



STATE OF IOWA DEPARTMENT OF  
**Health** AND **Human**  
SERVICES

**Managed Care Organization (MCO)**  
**Quarterly Performance Report**  
SFY2023, Quarter I  
(July - September 2022)

Published December 2022

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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

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

### Notes about the reported data:

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

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

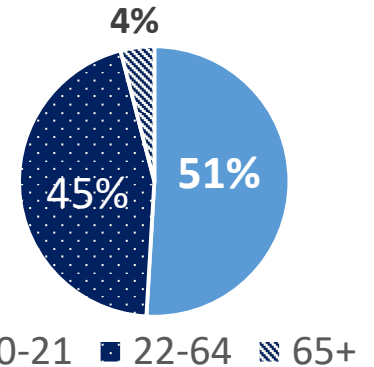
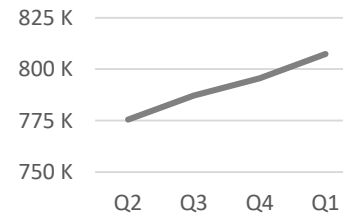
# MCO Member Summary - All MCO Counts

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

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

All MCO Members

**807,413**



**+ 11,906 Members**  
1.50% Increase

**All MCO Enrollment**  
(by Age)

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

	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Distinct
<b>MCO Member Summary - Overall Counts</b>	775,507	787,187	795,507	<b>807,413</b>	791,404	<b>841,836</b>
0-21	400,213	404,569	407,098	411,121	405,750	426,544
22-64	345,001	351,867	356,845	363,817	354,383	378,779
65+	30,293	30,751	31,564	32,475	31,271	36,513
<b>Fee-For-Service (FFS) - Non MCO Enrollees</b>	46,254	46,896	47,940	<b>48,623</b>	47,428	<b>51,968</b>
<b>Significant Change in Data? (+/-)</b>	No <input type="checkbox"/>		Yes <input checked="" type="checkbox"/>		<b>Iowa Medicaid Population</b>	<b>893,804</b>
<i>If Yes, explain:</i>						1 year distinct count
<ul style="list-style-type: none"> <li>o Disenrollment increased between Q4 and Q1 for each MCO because of Open Enrollment</li> <li>o MCO Market Share &gt; All new members are being assigned to Iowa Total Care prior to Molina implementation</li> </ul>						

# MCO Member Summary



SFY22 Q4    SFY23 Q1

<b>All Members - by MCO</b>	455,273	<b>455,190</b>
Traditional Medicaid	280,403	281,794
Wellness Plan - IHAWP/Expansion	129,728	129,781
M-CHIP - Expansion	9,842	9,921
Healthy and Well Kids in Iowa (Hawki)	35,300	33,694
MCO Member Market Share	57.4%	56.4%
Disenrolled	517	1,451



SFY22 Q4    SFY23 Q1

<b>All Members - by MCO</b>	340,234	<b>352,223</b>
Traditional Medicaid	210,236	217,967
Wellness Plan - IHAWP/Expansion	108,181	112,810
M-CHIP - Expansion	6,779	6,977
Healthy and Well Kids in Iowa (Hawki)	15,038	14,469
MCO Member Market Share	42.8%	43.6%
Disenrolled	334	905

<b>Long-Term Service &amp; Support (LTSS)</b>	21,436	<b>21,061</b>
HCBS Waivers	69.0%	69.4%
Facility Based Services	31.0%	30.6%
<b>HCBS Waivers <sup>1</sup></b>	14,785	<b>14,624</b>
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
<b>Facility Based Services <sup>2</sup></b>	6,651	<b>6,437</b>
ICF/ID <sup>3</sup>	849	817
Mental Health Institute (MHI)	43	29
Nursing Facilities (NF)	5,411	5,242
Nursing Facilities for Mentally Ill	59	58
Skilled	88	87
PMIC <sup>4</sup>	201	204

<b>Long-Term Service &amp; Support (LTSS)</b>	14,669	<b>14,998</b>
HCBS Waivers	65.3%	64.9%
Facility Based Services	34.7%	35.1%
<b>HCBS Waivers <sup>1</sup></b>	9,583	<b>9,730</b>
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
<b>Facility Based Services <sup>2</sup></b>	5,086	<b>5,268</b>
ICF/ID <sup>3</sup>	503	491
Mental Health Institute (MHI)	30	31
Nursing Facilities (NF)	4,339	4,531
Nursing Facilities for Mentally Ill	31	35
Skilled	67	76
PMIC <sup>4</sup>	116	104

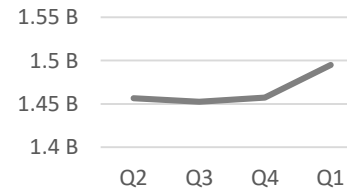
<sup>1</sup> Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24. <sup>2</sup> Facility Based Services listed above only include the institutional groups where members are most likely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

# MCO Financial Summary - All MCO Counts

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

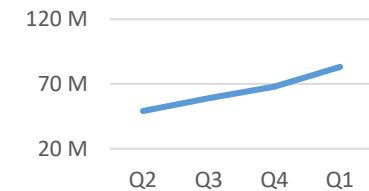
The MCOs are responsible for recovering Medicaid dollars when it is determined that other insurance coverage is available (e.g. health, auto, worker's comp, or even Medicare). This process is known as Third Party Liability (TPL). The MCO retains all recovered TPL funds: however, these funds are then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

All Capitation Payments  
**\$1.5 Billion**



**+ \$38.2 Million**  
2.6% Increase

Third Party Liability Recovered  
**\$83.1 Million**



**+ \$ 15.5 Million**  
22.8% increase

**Data Notes:** September 2022 enrollment data as of November 2022. All Third Party Liability (TPL) data reported above is self-reported by MCOs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

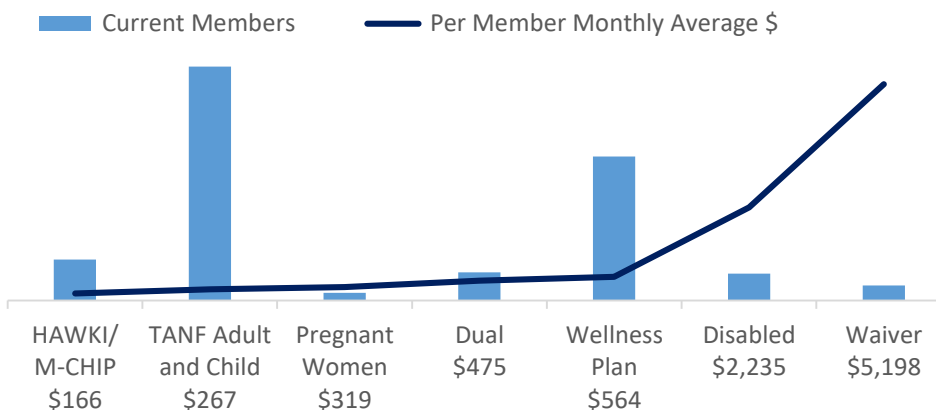
	SFY22 Q2	SFY22 Q3	SFY22 Q4	SFY23 Q1	Average	Total
<b>Financial Summary</b>						
Capitation Payments	\$1.46 B	\$1.45 B	\$1.46 B	<b>\$1.5 B</b>	\$1.47 B	\$5.86 B
Third Party Liability (TPL) Recovered	\$49.2 M	\$58.9 M	\$67.7 M	<b>\$83.1 M</b>	\$64.7 M	\$258.9 M
<b>Significant Change in Data? (+/-)</b>	No <input type="checkbox"/>		Yes <input checked="" type="checkbox"/>			
<i>If Yes, explain:</i>	<div style="border: 1px solid black; padding: 5px;"> <p>o Third Party Liability Recovered increased by 22.8% (\$67.7M to \$83.1M)</p> </div>					

