Department of HUMAN SERVICES

Julie Lovelady, Interim Medicaid Director **Medical Assistance Advisory Council (MAAC)**

MAAC MATERIALS

February 24, 2021

1. Agenda of Meeting for February 24, 2021
2. October 8, 2020, Full Council Meeting Minutes
3. Executive Talking Points
4. MCO Quarterly Report SFY21, Quarter 1
5. Dental Program Update Presentation

Department of HUMAN SERVICES

Julie Lovelady, Interim Medicaid Director **Medical Assistance Advisory Council (MAAC)**

AGENDA
Medical Assistance Advisory Council Meeting

Wednesday, February 24, 2021
Time: 1:00 P.M. – 4:00 P.M.
Teleconference (Due to COVID-19)
Join Zoom Meeting:
https://www.zoomgov.com/j/1619343776?pwd=dmExRjQ0V3JFWGhPRlZmVm9VQndBQT09

Meeting ID: 161 934 3776
Passcode: 916256

Call In: 1 (551) 285-1373

1:00 Introduction and roll call – **Sarah Reisetter**

1:05 Approval of Minutes – **Sarah Reisetter**
- October 8, 2020 Meeting

1:15 Update from the Medicaid Director – **Julie Lovelady**
- **COVID-19 Update**
- **MCO Financial Withholds**

2:10 MCO Quarterly Report – SFY21, Quarter 1[1] –**Mary Stewart**

2:40 Children's Medicaid Dental Transition – **Heather Miller**

3:00 Updates from the MCOs – **MCOs**
- Amerigroup Iowa (10 minutes)
- Iowa Total Care (10 minutes)

3:40 Open Comment – **Co-Chairs**

4:00 Adjourn

This meeting is accessible to persons with disabilities. (If you have special needs, please contact the Department of Human Services (515) 281-5452 two days prior to the meeting.) Note: Times listed on agenda for specific items are approximate and may vary depending on the length of discussion for preceding items. Please plan accordingly.

[1] https://dhs.iowa.gov/sites/default/files/SFY21_Q1_Report.pdf

Department of HUMAN SERVICES

Julie Lovelady, Interim Medicaid Director **Medical Assistance Advisory Council (MAAC)**

Summary of Meeting Minutes
October 8, 2020

Call to Order and Roll Call

Jason Haglund, Public Member and Co-Chair of the Medical Assistance Advisory Council (MAAC), called roll at 1:00 P.M. Attendance is reflected in the separate roll call sheet. Jason announced a quorum.

Approval of Previous Meeting Minutes

Jason called for a motion to approve minutes from the August 13, 2020 meeting. The minutes were approved.

Medicaid Director's Update

Julie Lovelady, Interim Medicaid Director, gave updates on the Iowa Medicaid program. Julie announced the U.S. Department of Health and Human Services (HHS) has extended the COVID-19 Public Health Emergency (PHE) another 90 days through January 21, 2021. This means that all of the waivers and flexibilities the Department currently has in place will continue at least through January 21, 2021. The Department has begun working internally and with the Managed Care Organizations (MCOs) and other stakeholders to discuss how to wind down waivers and flexibilities implemented during the PHE. Last week, HHS announced $20 Billion in new funding for providers. Applications for the new round of funding opened Monday, October 5, 2020, and will be available through Friday, November 6, 2020. This funding is open to providers that have already received Provider Relief Fund payments to apply for additional funding that considers financial losses and changes in operating expenses caused by the coronavirus.

The Department has extended the deadline for Home- and Community-Based Services (HCBS) waiver and habilitation direct service providers, substance use disorder (SUD), and mental health (MH) service providers to apply to receive a CARES Act grant from the Department to help offset the impacts of the COVID-19 pandemic. The deadline to apply is now Monday, October 19, 2020. Providers, who did not apply for funding during the first round, ending on September 11, 2020, are encouraged to apply for this new round of funding. The Department is distributing a total of $50 Million in grants to providers; $30 Million has been earmarked for HCBS providers, $10 Million for MH providers, and $10 Million for SUD providers.

CareBridge, the MCO Electronic Visit Verification (EVV) vendor, and the MCOs are on track to meet the January 1, 2021, federal requirement for EVV implementation. CareBridge along with the MCOs and the Department have been holding monthly informational meetings for

stakeholders since August 2020. These meetings give an overview of EVV and the implementation plan. These are not trainings, just informational meetings. Registration is now open for the final two informational meetings, scheduled for November 10, 2020, and December 2, 2020. In-depth EVV training has started and providers are encouraged to register online. Trainings for providers who are required to use EVV are available on many different days and times and in a variety of different ways. EVV is only required for Managed Care beginning January 1, 2021; Fee-for-Service (FFS) will continue to bill as they already do.

At the last meeting of the MAAC, the Council requested an update on how telehealth is measured by the Department. During the PHE, the Department has focused on maintaining access for typically face-to-face services through the use and expansion of telehealth. The Department is now analyzing the quantitative data available to identify priorities and patterns of use. The Department will use findings in this analysis to develop measures of telehealth quality. These measures in turn will be used to ascertain the quality and impact of telehealth services in three time-periods: telehealth services before the pandemic, what the Department implemented during the pandemic, and what the Department is considering implementing going forward. The Department is involved in peer-networking and problem solving with other states struggling with the same task. The Department is meeting with the MCOs and other shareholders to discuss what telehealth flexibilities make sense to carry forward post-pandemic. Additionally the Department is awaiting guidance from the Centers for Medicare and Medicaid Services (CMS) on some telehealth flexibilities. Julie stated the Department would welcome any guidance or input on this issue from the council.

Dennis Tibben, Iowa Medical Society, asked when the Department would make decisions about which telehealth flexibilities will be made permanent. Julie answered that while she could not provide a definite timeline, the Department is in process on making those decisions. Julie added that the next monthly COVID-19 stakeholder meeting is intended to focus on telehealth flexibilities, specifically asking for stakeholder input on what flexibilities should remain after the PHE ends.

Julie provided an update on Medicaid's role in the Return to Learn program. The Department continues to have conversations with CMS regarding the virtual learning process and what support Medicaid can provide. The Department is allowing respite providers to assist in the virtual learning process in a similar capacity to what parents would provide: helping children log on to internet, access virtual learning platforms, provide supervision, and assist with issues that may arise. The MCOs have performed targeted outreach across the state to parents who have children accessing virtual learning platforms to help establish some information about what issues parents might be having. The Department is in the process of analyzing this data, and has identified several key trends: lack of internet access, parents having to adjust work schedules, additional supervision needed while accessing virtual learning, parents having to manage multiple children virtual learning. Julie noted that many parents have stated they had no concerns and that virtual learning was going well for them. Many of the issues are out of the realm of Medicaid and

fall more into the realm of Education, but the Department continues to work with CMS to identify areas the Medicaid program can assist.

Dr. Amy Shriver, Public Member, asked how providers could help families access the respite support. Julie answered that questions or needs for assistance could be brought to her.

Managed Care Quarterly Report: State Fiscal Year (SFY) 2020 Quarter 4

Mary Stewart, Bureau Chief, Managed Care reviewed the report. This is the second report that reflects impacts from COVID-19. The Managed Care Bureau tracked the following statistics through June 30, 2020: 19,857 individuals were tested for COVID-19 through MCOs; 481 of these members tested positive for COVID-19; the MCOs reported 1,867 inpatient stays due to COVID-19; and 120 deaths related to COVID-19 were reported. Mary went on to highlight: member to coordinator ratios; MCO member grievances; secret shopper data; prior authorizations; non-pharmacy claims data; utilization of value added services; value based purchasing enrollment; financial ratios, specifically Medical Loss Ratio (MLR) for each MCO; and fraud, waste and abuse data.

Dr. Shriver noted that 44 percent of pharmacy prior authorizations were denied, and asked if the Department to investigate. Mary offered to look into this issue and respond to Dr. Shriver.

Dr. Shriver requested that data presented in quarterly reports be disaggregated by age. Shelly Chandler, Iowa Association of Community Providers, asked that information be disaggregated for Long Term Services and Supports (LTSS) as well.

Iowa Wellness Plan Annual Report

Anna Ruggle, Iowa Medicaid, presented the 2020 Iowa Wellness Plan Annual Report. Approximately 195,000 members are enrolled in the Iowa Health and Wellness Plan (IHAWP). Anna acknowledged some changes to the program in 2019: UnitedHealthcare leaving the program and Iowa Total Care coming on board; and the implementation of passive assignment, which allows members to be assigned to an MCO immediately rather than spending 30 days assigned to FFS. Anna then discussed Healthy Behaviors, completion of a health risk assessment and either a wellness exam or a dental wellness exam, noting that 17 percent of members complete the required Healthy Behaviors. Finally, Anna announced that CMS has approved Iowa's waiver extension for the Iowa Health and Wellness Plan; this extension will expire December 31, 2024.

Shelly Chandler noted the percentage of members participating in Healthy Behaviors, 17 percent, seemed low and asked what the target percentage is and what the state is doing to increase engagement. Anna answered the target percentage is 40 percent and the

Department sends out information on Healthy Behaviors. Anna noted that it is difficult to drive engagement on Healthy Behaviors with members.

Senator Joe Bolkcom observed that the IHAWP has been a success, and that the reimbursement from the federal government is an important source of funding for rural healthcare providers, especially during the pandemic.

Updates from the MCOs

Amerigroup Iowa, Inc.

John McCalley, of Amerigroup Iowa, Inc. (Amerigroup), presented Amerigroup's update. John began by discussing Amerigroup's response to COVID-19 and the August 10, 2020, derecho storm, including donations of Personal Protective Equipment (PPE) and charitable donations to housing non-profits and food banks around the state of Iowa. John went on to highlight the work the Anthem Foundation has done including: partnering with Count The Kicks, a non-profit dedicated to maternal-child health; a partnership with the Boys and Girls Club of America, recently adding a Council Bluffs chapter; and work with a variety of community action agencies around food insecurity and housing security.

Representative Heather Matson thanked John for Amerigroup's quick response in resolving some transportation issues for some of her constituents. John thanked the representative and announced that Amerigroup has contracted with transportation vendor Access2Care beginning October 1, 2020.

