STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

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:

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.

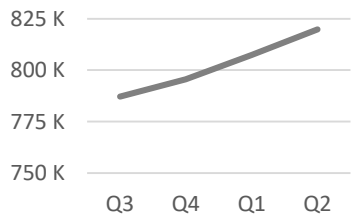
MCO Member Summary - All MCO Counts

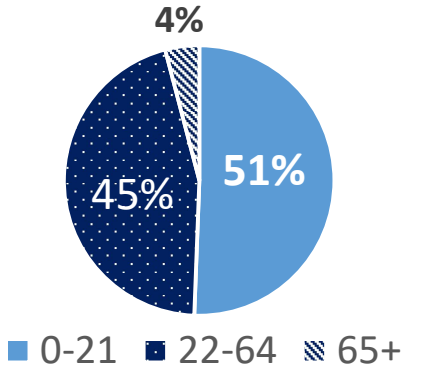
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

Amerigroup (An Anthem Company)	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
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

iowa total care	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
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)

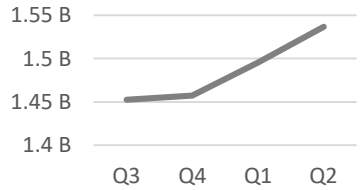
MCO Financial Summary - All MCO Counts

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

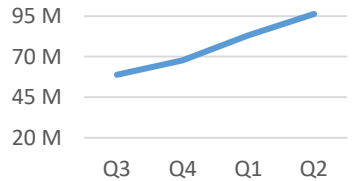
$1.5 Billion



+ $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 [ ]

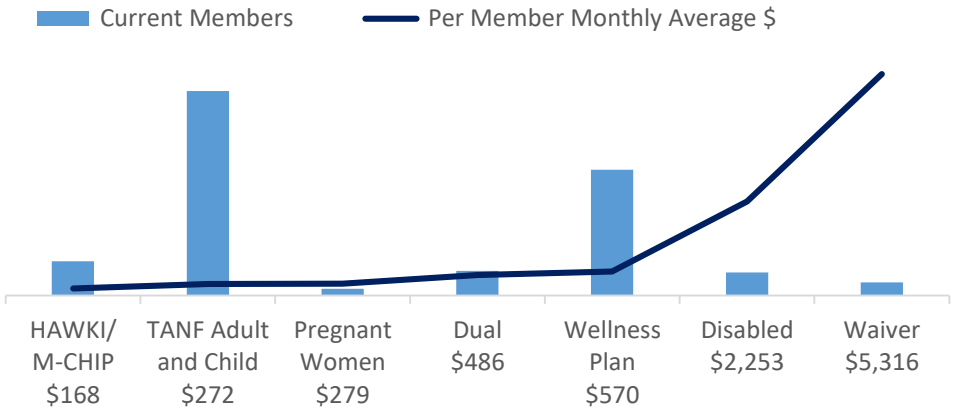
If Yes, explain:

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.

Monthly Capitation Expenditures



Amerigroup An Anthem Company

	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**

iowa total care

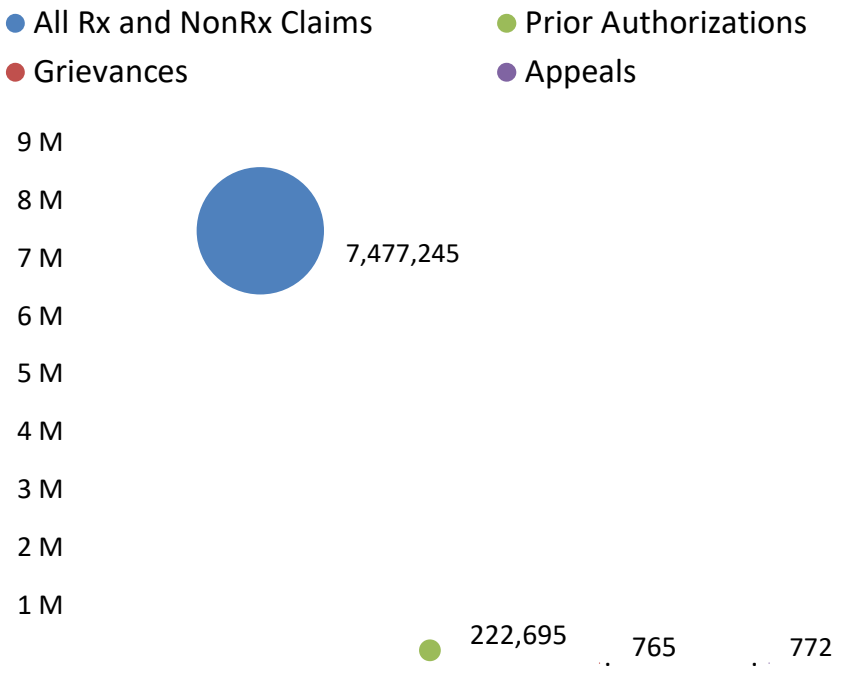
	SFY23 Q1	SFY23 Q2
Capitation Totals	$638.84 M	**$678.99 M**
Adjustments	-$56 K	$2.81 M
Current	$617.42 M	$647.12 M
Retro	$21.47 M	$29.07 M
Third Party Liability (TPL)	$54.8 M	**$72.5 M**
Financial Ratios		
Medical Loss Ratio (MLR)	95.5%	**97.1%**
Administrative Loss Ratio (ALR)	6.0%	5.3%
Underwriting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

