MAAC MATERIALS

November 10, 2021

1. Agenda of Meeting for November 10, 2021
2. August 26, 2021, Council Meeting Minutes
3. MCO Quarterly Report SFY21, Quarter 4
4. Telehealth Update
5. Telehealth Pre-COVID Procedure Codes
6. Telehealth Post-COVID Clinical Additions
7. Telehealth Post-COVID HCBS Additions

Department of HUMAN SERVICES

Elizabeth Matney, Medicaid Director

Medical Assistance Advisory Council (MAAC)

AGENDA
Medical Assistance Advisory Council Meeting

Wednesday, November 10, 2021
Time: 2:00 P.M. – 4:00 P.M.
Teleconference (Due to COVID-19)
Join Zoom Meeting:
https://www.zoomgov.com/j/1617313780?pwd=aVNMeE1JZnNxelBVbitVcEhjV0kvQT09
Meeting ID: 161 731 3780
Passcode: 026275

Call In: 1 (551) 285-1373

2:00 Introduction and roll call – **Sarah Reisetter**

2:05 Approval of Minutes – **Sarah Reisetter**
- August 26, 2021 Meeting

2:15 MCO Quarterly Report Q4 SFY21[1] – **Kurt Behrens**

2:35 Update from the Medicaid Director – **Liz Matney**
- Telehealth

3:20 Updates from the MCOs – **MCOs**
- Amerigroup Iowa (10 minutes)
- Iowa Total Care (10 minutes)

3:50 Open Comment – **Co-Chairs**

4:00 Adjourn

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

[1] https://dhs.iowa.gov/sites/default/files/SFY21_Q4_Report.pdf?092420211504

Department of HUMAN SERVICES

Elizabeth Matney, Medicaid Director

Medical Assistance Advisory Council (MAAC)

Summary of Meeting Minutes
August 26, 2021

Call to Order and Roll Call

Sarah Reissetter, Iowa Department of Public Health (IDPH) 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. A quorum was achieved.

Approval of Previous Meeting Minutes

Maribel Slinde, Iowa CareGivers, provided a correction to previous meeting minutes regarding which organization Amerigroup Iowa, Inc. provided a donation to, namely the Iowa Healthcare Association Foundation. Sarah called for a motion to approve minutes from the August 26, 2021, meeting including the proposed correction. The minutes were approved as corrected.

Update from Managed Care Ombudsman

Pamela Rupprecht, Iowa Managed Care Ombudsman, gave an update on the work of her office. Pam discussed trends in issues raised by members for State Fiscal Year (SFY) 2020 and SFY 2021. For SFY 2020 the top trends related to access to services and benefits; members identified issues with accessing providers for approved daily chore services. A second trend was transportation issues; including a lack of training by transportation providers to understand specific needs of members, and a lack of specialized equipment necessary to transport members. Consumer Directed Attendant Care (CDAC) and Consumer Choice Option (CCO) impacts were another trend where members reported dissatisfaction with services. Specifically, these complaints included the difficulty of finding providers and denial or reduction of service units. Another trend was the lack of service providers, where members reported a lack of providers available to provide services for which they were approved.

Pam stated that for the last three months, the top complaints have been related to access to service and benefits. Members have reported a lack of CDAC staff available to them, a lack of chore providers available, and challenges finding skilled care and bath aides. Members have also reported issues with case management; complaining of getting assigned new case managers without requesting a change and a lack of face-to-face visits.

Managed Care Organization (MCO) Quarterly Report Quarter 3 SFY 2021

Kurt Behrens, Iowa Medicaid Enterprise (IME), reviewed the MCO Quarterly Report for Q3 SFY 21. Kurt reviewed enrollment numbers, noting that as the federal Public Health Emergency (PHE) continues IME cannot disenroll members. Kurt continued into the report, discussing MCO financials, claims data, a new section of data focusing on children, and Long-Term Services and Supports (LTSS) data.

Susie Roberts, Iowa Academy of Nutrition and Diatetics, asked if data showing which category claims were coming from is available. Kurt stated that information would have to be requested ad hoc.

Dr. Amy Shriver commented that the data presented on children was excellent but asked for percentage of eligible children served. Kurt replied that he is developing a way to show the children's data in relation to healthcare effectiveness data and information sets (HEDIS) data.

Liz Matney, Medicaid Director, stated that IME staff are happy to provide data requested by MAAC members, even if that data is not present in the quarterly reports.

Dennis Tibben asked about the Provider Network Access Summary. Dennis noted that provider counts for both Adult and Pediatric Primary Care Physicians (PCPs) decreased by roughly one thousand for Amerigroup's network between Q2 and Q3. Kurt stated that he would check into the issue. Kurt added that the contract requirement percentage had not changed from quarter to quarter; and IME, typically, only investigates provider network issues when the contract requirement percentage changes.

Shelley Chandler raised concerns about the ratios of case managers to members enrolled in HCBS waivers. Shelley then asked for more useful measures for the LTSS population. Liz stated that the Department will take that back and work to develop more meaningful measures in this report.

Health Dashboard Demonstration

Kurt presented the new informational dashboard section of the Department's website. Kurt showed the Council how to navigate the menus and information presented in the dashboard. Shelly asked how often the dashboards are updated. Kurt answered that the intent is to have the dashboard updated monthly.

Medicaid Director's Update

Liz began her update by addressing the Department's unwinding plans for the PHE. Following guidance from the Centers for Medicare and Medicaid Services (CMS), the Department planned to reduce administrative strain by beginning eligibility reviews for members prior to the end of the PHE. Members found to be ineligible would then be sent letters notifying them that once the PHE ends they will be automatically disenrolled from Medicaid. However, CMS recently issued new guidance stating that members could not be automatically disenrolled in this way, and that prior to disenrollment a member must have their eligibility redetermined.

Liz then turned to the Iowa Total Care capitation payment withhold from January 2020; about $44 million was withheld from Iowa Total Care. The Department contracted with a third party, accounting firm Myers and Stauffer, to review Iowa Total Care's claims configurations and appropriate claims payment. The withhold was released in three phases; with the final payment released in July 2021, following the final report from Myers and Stauffer.

The American Rescue Plan Act provided enhanced federal funds for Home- and Community-Based Services (HCBS) for the period of April 2021 through the end of March 2022 - the enhanced funds amount to a little over $100 million. CMS has given states the ability to submit plans on how they would like to spend the money. The Department has submitted a plan which includes: the development of a robust personal care registry; improved provider retainment and recruiting bonuses; training for providers, ideally a statewide software system, but face-to-face training will be included; and a large assessment of services available to individuals across the state for behavioral health, disability services, and services tied to aging.

Shelly asked if CMS has responded to IME's submitted plan, stating she has not heard of any plans from states being approved. Liz answered that while IME has not received a response, she has heard of some states receiving approval for their plans, although more states have received denials.

Liz announced a series of Member and Provider Town Halls focusing on Community Integration, beginning on August 26, 2021. Branden Hagen asked if these town halls would replace the quarterly provider trainings. Liz answered that these town halls are not replacing provider trainings but are a platform for more direct communication with broader provider community and with the individuals we serve.

Iowa Wellness Plan Annual Report

Anna Ruggle, IME, discussed the Iowa Wellness Plan (IWP) Annual Report for SFY 2021. The IWP covers adults ages 19-24, with an income between 0% and 133% of the federal poverty level (FPL). In 2020 that was just slightly less than 17,000 per year. The enrollment number in 2019 was 177,000 members; in 2020 went up to 209,000 members, a 15% increase. As of July 2021, enrollment was 228,578 members. Some of the reasons for these increases include: the ban on disenrollments due to the PHE; member contributions and healthy behavior requirements waived, again due to the PHE; and job losses due to the COVID-19 pandemic.

With the new waiver approval by CMS, a lot of new performance measures are required to be reported on. These measures include topics of enrollment statistics, enrollment, disenrollment, members who chose not to renew; divided into categories such as gender, population such as FPL. Quality measures include: smoking cessation programs, access to care, number of providers, number of specialty providers, healthy behaviors, who's paying contributions.

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 the PHE. Amerigroup continues to work closely with IME to implement any required State Plan Amendments (SPAs) and any other policy changes, as well as reinforce messaging around vaccination efforts. Amerigroup has made over 200,000 phone calls from case managers to members on the

topic of vaccination. John highlighted the work of the Iowa Developmental Disability Council in creating a video on the benefits of vaccination and stated that Amerigroup has provided this video to case managers to share with members. Amerigroup continues to work closely with the Department's community integration strategy, with the goal of transitioning members from facility-based care to community-based living environments. This work has included enhancing Amerigroup's provider network, including recruiting out-of-state providers to provide services to members within the state.

John noted that community-based case managers resumed face-to-face member meetings beginning July 2021, at member choice. Zoom options are still an option for members. Case managers use member meetings to perform required assessments, develop care plans, and check-in with members. Case managers are in full personal protective equipment (PPE) protocols during these meetings. Vast majority of members choose face-to-face meetings, member feedback is a sense of relief to have the face-to-face option.

John discussed Amerigroup's work to address social determinants of health and move more into addressing health inequities. John highlighted Amerigroup's housing stability initiative: piloted in Des Moines, the program will be rolled out to 23 counties across the state. Work on food insecurity has grown, work begun with Double-Up Food Bucks has developed into a partnership between Amerigroup, Double-Up Food Bucks, and Broadlawns called Food Is Medicine. The partnership is currently pursuing federal grants to expand the program across the state of Iowa. Amerigroup announced a partnership with the Iowa State University Extension Program supporting community gardens. Amerigroup has donated funding to support two dozen community gardens.

Iowa Total Care (ITC)

Brian Sanders, Senior Vice President for Population Health and Clinical Operations for ITC, presented an update. Brian began by stating ITC's commitment to forming strong partnerships with IME and their fellow MCOs, highlighting the work of all three organizations during the PHE. Brian discussed the move to virtual platforms during the PHE, both for ITC operations and for coordinating and communicating with members. Throughout the course of the PHE ITC distributed digital tablets to members and provider organizations, for the purposes of engaging with the MCO. Brian noted that these tablets were not only used for communicating with the MCO, but for things like cooking and exercise classes. ITC implemented texting and auto-dialer campaigns to share and collect information about the COVID-19 vaccine. Brian discussed ITC's telehealth efforts through the vendor Babylon. Brian highlighted Babylon's capacity for members to have a virtual appointment with their providers outside of normal office hours and noted how this flexibility has increased member usage of services. ITC's My Health Pays program is very popular with members, members are rewarded for completing healthy behaviors. In July 2021, ITC added an electronic breast pump benefit for new and expecting mothers. ITC has partnered with several organizations and programs to support literacy in the state of Iowa. ITC has partnered with the National Council on Independent Living on an initiative called the Barrier Removal Fund, which provides grants that pay for removing of barriers for individuals with a disability to access health care across Iowa. Grants fund things such as paving parking lots, curb cuts, noise-

canceling headphones. Brian ended his update with a member story about a case manager learning Russian to cultivate a relationship with a member's family.

Dr. Shriver commented that she applauded ITC's efforts to promote literacy and encouraged ITC to connect with the state-wide organization Reach Out and Read Iowa. Brian said that ITC would reach out to Dr. Shriver for more information on Reach Out and Read Iowa.

Mental Health Subcommittee Establishment

Liz provided an update on ongoing work the Department is performing related to behavioral and mental health. In 2020, IME made CARES Act funds available to behavioral health providers: up to $10 million was available for mental health providers; and another $10 million was made available for substance use providers. In the 2021 legislative session, the legislature appropriated $8 million in state funds to enhance Home-Based Habilitation rates; this includes a higher tier to support intensive residential services. Telehealth for mental health services is ongoing and has been a success for the program. The Department has been monitoring the utilization of telehealth services and has been considering how it improves members outcomes. Additional inpatient services have been in development in Clive and Bettendorf. Liz shared a preliminary draft of a continuum of care document designed to assist in the identification of available behavioral and mental health services.

Sarah discussed the alignment work between the Department of Human Services (DHS) and the IDPH. The Departments are holding multiple planning meetings between department staff and leadership. DHS and IDPH have also engaged in meetings with external partners: the Mental Health Planning Council, the Iowa Board of Health, provider associations, the Integrated Provider Network (IPN), and community mental health centers (CMHCs). The goal of these meetings is to seek public comment from the mental health and substance use providers, review block grant statutory requirements and identify shared alignment goals between departments. Additionally, DHS and IDPH are developing joint system block grant goals.

