Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2022, Quarter 3

(January - March 2022)

Performance Data

Published June 2022

Department of HUMAN SERVICES

Contents

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

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

Executive Summary

This report is based on Quarter 3 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:

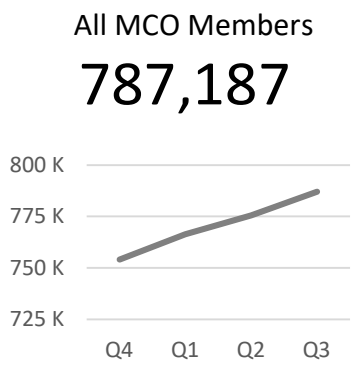
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period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

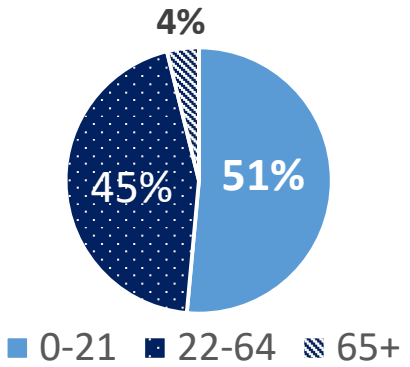
Mission/Vision Statement: Iowa Medicaid is committed to ensuring that all members have access to high quality services that promote dignity, removing barriers to increase health engagement, and improving whole person health. Our vision is operating a sustainable Medicaid program that improves the lives 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.





+ 11,680 Members
1.51% Increase

All MCO Enrollment (by Age)

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

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3	Average	Distinct
MCO Member Summary - *Overall Counts*	754,103	766,267	775,507	**787,187**	770,766	**824,918**
0-21	393,703	397,383	400,213	404,569	398,967	421,733
22-64	330,873	338,971	345,001	351,867	341,678	368,327
65+	29,527	29,913	30,293	30,751	30,121	34,858
Fee-For-Service (FFS) - *Non MCO Enrollees*	43,938	45,062	46,254	**46,896**	45,538	**50,880**

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

If Yes, explain:

Iowa Medicaid Population **875,798**
1 year distinct count

o Total disenrollment decreased slightly from Q2 to Q3.

MCO Member Summary

Amerigroup (An Anthem Company)	SFY22 Q2	SFY22 Q3
All Members - *by MCO*	447,581	451,600
Traditional Medicaid	274,834	278,594
Wellness Plan - IHAWP/Expansion	126,843	128,223
M-CHIP - Expansion	7,833	8,051
Healthy and Well Kids in Iowa (Hawki)	38,071	36,732
MCO Member Market Share	57.7%	57.4%
Disenrolled	599	401
Long-Term Service & Support (LTSS)	21,849	21,502
HCBS Waivers	68.6%	68.7%
Facility Based Services	31.4%	31.3%
HCBS Waivers [1]	14,985	14,778
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,864	6,724
ICF/ID [3]	967	912
Mental Health Institute (MHI)	36	36
Nursing Facilities (NF)	5,534	5,436
Nursing Facilities for Mentally Ill	58	54
Skilled	82	87
PMIC [4]	187	199

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All Members - *by MCO*	327,926	335,587
Traditional Medicaid	201,591	206,374
Wellness Plan - IHAWP/Expansion	103,988	106,807
M-CHIP - Expansion	6,587	6,924
Healthy and Well Kids in Iowa (Hawki)	15,760	15,482
MCO Member Market Share	42.3%	42.6%
Disenrolled	403	461
Long-Term Service & Support (LTSS)	14,664	14,667
HCBS Waivers	65.2%	65.0%
Facility Based Services	34.8%	35.0%
HCBS Waivers [1]	9,561	9,540
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,103	5,127
ICF/ID [3]	572	524
Mental Health Institute (MHI)	23	29
Nursing Facilities (NF)	4,298	4,340
Nursing Facilities for Mentally Ill	32	30
Skilled	65	76
PMIC [4]	113	128

