



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

Managed Care Organization (MCO)
Quarterly Performance Report
SFY2022, Quarter 4
(April - June 2022)

Published September 2022

Contents

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

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

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Executive Summary

This report is based on Quarter 4 of State Fiscal Year (SFY) 2022 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

Notes about the reported data:

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

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

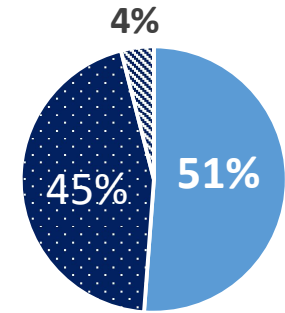
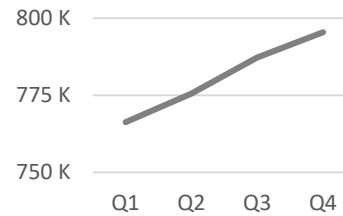
MCO Member Summary - All MCO Counts

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

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

All MCO Members

795,507



■ 0-21 ■ 22-64 ■ 65+

+ 8,320 Members
1.06% Increase

All MCO Enrollment
(by Age)

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

	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Distinct
MCO Member Summary - Overall Counts	766,267	775,507	787,187	795,507	781,117	832,477
0-21	397,383	400,213	404,569	407,098	402,316	423,377
22-64	338,971	345,001	351,867	356,845	348,171	373,361
65+	29,913	30,293	30,751	31,564	30,630	35,739
Fee-For-Service (FFS) - Non MCO Enrollees	45,062	46,254	46,896	47,940	46,538	51,721
Significant Change in Data? (+/-)	No <input checked="" type="checkbox"/>	Yes <input type="checkbox"/>			Iowa Medicaid Population	884,198
<i>If Yes, explain:</i>					1 year distinct count	

MCO Member Summary



SFY22 Q3 SFY22 Q4

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



SFY22 Q3 SFY22 Q4

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

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

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

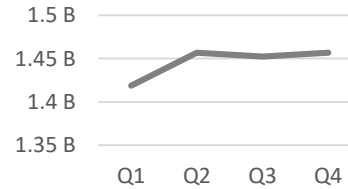
¹ Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24. ² Facility Based Services listed above only include the institutional groups where members are most likely to have an option to transition to an HCBS setting. Excluded institution types include Hospice (AGP 419; ITC 388). ³ Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). ⁴ Psychiatric Medical Institutions for Children (PMIC)

MCO Financial Summary - All MCO Counts

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

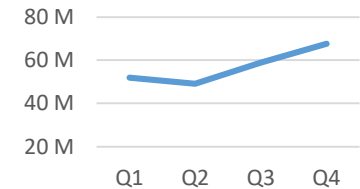
The MCOs are responsible for recovering Medicaid dollars when it is determined that other insurance coverage is available (e.g. health, auto, worker's comp, or even Medicare). This process is known as Third Party Liability (TPL). The MCO retains all recovered TPL funds: however, these funds are then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

All Capitation Payments
\$1.45 Billion



+ \$4.6 Million
0.32% Increase

Third Party Liability Recovered
\$58.94 Million



+ \$ 8.7 Million
14.83% increase

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

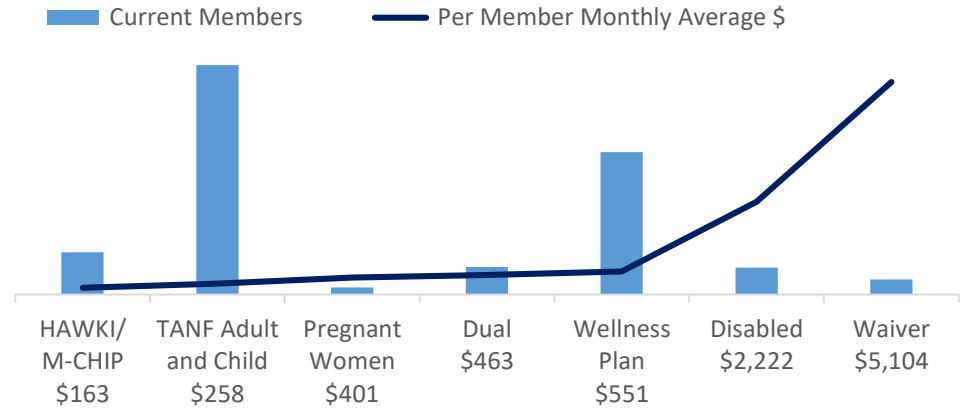
	SFY22 Q1	SFY22 Q2	SFY22 Q3	SFY22 Q4	Average	Total
Financial Summary						
Capitation Payments	\$1.42 B	\$1.46 B	\$1.45 B	\$1.46 B	\$1.45 B	\$5.79 B
Third Party Liability (TPL) Recovered	\$51.95 M	\$49.17 M	\$58.94 M	\$67.67 M	\$56.93 M	\$227.73 M
Significant Change in Data? (+/-)	No <input checked="" type="checkbox"/>		Yes <input type="checkbox"/>			
<i>If Yes, explain:</i>	<div style="border: 1px solid black; padding: 10px; min-height: 100px;"> <p>o TPL increased by \$8.7M or 14.83% between Q3 and Q4.</p> </div>					

MCO Financial Summary

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

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

Monthly Capitation Expenditures



SFY22 Q3 SFY22 Q4



SFY22 Q3 SFY22 Q4

Capitation Totals	\$841.06 M	\$843.74 M
Adjustments	-\$0.22 M	\$0.57 M
Current	\$822.18 M	\$823.45 M
Retro	\$19.1 M	\$19.72 M
Third Party Liability (TPL) Recovered	\$22.91 M	\$28.23 M
Financial Ratios		
Medical Loss Ratio (MLR)	89.9%	93.9%
Administrative Loss Ratio (ALR)	5.4%	5.5%
Underwriting Ratio (UR)	4.7%	0.6%
	Annual MLR⁵	90.0%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	Y

Capitation Totals	\$611.36 M	\$613.33 M
Adjustments	-\$0.82 M	-\$0.02 M
Current	\$588.32 M	\$594.66 M
Retro	\$23.87 M	\$18.68 M
Third Party Liability (TPL) Recovered	\$36.03 M	\$39.45 M
Financial Ratios		
Medical Loss Ratio (MLR)	95.1%	94.2%
Administrative Loss Ratio (ALR)	3.8%	7.6%
Underwriting Ratio (UR)	1.1%	-1.8%
	Annual MLR⁵	93.3%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	Y