Cheryl Jones, Iowa Association of Nurse Practitioners, and Dr. Shriver applauded the presentation on the Mental Health Subcommittee. Cheryl highlighted the presentation's focus on children's mental health, particularly children in foster care.

Open Discussion

Maribel stated that she was pleased with Liz's comments regarding direct care workers.

Dave Beeman, Iowa Psychological Association, stated he and other psychologists would be happy to join in on the conversation on children's mental health.

Adjournment

Meeting adjourned at 3:12 P.M.

Submitted by,
Michael Kitzman
Recording Secretary
mk

Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 4

(April - June 2021)

Performance Data

Published September 2021

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 4 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)

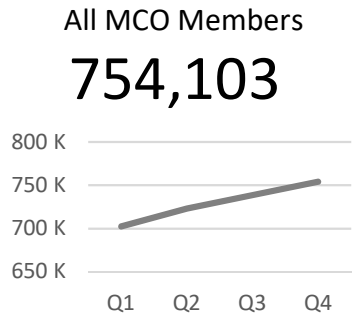
Notes about the reported data:

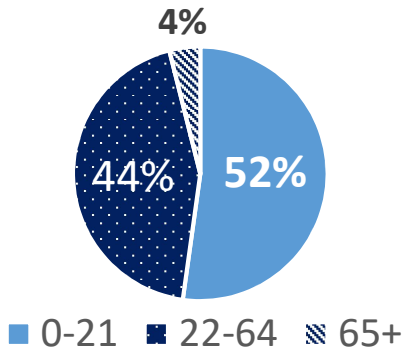
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period 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.





+ 15,364 Members
2.08% Increase

All MCO Enrollment (by Age)

Data Notes: June 2021 enrollment data as of July, 2021. 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.

	SFY21 Q1	SFY21 Q2	SFY21 Q3	SFY21 Q4	Average	Distinct
MCO Member Summary - *Overall Counts*	702,432	723,211	738,739	**754,103**	729,621	**781,673**
0-21	375,723	383,041	388,655	393,703	385,281	404,387
22-64	298,168	311,554	321,248	330,873	315,461	342,108
65+	28,541	28,616	28,836	29,527	28,880	35,178
Fee-For-Service (FFS) - *Non MCO Enrollees*	40,370	41,375	42,216	**43,938**	41,975	**47,986**

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

If Yes, explain:

Iowa Medicaid Population **829,659**
1 year distinct count

o MCO enrollment increased by 15,364 members (or 2.08% increase)
o Effective April 2021, the Department resumed some Medicaid eligibility processes currently suspended under the COVID-19 public health emergency (PHE). For additional information reference the DHS website: http://dhs.iowa.gov/ime/members/COVID19/unwind.

MCO Member Summary

Amerigroup	SFY21 Q3	SFY21 Q4
All Members - *by MCO*	432,718	438,975
MCO Member Market Share	58.4%	58.2%
Disenrolled [6]	223	242
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	50,468	49,659
Long-Term Service & Support (LTSS)	22,367	22,429
HCBS Waivers	69.4%	68.8%
Facility Based Services	30.6%	31.2%
HCBS Waivers [3] - Reference p. 23-24 for HCBS waiver and service plan enrollment	15,515	15,428
Facility Based Services [4]	6,852	7,001
ICF/ID [5]	1,014	1,012
Mental Health Institute (MHI)	23	36
Nursing Facilities (NF)	5,649	5,788
Nursing Facilities for Mentally Ill	73	73
Skilled	93	92

iowa total care	SFY21 Q3	SFY21 Q4
All Members - *by MCO*	308,767	315,128
MCO Member Market Share	41.6%	41.8%
Disenrolled [6]	442	347
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	24,544	23,812
Long-Term Service & Support (LTSS)	14,714	14,824
HCBS Waivers	65.7%	65.3%
Facility Based Services	34.3%	34.7%
HCBS Waivers [3] - Reference p. 23-24 for HCBS waiver and service plan enrollment	9,667	9,676
Facility Based Services [4]	5,047	5,148
ICF/ID [5]	607	608
Mental Health Institute (MHI)	18	27
Nursing Facilities (NF)	4,316	4,414
Nursing Facilities for Mentally Ill	32	31
Skilled	74	68

[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). [6] Measure previously reported zeros for disenrollment during COVID incorrectly; While disenrollment under COVID was "suspended" reporting zeros failed to capture member "reassignments" between MCOs.

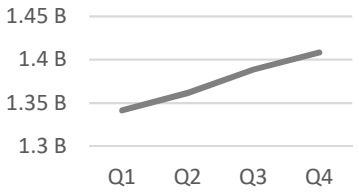
MCO Financial Summary - All MCO Counts

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

$1.41 Billion

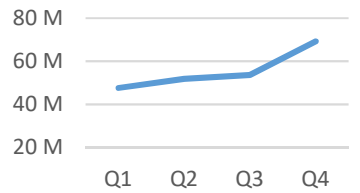


+ $19.6 Million

1.41% Increase

Third Party Liability Recovered

$69.23 Million



+ $ 15.5 Million

28.85% increase

Data Notes: June 2021 capitation data as of July 2021. 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.

	SFY21 Q1	SFY21 Q2	SFY21 Q3	SFY21 Q4	Average	Total
Financial Summary						
Capitation Payments	$1.34 B	$1.36 B	$1.39 B	**$1.41 B**	$1.37 B	$5.5 B
Third Party Liability (TPL) Recovered	$47.65 M	$51.91 M	$53.73 M	**$69.23 M**	$55.63 M	$222.53 M

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

If Yes, explain:

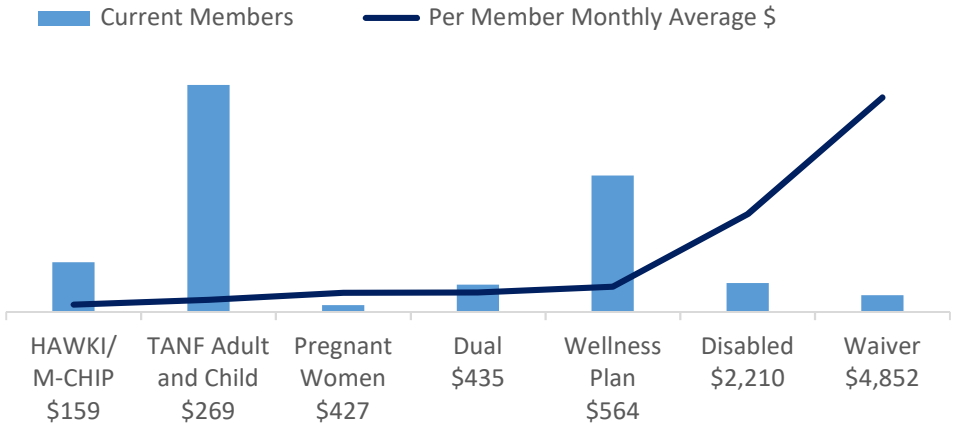
o In June 2021, the last installment of the initial $44M withheld from ITC due to internal SFY20 claims payment issues was returned to them after completing our series of claims audits.
o TPL increased by $15.5M or 28.85% between Q3 and Q4

MCO Financial Summary

Per member Medicaid capitation is determined by program eligibility. Medicaid capitation expenditures vary based on member eligibility group size and per member capitation rate. In Iowa, about 50% of all capitation expenditures are allocated to supporting the disabled & waiver eligibility groups.

Medical loss ratios (MLR) capture how much money is spent on medical claims and quality measures versus administrative expenses and profits. By contract, MCOs are required to spend a certain percentage of their capitation payments on claims annually or risk having to return the difference.

Monthly Capitation Expenditures



Amerigroup An Anthem Company

	SFY21 Q3	SFY21 Q4
Capitation Totals	$818.12 M	**$828.47 M**
Adjustments	-$4.18 M	$8.47 M
Current	$800.26 M	$800.26 M
Retro	$22.04 M	$19.73 M
Third Party Liability (TPL) Recovered	$24.32 M	**$29.29 M**
Financial Ratios		
Medical Loss Ratio (MLR)	91.5%	**87.0%**
Administrative Loss Ratio (ALR)	5.6%	5.9%
Underwriting Ratio (UR)	2.9%	7.0%
Annual MLR [7]		88.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

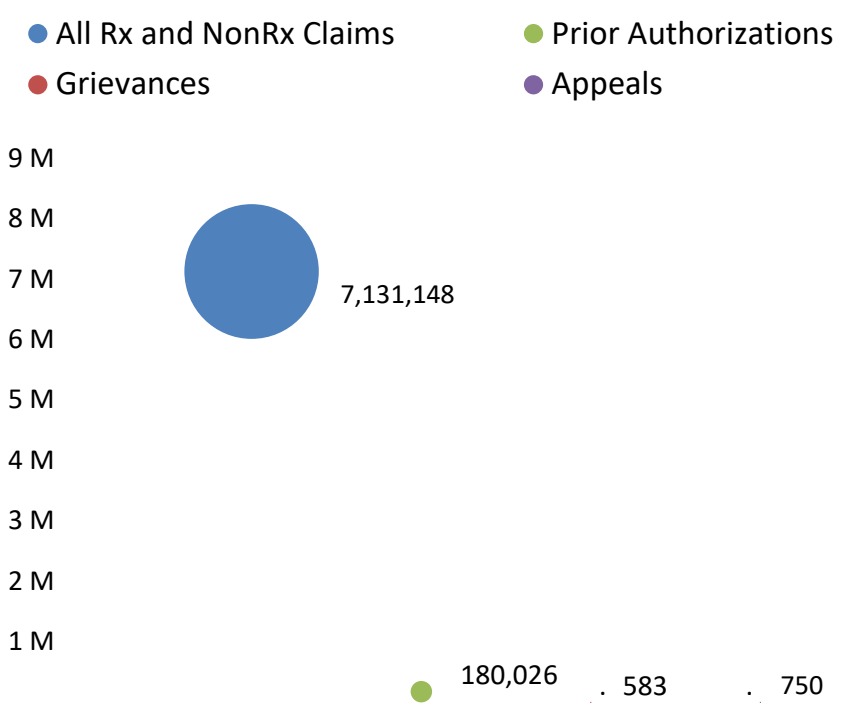
	SFY21 Q3	SFY21 Q4
Capitation Totals	$570.55 M	**$579.81 M**
Adjustments	$1.59 M	$12.58 M
Current	$548.53 M	$548.53 M
Retro	$20.43 M	$18.71 M
Third Party Liability (TPL) Recovered	**$29.41 M**	**$39.94 M**
Financial Ratios		
Medical Loss Ratio (MLR)	94.0%	**91.8%**
Administrative Loss Ratio (ALR)	5.6%	4.4%
Underwriting Ratio (UR)	0.4%	3.7%
Annual MLR [7]		92.3%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[7] 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	2.52%
Grievances	0.01%
Appeals	0.01%

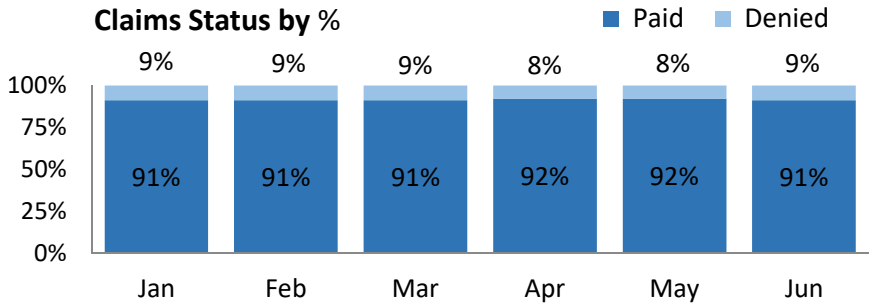
	SFY21 Q1	SFY21 Q2	SFY21 Q3	SFY21 Q4	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.02 M	6.77 M	6.84 M	**7.13 M**	6.94 M	27.77 M
Non-Pharmacy	4.02 M	3.96 M	4.00 M	4.21 M	4.05 M	16.19 M
Pharmacy	3.00 M	2.81 M	2.84 M	2.92 M	2.89 M	11.58 M
Prior Authorization Summary (p. 13-14)	172,937	176,060	185,570	**180,026**	178,648	714,593
Non-Pharmacy - All PAs Submitted	133,417	133,643	139,780	138,319	136,290	545,159
Pharmacy - All PAs Submitted	39,520	42,417	45,790	41,707	42,359	169,434
Grievances & **Appeals Summary** (p. 15-16)						
Grievances	718	629	604	**583**	634	2,534
Appeals	613	592	649	**750**	651	2,604