Iowa Total Care

Mitch Wasden of Iowa Total Care (ITC), presented ITC's update. Mitch began by addressing concerns regarding ITC's MLR. ITC has partnered with a third party auditor which will test claims against configuration changes, following this ITC will revisit corrective action plans and the capitation suspension ITC received earlier in 2020. Mitch moved on to discuss ITC's efforts to assist Iowans affected by the derecho storm on August 10, 2020. Mitch discussed ITC's My Health Pays Reward program, noting 110,000 members are enrolled in the program, which incentivizes members to complete healthy activities. Mitch provided an update on ITC's texting program, stating it has been a success in helping engage members. ITC has launched their own telehealth application, launched in July 2020. Mitch stated that over 50 percent of the visits scheduled through the app are on weekends or after hours. Mitch announced that ITC will launch a medication adherence program in coming months.

Open Discussion

Dr. Shriver discussed the need for high quality metrics that specifically separate information regarding children and adults.

Brandon Hagen, Iowa Healthcare Association, asked how Amerigroup plans to raise its MLR from 80.5 percent to the required 88 percent. John stated he would take that question back and work with his team to provide an answer. John pointed out that the 88 percent is not required on a quarter-by-quarter basis, but is examined on an annual basis.

Dr. Shriver raised concerns regarding the transportation provider Access2Care: the provider does not have a website that will allow members to schedule an appointment online; the provider has a policy that does allows only one parent to receive transportation with a child. Dr. Shriver also requested that the MCOs cover flu shots, and cover nebulizers more frequently than every five years.

Brandon asked if there is any concern about the accuracy of claims payments, stating he has heard concerns from Iowa Healthcare Association providers that claims payments are often inaccurate. Julie answered that accuracy of payments is important, and that the Department monitors trends around this issue. Julie cautioned that claims payment issues can arise for a variety of reasons. Brandon asked how the MCOs determine that a claims payment adjustment project has concluded. Mitch answered that the process is complex coordination between the provider and the MCOs, often involving several rounds of fine-tuning before an issue can be resolved, but once an issue is resolved payments are paid accurately going forward. Brandon offered to bring specific instances to Mitch and John offline.

Adjournment

Meeting adjourned at 2:28 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Department of HUMAN SERVICES

Julie Lovelady, Interim Medicaid Director | **Medical Assistance Advisory Council (MAAC)**

Medicaid Director Executive Summary

February 24, 2021

Federal Public Health Emergency (PHE) Extended

- The U.S. Department of Health and Human Services (HHS) has extended the COVID-19 PHE through **April 20, 2021**.
- This means that all the Medicaid waivers and flexibilities currently in place will continue through at least that date.
- Nothing official yet, but HHS has indicated that the PHE may remain in place for all of calendar year 2021.

COVID-19 Vaccine Information for Providers

- The COVID-19 vaccine is a covered Medicaid benefit.
- There is no prior authorization required to receive the vaccine, and there is no co-pay for members.
- Providers will receive an administration fee for the vaccine.
    - Complete details are available in Informational Letter (IL) 2207-MC-FFS-CVD[1].
    - Submit billing questions to IMEVACCINEBILLING@dhs.state.ia.us.

Service Utilization during COVID-19

- There has been an upward trend of telehealth utilization throughout the pandemic.
- The biggest increases in telehealth utilization have been in:
    - Evaluation and management
    - Behavioral testing/assessment
    - Vision and hearing
    - Alcohol and drug abuse treatment
- Claims for non-emergency medical transportation (NEMT) have been down about 45 percent compared to the previous year.

Provider Relief Funds Through the State

- For providers who have received grant funds from the Coronavirus Aid, Relief and Economic Security (CARES) Act through the State, the deadline has been extended[2] to June 30, 2021 for when providers must use the funds.

Managed Care Organization (MCO) Contract Changes

- Added contract language about different relief payments available to providers during the COVID-19 PHE.
- Appeal rights now remove the restriction of following a verbal notice with a written notice.
- Both MCOs are required to use the same Electronic Visit Verification (EVV) vendor, CareBridge.
- Added a Pay for Performance measure around social determinants of health.
- MCOs must reprocess 90 percent of all claim errors within 30 calendar days unless the MCO must implement a system configuration change.
- Adjusted the Medical Loss Ratio (MLR) for the MCOs from 88 percent to 89 percent for State Fiscal Year 2021 (SFY21).
- A risk corridor is in place for the January 1, 2021, through June 30, 2021, rating period.

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[1] https://dhs.iowa.gov/sites/default/files/2207-MC-FFS_COVID-19_Vaccines__Monoclonal_Antibodies.pdf

[2] https://dhs.iowa.gov/sites/default/files/2208-MC-FFS-CVD_CARES_Act_Spending_Deadline_Extended_Through_June%2030%202021.pdf

Iowa Total Care (ITC) Claims Audit

- In January 2020, the Department withheld $44 million from ITC due to multiple inaccurate claims payments to providers.
- An outside vendor, Myers and Stauffer, has been working with ITC to conduct a claims audit.
- There's two phases to the audit.
    - Phase 1: Sampling of claims for 13 specific providers with multiple payment issues; completed in December 2020.
    - Phase 2: Verifying ITC's claims system configuration corrections through analytics and sampling; completed by the end of March 2021.
- Payments will be made to ITC based on the validation of audit.

EVV Update

- The Department implemented EVV on January 1, 2021, for personal care services provided through a MCO.
- The Department allowed a 30-day grace period for providers to become familiar with the CareBridge application before denying claims.
- Effective with dates of service February 1, 2021, and after, claims not submitted through the CareBridge EVV solution will be denied.
    - This does not apply to assisted living facilities or residential care facilities. The Department has delayed implementation until July 1, 2021, for these provider types.

Medicaid Coverage for Marshallese

- The Department is now providing full Medicaid benefits to all eligible adult citizens of Palau, the Marshall Islands, and the Federated States of Micronesia living in Iowa through treaties known as the Compacts of Free Association (COFA).
- Federal law was passed in December 2020 that allowed for this change. This change directly affects COFA adults. There is no change to Medicaid eligibility for COFA children. In Iowa, COFA children have been eligible for full Medicaid benefits since 2010.
- COFA adults must still meet all other Medicaid eligibility requirements.

Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 1

(July - September)

Performance Data

Published December 2020

Department of HUMAN SERVICES

Contents

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

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

Executive Summary

This report is based on Quarter 1 of State Fiscal Year (SFY) 2021 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

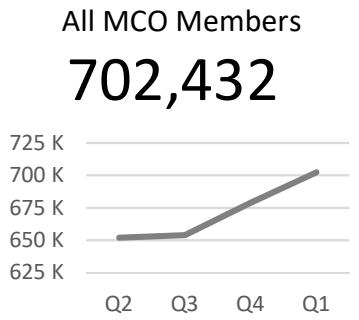
Notes about the reported data:

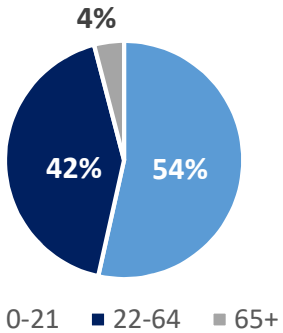
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period 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.
- All encounter data is provided "as is". The IME takes measures to attempt to ensure the accuracy, completeness, and reliability of the data. However, users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.
- 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: http://dhs.iowa.gov/iahealthlink

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.





+ 23,384 Members
3.44% Increase

All MCO Enrollment (by Age)

Data Notes: September 2020 enrollment data as of October 28, 2020. The "Average" column below represents a four-quarter rolling average while the "Distinct" column represents the total number of unique individuals appearing within populations at least once during the past four-quarters.

	SFY20 Q2	SFY20 Q3	SFY20 Q4	SFY21 Q1	Average	Distinct
MCO Member Summary	652,005	653,929	679,048	**702,432**	671,854	**771,482**
0-21	352,083	353,122	366,686	375,723	361,903	405,455
22-64	273,842	274,650	285,200	298,168	282,965	331,853
65+	26,080	26,157	27,162	28,541	26,985	34,174
Fee-For-Service (FFS) - Non MCO Enrollees	38,306	38,172	38,979	**40,370**	38,957	**44,763**

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

If Yes, explain:

Iowa Medicaid Population **816,245**
1 year distinct count

o MCO enrollment increased by 23,384 members (or 3.44% increase)
o Since March 2020, all MCO disenrollment has been suspended because of COVID-19

MCO Member Summary

Amerigroup	SFY20 Q4	SFY21 Q1
Members	400,127	412,180
MCO Member Market Share	58.9%	58.7%
Disenrolled	-	-
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	49,370	49,052
Long-Term Service & Support (LTSS)	23,575	23,418
HCBS Waivers	67.8%	68.0%
Facility Based Services	32.2%	32.0%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	15,990	15,918
Facility Based Services [4]	7,585	7,500
ICF/ID [5]	1,033	1,041
Mental Health Institute (MHI)	10	23
Nursing Facilities (NF)	6,379	6,278
Nursing Facilities for Mentally Ill	67	69
Skilled	96	89

iowa total care	SFY20 Q4	SFY21 Q1
Members	278,921	290,252
MCO Member Market Share	41.1%	41.3%
Disenrolled	-	-
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	25,519	24,897
Long-Term Service & Support (LTSS)	15,405	15,294
HCBS Waivers	61.3%	64.1%
Facility Based Services	38.7%	35.9%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	9,809	9,811
Facility Based Services [4]	5,596	5,483
ICF/ID [5]	620	612
Mental Health Institute (MHI)	12	12
Nursing Facilities (NF)	4,860	4,750
Nursing Facilities for Mentally Ill	29	32
Skilled	75	77

[3] Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 21-22.

[4] 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 and Psychiatric Medical Institutions for Children (PMICs).

[5] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID)

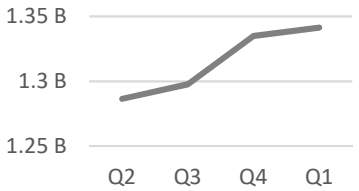
MCO Financial Summary - All MCO Counts

The MCOs receive capitation payments for the payment of 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

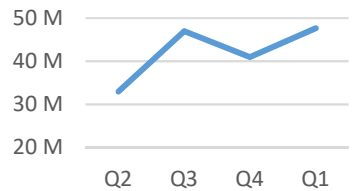
$1.34 Billion



+ $6 Million
0.49% Increase

Third Party Liability Recovered

$ 47.65 Million



$ 7 Million
16.23% increase

Data Notes: September 2020 capitation data as of October 5, 2020. 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.