# 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



SFY22 Q4 | SFY23 Q1

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



SFY22 Q4 | SFY23 Q1

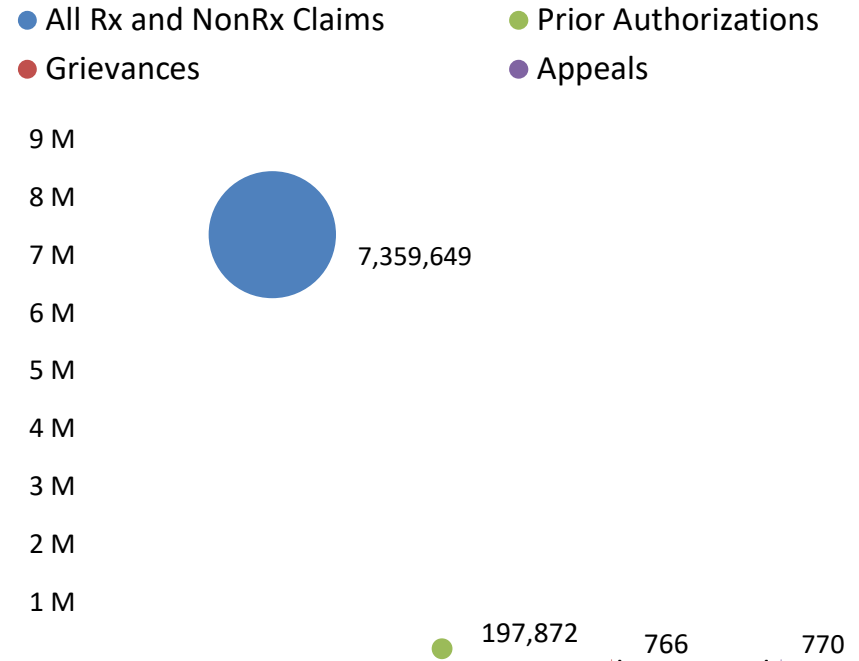
<b>Capitation Totals</b>	\$613.33 M	<b>\$638.84 M</b>
Adjustments	-\$18 K	-\$56 K
Current	\$594.66 M	\$617.42 M
Retro	\$18.68 M	\$21.47 M
<b>Third Party Liability (TPL) Recovered</b>	\$39.4 M	<b>\$54.8 M</b>
<b>Financial Ratios</b>		
Medical Loss Ratio (MLR)	94.2%	<b>91.7%</b>
Administrative Loss Ratio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

<sup>5</sup> Converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

# MCO Claims Universe - All MCO Counts

This illustration provides context to the volume of the following actions in comparison to the overall claims universe:

- Some benefits may require **Prior Authorization** before service
- Members may elect to file a **Grievance** to express general plan dissatisfaction
- Members or Providers may **Appeal** a filed claim based on a reduction in benefits or an outright rejection



	% of Claims Universe
Prior Authorizations	2.69%
Grievances	0.01%
Appeals	0.01%

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



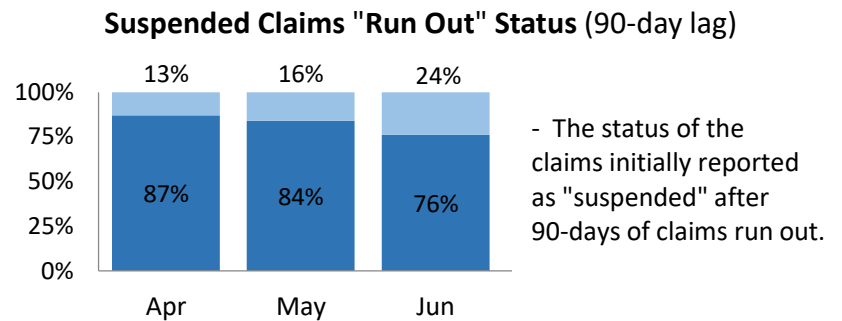
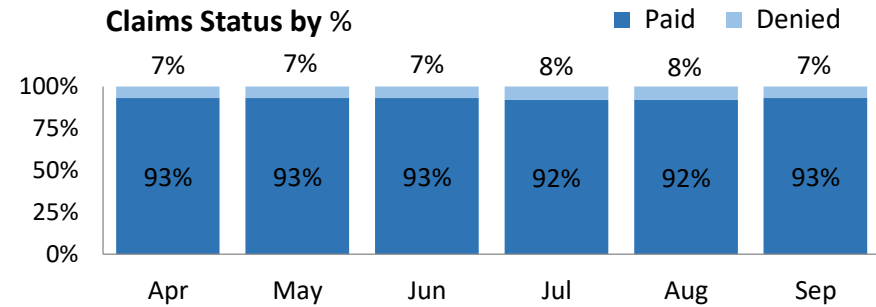
# Claims Summary (Non-Pharmacy)

**2.37 Million**  
Claims Paid & Denied



Jul      Aug      Sept

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



## Top 10 Reasons for Claims Denials (Non-Pharmacy)

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

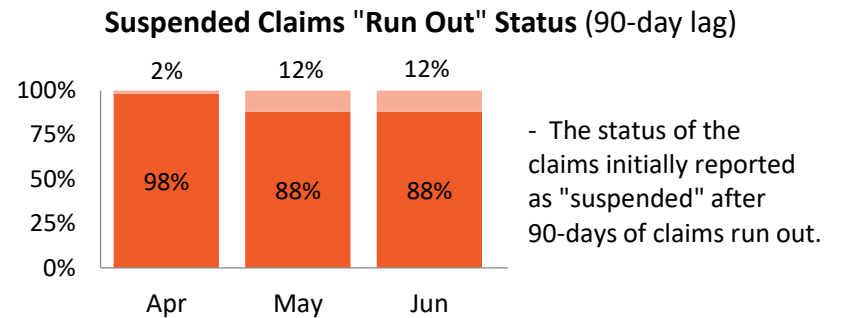
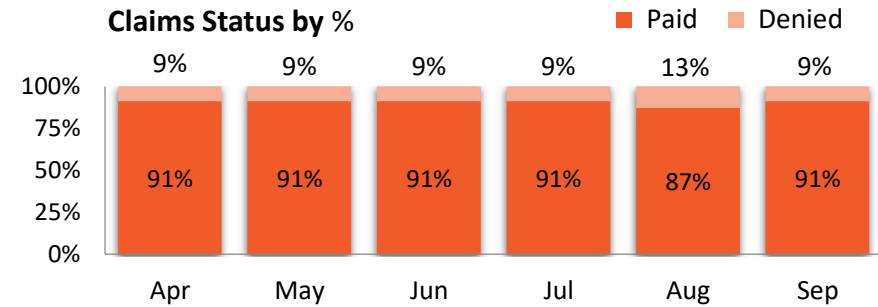
# Claims Summary (Non-Pharmacy)