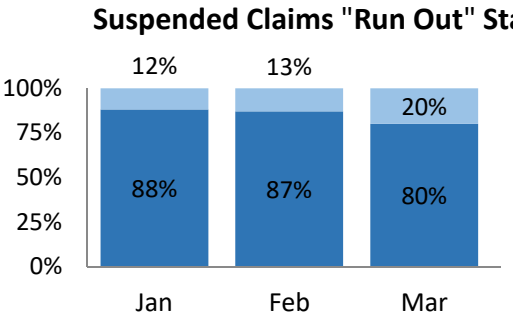
Claims Summary (Non-Pharmacy)

2.42 Million
Claims Paid & Denied

Amerigroup
An Anthem Company

	Apr	May	Jun
All Claims			
Paid	676,696	724,738	819,522
Denied	57,841	65,213	78,628
Suspended	252,377	229,915	175,781
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	99%	97%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	8	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	25%	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.	8%	Service not payable per managed care contract
5.	8%	Expenses incurred after coverage terminated
6.	6%	Precertification/authorization/notification absent
7.	5%	An attachment/other documentation is required to adjudicate this claim/service.
8.	5%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	3%	The time limit for filing has expired
10.	3%	Benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

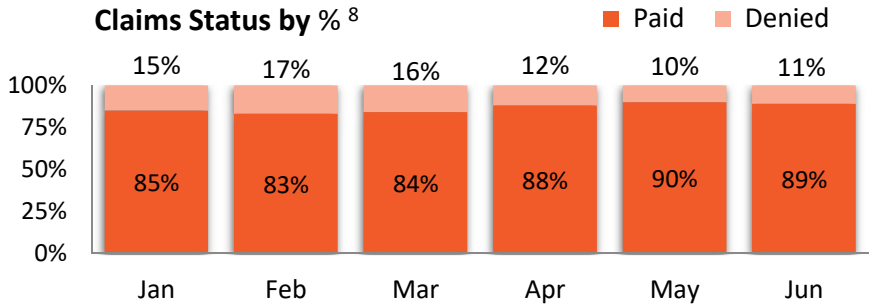
Claims Summary (Non-Pharmacy)

1.79 Million
Claims Paid & Denied

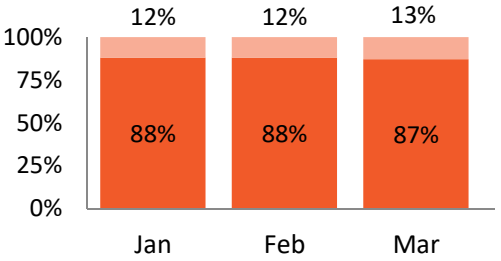
iowa total care

	Apr	May	Jun
All Claims			
Paid	536,957	503,519	540,579
Denied	76,031	57,872	70,097
Suspended	97,245	146,712	136,344
Clean Claims Processed [8]			
in 30-days (Requirement 90%)	96%	97%	99%
in 45-days (Requirement 95%)	98%	99%	100%
Average Days to Pay [8]	10	10	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	97%	98%	99%

Claims Status by % [8]



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



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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	28%	Duplicate claim service
2.	14%	Service can not be combined with other service on same day
3.	11%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	10%	No authorization on file that matches service(s) billed
5.	10%	Service is not covered
6.	7%	Invoice is missing/invalid for pricing
7.	6%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
8.	6%	Diagnosis code incorrectly coded per ICD10 manual
9.	4%	Provider Medicaid ID required
10.	4%	Ace claim level return to provider (review claim remarks)

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

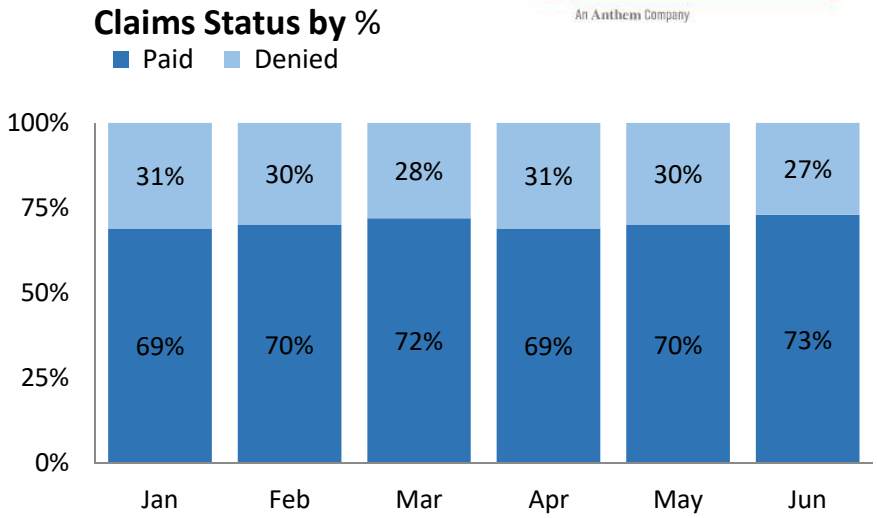
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **April**: 10,192
- **May**: 11,252
- **June**: 14,892

Claims Summary (Pharmacy)

1.65 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	358,521	364,932	452,424
Denied	158,320	153,504	165,144
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



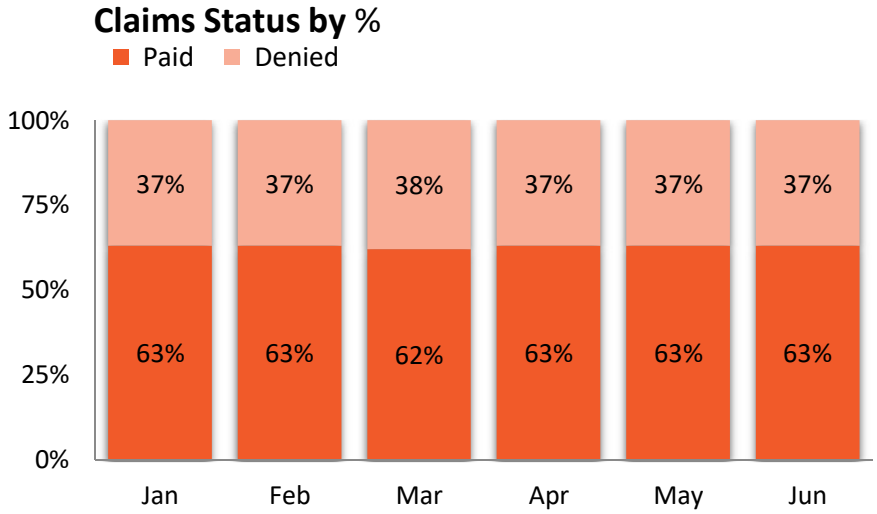
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	40%	Refill too soon
2.	14%	Submit bill to other processor or primary payer
3.	14%	Prior authorization required
4.	10%	National Drug Code (NDC) not covered
5.	5%	M/I other payer reject code
6.	5%	Plan limitations exceeded
7.	2%	Non matched prescriber ID
8.	2%	Filled after coverage terminated
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	Discontinued National Drug Code (NDC) number

Claims Summary (Pharmacy)

1.27 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	267,219	261,365	275,964
Denied	154,512	152,130	159,420
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



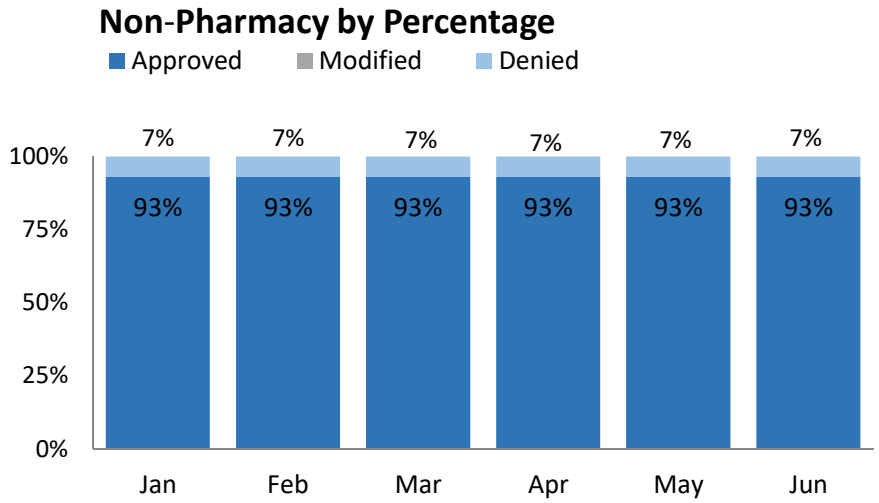
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	29%	Refill too soon
2.	10%	Prior authorization required
3.	3%	Quantity dispensed exceeds maximum allowed
4.	3%	Product not on formulary
5.	3%	Claim not processed
6.	3%	Submit bill to other processor or primary payer
7.	2%	National Drug Code (NDC) not covered
8.	2%	Drug Utilization Review (DUR) reject error
9.	2%	Drug not covered for patient age
10.	2%	Filled after coverage terminated

Prior Authorization Summary

83,721
All PAs Submitted [9]

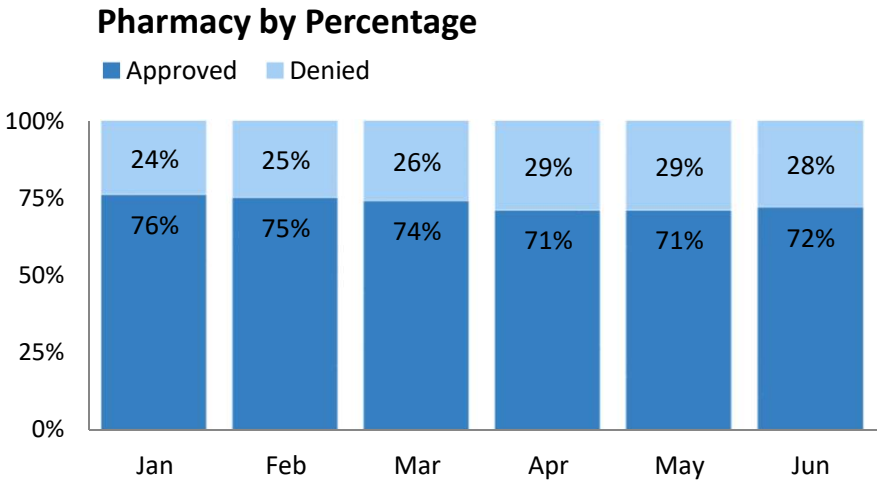
Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	19,822	17,816	18,743
Denied	1,372	1,332	1,391
Modified	43	47	29
Average Days to Process	5	5	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	99%	100%	100%



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	5,804	5,122	5,618
Denied	2,321	2,071	2,153
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	99.9%



[9] 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.