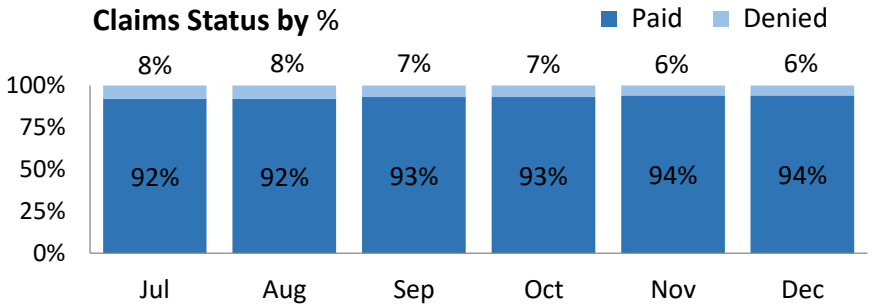
	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.7 M	7.4 M	7.4 M	**7.5 M**	7.5 M	30.0 M
Non-Pharmacy	4.4 M	4.4 M	4.2 M	4.3 M	4.3 M	17.4 M
Pharmacy	3.3 M	3.0 M	3.1 M	3.1 M	3.1 M	12.6 M
Prior Authorization Summary (p. 13-14)	186,524	193,729	197,872	**222,695**	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

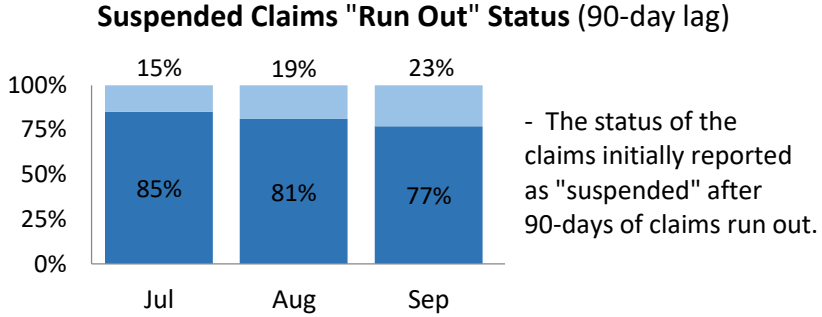
Claims Summary (Non-Pharmacy)

2.5 Million
Claims Paid & Denied

Amerigroup
An Anthem Company

	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

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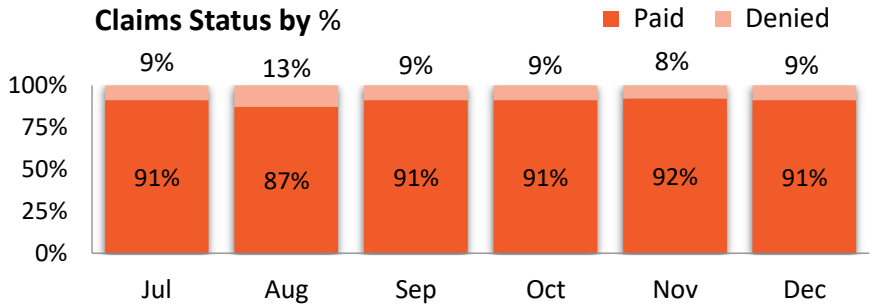
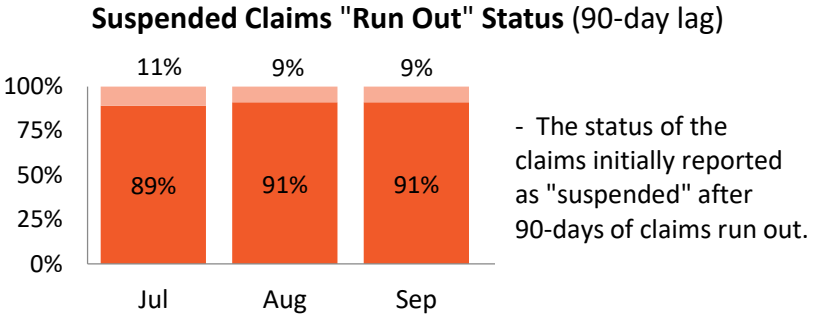
	Oct	Nov	Dec
All Claims			
Paid	524,852	621,456	527,461
Denied	49,347	54,484	51,838
Suspended	140,268	97,276	139,934
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	99%	99%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	9	11	8
Provider Adjustment Requests & Errors Reprocessed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





