STATE OF IOWA DEPARTMENT OF
Health and Human
SERVICES

Medical Assistance Advisory Council (MAAC)

NOVEMBER 17, 2022
MEETING MATERIALS

1. Agenda of Meeting for November 17, 2022
2. August 18, 2022 Council Meeting Minutes
3. MCO Quarterly Report SFY 22, Quarter 4 Executive Summary
4. MCO quarterly Report SFY 22, Quarter 4

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

MEETING AGENDA			
DIVISION	Iowa Department of Health and Human Services		
MEETING TITLE	Medical Assistance Advisory Council		
FACILITATOR	Angie Doyle-Scar		
DATE	November 17, 2022	TIME	1:00 PM
LOCATION	Virtual (Zoom): https://www.zoomgov.com/j/1610182867?pwd=L25BdWZiWElGckFsUUY4VDZVL3hKdz09		

MEETING OBJECTIVES

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

AGENDA TOPIC

1. Call Meeting To Order and Roll Call
2. Approval of Previous Meeting Minutes
3. Managed Care Quarterly Report Quarter 4 State Fiscal Year 2022
4. Medicaid Director's Update
5. Managed Care Plan (MCP) Updates
6. Open Comment

Medical Assistance Advisory Council

MEETING MINUTES
AUGUST 19, 2022

CALL TO ORDER AND ROLL CALL

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

APPROVAL OF PREVIOUS MEETING MINUTES

Angie called for a motion to approve minutes from the May 19, 2022, meeting. Shelly Chandler, Iowa Association of Community Providers, motioned to approve, Brett Barker, Iowa Pharmacy Association, seconded the motion, the minutes were approved.

MANAGED CARE ORGANIZATION (MCO) QUARTERLY REPORT QUARTER 3 STATE FISCAL YEAR 2022

Kurt Behrens, Iowa Medicaid, reviewed the MCO Quarterly Report for Q3 SFY 22. Kurt began by reviewing MCO enrollment, which stood at 787,187 members, an increase of 11,680 or 1.51 percent between Q2 and Q3 of SFY 22. Moving on to the financial summary of the report, Kurt noted that Amerigroup Iowa, Inc. (Amerigroup) had increased their third-party liability (TPL) claims recovery by $6.4 million, a 38.76 percent increase. Amerigroup attributes this recovery to a rise in the number of major medical claims from the previous quarter, which in turn resulted in more recovered dollars. Kurt then discussed pharmacy prior authorizations (PAs), which have a federal requirement for all such PAs to be completed within 24 hours. Iowa Total Care (ITC) met this requirement for two out of the three months of the quarter, missing one PA in February, completing 6,789 of 6,790 Pharmacy PAs for that month. Amerigroup performed similarly, missing one PA in January, completing 9,593 of 9,594 for that month, and three Pharmacy PAs in February, completing 9,240 of 9,243. Call center performance metrics were reviewed next, Kurt highlighted the performance of both MCOs non-emergency medical transportation (NEMT) helplines. Amerigroup and ITC both contract with Access2Care for their NEMT helplines; for the past several quarters Access2Care has had difficulty meeting the required 80 percent service level threshold due to staffing issues. This quarter both MCOs NEMT Helplines operated by Access2Care exceeded the 80 percent service level threshold for all three months.

Brandon Hagen, Iowa Health Care Association, asked about Value Based Purchasing (VBP) metrics, specifically what constitutes VBP. Kurt answered that several factors go into it, and he'd be happy to send Brandon the specific data definitions via email, but generally the measure presented in the report is the percentage of members that interact with a VBP contract negotiated by their MCO. Director Elizabeth Matney added that the number in the report reflects the number of members covered under a

VBP agreement and is not the number of contracted services, but the number of their members that can access a VBP contracted service. Shelly asked to receive the VBP data definitions from Kurt as well.

Jason Haglund, public member, and co-chair, asked about network access metrics, specifically measuring differences between access in urban and rural areas. Kurt answered that many different layers of data analysis go into evaluating the difference in access between urban and rural settings, and that the quarterly report does not show this difference for every type of service, and it does not make sense to ask this question for some specialty services. Director Matney added that Exhibit B of the managed care contract contains the network adequacy standards broken down by provider type. Most of these standards do not differentiate between rural and urban settings. For primary care physician access, the standard is 30 minutes or 30 miles from the person's place of residence. Hospital and emergency services standards are slightly different. Director Matney quoted Exhibit B for hospitals:

> "Transport time shall be the usual and customary, not to exceed 30 minutes or 30 miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions shall be justified and documented to the State based on community standards."

Director Matney noted that community standards means that the members' access to services must be the same whether they were on Medicaid or not.

Jason stated he was curious how workforce issues were affecting member's access to care. Director Matney agreed that is an issue but noted a silver lining of the Public Health Emergency (PHE) has been the rapid deployment of telehealth which should help bridge some gaps for members, especially in rural areas.

Kurt showed the council the Iowa HHS' Access and Quality Reporting tool, which measures access and quality by provider type. The tool shows the ratio of members to providers, how many units of service were performed, and how many claims went through each MCOs provider network versus how many were processed from providers outside their networks. Director Matney offered to share the Access and Quality Reporting template with anyone that is interested.

Shelly commented that the information on network adequacy and standards in rural versus urban settings was interesting, but currently the larger issue is whether providers are willing to accept members into service because of workforce shortages; stating whether a member can access care because of a provider's waitlist is a different question than traditional network adequacy. Director Matney agreed with Shelly, and said Iowa HHS is working on ways to measure this issue, part of this effort ties into Iowa Medicaid's modernization efforts.

Brandon asked about non-pharmacy claims denials, specifically the category "charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement". Brandon stated that pharmacy providers follow a billing practice wherein they bill customary amounts for services and receive back a payment at the contracted amount, and if this is the case for non-pharmacy providers, why would a provider receive a denial for billing this way no matter how much the provider submitted for their customary charges? Kurt answered that he would investigate and get a summary for the MAAC. John McCalley, Amerigroup, said he'd have to take the question back as well.

Brandon asked if there is any way to look at the appropriateness of claims denials, from a provider perspective there are many denials received that are inaccurate. Kurt answered that such an analysis would require Iowa HHS to evaluate claims denials on a case-by-case basis, but that he would ask Amerigroup and ITC to look into putting together such a summary.

Angie highlighted the inclusion of mental health and behavioral health data provided on the report, noting that Dr. Shriver and Dr. Beeman had previously called for the presentation of this data. Angie invited Dr. Beeman to comment on the mental and behavioral health data in the report. Dr. Beeman said he was excited to see the inclusion of this data and has plans to review and track this data from quarter to quarter.

Dee Sandquist, public member, asked to make a comment: Dee sits on the Regions Mental Health Board for Southeast Iowa and at their last meeting a comment was made that the local Coordinator of Disability Services (CDS) had a client who was a case manager/parent. They couldn't figure out all the systems and services and the bottom line of the comment was a request to simplify the systems, specifically the systems associated with child mental health. Angie asked if the parent was having trouble accessing the providers or the benefits. Director Matney asked Dee to send her the parents contact information, and she would follow up with the parents.

Marcie Strouse, public member, commented that she also loved having the mental and behavioral health data for children but asked if this data was available for adults. Kurt said there are no current plans to share this data in the MCO Quarterly Report, but that this data could be added to dashboards available on Iowa HHS' website. Director Matney praised Kurt for his work building out reporting projects for Iowa HHS, specifically a project that translates data provided in quarterly reports into a live dashboard on the agency's website. Marcie added that the data for mental health is going to be especially important once the legislature is in session, citing an ongoing and increased need for mental health services around the state.

MEDICAID DIRECTOR'S UPDATE

Director Matney began her update by discussing the re-alignment of the Iowa Department of Public Health and the Department of Human Services into one agency known as the Department of Health and Human Services (HHS) effective July 1, 2022. Director Matney stated that uniting the two agencies into one organization will allow for improved collaboration, data sharing, increased efficiencies and better collaboration between the two departments. Branding for the new agency will be released shortly along with tables outlining Iowa HHS' new organization.

The PHE has not ended and is currently extended through the middle of October, however, the Centers for Medicare and Medicaid Services (CMS) has not given notice that it will end in October, which indicates it will likely be extended again through the rest of the calendar year. Communications regarding plans for the unwinding process for the PHE are being developed. Iowa Medicaid is in the process of evaluating which flexibilities, such as telehealth flexibilities, implemented during the PHE will stay in place, and which flexibilities will end.

Once the PHE ends, Iowa Medicaid will be required to redetermine the eligibility of most members. When the PHE ends, members who have had an eligibility redetermination within the last 12 months will not need to have their eligibility re-examined until a further 12 months have passed. Iowa Medicaid has created work plans for these eligibility processes. Currently staff are focusing on ensuring members have their current address updated in the system, as eligibility redetermination forms will be mailed to affected members.

Iowa Medicaid will be awarding a contract for the recent managed care request for proposal (RFP) at the end of the month.

Mathematica is still working on the Community-Based Services Evaluation (CBSE). Liz said Iowa Medicaid is hoping to have this evaluation in hand for the next legislative session, as some issues may only be resolved through legislation.

Related to eligibility redetermination, Brandon Hagen noted that 180,000 members were added during the PHE and asked how many of these members Iowa Medicaid expects to stay on once the PHE ends. Liz said this is a difficult question to answer, but some organizations that study this topic estimate roughly 15 to 20 percent of members enrolled during the PHE will remain enrolled once the PHE ends, and eligibility redetermination processes have concluded. Iowa Medicaid has begun eligibility redetermination reviews and of the members reviewed so far, staff are reporting that this estimate of fifteen to twenty percent appears to be accurate.

Maribel Slinde asked about the onboarding of a new MCO. Liz said the managed care RFP is in evaluation and will have an announcement and letter of award at the end of this month.

UPDATES FROM THE MCOS

Amerigroup Iowa, Inc.

John McCalley, Amerigroup, began his update by noting the ongoing work collaborative efforts between Amerigroup and Iowa Medicaid to prepare for the end of the PHE. Amerigroup meets regularly with Iowa Medicaid and ITC to discuss these plans.

Amerigroup continues to collaborate with Iowa Medicaid, the State Resource Centers, and ITC to come into compliance with the Department of Justice transition of the State Resources Centers (SRCs). Amerigroup is looking to transition Glenwood Resource Center (GRC) members to Home-and Community-Based Services (HBCS) providers. These efforts include working with providers to build capacity. Capacity to accept new members requires training staff and as well as providing capital to develop infrastructure. Amerigroup has contracted with four intensive residential service homes (IRSH) providers, which complies with legislation requirements passed in 2019.

Amerigroup continues to implement health equity plans discussed at previous meetings, with a new partnership with private organizations to conduct outreach to high-risk members through a vendor named MedAware. This outreach will begin in Polk County, focusing on 446 members identified with high needs. Amerigroup plans to expand this outreach and case management work to other counties in both urban and rural areas in coming months.

