Department of HUMAN SERVICES

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

MAAC MATERIALS

May 20, 2021

1. Agenda of Meeting for May 20, 2021
2. February 24, 2021, Full Council Meeting Minutes
3. Executive Talking Points
4. Iowa Administrative Code 441-79.7(249A)
5. Professional and Business Entities Election Ballot
6. MCO Quarterly Report SFY21, Quarter 2

Department of HUMAN SERVICES

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

AGENDA
Medical Assistance Advisory Council Meeting

Thursday, May 20, 2021
Time: 1:00 P.M. – 4:00 P.M.
Teleconference (Due to COVID-19)
Join Zoom Meeting:
https://www.zoomgov.com/j/1600983115?pwd=cXJ2OFEvb05OZjhnZ2VndUhpSjhBZz09

Meeting ID: 160 098 3115
Passcode: 531486

Call In: 1 (551) 285-1373

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

1:05 Approval of Minutes – **Sarah Reisetter**
- February 24, 2021 Meeting

1:15 Medicaid Eligibility COVID-19 Unwinding Plan – **Amela Alibasic**

2:10 Update from the Medicaid Director – **Julie Lovelady**

2:40 Upcoming Professional and Business Entity Election – **Michael Kitzman**

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.

Summary of Meeting Minutes
February 24, 2021

Call to Order and Roll Call

Sara Reissetter, Iowa Department of Public Health and Chair of the Medical Assistance Advisory Council (MAAC), called roll at 1:01 P.M. Attendance is reflected in the separate roll call sheet. Jason announced a quorum.

Approval of Previous Meeting Minutes

Sarah called for a motion to approve minutes from the October 8, 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 April 20, 2021. This means that all of the waivers and flexibilities the Department currently has in place will continue at least through April 20, 2021. HHS will provide the Department with 60 days notice prior to the termination of the PHE; HHS has indicated they expect the PHE to extend through the rest of 2021.

The COVID-19 vaccine is a covered benefit, there is no prior authorization (PA) required to receive the vaccine, and there is no cost to members. Providers receive an administration fee for vaccinating members. Any questions providers may have regarding billing can be sent to IMEVaccineBilling@dhs.state.ia.us. The provider relief fund spendingdeadline has been extended through June 30, 2021.

Julie turned to an update regarding the Department's Managed Care (MC) program. The Centers for Medicare and Medicaid Services (CMS) has renewed the Department's waiver to operate the IA Healthlink MC program through March 31, 2026. Julie discussed changes to the contracts the Department has with Managed Care Organizations (MCOs) highlighting the following:

- Additional language regarding various relief payments available to providers during the COVID-19 PHE;
- MCOs are required to use the same Electronic Visit Verification (EVV) vendor, CareBridge;
- A new pay-for-performance measure around Social Determinants of Health (SDOH);
- MCOs must reprocess 90 percent of all claim errors within 30 calendar days, unless the MCO is implementing a system configuration change;

- The required Medical Loss Ratio (MLR) for MCOs has been adjusted from 88 percent to 89 percent for State Fiscal Year 2021 (SFY21).

Julie addressed the recent claims audit Iowa Total Care (ITC) underwent. In January 2020, the Department withheld $44 million from ITC due to multiple inaccurate claims payments to providers. An outside vendor, Myers and Stauffer, worked with ITC to conduct a claims audit in two phases. The first phase, completed in December 2020, sampled claims for 13 specific providers with multiple payment issues. The second phase will verify ITC's claims system configuration corrections thorough analytics and sampling; this phase is expected to be completed by the end of March 2021. Myers and Stauffer will send preliminary findings to ITC as soon as they are developed so that ITC can work quickly to resolve issues.

EVV was implemented on January 1, 2021, and is required for all providers except for assisted living and residential care facilities, and health home providers; these providers will begin EVV at a later date. The Department allowed a 30-day grace period for providers to adjust. The MCOs worked very hard to contact providers and provide information regarding EVV. Claims not submitted through CareBridge will be denied.

The Department is now providing full Medicaid benefits to eligible adult citizensof the Marshall Islands and Micronesia living in Iowa. This is in accord with Section 208 of the 2021 Consolidated Appropriations Act (CAA), which adds Medicaid coverage for citizens of Palau, the Marshall Islands, and the Federated States of Micronesia living in the United States through the set of treaties known as the Compact of Free Association (COFA).

Shelly Chandler asked when the Department expects to report on the findings of the ITC claims audit. Julie stated that she could not state with certainty when the Department would be able to report, but expects to have the findings before the next MAAC meeting in May 2021.

Managed Care Quarterly Report: State Fiscal Year (SFY) 2021 Quarter 1

Kurt Behrens, Iowa Medicaid Enterprise (IME), Bureau of Managed Care, reviewed the report. Kurt noted there were significant changes made to the layout and information presented in the report. These changes were made in an effort to make the report easier to read and provide information requested by stakeholders. Kurt highlighted specific changes including: the report is now presented in a landscape format; it includes an additional two pages of information regarding Waiver Service Plans; historic information from previous quarters has been added to pages throughout the report to provide more context; information regarding Hawki members has been separated out; and information regarding Home- and Community-Based Services (HCBS) has been separated out.

Shelly Chandler and Dr. Amy Shriver both thanked Kurt and the Managed Care Bureau team for the changes to the report.

Children’s Medicaid Dental Transition

Heather Miller, IME Bureau of Managed Care, presented on the transition of administration of children’s Medicaid dental benefits from the Fee-for-Service (FFS) program to MC. The Department plans to implement this transition on July 1, 2021; after that date children’s dental benefits will be administered by two Prepaid Ambulatory Health Plans (PAHPs): Delta Dental of Iowa (DDIA) and Managed Care of North America (MCNA). This transition will affect children ages 0 through 18. There will be no impact to members enrolled in the Hawki program. Members will have a choice between the PAHPs. The Department has developed an algorithm to ensure families are placed within the same PAHP. Members can request a change to their assigned PAHP through September 30, 2021. Beginning October 1, 2021, members must meet “good cause” reasons in order to switch to a different PAHP. Members will have an annual choice period where they can change PAHPs. Members will be sent notification of the transition in March 2021.

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 Anthem Foundation’s work in 2020 and 2021 on SDOH and health disparities management. Amerigroup continues to work with the IME on processing enhanced CARES Act payments to providers. Amerigroup and the IME have been discussing rollout of COVID-19 vaccine distribution, especially to homebound individuals and other members who may not be able to access the vaccine on their own. Amerigroup has several projects addressing SDOH. One of Amerigroup’s projects is a partnership with Monroe Elementary School that the Anthem Foundation is using to test programs targeting homelessness diversion and food insecurity. Amerigroup has established similar partnerships in four counties and plans to expand to 23 counties across Iowa in 2021. Amerigroup has found that one issue SDOH members often struggle with is employment or underemployment. Amerigroup has collaborated with Project Iowa to provide targeted high-technology training for Amerigroup members; this has resulted in 88% of Amerigroup members trained by Project Iowa being placed into jobs above minimum wage with benefits. Amerigroup has revised their Value Added Benefits, updating the Healthy Rewards program and adding a benefit providing eligible members with an electronic breast pump.

Iowa Total Care

Mitch Wasden, Chief Executive Officer of ITC, presented an update. Mitch began by addressing the claims audit ITC is currently undergoing; stating ITC has received the first round of data from the auditors. Mitch expects ITC to be in a good position once the claims audit concludes, noting currently ITC processes 99% of claims within 40 days, and the contract standard is 95% of claims processed within 40 days. ITC has been working closely with Amerigroup and the Department to identify groups of members who will be eligible for COVID-19 vaccines at various phases. ITC plans to launch an outreach campaign to members as they become eligible for the COVID-19 vaccine. ITC is working with county health agencies and providers to share data to facilitate members gaining access to the vaccine. ITC is collaborating with the National Council on Independent Living (NCIL), organizing a competitive grant to support the removal of physical and disability access barriers for various group practice and clinic service locations. Grant applications must be submitted by February 28, 2021. Mitch discussed initial findings from data analysis regarding SDOH ITC has been conducting in the past year. ITC has determined that member understanding of health information and member's confidence in their own health are key drivers of top 10 SDOH needs of providers. Mitch went on to discuss ITC's My Health Pays program, noting that close to half of ITC's membership is enrolled in the program. Mitch stated that of all the Centene Medicaid managed care programs, ITC has one of the highest adoption rates for this program. ITC will expand the program in 2021, adding financial incentives to more healthy behaviors. Mitch highlighted ITC's National Committee for Quality Assurance (NCQA) interim accreditation score 49.5 out of 50.

Kady Reese, Iowa Medical Society, asked what plans ITC has to share results of the data analysis surrounding SDOH, specifically findings regarding member understanding and member confidence, with providers. Mitch stated that ITC's approach to SDOH is that actions need to be data-driven and performed at scale. Mitch stated that ITC will work closely with providers to develop strategies as more data becomes available.

Open Discussion

John Dooley stated that he has heard concerns from members that there may be a difference in services covered between the FFS program and the MC program. John also raised a question asked to him about the difference between Medicare and Medicaid. Julie answered that Medicaid benefits, by law, must be the same between FFS and MC programs. In response to John's second question Julie stated that there are differences between what Medicare and Medicaid covers. John stated he would send further specific questions to Julie.

Dr. Shriver raised an issue concerning consultation requirements for pediatric dietary providers, stating that currently the requirements dictate the dietary consultation happens on the same day as a visit to a primary care physician, which slows down and overschedules both member and provider. Dr. Shriver went on to note the decrease in well child visits since

the start of the PHE. Julie stated that she was writing down Dr. Shriver's comments and would be happy to work with Dr. Shriver to come up with ways to increase well child visits.

Megan Gerjets, Iowa Speech and Hearing Association (ISHA) asked John McCalley if Amerigroup had any update on prior authorizations for pediatric members requiring speech and hearing services. John stated he would follow up with Megan.

Senator Joe Bolkcom asked if the Department had any update on the search for a new Medicaid director. Julie stated that the Department has posted the position again for a third time.

Matthew Flatt, NuCara Home Medical, noted that in the Managed Care Quarterly Report a high percentage of appeals go to Durable Medical Equipment (DME). Matthew asked if a breakdown of the specific pieces of equipment could be made available. Kurt stated he would follow up with Matthew and provide him with this information.

Adjournment

Meeting adjourned at 2:39 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Medicaid Director Executive Summary

May 20, 2021

Federal Public Health Emergency (PHE) Extended

- The U.S. Department of Health and Human Services (HHS) has extended the COVID-19 PHE through **July 14, 2021**.
- This means that all the Medicaid waivers and flexibilities currently in place will continue through at least that date.

COVID-19 Vaccine Information for Providers

- Effective April 1, 2021, the COVID-19 vaccine administration rate per dose is $40 for both Managed Care and Fee-for-Service.
  - This is $80 total for a two dose vaccine, and $40 for a single dose vaccine.
  - Doses provided prior to April 1, 2021, will be paid at the previous vaccine administration rate.
- COVID-19 vaccine eligibility has been expanded to the following Medicaid groups:
  - COVID-19 testing coverage
  - Presumptive eligibility for pregnant women
  - Hawki dental only
  - Limited Medicaid for non-citizens

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, conducted a claims audit.
- There were two phases to the audit.
  - Phase 1: Sampling of claims for 13 specific providers with multiple payment issues. This was completed in December 2020.
  - Phase 2: Verifying ITC's claims system configuration corrections through analytics and sampling. This phase was broken into three tiers.
  - Partial release of the $44 million withheld is contingent on ITC achieving 75 percent or greater reconciliation for each of the tiers.
    - 75% threshold for Tiers 1 and 2 was met; $14 million was paid to ITC on March 26, 2021; and $2.5 million was paid on April 29, 2021.
    - IME is reviewing the results of Tier 3 and will make a decision soon on the release of the final payment.