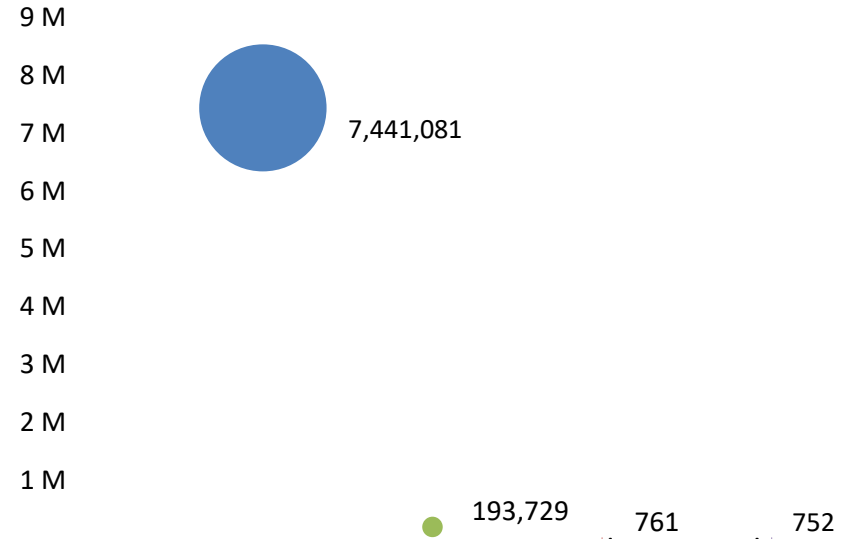
⁵ Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

MCO Claims Universe - All MCO Counts

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

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

- All Rx and NonRx Claims
- Grievances
- Prior Authorizations
- Appeals



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

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

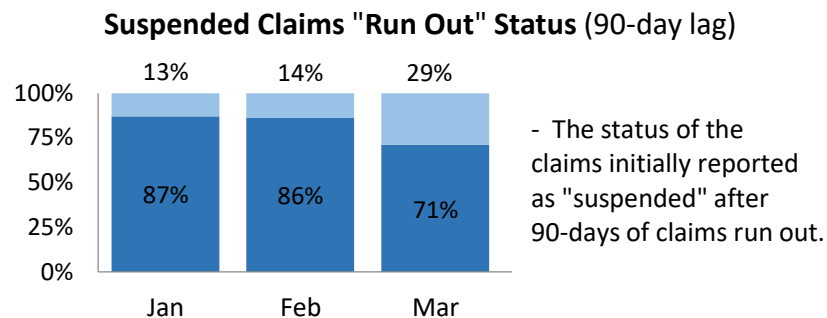
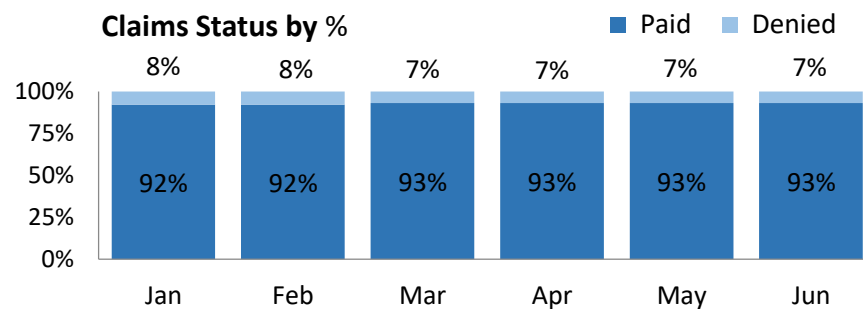
Claims Summary (Non-Pharmacy)

2.49 Million
Claims Paid & Denied



Apr May Jun

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



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

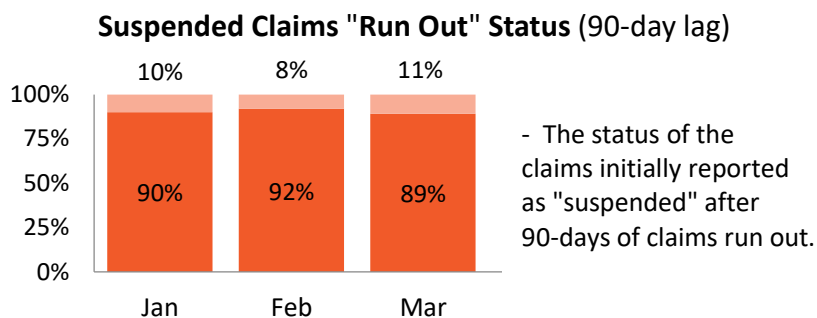
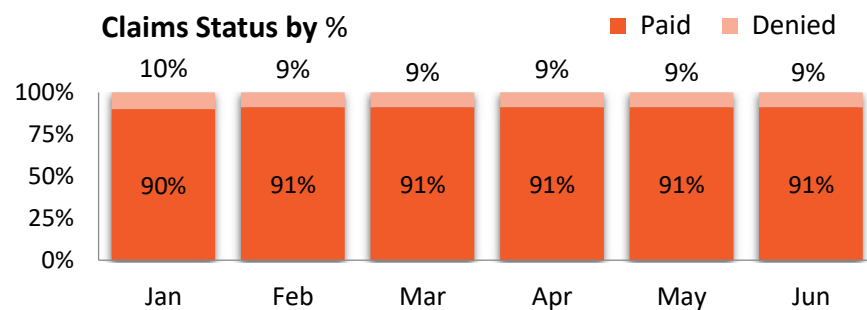
Claims Summary (Non-Pharmacy)

1.92 Million
Claims Paid & Denied



Apr May Jun

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



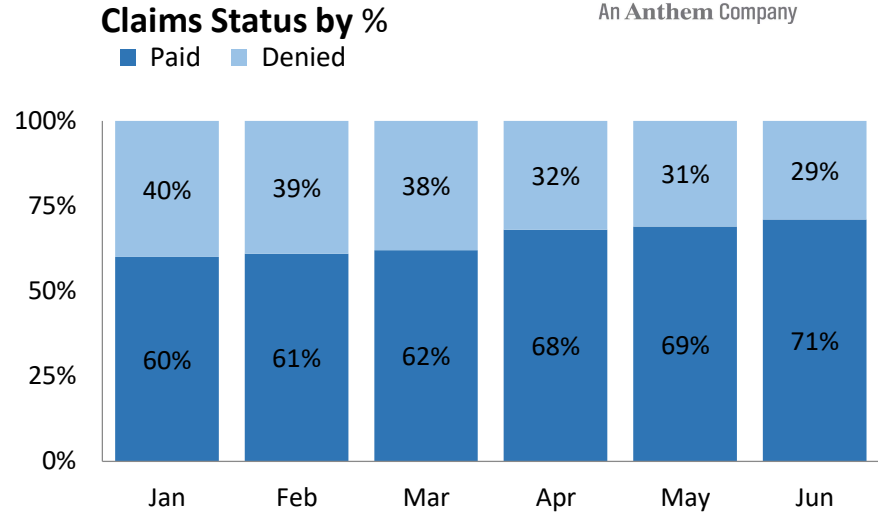
Top 10 Reasons for Claims Denials (Non-Pharmacy)		
	%	
1.	15%	Duplicate claim/service
2.	9%	Service can not be combined with other service on same day
3.	9%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	6%	The time frame for filing a claim reconsideration has expired
5.	5%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