[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 398; ITC 361). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

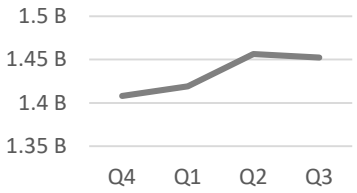
MCO Financial Summary - All MCO Counts

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

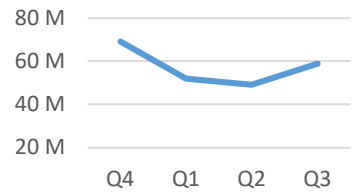


- $4.2 Million

0.29% Decrease

Third Party Liability Recovered

$58.94 Million



+ $ 9.8 Million

19.86% increase

Data Notes: March 2022 enrollment data as of May 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.

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3	Average	Total
Financial Summary						
Capitation Payments	$1.41 B	$1.42 B	$1.46 B	**$1.45 B**	$1.43 B	$5.74 B
Third Party Liability (TPL) Recovered	$69.23 M	$51.95 M	$49.17 M	**$58.94 M**	$57.32 M	$229.29 M

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

If Yes, explain:

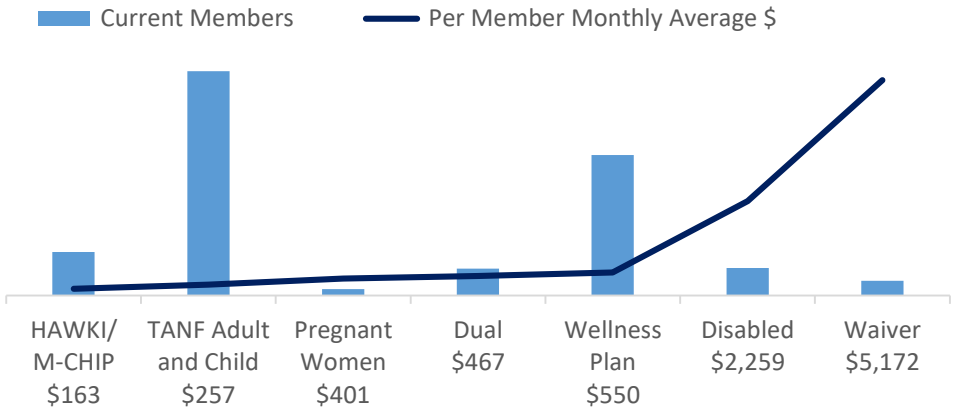
o TPL increased by $9.8M or 19.86% between Q2 and Q3.

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

	SFY22 Q2	SFY22 Q3
Capitation Totals	$851.01 M	**$841.06 M**
Adjustments	$5.38 M	-219508
Current	$825.03 M	$822.18 M
Retro	$20.61 M	$19.1 M
Third Party Liability (TPL) Recovered	$16.51 M	**$22.91 M**
Financial Ratios		
Medical Loss Ratio (MLR)	85.8%	**89.9%**
Administrative Loss Ratio (ALR)	5.4%	5.4%
Underwriting Ratio (UR)	8.9%	4.7%
Annual MLR [5]		88.7%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