Electronic Visit Verification (EVV) Update

- EVV implementation became effective January 1, 2021 for all caregivers and providers of personal care type services to members.
- IME delayed implementation for assisted living and residential care facilities until July 1, 2021.

Pharmacist Providers

- Effective June 1, 2021, pharmacists may enroll as a new Medicaid provider type.
- Any pharmacist who plans to administer or supervise administration of any Medicaid covered vaccine, other than the COVID-19 vaccine, must be enrolled with Iowa Medicaid for the pharmacy or pharmacist to be eligible for reimbursement.
- Once the provider has completed IME enrollment, then they must complete the credentialing and contracting process with the Managed Care Organizations (MCOs).

441—79.7(249A) Medical assistance advisory council.

79.7(1) *Officers.*

a. The public co-chairperson's term of office shall be two years. A public co-chairperson shall serve no more than two consecutive terms.

b. The public co-chairperson shall have the right to vote on any issue before the council. The public health director co-chairperson serves as a nonvoting member of the council.

c. The position of public co-chairperson shall be held by one of the five public council members. Ballots will be distributed to the public council members at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and administered by department of human services staff. The initial ballot following July 1, 2019, will be distributed by email prior to the first meeting in that fiscal year in order to identify the public co-chairperson prior to the council's first meeting.

d. The co-chairpersons shall appoint members to other committees approved by the council.

e. Responsibilities.

(1) The co-chairpersons shall be responsible for development of the agendas for meetings of the council. Agendas will be developed and distributed in compliance with the advance notice requirements of Iowa Code section 21.4. Agendas will be developed in consultation with the staff and director of human services, taking into consideration the following:

1. Workplans. Items will be added to the council's agenda as various tasks for the council are due to be discussed based on calendar requirements. Council deliberations are to be conducted within a time frame to allow the council to receive and make recommendations to the director and for the director to consider those recommendations as budgets and policy for the medical assistance program are developed for the review of the council on human services and the governor, as well as for the upcoming legislative session.

2. Requests from the director of human services.

3. Discussion and action items from council members. The co-chairpersons will review any additional suggestions from council members at any time, including after the draft agenda has been distributed. The agenda will be distributed in draft form five business days prior to the council meeting, and the final agenda will be distributed no later than 24 hours prior to the council meeting.

(2) The co-chairpersons shall preside over all council meetings, calling roll, determining a quorum, counting votes, and following the agenda for the meeting.

(3) The co-chairpersons shall consult with the department of human services on other administrative tasks to oversee the council and shall participate in workgroups and subcommittees as appropriate.

79.7(2) *Membership.* The membership of the council shall be as prescribed in Iowa Code section 249A.4B.

a. Council membership of professional and business entities shall number five and be identified from a vote among those entities outlined in Iowa Code section 249A.4B(3). Professional and business entities shall vote every year to identify the entities and their subsequent representatives that will represent the body of professional and business stakeholders on the council. Professional and business entities will also report their contact information to the department of human services.

(1) An initial election in SFY 2020 of five professional and business members shall be held. From this initial election of five members, three members with the most votes shall serve a three-year term and the other two members shall serve a two-year term. Once these members have served their initial term, the length of term for all following elected members shall be two years.

(2) Elections shall be organized along the following guidelines.

1. Ballots will be distributed at the quarterly meeting closest to the beginning of the next state fiscal year and will be collected in paper and electronic format and counted by department of human services staff.

2. The entities that receive the most votes shall serve on the council.

(3) Should any vacancy occur on the council, the entity that received the next highest number of votes in the most recent election shall serve on the council.

(4) If a voting entity's representative does not attend more than three consecutive meetings, the department of human services will notify the entity and representative and verify whether an alternative contact is needed. If a fourth consecutive meeting is missed after the notification, the voting entity's seat will be considered vacant and will be filled as outlined in subparagraph 79.7(2)*"a"*(3).

b. Council membership of public representatives shall consist of five representatives, of which one must be a recipient of medical assistance. All five public representatives will be appointed by the governor for staggered terms of two years each. All five public representatives will be voting members of the council.

c. A member of the hawki board, created in Iowa Code section 514I.5, selected by the members of the hawki board, shall be a member of the council. The hawki board member representative will be a nonvoting member of the council.

d. Council membership shall also consist of state agency and medical school partners, including representatives from the department of public health, the department on aging, the office of the long-term care ombudsman, Des Moines University and the University of Iowa College of Medicine.

(1) Partner agency and medical school representatives will be nonvoting members of the council.

(2) If an agency's or school's representative does not attend more than three consecutive meetings, the department of human services will notify the agency or school.

(3) Partner agencies and medical schools shall determine the length of appointment of their representatives. The department of human services will confirm each representative's participation every two years.

e. The following members of the general assembly shall be members of the council, each for a term of two years as provided in Iowa Code section 69.16B. Members appointed from the general assembly will serve as nonvoting members of the council.

(1) Two members of the house of representatives, one appointed by the speaker of the house of representatives and one appointed by the minority leader of the house of representatives from their respective parties.

(2) Two members of the senate, one appointed by the president of the senate after consultation with the majority leader of the senate and one appointed by the minority leader of the senate from their respective parties.

79.7(3) *Responsibilities, duties and meetings.* The responsibility of the medical assistance advisory council is to provide recommendations on the medical assistance program to the department of human services .

a. Recommendations. Recommendations made by the council shall be advisory and not binding upon the department of human services or the professional and business entities represented. The director of the department of human services shall consider the recommendations in the director's preparation of medical assistance budget recommendations to the council on human services, pursuant to Iowa Code section 217.3 and implementation of medical assistance program policies.

b. Council. The council shall be provided with information to deliberate and provide input on the medical assistance program. The council will use that input in making final recommendations to the department of human services.

(1) Council meetings.

1. The council will meet no more than quarterly.

2. Meetings may be called by the co-chairpersons; upon written request of at least 50 percent of members; or by the director of the department of human services.

3. Meetings shall be held in the Des Moines, Iowa, area unless other notification is given. Meetings will also be made available via teleconference, when available.

4. Written notice of council meetings shall be electronically mailed at least five business days in advance of the meeting. Each notice shall include an agenda for the meeting. The final agenda will be distributed no later than 24 hours prior to the meeting.

(2) The council shall advise the professional and business entities represented and act as liaison between them and the department.

(3) The council shall perform other functions as may be provided by state or federal law or regulation.

(4) Pursuant to 2016 Iowa Acts, chapter 1139, section 93, the council shall regularly review Medicaid managed care. The council shall submit an executive summary of pertinent information regarding deliberations during the prior year relating to Medicaid managed care to the department of human services no later than November 15 annually.

(5) Pursuant to 2016 Iowa Acts, chapter 1139, section 94, the council shall submit to the chairpersons and ranking members of the human resources committees of the senate and house of representatives and to the chairpersons and ranking members of the joint appropriations subcommittee on health and human services, on a quarterly basis, minutes of the council meetings during which the council addressed Medicaid managed care.

79.7(4) *Procedures.*

a. A quorum shall consist of 50 percent (five persons) of the current voting members.

b. Where a quorum is present, a position is carried by two-thirds of the present council members .

c. Minutes of council meetings and other written materials developed by the council shall be distributed by the department to each member of the council.

d. In cases not covered by these rules, Robert's Rules of Order shall govern.

79.7(5) *Expenses, staff support, and technical assistance.* Expenses of the council, such as those for clerical services, mailing, telephone, and meeting place, shall be the responsibility of the department of human services. The department shall arrange for a meeting place, related services, and accommodations. The department shall provide staff support and independent technical assistance to the council .

a. The department shall provide reports, data, and proposed and final amendments to rules, laws, and guidelines to the council for its information, review, and comment.

b. The department shall present the annual budget for the medical assistance program for review and comment.

c. The department shall permit staff members to appear before the council to review and discuss specific information and problems.

d. The department shall maintain a current list of members on the council .

e. The department shall be responsible for the organization of all council meetings and notice of meetings.

f. As required in Iowa Code section 21.3, minutes of the meetings of the council will be kept by the department. The council will review minutes before distribution to the public.

[**ARC 8263B**, IAB 11/4/09, effective 12/9/09; **ARC 3006C**, IAB 3/29/17, effective 6/1/17; **ARC 4975C**, IAB 3/11/20, effective 4/15/20]

MAAC Voting Member Ballot: Professional or Business Entities

SAMPLE BALLOT

Only ballots for voting members of the council will be counted.

Name: ____

Professional Entity:
____

Please select Two (2) from the list below. Mark the checkbox next to your selections. Please note that the list of choices continues on page 2 of the ballot.

Professional or Business Entity	Vote
Hospitals	
Iowa Hospital Association *	
Pharmacies	
Iowa Pharmacy Association*	
Physicians	
Iowa Academy of Family Physicians	
Iowa Association of Rural Health Clinics	
Iowa Chapter of the American Academy of Pediatrics	
Iowa Medical Society	
Iowa Osteopathic Medical Association	
Iowa Physician Assistant Society	
Iowa Primary Care Association	
Specialty Providers	
Free Clinics of Iowa	
Iowa Academy of Nutrition and Dietetics	
Iowa Adult Day Services Association	
Iowa Association of Hearing Health Professionals	
Iowa Association of Nurse Practitioners	
Iowa Behavioral Health Association	
Iowa Caregivers Association	
Iowa Chapter of the National Association of Social Workers	
Iowa Chiropractic Society	
Iowa Council of Health Care Centers	
Iowa Dental Association	
Iowa Nurses Association	
Iowa Nurse Practitioner Society	
Iowa Optometric Association	
Iowa Occupational Therapy Association	
Iowa Physical Therapy Association	
Iowa Podiatric Medical Society	
Iowa Psychiatric Society	
Iowa Psychological Association	
Iowa Speech-Language-Hearing Association	
Iowa State Association of Counties	
Midwest Association of Medical Equipment Suppliers	
(Professional and Business Entities Continue on page 2)	

MAAC Voting Member Ballot: Professional or Business Entities

Professional and Business Entities Continued

Professional or Business Entity	Vote
Long Term Care and Home and Community-Based Services Providers	
Iowa Alliance in Home Care	
Iowa Association of Community Providers	
Iowa Health Care Association*	
Leading Age Iowa	
Advocacy Groups	
AARP	
ARC of Iowa	
Coalition for Family and Children's Services in Iowa	
Iowa Association of Area Agencies on Aging	
Iowa Developmental Disabilities Council	
National Alliance on Mental Illness	

Entities Marked with an asterisk are currently serving as voting members and will not have their terms expire until June 30, 2022.

Disclaimer: Professional and business entities who have not provided contact information for representatives are not listed for voting. Those entities include:

- *Iowa Coalition of Home and Community-Based Services for Seniors*
- *Opticians Association of Iowa*

SAMPLE BALLOT

If you have any questions about this ballot or this process please contact Recording Secretaries Michael Kitzman and John Riemenschneider at mkitzma@dhs.state.ia.us and jriemen@dhs.state.ia.us.

Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 2

(October - December 2020)

Performance Data

Published March 2021

IOWA
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:

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Executive Summary

This report is based on Quarter 2 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

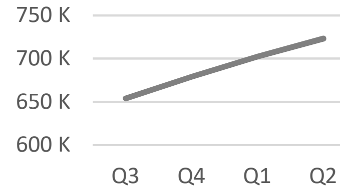
MCO Member Summary - All MCO Counts

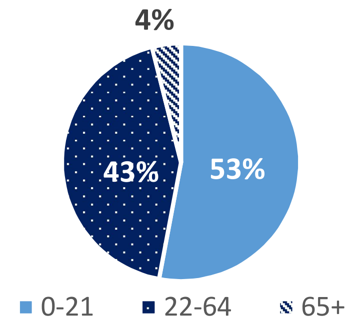
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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.

All MCO Members

723,211





+ 20,779 Members

2.96% Increase

All MCO Enrollment (by Age)

Data Notes: December 2020 enrollment data as of February 9, 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 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Distinct
MCO Member Summary	653,929	679,048	702,432	**723,211**	689,655	**727,293**
0-21	353,122	366,686	375,723	383,041	369,643	384,577
22-64	274,650	285,200	298,168	311,554	292,393	312,711
65+	26,157	27,162	28,541	28,616	27,619	30,005
Fee-For-Service (FFS) - Non MCO Enrollees	38,172	38,979	40,370	**41,375**	39,724	**42,911**

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

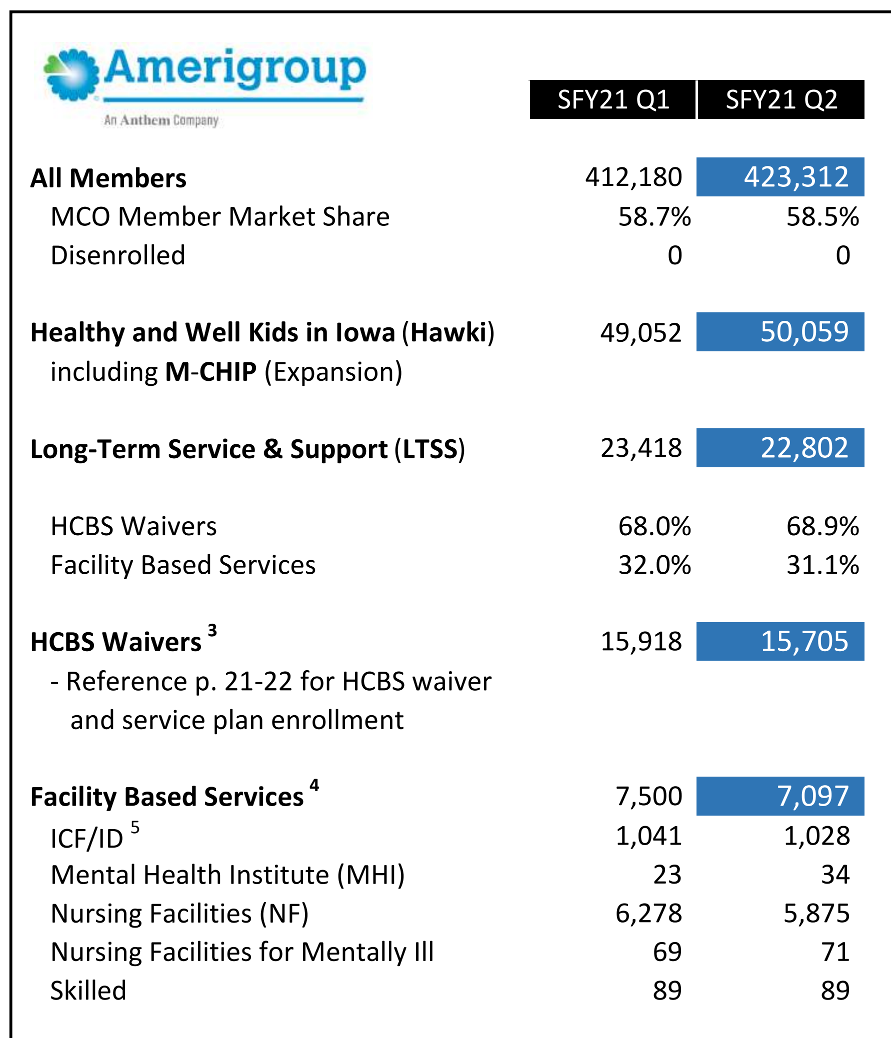
If Yes, explain:

Iowa Medicaid Population **770,204**

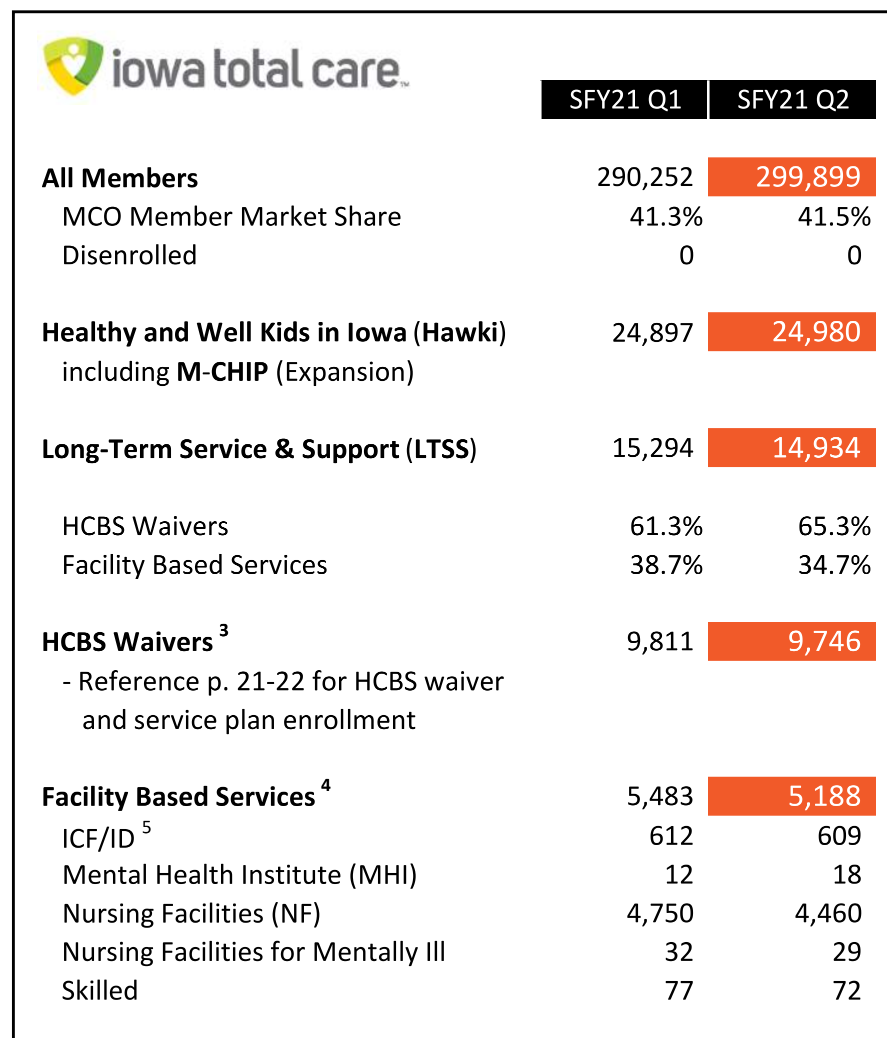
1 year distinct count

o MCO enrollment increased by 20,779 members (or 2.96% increase)
o Since March 2020, all MCO disenrollment has been suspended because of COVID-19

MCO Member Summary



Amerigroup (An Anthem Company)	SFY21 Q1	SFY21 Q2
All Members	412,180	423,312
MCO Member Market Share	58.7%	58.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (**Hawki**) including **M-CHIP** (Expansion)	49,052	50,059
Long-Term Service & Support (**LTSS**)	23,418	22,802
HCBS Waivers	68.0%	68.9%
Facility Based Services	32.0%	31.1%
HCBS Waivers [3]	15,918	15,705
- Reference p. 21-22 for HCBS waiver and service plan enrollment		
Facility Based Services [4]	7,500	7,097
ICF/ID [5]	1,041	1,028
Mental Health Institute (MHI)	23	34
Nursing Facilities (NF)	6,278	5,875
Nursing Facilities for Mentally Ill	69	71
Skilled	89	89



iowa total care	SFY21 Q1	SFY21 Q2
All Members	290,252	299,899
MCO Member Market Share	41.3%	41.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (**Hawki**) including **M-CHIP** (Expansion)	24,897	24,980
Long-Term Service & Support (**LTSS**)	15,294	14,934
HCBS Waivers	61.3%	65.3%
Facility Based Services	38.7%	34.7%
HCBS Waivers [3]	9,811	9,746
- Reference p. 21-22 for HCBS waiver and service plan enrollment		
Facility Based Services [4]	5,483	5,188
ICF/ID [5]	612	609
Mental Health Institute (MHI)	12	18
Nursing Facilities (NF)	4,750	4,460
Nursing Facilities for Mentally Ill	32	29
Skilled	77	72

[3] 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.

[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)

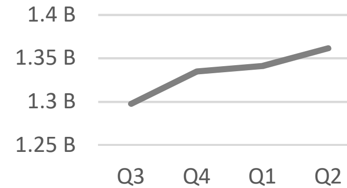
MCO Financial Summary - All MCO Counts

The MCOs receive capitation payments 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

$1.36 Billion

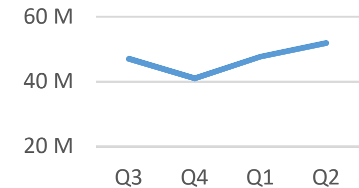


+ $20.3 Million

1.51% Increase

Third Party Liability Recovered

$ 51.91 Million



+ $ 4.3 Million

8.94% increase

Data Notes: December 2020 capitation data as of February 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 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Financial Summary						
Capitation Payments	$1.3 B	$1.33 B	$1.34 B	**$1.36 B**	$1.33 B	$5.34 B
Third Party Liability (TPL) Recovered	$46.41 M	$41.63 M	$47.65 M	**$51.91 M**	$46.90 M	$187.60 M

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

If Yes, explain:

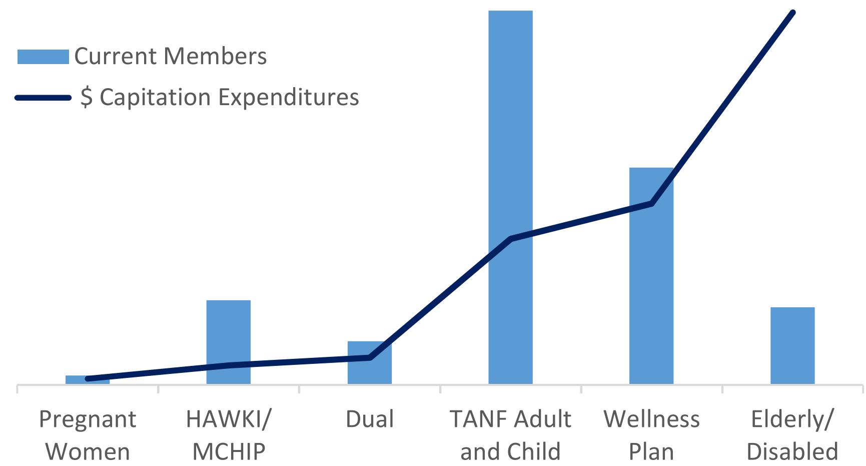
o Medical Loss Ratio (MLR) - The MLR is contractually set at 89% for the time period of July 1, 2020 through December 31, 2020.

o In Q3 SFY2020, the Department withheld $44M from ITC due to internal claims payments issues. As of the end of Q2 SFY21, this amount has still 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.



