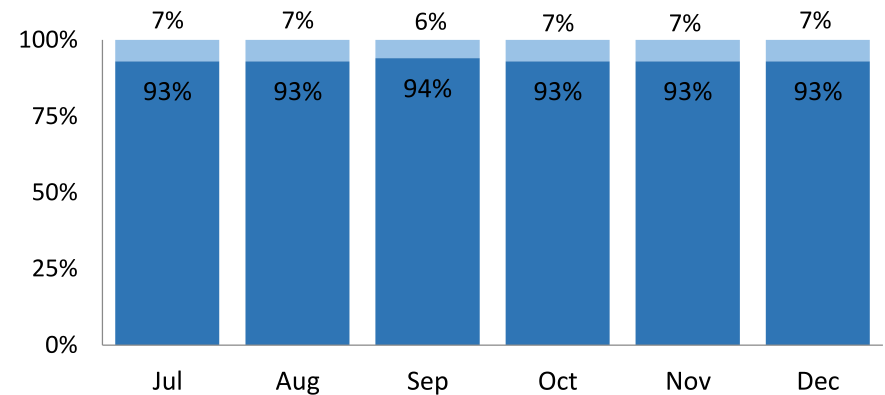
Prior Authorization Summary

87,221
All PAs Submitted [6]

Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	18,341	18,564	17,458
Denied	1,327	1,405	1,261
Modified	0	0	0
Average Days to Process	5	5	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

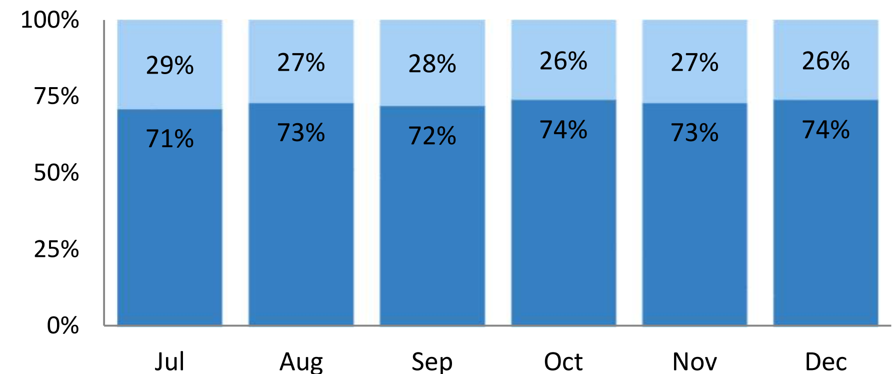
Non-Pharmacy by Percentage



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	6,659	7,267	7,348
Denied	2,329	2,715	2,525
PAs Completed in 24-hours (Requirement 100%)	100.0%	99.9%	99.9%

Pharmacy by Percentage



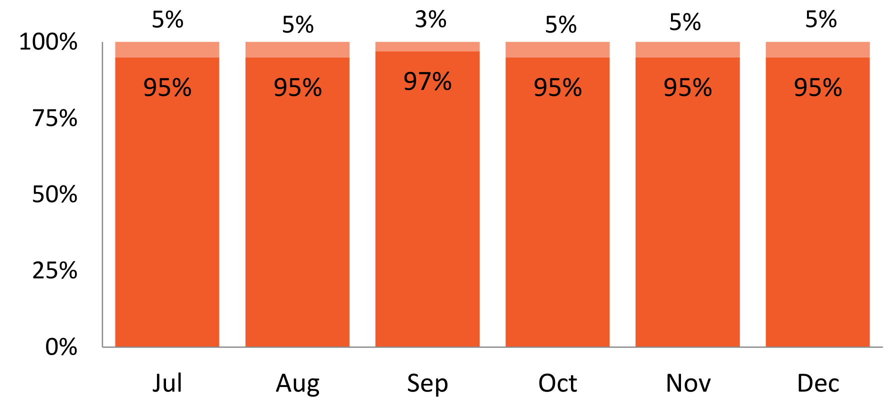
[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

135,474
All PAs Submitted [6]

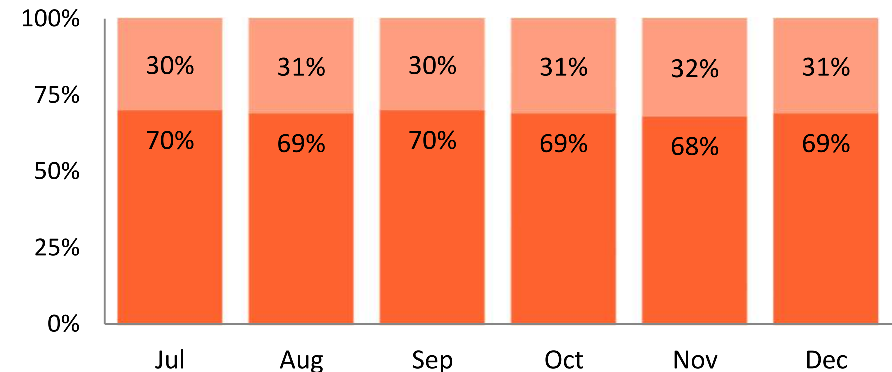
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	34,606	34,936	35,635
Denied	1,635	1,702	1,854
Modified	0	0	0
Average Days to Process	1	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

	Oct	Nov	Dec
Prior Authorizations			
Approved	5,049	5,158	4,984
Denied	2,226	2,414	2,257
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	99.9%