	SFY20 Q2	SFY20 Q3	SFY20 Q4	SFY21 Q1	Average	Total
Financial Summary						
Capitation Payments	$1.29 B	$1.3 B	$1.33 B	**$1.34 B**	$1.32 B	$5.26 B
Third Party Liability (TPL) Recovered	$33.12 M	$46.41 M	$41.63 M	**$47.65 M**	$42.20 M	$168.81 M

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

If Yes, explain:

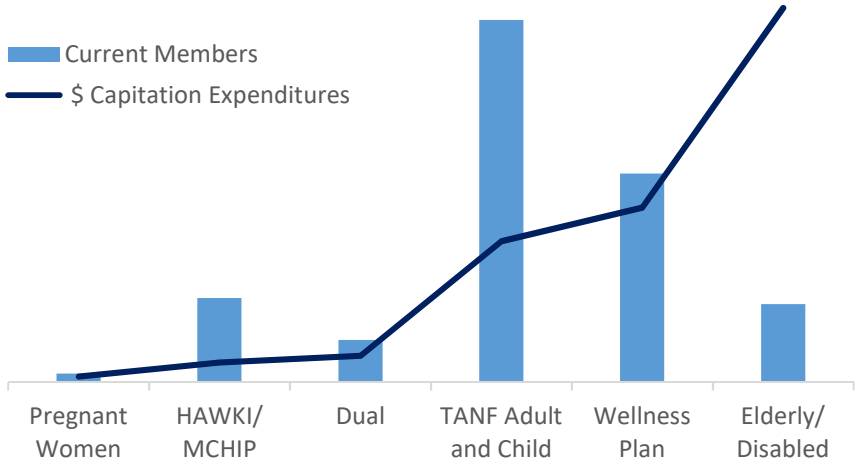
o Medical Loss Ratio (MLR) - The MLR is contractually set at 89% for the time period of July 1, 2020 through December 31, 2020.

o In Q3 SFY2020, the Department withheld $44M from ITC due to internal claims payments issues. As of December 2020, this withhold has not been released.

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, over 50% of all capitation expenditures are allocated to supporting the elderly/ disabled eligibility group.

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.



Amerigroup An Anthem Company

	SFY20 Q4	SFY21 Q1
Capitation Totals	$801.01 M	**$802.56 M**
Adjustments	-$709 k	-$2.2 M
Current	$765.46 M	$783.29 M
Retro	$36.26 M	$21.48 M
Third Party Liability (TPL) Recovered	$15.45 M	**$23.26 M**
Financial Ratios		
Medical Loss Ratio (MLR)	*80.5%*	**86.2%**
Administrative Loss Ratio (ALR)	*5.7%*	6.7%
Underwriting Ratio (UR)	*13.8%*	7.1%
Annual MLR [6]		86.2%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

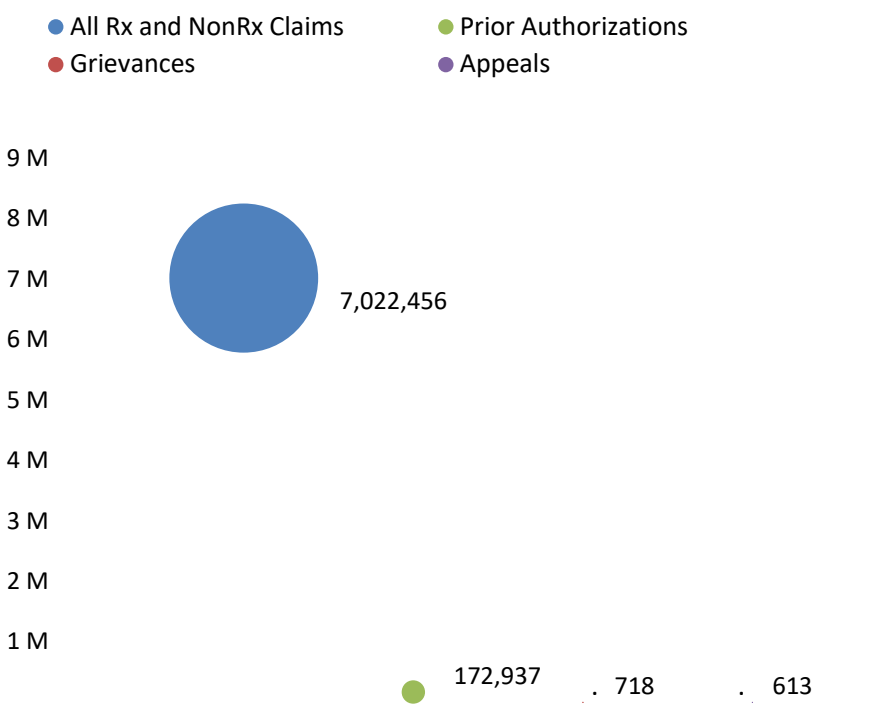
	SFY20 Q4	SFY21 Q1
Capitation Totals	**$533.87 M**	**$538.8 M**
Adjustments	-$986 k	-$2.04 M
Current	$505.02 M	$520.41 M
Retro	$29.83 M	$20.44 M
Third Party Liability (TPL) Recovered	$26.18 M	**$24.40 M**
Financial Ratios		
Medical Loss Ratio (MLR)	*90.8%*	**94.8%**
Administrative Loss Ratio (ALR)	*5.0%*	5.1%
Underwriting Ratio (UR)	*4.2%*	0.1%
Annual MLR [6]		94.8%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[6] Year-to-date average that follows state fiscal year. All amounts listed are unaudited. The 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	2.46%
Grievances	0.01%
Appeals	0.01%

	SFY20 Q2	SFY20 Q3	SFY20 Q4	SFY21 Q1	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	6.78 M	7.79 M	5.95 M	**7.02 M**	6.89 M	27.55 M
Non-Pharmacy	3.99 M	4.62 M	3.17 M	4.02 M	3.95 M	15.80 M
Pharmacy	2.79 M	3.17 M	2.79 M	3.00 M	2.94 M	11.75 M
Prior Authorization Summary (p. 13-14)	217,007	178,919	145,452	**172,937**	178,579	714,315
Non-Pharmacy - All PAs Submitted	159,522	137,044	115,665	133,417	136,412	545,648
Pharmacy - All PAs Submitted	57,485	41,875	29,787	39,520	42,167	168,667
Grievances & **Appeals Summary** (p. 15-16)						
Grievances	1,066	936	422	**718**	786	3,142
Appeals	554	612	577	**613**	589	2,356

Claims Summary (Non-Pharmacy)

2.11 Million
Claims Paid & Denied

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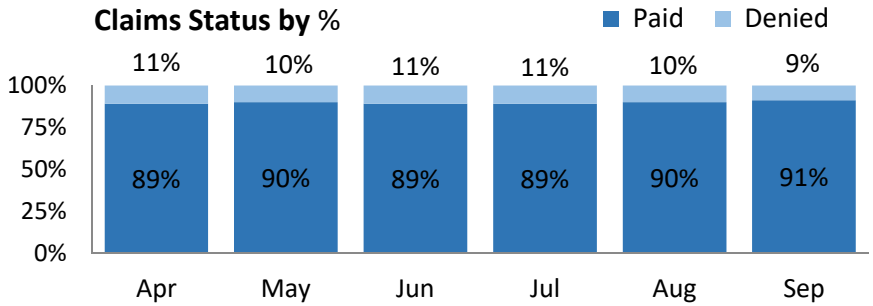
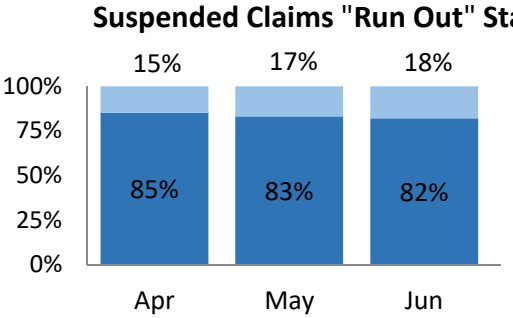
	July	Aug	Sept
All Claims			
Paid	605,261	590,456	700,395
Denied	71,964	67,844	73,076
Suspended	155,641	154,521	129,102
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	98%	99%
in 45-days (Requirement 95%)	99%	99%	100%
Average Days to Pay	8	9	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	26%	Duplicate claim service
2.	11%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Expenses incurred after coverage terminated
4.	8%	Service not payable per managed care contract
5.	7%	Precertification/authorization/notification absent
6.	6%	The impact of prior payer(s) adjudication including payments and/or adjustments.
7.	5%	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
8.	5%	An attachment/other documentation is required to adjudicate this claim/service
9.	5%	The time limit for filing has expired
10.	2%	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

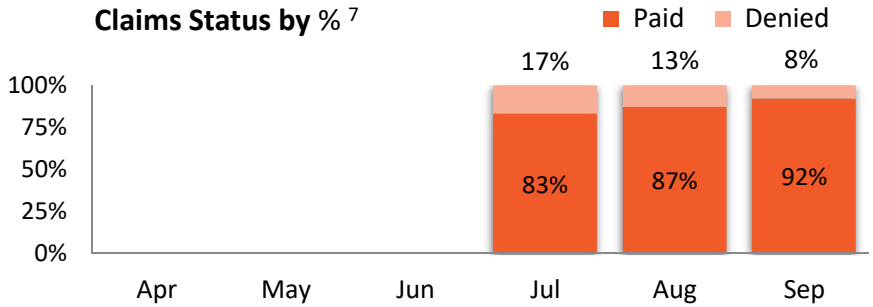
Claims Summary (Non-Pharmacy)

1.91 Million
Claims Paid & Denied

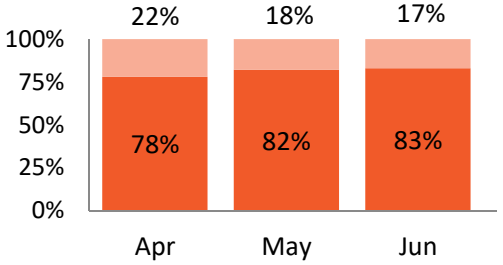
iowa total care

	July	Aug	Sept
All Claims			
Paid	541,872	387,852	744,650
Denied	114,298	57,113	66,183
Suspended	144,265	144,367	83,099
Clean Claims Processed [7]			
in 30-days (Requirement 90%)	86%	95%	96%
in 45-days (Requirement 95%)	92%	97%	98%
Average Days to Pay [7]	18	14	12
Provider Adjustment Requests & Errors Reprocessed in 30-days	90%	97%	99%

Claims Status by % [7]



Suspended Claims "Run Out" Status (90-day lag)



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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	27%	Duplicate claim service
2.	11%	No authorization on file that matches service(s) billed
3.	8%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	5%	Procedure coverage not defined by Medicaid; Provider to resubmit
5.	5%	National Drug Code (NDC) missing/invalid or not appropriate for procedure
6.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
7.	4%	Advanced claim edits (ACE) claim level return to provider
8.	3%	Referring provider not registered with IA DHS/Iowa Medicaid
9.	3%	ACE line item denial
10.	3%	Ancillary charges not separately Payable

[7] In prior quarters **Clean Claims Processed**, **Average Days to Pay**, and **Claims Status by %** were reported separately because of system configuration issues.