**1.88 Million**  
Claims Paid & Denied



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



## Top 10 Reasons for Claims Denials (Non-Pharmacy)

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

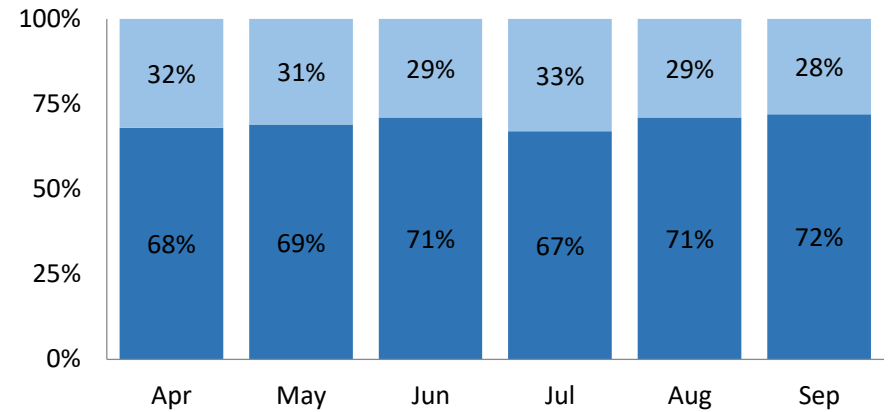
# Claims Summary (Pharmacy)



**1.76 Million**  
Claims Paid & Denied

**Claims Status by %**  
■ Paid ■ Denied

	Jul	Aug	Sept
<b>All Claims (Pharmacy)</b>			
Paid	339,312	430,108	466,265
Denied	163,569	175,894	181,234
<b>Clean Claims Processed</b>			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
<b>Average Days to Pay</b>	11	11	11