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

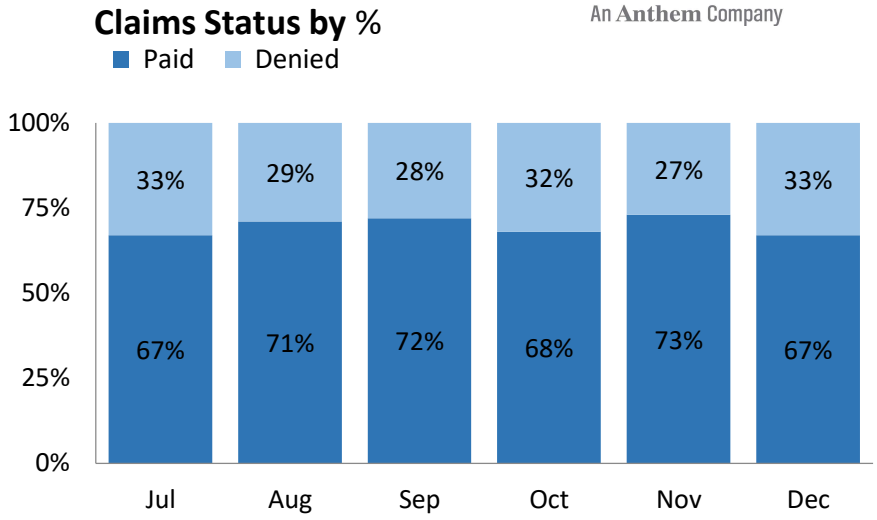
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
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



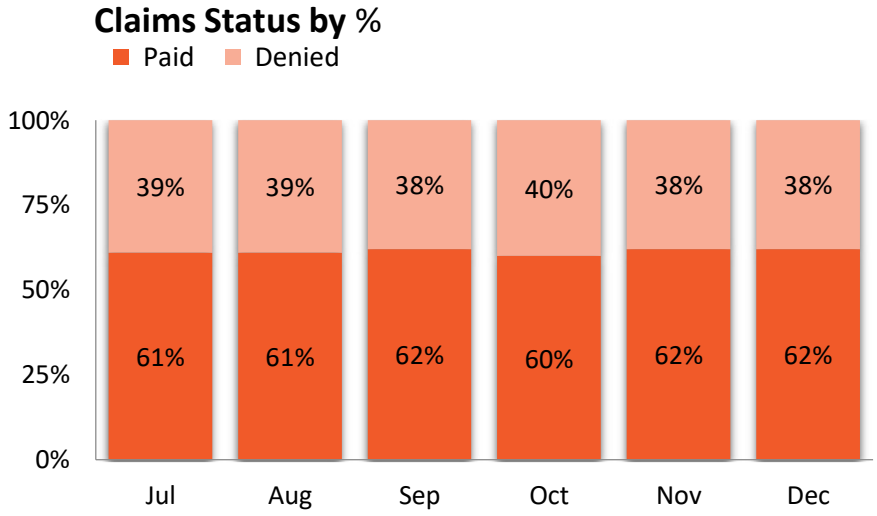
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
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



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

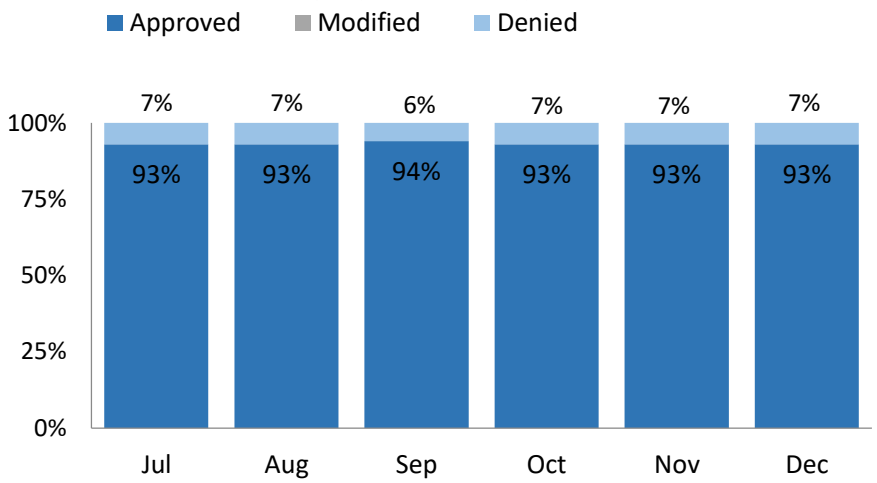
87,221
All PAs Submitted [6]