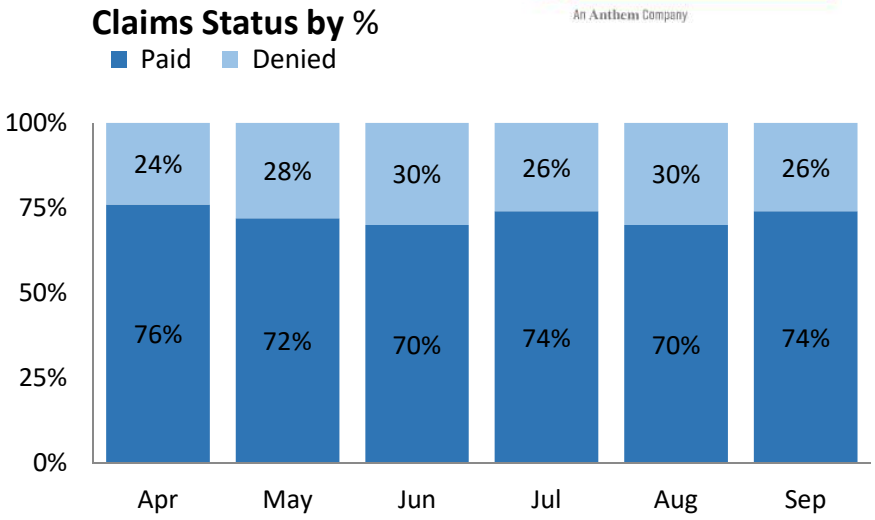
As of **Q1 SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **July**: 8,985
- **August**: 13,108
- **September:** 7,827

Claims Summary (Pharmacy)

1.68 Million
Claims Paid & Denied

	July	Aug	Sept
All Claims (Pharmacy)			
Paid	435,473	342,230	442,664
Denied	154,247	146,088	154,474
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	12	11	12

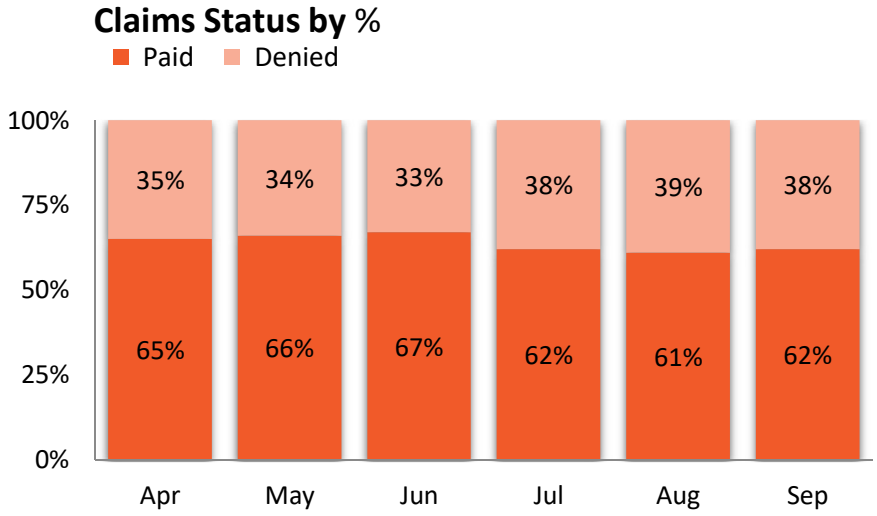


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	43%	Refill too soon
2.	15%	Submit bill to other processor or primary payer
3.	14%	Prior authorization required
4.	8%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	2%	M/I other payer reject code
7.	2%	Filled after coverage terminated
8.	2%	Non matched prescriber ID
9.	2%	MA not covered; Plan exclusion
10.	1%	Discontinued National Drug Code (NDC)

Claims Summary (Pharmacy)

1.33 Million
Claims Paid & Denied

	July	Aug	Sept
All Claims (Pharmacy)			
Paid	274,930	280,805	265,686
Denied	166,492	177,877	160,526
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	3	3	3



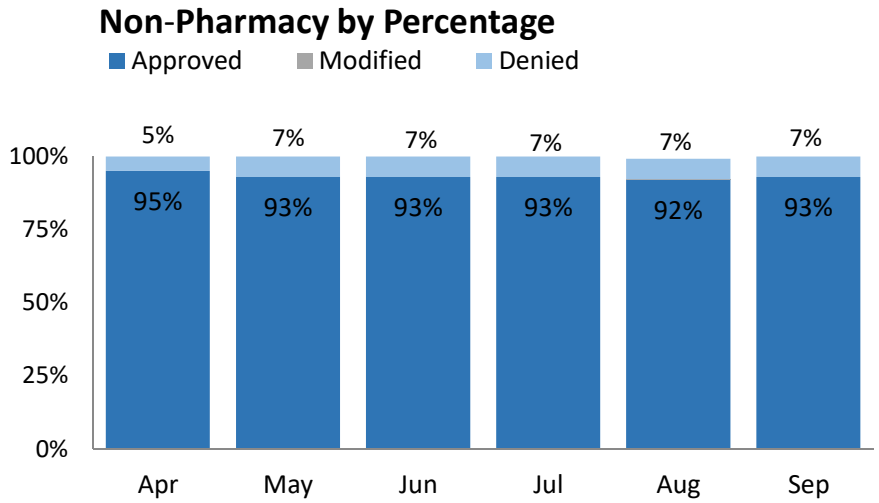
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	26%	Refill too soon
2.	10%	Prior authorization required
3.	3%	Quantity dispensed exceeds maximum allowed
4.	3%	Claim not processed
5.	3%	Product not on formulary
6.	2%	Submit bill to other processor or primary payer
7.	2%	Drug Utiliztion Review (DUR) reject error
8.	2%	Filled after coverage expired
9.	2%	Drug not covered for patient age
10.	1%	National Drug Code (NDC) not covered

Prior Authorization Summary

79, 407
All PAs Submitted [8]

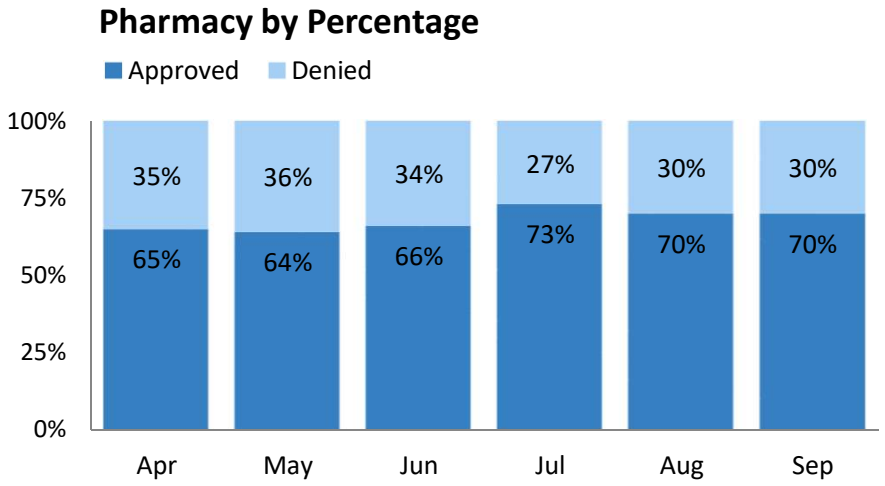
Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	17,959	15,898	18,318
Denied	1,369	1,269	1,353
Modified	40	52	48
Average Days to Process	3	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	99.3%



Pharmacy

	July	Aug	Sept
Prior Authorizations			
Approved	6,148	5,117	5,110
Denied	309	2,164	2,232
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	100%



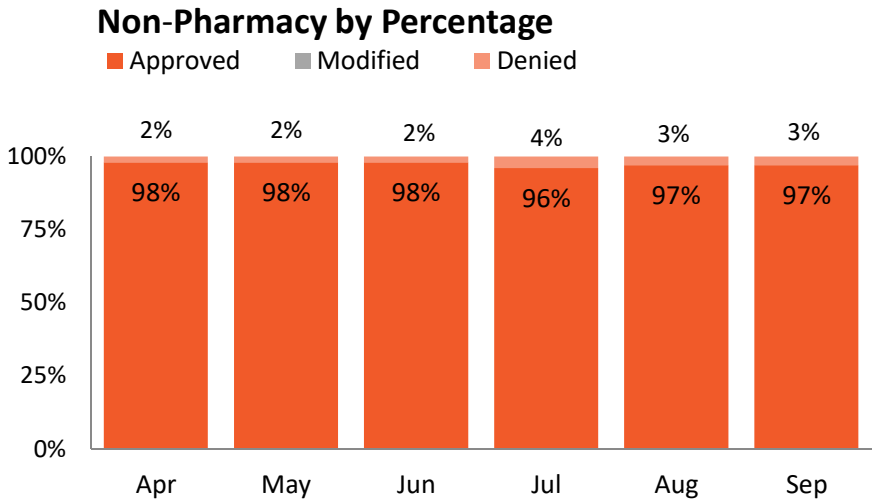
[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

93,530
All PAs Submitted [8]