	SFY21 Q1	SFY21 Q2
Capitation Totals	$802.56 M	**$811.95 M**
Adjustments	-$2.2 M	-$2.3 M
Current	$783.29 M	$793.35 M
Retro	$21.48 M	$20.9 M
Third Party Liability (TPL) Recovered	$23.26 M	**$22.40 M**
Financial Ratios		
Medical Loss Ratio (MLR)	86.2%	**88.8%**
Administrative Loss Ratio (ALR)	6.7%	6.3%
Underwriting Ratio (UR)	7.1%	5.8%
Annual MLR [6]		87.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

	SFY21 Q1	SFY21 Q2
Capitation Totals	$538.8 M	**$549.7 M**
Adjustments	-$2.04 M	-$1.34 M
Current	$520.41 M	$531.3 M
Retro	$20.44 M	$19.74 M
Third Party Liability (TPL) Recovered	$24.40 M	**$29.52 M**
Financial Ratios		
Medical Loss Ratio (MLR)	94.8%	**88.8%**
Administrative Loss Ratio (ALR)	5.1%	5.5%
Underwriting Ratio (UR)	0.1%	5.7%
Annual MLR [6]		91.7%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

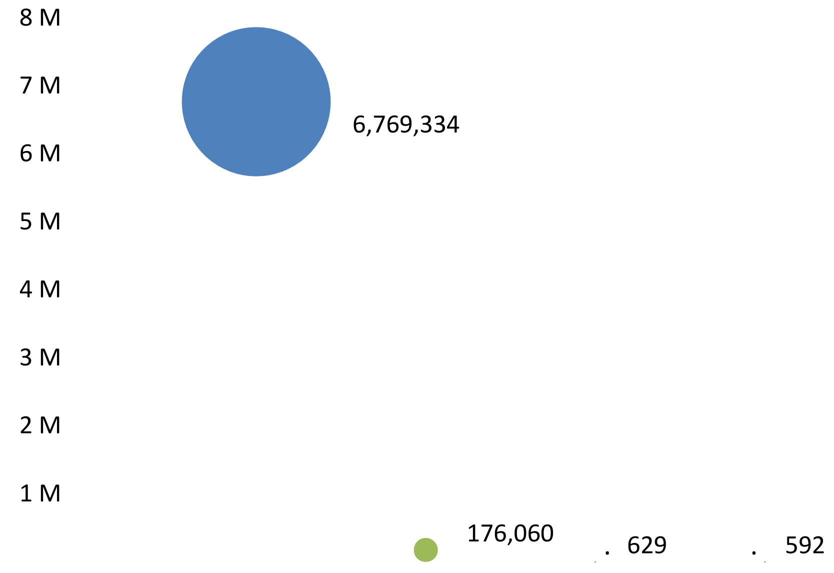
[6] Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

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%

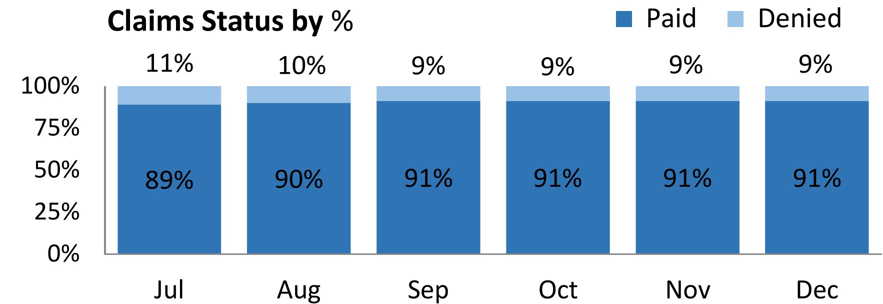


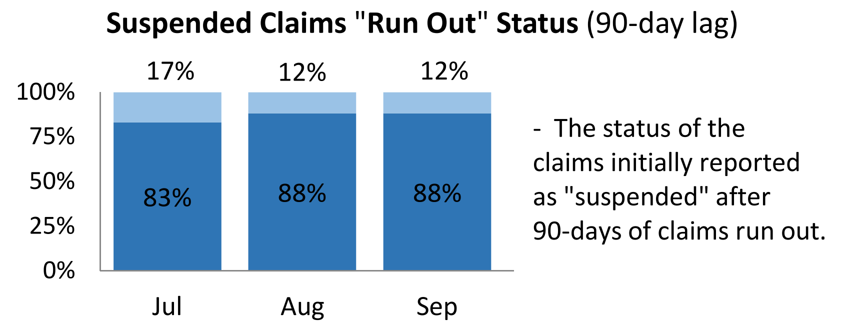
	SFY20 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Claim Counts - All Paid & Denied (p. 9-12)	7.79 M	5.95 M	7.02 M	**6.77 M**	6.88 M	27.54 M
Non-Pharmacy	4.62 M	3.17 M	4.02 M	3.96 M	3.94 M	15.77 M
Pharmacy	3.17 M	2.79 M	3.00 M	2.81 M	2.94 M	11.77 M
Prior Authorization Summary (p. 13-14)	178,919	145,452	172,937	**176,060**	168,342	673,368
Non-Pharmacy - All PAs Submitted	137,044	115,665	133,417	133,643	129,942	519,769
Pharmacy - All PAs Submitted	41,875	29,787	39,520	42,417	38,400	153,599
Grievances & Appeals Summary (p. 15-16)						
Grievances	936	422	718	**629**	676	2,705
Appeals	612	577	613	**592**	599	2,394

Claims Summary (Non-Pharmacy)

2.14 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	658,610	602,325	686,521
Denied	63,876	62,327	65,588
Suspended	139,459	151,215	115,585
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	99%	99%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	7	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	100%	97%





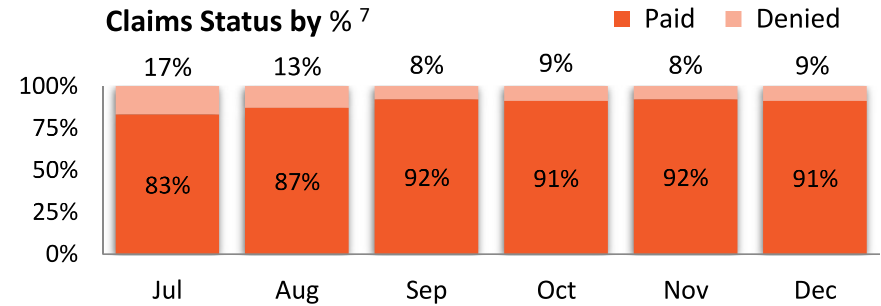
- The status of the claims initially reported as "suspended" after 90-days of claims run out.

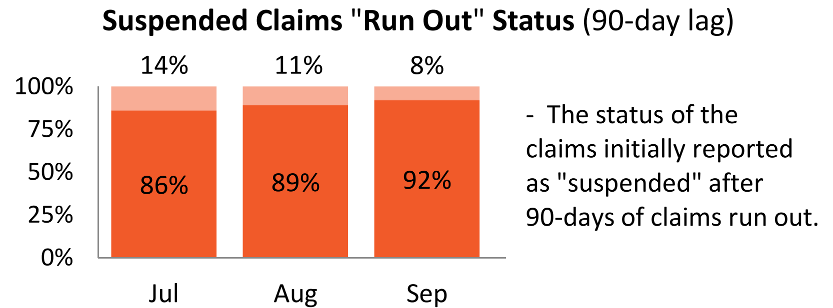
	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	33%	Duplicate claim service
2.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Claim/service lacks information or has submission/billing error(s)
4.	5%	Precertification/authorization/notification absent
5.	5%	Service not payable per managed care contract
6.	5%	An attachment/other documentation is required to adjudicate this claim/service.
7.	5%	The time limit for filing has expired
8.	3%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	3%	Claim/Service denied. At least one Remark Code must be provided
10.	2%	Expenses incurred after coverage terminated

Claims Summary (Non-Pharmacy)

1.82 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	503,711	576,638	584,590
Denied	52,838	47,853	57,720
Suspended	173,513	218,331	82,791
Clean Claims Processed [7]			
in 30-days (Requirement 90%)	98%	97%	98%
in 45-days (Requirement 95%)	99%	99%	99%
Average Days to Pay [7]	10	10	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	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.	15%	Duplicate claim service
2.	10%	National Drug Code (NDC) missing/invalid or not appropriate for procedure
3.	9%	Service can not be combined with other service on same day
4.	8%	No authorization on file that matches service(s) billed
5.	7%	Advanced claim edits (ACE) claim level return to provider
6.	7%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
7.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
8.	4%	Procedure coverage not defined by Medicaid; Provider to resubmit
9.	3%	Provider Medicaid ID required
10.	3%	ACE line item denial

[7] In SFY20, **Clean Claims Processed**, **Average Days to Pay**, and **Claims Status by %** were reported separately because of system configuration issues.

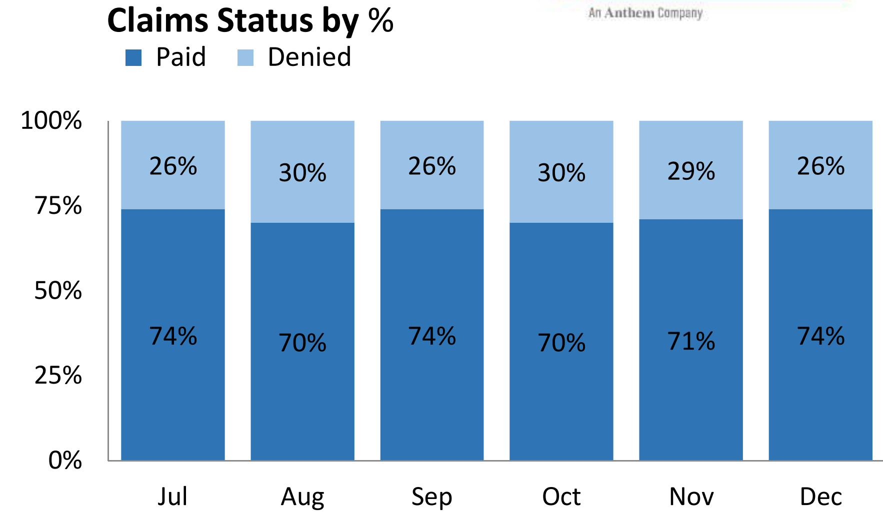
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **October**: 9,680
- **November**: 5,232
- **December**: 11,576

Claims Summary (Pharmacy)

1.6 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	357,245	353,842	437,935
Denied	153,240	142,138	151,481
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	12

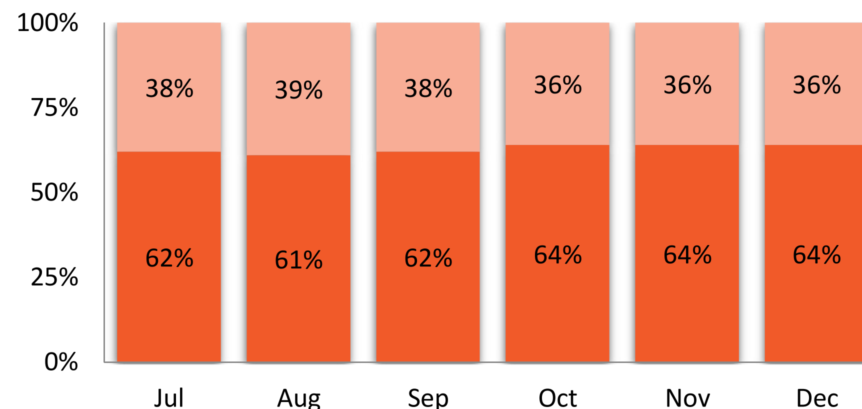


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	45%	Refill too soon
2.	15%	Prior authorization required
3.	14%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	3%	M/I other payer reject code
7.	2%	Filled after coverage terminated
8.	2%	Non matched prescriber ID
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	Discrepancy between other coverage code and other coverage information on file