Amerigroup
An Anthem Company

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%

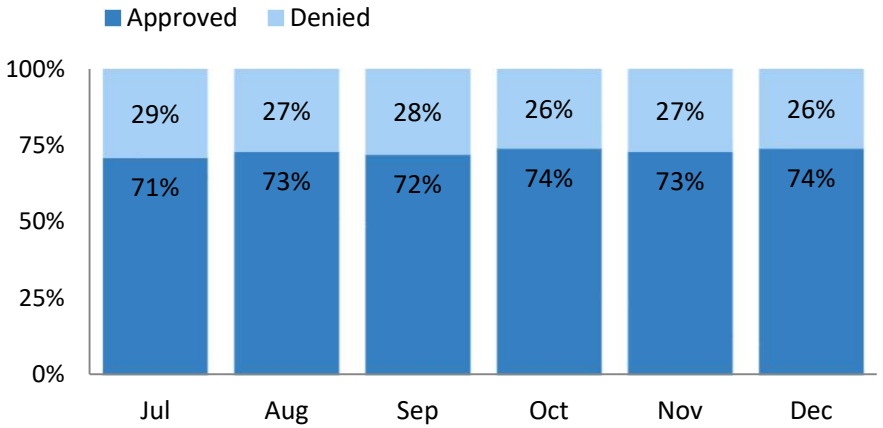
Non-Pharmacy by Percentage



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



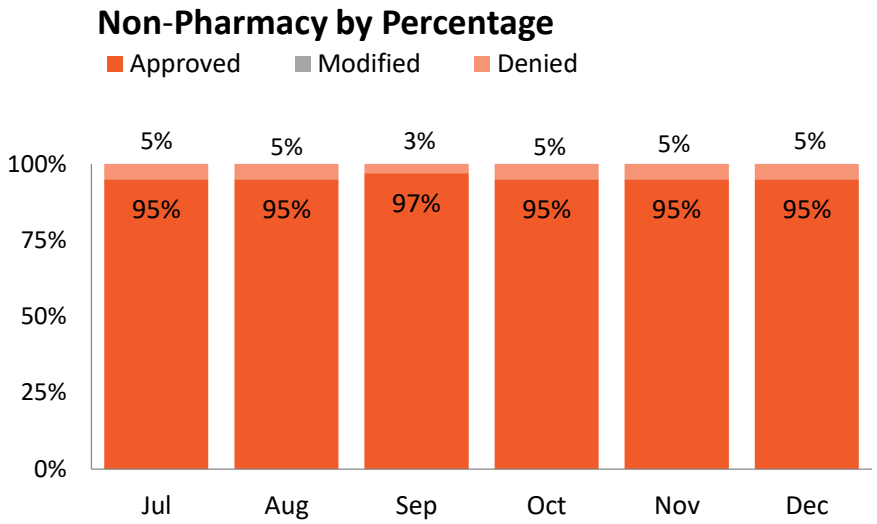
[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

135,474
All PAs Submitted [6]