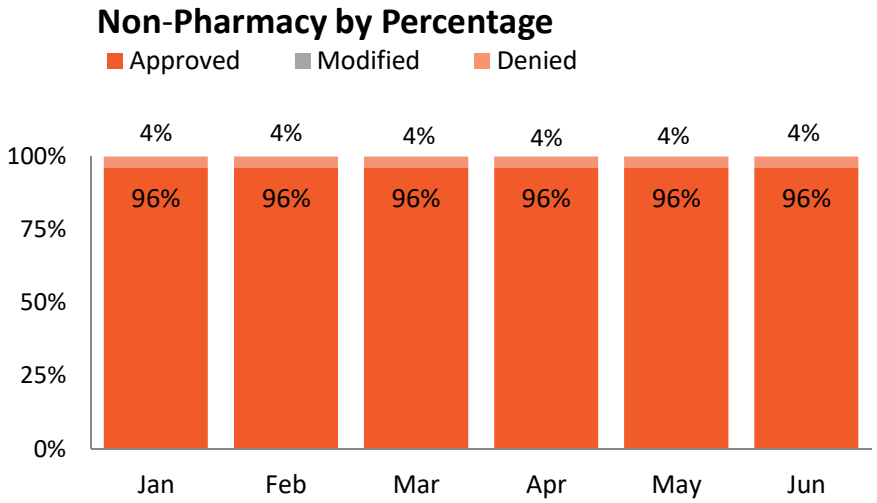
Prior Authorization Summary

96,305
All PAs Submitted [9]

iowa total care

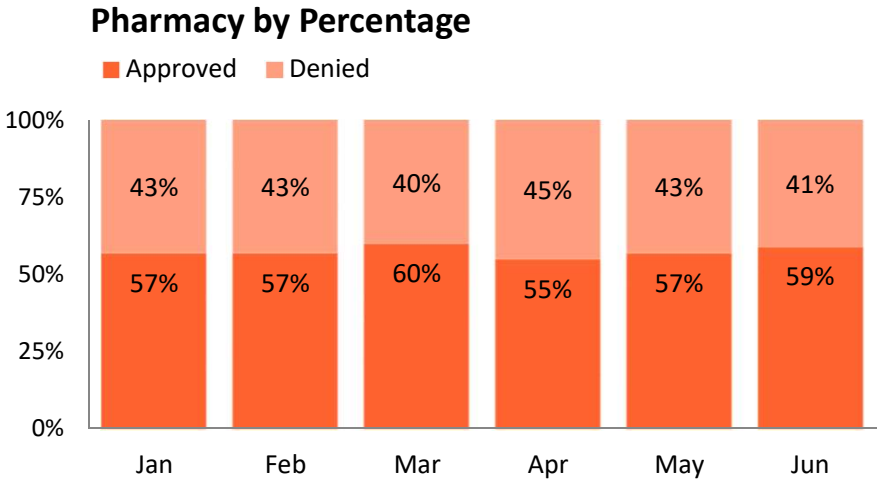
Non-Pharmacy

	Apr	May	Jun
Standard Prior Authorizations (PAs)			
Approved	24,852	24,219	24,686
Denied	1,163	1,009	1,056
Modified	0	0	0
Average Days to Process	4	4	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	99%



Pharmacy

	Apr	May	Jun
Prior Authorizations			
Approved	3,367	2,960	3,305
Denied	2,772	2,225	2,296
PAs Completed in 24-hours (Requirement 100%)	99.2%	100%	99.8%

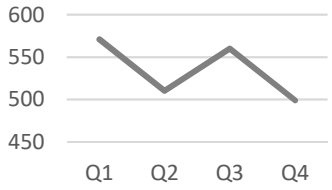


[9] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

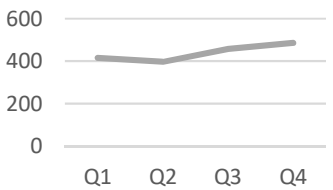
Grievances

499



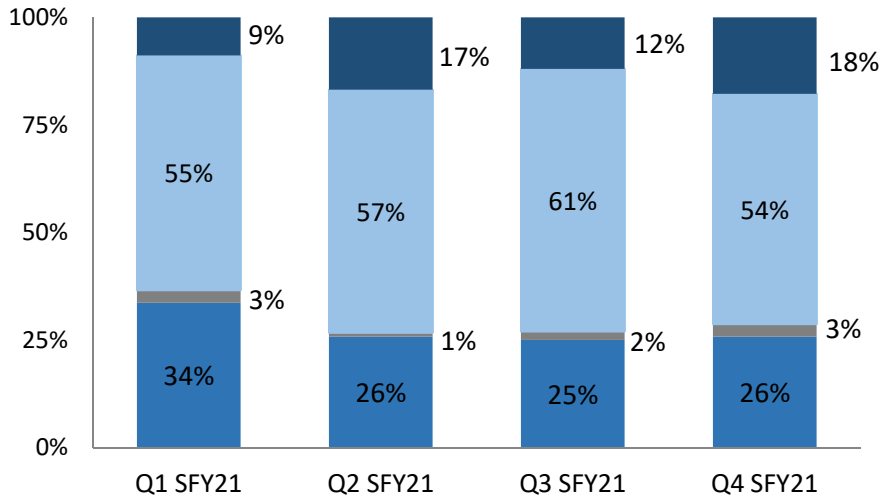
Appeals

486



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

Appeal Outcome Percentages



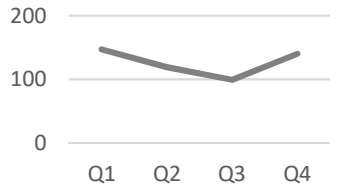
	%	Top 10 Reasons for Grievances
1.	35%	Voluntary disenrollment
2.	17%	Provider balance billed
3.	10%	Adequacy of treatment record keeping
4.	5%	Availability of appointments
5.	4%	Transportation - Driver delay
6.	4%	Provider attitude/rudeness
7.	3%	Transportation - Driver no-show
8.	3%	Treatment dissatisfaction
9.	3%	Inadequate benefit access
10.	2%	Provider refusal to treat

%	Top 10 Reasons for Appeals
29%	DME
20%	Pharmacy - Non Injectable
12%	Radiology
6%	Pharmacy - Injectable
6%	Anesthesia for Dental Surgery
5%	Inpatient - Medical
5%	BH - Op Service
4%	Surgery
4%	Therapy - PT
3%	Pain Mgmt.

Grievances and Appeals

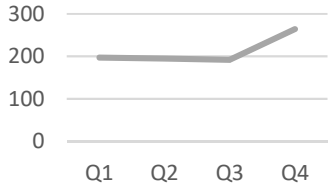
Grievances

140



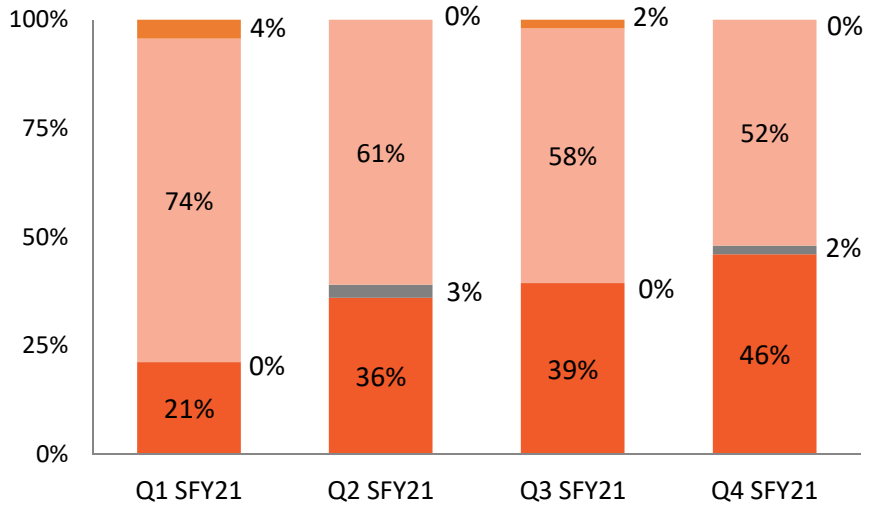
Appeals

264



Resolved in 30-days	Resolved in 30-days
99%	100%

Appeal Outcome Percentages



	%	Top 10 Reasons for Grievances
1.	22%	Access to Care - Network Availability
2.	17%	Unhappy with Benefits
3.	14%	Transportation - General Complaint Vendor
4.	6%	Transportation - Missed Appointment
5.	5%	Transportation - Late Appointment
6.	5%	Provider Staff
7.	4%	Provider
8.	3%	Transportation - Driver no-show
9.	3%	Transportation - Unsafe Driving
10.	3%	Lack of Caring/Concern

%	Top 10 Reasons for Appeals
33%	RX - Does Not Meet Prior AuthGuidelines
8%	Other - Mental Health Service
6%	Diagnostic - MRI
5%	DME - Other
5%	Diagnostic - CAT Scan
4%	Outpatient - Procedure
3%	DME - Wheelchair
3%	Therapy - Physical Therapy
3%	DME - Blood Glucose Monitor
3%	Diagnostic - Test

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 Q3	SFY21 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%) [10]	59%	60%

iowa total care	SFY21 Q3	SFY21 Q4
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%) [10]	89%	90%

Top 5 - Value Added Services (VAS)

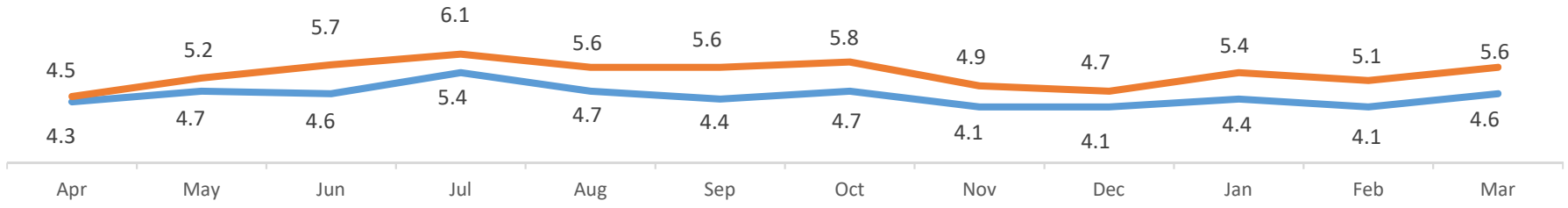
Value Added Services (VAS) are optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

Amerigroup	SFY21 Q3	SFY21 Q4
Healthy Rewards	5,633	4,466
Taking Care of Baby and Me	2,654	1,514
Community Resource Link	1,028	1,007
Dental Hygiene Kit	844	565
SafeLink Mobile Phone	616	447

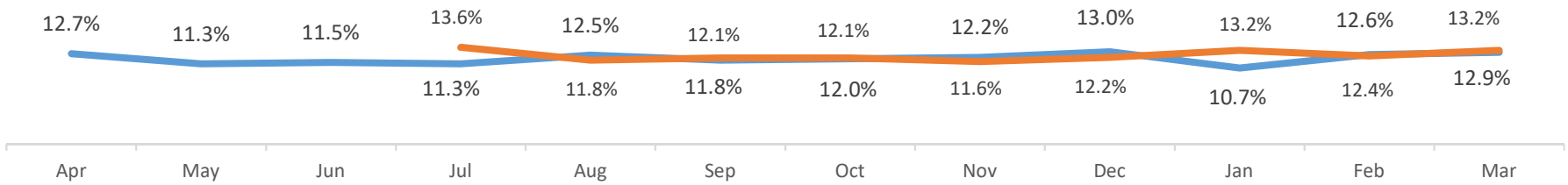
iowa total care	SFY21 Q3	SFY21 Q4
My Health Pays Program	11,284	10,387
Start Smart for Your Baby	1,529	1,445
The Flu Program	4,715	974
Mobile App	666	933
SafeLink Phones	159	335

[10] *Updated "members covered" in 40% requirement to include long term care, dual eligible, Hawki, and breast cervical cancer program members*

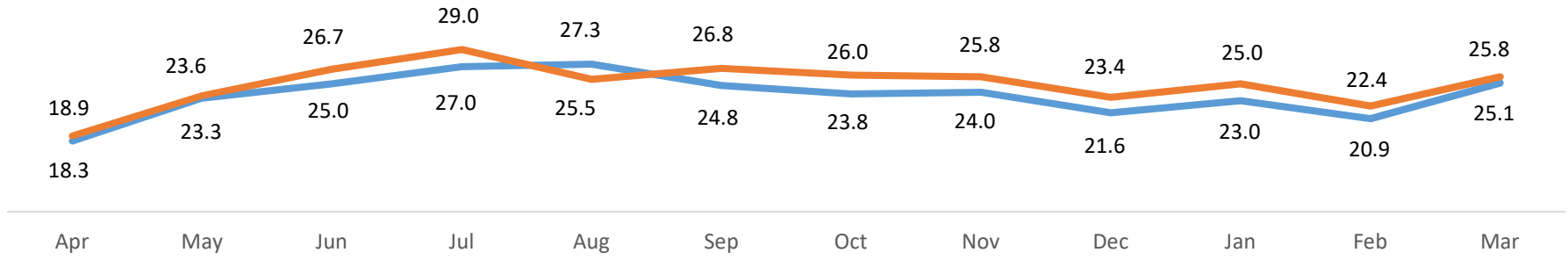
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