Claims Summary (Pharmacy)

1.21 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	264,239	249,688	260,731
Denied	150,970	141,568	143,660
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	4



Top 10 Reasons for Claims Denials (Pharmacy)

	%	Reason
1.	31%	Refill too soon
2.	10%	Prior authorization required
3.	4%	Quantity dispensed exceeds maximum allowed
4.	3%	Claim not processed
5.	3%	Product not on formulary
6.	3%	Submit bill to other processor or primary payer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Drug not covered for patient age
9.	2%	Filled after coverage expired
10.	2%	National Drug Code (NDC) not covered

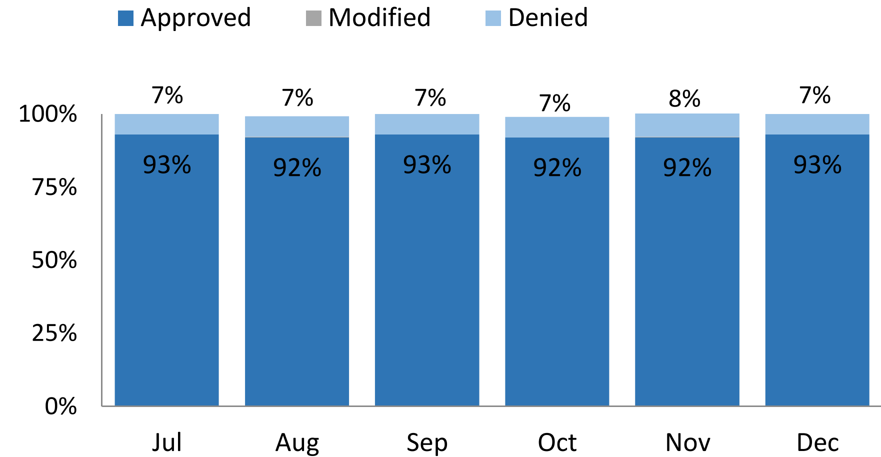
Prior Authorization Summary

81,521
All PAs Submitted [8]

Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	18,750	16,279	17,911
Denied	1,481	1,324	1,273
Modified	47	34	48
Average Days to Process	5	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

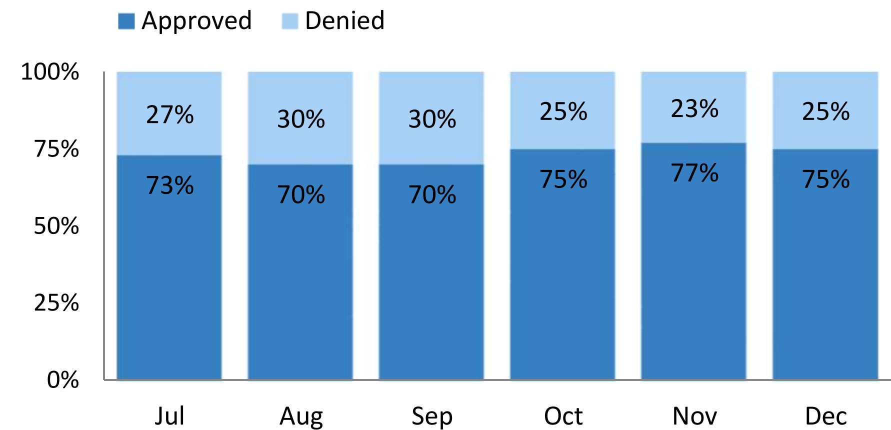
Non-Pharmacy by Percentage



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	6,921	5,940	5,490
Denied	2,354	1,773	1,873
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	99.9%

Pharmacy by Percentage



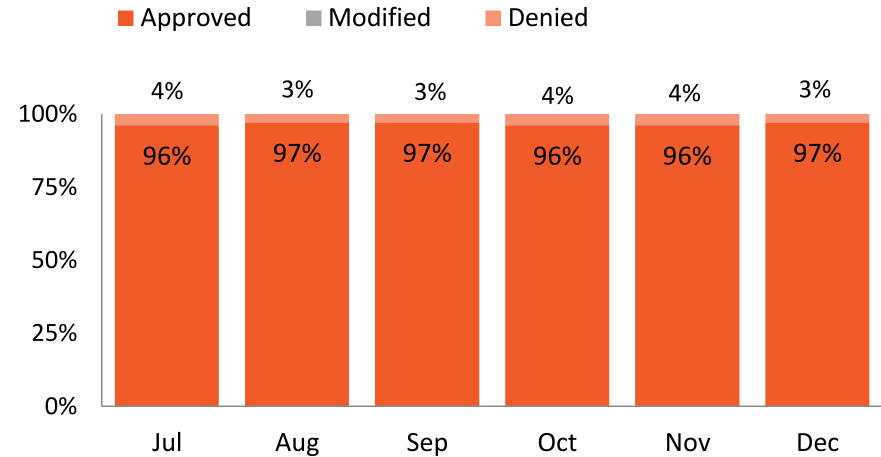
[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

94,539
All PAs Submitted [8]

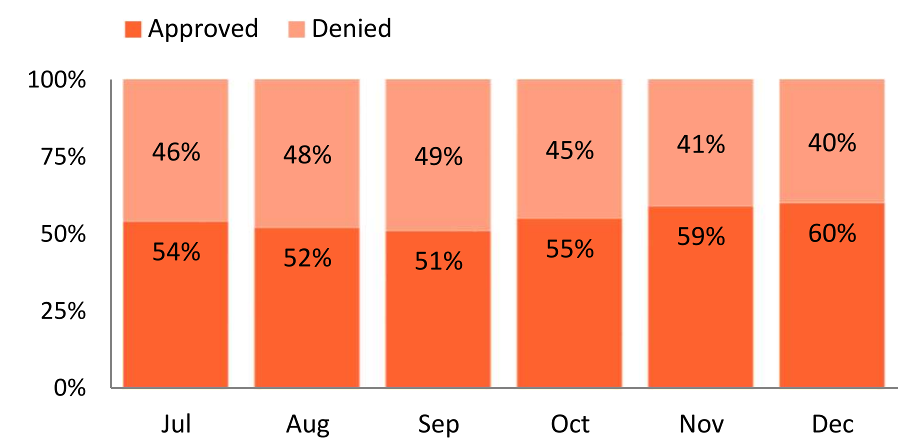
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	24,444	21,508	26,148
Denied	1,055	903	947
Modified	0	0	0
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%	100%



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	3,024	3,087	3,258
Denied	2,459	2,122	2,200
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	99.9%

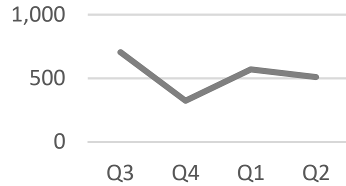


[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

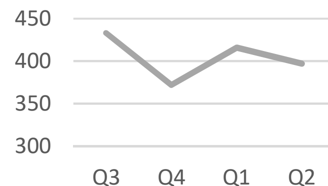
Grievances

510



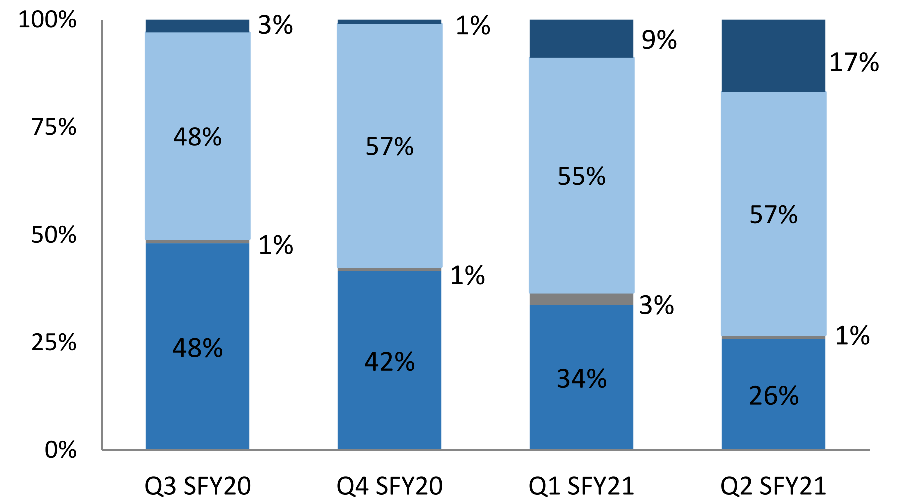
Appeals

397



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

Appeal Outcome Percentages



Withdrawn Upheld
Partially Overturned Overturned

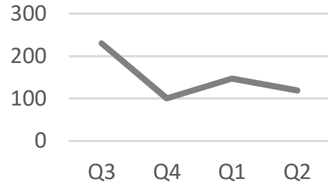
	%	Top 10 Reasons for Grievances
1.	39%	Voluntary Disenrollment
2.	18%	Provider balance billed
3.	7%	Adequacy of treatment record keeping
4.	6%	Transportation - Driver no-show
5.	4%	Availability of appointments
6.	4%	Transportation - Driver Delay
7.	4%	Treatment Dissatisfaction
8.	4%	Provider attitude/rudeness
9.	3%	Delay in Treatment
10.	3%	Inadequate benefit access

%	Top 10 Reasons for Appeals
20%	Pharmacy - Non Injectable
18%	Durable Medical Equipment (DME)
10%	Radiology
9%	Surgery
8%	Therapy - Physical Therapy
8%	Pharmacy - Injectable
4%	Inpatient Services - Medical
4%	Laboratory
3%	Behavioral Health (BH) - Op Service
3%	Behavioral Health (BH) - Inpatient