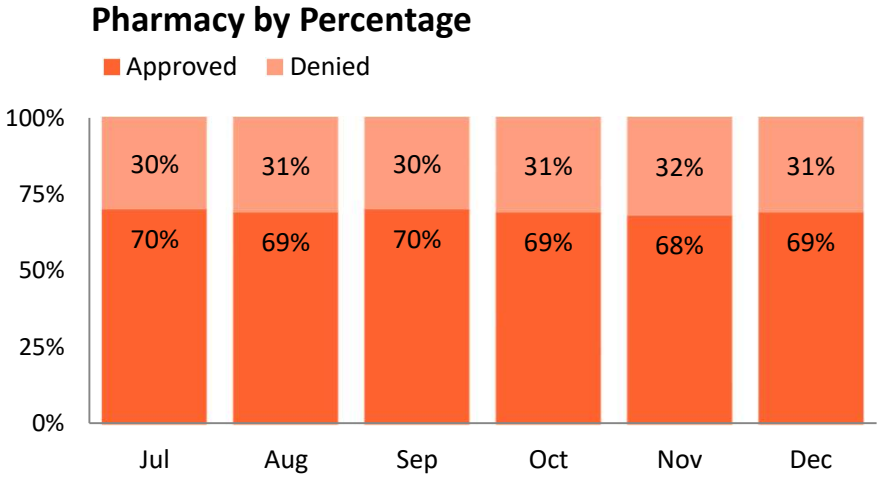
Non-Pharmacy

	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%

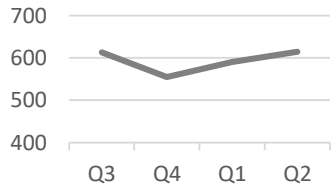


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

Standard Grievances

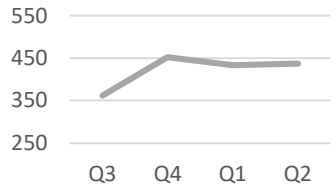
615



Resolved in 30-days
100%

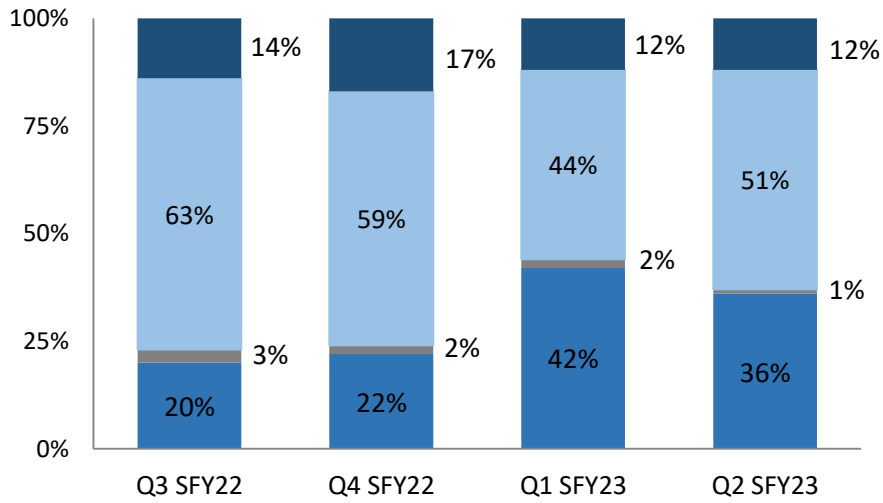
Standard Appeals/ 1st Level Review

437



Resolved in 30-days
100%

Standard Appeal Outcome %



	%	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

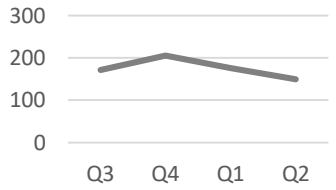
%	Top 10 Reasons for Appeals [7]
34%	Pharmacy - Non Injectable
21%	DME
16%	Pharmacy - Injectable
14%	Outpatient Services - Medical
6%	Surgery
4%	Radiology
4%	Inpatient - Medical
3%	Therapy OT/PT
3%	Pain Mgmt
1%	BH - Op Service

[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

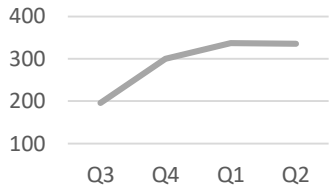
150



Resolved in 30-days
100%

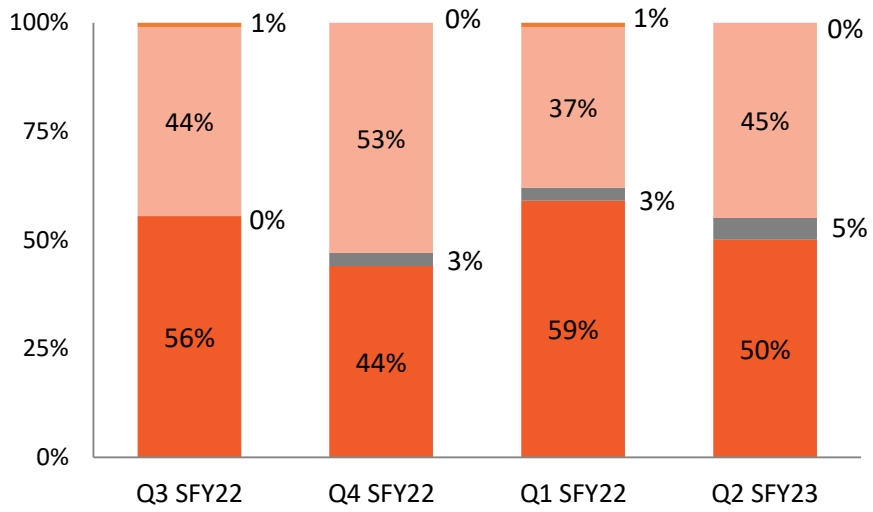
Standard Appeals/ 1st Level Review

335



Resolved in 30-days
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.

MCO Care Quality and Outcomes

Value Based Purchasing (VBP) Agreement

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

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	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

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	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

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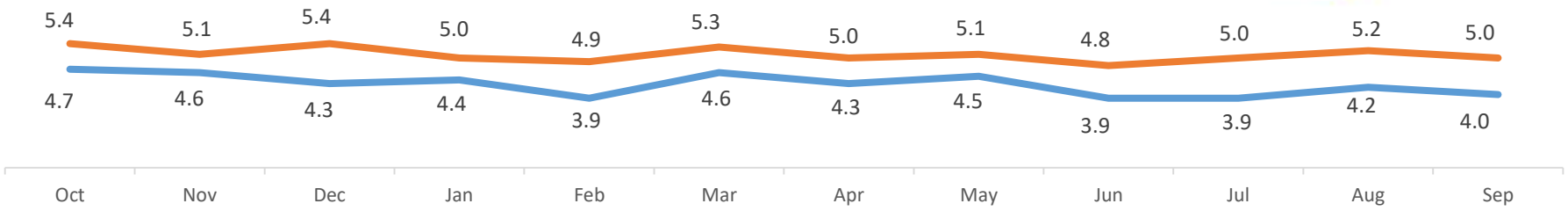
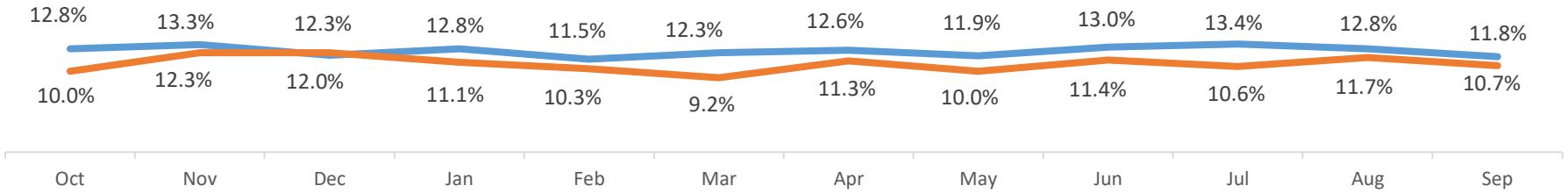
	SFY23 Q1	SFY23 Q2
The Flu Program	610	14,212
My Health Pays Program	10,346	12,676
In Home Diabetic Test Kits	3	3,497
Mobile App	1,448	1,831
Start Smart for Your Baby	1,698	1,743