Claims Summary (Pharmacy)



1.69 Million
Claims Paid & Denied

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



Top 10 Reasons for Claims Denials (Pharmacy)

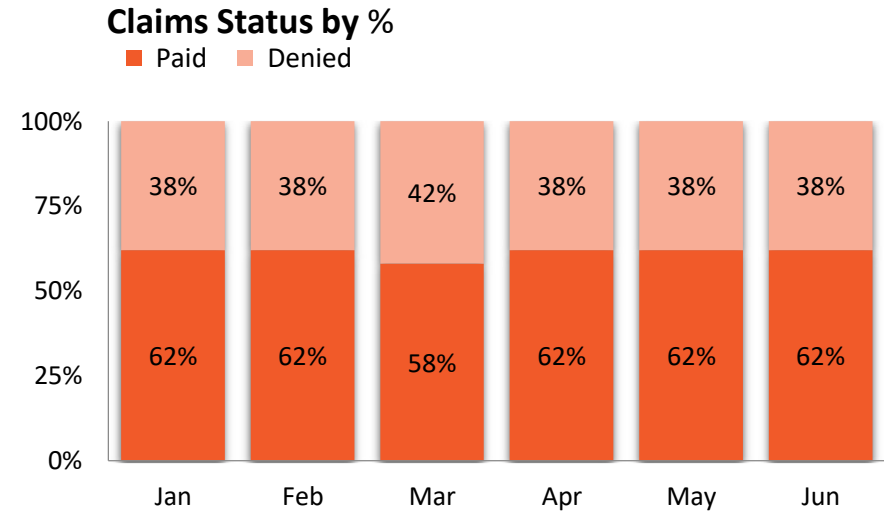
	%	Reason
1.	38%	Refill too soon
2.	16%	Prior authorization required
3.	13%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	6%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	3%	M/I processor control number
8.	2%	Pharmacy not enrolled in State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

Claims Summary (Pharmacy)



1.34 Million
Claims Paid & Denied

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



Top 10 Reasons for Claims Denials (Pharmacy)

	%	Reason
1.	26%	Refill too soon
2.	12%	Prior authorization required
3.	9%	National Drug Code (NDC) not covered
4.	5%	Submit bill to other processor or primary payer
5.	5%	Plan limitations exceeded
6.	3%	Product not covered - non-participating manufacturer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Discrepancy - other coverage code & other payer amount paid
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	Drug not covered for patient age