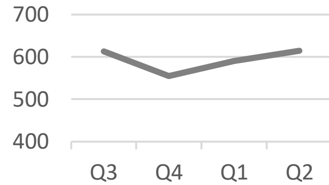


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

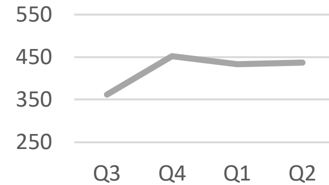
Standard Grievances

615



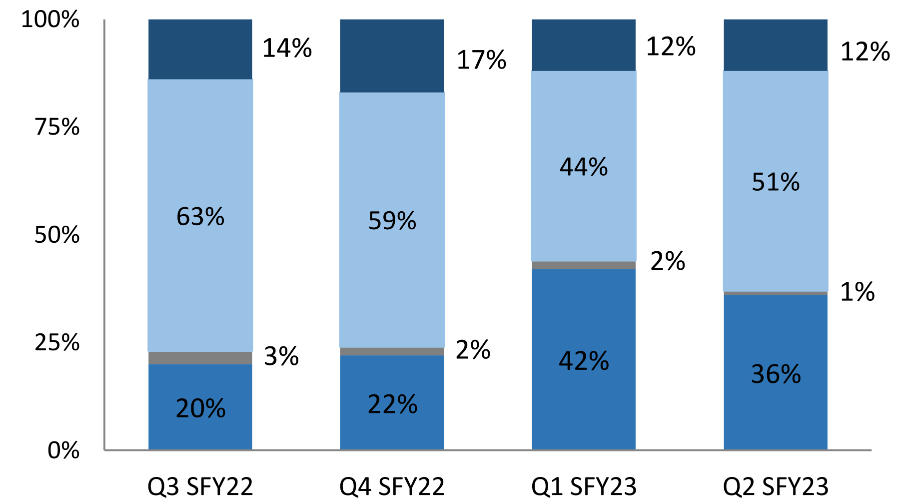
Standard Appeals/ 1st Level Review

437



Standard Appeal Outcome %

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



	%	Top 10 Reasons for Grievances [7]
1.	33%	Voluntary disenrollment
2.	19%	Provider balance billed
3.	6%	Provider Dissatisfaction
4.	5%	Treatment Dissatisfaction
5.	5%	Transportation - No Show
6.	3%	Transportation - Driver Delay
7.	3%	Routine Appointments
8.	3%	Inadequate Benefit Access
9.	2%	Poor Customer Service
10.	2%	Continuity of Care

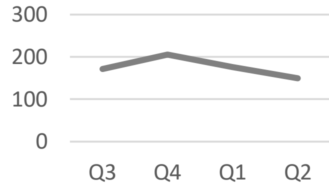
%	Top 10 Reasons for Appeals [7]
34%	Pharmacy - Non Injectable
21%	DME
16%	Pharmacy - Injectable
14%	Outpatient Services - Medical
6%	Surgery
4%	Radiology
4%	Inpatient - Medical
3%	Therapy OT/PT
3%	Pain Mgmt
1%	BH - Op Service

[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

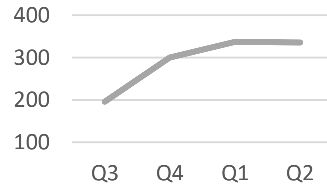
Standard Grievances

150



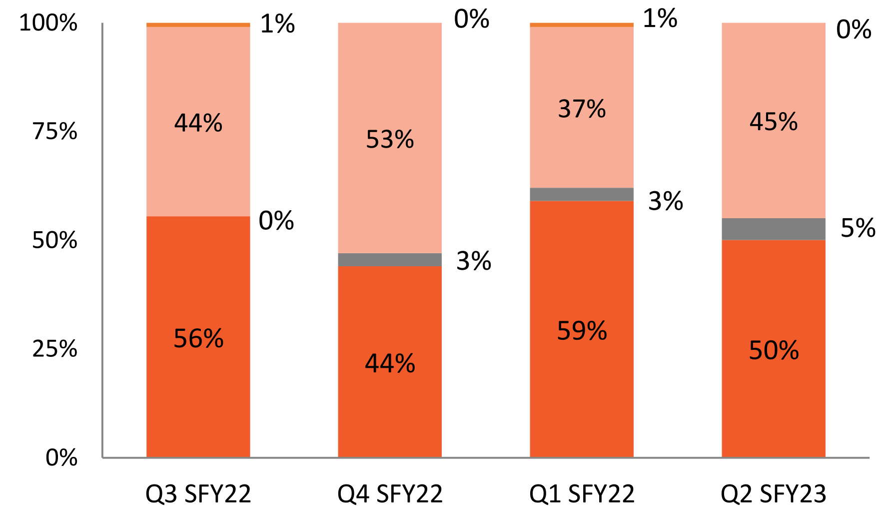
Standard Appeals/ 1st Level Review

335



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

Standard Appeal Outcome %



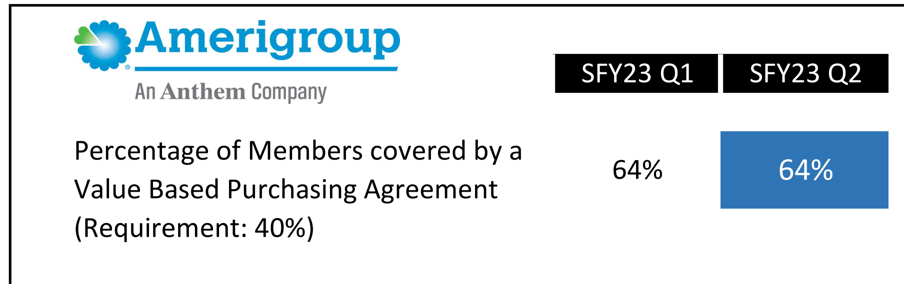
	%	Top 10 Reasons for Grievances [7]
1.	25%	Provider Not in Network
2.	21%	Unhappy with Benefits
3.	10%	General Complaint Vendor
4.	7%	Transportation - Driver did not show
5.	6%	Lack of Caring/Concern
6.	5%	Late Appointment
7.	5%	Provider
8.	3%	General Complaint Vendor CSR
9.	3%	Health Plan Staff
10.	2%	Benefit Concern