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

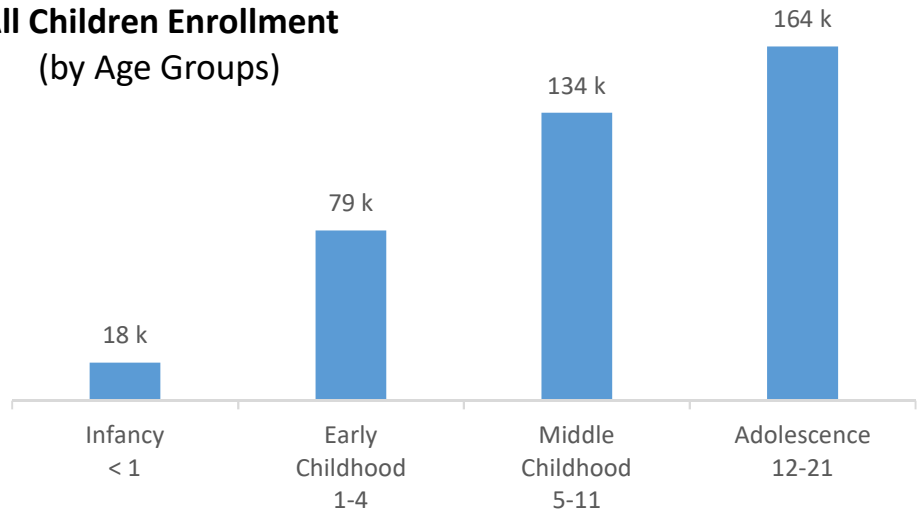
[12] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

MCO Children Summary

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

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

All Children Enrollment
(by Age Groups)



Amerigroup
An Anthem Company

	SFY20 Q4	SFY21 Q4
Member Enrollment	**223,742**	**236,807**
Infancy < 1	11,082	9,176
Early Childhood 1 - 4	46,773	47,242
Middle Childhood 5 - 11	77,497	80,950
Adolescence 12 - 21	88,390	99,439
Well Child Exams (Preventive Visits)	34,193	34,253
Infancy < 1	11,946	10,117
Early Childhood 1 - 4	11,620	11,443
Middle Childhood 5 - 11	5,319	6,719
Adolescence 12 - 21	5,308	5,974
Lead Screenings	3,917	4,315
Infancy < 1	91	116
Early Childhood 1 - 4	3,588	3,890
Middle Childhood 5 - 11	221	272
Adolescence 12 - 21	17	37

iowa total care

	SFY20 Q4	SFY21 Q4
Member Enrollment	**147,722**	**158,536**
Infancy < 1	10,164	8,480
Early Childhood 1 - 4	28,862	31,936
Middle Childhood 5 - 11	50,530	52,915
Adolescence 12 - 21	58,166	65,205
Well Child Exams (Preventive Visits)	22,277	28,304
Infancy < 1	10,728	10,457
Early Childhood 1 - 4	5,777	8,299
Middle Childhood 5 - 11	3,278	4,823
Adolescence 12 - 21	2,494	4,725
Lead Screenings	2,092	3,248
Infancy < 1	55	109
Early Childhood 1 - 4	1,864	2,875
Middle Childhood 5 - 11	144	244
Adolescence 12 - 21	29	20

MCO Children Summary

Amerigroup An Anthem Company

	SFY20 Q4	SFY21 Q4
Hearing Screenings	1,564	1,674
Infancy < 1	124	129
Early Childhood 1 - 4	727	766
Middle Childhood 5 - 11	521	532
Adolescence 12 - 21	192	247
Vision Screenings	729	1,481
Infancy < 1	11	28
Early Childhood 1 - 4	400	833
Middle Childhood 5 - 11	200	426
Adolescence 12 - 21	118	194

Immunization Summary - 21 & Under

Vaccination Totals	46,015	49,705
COVID-19 Dose 1	0	3,894
COVID-19 Dose 2	0	3,156
COVID-19 Single-Dose	0	78
DTaP (Diphtheria, Tetanus, Pertussis)	9,498	8,674
Influenza (FLU)	867	755
HepA (Hepatitis A)	4,608	4,191
HepB (Hepatitis B)	909	793
Haemophilus Influenza Type B (Hib)	5,444	4,656
Human Papillomavirus (HPV)	1,872	2,424
Meningococcal ACWY (MenACWY)	1,619	2,280
MMR (Measles, Mumps, Rubella)	3,817	3,439
Pneumococcal (PCV13)	8,128	6,871
Polio (IPV)	153	213
RV (Rotavirus)	4,998	4,462
TDAP (Tetanus, Diphtheria, Pertussis)	1,667	1,970
Varicella Virus Vaccine (VAR)	2,435	1,849

iowa total care

	SFY20 Q4	SFY21 Q4
Hearing Screenings	799	1,186
Infancy < 1	107	119
Early Childhood 1 - 4	350	494
Middle Childhood 5 - 11	247	394
Adolescence 12 - 21	95	179
Vision Screenings	438	1,015
Infancy < 1	19	28
Early Childhood 1 - 4	245	569
Middle Childhood 5 - 11	133	312
Adolescence 12 - 21	41	106

Immunization Summary - 21 & Under

Vaccination Totals	28,088	38,900
COVID-19 Dose 1	0	2,273
COVID-19 Dose 2	0	1,939
COVID-19 Single-Dose	0	40
DTaP (Diphtheria, Tetanus, Pertussis)	6,702	7,247
Influenza (FLU)	596	673
HepA (Hepatitis A)	2,274	3,101
HepB (Hepatitis B)	772	710
Haemophilus Influenza Type B (Hib)	1,234	4,080
Human Papillomavirus (HPV)	1,223	1,702
Meningococcal ACWY (MenACWY)	1,008	1,453
MMR (Measles, Mumps, Rubella)	1,843	2,604
Pneumococcal (PCV13)	5,868	6,019
Polio (IPV)	139	132
RV (Rotavirus)	4,255	3,972
TDAP (Tetanus, Diphtheria, Pertussis)	1,114	1,346
Varicella Virus Vaccine (VAR)	1,060	1,609

Non-LTSS Care Coordination and HCBS Case Management

Amerigroup
An Anthem Company

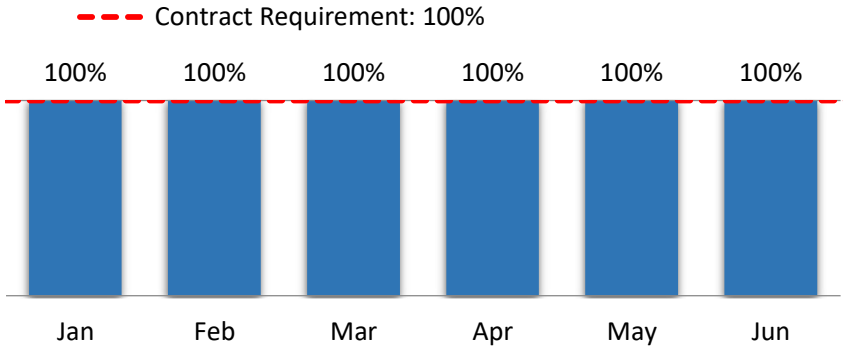
Average Number of Contacts Per Month	SFY21 Q3	SFY21 Q4
by Care Coordinators	0.8	**0.9**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	27	**34**
HCBS Members to Case Managers	67	**65**

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.

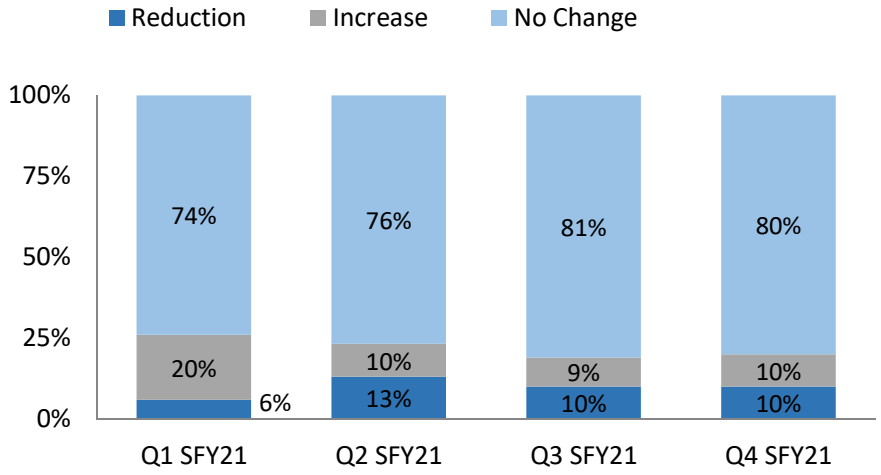
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q3	SFY21 Q4
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	0.6%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.4%	100.0%
Their services make their lives better.	I don't know	0.3%	0.9%
	No	0.6%	0.3%
	Sometimes	2.3%	0.0%
	Yes	96.8%	98.8%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

iowa total care

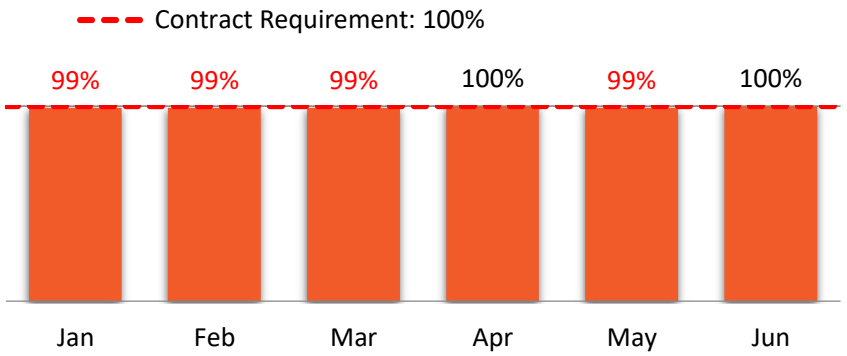
Average Number of Contacts Per Month	SFY21 Q3	SFY21 Q4
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	25	**47**
HCBS Members to Case Managers	41	**41**

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

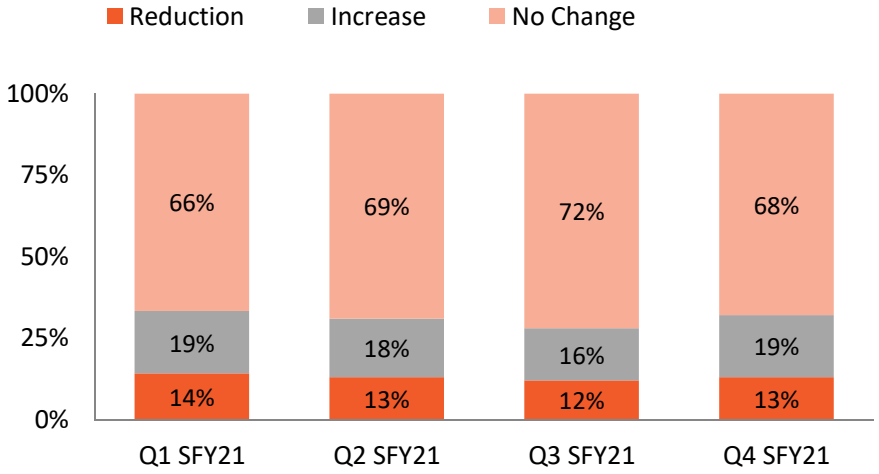
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q3	SFY21 Q4
They were part of service planning.	I don't know	0.4%	0.0%
	No	1.8%	1.4%
	Sometimes	1.8%	0.4%
	Yes	96.0%	98.2%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.4%	1.4%
	Sometimes	1.1%	0.4%
	Yes	98.5%	98.2%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.4%	1.4%
	Sometimes	2.6%	0.7%
	Yes	97.1%	97.8%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