Prior Authorization Summary



93,082
All PAs Submitted ⁶

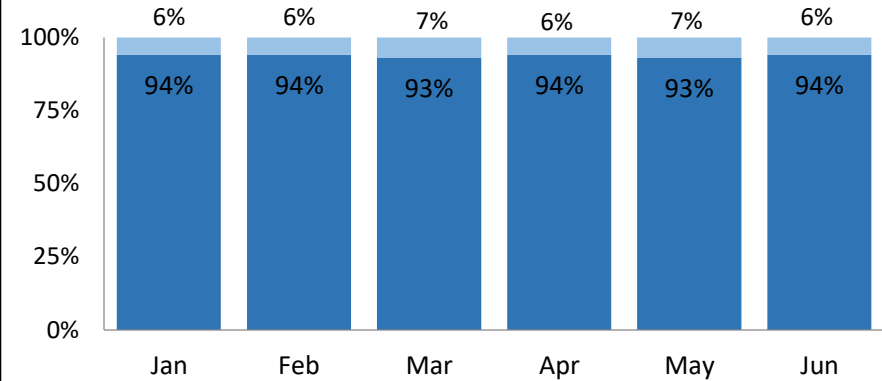
Non-Pharmacy

Apr May Jun

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

Non-Pharmacy by Percentage

■ Approved ■ Modified ■ Denied



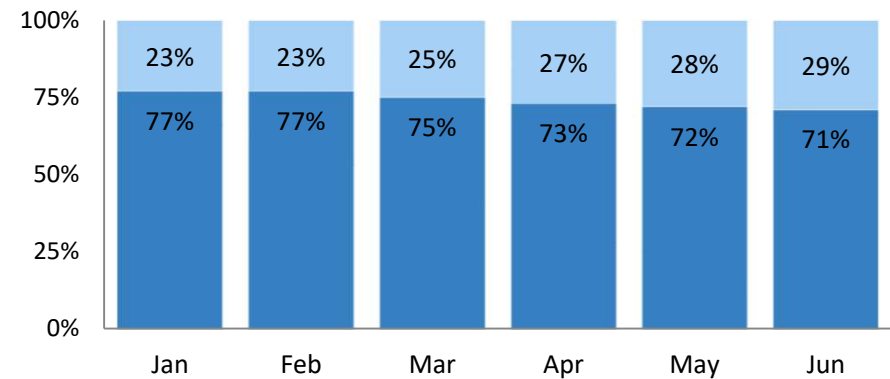
Pharmacy

Apr May Jun

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

Pharmacy by Percentage

■ Approved ■ Denied



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

Prior Authorization Summary



100,647
All PAs Submitted ⁶

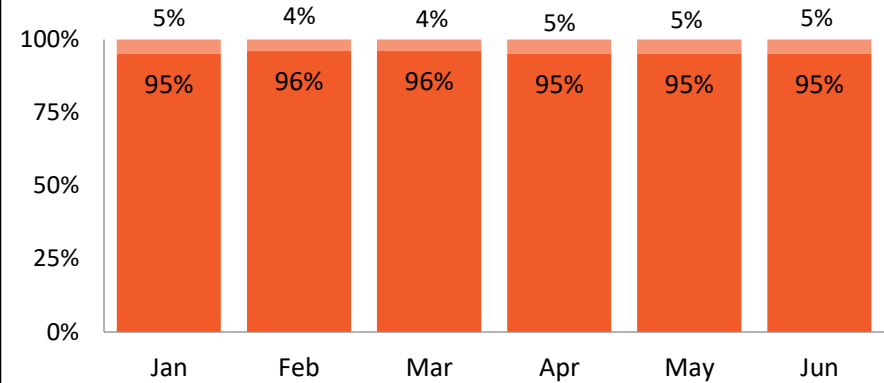
Non-Pharmacy

Apr May Jun

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

Non-Pharmacy by Percentage

Approved Modified Denied



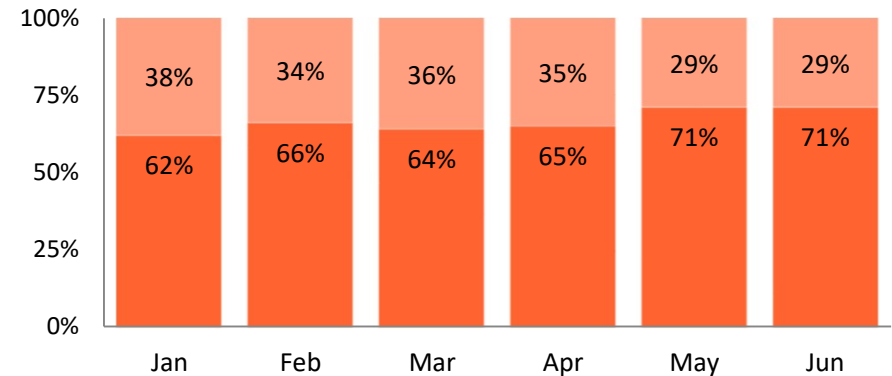
Pharmacy

Apr May Jun

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

Pharmacy by Percentage

Approved Denied



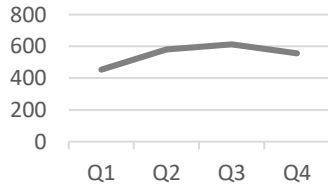
⁶ Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals



Standard Grievances

555

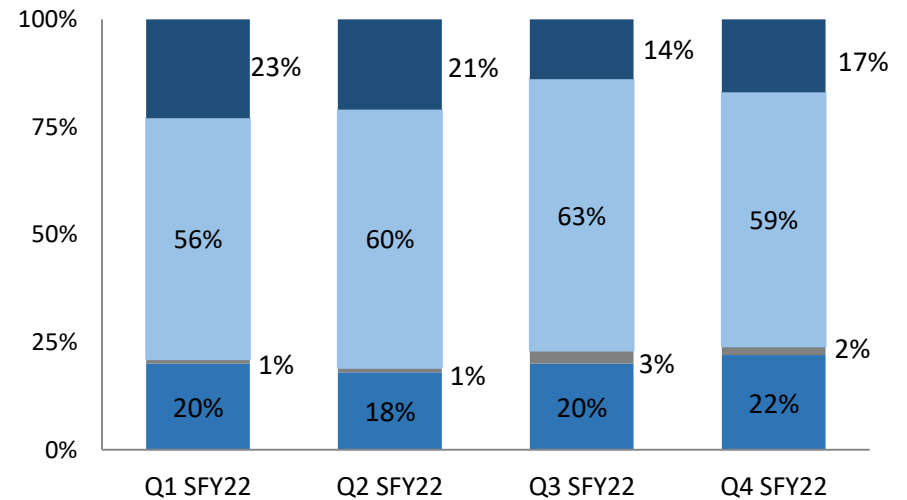


Standard Appeals/ 1st Level Review

452



Standard Appeal Outcome %



Resolved in 30-days
100%

Resolved in 30-days
100%

■ Withdrawn ■ Upheld
■ Partially Overturned ■ Overturned

Top 10 Reasons for Grievances ⁷

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

Top 10 Reasons for Appeals ⁷

	%	Reason
	35%	Pharmacy - Non Injectable
	24%	DME
	13%	Outpatient Services - Medical
	12%	Radiology
	8%	Pharmacy - Injectable
	6%	Inpatient - Medical
	5%	Surgery
	3%	Pain Management
	3%	BH - Op Service
	2%	Personal Care Services - Self

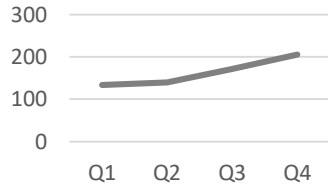
⁷ Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Grievances and Appeals