%	Top 10 Reasons for Appeals [7]
25%	RX - Does Not Meet Prior AuthGuidelines
13%	Therapy - Occupational Therapy
9%	Therapy - Physical Therapy
6%	Therapy - Speech Therapy
4%	DME - Wheelchair
4%	Injections - Epidural Injections
3%	Diagnostic - CAT Scan
3%	Other - Mental Health Service
3%	Outpatient - Procedure
3%	DME - Other

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

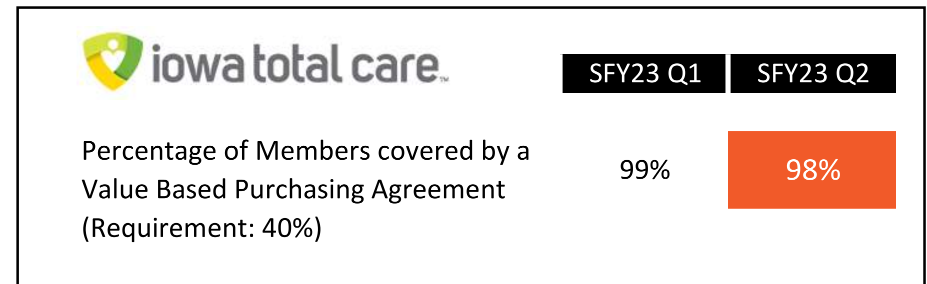
Value Based Purchasing (VBP) Agreement

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.



Amerigroup (An Anthem Company)

	SFY23 Q1	SFY23 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	64%	64%



iowa total care

	SFY23 Q1	SFY23 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	99%	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)

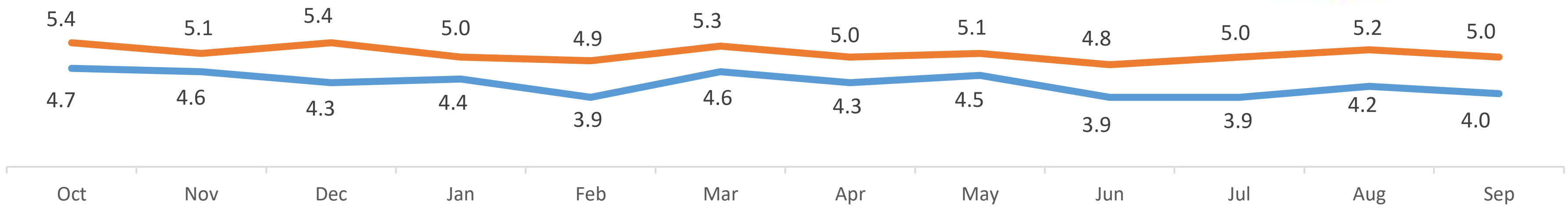
	SFY23 Q1	SFY23 Q2
Healthy Rewards	4,544	6,574
SafeLink Mobile Phone	1,351	2,613
Taking Care of Baby and Me	1,226	2,145
Community Resource Link	1,426	1,977
Dental Hygiene Kit	448	514

iowa total care

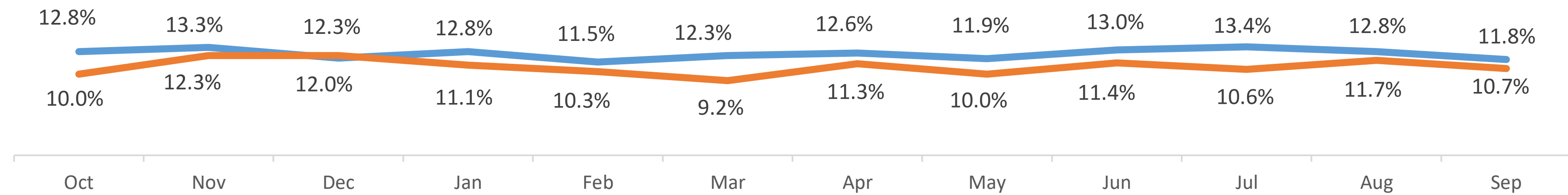
	SFY23 Q1	SFY23 Q2
The Flu Program	610	14,212
My Health Pays Program	10,346	12,676
In Home Diabetic Test Kits	3	3,497
Mobile App	1,448	1,831
Start Smart for Your Baby	1,698	1,743

MCO Care Quality and Outcomes

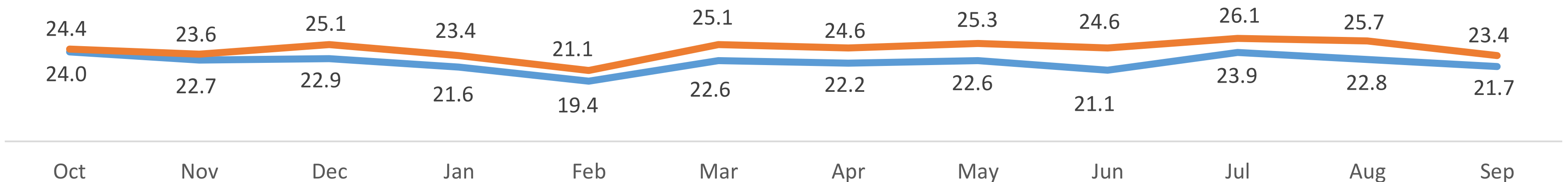
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