Grievances and Appeals

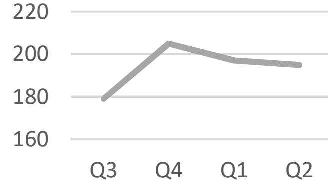
Grievances

119

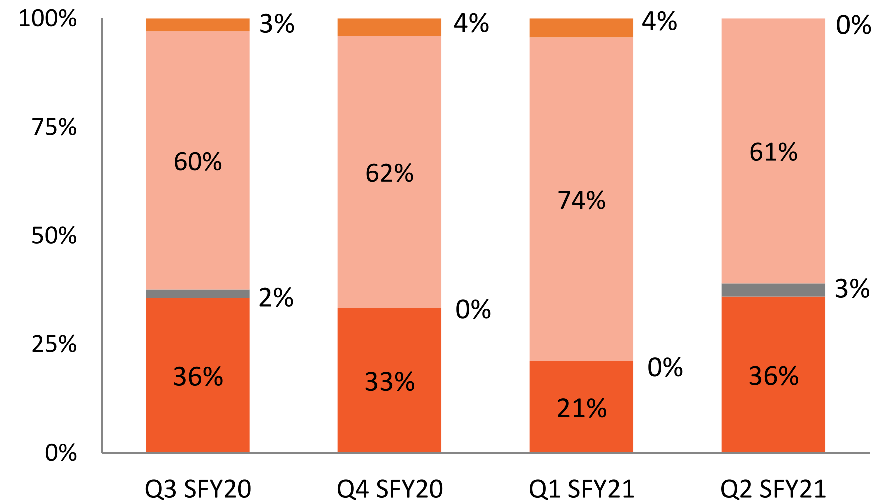


Appeals

195



Appeal Outcome Percentages



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

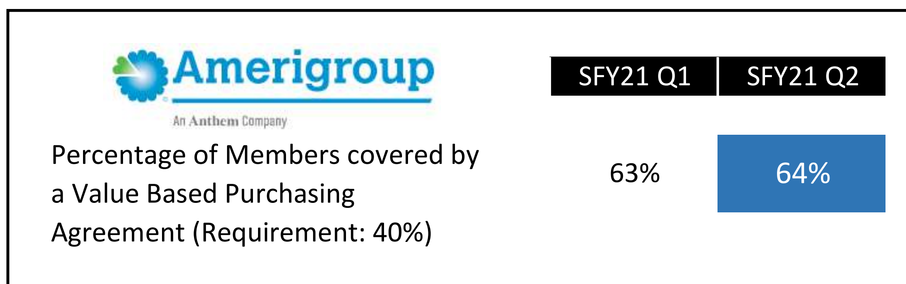
Withdrawn
Upheld
Partially Overturned
Overturned

	%	Top 10 Reasons for Grievances
1.	27%	Access to Care - Network Availability
2.	17%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	5%	Transportation - Missed Appointment
5.	4%	Provider
6.	4%	Transportation - Late Appointment
7.	3%	Lack of Caring/Concern
8.	3%	Health Plan Staff
9.	3%	Claim Dispute
10.	2%	Transportation - Unsafe Driving

%	Top 10 Reasons for Appeals
39%	RX - Does Not Meet Prior AuthGuidelines
17%	Other - Mental Health Service
5%	Diagnostic - CAT Scan
3%	Diagnostic - MRI
3%	DME - Wheelchair
2%	DME - Other
2%	Injections - Epidural
2%	DME - Orthopedic Devices
2%	Outpatient - Home Health Visits
1%	DME - CPAP Machine

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	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	64%

Iowa Total Care	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	84%	84%

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

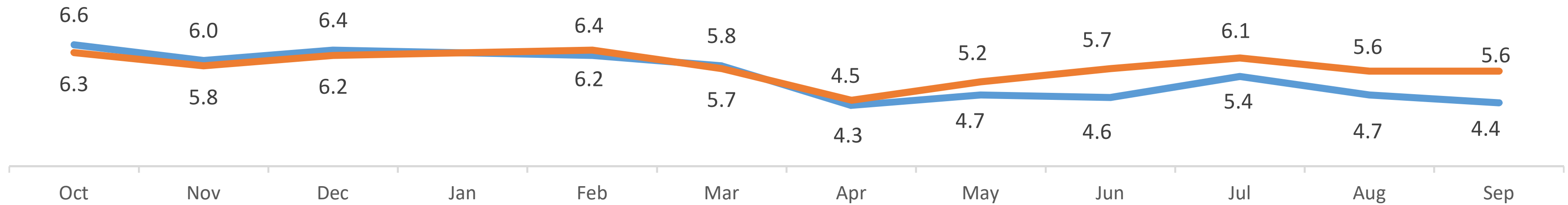
Amerigroup	SFY21 Q1	SFY21 Q2
Community Resource Link	841	2,989
Taking Care of Baby and Me	2,095	2,482
Healthy Rewards[9]	1,678	1,408
Dental Hygiene Kit	683	711
SafeLink Mobile Phone	723	581

Iowa Total Care	SFY21 Q1	SFY21 Q2
My Health Pays Program	8,755	13,222
The Flu Program	2,689	3,427
Start Smart for Your Baby	1,558	1,215
Mobile App	544	989
myStrength.com	28	428

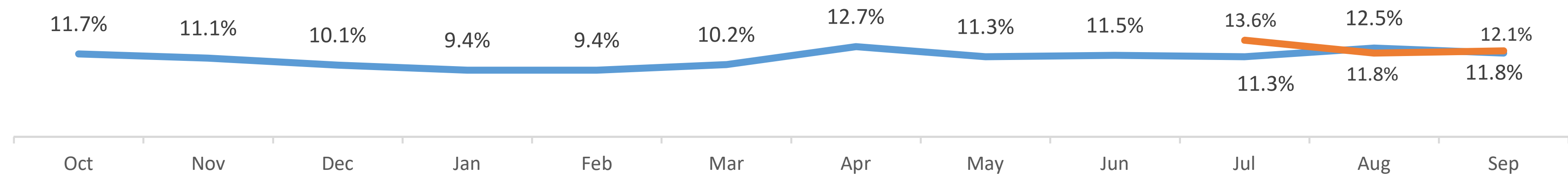
[9] *Amerigroup is reporting the total number of members who received an award in quarter (not the total enrolled in program).*

MCO Care Quality and Outcomes

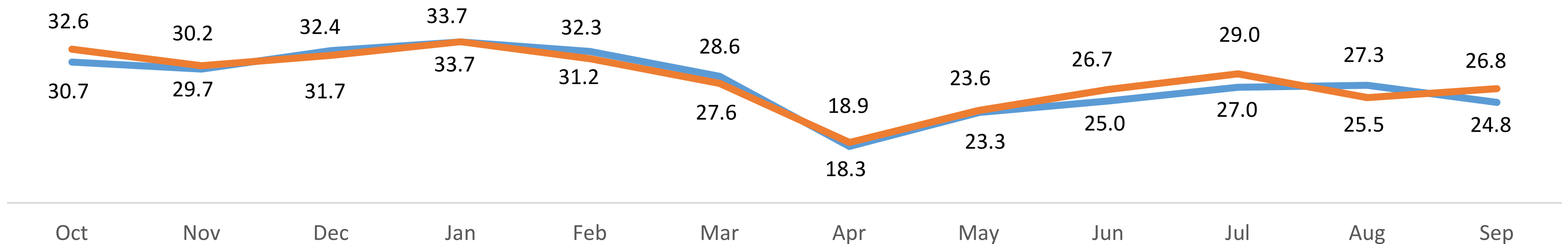
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [10]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [11]



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

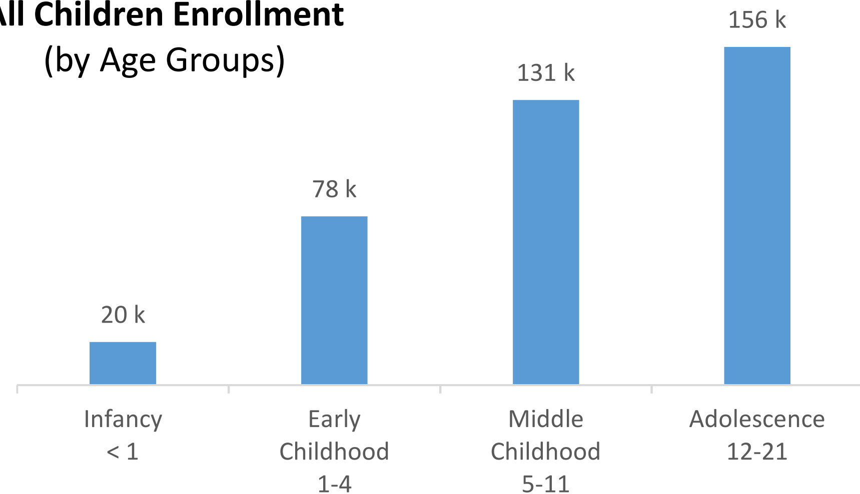
[11] Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.

MCO Children Summary

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

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 Hawki eligible.

Data Note: MCO Enrollment, Well Child Exams, Screenings, and Immunizations are compared using the same quarter 1-year apart.



	SFY20 Q2	SFY21 Q2
Member Enrollment	**225,398**	**231,588**
Infancy < 1	13,684	10,159
Early Childhood 1 - 4	46,178	47,354
Middle Childhood 5 - 11	78,030	79,742
Adolescence 12 - 21	87,506	94,333
Well Child Exams (Preventive Visits)	46,157	43,306
Infancy < 1	15,136	11,524
Early Childhood 1 - 4	13,674	12,993
Middle Childhood 5 - 11	9,270	9,947
Adolescence 12 - 21	8,077	8,842
Lead Screenings	5,386	4,313
Infancy < 1	228	98
Early Childhood 1 - 4	4,777	3,853
Middle Childhood 5 - 11	343	323
Adolescence 12 - 21	38	39

	SFY20 Q2	SFY21 Q2
Member Enrollment	**150,165**	**154,855**
Infancy < 1	8,547	9,615
Early Childhood 1 - 4	30,611	30,738
Middle Childhood 5 - 11	52,051	52,334
Adolescence 12 - 21	58,956	62,168
Well Child Exams (Preventive Visits)	32,242	30,439
Infancy < 1	10,652	10,480
Early Childhood 1 - 4	9,048	7,949
Middle Childhood 5 - 11	6,801	6,423
Adolescence 12 - 21	5,741	5,587
Lead Screenings	3,921	2,961
Infancy < 1	136	69
Early Childhood 1 - 4	3,476	2,661
Middle Childhood 5 - 11	284	217
Adolescence 12 - 21	25	14

MCO Children Summary

	SFY20 Q2	SFY21 Q2
Hearing Screenings	2,810	1,872
Infancy < 1	225	113
Early Childhood 1 - 4	1,236	830
Middle Childhood 5 - 11	1,009	654
Adolescence 12 - 21	340	275
Vision Screenings	974	901
Infancy < 1	65	10
Early Childhood 1 - 4	476	374
Middle Childhood 5 - 11	276	343
Adolescence 12 - 21	157	174

Immunization Summary - Vaccines for Children (VFC)

	SFY20 Q2	SFY21 Q2
Vaccination Totals	104,285	91,072
DTaP (Diphtheria, Tetanus, Pertussis)	11,737	10,124
Influenza (FLU)	46,228	40,164
HepA (Hepatitis A)	5,353	4,956
HepB (Hepatitis B)	2,489	951
Haemophilus Influenza Type B (Hib)	6,169	5,238
Human Papillomavirus (HPV)	3,243	3,092
Meningococcal ACWY (MenACWY)	2,614	3,103
Meningococcal B - (MenB)	1,423	1,430
MMR (Measles, Mumps, Rubella)	4,607	4,389
Pneumococcal (PCV13)	9,284	7,727
Pneumococcal (PPSV23)	104	72
Polio (IPV)	362	297
RV (Rotavirus)	5,968	4,874
Tetanus and diphtheria (Td)	68	43
TDAP (Tetanus, Diphtheria, Pertussis)	2,093	2,247
Varicella Virus Vaccine (VAR)	2,543	2,365

	SFY20 Q2	SFY21 Q2
Hearing Screenings	1,452	1,072
Infancy < 1	97	83
Early Childhood 1 - 4	614	420
Middle Childhood 5 - 11	502	391
Adolescence 12 - 21	239	178
Vision Screenings	660	669
Infancy < 1	23	19
Early Childhood 1 - 4	314	281
Middle Childhood 5 - 11	212	245
Adolescence 12 - 21	111	124

Immunization Summary - Vaccines for Children (VFC)