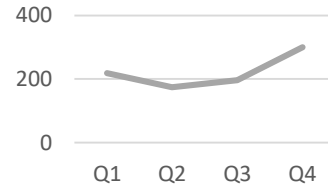
Standard Grievances

206



Standard Appeals/ 1st Level Review

300



Resolved in 30-days

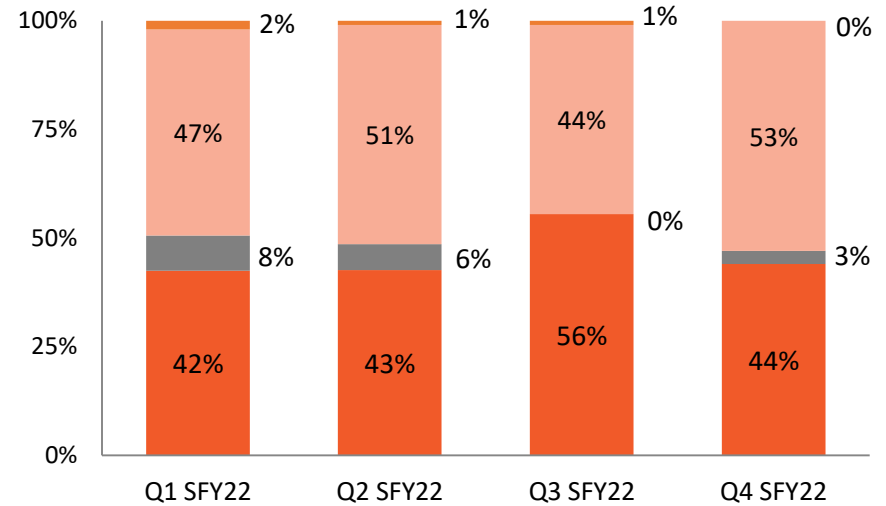
100%

Resolved in 30-days

100%



Standard Appeal Outcome %



Top 10 Reasons for Grievances ⁷

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

Top 10 Reasons for Appeals ⁷

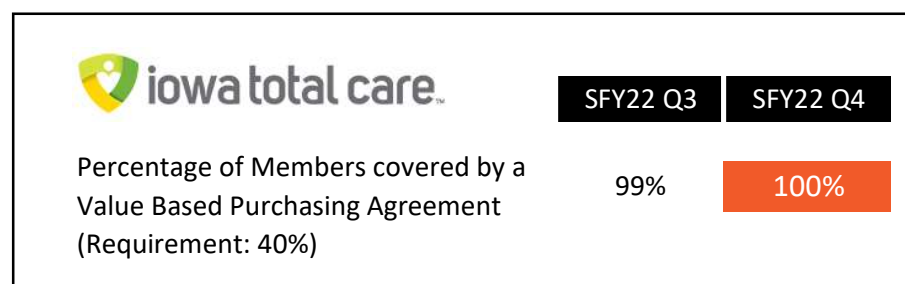
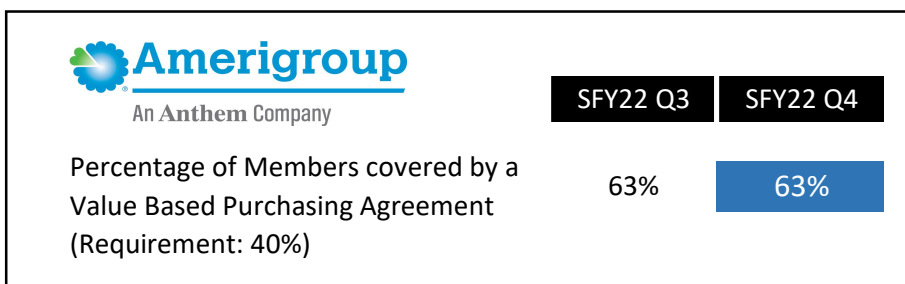
	%	Reason
	30%	RX - Does Not Meet PriorAuth Guidelines
	6%	Therapy - Speech Therapy
	6%	Other - Mental Health Service
	5%	DME - Other
	4%	Injections - Epidural Injections
	4%	Therapy - Occupational Therapy
	3%	Outpatient - Procedure
	3%	DME - Blood Glucose Monitor
	3%	Diagnostic - MRI
	2%	DME - Wheelchair

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

MCO Care Quality and Outcomes

Value Based Purchasing (VBP) Agreement

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



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>

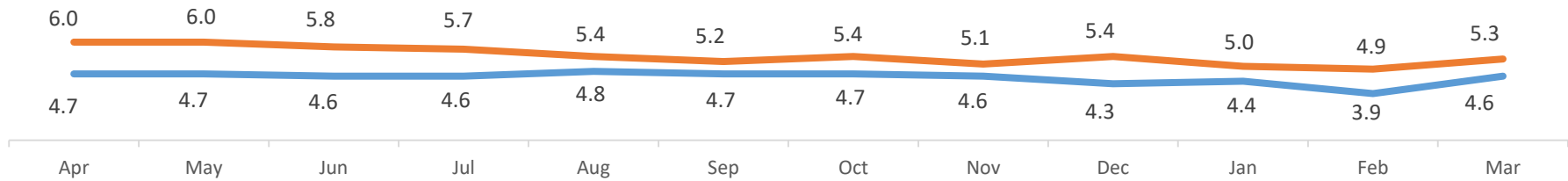
	SFY22 Q3	SFY22 Q4
Amerigroup An Anthem Company		
Healthy Rewards	8,502	3,295
Taking Care of Baby and Me	2,829	2,661
Community Resource Link	1,140	1,242
SafeLink Mobile Phone	1,222	928
Breast Pump	474	543

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

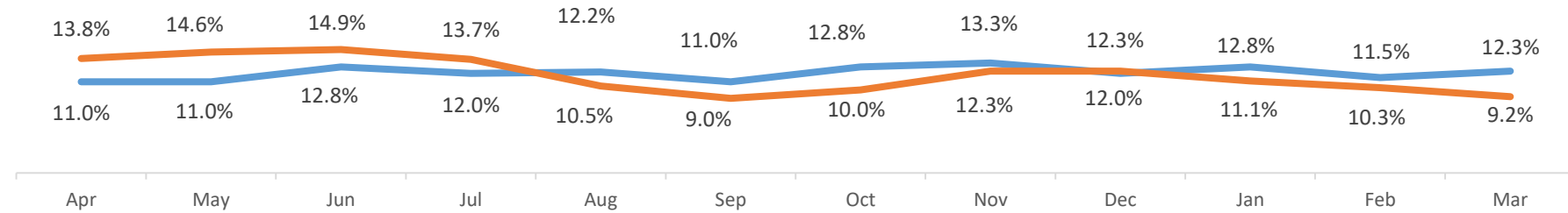
MCO Care Quality and Outcomes



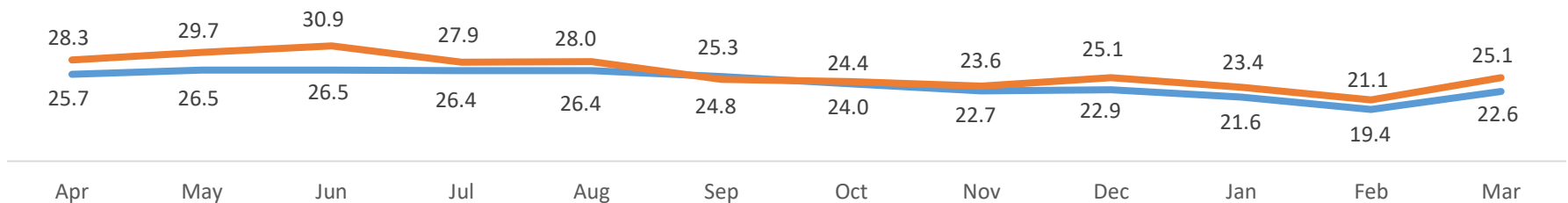
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