Amerigroup has partnered with Reach Out and Read, providing a grant to purchase 3,000 books, and supporting programming to the Community Health Center of Southeast Iowa, located in Des Moines County. Amerigroup partnered with Reach Out and Read on this project in hopes of incentivizing well child visits on the part of Medicaid members, as Des Moines County has one of the lowest well child visit rates in the state.

Amerigroup continues its work on social determinants of health (SDOH) with their Champ Housing Stability Initiative. The initiative has served more than 650 Amerigroup members. Some of these members were at risk of eviction; others were houseless and in search of stable housing. John ended with a member story highlighting the impact of this program. One member working with the obstetrics (OB) case management team, was experiencing a high-risk pregnancy and a recent transplant to the area. The member was fully employed but found herself 27 weeks pregnant and homeless. She was living in her car, suffering from severe anxiety and behavioral disorders. Amerigroup found her transition housing in a hotel and within a week found an apartment for her. She only needed help with the deposit and could afford the rent. Amerigroup later received a note from her explaining the dire medical situation she was in when she began working with the case management team saying, "you have saved two lives".

Iowa Total Care

Stacie Maass gave an update for ITC. Stacie began by discussing the collaboration between ITC, Iowa Medicaid and Amerigroup, highlighting the ongoing work to plan the transition out of the PHE. ITC is working on implementing the rate increases passed during the spring legislative session. ITC is

collaborating with Iowa Medicaid to distribute American Rescue Plan Act (ARPA) funds to providers. ITC continues to participate in regular meetings discussing operational and strategic ways to improve the Medicaid program, address work force issues and members access to services. Stacie discussed the work of ITC's quality team, both internally and in public facing settings. A major goal of the quality team is to improve member health outcomes. Part of this work is ITC's focus on health equities and SDOH. ITC is analyzing the impact of existing programs and searching for new ways to connect with members.

ITC continues to support community events such as the Special Olympics. ITC uses community events as an opportunity to reach out to providers in the community and perform outreach and education to members on SDOH barriers such as transportation, food, rent and utilities. ITC has uses geographical data to target events, looking for areas where there is high concentration of members or potential members. ITC participated in Des Moines University's back to school events, providing free back to school physicals, along with information on free programs and other offerings.

ITC has been participating in the Iowa Stops Hunger Program, statewide initiative to combat food insecurity in Iowa. Launching a program working with women ages 21 to 24 who are food insecure, ITC is planning to provide 30 days of meals to those identified in the program.

ITC has bilingual staff who appear quarterly on Spanish speaking radio shows to highlight programs and information.

ITC has a new Doula offering piloting in three counties: Polk, Muscatine, and Johnson. The program sets up new mothers with a doula who can help identify barriers, provide birth support before after and during a pregnancy and work with care managers on other needs.

ITC had a health equity intern over the summer who was passionate about rugby. ITC and the intern partnered with community providers in Iowa City to hold a "Rugby Sports Clinic" for children ages six to 14. The event was designed to increase physical activity, improve mental health and support Iowa's healthiest state initiative. Stacie extended thanks to the members of the University of Iowa women's rugby team who made up most of the volunteers for the event.

ITC's quality team, in addition to direct member outreach, is meeting face-to-face with providers to talk about ways ITC can be more collaborative, inclusive of provider needs and discuss providers' thoughts on how ITC could better serve their members. Stacie said that providers have given feedback on what reporting they find useful and how ITC can tailor reports specific to each provider. One provider had had significant gaps in immunizations, and ITC developed a report to assist that provider with making operational changes to improve immunization.

ITC continues to run several successful texting campaigns for members. Currently ITC has around 200,000 phone numbers they send texts to. ITC is developing the capacity to focus these campaigns, partnering with specific providers to tailor messages members will be more likely to respond to. When they began their text campaigns, ITC targeted specific services one at a time. ITC is developing campaigns that look at the member, piloting a campaign based on women's health and an array of services rather than just one service.

ITC has recently launched new pay-for-performance measures with behavioral health providers. ITC is starting to see data returns from this behavioral health pay-for-performance measure and anticipates

developing further measures including providing incentives for: housing insecurity, homelessness, employment, and follow up after hospitalization for mental illness. Stacie said ITC will work with providers to see how they can help members together.

Stacie ended her update with a member story. This particular member has issues with balance. After multiple conversations with the member, over a period of months, ITC staff made the recommendation to find member a three wheeled bike. Staff found a provider who was willing to offer a donated bike. After biking and being able to spend more time with family, the member is exploring new places, has lost weight, and gained new confidence. The member recently gained a new driver's license to operate a specially-modified car.

Barb Niebel, Iowa Speaking and Hearing Association, commented that during the last meeting of the council she had informed Stacie of several issues that speech, occupational and physical therapists were having with pediatric prior authorizations. The National Imaging Associates (NIA) became involved to help facilitate PAs. Barb stated that NIA involvement has improved the situation, largely by providing education to providers on how to submit PA documentation. However, Barb noted, that there are still issue with PAs in this area. Stacie said she would circle back with Barb and her team.

MCNA

Sabrina Johnson, MCNA Dental, provided an update. Summer is a busy time for dental appointments in addition to a new contract period that began July 1, 2022. With the new contract period MCNA is in the process of reviewing updated language, working closely with Iowa Medicaid to ensure MCNA follows the new contract and expectations. MCNA recently completed an external quality review (EQR) audit, a contractual managed care requirement. Sabrina said the audit went well.

MCNA Provider Relations has been gearing up to do site contacts, MCNA likes to complete site contacts at least once a year, if not more. During the site contact MCNA updates and verifies information in their provider portal is accurate, reviews contact information, hours of operation and access and availability. MCNA also reviews whether the provider is accepting new members, this is reflected in MCNA's provider locator tool.

MCNA is adding information to the provider locator tool, which will now provide information on member accommodations, such as whether the location's bathroom has handrails and other accommodations.

MCNA has deployed a practice site performance summary (PSPS) over the last year. The PSPS is available to facilities that have seen 50 or more members in the last 12 months. The PSPS reviews various performance measures and is shared with the provider along with examples from comparative providers to allow providers to make changes to improve their performance. MCNA has increased the number of facilities receiving the PSPS from 76 at the beginning of this year to 125.

MCNA works closely with the Iowa Medicaid Communications team, participating in weekly calls to ensure information and updates for members are in line with Iowa Medicaid. In the last call it was discussed how the meeting could be beneficial for both the dental and medical plans. MCNA will provide the medical plans with information on what dental resources MCNA has available, and how to navigate MCNA's member and provider websites so that the medical plans can relay that to members and

providers as necessary. A self-equity assessment has been developed in partnership between MCNA, Delta Dental, Iowa Medicaid and a company called PreVisor. Each question on the survey provides an opportunity for MCNA to contact their members regarding the survey, for every answer there is an action MCNA must take. The assessment includes questions that were mentioned by ITC; assessing if the member needs resources or help with food insecurity or transportation.

As part of the new contract period MCNA is working to update their fee schedule, currently the new feed schedule is being reviewed by MCNA leadership, once this final review is completed the fee schedule will be sent to Iowa Medicaid for review and approval.

Delta Dental of Iowa (DDIA)

Gretchen Hageman, DDIA, provided an update, starting by noting that DDIA has been part of the managed care plan for the Iowa Dental Wellness Program (DWP) and the Hawki program for several years. DDIA began administering the Hawki program dental contract in 2008. Gretchen provided outcome data related to DDIA's reports, noting that Iowa Medicaid is developing a quarterly dashboard. DDIA has about 29 percent of adults that have had a dental service in Iowa. There are roughly a thousand providers under their network, and 69 percent of these providers are seeing 10 or more members. DDIA has a partnership with I-Smile, run through local title five agencies.They serve as infrastructure for care coordination and some direct services for members. Through this partnership 900 members have had a service through I-Smile.

Regarding quality measures for their adult population, DDIA has developed a risk assessment for members. Members fill out the assessment identifying various risk factors such as diabetes. Members are then provided with oral hygiene kits. DDIA works with members that haven't had any services and focuses their outreach and care coordination to get them into a dental home. DDIA is also working to formalize a partnership that would identify members requiring a dental service where the need was identified in an emergency room. This would allow the member to be referred to a dentist to perform the service within a specific timeframe.

DDIA is examining geographic data to identify areas where members have low access rates to dental services, looking for ways to get more members in these areas into the dentist. As far as DWP kids, roughly 47 percent of them have had a dental service. DDIA has contracted with around 1,000 providers to see DWP kids. 72 percent of these providers are seeing 10 or more members. I-Smile infrastructure has provided 15,000 DWP kids with around 70,000 services through clinics. DDIA has developed head start sealant clinics at the school childcare center to provide dental sealant services to children and identify high-risk members.

56 percent of Hawki members have had a dental service in the past year. The focus area for Hawki is adolescents with no dental services. DDIA is excited to have the risk assessment Sabrina mentioned in her update as well, looking forward to having additional data related to SDOH and using that data as they work with members. DDIA's efforts around providers have been focused on continuing to address access issues, particularly in certain geographic areas, developing incentives for providers to rejoin the Medicaid system. Angie commented that she is a fan of the I-Smile program.

OPEN DISCUSSION

Dr. David Beeman raised several concerns about the current composition of the council, specifically that he feels the current make-up of the council does not conform to state and federal regulations. Additionally, Dr. Beeman is concerned about the council's lack of diversity, being composed of primarily white middle class to upper middle-class members. Dr. Beeman is also interested in evaluating how well the council represents children and children's mental health. Dr. Beeman stressed that he does not want to raise these issues as an offense to anyone currently serving on the council.

Dr. Beeman's first concern regarding the composition of the council is that in his interpretation of the federal and state regulations, they require at least once council member to be a recipient of Medicaid. Dr. Beeman stated that he is unsure if this definition extends to family members, and that he is unaware of anyone on the council receiving Medicaid. Director Matney replied that it is her understanding of the code that it does include family members.

Dr. Beeman's second concern is that the Iowa Code, in the paragraph that outlines requirements for the five public members of the council, states "none of whom shall be members of, or practitioners of, or have a pecuniary interest in any of the professional or business entities specifically represented under paragraph "a". Paragraph "a" here refers to the list of 41 professional and business entities outlined in Iowa Code as being statutory non-voting members of the council. Dr. Beeman stated that the five public members currently serving on the council include two physicians and a dietician, which conflicts with the cited requirement. Dr. Beeman's next concern is that the cited requirement contradicts federal regulations which require at least one board-certified physician to serve on the council. Dr. Beeman's reading of the federal regulation and the Iowa code taken together is that a board-certified physician is required but must be elected from among the 41 professional and business entities, and not appointed as a public member. Dr. Beeman asked the council to consider whether his concerns are correct or not, and if they are valid, what course of action will be taken to remedy the conflicts with federal and state regulations, adding that regardless of the council's response he is still concerned about the lack of diverse representation.