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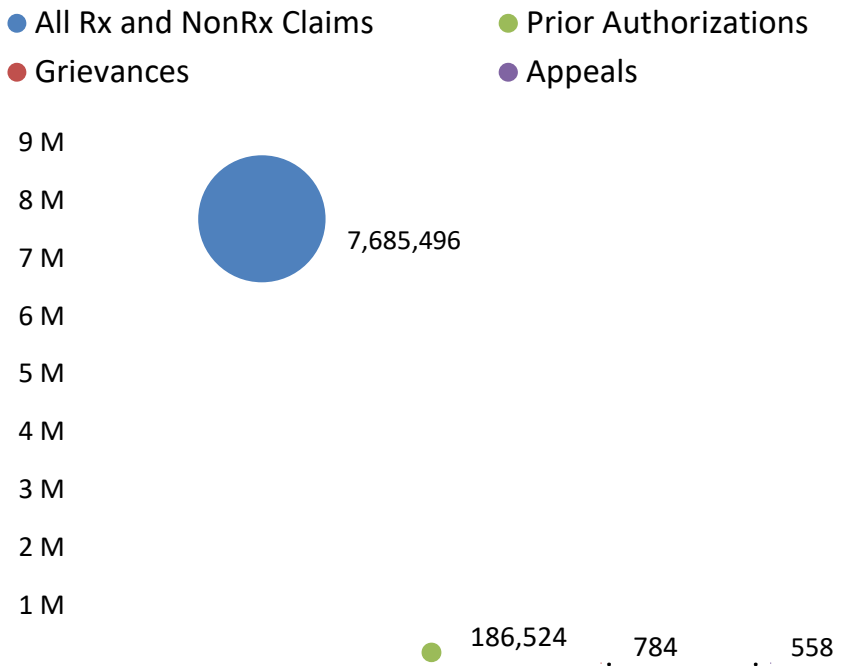
	SFY22 Q2	SFY22 Q3
Capitation Totals	**$605.63 M**	**$611.36 M**
Adjustments	$5.46 M	-820,483
Current	$580.67 M	$588.32 M
Retro	$19.5 M	$23.87 M
Third Party Liability (TPL) Recovered	$32.66 M	**$36.03 M**
Financial Ratios		
Medical Loss Ratio (MLR)	90.9%	**95.1%**
Administrative Loss Ratio (ALR)	4.5%	3.8%
Underwriting Ratio (UR)	4.6%	1.1%
Annual MLR [5]		93.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

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

MCO Claims Universe - All MCO Counts

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

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



	% of Claims Universe
Prior Authorizations	2.43%
Grievances	0.01%
Appeals	0.01%

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.13 M	7.10 M	7.44 M	**7.69 M**	7.34 M	29.36 M
Non-Pharmacy	4.21 M	4.21 M	4.46 M	4.39 M	4.32 M	17.27 M
Pharmacy	2.92 M	2.90 M	2.98 M	3.29 M	3.02 M	12.09 M
Prior Authorization Summary (p. 13-14)	180,026	171,159	169,391	**186,524**	176,775	707,100
Non-Rx - Standard PAs Submitted	138,319	127,869	124,736	134,628	131,388	525,552
Pharmacy - Standard PAs Submitted	41,707	43,290	44,655	51,896	45,387	181,548
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	583	587	720	**784**	669	2,674
Standard Appeals	750	701	574	**558**	646	2,583

Claims Summary (Non-Pharmacy)

2.34 Million
Claims Paid & Denied

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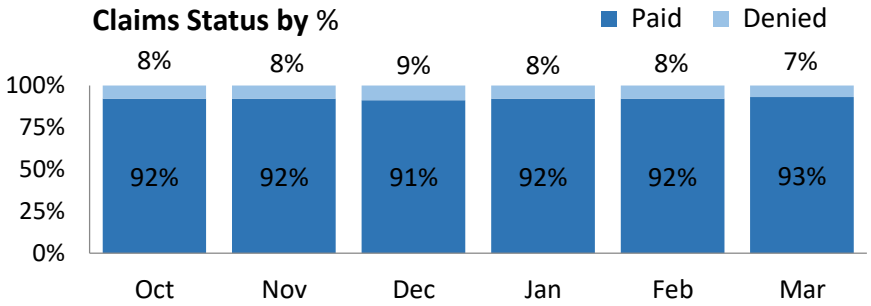
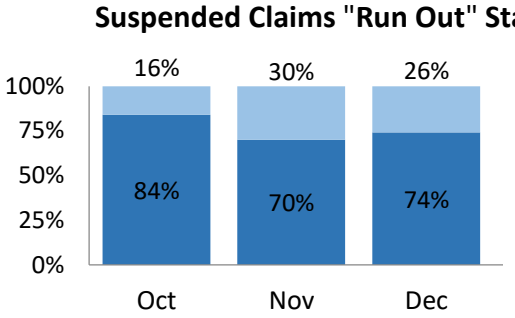
	Jan	Feb	Mar
All Claims			
Paid	665,312	679,880	814,592
Denied	55,954	56,519	64,117
Suspended	166,459	179,885	184,199
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	6	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	18%	Duplicate claim/service
2.	14%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	7%	The impact of prior payer(s) adjudication including payments and/or adjustments.
4.	6%	Claim/service lacks information or has submission/billing error(s) - primary payer information required
5.	6%	The time limit for filing has expired
6.	6%	Precertification/authorization/notification absent
7.	5%	Service not payable per managed care contract
8.	5%	Expenses incurred after coverage terminated
9.	4%	Attachment/Other Documentation Required
10.	4%	Prior processing information appears incorrect