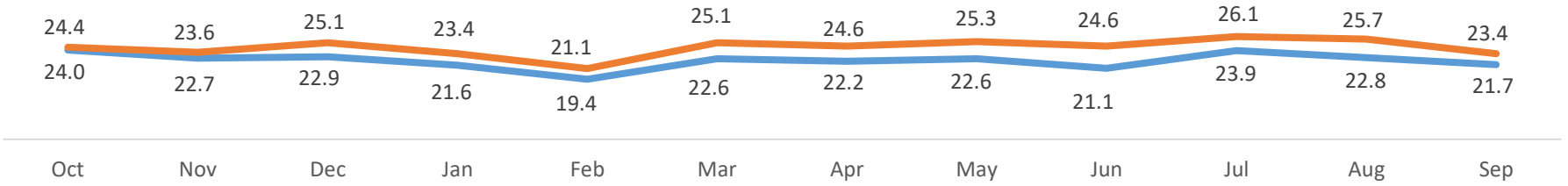
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



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

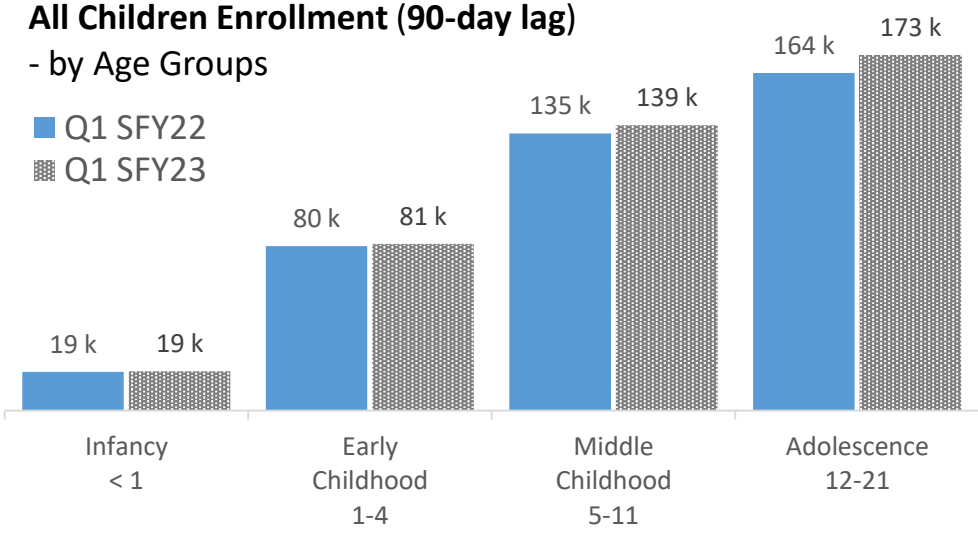
[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

MCO Children Summary

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

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

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



Amerigroup An Anthem Company

	SFY22 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

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	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

Amerigroup An Anthem Company	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

iowa total care	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

Amerigroup An Anthem Company

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

iowa total care

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*	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

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

Amerigroup An Anthem Company	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

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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

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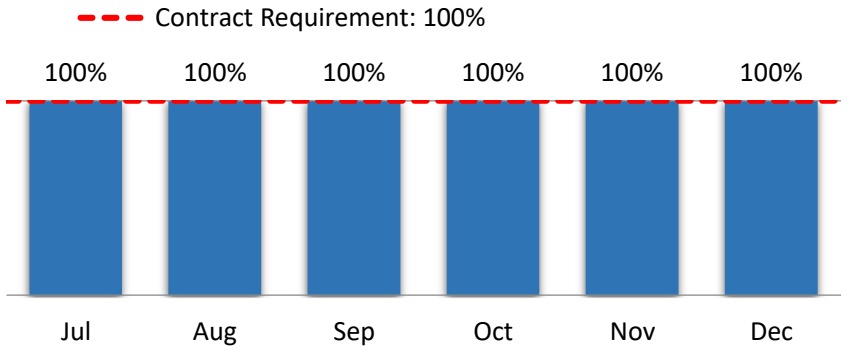
Average Number of Contacts Per Month	SFY23 Q1	SFY23 Q2
by Care Coordinators	2.0	**38.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	15	**12**
HCBS Members to Case Managers	69	**76**

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.