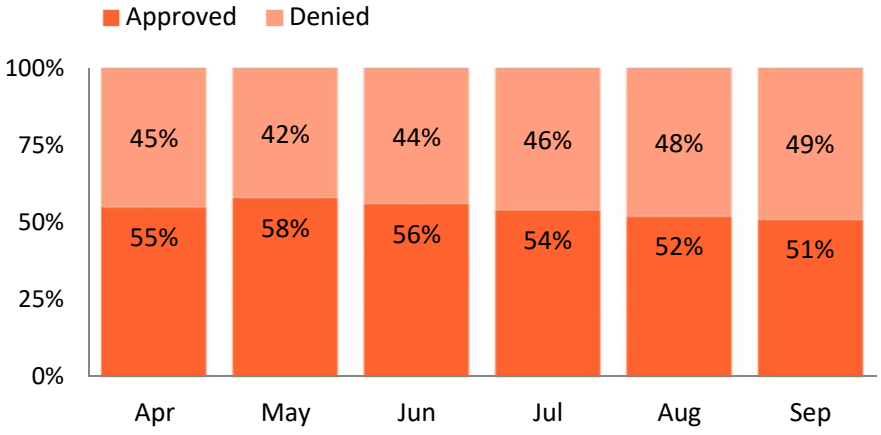
Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	23,294	23,820	26,906
Denied	876	783	858
Modified	0	0	0
Average Days to Process	3	3	3
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	July	Aug	Sept
Prior Authorizations			
Approved	2,801	2,348	2,492
Denied	2,351	2,136	2,407
PAs Completed in 24-hours (Requirement 100%)	100%	100%	100%

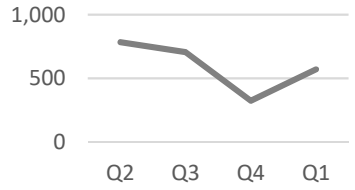


[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

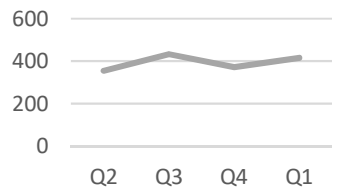
Grievances

571



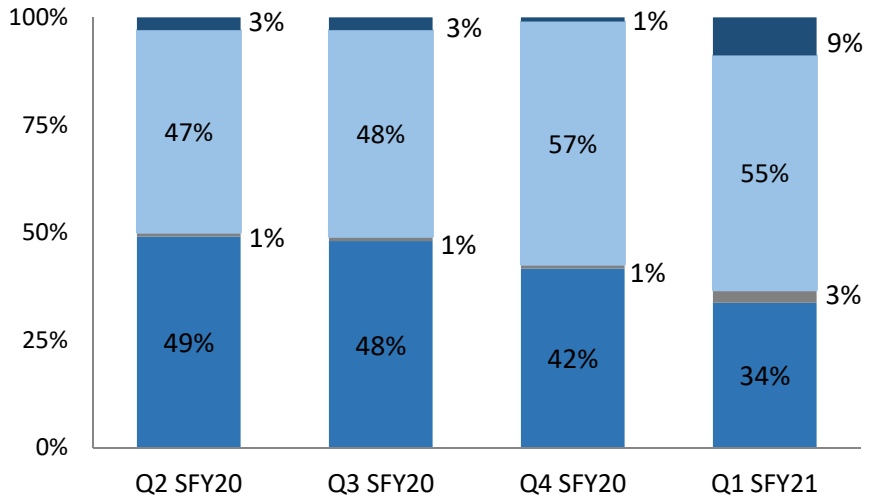
Appeals

416



Resolved in 30-days	Resolved in 30-days
99.80%	100.0%

Appeal Outcome Percentages



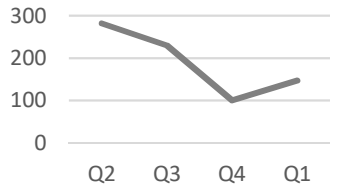
	%	Top 10 Reasons for Grievances
1.	37%	Voluntary Disenrollment
2.	13%	Provider balance billed
3.	12%	Transportation - Driver no-show
4.	9%	Transportation - Driver Delay
5.	5%	Treatment Dissatisfaction
6.	5%	Adequacy of treatment record keeping
7.	4%	Provider attitude/rudeness
8.	3%	Transportation - Unsafe Driving
9.	2%	Availability of appointments
10.	2%	Inadequate benefit access

%	Top 10 Reasons for Appeals
21%	Durable Medical Equipment (DME)
16%	Pharmacy - Non Injectable
12%	Radiology
9%	Pharmacy - Injectable
7%	Surgery
7%	Behavioral Health (BH) - Op Service
7%	Therapy - Physical Therapy
3%	BH - Inpatient
3%	Other
3%	Outpatient Services - Medical

Grievances and Appeals

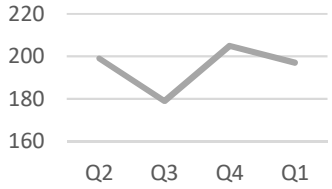
Grievances

147



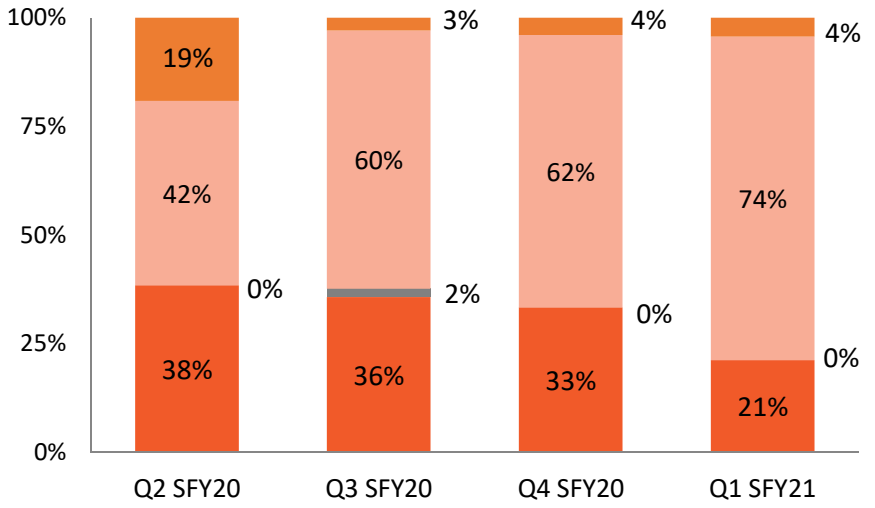
Appeals

197



Resolved in 30-days	Resolved in 30-days
100%	100.0%

Appeal Outcome Percentages



	%	Top 10 Reasons for Grievances
1.	25%	Access to Care - Network Availability
2.	20%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	5%	Provider
5.	4%	Transportation - Unsafe Driving
6.	4%	Health Plan Staff
7.	4%	Transportation - Missed Appointment
8.	3%	Lack of Caring/Concern
9.	3%	Transportation - General Complaint Vendor/CSR
10.	2%	Transportation - Driver did not show

%	Top 10 Reasons for Appeals
28%	RX - Does Not Meet Prior AuthGuidelines
17%	Other - Mental Health Service
5%	DME - Other
4%	DME - Wheelchair
3%	DME - Orthopedic Devices
3%	DME - Wheelchair Accessories
3%	Diagnostic - CAT Scan
2%	Therapy - Physical Therapy
2%	DME - Pneumatic Compressor/Appliance
2%	Diagnostic - MRI

MCO Care Quality and Outcomes

Value Based Purchasing Enrollment

Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	SFY20 Q4	SFY21 Q1
	63%	63%

Utilization of Value Added Services

In addition to traditional services.	SFY20 Q4	SFY21 Q1
Taking Care of Baby and Me	2,754	2,095
Healthy Rewards [9]	1,765	1,678
Community Resource Link	715	841
SafeLink Mobile Phone	652	723
Dental Hygiene Kit	80	683
Exercise Kit	79	521
Weight Watchers	853	125
Healthy Families Program	14	25
Boys & Girls Club	-	13
Comfort Item	3	5
Personal Care Attendant	1	1

[9] *Amerigroup is reporting the total number of members who received an award in quarter (not the total enrolled in program).*

Value Based Purchasing Enrollment

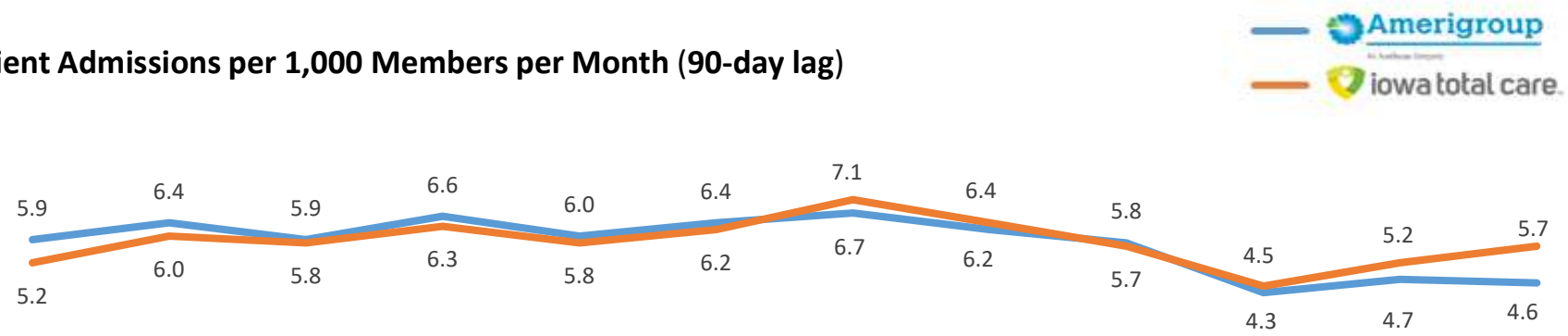
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	SFY20 Q4	SFY21 Q1
	32% [10]	84%