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

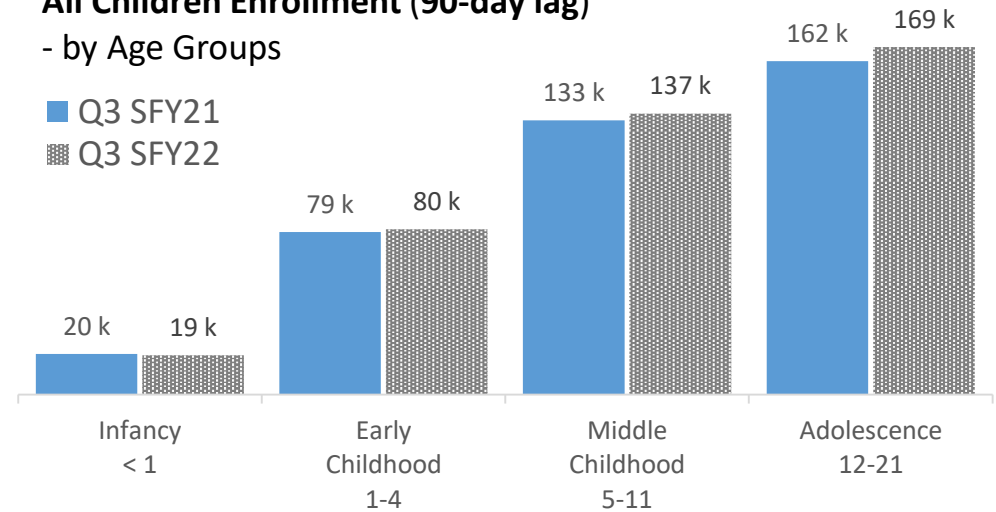
⁹ Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.

MCO Children Summary

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

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

All Children Enrollment (90-day lag) - by Age Groups



SFY21 Q3 SFY22 Q3



SFY21 Q3 SFY22 Q3

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

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

MCO Children Summary



SFY21 Q3 **SFY22 Q3**



SFY21 Q3 **SFY22 Q3**

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

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

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

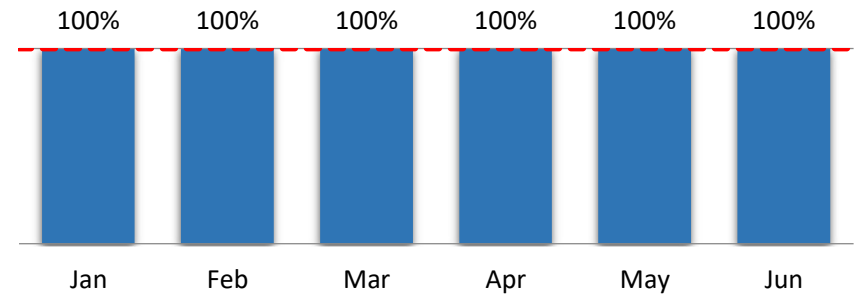


Average Number of Contacts Per Month	SFY22 Q3	SFY22 Q4
by Care Coordinators	0.8	2.2
by Case Managers	1.1	1.0
"Members to" Ratios		
Members to Care Coordinators	15	16
HCBS Members to Case Managers	56	62

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

Percentage of Level of Care (LOC) Reassessments Completed Timely

--- Contract Requirement: 100%

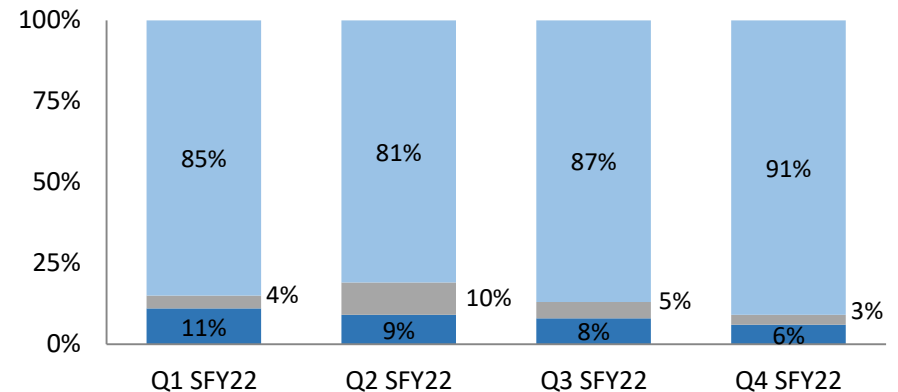


Iowa Participant Experience Survey (IPES)

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

Waiver Service Plan Outcomes

■ Reduction ■ Increase ■ No Change



Long Term Services - Care Quality and Outcomes

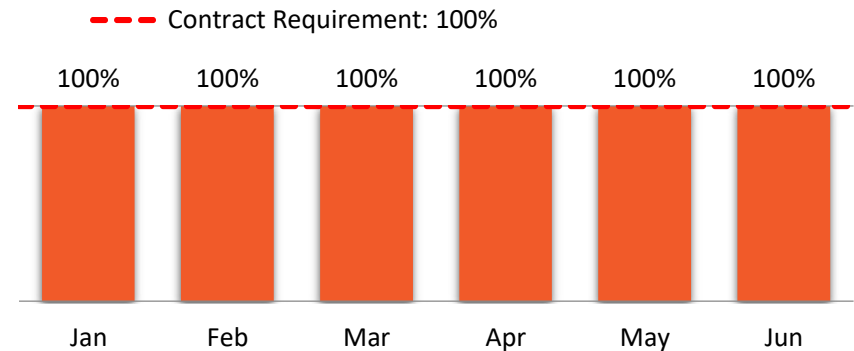
Non-LTSS Care Coordination and HCBS Case Management



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

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

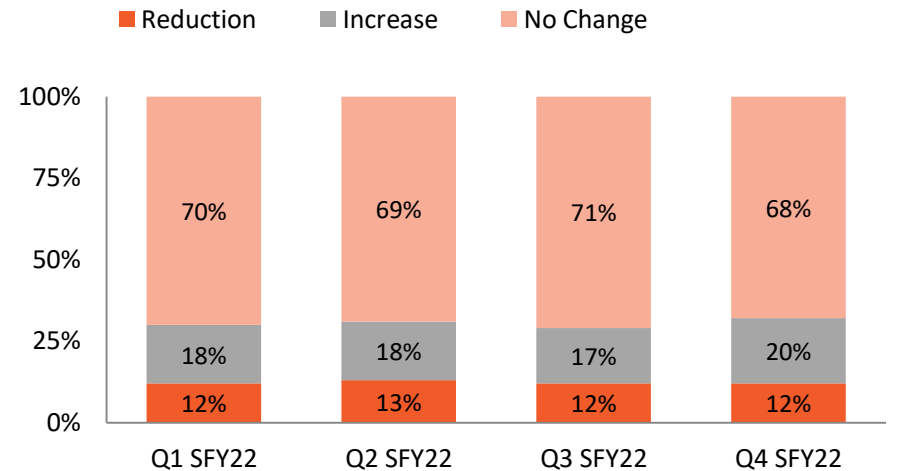
Percentage of Level of Care (LOC) Reassessments Completed Timely