## Top 10 Reasons for Claims Denials (Pharmacy)

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

# Claims Summary (Pharmacy)



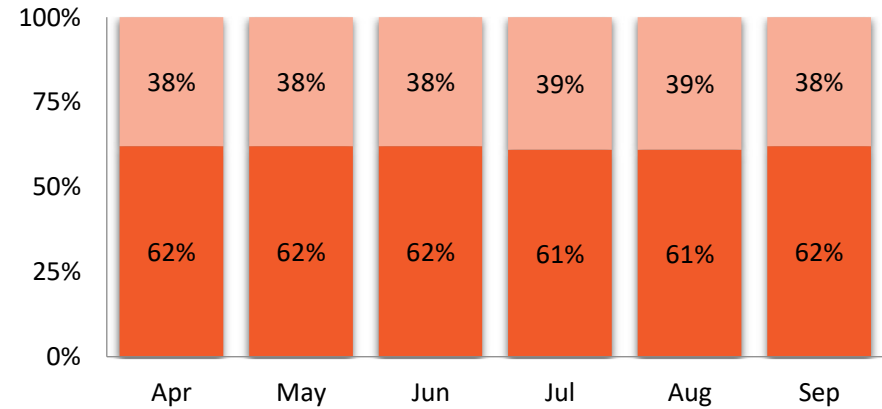
**1.36 Million**  
Claims Paid & Denied

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

### Claims Status by %

■ Paid ■ Denied



## Top 10 Reasons for Claims Denials (Pharmacy)

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

# Prior Authorization Summary



**88,689**  
All PAs Submitted <sup>6</sup>

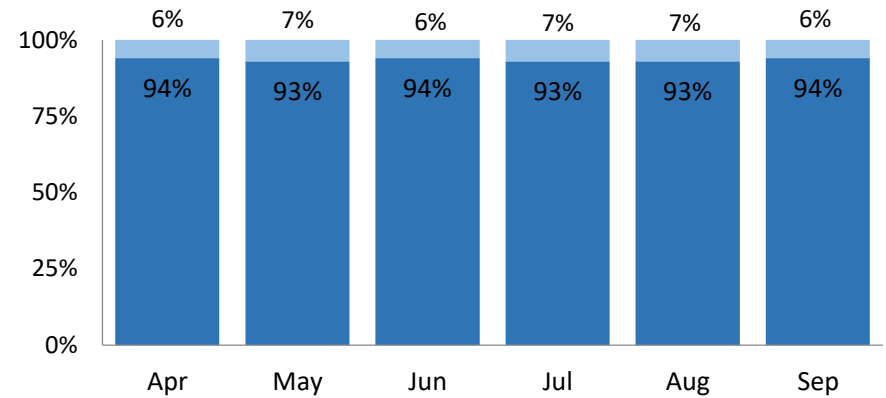
## Non-Pharmacy

Jul      Aug      Sept

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

## Non-Pharmacy by Percentage

■ Approved    ■ Modified    ■ Denied



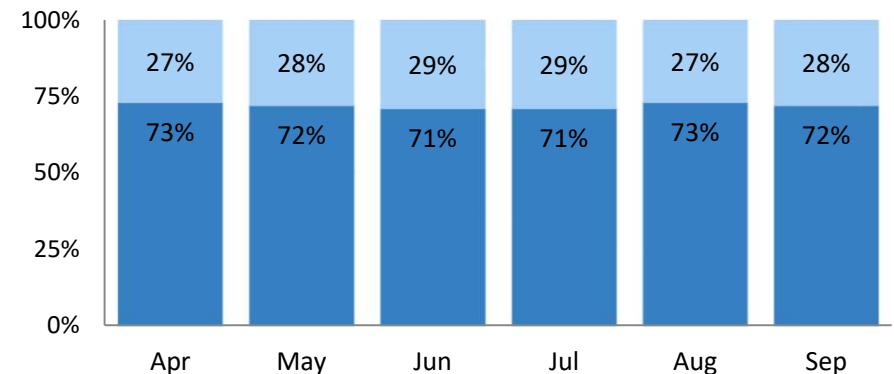
## Pharmacy

Jul      Aug      Sept

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

## Pharmacy by Percentage

■ Approved    ■ Denied



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

# Prior Authorization Summary



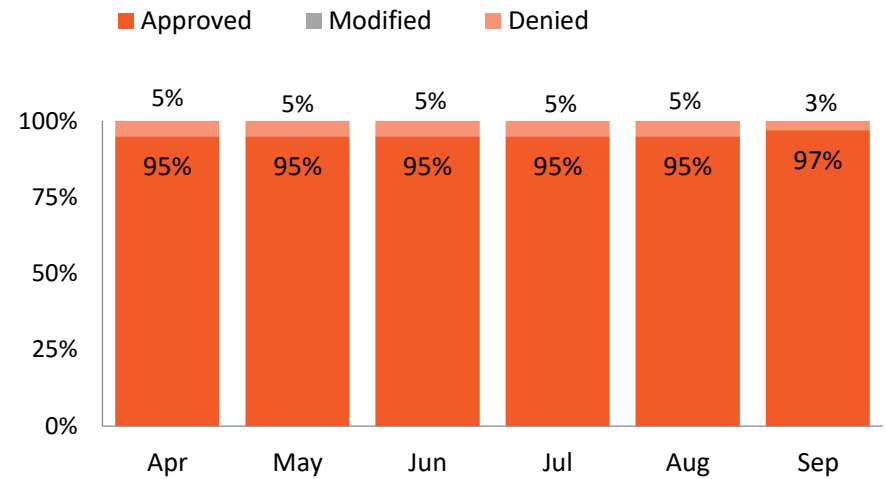
**109,183**

All PAs Submitted <sup>6</sup>

## Non-Pharmacy

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

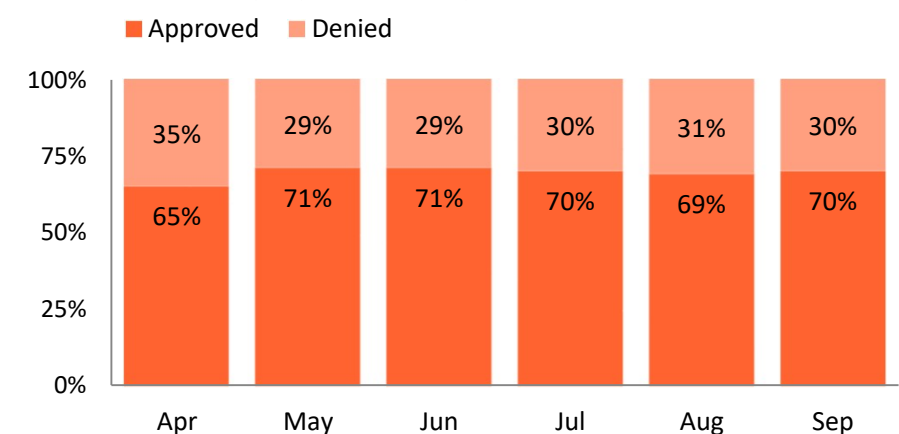
## Non-Pharmacy by Percentage



## Pharmacy

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

## Pharmacy by Percentage



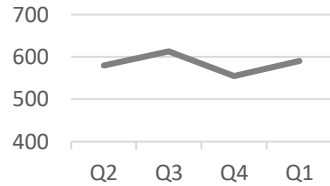
<sup>6</sup> Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

# Grievances and Appeals



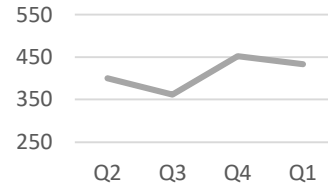
Standard Grievances

**590**



Standard Appeals/ 1st Level Review

**433**

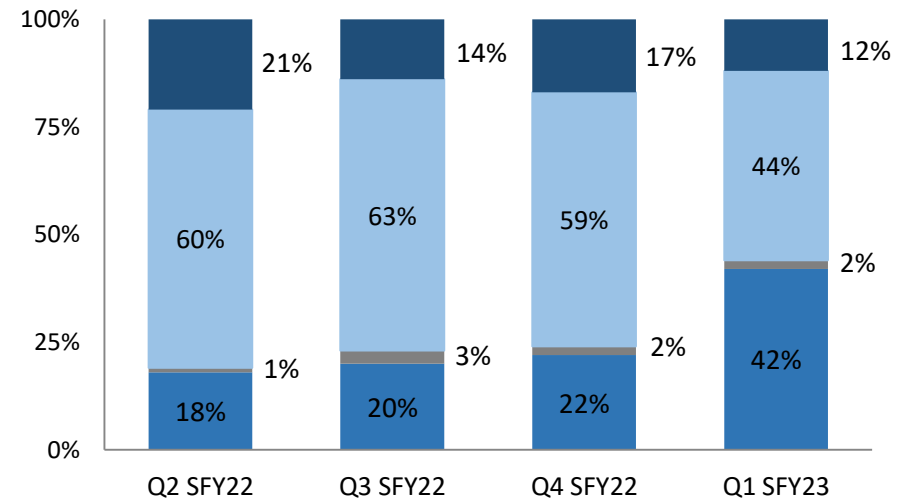


**Resolved in 30-days  
100%**

**Resolved in 30-days  
100%**

■ Withdrawn      ■ Upheld  
■ Partially Overturned      ■ Overturned

Standard Appeal Outcome %



## Top 10 Reasons for Grievances <sup>7</sup>

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

## Top 10 Reasons for Appeals <sup>7</sup>

	%	Reason
	36%	Pharmacy - Non Injectable
	19%	DME
	10%	Pharmacy - Injectable
	9%	Outpatient Services - Medical
	4%	Surgery
	4%	Radiology
	4%	Pain Management
	4%	Inpatient - Medical
	1%	Skilled Nursing
	1%	Personal Care Services Self Directed

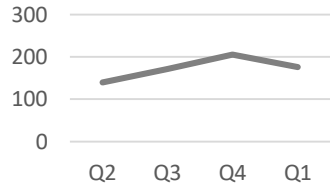
<sup>7</sup> Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

# Grievances and Appeals



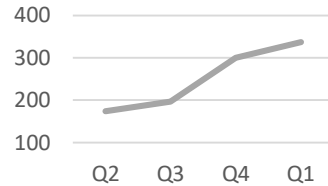
Standard Grievances

176



Standard Appeals/ 1st Level Review

337

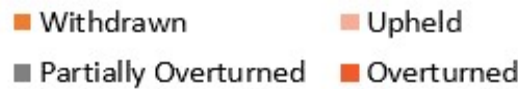


Resolved in 30-days

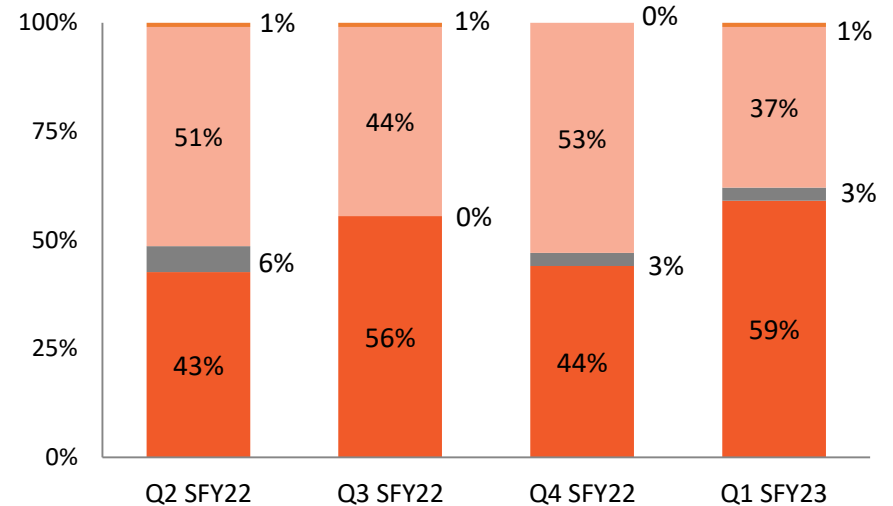
100%

Resolved in 30-days

100%



Standard Appeal Outcome %



## Top 10 Reasons for Grievances <sup>7</sup>

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

## Top 10 Reasons for Appeals <sup>7</sup>

	%	Reason
	26%	RX - Does Not Meet Prior Auth Guidelines
	15%	Therapy - Speech Therapy
	8%	Therapy - Physical Therapy
	6%	Therapy - Occupational Therapy
	5%	Injections - Epidural Injections
	4%	DME - Other
	3%	DME - Wheelchair
	3%	Outpatient - Procedure
	3%	Diagnostic - MRI
	2%	Diagnostic - CAT Scan