Utilization of Value Added Services

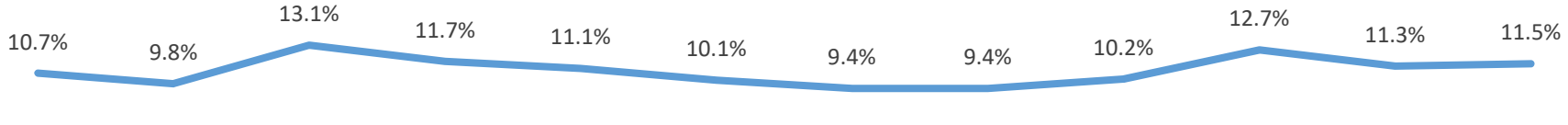
In addition to traditional services.	SFY20 Q4	SFY21 Q1
My Health Pays Program	13,421	8,755
SafeLink Mobile Phone	-	3,685
The Flu Program	1,517	2,689
Start Smart for Your Baby	1,417	1,558
Mobile App	349	544
Member Connections Program	110	132
Tobacco Cessation	90	77
myStrength.com	-	28

[10] *Iowa Total Care has until 12/31/2020 to meet the 40% contracted rate for value based agreements.*

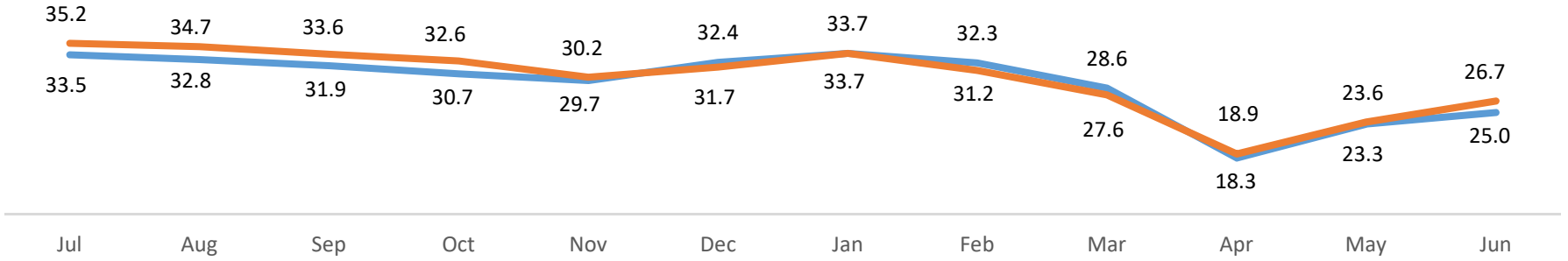
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [11]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [12]



[11] *This measure requires 12 months of continuous enrollment with the MCO. ITC data will first be available Q2 SFY2021.*

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

Non-LTSS Care Coordination and HCBS Case Management

Amerigroup
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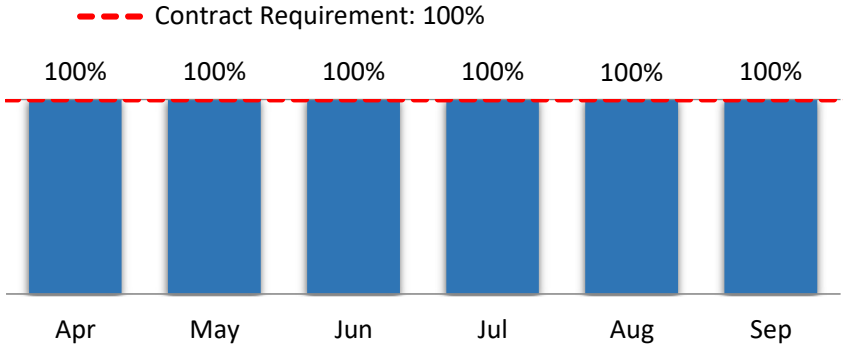
Average Number of Contacts Per Month	SFY20 Q4	SFY21 Q1
by Care Coordinators	0.9	**0.8**
by Case Managers	1.3	**1.2**
"Members to" Ratios		
Members to Care Coordinators	14	**16**
HCBS Members to Case Managers	65	**65**

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

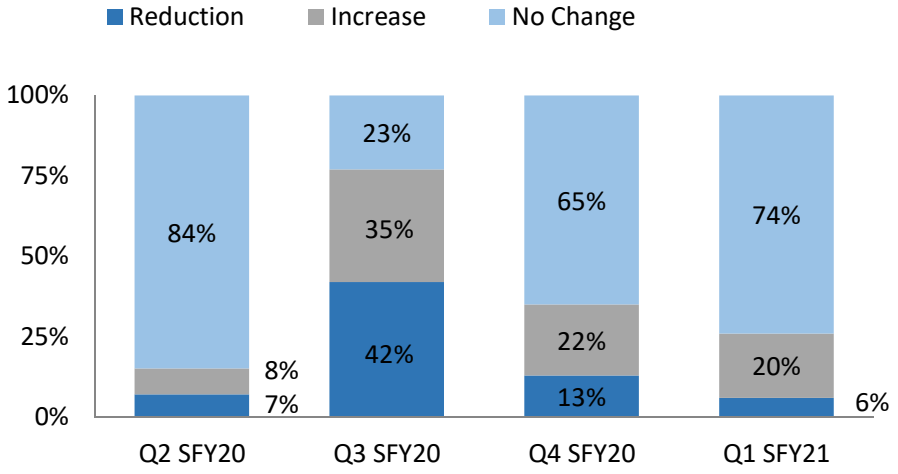
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY20 Q4	SFY21 Q1
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	1.5%	0.3%
	Sometimes	0.0%	0.0%
	Yes	98.5%	99.7%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.3%	0.3%
	Sometimes	0.6%	0.0%
	Yes	99.1%	99.7%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

iowa total care

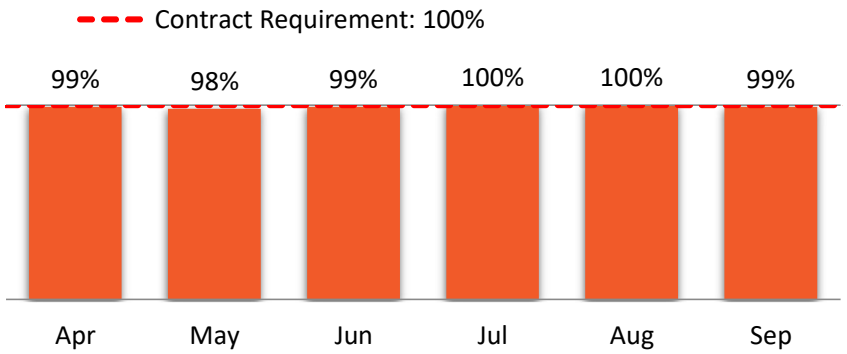
Average Number of Contacts Per Month	SFY20 Q4	SFY21 Q1
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	75	**36**
HCBS Members to Case Managers	38	**38**

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

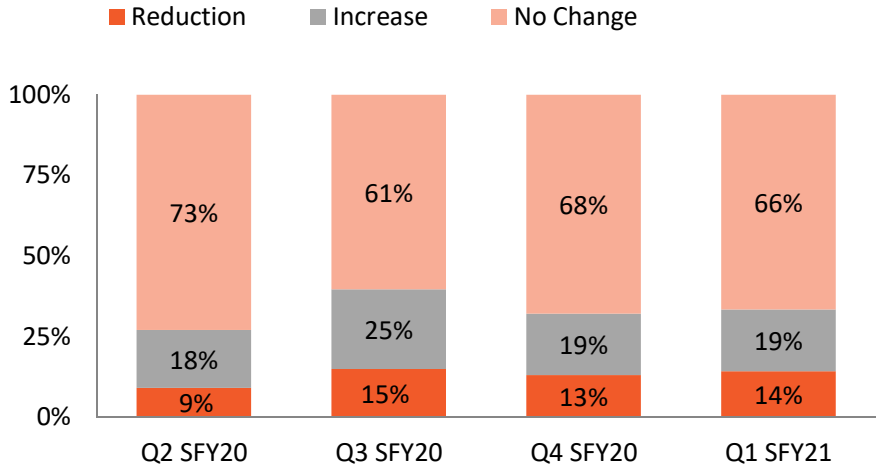
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY20 Q4	SFY21 Q1
They were part of service planning.	I don't know	1.1%	0.4%
	No	4.3%	5.2%
	Sometimes	2.1%	1.1%
	Yes	92.6%	93.3%
They feel safe where they live.	I don't know	3.2%	0.8%
	No	2.1%	2.3%
	Sometimes	3.2%	1.9%
	Yes	91.5%	95.1%
Their services make their lives better.	I don't know	1.1%	1.1%
	No	1.1%	1.9%
	Sometimes	4.3%	2.6%
	Yes	93.6%	94.4%

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

	SFY20 Q4	SFY21 Q1
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	15	16
Supported Community Living (daily)	3	1
CDAC (agency) by 15 minute units	1	1
CDAC (individual) by 15 minute units	3	-
-	-	-
Brain Injury (BI) Waivers	833	831
Financial Management Services	240	236
Supported Community Living (by unit)	218	224
Respite (by 15 minute units)	178	174
Personal Emergency Response	164	162
Supported Community Living (daily)	105	107
Children's Mental Health (CMH)	894	879
Respite (by 15 minute units)	444	441
Family and Community Support	281	271
Respite (by 15 minute units)	253	245
Respite (Resident Camp) by units	25	18
Respite (Resident Camp) by day	11	12
Elderly Waivers	4,904	4,886
Home Delivered Meals	3,244	3,213
Personal Emergency Response	3,131	3,144
Assisted Living Services	439	437
Personal Emergency Response (install)	388	343
CDAC (agency) by 15 minute units	601	319

Amerigroup
An Anthem Company

	SFY20 Q4	SFY21 Q1
Habilitation (Hab)	4,837	4,786
Supported Community Living (daily)	3,676	3,816
Home Health Aide	791	593
Long Term Job Coaching	474	403
Day Habilitation	161	213
Individual Supported Employment	188	184
Health & Disability (HD)	1,412	1,394
Financial Management Services	379	374
Home Delivered Meals	376	370
Respite (by 15 minute units)	359	364
Personal Emergency Response	361	363
Respite (by 15 minute units)	75	67
Intellectual Disability (ID)	7,153	7,150
Supported Community Living (daily)	2,133	1,965
Supported Community Living (by unit)	1,954	1,886
Day Habilitation	1,668	1,551
Financial Management Services	1,376	1,376
Long Term Job Coaching	1,006	980
Physical Disability (PD)	775	759
Personal Emergency Response	398	402
Personal Emergency Response (install)	101	75
CDAC (agency) by 15 minute units	135	70
Supported Community Living (daily)	58	60
Home Delivered Meals	108	55