Claims Summary (Non-Pharmacy)

2.06 Million
Claims Paid & Denied

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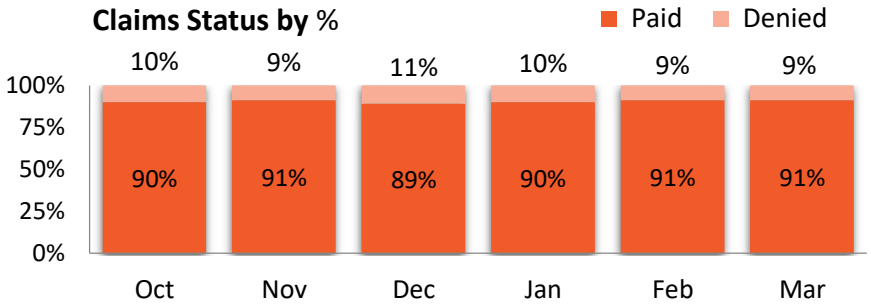
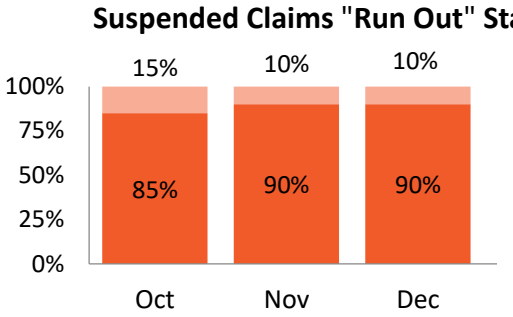
	Jan	Feb	Mar
All Claims			
Paid	512,284	613,547	743,756
Denied	54,397	60,707	73,268
Suspended	173,001	166,354	131,789
Clean Claims Processed			
in 30-days (Requirement 90%)	96%	98%	98%
in 45-days (Requirement 95%)	99%	100%	100%
Average Days to Pay	9	11	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	97%	99%