Angie stated that in the past she and Gerd Clabaugh, former director of the Iowa Department of Public Health, compared federal and state regulations concerning the council. Part of that examination was looking at how other states had structured their analogous councils, and Iowa had the largest council membership of any state they looked at. At the time the council had 60 members. The council retains this high membership, but the majority are non-voting members. Angie stated that due to this large statutory membership it would be very challenging to find public representatives that do not fall under one of the umbrellas of the wide membership base. Jason Haglund added that he was serving on the council with Gerd when the council was restructured in 2019, and discussions like Dr. Beeman's concerns regarding the council's compliance with regulations were had then, and Jason and Gerd were satisfied with the council's compliance at that time. Jason added that Dr. Beeman's concerns about inclusion and equity are something that should be considered further. Jason asserted that there are current public members who have adult children who receive Medicaid and have experiences with the Medicaid system.

Dr. Beeman stated that even if the council composition conformed to state and federal regulations at the time of the restructuring of the council in 2019, he feels that does not mean the council currently

complies with regulations. Dr. Beeman stated that he believes the state regulations are clear about composition requirements and asserted his belief that the intent is to foster a conversation between recipients, providers, and the Department to improve the Medicaid program in Iowa. Addressing the idea that a family member of a person receiving Medicaid fulfills the federal regulations, Dr. Beeman questioned the boundaries of the term, stating he has a sister who receives both Medicare and Medicaid, but believes that he does not fit the requirements of the federal regulations.

Angie stated that currently and historically, finding applicants to serve as public members of the council has been a struggle. Angie encouraged members of the council to reach out to people in their communities to find others who are willing and able to take the time to sit on the council.

Kady Reese, Iowa Medical Society, stated she found the conversation on diversity and inclusion very interesting. Kady previously served as a patient and family engagement champion with CMS. Citing her experience with CMS Kady encouraged the council to consider how prospective public members would engage with the council, how they could be empowered to engage, how they would be equipped to engage. Kady said this may be an opportunity for the council to work with the Iowa Primary Care Association (PCA) and federally qualifying health center (FQHC) partners who, by nature of their type of health center, have consumers serve on their boards and committees. These members may have the experience and interest required to be effective public members of the council.

Director Matney added that the council should remember the Hawki board and encourage the two groups to consider how they could work together collaboratively, suggesting a standing agenda item in which a Hawki board member could present to the council and vice versa. Director Matney also raised concerns about expanding membership too broadly, as the previous iteration of the council had issues meeting quorum requirements. Angie said that she serves on the Hawki board and may be able to facilitate collaboration between both boards. Dr. Beeman stated he was not advocating to returning to the previous iteration of the council, agreeing with the concerns about meeting quorum.

ADJOURNMENT

Meeting adjourned at 3:10 PM.

Submitted by,
Michael Kitzman
Recording Secretary
mk

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Managed Care Organization (MCO) Report: SFY 2022, Quarter 4 (April – June 2022)

EXECUTIVE SUMMARY

The SFY22 Q4 report is a comprehensive review of key metrics focused on consumer protection, outcome achievement, and program integrity.

MEMBER SUMMARY (P. 4-5):

Enrollment:
Current MCO enrollment is 795,507 members
Enrollment has increased by **8,320** members or **1.06**% between Q3 & Q4 (787,187 to 795,507)

FINANCIAL SUMMARY (P. 6-7):

Third Party Liability (TPL):
Total TPL increased by **$8.7M** or **14.83**% between Q3 and Q4

PHARMACY PRIOR AUTHORIZATION (PA) SUMMARY (P. 14):

Federal requirement to be completed within 24 hours and at 100% (No rounding).
AGP – June: Completed 9,128 of 9,129 = **99.9**%
ITC - May: Completed 6,826 of 6,832 = **99.9**%
ITC - June: Completed 7,018 of 7,022 = **99.9**%

GRIEVANCES AND APPEALS (P. 15 AND 16):

AGP - Appeals: Increase of **24.9**% from Q3 (362) to Q4 (452)
ITC - Appeals: Increase of **53.1**% from Q3 (196) to Q4 (300)
Both MCOs stated that their increase in appeals primarily was an increase in pharmacy appeals due to a change in the Preferred Drug List

CALL CENTER PERFORMANCE METRICS (P. 25-26):

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

Managed Care Organization (MCO) Quarterly Performance Report

SFY2022, Quarter 4

(April - June 2022)

Published September 2022

Contents

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

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

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Executive Summary

This report is based on Quarter 4 of State Fiscal Year (SFY) 2022 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.

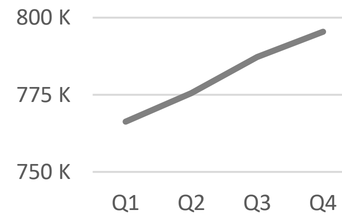
MCO Member Summary - All MCO Counts

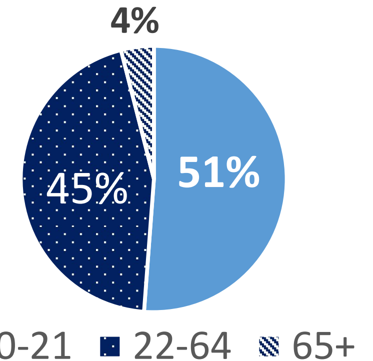
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

795,507





0-21 22-64 65+

+ 8,320 Members
1.06% Increase

All MCO Enrollment
(by Age)

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

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Distinct
MCO Member Summary - *Overall Counts*	766,267	775,507	787,187	**795,507**	781,117	**832,477**
0-21	397,383	400,213	404,569	407,098	402,316	423,377
22-64	338,971	345,001	351,867	356,845	348,171	373,361
65+	29,913	30,293	30,751	31,564	30,630	35,739
Fee-For-Service (FFS) - *Non MCO Enrollees*	45,062	46,254	46,896	**47,940**	46,538	**51,721**

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

If Yes, explain:

Iowa Medicaid Population **884,198**
1 year distinct count

MCO Member Summary

Amerigroup	SFY22 Q3	SFY22 Q4
All Members - *by MCO*	451,600	455,273
Traditional Medicaid	278,594	280,403
Wellness Plan - IHAWP/Expansion	128,223	129,728
M-CHIP - Expansion	8,051	35,300
Healthy and Well Kids in Iowa (Hawki)	36,732	9,842
MCO Member Market Share	57.4%	57.2%
Disenrolled	401	517

Amerigroup	SFY22 Q3	SFY22 Q4
Long-Term Service & Support (LTSS)	21,502	21,436
HCBS Waivers	68.7%	69.0%
Facility Based Services	31.3%	31.0%
HCBS Waivers [1]	14,778	14,785
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,724	6,651
ICF/ID [3]	912	849
Mental Health Institute (MHI)	36	43
Nursing Facilities (NF)	5,436	5,411
Nursing Facilities for Mentally Ill	54	59
Skilled	87	88
PMIC [4]	199	201

Iowa Total Care	SFY22 Q3	SFY22 Q4
All Members - *by MCO*	335,587	340,234
Traditional Medicaid	206,374	210,236
Wellness Plan - IHAWP/Expansion	106,807	108,181
M-CHIP - Expansion	6,924	6,779
Healthy and Well Kids in Iowa (Hawki)	15,482	15,038
MCO Member Market Share	42.6%	42.8%
Disenrolled	461	334

Iowa Total Care	SFY22 Q3	SFY22 Q4
Long-Term Service & Support (LTSS)	14,667	14,669
HCBS Waivers	65.0%	65.3%
Facility Based Services	35.0%	34.7%
HCBS Waivers [1]	9,540	9,583
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,127	5,086
ICF/ID [3]	524	503
Mental Health Institute (MHI)	29	30
Nursing Facilities (NF)	4,340	4,339
Nursing Facilities for Mentally Ill	30	31
Skilled	76	67
PMIC [4]	128	116

[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 419; ITC 388). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

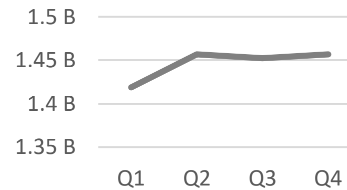
MCO Financial Summary - All MCO Counts

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

$1.45 Billion

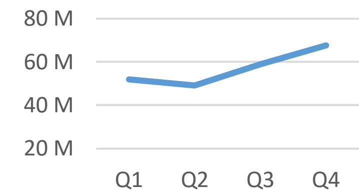


+ $4.6 Million

0.32% Increase

Third Party Liability Recovered

$58.94 Million



+ $ 8.7 Million

14.83% increase

Data Notes: June 2022 enrollment data as of August 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 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Total
Financial Summary						
Capitation Payments	$1.42 B	$1.46 B	$1.45 B	**$1.46 B**	$1.45 B	$5.79 B
Third Party Liability (TPL) Recovered	$51.95 M	$49.17 M	$58.94 M	**$67.67 M**	$56.93 M	$227.73 M

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

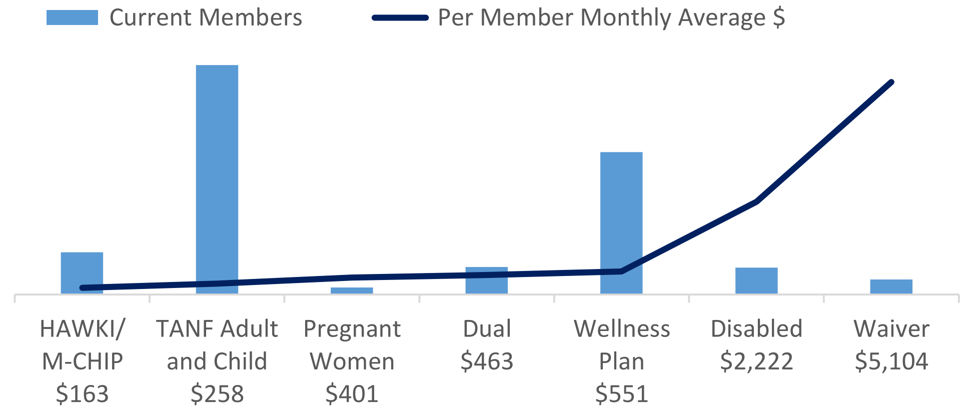
If Yes, explain:

o TPL increased by $8.7M or 14.83% between Q3 and Q4.

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.