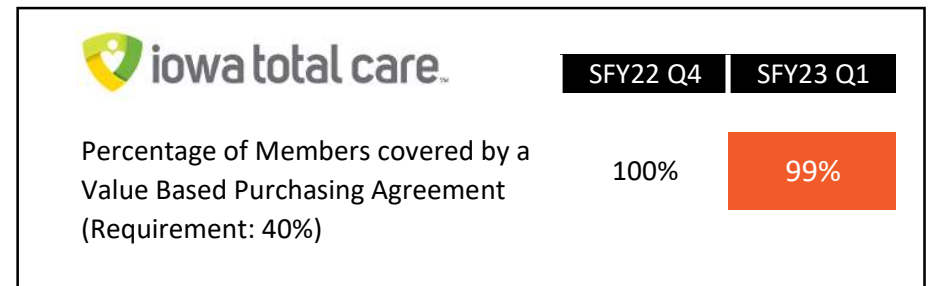
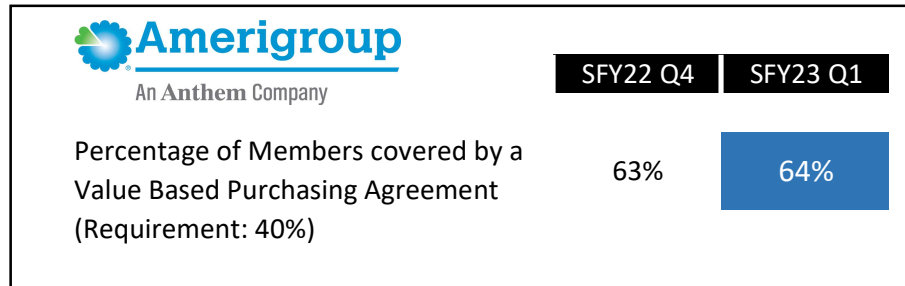
<sup>7</sup> Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.



# MCO Care Quality and Outcomes

## Value Based Purchasing (VBP) Agreement

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



## Top 5 - Value Added Services (VAS)

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

<https://dhs.iowa.gov/sites/default/files/Comm504.pdf>

**Amerigroup**  
An Anthem Company

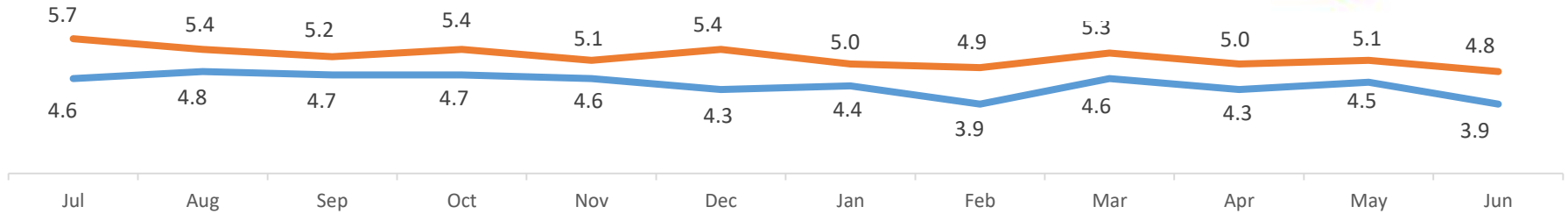
	SFY22 Q4	SFY23 Q1
Healthy Rewards	3,295	4,544
Community Resource Link	1,242	1,426
SafeLink Mobile Phone	928	1,351
Taking Care of Baby and Me	2,661	1,226
Breast Pump	543	503

**iowa total care**

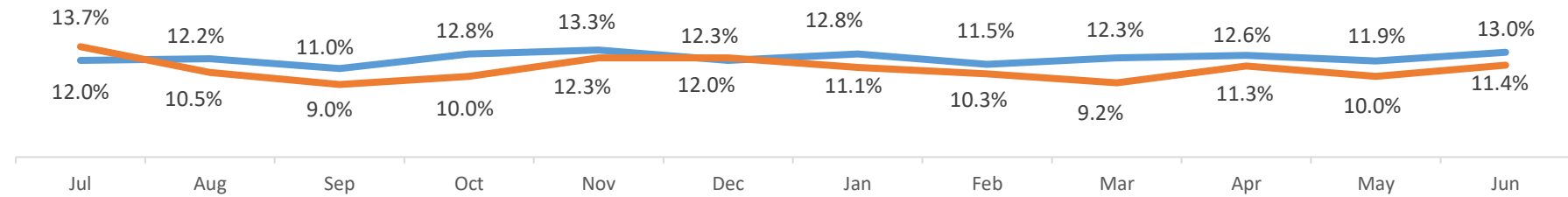
	SFY22 Q4	SFY23 Q1
My Health Pays Program	7,400	10,346
Start Smart for Your Baby	1,638	1,698
Mobile App	1,148	1,448
The Flu Program	885	610
Breast Pump	564	571

# MCO Care Quality and Outcomes

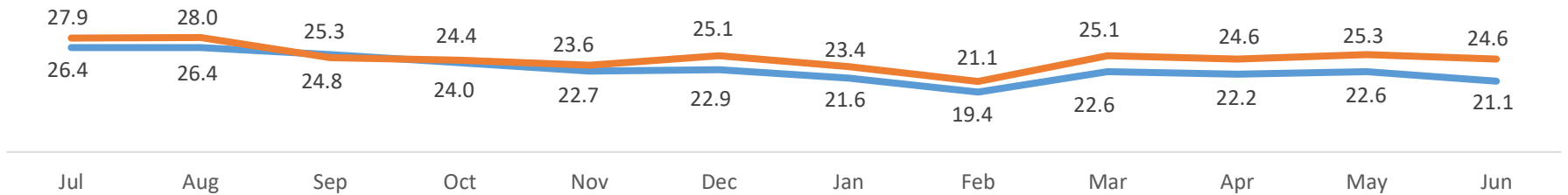
## Inpatient Admissions per 1,000 Members per Month (90-day lag)



## All Cause Readmissions within 30-days (90-day lag)<sup>8</sup>



## Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag)<sup>9</sup>



<sup>8</sup> This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.

<sup>9</sup> 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).

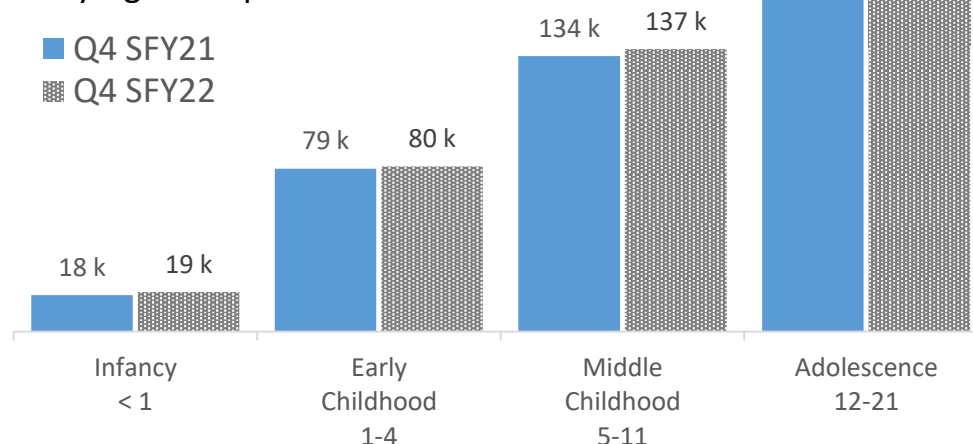


SFY21 Q4    SFY22 Q4

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

## All Children Enrollment (90-day lag)

- by Age Groups



SFY21 Q4    SFY22 Q4

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

# MCO Children Summary



SFY21 Q4      SFY22 Q4

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



SFY21 Q4      SFY22 Q4

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

# MCO Children Summary - Behavioral/Mental Health Treatment & Services



## Substance Use Disorder (SUD) Summary

SFY21 Q4 **SFY22 Q4**

	SFY21 Q4	SFY22 Q4
<b>Total Visits - As 1st or 2nd Diagnosis</b>	7,031	<b>6,235</b>
Alcohol	1,393	1,333
Cannabis	2,873	2,746
Cocaine	56	39
Nicotine	772	581
Opioid	444	576
Other	77	31
Other Psychoactive	478	425
Other Stimulant	809	390
Sedative	129	114