	SFY20 Q2	SFY21 Q2
Vaccination Totals	70,828	62,721
DTaP (Diphtheria, Tetanus, Pertussis)	8,076	7,639
Influenza (FLU)	29,211	24,481
HepA (Hepatitis A)	3,797	3,049
HepB (Hepatitis B)	4,895	4,576
Haemophilus Influenza Type B (Hib)	2,842	2,606
Human Papillomavirus (HPV)	2,467	2,066
Meningococcal ACWY (MenACWY)	1,921	1,913
Meningococcal B - (MenB)	26	14
MMR (Measles, Mumps, Rubella)	3,021	2,909
Pneumococcal (PCV13)	6,539	6,110
Pneumococcal (PPSV23)	0	0
Polio (IPV)	342	216
RV (Rotavirus)	4,292	4,019
Tetanus and diphtheria (Td)	51	14
TDAP (Tetanus, Diphtheria, Pertussis)	1,653	1,431
Varicella Virus Vaccine (VAR)	1,695	1,678

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

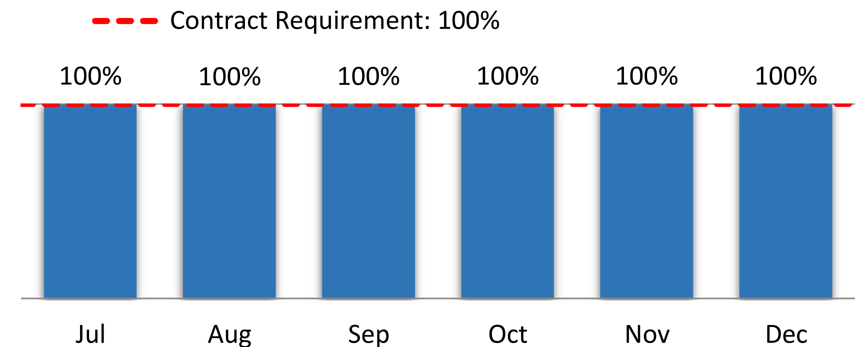
Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	16	**24**
HCBS Members to Case Managers	65	**65**

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.

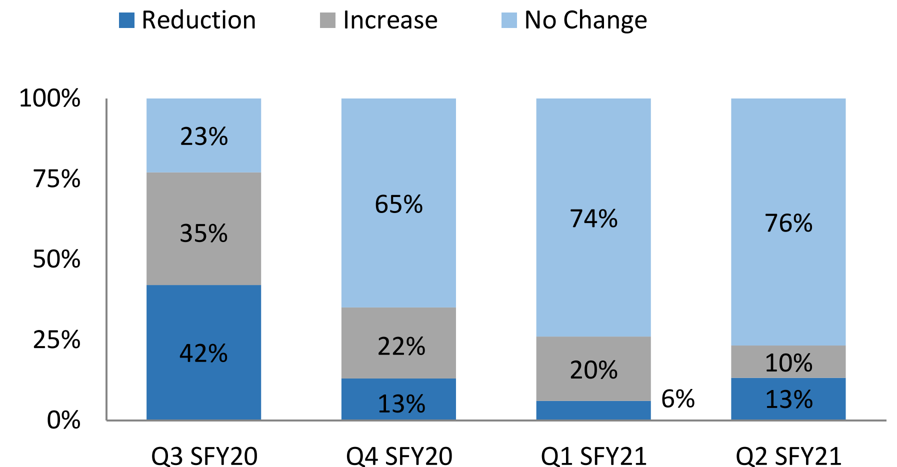
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.6%
	Yes	99.7%	99.4%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.7%	100.0%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



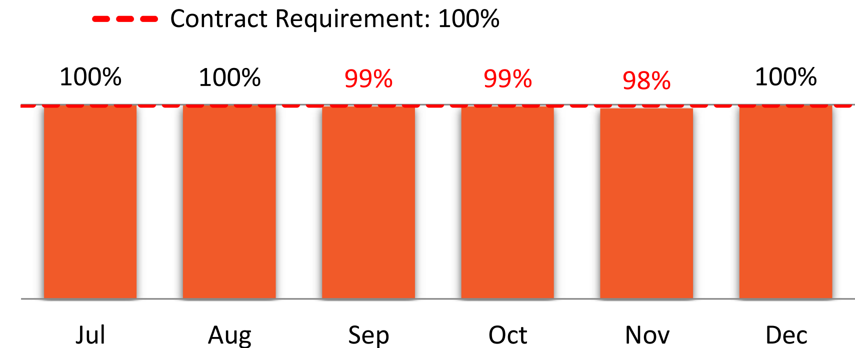
Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	36	**20**
HCBS Members to Case Managers	38	**41**

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

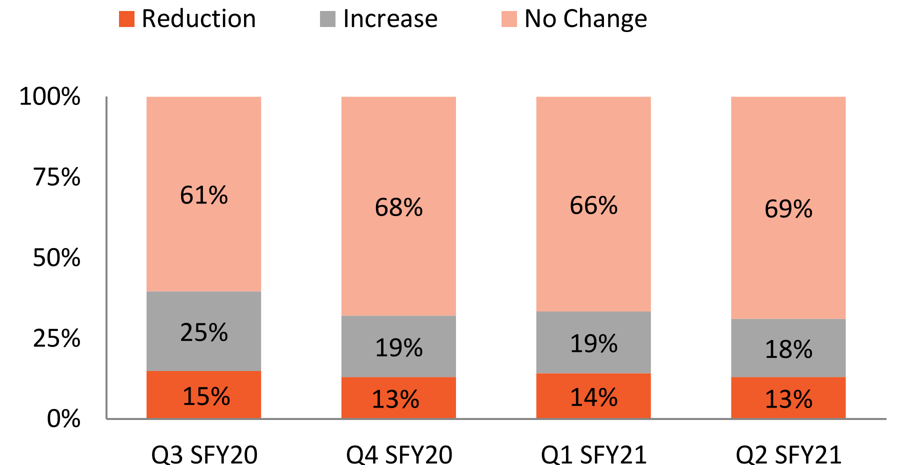
Percentage of Level of Care (LOC) Reassessments Completed Timely



Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.4%	0.4%
	No	5.2%	1.1%
	Sometimes	1.1%	1.9%
	Yes	93.3%	96.7%
They feel safe where they live.	I don't know	0.8%	0.4%
	No	2.3%	0.4%
	Sometimes	1.9%	1.5%
	Yes	95.1%	97.8%
Their services make their lives better.	I don't know	1.1%	0.0%
	No	1.9%	0.7%
	Sometimes	2.6%	2.6%
	Yes	94.4%	96.7%

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	SFY21 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	16	16
CDAC (individual) by 15 minute units	0	3
Supported Community Living (daily)	1	1
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	0	1
Brain Injury (BI) Waivers	831	821
Financial Management Services	236	239
Supported Community Living (by unit)	224	210
Respite (by 15 minute units)	174	170
Personal Emergency Response	162	163
Supported Community Living (daily)	107	107
Children's Mental Health (CMH)	879	876
Respite (by 15 minute units)	441	453
Family and Community Support	271	240
Respite (Hos/NF) - 15 minute units	245	232
Respite (Resident Camp) by units	18	14
Home Delivered Meals	8	8
Elderly Waivers	4,886	4,795
Home Delivered Meals	3,213	3,089
Personal Emergency Response	3,144	3,056
Assisted Living Services	437	412
CDAC (agency) by 15 minute units	319	349
Personal Emergency Response (install)	343	319

Service	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	4,786	4,696
Home-based Habilitation	3,816	3,991
Long Term Job Coaching	403	375
Day Habilitation (units by day)	213	319
Day Habilitation (by 15 minute units)	593	282
Individual Supported Employment	184	196
Health & Disability (HD)	1,394	1,359
Financial Management Services	374	361
Home Delivered Meals	364	356
Respite (by 15 minute units)	370	350
Personal Emergency Response	363	349
Respite (Hos/NF) - 15 minute units	67	67
Intellectual Disability (ID)	7,150	7,111
Supported Community Living (by unit)	1,886	1,848
Supported Community Living (daily)	1,965	1,586
Day Habilitation (units by day)	1,551	1,498
Financial Management Services	1,376	1,385
Supported Community Living (RCF)	966	1,107
Physical Disability (PD)	759	724
Personal Emergency Response	402	384
CDAC (agency) by 15 minute units	70	72
Personal Emergency Response (install)	75	63
Home-based Habilitation	60	52
Home Delivered Meals	55	51

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

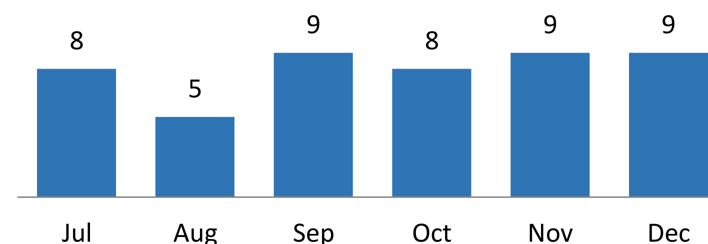
Waiver / Service	SFY21 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	13	11
Home Delivered Meals	7	7
CDAC (individual) by 15 minute units	6	5
Homemaker (by 15 minute units)	2	3
Supported Community Living (daily)	2	2
Day Habilitation (units by day)	1	1
Brain Injury (BI) Waivers	531	532
Supported Community Living (by unit)	233	234
Respite (by 15 minute units)	157	153
Personal Emergency Response	127	130
Supported Community Living (daily)	119	117
Transportation (1-way trip)	92	93
Children's Mental Health (CMH)	351	351
Respite (by 15 minute units)	173	192
Respite (Hos/NF) - 15 minute units	96	113
Family and Community Support	85	89
Mental Health Service	5	16
Respite (Resident Camp) by units	7	6
Elderly Waivers	3,336	3,310
Home Delivered Meals	2,548	2,610
Personal Emergency Response	2,451	2,526
CDAC (agency) by 15 minute units	1,285	1,330
Homemaker (by 15 minute units)	914	928
CDAC (individual) by 15 minute units	778	762

Waiver / Service	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	2,395	2,416
Home-based Habilitation	1,787	1,800
Day Habilitation (by 15 minute units)	370	350
Day Habilitation (units by day)	283	270
Long Term Job Coaching	225	240
Individual Supported Employment	145	153
Health & Disability (HD)	645	631
Respite (by 15 minute units)	297	292
Home Delivered Meals	203	190
Personal Emergency Response	180	176
CDAC (individual) by 15 minute units	130	130
CDAC (agency) by 15 minute units	111	109
Intellectual Disability (ID)	4,524	4,512
Supported Community Living (by unit)	1,949	1,939
Day Habilitation (by 15 minute units)	1,912	1,899
Day Habilitation (units by day)	1,778	1,769
Supported Community Living (RCF)	1,490	1,440
Respite (by 15 minute units)	1,075	1,079
Physical Disability (PD)	411	399
Personal Emergency Response	244	236
CDAC (agency) by 15 minute units	204	197
CDAC (individual) by 15 minute units	144	148
Transportation (1-way trip)	56	54
Personal Emergency Response (install)	40	28

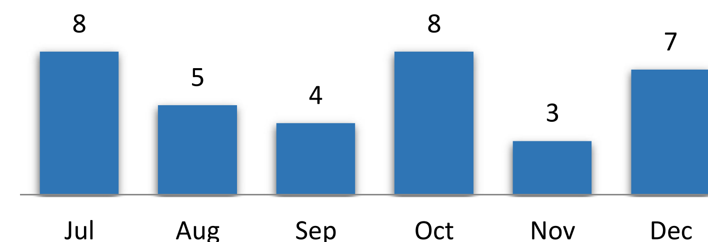
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	96.30%	96.77%	97.06%
Abandonment Rate - Must be 5% or less	1.08%	0.38%	0.50%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	90.51%	92.20%	94.57%
Abandonment Rate - Must be 5% or less	0.07%	0.07%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	90.98%	94.25%	91.36%
Abandonment Rate - Must be 5% or less	0.69%	0.19%	0.22%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	78.63%	90.80%	92.59%
Abandonment Rate - Must be 5% or less	3.25%	0.44%	0.80%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	76.62%	81.23%	94.60%
Abandonment Rate - Must be 5% or less	1.77%	1.29%	0.90%

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.