	SFY22 Q3	SFY22 Q4
Capitation Totals	$841.06 M	**$843.74 M**
Adjustments	-$.22 M	$.57 M
Current	$822.18 M	$823.45 M
Retro	$19.1 M	$19.72 M
Third Party Liability (TPL) Recovered	$22.91 M	**$28.23 M**
Financial Ratios		
Medical Loss Ratio (MLR)	89.9%	**93.9%**
Administrative Loss Ratio (ALR)	5.4%	5.5%
Underwriting Ratio (UR)	4.7%	0.6%
Annual MLR [5]		90.0%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

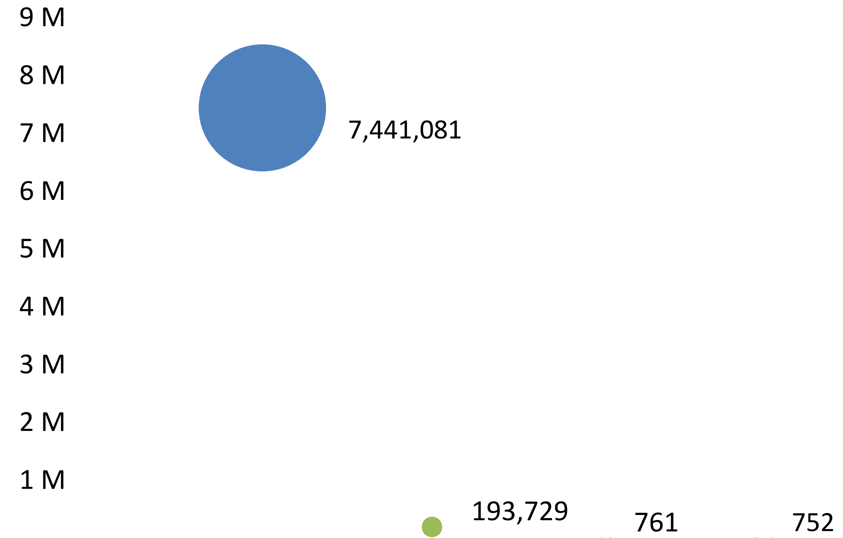
	SFY22 Q3	SFY22 Q4
Capitation Totals	**$611.36 M**	**$613.33 M**
Adjustments	-$.82 M	-$.02 M
Current	$588.32 M	$594.66 M
Retro	$23.87 M	$18.68 M
Third Party Liability (TPL) Recovered	$36.03 M	**$39.45 M**
Financial Ratios		
Medical Loss Ratio (MLR)	95.1%	**94.2%**
Administrative Loss Ratio (ALR)	3.8%	7.6%
Underwriting Ratio (UR)	1.1%	-1.8%
Annual MLR [5]		93.3%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[5] Annual MLR 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



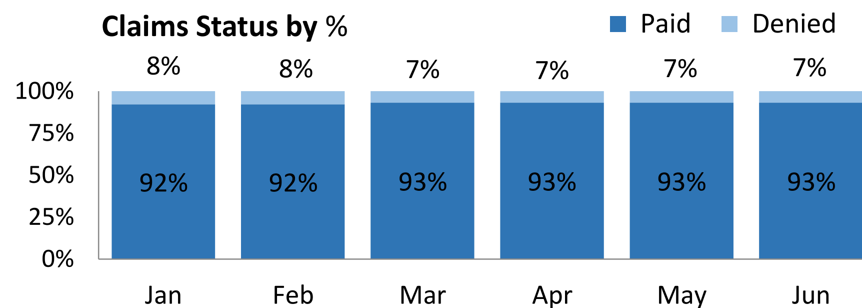
	% of Claims Universe
Prior Authorizations	2.60%
Grievances	0.01%
Appeals	0.01%

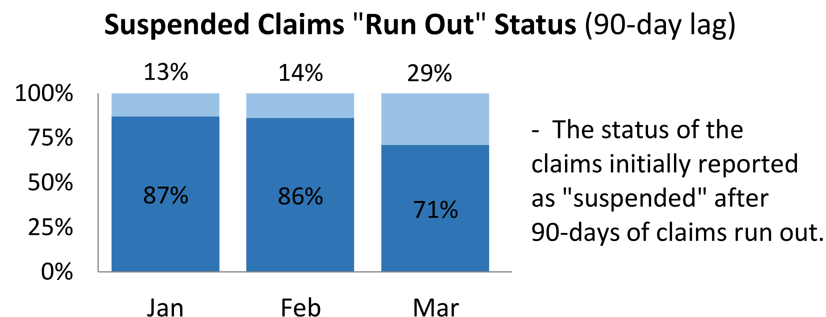
	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.10 M	7.44 M	7.69 M	**7.44 M**	7.42 M	29.67 M
Non-Pharmacy	4.21 M	4.46 M	4.39 M	4.41 M	4.37 M	17.48 M
Pharmacy	2.90 M	2.98 M	3.29 M	3.03 M	3.05 M	12.19 M
Prior Authorization Summary (p. 13-14)	171,159	169,391	186,524	**193,729**	180,201	720,803
Non-Rx - Standard PAs Submitted	127,869	124,736	134,628	142,964	132,549	530,197
Pharmacy - Standard PAs Submitted	43,290	44,655	51,896	50,765	47,652	190,606
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	587	720	784	**761**	713	2,852
Standard Appeals	701	574	558	**752**	646	2,585

Claims Summary (Non-Pharmacy)

2.49 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims			
Paid	720,421	819,395	781,608
Denied	50,975	58,023	63,333
Suspended	189,166	137,951	205,419
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	99%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	7	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.

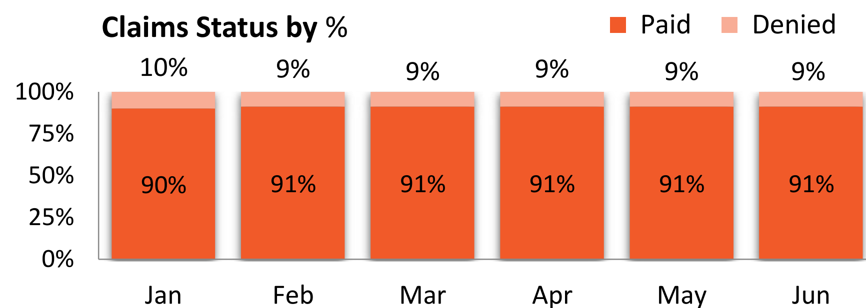
Top 10 Reasons for Claims Denials (Non-Pharmacy)

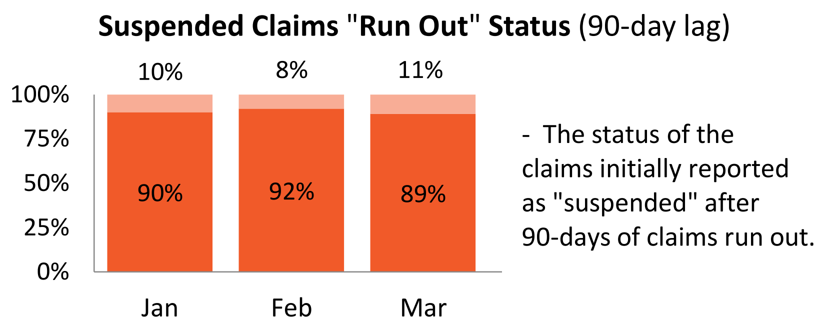
	%	Reason
1.	15%	Duplicate claim/service
2.	13%	Expenses incurred after coverage terminated
3.	12%	Service not payable per managed care contract
4.	10%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
5.	7%	The impact of prior payer(s) adjudication including payments and/or adjustments.
6.	4%	Claim/service lacks information or has submission/billing error(s) - primary payer information required
7.	4%	Precertification/authorization/notification absent
8.	4%	Attachment/Other Documentation Required
9.	4%	The time limit for filing has expired
10.	3%	Procedure code is inconsistent with modifier used or required modifier is missing

Claims Summary (Non-Pharmacy)

1.92 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims			
Paid	601,176	556,175	587,114
Denied	59,981	56,290	59,730
Suspended	162,188	183,954	127,262
Clean Claims Processed			
in 30-days (Requirement 90%)	98%	98%	98%
in 45-days (Requirement 95%)	100%	99%	99%
Average Days to Pay	9	11	10
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	94%	90%





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

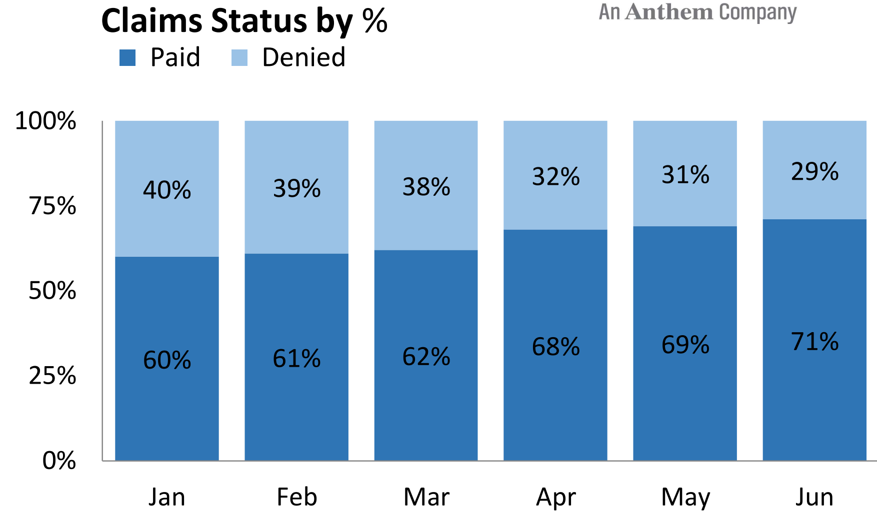
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
1.	15%	Duplicate claim/service
2.	9%	Service can not be combined with other service on same day
3.	9%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	6%	The time frame for filing a claim reconsideration has expired
5.	5%	Service is not covered
6.	5%	No authorization on file that matches service(s) billed
7.	4%	ACE claim level return to provider Diagnosis code incorrectly coded per ICD10 manual
8.	3%	Void Adjustment
9.	3%	Diagnosis code incorrectly coded per ICD10 manual
10.	2%	Referring Provider not registered with IA DHHS/IA Medicaid

Claims Summary (Pharmacy)

1.69 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	363,560	366,186	446,919
Denied	169,000	166,472	178,971
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	11	11



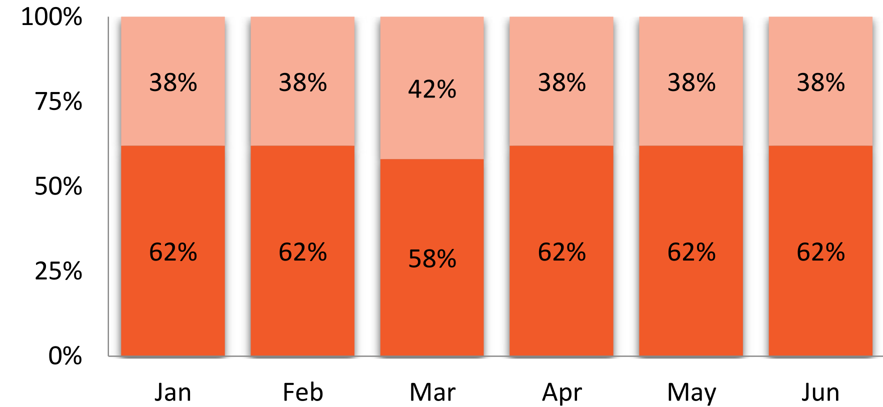
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	38%	Refill too soon
2.	16%	Prior authorization required
3.	13%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	6%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	3%	M/I processor control number
8.	2%	Pharmacy not enrolled in State Medicaid program
9.	1%	Filled after coverage terminated
10.	1%	Prescriber is not enrolled in State Medicaid program

Claims Summary (Pharmacy)

1.34 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	271,629	280,090	274,424
Denied	169,873	169,765	169,970
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	10	10	10