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 including a full list of available services reference our dedicated webpage: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services

- by Member Usage

	SFY20 Q4	SFY21 Q1
AIDS/HIV - Unique Service Plans	12	13
Home Delivered Meals	6	7
CDAC (individual) by 15 minute units	5	6
Supported Community Living (daily)	2	2
Homemaker (by 15 minute units)	1	2
Day Habilitation	1	1
Brain Injury (BI) Waivers	532	531
Supported Community Living (by unit)	232	233
Respite (by 15 minute units)	156	157
Personal Emergency Response	119	127
Supported Community Living (daily)	118	119
Transportation (1-way trip)	95	92
Children's Mental Health (CMH)	351	351
Integrated Health Home Services	245	249
Respite (by 15 minute units)	164	173
Respite (by 15 minute units)	90	96
Family and Community Support	82	85
Respite (Resident Camp) by units	6	7
Elderly Waivers	3,315	3,336
Home Delivered Meals	2,480	2,548
Personal Emergency Response	2,382	2,451
CDAC (agency) by 15 minute units	1,238	1,285
Homemaker (by 15 minute units)	893	914
CDAC (individual) by 15 minute units	775	778

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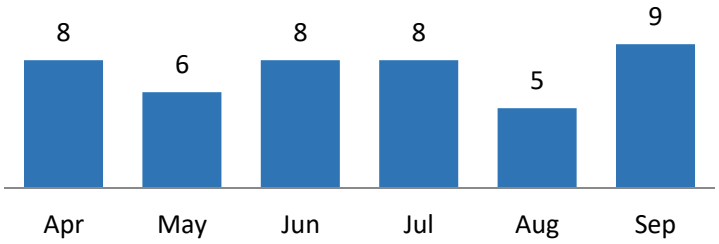
	SFY20 Q4	SFY21 Q1
Habilitation (Hab)	2,381	2,395
Supported Community Living (daily)	1,678	1,851
Integrated Health Home Services	1,820	1,836
Home Health Aide	364	354
Day Habilitation	281	271
Long Term Job Coaching	217	233
Health & Disability (HD)	644	645
Respite (by 15 minute units)	297	297
Home Delivered Meals	194	203
Personal Emergency Response	179	180
CDAC (individual) by 15 minute units	131	130
CDAC (agency) by 15 minute units	113	111
Intellectual Disability (ID)	4,534	4,524
Supported Community Living (by unit)	1,945	1,949
Home Health Aide	1,927	1,912
Day Habilitation	1,792	1,778
Supported Community Living (RCF)	1,509	1,490
Respite (by 15 minute units)	1,067	1,075
Physical Disability (PD)	421	411
Personal Emergency Response	238	244
CDAC (agency) by 15 minute units	199	204
CDAC (individual) by 15 minute units	138	144
Transportation (1-way trip)	56	56
Personal Emergency Response (install)	49	40

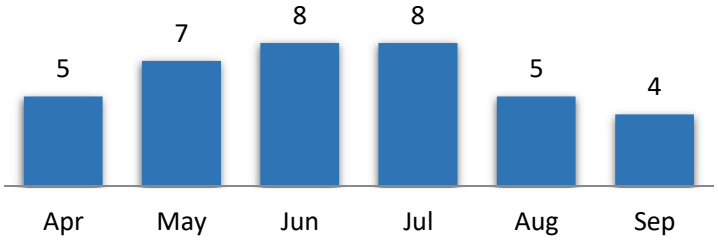
Call Center Performance Metrics

	Jul	Aug	Sept
Member Helpline			
Service Level (Requirement 80%)	91.51%	97.45%	98.48%
Abandonment Rate - Must be 5% or less	0.65%	1.20%	0.71%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	96.10%	97.64%	82.65%
Abandonment Rate - Must be 5% or less	0.12%	0.00%	0.06%
Provider Helpline			
Service Level (Requirement 80%)	89.06%	97.10%	97.27%
Abandonment Rate - Must be 5% or less	0.29%	0.51%	0.10%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	80.80%	69.69%	78.81%
Abandonment Rate - Must be 5% or less	0.44%	0.60%	0.46%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

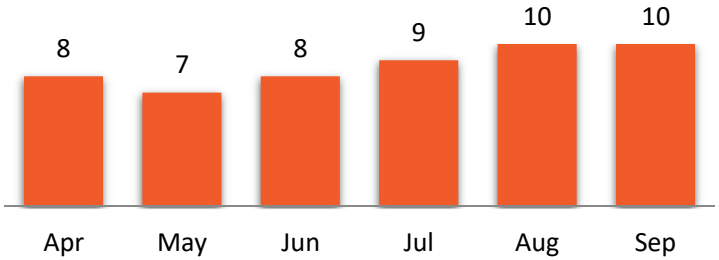
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Claim Inquiry
5.	Coordination of Benefits or OHI

Top 5 Call Reasons (Provider Helpline)
Authorization Status
Benefit Inquiry
Claim Status
Authorization New
Enrollment Inquiry

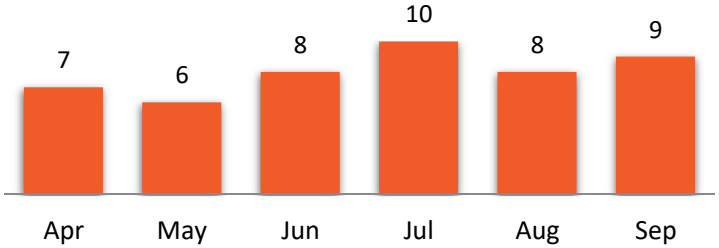
Call Center Performance Metrics

	Jul	Aug	Sept
Member Helpline			
Service Level (Requirement 80%)	90.00%	83.21%	87.90%
Abandonment Rate - Must be 5% or less	3.28%	7.04%	3.84%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	81.34%	75.37%	78.61%
Abandonment Rate - Must be 5% or less	4.97%	7.87%	4.56%
Provider Helpline			
Service Level (Requirement 80%)	84.47%	71.25%	81.61%
Abandonment Rate - Must be 5% or less	2.37%	7.48%	2.61%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	95.49%	90.51%	85.80%
Abandonment Rate - Must be 5% or less	1.48%	2.19%	2.55%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	90.97%	86.51%	83.02%
Abandonment Rate - Must be 5% or less	1.19%	1.13%	1.69%

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)
Medical Claims Inquiry for Provider
Coordination Of Benefits for Provider
Benefits and Eligibility for Provider
Provider Outreach for Provider
View Authorization for Provider

Provider Network Access Summary

Primary Care Providers (PCP)

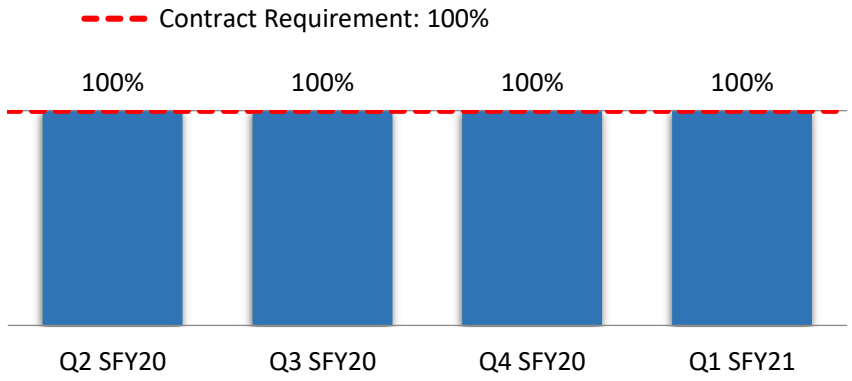
	SFY20 Q4	SFY21 Q1
Adults PCP		
Provider Count	-	6,591
Members with Access	-	204,945
Average Distance (Miles)	-	1.5
Pediatric PCP		
Provider Count	-	6,634
Members with Access	-	204,867
Average Distance (Miles)	-	1.6

Specialty Care & Behavioral Health (BH)

	SFY20 Q4	SFY21 Q1
OB/GYN Adult		
Provider Count	-	400
Members with Access	-	134,256
Average Distance (Miles)	-	5.7
Outpatient - Behavioral Health		
Provider Count	-	4,000
Members with Access	-	409,812
Average Distance (Miles)	-	2.1
Inpatient - Behavioral Health		
Provider Count	-	49
Rural Members		
Members with Access	-	168,321
Average Distance (Miles)	-	21.4
Urban Members		
Members with Access	-	241,491
Average Distance (Miles)	-	5.7

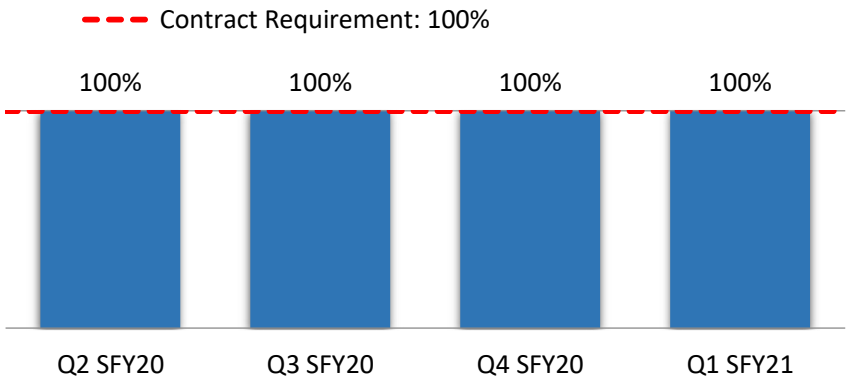
Adult PCP - Time Standards

30 minutes or 30 miles



Pediatric PCP - Time 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)