Iowa Participant Experience Survey (IPES)

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

Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage



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

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

Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage



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

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

Call Center Performance Metrics

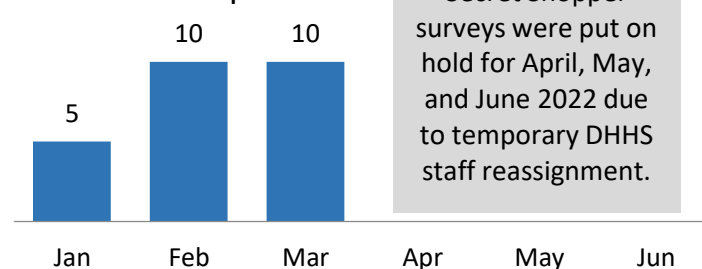


	Apr	May	Jun
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	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	96.39%	97.30%	93.13%
Abandonment Rate - Must be 5% or less	0.37%	0.30%	0.59%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.81%	99.60%	99.14%
Abandonment Rate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

Secret Shopper Scores

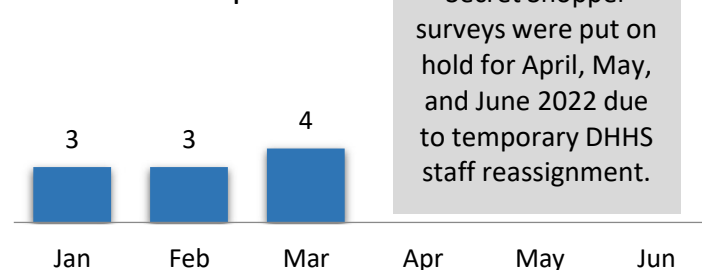
- Member Helpline



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

Secret Shopper Scores

- Provider Helpline



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

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

Top 5 Call Reasons (Member Helpline)

- Benefit Inquiry
- Over the Counter
- ID Card Request or Inquiry
- Enrollment Information
- Transportation Inquiry

Top 5 Call Reasons (Provider Helpline)

- Benefit Inquiry
- Authorization Status
- Claim Status
- Claim Payment Question or Dispute
- Enrollment Inquiry

Call Center Performance Metrics

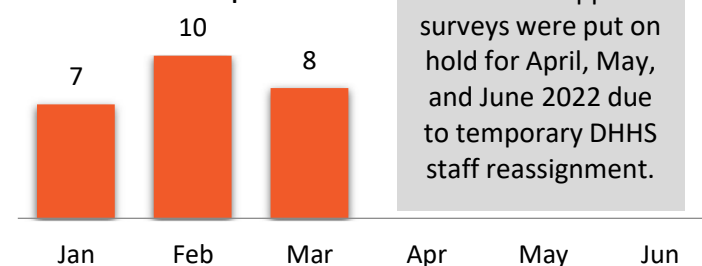


	Apr	May	Jun
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	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	83.54%	86.62%	87.92%
Abandonment Rate - Must be 5% or less	4.21%	4.29%	4.29%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	85.60%	86.80%	86.80%
Abandonment Rate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

Secret Shopper Scores

- Member Helpline



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

Secret Shopper Scores

- Provider Helpline



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

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

Top 5 Call Reasons (Member Helpline)

- Benefits and Eligibility for Member
- Coordination Of Benefits for Member
- Update PCP/PPG for Member
- Member Rewards for Member
- Order ID card

Top 5 Call Reasons (Provider Helpline)

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

Provider Network Access Summary



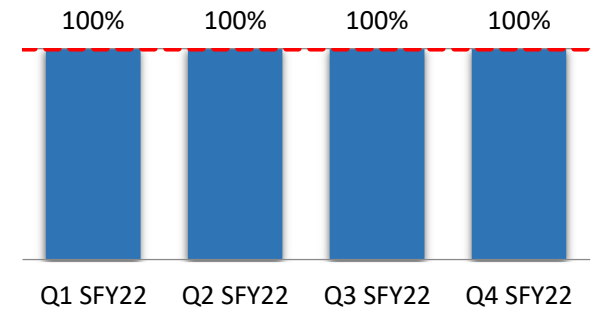
Primary Care Providers (PCP)

SFY22 Q1 SFY22 Q2 SFY22 Q3 SFY22 Q4

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

Adult PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Specialty Care &

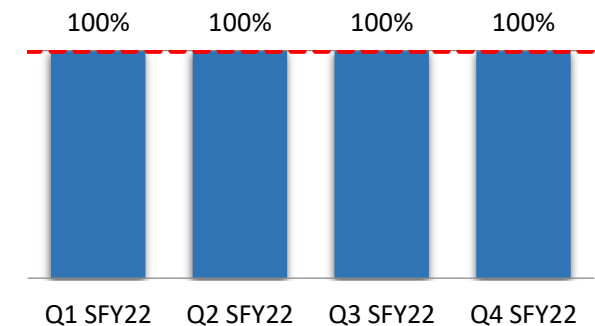
Behavioral Health (BH)

SFY22 Q1 SFY22 Q2 SFY22 Q3 SFY22 Q4

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

Pediatric PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Link to Geo Access Reports:

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

Provider Network Access Summary

Primary Care Providers (PCP)

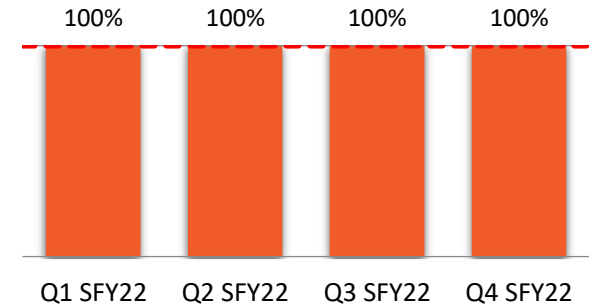
SFY22 Q1 SFY22 Q2 SFY22 Q3 SFY22 Q4

Adults PCP				
Provider Count	9,894	9,894	9,894	9,894
Members with Access	175,634	180,087	186,041	189,029
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	10,658	10,658	10,658	10,658
Members with Access	141,050	143,484	146,338	147,665
Average Distance (Miles)	2.1	2.1	2.1	2.1