Claims Status by %



	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	26%	Refill too soon
2.	12%	Prior authorization required
3.	9%	National Drug Code (NDC) not covered
4.	5%	Submit bill to other processor or primary payer
5.	5%	Plan limitations exceeded
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%	Pharmacy not enrolled in State Medicaid program
10.	1%	Drug not covered for patient age

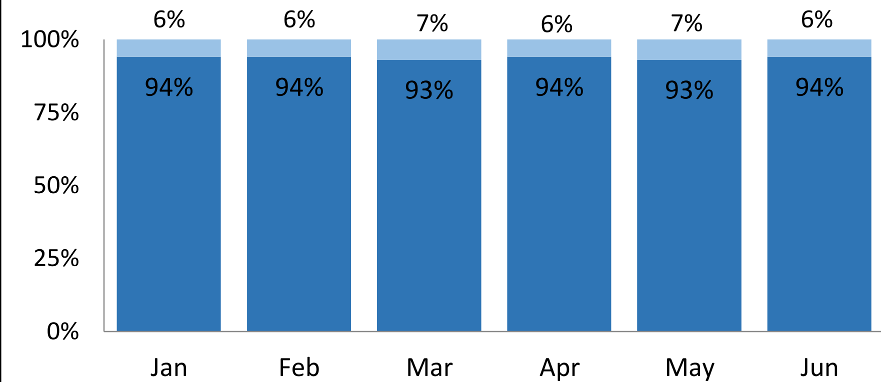
Prior Authorization Summary

93,082

All PAs Submitted [6]

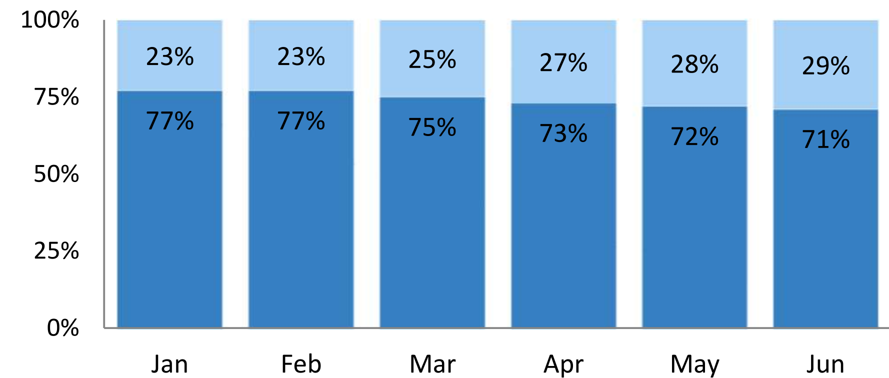
Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	21,221	19,966	20,727
Denied	1,436	1,414	1,386
Modified	0	0	0
Average Days to Process	5	5	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	6,384	6,503	6,516
Denied	2,376	2,507	2,613
PAs Completed in 24-hours (Requirement 100%)	100.0%	100.0%	99.9%



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

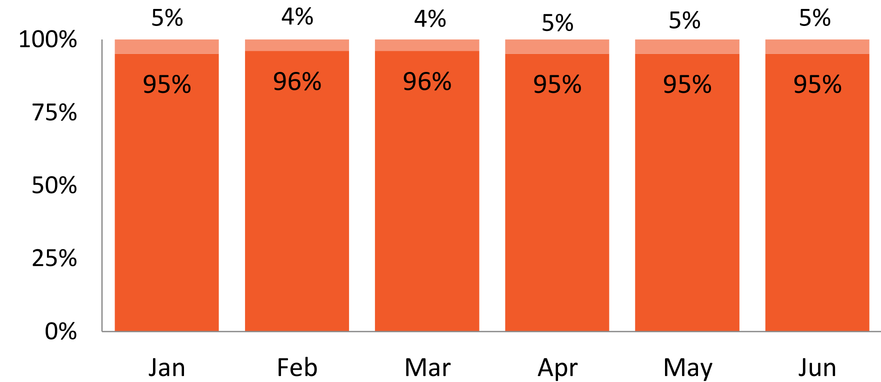
Prior Authorization Summary

100,647
All PAs Submitted [6]

Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	25,364	24,417	25,482
Denied	1,259	1,237	1,280
Modified	0	0	0
Average Days to Process	3	2	2
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

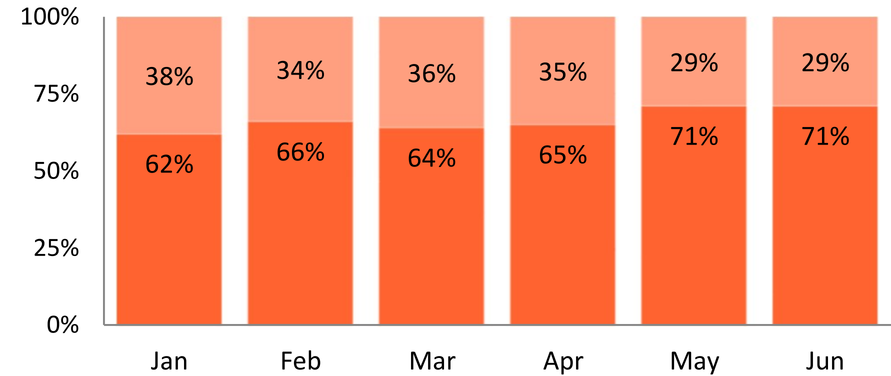
Non-Pharmacy by Percentage



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	4,695	4,884	4,960
Denied	2,506	1,948	2,062
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	99.9%

Pharmacy by Percentage

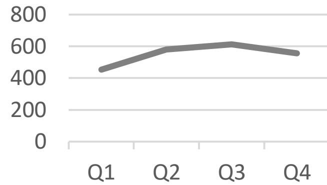


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

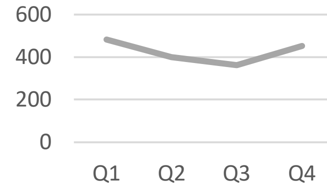
Standard Grievances

555



Standard Appeals/ 1st Level Review

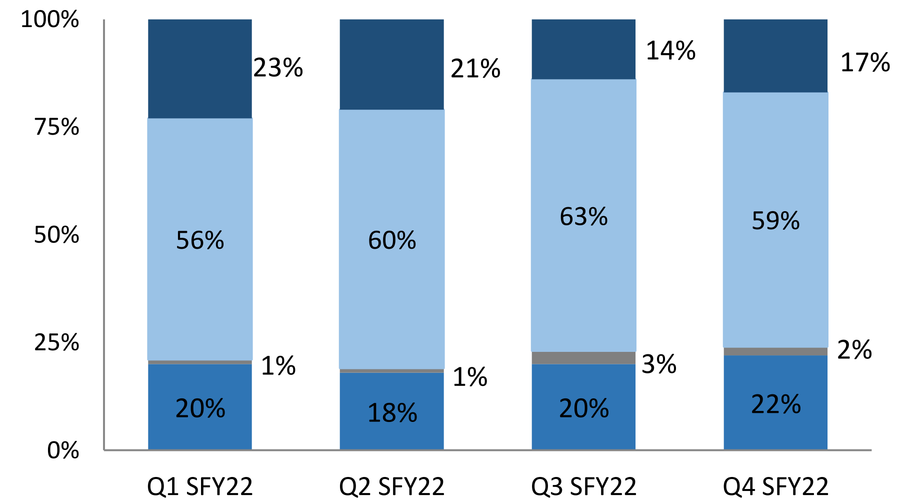
452



Resolved in 30-days
100%

Resolved in 30-days
100%

Standard Appeal Outcome %



Withdrawn
Upheld
Partially Overturned
Overturned

	%	Top 10 Reasons for Grievances [7]
1.	34%	Voluntary disenrollment
2.	24%	Provider balance billed
3.	9%	Provider Dissatisfaction
4.	6%	Treatment Dissatisfaction
5.	4%	Transportation - No Show
6.	3%	Transportation Delay
7.	3%	Transportation - Driver no-show
8.	3%	Access to Case Management
9.	3%	Poor Customer Service
10.	3%	Transportation - Unsafe Driving

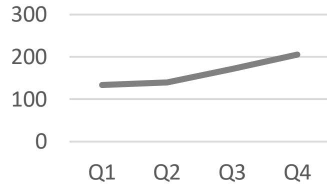
%	Top 10 Reasons for Appeals [7]
35%	Pharmacy - Non Injectable
24%	DME
13%	Outpatient Services - Medical
12%	Radiology
8%	Pharmacy - Injectable
6%	Inpatient - Medical
5%	Surgery
3%	Pain Management
3%	BH - Op Service
2%	Personal Care Services - Self

[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

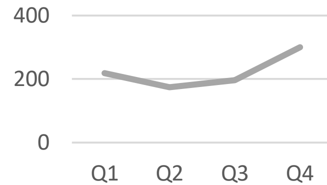
Standard Grievances

206



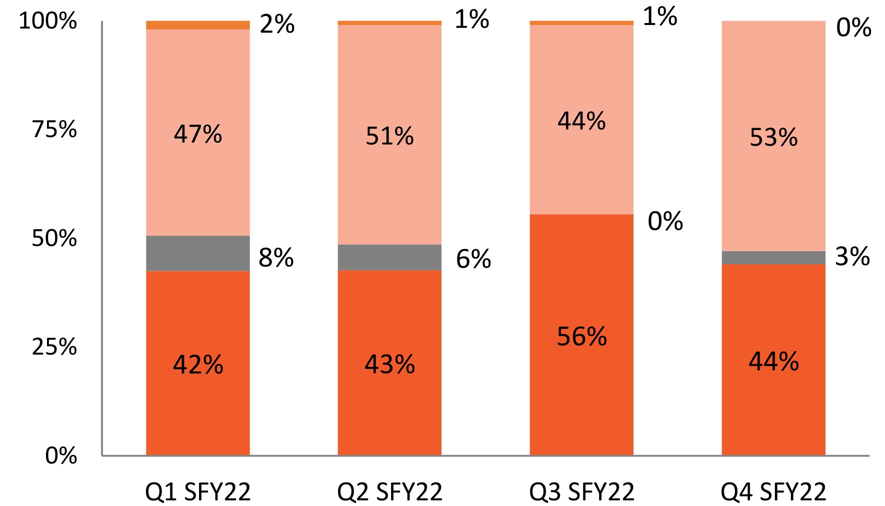
Standard Appeals/ 1st Level Review

300



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

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	18%	Provider Not in Network
2.	11%	Unhappy with Benefits
3.	9%	Transportation - Driver no-show
4.	8%	Lack of Caring/Concern
5.	7%	Transportation - Missed Appointment
6.	6%	General Complaint Vendor
7.	4%	Case Management Complaint
8.	4%	Transportation - Late appointment
9.	3%	Provider
10.	3%	Benefit Concern