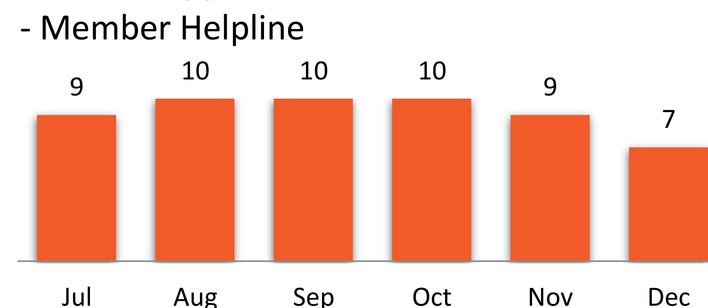
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Transportation Inquiry
5.	Claim Inquiry

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

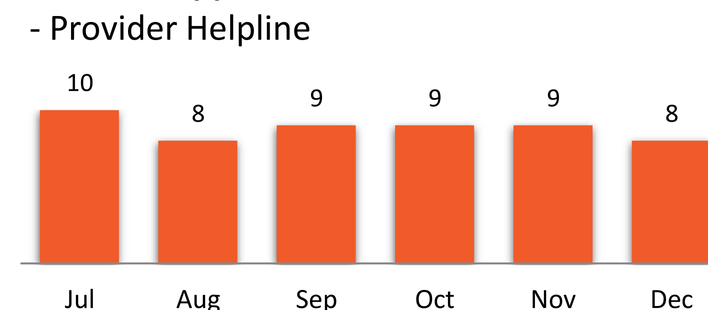
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	81.00%	72.93%	80.91%
Abandonment Rate - Must be 5% or less	4.35%	4.54%	2.87%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	89.70%	71.87%	90.18%
Abandonment Rate - Must be 5% or less	3.74%	4.92%	4.62%
Provider Helpline			
Service Level (Requirement 80%)	83.70%	79.11%	82.38%
Abandonment Rate - Must be 5% or less	2.75%	2.51%	2.95%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	92.41%	91.43%	92.33%
Abandonment Rate - Must be 5% or less	0.43%	0.22%	0.13%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	70.29%	77.73%	94.03%
Abandonment Rate - Must be 5% or less	2.01%	1.45%	1.20%

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.	Update PCP/PPG for Member
3.	Member Rewards for Member
4.	Coordination Of Benefits 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
View Authorization for Provider
Provider Outreach for Provider

Provider Network Access Summary

Primary Care Providers (PCP)

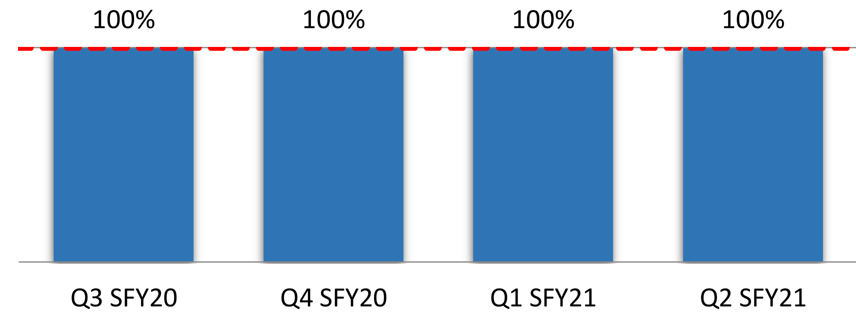
	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	6,591	6,641
Members with Access	204,945	210,795
Average Distance (Miles)	2	1.5
Pediatric PCP		
Provider Count	6,634	6,677
Members with Access	204,867	203,169
Average Distance (Miles)	2	1.6

Specialty Care & Behavioral Health (BH)

	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	400	399
Members with Access	134,256	137,341
Average Distance (Miles)	5.7	5.6
Outpatient - Behavioral Health		
Provider Count	4,000	4,043
Members with Access	409,812	413,964
Average Distance (Miles)	2	2.1
Inpatient - Behavioral Health		
Provider Count	49	48
Rural Members		
Members with Access	168,321	169,705
Average Distance (Miles)	21	21.6
Urban Members		
Members with Access	241,491	244,259
Average Distance (Miles)	6	5.7

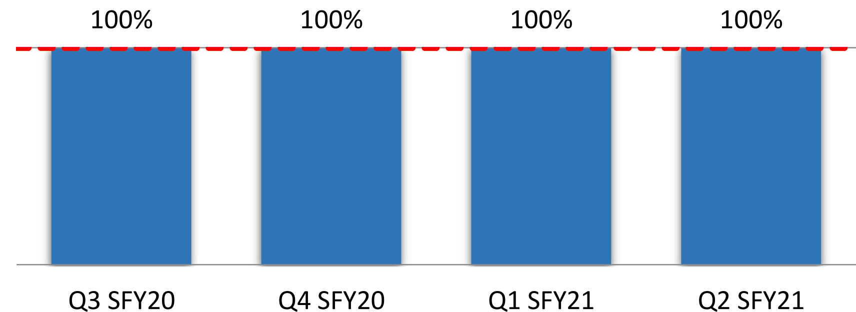
Adult PCP - Time Standards

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)

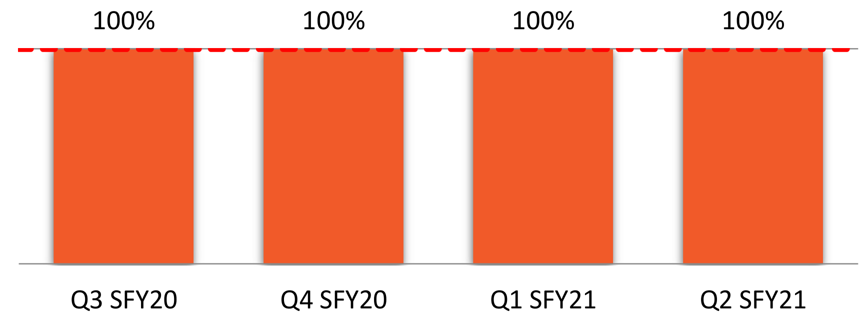
	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	8,301	8,548
Members with Access	153,137	160,490
Average Distance (Miles)	2.0	2.0
Pediatric PCP		
Provider Count	8,986	9,262
Members with Access	133,933	136,490
Average Distance (Miles)	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	1,183	1,207
Members with Access	102,412	106,694
Average Distance (Miles)	5.4	5.4
Outpatient - Behavioral Health		
Provider Count	7,842	8,251
Members with Access	287,070	296,980
Average Distance (Miles)	2.6	2.5
Inpatient - Behavioral Health		
Provider Count	35	35
Rural Members		
Members with Access	205,468	212,426
Average Distance (Miles)	25	24.7
Urban Members		
Members with Access	81,602	84,554
Average Distance (Miles)	8	8.4

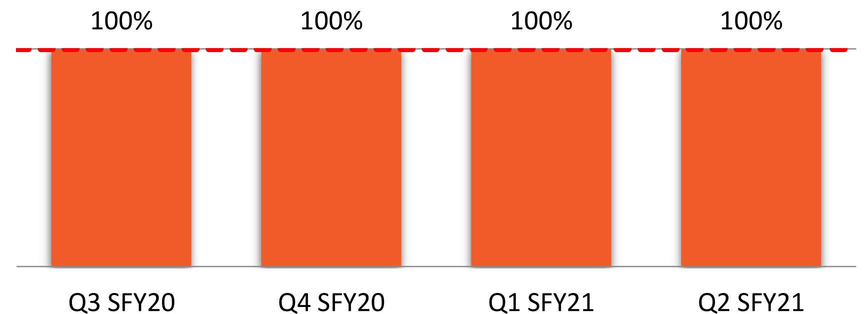
Adult PCP - Time Standards

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

MCO Program Integrity

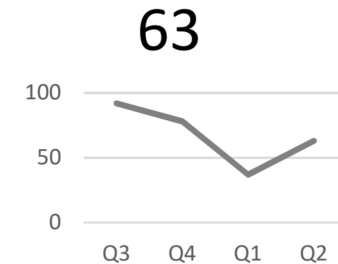
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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 - SFY21 Q2

63



9 Total Cases

Referred to MCFU

Program Integrity
- Fraud, Waste, & Abuse

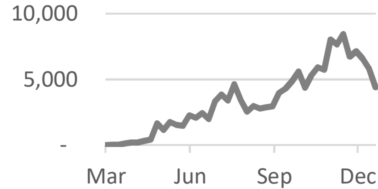
	SFY21 Q1	SFY21 Q2
Investigations opened	28	34
Overpayments identified	23	23
Member concerns referred to IME	6	3
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	6

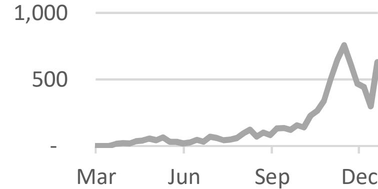
Program Integrity
- Fraud, Waste, & Abuse

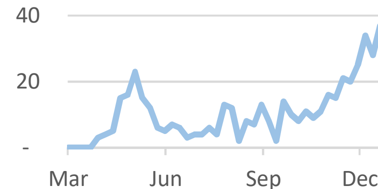
	SFY21 Q1	SFY21 Q2
Investigations opened	9	29
Overpayments identified	0	1
Member concerns referred to IME	8	4
Cases referred to the Medicaid Fraud Control Unit (MCFU)	1	3

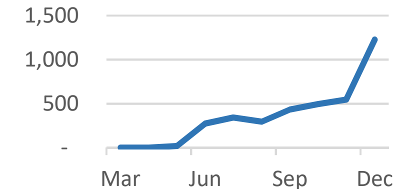
MCO COVID-19 Summary

Total Individuals Tested	Total Tested Positive	Total COVID Deaths	Total COVID Inpatient Stays [12]
146,288	7,098	462	3,625









81,802 tested in Q2	4.9%	0.06%	1.38%
78% 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. In Q2, ITC updated logic used to evaluate inpatient stays which lead to the adjustment of previously reported COVID Inpatient Stays. [12]

Claims Activity During COVID-19

MCO Total Counts	Q1 SFY21	Q2 SFY21
ER Visits - Counts	**298,300**	**255,268**
Amount Paid	$63.77 M	$64.17 M
Telehealth Services - Counts	**156,254**	**162,046**
Amount Paid	$14.08 M	$14.42 M
Transportation - Counts	**200,464**	**213,932**
Amount Paid	$9.35 M	$9.61 M
Home Maker Services - Counts	**6,283**	**7,921**
Amount Paid	$1.18 M	$1.26 M
COVID Testing - Counts	**46,040**	**81,802**
Amount Paid	$6.02 M	$9.72 M
Meals - Counts	**12,817**	**12,594**
Amount Paid	$6.44 M	$6.05 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