## Substance Use Disorder (SUD) Summary

SFY21 Q4 **SFY22 Q4**

	SFY21 Q4	SFY22 Q4
<b>Total Visits - As 1st or 2nd Diagnosis</b>	3,911	<b>4,078</b>
Alcohol	734	912
Cannabis	1,688	1,883
Cocaine	29	23
Nicotine	129	87
Opioid	482	405
Other	37	28
Other Psychoactive	234	218
Other Stimulant	387	463
Sedative	191	59

## Severe Emotional Disturbance (SED) for Children Summary

SFY21 Q4 **SFY22 Q4**

	SFY21 Q4	SFY22 Q4
<b>Total Visits - As 1st or 2nd Diagnosis</b>	235,508	<b>209,533</b>
ADHD <sup>10</sup>	51,916	45,006
Anxiety	41,824	40,543
Bipolar	3,908	3,063
Conduct Disorder	24,499	20,922
Depression	33,663	29,877
Obsessive Compulsive Disorder	899	723
Other	17,671	14,356
Post-traumatic Stress Disorder	60,511	54,602
Tourette Syndrome	617	441

## Severe Emotional Disturbance (SED) for Children Summary

SFY21 Q4 **SFY22 Q4**

	SFY21 Q4	SFY22 Q4
<b>Total Visits - As 1st or 2nd Diagnosis</b>	122,271	<b>118,847</b>
ADHD <sup>10</sup>	24,188	22,923
Anxiety	23,327	23,600
Bipolar	1,712	1,668
Conduct Disorder	12,153	11,603
Depression	18,223	17,580
Obsessive Compulsive Disorder	475	409
Other	8,396	7,923
Post-traumatic Stress Disorder	33,581	32,929
Tourette Syndrome	216	212

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

# MCO Children Summary - Behavioral/Mental Health Treatment & Services



SFY21 Q4    SFY22 Q4

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



SFY21 Q4    SFY22 Q4

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

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

<sup>11</sup> "B3" services are mental health and substance abuse services available to MCO members.

# Long Term Services - Care Quality and Outcomes

## Non-LTSS Care Coordination and HCBS Case Management

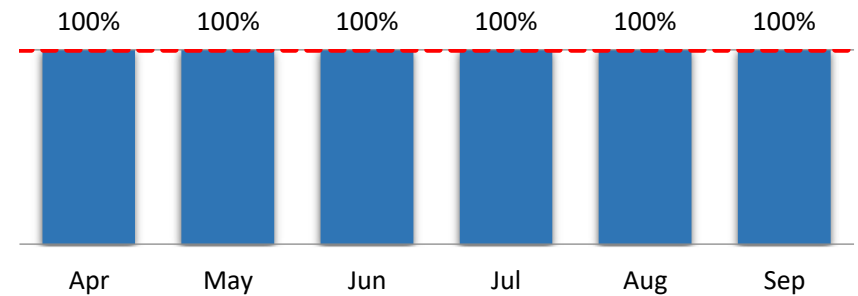


Average Number of Contacts Per Month	SFY22 Q4	SFY23 Q1
by Care Coordinators	2.2	2.0
by Case Managers	1.0	1.0
<b>"Members to" Ratios</b>		
Members to Care Coordinators	16	15
HCBS Members to Case Managers	62	69

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

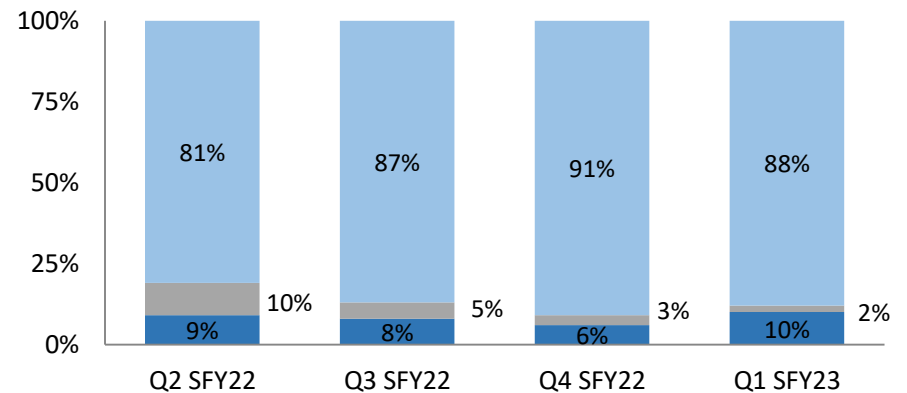
## Percentage of Level of Care (LOC) Reassessments Completed Timely

--- Contract Requirement: 100%



## Waiver Service Plan Outcomes

■ Reduction ■ Increase ■ No Change



## Iowa Participant Experience Survey (IPES)

Waiver members reporting...		SFY22 Q4	SFY23 Q1
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	1.0%	0.5%
	No	0.0%	0.5%
	Sometimes	0.5%	0.5%
	Yes	98.5%	98.5%

# Long Term Services - Care Quality and Outcomes

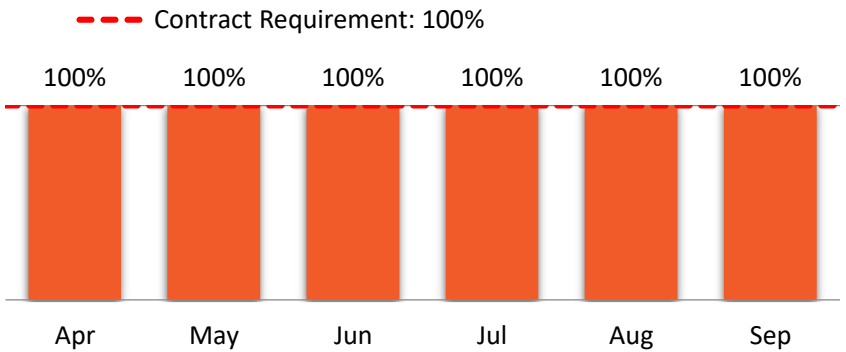
## Non-LTSS Care Coordination and HCBS Case Management



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

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

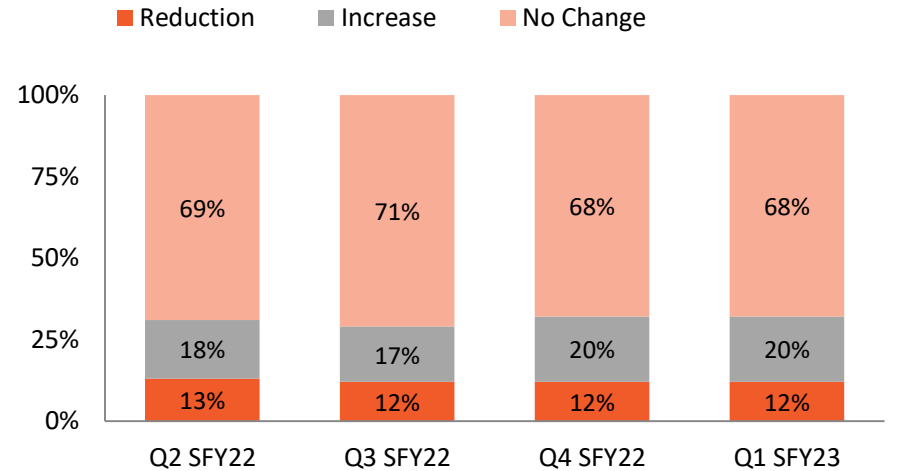
### Percentage of Level of Care (LOC) Reassessments Completed Timely



### Iowa Participant Experience Survey (IPES)

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

### 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 lowans that would otherwise require care in a medical institution. The following information captures the Top 5 services used by members with active waiver service plans.