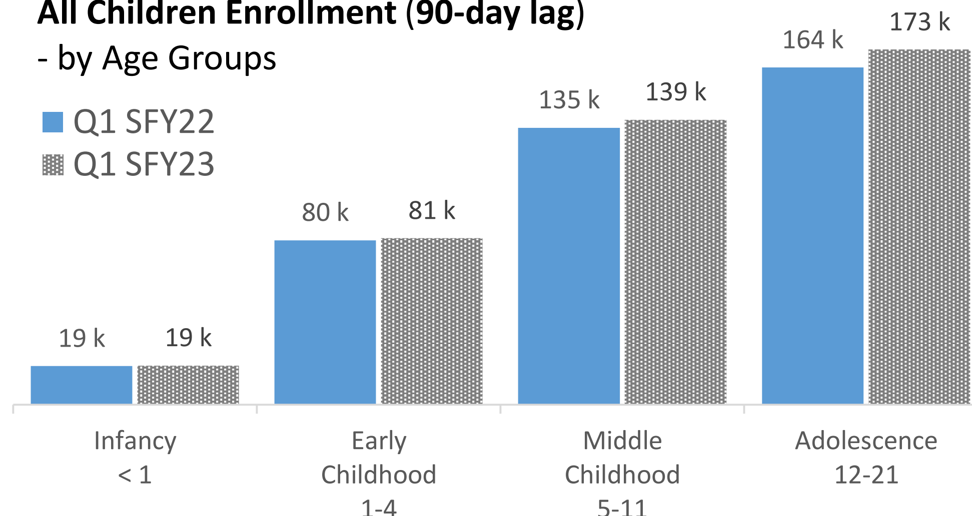
[8] *This measure requires 12 months of continuous enrollment with the MCO.*

[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 Q1	SFY23 Q1
Member Enrollment	237,586	239,523
Infancy < 1	9,827	9,295
Early Childhood 1 - 4	47,425	45,636
Middle Childhood 5 - 11	81,514	82,177
Adolescence 12 - 21	98,820	102,415
Well Child Exams (Preventive Visits)	59,597	64,729
Infancy < 1	11,307	12,366
Early Childhood 1 - 4	14,077	15,071
Middle Childhood 5 - 11	15,916	17,317
Adolescence 12 - 21	18,297	19,975
Lead Screenings	5,050	5,319
Infancy < 1	129	162
Early Childhood 1 - 4	4,184	4,444
Middle Childhood 5 - 11	676	661
Adolescence 12 - 21	61	52

	SFY22 Q1	SFY23 Q1
Member Enrollment	159,797	171,598
Infancy < 1	8,899	9,645
Early Childhood 1 - 4	32,520	35,319
Middle Childhood 5 - 11	53,211	56,391
Adolescence 12 - 21	65,167	70,243
Well Child Exams (Preventive Visits)	47,481	50,280
Infancy < 1	11,776	12,634
Early Childhood 1 - 4	11,818	12,711
Middle Childhood 5 - 11	11,025	11,788
Adolescence 12 - 21	12,862	13,147
Lead Screenings	4,757	4,762
Infancy < 1	172	173
Early Childhood 1 - 4	4,026	4,031
Middle Childhood 5 - 11	513	504
Adolescence 12 - 21	46	54

MCO Children Summary

	SFY22 Q1	SFY23 Q1
Hearing Screenings	2,009	2,230
Infancy < 1	147	166
Early Childhood 1 - 4	926	992
Middle Childhood 5 - 11	647	760
Adolescence 12 - 21	289	312
Vision Screenings	2,332	4,079
Infancy < 1	32	43
Early Childhood 1 - 4	944	1,216
Middle Childhood 5 - 11	849	1,633
Adolescence 12 - 21	507	1,187
Vaccination Totals	80,342	70,852
COVID-19 Dose 1	5,839	999
COVID-19 Dose 2 or Single-Dose (J&J)	5,271	1,308
DTaP (Diphtheria, Tetanus, Pertussis)	11,091	10,737
Influenza (FLU)	5,787	5,516
HepA (Hepatitis A)	5,222	5,074
HepB (Hepatitis B)	937	766
Haemophilus Influenza Type B (Hib)	4,956	4,531
Human Papillomavirus (HPV)	6,338	6,487
Meningococcal ACWY (MenACWY)	7,309	7,383
Meningococcal B - (MenB)	2,500	2,643
MMR (Measles, Mumps, Rubella)	5,701	5,858
Pneumococcal (PCV13)	7,220	7,168
Pneumococcal (PPSV23)	50	45
Polio (IPV)	333	423
RV (Rotavirus)	4,498	4,459
Tetanus and diphtheria (Td)	43	53
TDAP (Tetanus, Diphtheria, Pertussis)	4,935	5,057
Varicella Virus Vaccine (VAR)	2,312	2,345

	SFY22 Q1	SFY23 Q1
Hearing Screenings	1,250	1,610
Infancy < 1	128	152
Early Childhood 1 - 4	569	710
Middle Childhood 5 - 11	374	554
Adolescence 12 - 21	179	194
Vision Screenings	1,704	2,589
Infancy < 1	48	39
Early Childhood 1 - 4	729	952
Middle Childhood 5 - 11	575	966
Adolescence 12 - 21	352	632
Vaccination Totals	62,501	57,114
COVID-19 Dose 1	4,418	859
COVID-19 Dose 2 or Single-Dose (J&J)	3,965	676
DTaP (Diphtheria, Tetanus, Pertussis)	9,059	9,176
Influenza (FLU)	3,860	3,969
HepA (Hepatitis A)	4,389	4,476
HepB (Hepatitis B)	824	809
Haemophilus Influenza Type B (Hib)	4,485	4,248
Human Papillomavirus (HPV)	4,369	4,338
Meningococcal ACWY (MenACWY)	4,877	5,005
Meningococcal B - (MenB)	1,542	1,695
MMR (Measles, Mumps, Rubella)	4,198	4,526
Pneumococcal (PCV13)	6,557	6,823
Pneumococcal (PPSV23)	68	40
Polio (IPV)	279	492
RV (Rotavirus)	4,180	4,334
Tetanus and diphtheria (Td)	29	41
TDAP (Tetanus, Diphtheria, Pertussis)	3,423	3,485
Varicella Virus Vaccine (VAR)	1,979	2,122

MCO Children Summary - Behavioral/Mental Health Treatment & Services

Substance Use Disorder (SUD) Summary	SFY22 Q1	SFY23 Q1
Total Visits - *As 1st or 2nd Diagnosis*	6,961	5,667
Alcohol	1,587	1,157
Cannabis	3,037	2,495
Cocaine	48	77
Nicotine	778	673
Opioid	399	399
Other	36	23
Other Psychoactive	366	433
Other Stimulant	590	336
Sedative	120	74