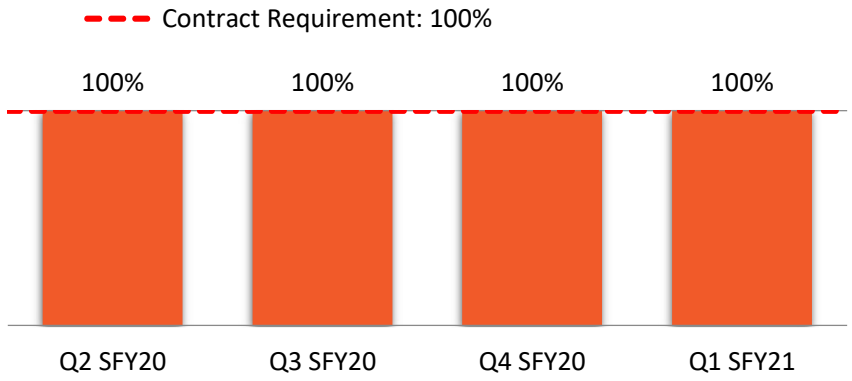
	SFY20 Q4	SFY21 Q1
Adults PCP		
Provider Count	-	8,301
Members with Access	-	212,044
Average Distance (Miles)	-	2.0
Pediatric PCP		
Provider Count	-	8,986
Members with Access	-	75,020
Average Distance (Miles)	-	2.2

Specialty Care & Behavioral Health (BH)

	SFY20 Q4	SFY21 Q1
OB/GYN Adult		
Provider Count	-	1,183
Members with Access	-	131,186
Average Distance (Miles)	-	5.5
Outpatient - Behavioral Health		
Provider Count	-	7,842
Members with Access	-	287,070
Average Distance (Miles)	-	2.6
Inpatient - Behavioral Health		
Provider Count	-	35
Rural Members		
Members with Access	-	205,468
Average Distance (Miles)	-	24.7
Urban Members		
Members with Access	-	81,602
Average Distance (Miles)	-	8.3

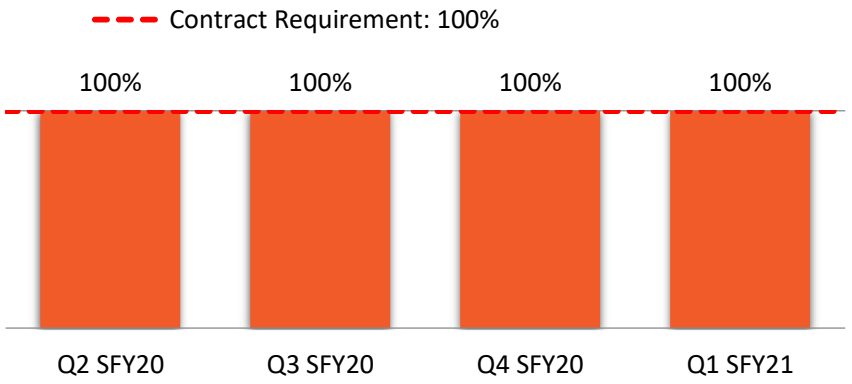
Adult PCP - Time Standards

30 minutes or 30 miles



Pediatric PCP - Time Standards

30 minutes or 30 miles



Link to Geo Access Reports:
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MCO Program Integrity

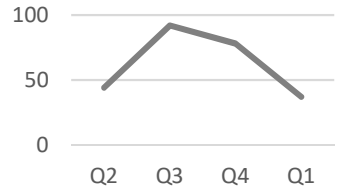
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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

37



7 Total Cases
Referred to MCFU

Amerigroup
An Anthem Company

Program Integrity
- Fraud, Waste, & Abuse

	SFY20 Q4	SFY21 Q1
Investigations opened	72	28
Overpayments identified	14	23
Member concerns referred to IME	5	6
Cases referred to the Medicaid Fraud Control Unit (MCFU)	4	6

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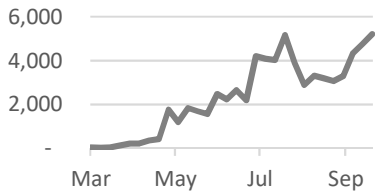
Program Integrity
- Fraud, Waste, & Abuse

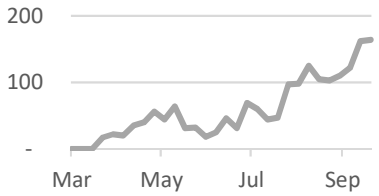
	SFY20 Q4	SFY21 Q1
Investigations opened	6	9
Overpayments identified	2	0
Member concerns referred to IME	4	8
Cases referred to the Medicaid Fraud Control Unit (MCFU)	3	1

MCO COVID-19 Summary

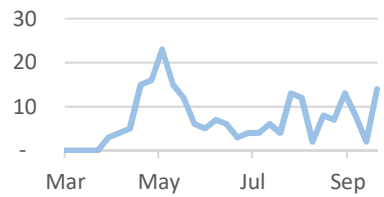
Total Individuals Tested
70,984



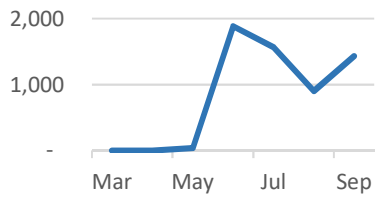
Total Tested Positive
1,787



Total COVID Deaths
217



Total COVID Inpatient Stays [13]
5,826



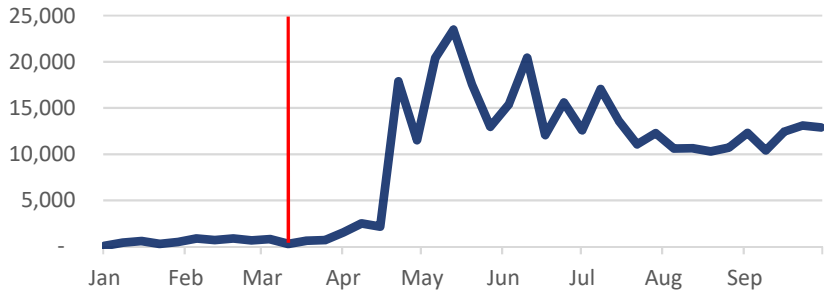
+ 51,387 Tested	2.5%	0.03%	3.31%
174% Increase	% Tested Positive	% of MCO Population	% of Total Inpatient stays

COVID-19 testing and treatment is a covered benefit for Medicaid members. Total test counts reflect multiple tests for some individuals. [13] Reported counts include patients initially hospitalized as "expected positive", but may have never tested positive.

Claims Activity During COVID-19

MCO Total Counts	Q4 SFY20	Q1 SFY21
ER Visits - Counts	**195,982**	**318,723**
Amount Paid	$39.05 M	$66.78 M
Telehealth Services - Counts	**184,528**	**157,524**
Amount Paid	$14.97 M	$14.17 M
Transportation Claims - Counts	**145,130**	**188,835**
Amount Paid	$6.7 M	$9.46 M
Home Maker Services - Counts	**6,260**	**6,301**
Amount Paid	$940 k	$1.18 M
COVID Testing - Counts	**18,770**	**51,387**
Amount Paid	$1.25 M	$6.02 M
Meals - Counts	**20,940**	**21,277**
Amount Paid	$4.57 M	$6.53 M

Telehealth Services - All MCO Counts



o In March, IL 2115-MC-FFS and IL 2119-MC-FFS authorized the expansion of telehealth services in Iowa.

o Since March, the Managed Care Organizations have reported a significant increase in telehealth services.

o IME is currently reviewing the continuation of telehealth service expansion once the public health emergency is lifted.

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. A member or a member's authorized representative may request an appeal following a decision made by an MCO. 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

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

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 - Recoup and repay when rate changes occur
- **Current**: Payments that occur within the paid month for same month

Capitation Expenditures (continued...):

- **Retro**: Payments for months prior to the current month for member months not previously paid for
  - o Member months are counted if request is to provide member months within a specific date range for more than one month
  - o Data is not pulled by paid date, but by eligibility month

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

Case Manager: See Community Based Case Management (CBCM)

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

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

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

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

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

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

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

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

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

Denied Claims: See Claims

Department of Human Services (**DHS**): The state's health and social services agency.

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 89%.

- **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
- 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.

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

Home Health Aide: Medical services that provide direct personal care. This may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompanying member to medical services, transporting member to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

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 Enterprise (**IME**): The division of DHS 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.

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.

Run Out: See Claims

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 specific waivers listed above.

Waiver Service Plan: See Service Plan

Department of HUMAN SERVICES

Medical Assistance Advisory Council (MAAC)

Dental Program Update

February 24, 2021

Children's Dental Transition

- IME plans to transition the administration of children's dental benefits from FFS Medicaid to Managed Care
  - Pre-Ambulatory Health Plans (PAHPs):
    - Delta Dental of Iowa (DDIA)
    - Managed Care of North America (MCNA)
- Target implementation date is July 1, 2021
- Impacts children 0 through age 18
- No impact to Hawki program

Children's Dental Transition

Support for Transition

- Members will have a choice in benefit administrator
- Families can now be enrolled with the same administrator to eliminate confusion
- PAHP's will have more provider influence and less administrative burdens for better access to care for members
- Contractually, the PAHP's are allowed to set their own reimbursement rates (up to 105% of FFS)
- PAHP's will be collaborating with I-Smile for outreach and education, care coordination and direct services
- Allows for a more predictable budget for the state to manage

Children's Dental Transition

Program Name

Dental Wellness Plan (DWP) Kids

Plan Design

Benefit package will remain the same

- EPSDT requirements must be met
- No annual benefit maximum
- No Healthy Behaviors

Children's Dental Transition

Capacity Plan

- 295,980 children enrolled in Medicaid
  - (approximately 163,562 households)
- Distribution based on readiness review
- Algorithm will keep families together
- Hawki members moving to DWP Kids will stay with DDIA

Member Notification and Assignment

- Members will be notified in March of the transition and plan assignment in June.
- Passively assigned effective July 1
- Members can request a change to the dental plan administrators they were assigned to up until September 30
- Beginning October 1, members must meet “good cause” in order to switch to a different dental plan administrator
- Members will still have an annual choice period where they can change dental plan administrators

Transition Timeline

- ❑ 12/14/20 Tribal Notice
- ❑ 1/11/21 Public Notice
- ❑ 2/26/21 Provider Training
- ❑ 3/1/21 CMS 1115 Waiver Submission
- ❑ 3/20/21 Member Notification
- ❑ 4/1/21 Readiness Review Begins
- ❑ 5/01/21 CMS Contract Submission
- ❑ 6/1/21 Member Assignment
- ❑ 7/1/21 Implementation

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