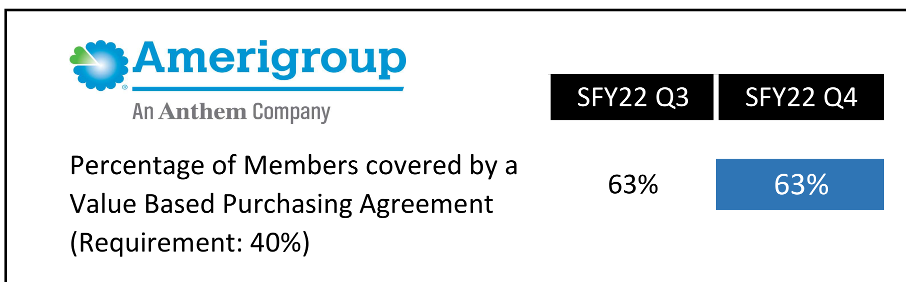
%	Top 10 Reasons for Appeals [7]
30%	RX - Does Not Meet PriorAuth Guidelines
6%	Therapy - Speech Therapy
6%	Other - Mental Health Service
5%	DME - Other
4%	Injections - Epidural Injections
4%	Therapy - Occupational Therapy
3%	Outpatient - Procedure
3%	DME - Blood Glucose Monitor
3%	Diagnostic - MRI
2%	DME - Wheelchair

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

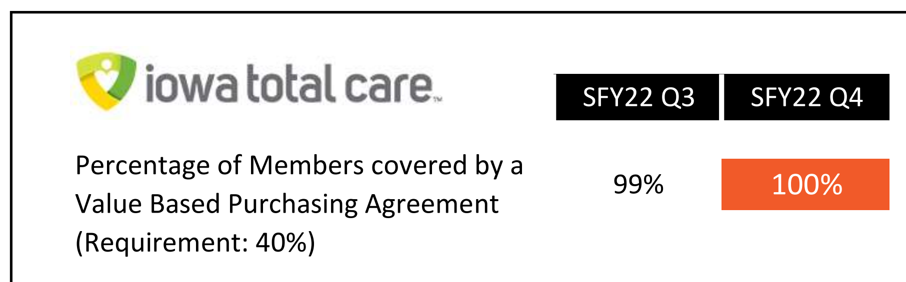
MCO Care Quality and Outcomes

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.



Amerigroup An Anthem Company	SFY22 Q3	SFY22 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	63%



iowa total care	SFY22 Q3	SFY22 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	99%	100%

Top 5 - Value Added Services (VAS)

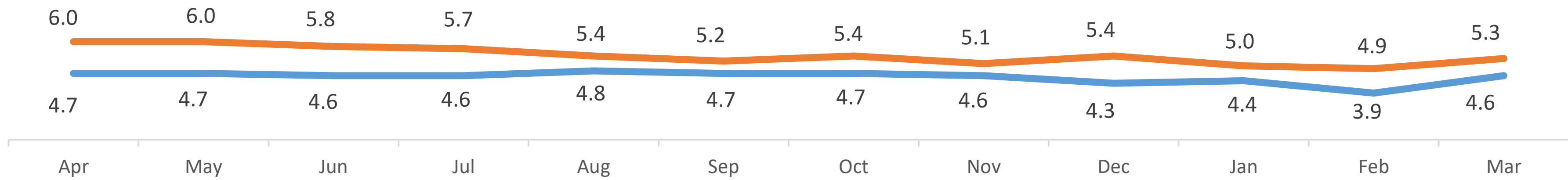
Value Added Services (VAS) are optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

Amerigroup An Anthem Company	SFY22 Q3	SFY22 Q4
Healthy Rewards	8,502	3,295
Taking Care of Baby and Me	2,829	2,661
Community Resource Link	1,140	1,242
SafeLink Mobile Phone	1,222	928
Breast Pump	474	543

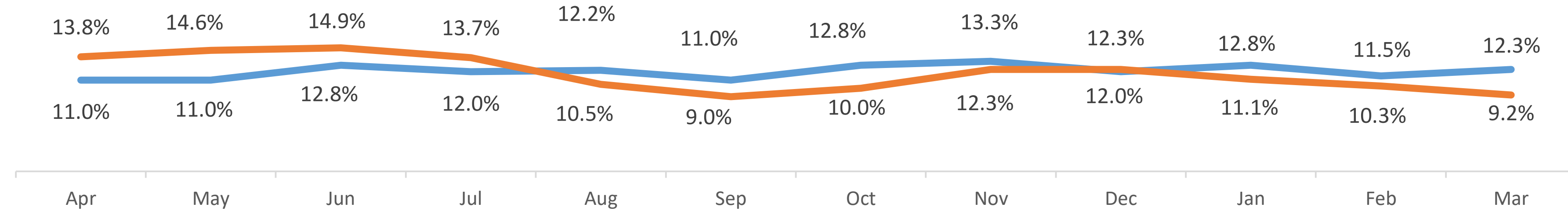
iowa total care	SFY22 Q3	SFY22 Q4
My Health Pays Program	8,719	7,400
Start Smart for Your Baby	1,638	1,638
Mobile App	1,072	1,148
The Flu Program	6,011	885
Breast Pump	553	564

MCO Care Quality and Outcomes

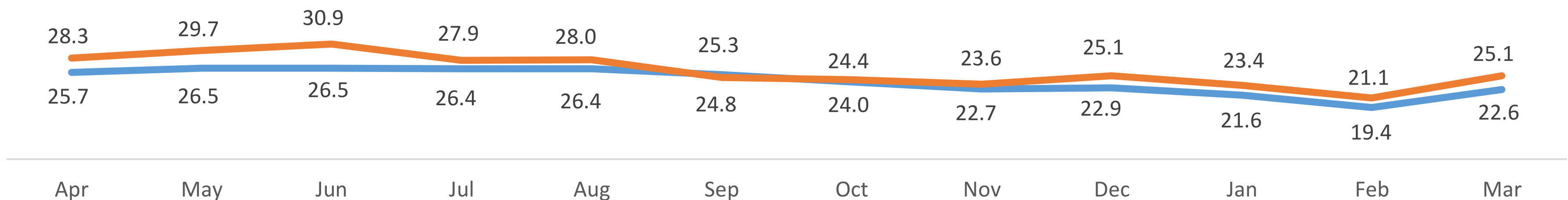
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



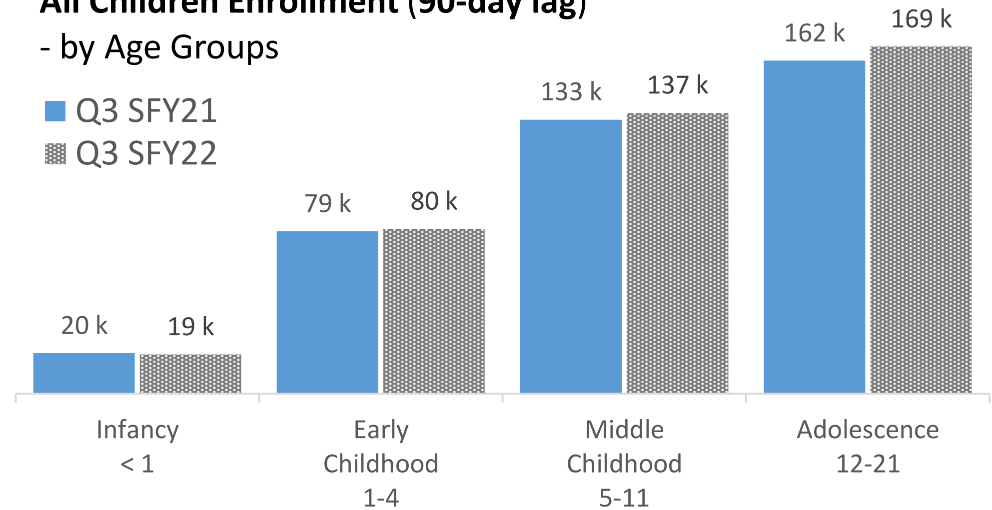
[8] *This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.*

[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).



	SFY21 Q3	SFY22 Q3
Member Enrollment	235,816	239,362
Infancy < 1	10,208	9,778
Early Childhood 1 - 4	47,404	46,510
Middle Childhood 5 - 11	80,518	81,881
Adolescence 12 - 21	97,686	101,193
Well Child Exams (Preventive Visits)	39,279	37,091
Infancy < 1	11,844	11,533
Early Childhood 1 - 4	12,642	11,573
Middle Childhood 5 - 11	7,507	7,029
Adolescence 12 - 21	7,286	6,956
Lead Screenings	4,509	3,899
Infancy < 1	97	111
Early Childhood 1 - 4	4,050	3,396
Middle Childhood 5 - 11	333	334
Adolescence 12 - 21	29	58

	SFY21 Q3	SFY22 Q3
Member Enrollment	158,103	165,207
Infancy < 1	9,409	9,262
Early Childhood 1 - 4	31,562	33,643
Middle Childhood 5 - 11	52,767	54,686
Adolescence 12 - 21	64,365	67,616
Well Child Exams (Preventive Visits)	31,819	32,931
Infancy < 1	11,555	12,181
Early Childhood 1 - 4	9,797	10,294
Middle Childhood 5 - 11	5,302	5,306
Adolescence 12 - 21	5,165	5,150
Lead Screenings	3,540	3,929
Infancy < 1	92	143
Early Childhood 1 - 4	3,129	3,455
Middle Childhood 5 - 11	289	271
Adolescence 12 - 21	30	60

MCO Children Summary

	SFY21 Q3	SFY22 Q3
Hearing Screenings	1,835	2,466
Infancy < 1	132	177
Early Childhood 1 - 4	799	1,267
Middle Childhood 5 - 11	588	758
Adolescence 12 - 21	316	264
Vision Screenings	1,517	1,993
Infancy < 1	19	55
Early Childhood 1 - 4	898	1,056
Middle Childhood 5 - 11	425	567
Adolescence 12 - 21	175	315
Vaccination Totals	59,215	57,417
COVID-19 Dose 1	944	957
COVID-19 Dose 2	196	1,003
COVID-19 Single-Dose	13	49
DTaP (Diphtheria, Tetanus, Pertussis)	10,237	9,543
Influenza (FLU)	8,961	9,801
HepA (Hepatitis A)	4,790	4,246
HepB (Hepatitis B)	1,003	939
Haemophilus Influenza Type B (Hib)	5,371	5,160
Human Papillomavirus (HPV)	2,901	2,452
Meningococcal ACWY (MenACWY)	2,365	1,986
Meningococcal B - (MenB)	1,108	988
MMR (Measles, Mumps, Rubella)	3,860	3,656
Pneumococcal (PCV13)	8,014	7,717
Pneumococcal (PPSV23)	67	57
Polio (IPV)	236	218
RV (Rotavirus)	5,138	4,975
Tetanus and diphtheria (Td)	33	26
TDAP (Tetanus, Diphtheria, Pertussis)	1,844	1,638
Varicella Virus Vaccine (VAR)	2,134	2,006