Severe Emotional Disturbance (SED) for Children Summary	SFY22 Q1	SFY23 Q1
Total Visits - *As 1st or 2nd Diagnosis*	205,330	193,211
ADHD [10]	46,610	43,253
Anxiety	37,676	38,258
Bipolar	3,424	3,025
Conduct Disorder	21,683	20,320
Depression	28,182	26,529
Obsessive Compulsive Disorder	881	689
Other	15,460	13,053
Post-traumatic Stress Disorder	50,882	47,702
Tourette Syndrome	532	382

Substance Use Disorder (SUD) Summary	SFY22 Q1	SFY23 Q1
Total Visits - *As 1st or 2nd Diagnosis*	3,696	3,537
Alcohol	780	696
Cannabis	1,787	1,765
Cocaine	20	32
Nicotine	69	72
Opioid	370	485
Other	32	19
Other Psychoactive	179	178
Other Stimulant	371	249
Sedative	88	41

Severe Emotional Disturbance (SED) for Children Summary	SFY22 Q1	SFY23 Q1
Total Visits - *As 1st or 2nd Diagnosis*	106,815	109,591
ADHD [10]	21,152	21,792
Anxiety	20,746	22,031
Bipolar	1,586	1,413
Conduct Disorder	10,933	11,374
Depression	15,190	15,609
Obsessive Compulsive Disorder	433	390
Other	7,417	7,520
Post-traumatic Stress Disorder	29,169	29,249
Tourette Syndrome	189	213

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 Q1	SFY23 Q1
Mental Health Assessments	10,069	8,648
Middle Childhood 5 - 11	3,489	3,345
Adolescence 12 - 21	6,580	5,303
Therapy/Counseling - Individual	65,580	62,393
Middle Childhood 5 - 11	25,125	23,363
Adolescence 12 - 21	40,455	39,030
Therapy/Counseling - Group & Family	9,851	8,044
Middle Childhood 5 - 11	3,657	2,908
Adolescence 12 - 21	6,194	5,136
Behavioral Intervention Services	19,192	20,949
Middle Childhood 5 - 11	11,434	12,593
Adolescence 12 - 21	7,758	8,356
Applied Behavior Analysis (ABA)	4,445	4,226
Middle Childhood 5 - 11	3,938	3,705
Adolescence 12 - 21	507	521
Residential Treatment	647	561
Middle Childhood 5 - 11	169	155
Adolescence 12 - 21	478	406
M/H & **Substance Abuse B3 Services** [11]	6,270	5,168
Middle Childhood 5 - 11	1,819	1,530
Adolescence 12 - 21	4,451	3,638

	SFY22 Q1	SFY23 Q1
Mental Health Assessments	5,808	5,397
Middle Childhood 5 - 11	1,987	2,061
Adolescence 12 - 21	3,821	3,336
Therapy/Counseling - Individual	36,471	37,150
Middle Childhood 5 - 11	14,660	14,376
Adolescence 12 - 21	21,811	22,774
Therapy/Counseling - Group & Family	5,173	5,127
Middle Childhood 5 - 11	2,029	2,038
Adolescence 12 - 21	3,144	3,089
Behavioral Intervention Services	11,512	13,669
Middle Childhood 5 - 11	6,981	8,015
Adolescence 12 - 21	4,531	5,654
Applied Behavior Analysis (ABA)	1,006	1,109
Middle Childhood 5 - 11	872	964
Adolescence 12 - 21	134	145
Residential Treatment	267	390
Middle Childhood 5 - 11	63	124
Adolescence 12 - 21	204	266
M/H & **Substance Abuse B3 Services** [11]	3,531	3,029
Middle Childhood 5 - 11	1,037	881
Adolescence 12 - 21	2,494	2,148

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

Average Number of Contacts Per Month	SFY23 Q1	SFY23 Q2
by Care Coordinators	2.0	**38.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	15	**12**
HCBS Members to Case Managers	69	**76**

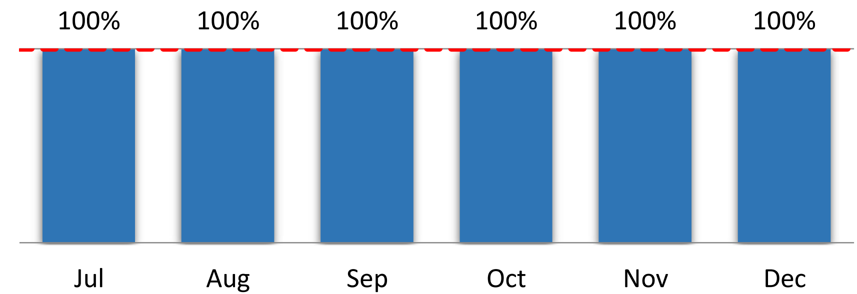
There are no current MCO contract standards for ratios of members to care coordinators or community based case managers. However, MCO contracts do state that members are to be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least 60 days between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

Iowa Participant Experience Survey (IPES)

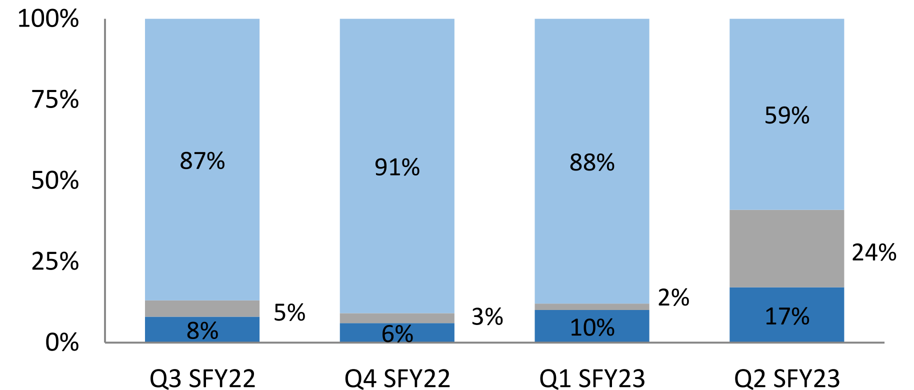
Waiver members reporting…		SFY23 Q1	SFY23 Q2
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	0.5%	0.0%
	No	0.5%	0.0%
	Sometimes	0.5%	0.0%
	Yes	98.5%	100.0%