	SFY21 Q3	SFY21 Q4
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	15	15
CDAC (individual) by 15 minute units	3	3
CDAC (agency) by 15 minute units	0	3
Homemaker (by 15 minute units)	1	0
Brain Injury (BI) Waivers	818	814
Financial Management Services	233	234
Supported Community Living (by unit)	198	178
Respite (by 15 minute units)	163	167
Personal Emergency Response	161	162
Supported Community Living (daily)	110	107
Children's Mental Health (CMH)	863	840
Respite (by 15 minute units)	436	415
Respite (Hos/NF) - 15 minute units	231	223
Family and Community Support	223	218
Respite (Resident Camp) by units	13	11
Home Delivered Meals	6	4
Elderly Waivers	4,703	4,637
Personal Emergency Response	3,009	2,920
Home Delivered Meals	3,049	2,903
CDAC (agency) by 15 minute units	225	461
Assisted Living Services	392	363
Personal Emergency Response (install)	306	285

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	SFY21 Q3	SFY21 Q4
Habilitation (Hab)	4,578	4,498
Home-based Habilitation	3,936	3,870
Long Term Job Coaching	360	393
Day Habilitation (units by day)	345	373
Individual Supported Employment	164	165
Day Habilitation (by 15 minute units)	130	131
Health & Disability (HD)	1,353	1,384
Financial Management Services	354	353
Respite (by 15 minute units)	353	345
Personal Emergency Response	332	318
Home Delivered Meals	329	306
Respite (Hos/NF) - 15 minute units	65	66
Intellectual Disability (ID)	7,065	7,053
Supported Community Living (by unit)	1,828	1,785
Financial Management Services	1,382	1,388
Day Habilitation (units by day)	1,439	1,363
Supported Community Living (RCF)	1,136	1,249
Supported Community Living (daily)	1,430	1,242
Physical Disability (PD)	694	681
Personal Emergency Response	370	355
CDAC (agency) by 15 minute units	33	88
CDAC (individual) by 15 minute units	41	58
Home Delivered Meals	45	42
Financial Management Services	31	35

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

	SFY21 Q3	SFY21 Q4
AIDS/HIV - Unique Service Plans	9	10
Home Delivered Meals	8	7
CDAC (individual) by 15 minute units	5	4
Homemaker (by 15 minute units)	2	2
Brain Injury (BI) Waivers	531	527
Supported Community Living (by unit)	235	229
Respite (by 15 minute units)	151	145
Personal Emergency Response	129	129
Supported Community Living (daily)	124	124
CDAC (agency) by 15 minute units	89	87
Children's Mental Health (CMH)	353	352
Respite (by 15 minute units)	206	201
Respite (Hos/NF) - 15 minute units	125	131
Family and Community Support	108	102
Mental Health Service	36	38
Respite (Resident Camp) by units	4	2
Elderly Waivers	3,275	3,285
Home Delivered Meals	2,672	2,432
Personal Emergency Response	2,611	2,393
CDAC (agency) by 15 minute units	1,399	1,284
Homemaker (by 15 minute units)	922	830
CDAC (individual) by 15 minute units	765	695

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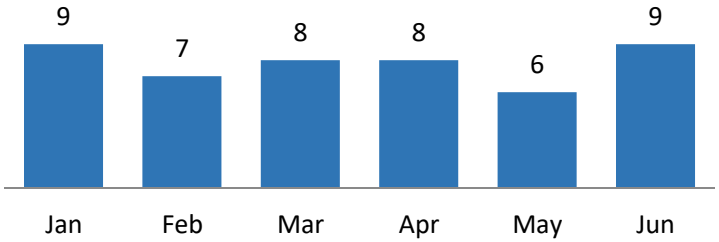
	SFY21 Q3	SFY21 Q4
Habilitation (Hab)	2,350	2,353
Home-based Habilitation	1,932	1,906
Day Habilitation (by 15 minute units)	349	341
Day Habilitation (units by day)	271	276
Long Term Job Coaching	259	256
Individual Supported Employment	155	140
Health & Disability (HD)	626	639
Respite (by 15 minute units)	294	286
Home Delivered Meals	181	169
Personal Emergency Response	170	154
CDAC (individual) by 15 minute units	127	118
CDAC (agency) by 15 minute units	109	112
Intellectual Disability (ID)	4,478	4,488
Supported Community Living (by unit)	1,931	1,854
Day Habilitation (by 15 minute units)	1,851	1,828
Day Habilitation (units by day)	1,729	1,673
Supported Community Living (RCF)	1,390	1,325
Respite (by 15 minute units)	1,075	1,039
Physical Disability (PD)	395	375
Personal Emergency Response	231	212
CDAC (agency) by 15 minute units	187	176
CDAC (individual) by 15 minute units	142	132
Transportation (1-way trip)	47	41
Personal Emergency Response (install)	20	15

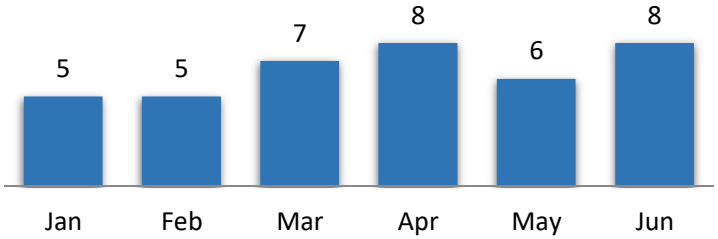
Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	93.10%	89.83%	95.93%
Abandonment Rate - Must be 5% or less	0.81%	0.73%	0.83%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	96.04%	96.68%	93.75%
Abandonment Rate - Must be 5% or less	0.11%	0.17%	0.34%
Provider Helpline			
Service Level (Requirement 80%)	90.05%	83.11%	83.38%
Abandonment Rate - Must be 5% or less	1.01%	1.37%	0.92%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	80.09%	88.65%	71.06%
Abandonment Rate - Must be 5% or less	3.62%	2.53%	3.60%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

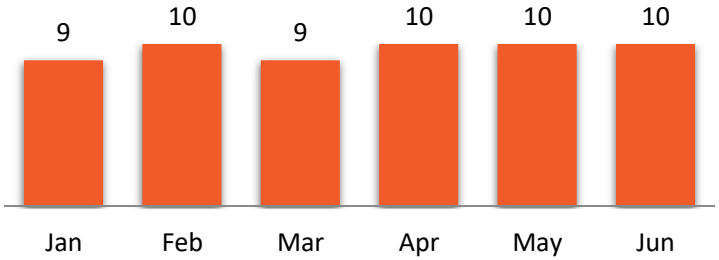
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Claim Inquiry
5.	Transportation Inquiry

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

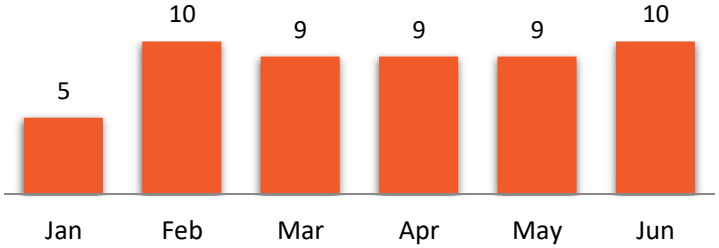
Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	82.13%	81.90%	82.16%
Abandonment Rate - Must be 5% or less	3.97%	3.77%	3.12%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	89.26%	93.64%	87.55%
Abandonment Rate - Must be 5% or less	2.96%	2.87%	2.97%
Provider Helpline			
Service Level (Requirement 80%)	85.63%	86.23%	83.32%
Abandonment Rate - Must be 5% or less	2.61%	2.55%	2.51%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	90.96%	91.57%	93.45%
Abandonment Rate - Must be 5% or less	2.03%	1.03%	0.76%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	89.86%	88.48%	74.54%
Abandonment Rate - Must be 5% or less	2.04%	2.32%	3.66%

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 Address for Member
3.	Coordination Of Benefits for Member
4.	Update PCP/PPG for Member
5.	Member Rewards for Member

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

Provider Network Access Summary

Primary Care Providers (PCP)

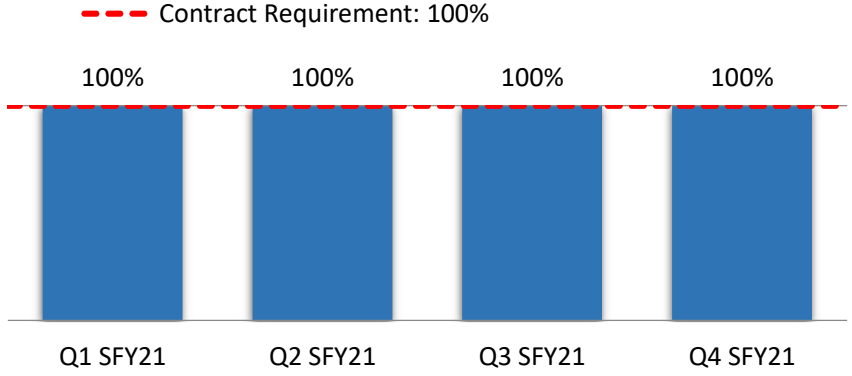
	SFY21 Q3	SFY21 Q4
Adults PCP		
Provider Count	6,672	6,632
Members with Access	219,428	224,574
Average Distance (Miles)	1.9	1.8
Pediatric PCP		
Provider Count	6,707	6,666
Members with Access	209,553	211,406
Average Distance (Miles)	2.0	2.0

Specialty Care & Behavioral Health (BH)

	SFY21 Q3	SFY21 Q4
OB/GYN Adult		
Provider Count	403	402
Members with Access	142,865	146,051
Average Distance (Miles)	5.7	5.6
Outpatient - Behavioral Health		
Provider Count	4,137	4,205
Members with Access	428,981	435,980
Average Distance (Miles)	2.3	2.3
Inpatient - Behavioral Health		
Provider Count	48	50
Rural Members		
Members with Access	175,907	178,368
Average Distance (Miles)	21.4	21.4
Urban Members		
Members with Access	253,074	257,612
Average Distance (Miles)	5.8	5.8

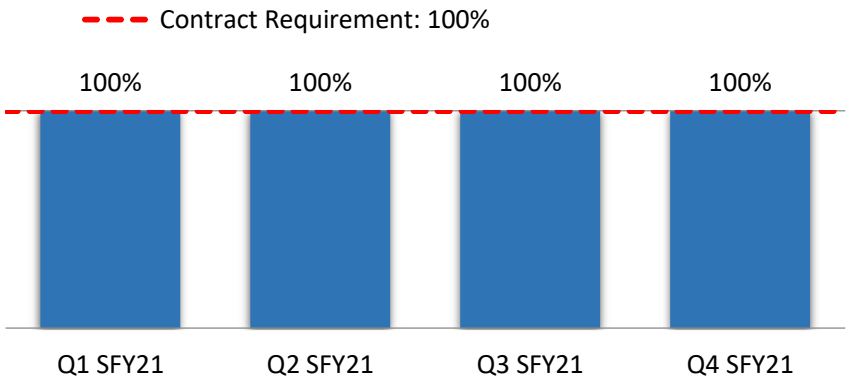
Adult PCP - Time Standards

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)

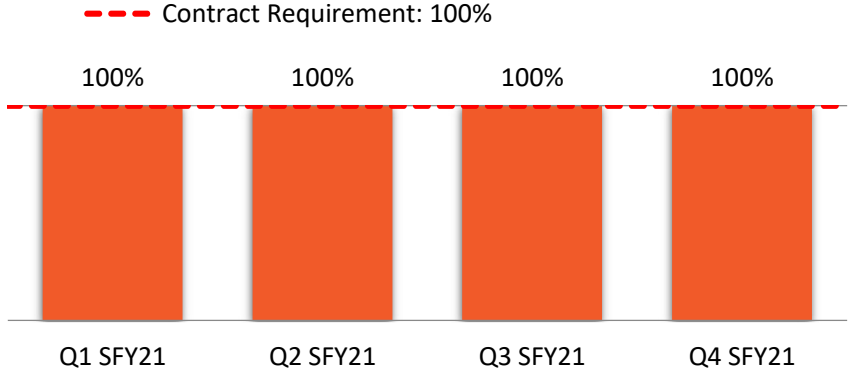
	SFY21 Q3	SFY21 Q4
Adults PCP		
Provider Count	9,085	9,704
Members with Access	166,971	171,647
Average Distance (Miles)	2.0	2.0
Pediatric PCP		
Provider Count	9,820	10,472
Members with Access	138,828	140,406
Average Distance (Miles)	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY21 Q3	SFY21 Q4
OB/GYN Adult		
Provider Count	1,234	1,286
Members with Access	110,381	113,317
Average Distance (Miles)	5.4	5.4
Outpatient - Behavioral Health		
Provider Count	8,737	9,476
Members with Access	305,799	312,053
Average Distance (Miles)	2.5	2.5
Inpatient - Behavioral Health		
Provider Count	36	36
Rural Members		
Members with Access	218,902	223,411
Average Distance (Miles)	24.6	24.6
Urban Members		
Members with Access	86,897	88,642
Average Distance (Miles)	8.4	8.4