	SFY21 Q3	SFY22 Q3
Hearing Screenings	1,130	1,709
Infancy < 1	126	169
Early Childhood 1 - 4	522	461
Middle Childhood 5 - 11	342	908
Adolescence 12 - 21	140	171
Vision Screenings	1,098	1,334
Infancy < 1	19	41
Early Childhood 1 - 4	693	704
Middle Childhood 5 - 11	290	367
Adolescence 12 - 21	96	222
Vaccination Totals	47,547	49,205
COVID-19 Dose 1	606	887
COVID-19 Dose 2	160	923
COVID-19 Single-Dose	17	22
DTaP (Diphtheria, Tetanus, Pertussis)	8,284	8,578
Influenza (FLU)	6,617	7,569
HepA (Hepatitis A)	3,733	3,670
HepB (Hepatitis B)	921	958
Haemophilus Influenza Type B (Hib)	4,737	4,656
Human Papillomavirus (HPV)	2,019	1,651
Meningococcal ACWY (MenACWY)	1,547	1,317
Meningococcal B - (MenB)	766	648
MMR (Measles, Mumps, Rubella)	3,070	3,043
Pneumococcal (PCV13)	7,034	7,139
Pneumococcal (PPSV23)	46	47
Polio (IPV)	233	276
RV (Rotavirus)	4,543	4,721
Tetanus and diphtheria (Td)	17	42
TDAP (Tetanus, Diphtheria, Pertussis)	1,276	1,207
Varicella Virus Vaccine (VAR)	1,921	1,851

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

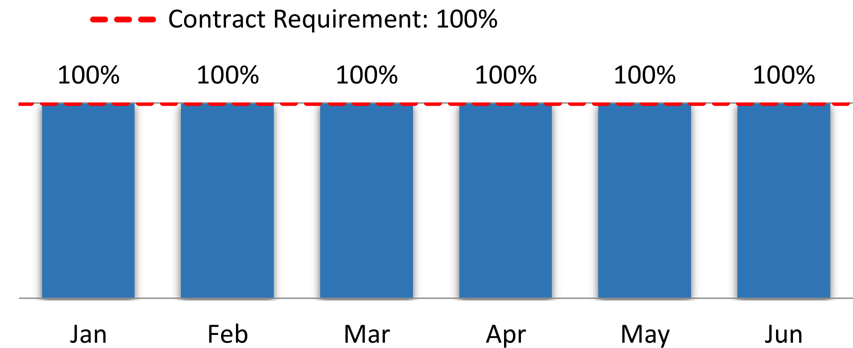
Average Number of Contacts Per Month	SFY22 Q3	SFY22 Q4
by Care Coordinators	0.8	**2.2**
by Case Managers	1.1	**1.0**
"Members to" Ratios		
Members to Care Coordinators	15	**16**
HCBS Members to Case Managers	56	**62**

Iowa Participant Experience Survey (IPES)

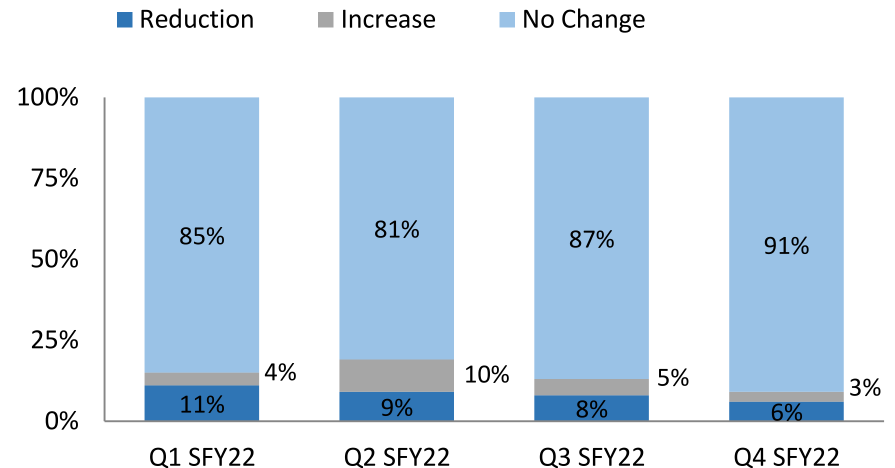
Waiver members reporting…		SFY22 Q3	SFY22 Q4
They were part of service planning.	I don't know	0.4%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.6%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	0.8%	1.0%
	No	0.0%	0.0%
	Sometimes	0.4%	0.5%
	Yes	98.8%	98.5%

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



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

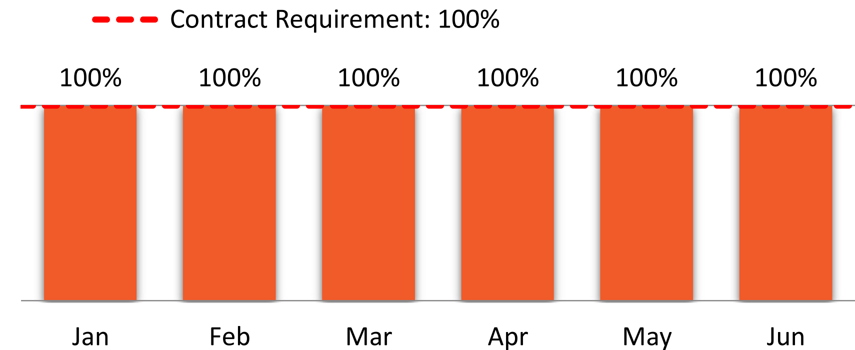
Average Number of Contacts Per Month	SFY22 Q3	SFY22 Q4
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	57	**50**
HCBS Members to Case Managers	40	**41**

Iowa Participant Experience Survey (IPES)

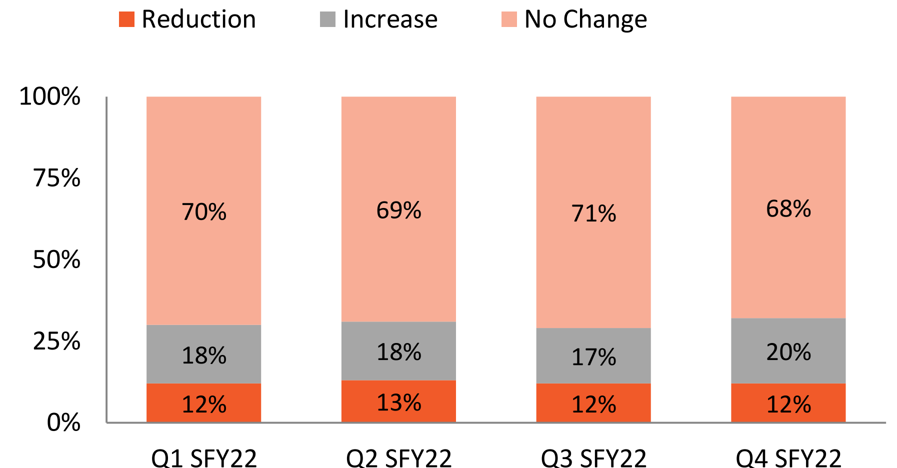
Waiver members reporting…		SFY22 Q3	SFY22 Q4
They were part of service planning.	I don't know	0.0%	1.9%
	No	2.6%	6.4%
	Sometimes	0.8%	3.4%
	Yes	95.9%	88.4%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.8%	2.2%
	Sometimes	1.5%	4.5%
	Yes	97.4%	93.3%
Their services make their lives better.	I don't know	0.0%	0.4%
	No	1.5%	3.4%
	Sometimes	1.9%	3.4%
	Yes	96.2%	92.9%

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

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services
- by Member Usage

Service	SFY22 Q3	SFY22 Q4
AIDS/HIV - Unique Service Plans	21	22
Home Delivered Meals	14	14
CDAC (agency) by 15 minute units	2	2
Financial Management Services	1	1
Brain Injury (BI) Waivers	786	769
Financial Management Services	241	226
Supported Community Living (by unit)	182	193
Respite (by 15 minute units)	157	164
Personal Emergency Response	165	160
Supported Community Living (daily)	109	109
Children's Mental Health (CMH)	739	783
Respite (by 15 minute units)	416	418
Respite (Hos/NF) - 15 minute units	198	216
Family and Community Support	200	185
Respite (Resident Camp) by units	10	19
Home Modification	2	3
Elderly Waivers	4,349	4,342
Home Delivered Meals	2,765	2,742
Personal Emergency Response	2,798	2,741
CDAC (agency) by 15 minute units	390	478
Assisted Living Services	334	330
Personal Emergency Response (install)	285	301

Service	SFY22 Q3	SFY22 Q4
Habilitation (Hab)	4,233	4,201
Home-based Habilitation	3,681	3,448
Long Term Job Coaching	412	406
Day Habilitation (units by day)	380	354
Individual Supported Employment	112	141
Day Habilitation (by 15 minute units)	129	138
Health & Disability (HD)	1,326	1,345
Respite (by 15 minute units)	352	377
Financial Management Services	376	363
Personal Emergency Response	311	314
Home Delivered Meals	290	296
CDAC (individual) by 15 minute units	48	62
Intellectual Disability (ID)	6,951	6,923
Supported Community Living (by unit)	1,775	1,794
Supported Community Living (RCF)	1,458	1,489
Day Habilitation (units by day)	1,386	1,378
Financial Management Services	1,431	1,343
Supported Community Living (daily)	1,133	1,183
Physical Disability (PD)	606	601
Personal Emergency Response	326	327
CDAC (agency) by 15 minute units	79	84
CDAC (individual) by 15 minute units	77	63
Financial Management Services	30	35
Personal Emergency Response (install)	24	27

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

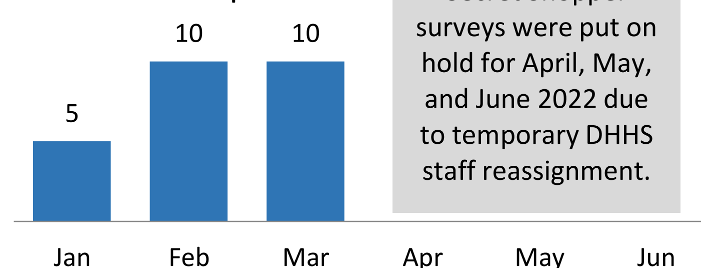
	SFY22 Q3	SFY22 Q4
AIDS/HIV - Unique Service Plans	7	8
Home Delivered Meals	8	8
CDAC (individual) by 15 minute units	2	1
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	1	1
Brain Injury (BI) Waivers	514	515
Supported Community Living (by unit)	222	216
Personal Emergency Response	132	139
Respite (by 15 minute units)	130	125
Supported Community Living (daily)	124	122
Transportation (1-way trip)	87	93
Children's Mental Health (CMH)	328	374
Respite (by 15 minute units)	192	215
Respite (Hos/NF) - 15 minute units	127	145
Family and Community Support	106	106
Mental Health Service	40	42
Respite (Resident Camp) by units	8	12
Elderly Waivers	3,257	3,277
Personal Emergency Response	2,542	2,542
Home Delivered Meals	2,513	2,477
CDAC (agency) by 15 minute units	1,353	1,303
Homemaker (by 15 minute units)	757	708
CDAC (individual) by 15 minute units	659	648