Adult PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Specialty Care &

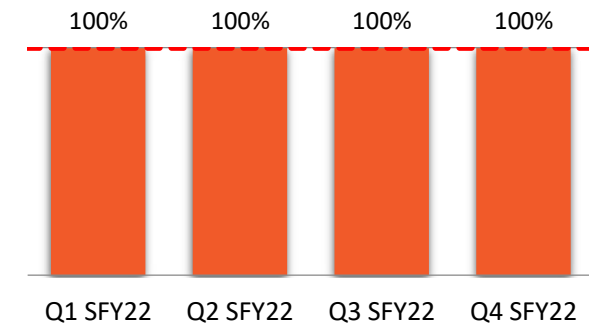
Behavioral Health (BH)

SFY22 Q1 SFY22 Q2 SFY22 Q3 SFY22 Q4

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

Pediatric PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Link to Geo Access Reports:

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

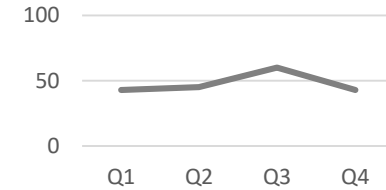
MCO Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the-art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems, which have a series of edits that reject inaccurate or duplicate claims. Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse. Therefore MCO investigations, overpayment recovery, and referrals to MFCU listed in this chart would be considered pending until final determinations are made.

Total Investigations
Opened in SFY22 Q4

43



2 Total Cases
Referred to MFCU Q4



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



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

Appendix: Glossary

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

Administrative Loss Ratio (ALR): See Financial Ratios

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

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

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

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

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

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

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

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

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

Capitation Expenditures (continued...):

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

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

Case Manager: See Community Based Case Management (CBCM)

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

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

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

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

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

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

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

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

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

Denied Claims: See Claims

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

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

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

Dual: Members who have both Medicare and Medicaid benefits.

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

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

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

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

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

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

Grievance (continued...):

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Medical Loss Ratio (MLR): See Financial Ratios

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

Monthly Capitation Expenditures: See Capitation Expenditures

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

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

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

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

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

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

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

Provider Adjustment Requests and Errors Reprocessed: See Claims

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

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

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

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

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

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

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

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

Underwriting Ratio (UR): See Financial Ratios

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

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

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

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

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

Waiver Service Plan: See Service Plan

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

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

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

Hawki Board of Directors Member List

Public Members

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

Statutory Members

Iowa Insurance Division

Doug Ommen - Commissioner
Angela Burke Boston - Designee

Iowa Department of Education

Dr. Ann Lebo - Director
Jim Donoghue - Designee

Iowa Department of Public Health

Kelly Garcia - Interim Director
Angie Doyle Scar - Designee

Department of Human Services (DHS) Staff

Elizabeth (Liz) Matney - Iowa Medicaid Director

Legislative Members - Ex Officio

Senator Nate Boulton
Senator Mark Costello
Representative Shannon Lundgren



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

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

See DHS website for all future and historical meeting information: https://dhs.iowa.gov/ime/about/advisory_groups/maac

MAAC Council Member List

Co-Chairpersons

Angela Doyle-Scar, Public Health

Jason Haglund, Public Member

Voting Members: Public Representatives

John Dooley, Public Member

Dee Sandquist, Public Member

Amy Shriver, Public Member

Marcie Strouse, Public Member

Voting Members: Professional and Business Entities

Brett Barker, Iowa Pharmacy Association

Erin Cubit, Iowa Hospital Association

Brandon Hagen, Iowa Health Care Association

Shelly Chandler, Iowa Association of Community Providers

Dennis Tibben, Iowa Medical Society

Members of the General Assembly

Senator Bolkcom

Senator Mark Costello

Representative John Forbes

Representative Ann Meyer

Other Statutory Members

VACANT, Des Moines University-Osteopathic Medical Center

Angela Van Pelt, Iowa Department of Aging

Cynthia Pedersen, Long-Term Care Ombudsman

Jennifer Harbison, University of Iowa College of Medicine

Angela Doyle Scar, Iowa Department of Public Health

Mary Nelle Trefz, Hawki Board

Professional and Business Entities

Anthony Carroll, AARP

Doug Cunningham, the ARC of Iowa

Kristie Oliver, Coalition for Family and Children's Services in Iowa

Wendy Gray, Free Clinics of Iowa

David Carlyle, Iowa Academy of Family Physicians

Patricia Hildebrand, Iowa Academy of Nutrition and Dietetics

Maria Jordan, Iowa Adult Day Services Association

Dan Royer, Iowa Alliance in Home Care

Helen Royer, Iowa Hearing Association

Cheryll Jones, Iowa Association of Nurse Practitioners

Edward Friedmann, Iowa Association of Rural Health Clinics

Di Findley, Iowa CareGivers

Continued...

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

MAAC Council Member List continued...

Professional and Business Entities

Flora Schmidt, Iowa Behavioral Health Association
Marianka Pille, Iowa Chapter of the American Academy of Pediatrics
Denise Rathman, Iowa Chapter of the National Association of Social Workers
Molly Lopez, Iowa Chiropractic Society
Josh Carpenter, Iowa Dental Association
Laurie Traetow, Iowa Dental Association
Brooke Lovelace, Iowa Developmental Disabilities Council
Bill Kallestad, Iowa Developmental Disabilities Council
Sue Whitty, Iowa Nurses Association
Sherry Buske, Iowa Nurse Practitioner Society
Steve Bowen, Iowa Occupational Therapy Association
Gary Ellis, Iowa Optometric Association
VACANT, Iowa Osteopathic Medical Association
Kate Walton, Iowa Physical Therapy Association
Kevin Kruse, Iowa Podiatric Medical Society
Erica Shannon, Iowa Primary Care Association
Sara Stramel Brewer, Iowa Psychiatric Society
Dave Beeman, Iowa Psychological Association
Barbara Nebel, Iowa Speech-Language-Hearing Association
Deb Eckerman Slack, Iowa State Association of Counties
Matt Blake, Leading Age Iowa
Matt Flatt, Midwest Association for Medical Equipment Services
Peggy Huppert, National Alliance on Mental Illness
Kay Vanags, Iowa Association of Area Agencies on Aging
Lynn Boes, Iowa Nurses Association
Marc Doobay, Iowa Physician Assistant Society
Cindy Baddeloo, Iowa Health Care Association/Iowa Center for Assisted Living
VACANT, Opticians Association of Iowa
Kady Reese, Iowa Medical Society
Susan Horras, Iowa Hospital Association

Appendix: Oversight Entities - Council on Human Services

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

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

Council on Human Services Member List

Iowa Council on Human Services Members

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

Legislative Members - Ex Officio

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