Percentage of Level of Care (LOC) Reassessments Completed Timely

Contract Requirement: 100%



Waiver Service Plan Outcomes



Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

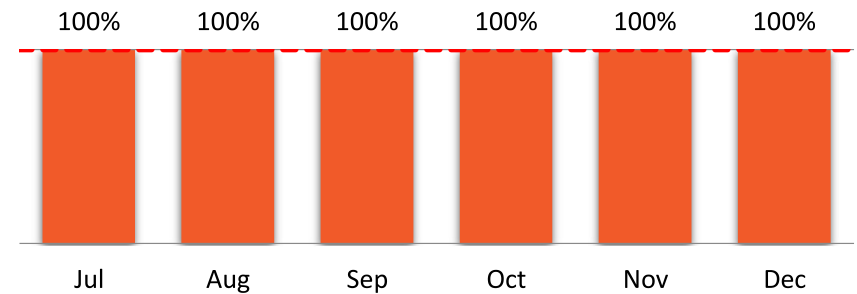
Average Number of Contacts Per Month	SFY23 Q1	SFY23 Q2
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	47	**44**
HCBS Members to Case Managers	42	**44**

Iowa Participant Experience Survey (IPES)

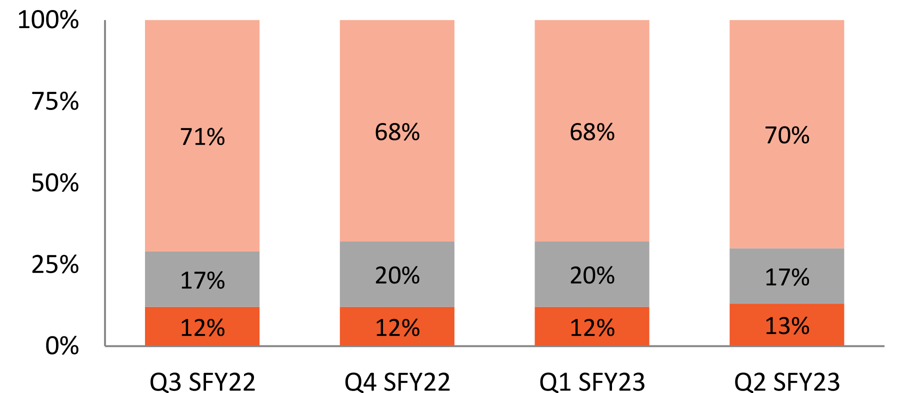
Waiver members reporting…		SFY23 Q1	SFY23 Q2
They were part of service planning.	I don't know	1.1%	2.1%
	No	2.6%	3.5%
	Sometimes	2.2%	1.1%
	Yes	94.0%	92.2%
They feel safe where they live.	I don't know	0.0%	0.4%
	No	2.6%	5.7%
	Sometimes	3.0%	2.1%
	Yes	94.4%	91.5%
Their services make their lives better.	I don't know	0.0%	1.8%
	No	1.5%	3.5%
	Sometimes	3.4%	4.2%
	Yes	95.1%	90.1%

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

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

	SFY23 Q1	SFY23 Q2
AIDS/HIV - Waiver Member Count	23	25
Home Delivered Meals	16	18
CDAC (individual) by 15 minute units	4	3
Financial Management Services	1	2
Brain Injury (BI) Waivers	764	755
Financial Management Services	209	204
Supported Community Living (by unit)	190	199
Personal Emergency Response	166	171
Respite (by 15 minute units)	166	151
Supported Community Living (daily)	111	115
Children's Mental Health (CMH)	810	799
Respite (by 15 minute units)	443	445
Respite (Hos/NF) - 15 minute units	244	236
Family and Community Support	193	193
Respite (Resident Camp) by units	24	21
Home Modification	3	3
Elderly Waivers	4,191	4,027
Personal Emergency Response	2,771	2,746
Home Delivered Meals	2,767	2,724
CDAC (agency) by 15 minute units	422	345
Assisted Living Services	322	317
Personal Emergency Response (install)	302	251

	SFY23 Q1	SFY23 Q2
Habilitation (Hab)	4,102	4,076
Home-based Habilitation	3,361	3,381
Long Term Job Coaching	391	386
Day Habilitation (units by day)	331	333
Individual Supported Employment	160	204
Day Habilitation (by 15 minute units)	139	157
Health & Disability (HD)	1,347	1,357
Respite (by 15 minute units)	397	397
Financial Management Services	366	347
Personal Emergency Response	313	321
Home Delivered Meals	307	312
Respite (Hos/NF) - 15 minute units	54	57
Intellectual Disability (ID)	6,898	6,899
Supported Community Living (by unit)	1,797	1,822
Supported Community Living (RCF)	1,492	1,514
Day Habilitation (units by day)	1,338	1,321
Supported Community Living (daily)	1,170	1,193
Financial Management Services	1,264	1,150
Physical Disability (PD)	591	569
Personal Emergency Response	321	320
CDAC (agency) by 15 minute units	57	42
CDAC (individual) by 15 minute units	47	37
Financial Management Services	30	30
Personal Emergency Response (install)	28	29