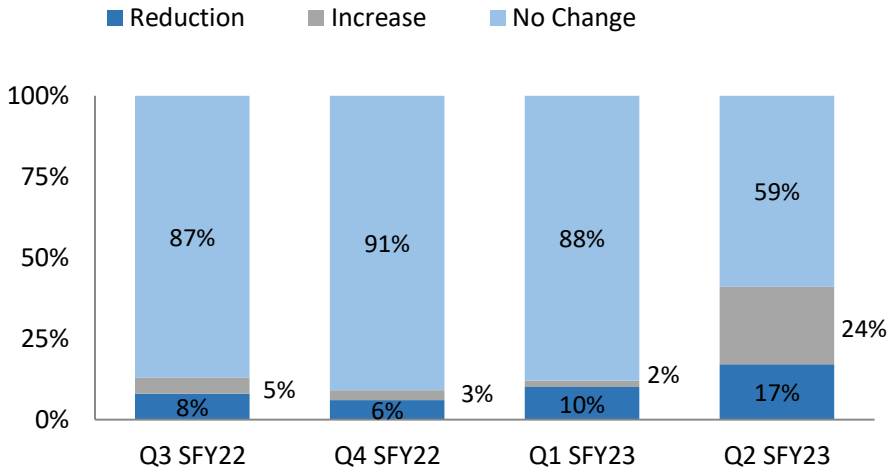
Iowa Participant Experience Survey (IPES)

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



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

iowa total care

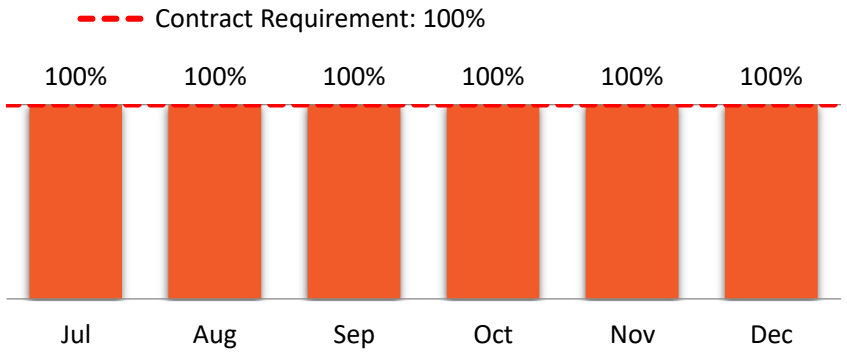
Average Number of Contacts Per Month	SFY23 Q1	SFY23 Q2
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	47	**44**
HCBS Members to Case Managers	42	**44**

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

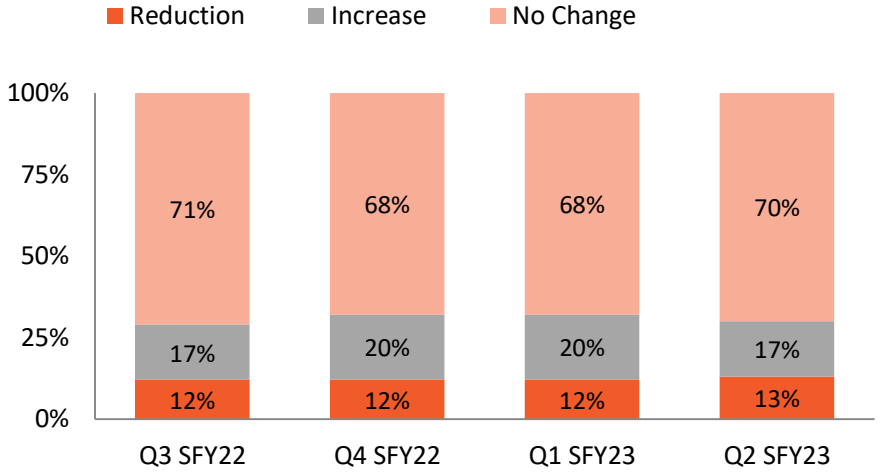
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY23 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%

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

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	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

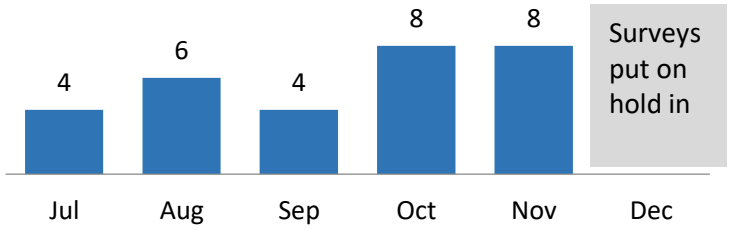
	SFY23 Q1	SFY23 Q2
AIDS/HIV - Waiver Member Count	8	8
Home Delivered Meals	8	8
CDAC (individual) by 15 minute units	1	3
Homemaker (by 15 minute units)	1	1
CDAC (agency) by 15 minute units	1	1
Brain Injury (BI) Waivers	524	519
Supported Community Living (by unit)	215	214
Personal Emergency Response	141	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

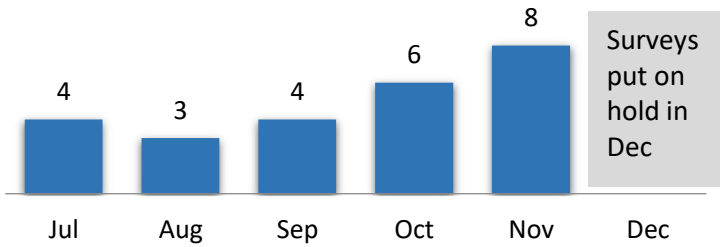
Call Center Performance Metrics

	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.