### Top 5 Waiver Services

- by Member Usage



	SFY22 Q4	SFY23 Q1		SFY22 Q4	SFY23 Q1
<b>AIDS/HIV - Unique Service Plans</b>	22	23	<b>Habilitation (Hab)</b>	4,201	4,102
Home Delivered Meals	14	16	Home-based Habilitation	3,448	3,361
CDAC (individual) by 15 minute units	0	4	Long Term Job Coaching	406	391
Financial Management Services	1	1	Day Habilitation (units by day)	354	331
			Individual Supported Employment	141	160
			Day Habilitation (by 15 minute units)	138	139
<b>Brain Injury (BI) Waivers</b>	769	764	<b>Health &amp; Disability (HD)</b>	1,345	1,347
Financial Management Services	226	209	Respite (by 15 minute units)	377	397
Supported Community Living (by unit)	193	190	Financial Management Services	363	366
Respite (by 15 minute units)	164	166	Personal Emergency Response	314	313
Personal Emergency Response	160	166	Home Delivered Meals	296	307
Supported Community Living (daily)	109	111	CDAC (individual) by 15 minute units	62	62
<b>Children's Mental Health (CMH)</b>	783	810	<b>Intellectual Disability (ID)</b>	6,923	6,898
Respite (by 15 minute units)	418	443	Supported Community Living (by unit)	1,794	1,797
Respite (Hos/NF) - 15 minute units	216	244	Supported Community Living (RCF)	1,489	1,492
Family and Community Support	185	193	Day Habilitation (units by day)	1,378	1,338
Respite (Resident Camp) by units	19	24	Financial Management Services	1,343	1,264
Respite (Resident Camp) by day	3	4	Supported Community Living (daily)	1,183	1,170
<b>Elderly Waivers</b>	4,342	4,191	<b>Physical Disability (PD)</b>	601	591
Personal Emergency Response	2,741	2,771	Personal Emergency Response	327	321
Home Delivered Meals	2,742	2,767	CDAC (agency) by 15 minute units	84	57
CDAC (agency) by 15 minute units	478	422	CDAC (individual) by 15 minute units	63	47
Assisted Living Services	330	322	Financial Management Services	35	30
Personal Emergency Response (install)	301	302	Personal Emergency Response (install)	27	28

## Long Term Services - Waiver Service Plan Participation

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

### Top 5 Waiver Services

- by Member Usage



	SFY22 Q4	SFY23 Q1		SFY22 Q4	SFY23 Q1
<b>AIDS/HIV - Unique Service Plans</b>	8	8	<b>Habilitation (Hab)</b>	2,371	2,335
Home Delivered Meals	8	8	Home-based Habilitation	1,954	1,914
CDAC (individual) by 15 minute units	1	1	Day Habilitation (by 15 minute units)	329	354
CDAC (agency) by 15 minute units	1	1	Day Habilitation (units by day)	277	290
Homemaker (by 15 minute units)	1	0	Long Term Job Coaching	273	271
			Individual Supported Employment	126	132
<b>Brain Injury (BI) Waivers</b>	515	524	<b>Health &amp; Disability (HD)</b>	590	588
Supported Community Living (by unit)	216	215	Respite (by 15 minute units)	276	277
Personal Emergency Response	139	141	Home Delivered Meals	149	151
Respite (by 15 minute units)	125	126	Personal Emergency Response	152	150
Supported Community Living (daily)	122	119	CDAC (individual) by 15 minute units	95	98
Transportation (1-way trip)	93	96	CDAC (agency) by 15 minute units	100	97
<b>Children's Mental Health (CMH)</b>	374	385	<b>Intellectual Disability (ID)</b>	4,435	4,427
Respite (by 15 minute units)	215	227	Supported Community Living (by unit)	1,751	1,750
Respite (Hos/NF) - 15 minute units	145	159	Day Habilitation (by 15 minute units)	1,693	1,693
Family and Community Support	106	110	Day Habilitation (units by day)	1,559	1,546
Mental Health Service	42	37	Supported Community Living (RCF)	1,214	1,202
Respite (Resident Camp) by units	12	16	Supported Community Living	951	964
<b>Elderly Waivers</b>	3,277	3,404	<b>Physical Disability (PD)</b>	384	394
Personal Emergency Response	2,542	2,576	Personal Emergency Response	213	216
Home Delivered Meals	2,477	2,554	CDAC (agency) by 15 minute units	161	169
CDAC (agency) by 15 minute units	1,303	1,331	CDAC (individual) by 15 minute units	114	119
Homemaker (by 15 minute units)	708	719	Transportation (1-way trip)	41	44
CDAC (individual) by 15 minute units	648	648	Personal Emergency Response (install)	26	28

# Call Center Performance Metrics

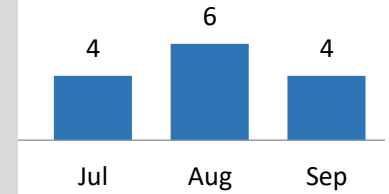


	Jul	Aug	Sep
<b>Member Helpline</b>			
Service Level (Requirement 80%)	93.65%	96.36%	90.33%
Abandonment Rate - Must be 5% or less	0.28%	0.22%	0.51%
<b>Member Pharmacy Helpline</b>			
Service Level (Requirement 80%)	99.90%	99.74%	99.90%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%
<b>Provider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

## Secret Shopper Scores

### - Member Helpline

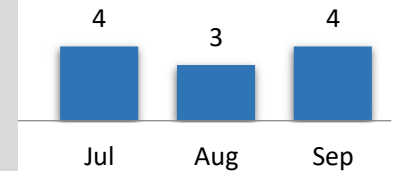
Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.