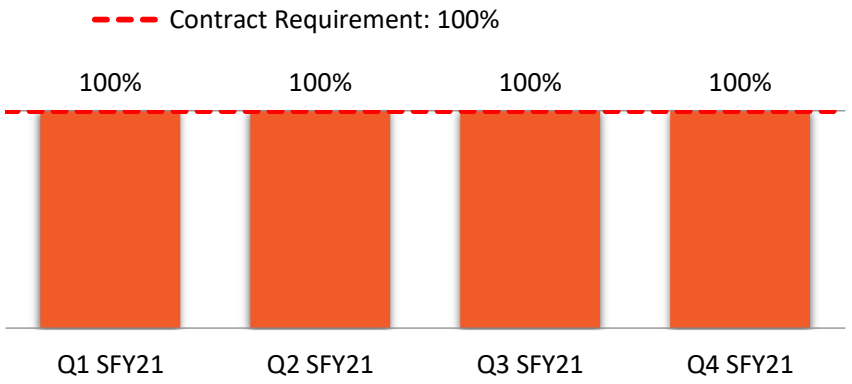
Adult PCP - Time Standards

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

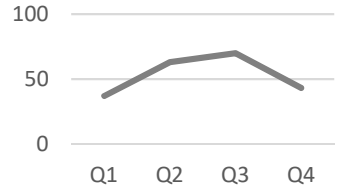
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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 Q4

43



18 Total Cases
Referred to MCFU

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Program Integrity
- Fraud, Waste, & Abuse

	SFY21 Q3	SFY21 Q4
Investigations opened	42	33
Overpayments identified	10	23
Member concerns referred to IME	4	2
Cases referred to the Medicaid Fraud Control Unit (MCFU)	2	6

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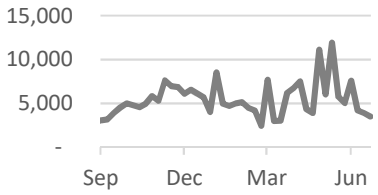
Program Integrity
- Fraud, Waste, & Abuse

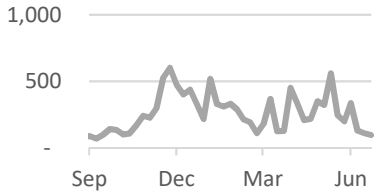
	SFY21 Q3	SFY21 Q4
Investigations opened	28	10
Overpayments identified	0	6
Member concerns referred to IME	6	10
Cases referred to the Medicaid Fraud Control Unit (MCFU)	2	12

MCO COVID-19 Summary

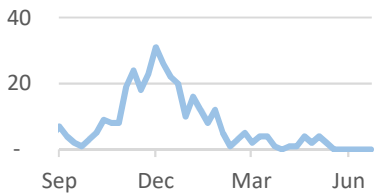
Total Individuals Tested
277,746



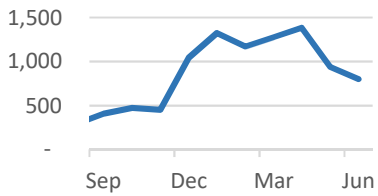
Total Tested Positive
12,449



Total COVID Deaths [13]
470



Total COVID Inpatient Stays
10,156



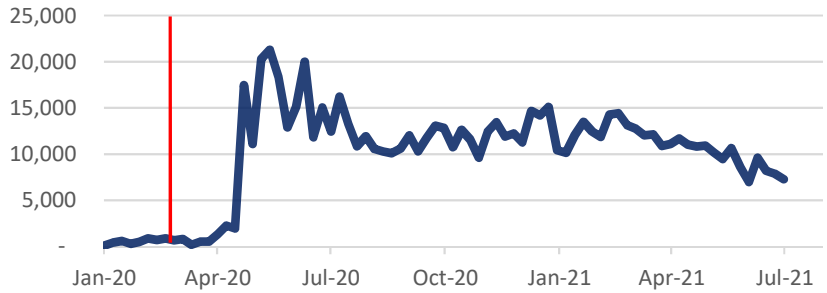
78,246 tested in Q4	4.5%	0.06%	2.24%
18% Increase	% Tested Positive	% of MCO Population	% of Total Inpatient Stays

COVID-19 testing and treatment is a covered benefit for Medicaid members. Total test counts reflect multiple tests for some individuals. In Q3, ITC updated logic used to evaluate COVID deaths which lead to the adjustment of previously reported COVID deaths. [13]

Claims Activity During COVID-19

MCO Total Counts	SFY21 Q3	SFY21 Q4
ER Visits - Counts	**246,919**	**292,943**
Amount Paid	$49.78 M	$61.74 M
Telehealth Services - Counts	**160,751**	**123,258**
Amount Paid	$13.22 M	$10.26 M
Transportation - Counts	**217,091**	**234,465**
Amount Paid	$9.23 M	$10.28 M
Home Maker Services - Counts	**18,361**	**28,440**
Amount Paid	$1.58 M	$928 k
COVID Testing - Counts	**66,033**	**78,246**
Amount Paid	$6.1 M	$6.02 M
Meals - Counts	**19,785**	**18,782**
Amount Paid	$4.84 M	$5.17 M

Telehealth Services - Weekly MCO Counts



o In March 2020, 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.

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

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

Dual: Members who have both Medicare and Medicaid benefits.

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

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

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

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

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

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

Grievance (continued…):

- Rights and dignity
- Member is commended changes in policies and services
- Any other access to care issues

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

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

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

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.

Monthly Capitation Expenditures: See Capitation Expenditures

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

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

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

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

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

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

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

Provider Adjustment Requests and Errors Reprocessed: See Claims

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

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

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

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

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

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

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

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

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

Value Added Services (**VAS**): Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

- **Taking Care of Baby and Me®** (**AGP**): It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

- **My Health Pays** (**ITC**): This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

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

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

Waiver Service Plan: See Service Plan

Department of HUMAN SERVICES

Telehealth Code Set Rationale and Assumptions

The short list of telehealth codes to consider for continuation post public health emergency (PHE) took into consideration several factors. Lists were created with all IME codes approved for telehealth pre PHE and Centers for Medicare and Medicaid Services (CMS) approved telehealth codes pre PHE and those approved for telehealth during the PHE. Then claims data from January 1, 2020, to December 31, 2021, was cross-referenced to examine how the network was using each code.

The Quality Improvement Organization (QIO) Medical Director and other team members then considered each code based on whether the same level of care could be provided virtually, it enhanced the care or quality, or increased access for the member. The Medical Director's recommendation was fairly conservative and based on the belief that this is a fluid list, and that data and evidence will continue to emerge in support of opening other codes. In addition, new requests from the network will emerge.

The proposed list was then run by the Managed Care Organization (MCO) Medical Directors and members of the Clinical Advisory Committee (CAC) as individual contributors. Home- and Community-Based Services (HCBS) policy looked specifically at the HCBS codes and made recommendations for continuation post PHE.

In addition, articles and presentations from experts were considered, as well as feedback from the provider network. The proposed list only contains codes that the Department is putting forward for continued coverage post PHE.

The QIO has a dedicated email for questions, concerns, or additional requests around telehealth: IME_telehealth@dhs.state.ia.us.

Department of HUMAN SERVICES

ia health link

Telehealth Pre COVID

Procedure Code	Description
90785	Interactive complexity (List separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90951	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90952	End-stage renal disease (ESRD) related services monthly, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90954	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90955	End-stage renal disease (ESRD) related services monthly, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90957	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 4 or more face-to-face visits by a physician or other qualified health care professional per month

90958	End-stage renal disease (ESRD) related services monthly, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of parents; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90960	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 4 or more face-to-face visits by a physician or other qualified health care professional per month
90961	End-stage renal disease (ESRD) related services monthly, for patients 20 years of age and older; with 2-3 face-to-face visits by a physician or other qualified health care professional per month
90963	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients younger than 2 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of patients
90964	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 2-11 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of patients
90965	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 12-19 years of age to include monitoring for the adequacy of nutrition, assessment of growth and development, and counseling of patients
90966	End-stage renal disease (ESRD) related services for home dialysis per full month, for patients 20 years of age and older
90967	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients younger than 2 years of age
90968	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 2-11 years of age
90969	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 12-19 years of age
90970	End-stage renal disease (ESRD) related services for dialysis less than a full month of service, per day; for patients 20 years of age and older
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)

96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision-making)
96158	Health behavior intervention, individual, face-to-face; initial 30 minutes
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
97802	Medical nutrition therapy; initial assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97803	Medical nutrition therapy; re-assessment and intervention, individual, face-to-face with the patient, each 15 minutes
97804	Medical nutrition therapy; initial assessment and intervention, group (2 or more individual(s)), each 30 minutes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.

99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.
99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.

99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99354	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; first hour (List separately in addition to code for outpatient Evaluation and Management or psychotherapy service, except with office or other outpatient serviecs [99202, 99203, 99204, 99205, 99212, 99213, 99214, 99215])
99355	Prolonged service(s) in the outpatient setting requiring direct patient contact beyond the time of the usual service; each additional 30 minutes (List searately in addition to code for prolonged service)
99356	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; first hour (List separately in addition to code for inpatient or observation Evaluation and Management service)

99357	Prolonged service in the inpatient or observation setting, requiring unit/floor time beyond the usual service; each additional 30 minutes (List separately in addition to code for prolonged service)
99407	Smoking and tobacco use cessation counseling visit, intermediate, greater than 3 minutes up to 10 minutes
99497	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; first 30 minutes, face-to-face with the patient, family member(s), and/or surrogate
99498	Advance care planning including the explanation and discussion of advance directives such as standard forms (with completion of such forms, when performed), by the physician or other qualified health care professional; each additional 30 minutes (List separately in addition to code for primary procedure)
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0109	Diabetes outpatient self-management trainng services, group session (two or more), per 30 minutes
G0270	Medical nutrition therapy; reassessment and subsequent intervention(s) following second referral in same year for change in diagnosis, medical condition or treatment regimen (including additional hours needed for renal disease), individual, face-to-face with the patient, each 15 minutes
G0438	Annual wellness visit, includes a personalized prevention plan of service (PPS), initial visit
G0439	Annual wellness visit, includes a personalized prevention plan of service (PPS), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0443	Brief face-to-face behavioral counseling for alcohol misuse, 15 minutes
G0444	Annual depression screening, 15 minutes
G0445	Semiannual high intensity behavioral counseling to prevent STIs , individual, face-to-face, includes education skills training & guidance on how to change sexual behavior
G0446	Annual, face-to-face intensive behavioral therapy for cardiovascular disease, individual, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0506	Comprehensive assessment of and care planning for patients requiring chronic care management serviecs (List separately in addition to primary monthly care management service)