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

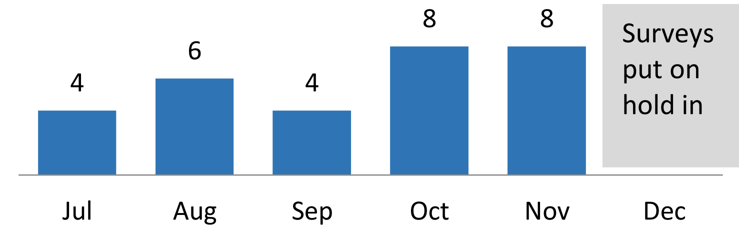
	SFY23 Q1	SFY23 Q2
AIDS/HIV - Waiver Member Count	8	8
Home Delivered Meals	8	8
CDAC (individual) by 15 minute units	1	3
Homemaker (by 15 minute units)	1	1
CDAC (agency) by 15 minute units	1	1
Brain Injury (BI) Waivers	524	519
Supported Community Living (by unit)	215	214
Personal Emergency Response	141	150
Supported Community Living (daily)	119	121
Respite (by 15 minute units)	126	87
Transportation (1-way trip)	96	87
Children's Mental Health (CMH)	385	385
Respite (by 15 minute units)	227	243
Respite (Hos/NF) - 15 minute units	159	163
Family and Community Support	110	113
Respite (Resident Camp) by units	16	14
Elderly Waivers	3,404	3,569
Personal Emergency Response	2,576	2,650
Home Delivered Meals	2,554	2,621
CDAC (agency) by 15 minute units	1,331	1,343
Homemaker (by 15 minute units)	719	720
CDAC (individual) by 15 minute units	648	612

	SFY23 Q1	SFY23 Q2
Habilitation (Hab)	2,335	2,410
Home-based Habilitation	1,914	1,908
Day Habilitation (by 15 minute units)	354	373
Day Habilitation (units by day)	290	298
Long Term Job Coaching	271	271
Individual Supported Employment	132	134
Health & Disability (HD)	588	587
Respite (by 15 minute units)	277	201
Home Delivered Meals	151	152
Personal Emergency Response	150	139
CDAC (individual) by 15 minute units	98	97
CDAC (agency) by 15 minute units	97	96
Intellectual Disability (ID)	4,427	4,466
Supported Community Living (by unit)	1,750	1,716
Day Habilitation (by 15 minute units)	1,693	1,691
Day Habilitation (units by day)	1,546	1,550
Supported Community Living (RCF)	1,202	1,195
Supported Community Living	964	942
Physical Disability (PD)	394	403
Personal Emergency Response	216	225
CDAC (agency) by 15 minute units	169	176
CDAC (individual) by 15 minute units	119	126
Transportation (1-way trip)	44	42
Personal Emergency Response (install)	28	30

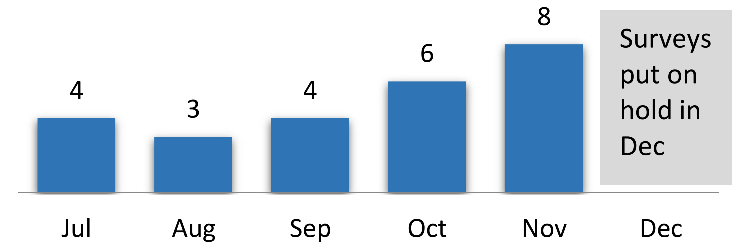
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	86.50%	85.30%	97.85%
Abandonment Rate - Must be 5% or less	1.26%	0.92%	0.29%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.30%	99.55%	99.28%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	76.79%	80.13%	96.08%
Abandonment Rate - Must be 5% or less	2.32%	0.87%	0.21%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	95.78%	95.35%	95.89%
Abandonment Rate - Must be 5% or less	0.54%	0.19%	0.06%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	85.88%	83.33%	84.00%
Abandonment Rate - Must be 5% or less	0.93%	1.77%	1.70%

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.

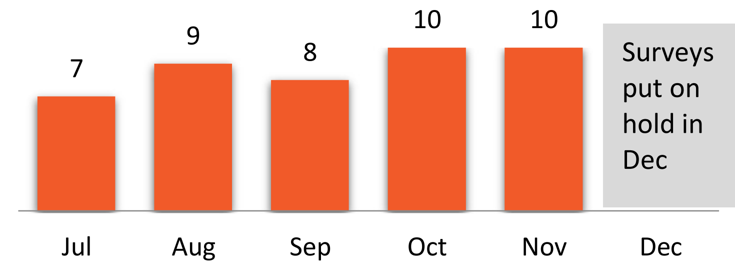
	Top 5 Call Reasons (Member Helpline)	Top 5 Call Reasons (Provider Helpline)
1.	Benefit Inquiry	Benefit Inquiry
2.	Enrollment Information	Authorization Status
3.	Over the Counter	Claim Status
4.	ID Card Request or Inquiry	Claim Payment Question or Dispute
5.	Other	Authorization New

Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	83.01%	75.01%	94.96%
Abandonment Rate - Must be 5% or less	2.88%	3.51%	0.90%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	82.54%	80.09%	97.09%
Abandonment Rate - Must be 5% or less	0.64%	1.89%	0.84%
Provider Helpline			
Service Level (Requirement 80%)	83.59%	77.89%	96.99%
Abandonment Rate - Must be 5% or less	1.20%	1.60%	0.40%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.70%	93.64%	93.85%
Abandonment Rate - Must be 5% or less	0.86%	0.36%	0.62%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	87.78%	88.98%	92.79%
Abandonment Rate - Must be 5% or less	0.70%	0.50%	0.71%

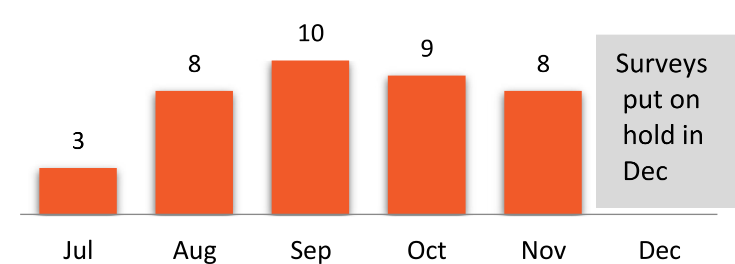
Secret Shopper Scores

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

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

Provider Network Access Summary

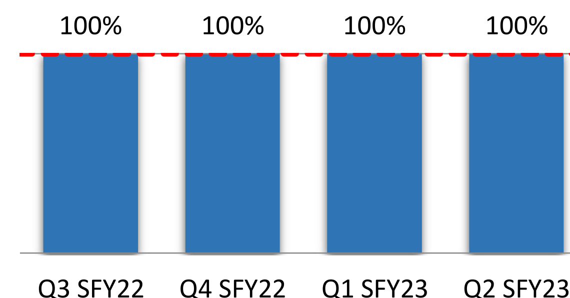
Primary Care Providers (PCP)