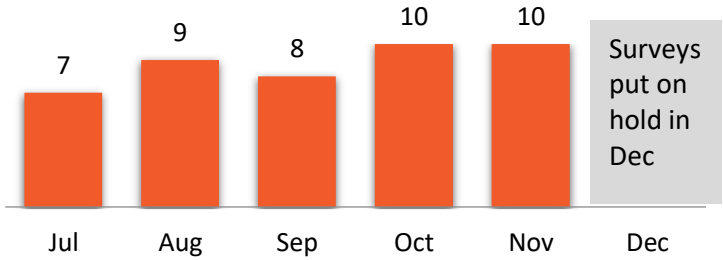
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	Enrollment Information
3.	Over the Counter
4.	ID Card Request or Inquiry
5.	Other

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

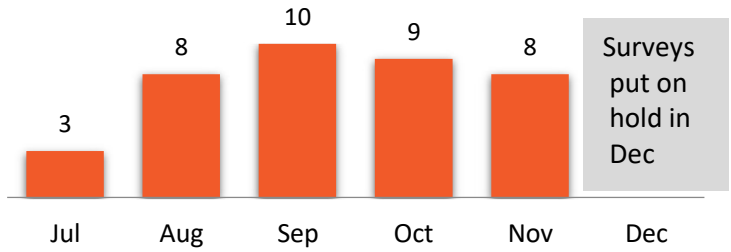
Call Center Performance Metrics

	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%
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

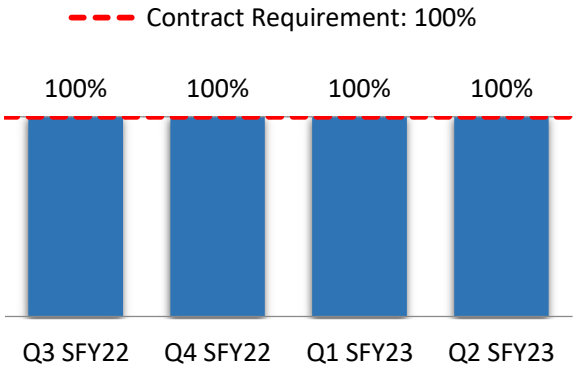
Specialty Care & Behavioral Health (BH)

	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

Amerigroup
An Anthem Company

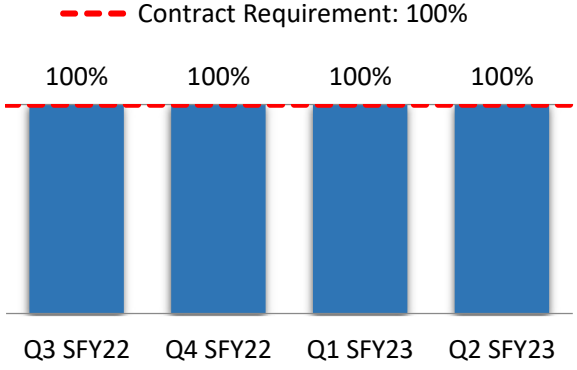
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

Provider Network Access Summary

Primary Care Providers (PCP)

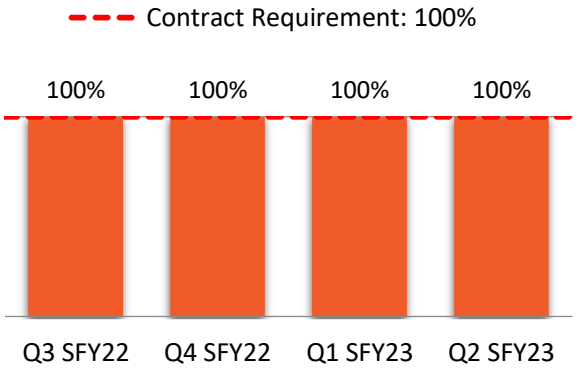
	SFY22 Q3	SFY22 Q4	SFY23 Q1	SFY23 Q2
Adults PCP				
Provider Count	9,894	9,894	9,894	9,894
Members with Access	186,041	189,029	196,756	206,246
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	10,658	10,658	10,658	10,658
Members with Access	146,338	147,665	151,411	155,500
Average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

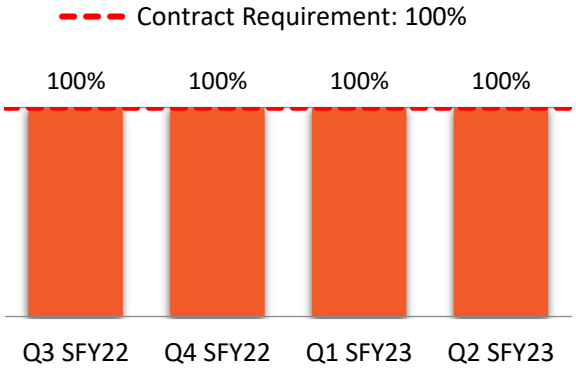
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

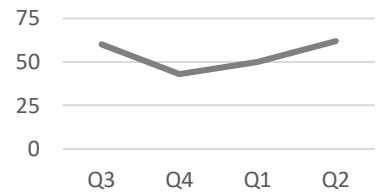
MCO Program Integrity

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

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

Total Investigations Opened in SFY23 Q2

62



15 Total Cases
Referred to MFCU Q2

Amerigroup
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	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

iowa total care

	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