Department of HUMAN SERVICES

ia health link

Post COVID Clinical Additions

Procedure Code	Description
90785	Interactive complexity (List separately in addition to the code for primary procedure)
90791	Psychiatric diagnostic evaluation
90792	Psychiatric diagnostic evaluation with medical services
90832	Psychotherapy, 30 minutes with patient
90833	Psychotherapy, 30 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90834	Psychotherapy, 45 minutes with patient
90836	Psychotherapy, 45 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90837	Psychotherapy, 60 minutes with patient
90838	Psychotherapy, 60 minutes with patient when performed with an evaluation and management service (List separately in addition to the code for primary procedure)
90839	Psychotherapy for crisis; first 60 minutes
90840	Psychotherapy for crisis; each additional 30 minutes (List separately in addition to code for primary service)
90846	Family psychotherapy (without the patient present), 50 minutes
90847	Family psychotherapy (conjoint psychotherapy) (with patient present), 50 minutes
90849	Multiple-family group psychotherapy
90853	Group psychotherapy (other than of a multiple-family group)
90863	Pharmacologic management, including prescription and review of medication, when performed with psychotherapy services (List separately in addition to the code for primary procedure)
92526	Treatment of swallowing dysfunction and/or oral function for feeding
92609	Therapeutic services for the use of speech-generating device, including programming and modification
95251	Ambulatory continuous glucose monitoring of interstitial tissue fluid via a subcutaneous sensor for a minimum of 72 hours; analysis, interpretation and report
95984	Electronic analysis of implanted neurostimulator pulse generator/transmitter (eg, contact group[s], interleaving, amplitude, pulse width, frequency [Hz], on/off cycling, burst, magnet mode, dose lockout, patient selectable parameters, responsive neurostimulation, detection algorithms, closed loop parameters, and passive parameters) by physician or other qualified health care professional; with brain neurostimulator pulse generator/transmitter programming, each additional 15 minutes face-to-face time with physician or other qualified health care professional (List separately in addition to code for primary procedure)

96110	Developmental screening (eg, developmental milestone survey, speech and language delay screen), with scoring and documentation, per standardized instrument
96116	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; first hour
96121	Neurobehavioral status exam (clinical assessment of thinking, reasoning and judgment, [eg, acquired knowledge, attention, language, memory, planning and problem solving, and visual spatial abilities]), by physician or other qualified health care professional, both face-to-face time with the patient and time interpreting test results and preparing the report; each additional hour (List separately in addition to code for primary procedure)
96125	Standardized cognitive performance testing (eg, Ross Information Processing Assessment) per hour of a qualified health care professional's time, both face-to-face time administering tests to the patient and time interpreting these test results and preparing the report
96127	Brief emotional/behavioral assessment (eg, depression inventory, attention-deficit/hyperactivity disorder [ADHD] scale), with scoring and documentation, per standardized instrument
96130	Psychological testing evaluation services by physician or other qualified health care professional, including integration of patient data, interpretation of standardized test results and clinical data, clinical decision making, treatment planning and report, and interactive feedback to the patient, family member(s) or caregiver(s), when performed; first hour
96156	Health behavior assessment, or re-assessment (ie, health-focused clinical interview, behavioral observations, clinical decision making)
96159	Health behavior intervention, individual, face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96160	Administration of patient-focused health risk assessment instrument (eg, health hazard appraisal) with scoring and documentation, per standardized instrument
96161	Administration of caregiver-focused health risk assessment instrument (eg, depression inventory) for the benefit of the patient, with scoring and documentation, per standardized instrument
96164	Health behavior intervention, group (2 or more patients), face-to-face; initial 30 minutes
96165	Health behavior intervention, group (2 or more patients), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
96167	Health behavior intervention, family (with the patient present), face-to-face; initial 30 minutes
96168	Health behavior intervention, family (with the patient present), face-to-face; each additional 15 minutes (List separately in addition to code for primary service)
97153	Adaptive behavior treatment by protocol, administered by technician under the direction of a physician or other qualified health care professional, face-to-face with one patient, each 15 minutes

97156	Family adaptive behavior treatment guidance, administered by physician or other qualified health care professional (with or without the patient present), face-to-face with guardian(s)/caregiver(s), each 15 minutes
99202	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 15-29 minutes of total time is spent on the date of the encounter.
99203	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 30-44 minutes of total time is spent on the date of the encounter.
99204	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 45-59 minutes of total time is spent on the date of the encounter.
99205	Office or other outpatient visit for the evaluation and management of a new patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 60-74 minutes of total time is spent on the date of the encounter.
99211	Office or other outpatient visit for the evaluation and management of an established patient, that may not require the presence of a physician or other qualified health care professional. Usually, the presenting problem(s) are minimal.
99212	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and straightforward medical decision making. When using time for code selection, 10-19 minutes of total time is spent on the date of the encounter.
99213	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and low level of medical decision making. When using time for code selection, 20-29 minutes of total time is spent on the date of the encounter.
99214	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and moderate level of medical decision making. When using time for code selection, 30-39 minutes of total time is spent on the date of the encounter.
99215	Office or other outpatient visit for the evaluation and management of an established patient, which requires a medically appropriate history and/or examination and high level of medical decision making. When using time for code selection, 40-54 minutes of total time is spent on the date of the encounter.

99231	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering or improving. Typically, 15 minutes are spent at the bedside and on the patient's hospital floor or unit.
99232	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 25 minutes are spent at the bedside and on the patient's hospital floor or unit.
99233	Subsequent hospital care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is unstable or has developed a significant complication or a significant new problem. Typically, 35 minutes are spent at the bedside and on the patient's hospital floor or unit.
99238	Hospital discharge day management; 30 minutes or less
99239	Hospital discharge day management; more than 30 minutes
99281	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A problem focused history; A problem focused examination; and Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor.
99282	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity.

99283	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: An expanded problem focused history; An expanded problem focused examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate severity.
99284	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components: A detailed history; A detailed examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity, and require urgent evaluation by the physician, or other qualified health care professionals but do not pose an immediate significant threat to life or physiologic function.
99285	Emergency department visit for the evaluation and management of a patient, which requires these 3 key components within the constraints imposed by the urgency of the patient's clinical condition and/or mental status: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of high severity and pose an immediate significant threat to life or physiologic function.
99291	Critical care, evaluation and management of the critically ill or critically injured patient; first 30-74 minutes
99304	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A detailed or comprehensive history; A detailed or comprehensive examination; and Medical decision making that is straightforward or of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of low severity. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99305	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of moderate severity. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.

99306	Initial nursing facility care, per day, for the evaluation and management of a patient, which requires these 3 key components: A comprehensive history; A comprehensive examination; and Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the problem(s) requiring admission are of high severity. Typically, 45 minutes are spent at the bedside and on the patient's facility floor or unit.
99307	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is stable, recovering, or improving. Typically, 10 minutes are spent at the bedside and on the patient's facility floor or unit.
99308	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient is responding inadequately to therapy or has developed a minor complication. Typically, 15 minutes are spent at the bedside and on the patient's facility floor or unit.
99309	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the patient has developed a significant complication or a significant new problem. Typically, 25 minutes are spent at the bedside and on the patient's facility floor or unit.
99310	Subsequent nursing facility care, per day, for the evaluation and management of a patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 35 minutes are spent at the bedside and on the patient's facility floor or unit.
99315	Nursing facility discharge day management; 30 minutes or less

99316	Nursing facility discharge day management; more than 30 minutes
99334	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self-limited or minor. Typically, 15 minutes are spent with the patient and/or family or caregiver.
99335	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent with the patient and/or family or caregiver.
99336	Domiciliary or rest home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. Typically, 40 minutes are spent with the patient and/or family or caregiver.
99347	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A problem focused interval history; A problem focused examination; Straightforward medical decision making. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are self limited or minor. Typically, 15 minutes are spent face-to-face with the patient and/or family.
99348	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: An expanded problem focused interval history; An expanded problem focused examination; Medical decision making of low complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of low to moderate severity. Typically, 25 minutes are spent face-to-face with the patient and/or family.

99349	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A detailed interval history; A detailed examination; Medical decision making of moderate complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are moderate to high severity. Typically, 40 minutes are spent face-to-face with the patient and/or family.
99350	Home visit for the evaluation and management of an established patient, which requires at least 2 of these 3 key components: A comprehensive interval history; A comprehensive examination; Medical decision making of moderate to high complexity. Counseling and/or coordination of care with other physicians, other qualified health care professionals, or agencies are provided consistent with the nature of the problem(s) and the patient's and/or family's needs. Usually, the presenting problem(s) are of moderate to high severity. The patient may be unstable or may have developed a significant new problem requiring immediate physician attention. Typically, 60 minutes are spent face-to-face with the patient and/or family.
99421	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 5-10 minutes
99422	Online digital evaluation and management service, for an established patient, for up to 7 days, cumulative time during the 7 days; 11-20 minutes
99441	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion
99442	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 11-20 minutes of medical discussion
99443	Telephone evaluation and management service by a physician or other qualified health care professional who may report evaluation and management services provided to an established patient, parent, or guardian not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 21-30 minutes of medical discussion

99451	Interprofessional telephone/Internet/electronic health record assessment and management service provided by a consultative physician, including a written report to the patient's treating/requesting physician or other qualified health care professional, 5 minutes or more of medical consultative time
99457	Remote physiologic monitoring treatment management services, clinical staff/physician/other qualified health care professional time in a calendar month requiring interactive communication with the patient/caregiver during the month; first 20 minutes
99483	Assessment of and care planning for a patient with cognitive impairment, requiring an independent historian, in the office or other outpatient, home or domiciliary or rest home, with all of the following required elements: Cognition-focused evaluation including a pertinent history and examination; Medical decision making of moderate or high complexity; Functional assessment (eg, basic and instrumental activities of daily living), including decision-making capacity; Use of standardized instruments for staging of dementia (eg, functional assessment staging test [FAST], clinical dementia rating [CDR]); Medication reconciliation and review for high-risk medications; Evaluation for neuropsychiatric and behavioral symptoms, including depression, including use of standardized screening instrument(s); Evaluation of safety (eg, home), including motor vehicle operation; Identification of caregiver(s), caregiver knowledge, caregiver needs, social supports, and the willingness of caregiver to take on caregiving tasks; Development, updating or revision, or review of an Advance Care Plan; Creation of a written care plan, including initial plans to address any neuropsychiatric symptoms, neuro-cognitive symptoms, functional limitations, and referral to community resources as needed (eg, rehabilitation services, adult day programs, support groups) shared with the patient and/or caregiver with initial education and support. Typically, 50 minutes are spent face-to-face with the patient and/or family or caregiver.
99510	Home visit for individual, family, or marriage counseling
G0108	Diabetes outpatient self-management training services, individual, per 30 minutes
G0439	Annual wellness visit, includes a personalized prevention plan of service (pps), subsequent visit
G0442	Annual alcohol misuse screening, 15 minutes
G0444	Annual depression screening, 15 minutes
G0447	Face-to-face behavioral counseling for obesity, 15 minutes
G0463	Hospital outpatient clinic visit for assessment and management of a patient
G2012	Brief communication technology-based service, e.g. virtual check-in, by a physician or other qualified health care professional who can report evaluation and management services, provided to an established patient, not originating from a related E/M service provided within the previous 7 days nor leading to an E/M service or procedure within the next 24 hours or soonest available appointment; 5-10 minutes of medical discussion

G2025	Payment for a telehealth distant site service furnished by a rural health clinic (RHC) or federally qualified health center (FQHC) only
G2212	Prolonged office or other outpatient evaluation and management service(s) beyond the maximum required time of the primary procedure which has been selected using total time on the date of the primary service; each additional 15 minutes by the physician or qualified healthcare professional, with or without direct patient contact (list separately in addition to CPT codes 99205, 99215 for office or other outpatient evaluation and management services) (do not report G2212 on the same date of service as 99354, 99355, 99358, 99359, 99415, 99416). (do not report G2212 for any time unit less than 15 minutes)
G9012	Other specified case management service not elsewhere classified
H0031	Mental health assessment, by non-physician
H0032	Mental health service plan development by non-physician
H0038	Self-help/peer services, per 15 minutes
H0046	Mental health services, not otherwise specified
H0049	Alcohol and/or drug screening
H1003	Prenatal care, at-risk enhanced service; education
H2010	Comprehensive medication services, per 15 minutes
H2011	Crisis intervention service, per 15 minutes
Q3014	Telehealth originating site facility fee
T1013	Sign language or oral interpretive services, per 15 minutes
T1015	Clinic visit/encounter, all-inclusive

Post COVID HCBS Additions

Procedure Code	Description
T1016	Case management, each 15 minutes
T1017	Targeted case management, each 15 minutes
T1027	Family training and counseling for child development, per 15 minutes