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2
Adults PCP				
Provider Count	6,768	6,893	7,093	6,725
Members with Access	230,958	237,584	238,093	231,049
Average Distance (Miles)	1.8	1.8	1.8	1.8
Pediatric PCP				
Provider Count	6,798	6,924	7,124	6,755
Members with Access	214,637	214,390	213,457	213,503
Average Distance (Miles)	1.9	1.9	1.9	1.9

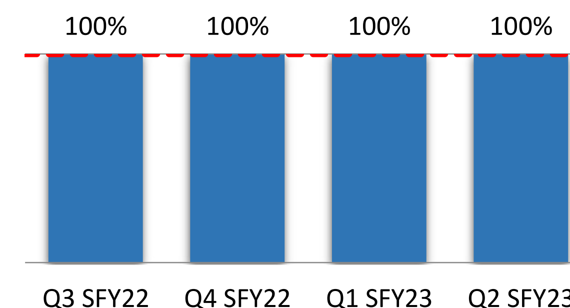
Specialty Care & Behavioral Health (BH)

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2
OB/GYN Adult				
Provider Count	409	423	440	406
Members with Access	150,019	154,186	154,298	150,203
Average Distance (Miles)	5.5	5.5	5.5	5.5
Outpatient - Behavioral Health				
Provider Count	4,503	4,543	4,679	4,449
Members with Access	445,595	451,974	451,550	444,552
Average Distance (Miles)	2.2	2.2	2.2	2.2
Inpatient - Behavioral Health				
Provider Count	51	51	53	51
Rural Members				
Members with Access	181,707	184,359	184,040	181,380
Average Distance (Miles)	18.3	21.0	18.8	18.3
Urban Members				
Members with Access	263,888	267,615	267,510	263,172
Average Distance (Miles)	5.8	5.8	5.7	5.8

Adult PCP - Standards
30 minutes or 30 miles
Contract Requirement: 100%



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)

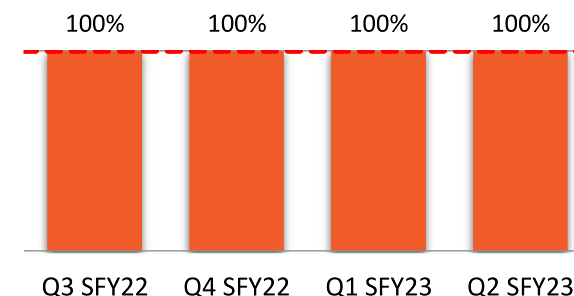
	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2
Adults PCP				
Provider Count	9,894	9,894	9,894	9,894
Members with Access	186,041	189,029	196,756	206,246
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	10,658	10,658	10,658	10,658
Members with Access	146,338	147,665	151,411	155,500
Average Distance (Miles)	2.1	2.1	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2
OB/GYN Adult				
Provider Count	1,298	1,298	1,298	1,298
Members with Access	121,417	123,122	127,515	133,013
Average Distance (Miles)	5.3	5.4	5.3	5.3
Outpatient - Behavioral Health				
Provider Count	9,688	9,688	9,688	9,688
Members with Access	332,379	336,694	348,179	361,746
Average Distance (Miles)	2.4	2.5	2.5	2.4
Inpatient - Behavioral Health				
Provider Count	36	36	36	36
Rural Members				
Members with Access	238,027	241,452	249,950	259,591
Average Distance (Miles)	24.5	24.5	24.4	24.4
Urban Members				
Members with Access	94,352	95,242	98,229	102,155
Average Distance (Miles)	8.4	8.4	8.4	8.4

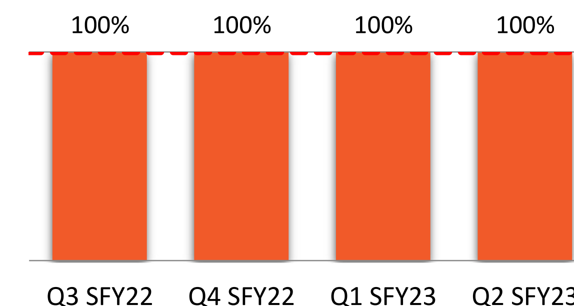
Adult PCP - Standards
30 minutes or 30 miles

Contract Requirement: 100%



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

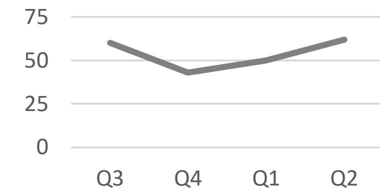
MCO Program Integrity

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 Q2

62



15 Total Cases Referred to MFCU Q2

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Total
Investigations opened	44	25	36	41	37	146
Overpayments identified	28	10	14	8	15	60
Member concerns referred to IME	0	4	2	2	2	8
Cases referred to the Medicaid Fraud Control Unit (MFCU)	3	2	3	9	4	17

	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Total
Investigations opened	16	18	14	21	17	69
Overpayments identified	9	6	19	21	14	55
Member concerns referred to IME	6	4	4	4	5	18
Cases referred to the Medicaid Fraud Control Unit (MFCU)	3	0	2	6	3	11

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…

MAAC Council Member List continued...

Professional and Business Entities

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

Appendix: Oversight Entities - Council on Human Services

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

See DHS website for all future and historical meeting information: https://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