## Secret Shopper Scores

### - Provider Helpline

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



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

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

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

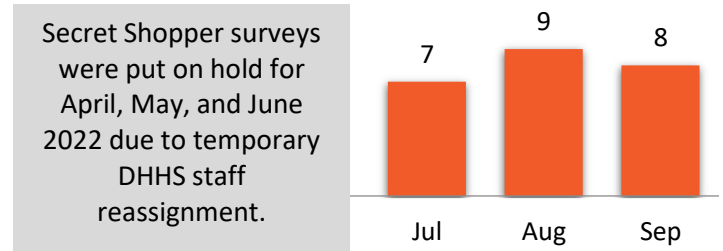
# Call Center Performance Metrics



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

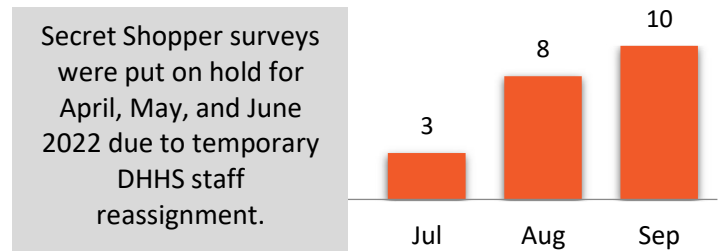
## Secret Shopper Scores

### - Member Helpline



## Secret Shopper 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
	Provider Outreach for Provider
	View Authorization for Provider

# Provider Network Access Summary



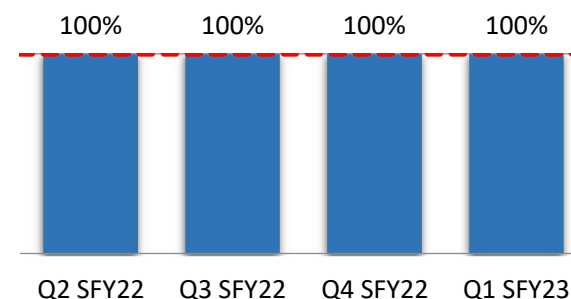
## Primary Care Providers (PCP)

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

### Adult PCP - Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



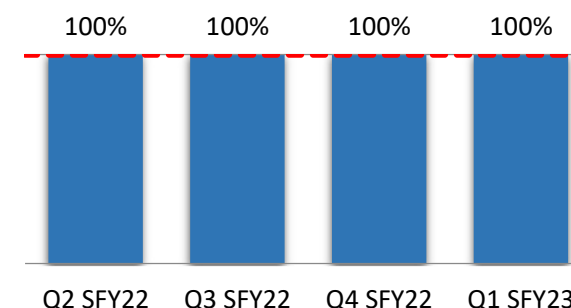
## Specialty Care & Behavioral Health (BH)

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

### Pediatric PCP - Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



Link to Geo Access Reports:

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

# Provider Network Access Summary

## Primary Care Providers (PCP)

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

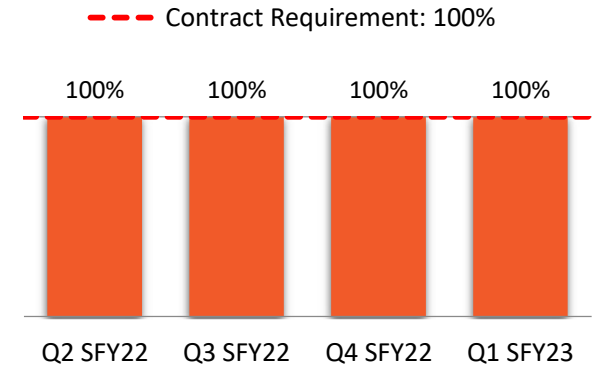
## Specialty Care & Behavioral Health (BH)

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



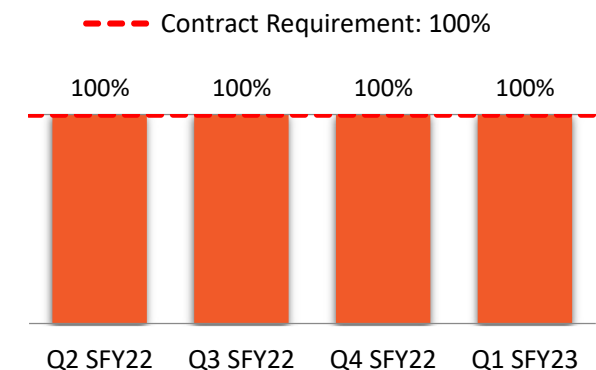
### Adult PCP - Standards

30 minutes or 30 miles



### Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

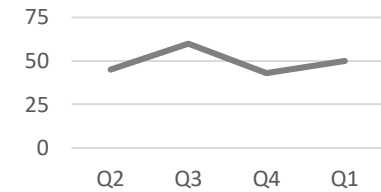
# MCO Program Integrity

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 Q1

50



5 Total Cases  
Referred to MFCU Q1



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



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

## Appendix: Glossary

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

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

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

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

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

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

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

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

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

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

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



**Capitation Expenditures** (continued...):

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

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

**Case Manager:** See Community Based Case Management (CBCM)

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

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

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

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

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

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

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

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

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

**Denied Claims:** See Claims

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

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

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

**Dual:** Members who have both Medicare and Medicaid benefits.

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

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

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

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

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

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

**Grievance** (continued...):

- Rights and dignity
- Any other access to care issues

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

**Monthly Capitation Expenditures:** See Capitation Expenditures

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

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

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

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

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

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

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

**Provider Adjustment Requests and Errors Reprocessed:** See Claims

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

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

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

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

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

**Skilled Nursing Care:** See Nursing Facility

**Suspended Claims:** See Claims

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

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

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

**Value Added Services (VAS):** Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can also be found here:

<https://dhs.iowa.gov/sites/default/files/Comm504.pdf>

- **Taking Care of Baby and Me® (AGP):** It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.
- **My Health Pays (ITC):** This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

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

**Waivers:** See Home and Community Based Services (HCBS) or reference by individual waiver descriptions (Elderly, Physical Disability, Health and Disability, AIDS/HIV, Brain Injury, Intellectual Disability, or Children's Mental Health)

**Waiver Service Plan:** See Service Plan

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

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

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

### Hawki Board of Directors Member List

#### Public Members

MaryNelle Trefz, Chair  
Mary Scieszinski, Vice Chair  
Shawn Garrington  
Mike Stopulos

#### Statutory Members

##### Iowa Insurance Division

Doug Ommen - Commissioner  
Angela Burke Boston - Designee

##### Iowa Department of Education

Dr. Ann Lebo - Director  
Jim Donoghue - Designee

##### Iowa Department of Health and Human Services (HHS)

Kelly Garcia - Director  
Angie Doyle Scar - Designee

#### Iowa Medicaid

Elizabeth (Liz) Matney - Director

#### Legislative Members - Ex Officio

Senator Nate Boulton  
Senator Mark Costello  
Representative Shannon Lundgren



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

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

See DHS website for all future and historical meeting information: [https://dhs.iowa.gov/ime/about/advisory\\_groups/maac](https://dhs.iowa.gov/ime/about/advisory_groups/maac)

### MAAC Council Member List

#### Co-Chairpersons

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

#### Voting Members: Public Representatives

John Dooley, Public Member  
Dee Sandquist, Public Member  
Amy Shriver, Public Member  
Marcie Strouse, Public Member

#### Voting Members: Professional and Business Entities

Casey Ficek, Iowa Pharmacy Association  
Erin Cubit, Iowa Hospital Association  
Cindy Baddeloo, Iowa Health Care Association  
Shelly Chandler, Iowa Association of Community Providers  
Dennis Tibben, Iowa Medical Society

#### Members of the General Assembly

Senator Bolcom  
Senator Mark Costello  
Representative John Forbes  
Representative Ann Meyer

#### Professional and Business Entities

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

**Continued...**



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

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### 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

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

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

### Council on Human Services Member List

#### **Iowa Council on Human Services Members**

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

#### **Legislative Members - Ex Officio**

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

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

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

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

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

### MHDS Commission Member List

#### Voting Members:

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

#### Non-Voting Members:

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

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

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

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

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

### For more information, contact:

**Managed Care Ombudsman**

510 E 12th St., Ste. 2

Des Moines, IA 50319

(866) 236-1430

ManagedCareOmbudsman@iowa.gov