	SFY22 Q3	SFY22 Q4
Habilitation (Hab)	2,364	2,371
Home-based Habilitation	1,966	1,954
Day Habilitation (by 15 minute units)	343	329
Day Habilitation (units by day)	296	277
Long Term Job Coaching	285	273
Individual Supported Employment	135	126
Health & Disability (HD)	593	590
Respite (by 15 minute units)	276	276
Personal Emergency Response	159	152
Home Delivered Meals	158	149
CDAC (agency) by 15 minute units	112	100
CDAC (individual) by 15 minute units	101	95
Intellectual Disability (ID)	4,466	4,435
Supported Community Living (by unit)	1,823	1,751
Day Habilitation (by 15 minute units)	1,736	1,693
Day Habilitation (units by day)	1,623	1,559
Supported Community Living (RCF)	1,284	1,214
Respite (by 15 minute units)	1,019	965
Physical Disability (PD)	375	384
Personal Emergency Response	196	213
CDAC (agency) by 15 minute units	155	161
CDAC (individual) by 15 minute units	126	114
Transportation (1-way trip)	40	41
Personal Emergency Response (install)	22	26

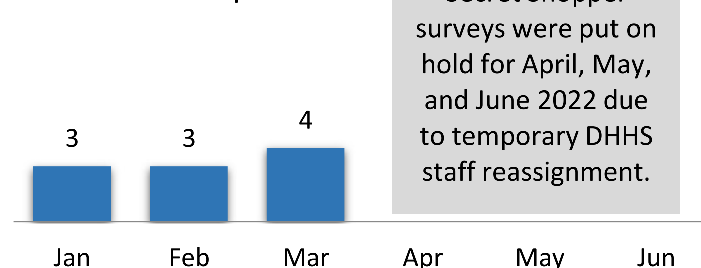
Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	96.39%	97.30%	93.13%
Abandonment Rate - Must be 5% or less	0.37%	0.30%	0.59%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.81%	99.60%	99.14%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.09%
Provider Helpline			
Service Level (Requirement 80%)	94.07%	95.40%	90.20%
Abandonment Rate - Must be 5% or less	0.55%	0.33%	0.46%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.68%	96.12%	95.09%
Abandonment Rate - Must be 5% or less	0.28%	0.31%	0.05%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	80.81%	83.46%	90.23%
Abandonment Rate - Must be 5% or less	2.69%	2.98%	1.14%

Secret Shopper Scores - Member Helpline



Secret Shopper Scores - Provider Helpline



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

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

Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	83.54%	86.62%	87.92%
Abandonment Rate - Must be 5% or less	4.21%	4.29%	4.29%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	85.60%	86.80%	86.80%
Abandonment Rate - Must be 5% or less	0.90%	1.00%	1.30%
Provider Helpline			
Service Level (Requirement 80%)	80.50%	85.30%	87.60%
Abandonment Rate - Must be 5% or less	1.90%	1.42%	1.20%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.72%	97.53%	98.81%
Abandonment Rate - Must be 5% or less	0.22%	0.33%	0.05%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	79.85%	84.84%	91.36%
Abandonment Rate - Must be 5% or less	2.08%	2.16%	0.83%

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 PCP/PPG for Member
4.	Member Rewards for Member
5.	Order ID card

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

Provider Network Access Summary

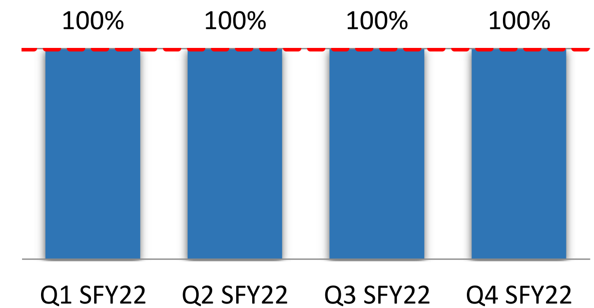
Primary Care Providers (PCP)

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4
Adults PCP				
Provider Count	6,589	6,688	6,768	6,893
Members with Access	228,637	231,146	230,958	237,584
Average Distance (Miles)	1.8	1.8	1.8	1.8
Pediatric PCP				
Provider Count	6,621	6,719	6,798	6,924
Members with Access	213,136	212,453	214,637	214,390
Average Distance (Miles)	2.0	1.9	1.9	1.9

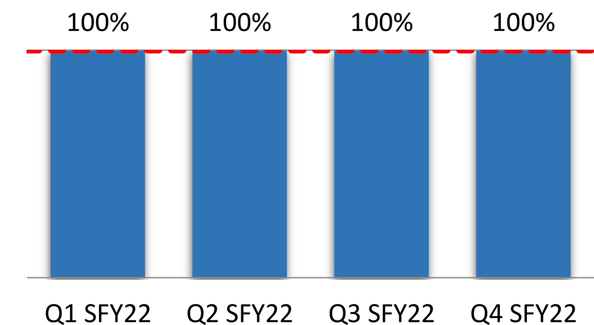
Specialty Care & Behavioral Health (BH)

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4
OB/GYN Adult				
Provider Count	401	405	409	423
Members with Access	148,670	150,083	150,019	154,186
Average Distance (Miles)	5.6	5.6	5.5	5.5
Outpatient - Behavioral Health				
Provider Count	4,305	4,456	4,503	4,543
Members with Access	441,773	443,599	445,595	451,974
Average Distance (Miles)	2.3	2.2	2.2	2.2
Inpatient - Behavioral Health				
Provider Count	50	51	51	51
Rural Members				
Members with Access	180,629	181,008	181,707	184,359
Average Distance (Miles)	21.4	18.5	18.3	21.0
Urban Members				
Members with Access	261,144	262,591	263,888	267,615
Average Distance (Miles)	5.8	5.8	5.8	5.8

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

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4
Adults PCP				
Provider Count	9,894	9,894	9,894	9,894
Members with Access	175,634	180,087	186,041	189,029
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	141,050	143,484	146,338	147,665
Average Distance (Miles)	2.1	2.1	2.1	2.1

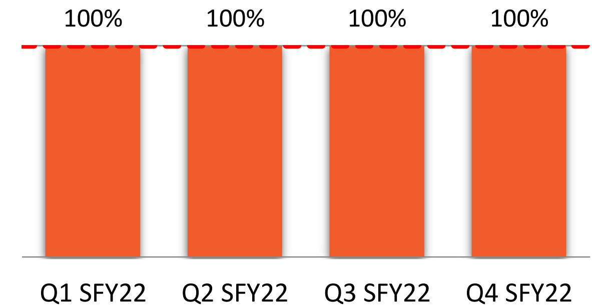
Specialty Care & Behavioral Health (BH)

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4
OB/GYN Adult				
Provider Count	1,298	1,298	1,298	1,298
Members with Access	115,394	118,135	121,417	123,122
Average Distance (Miles)	5.4	5.4	5.3	5.4
Outpatient - Behavioral Health				
Provider Count	9,688	9,688	9,688	9,688
Members with Access	316,684	323,571	332,379	336,694
Average Distance (Miles)	2.4	2.4	2.4	2.5
Inpatient - Behavioral Health				
Provider Count	36	36	36	36
Rural Members				
Members with Access	226,908	231,823	238,027	241,452
Average Distance (Miles)	24.6	24.5	24.5	24.5
Urban Members				
Members with Access	89,776	91,748	94,352	95,242
Average Distance (Miles)	8.4	8.4	8.4	8.4

Adult PCP - Standards

30 minutes or 30 miles

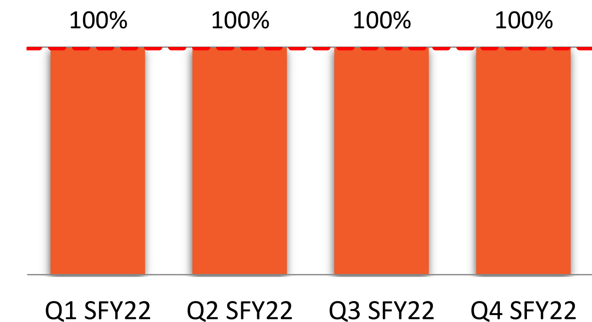
Contract Requirement: 100%



Pediatric PCP - Standards

30 minutes or 30 miles

Contract Requirement: 100%



Link to Geo Access Reports:

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

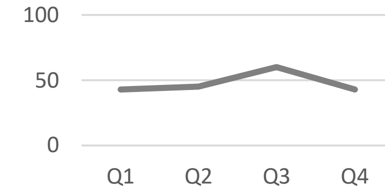
MCO Program Integrity

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 SFY22 Q4

43



2 Total Cases

Referred to MFCU Q4

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Total
Investigations opened	28	31	44	25	32	128
Overpayments identified	14	25	28	10	19	77
Member concerns referred to IME	2	5	0	4	3	11
Cases referred to the Medicaid Fraud Control Unit (MFCU)	6	4	3	2	4	15

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Total
Investigations opened	15	12	16	18	15	61
Overpayments identified	12	17	9	6	11	44
Member concerns referred to IME	10	5	6	4	6	25
Cases referred to the Medicaid Fraud Control Unit (MFCU)	16	3	3	0	6	22

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://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**:
  - 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
- Member is commended changes in policies and services
- 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://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, 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 Human Services 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 Public Health
- Kelly Garcia - Interim Director
- Angie Doyle Scar - Designee

Department of Human Services (DHS) Staff
- Elizabeth (Liz) Matney - Iowa Medicaid 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

MAAC Council Member List

Co-Chairpersons
- Angela Doyle-Scar, Public Health
- Jason Haglund, 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
- Brett Barker, 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

Other Statutory Members
- VACANT, Des Moines University-Osteopathic Medical Center
- Angela Van Pelt, Iowa Department of Aging
- Cynthia Pedersen, Long-Term Care Ombudsman
- Jennifer Harbison, University of Iowa College of Medicine
- Angela Doyle Scar, Iowa Department of Public Health
- Mary Nelle Trefz, Hawki Board

Professional and Business Entities
- 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
- 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

Continued…

MAAC Council Member List continued...

Professional and Business Entities

Flora Schmidt, Iowa Behavioral Health Association
Marianka Pille, Iowa Chapter of the American Academy of Pediatrics
Denise Rathman, Iowa Chapter of the National Association of Social Workers
Molly Lopez, Iowa Chiropractic Society
Josh Carpenter, Iowa Dental Association
Laurie Traetow, Iowa Dental Association
Brooke Lovelace, Iowa Developmental Disabilities Council
Bill Kallestad, 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
VACANT, Iowa Osteopathic Medical Association
Kate Walton, Iowa Physical Therapy Association
Kevin Kruse, Iowa Podiatric Medical Society
Erica Shannon, 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
Kay Vanags, Iowa Association of Area Agencies on Aging
Lynn Boes, Iowa Nurses Association
Marc Doobay, Iowa Physician Assistant Society
Cindy Baddeloo, Iowa Health Care Association/Iowa Center for Assisted Living
VACANT, Opticians Association of Iowa
Kady Reese, Iowa Medical Society
Susan Horras, Iowa Hospital Association

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://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