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

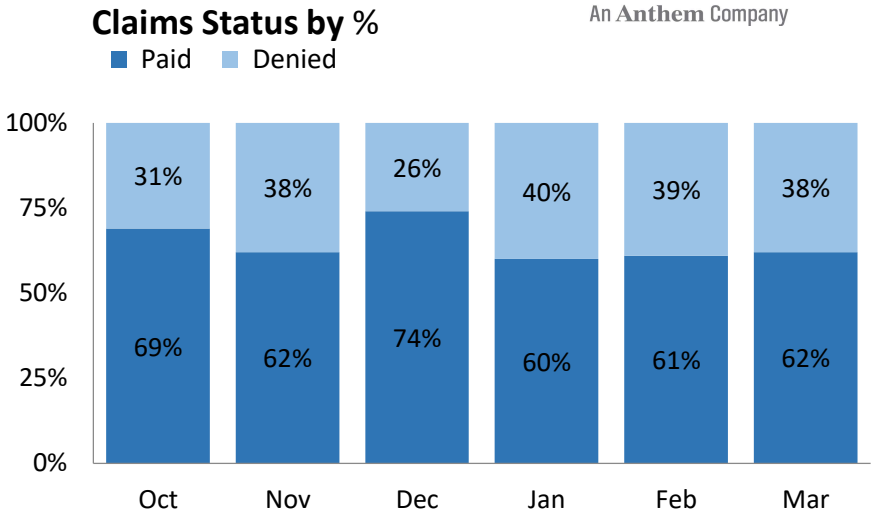
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	18%	Duplicate claim service
2.	12%	Service can not be combined with other service on same day
3.	9%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	7%	Service is not covered
5.	6%	No authorization on file that matches service(s) billed
6.	4%	ACE claim level return to provider
7.	4%	Diagnosis code incorrectly coded per ICD10 manual
8.	3%	Void Adjustment
9.	2%	Billing NPI not registered with IA DHS/Iowa Medicaid
10.	2%	No action needed - will be reprocessed after state reviews new code

Claims Summary (Pharmacy)

1.93 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	392,224	363,757	414,328
Denied	264,164	236,324	258,981
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	10	11

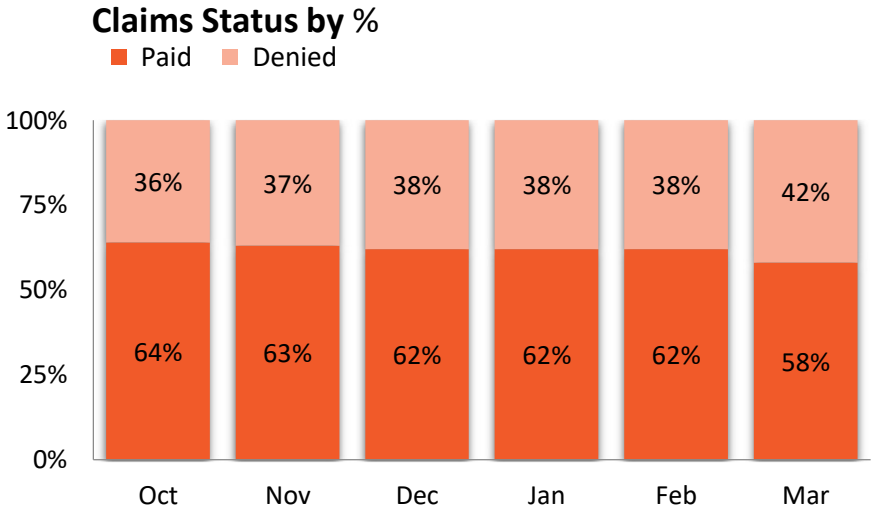


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	30%	Refill too soon
2.	14%	Prior authorization required
3.	11%	Submit bill to other processor or primary payer
4.	7%	National Drug Code (NDC) not covered
5.	6%	Plan limitations exceeded
6.	3%	M/I other payer reject code
7.	2%	M/I processor control number
8.	1%	Prescriber is not covered
9.	1%	Filled after coverage terminated
10.	1%	Pharmacy not enrolled in State Medicaid program

Claims Summary (Pharmacy)

1.36 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	277,450	258,828	286,757
Denied	171,930	161,425	204,995
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)

	%	
1.	24%	Refill too soon
2.	12%	Prior authorization required
3.	8%	National Drug Code (NDC) not covered
4.	6%	Submit bill to other processor or primary payer
5.	5%	Plan limitations exceeded
6.	2%	Product not covered - non-participating manufacturer
7.	2%	Drug Utilization Review (DUR) reject error
8.	1%	Discrepancy - other coverage code & other payer amount paid
9.	1%	Prescriber is not enrolled in State Medicaid program
10.	1%	Drug not covered for patient age

Prior Authorization Summary

80,940
All PAs Submitted [6]

Amerigroup
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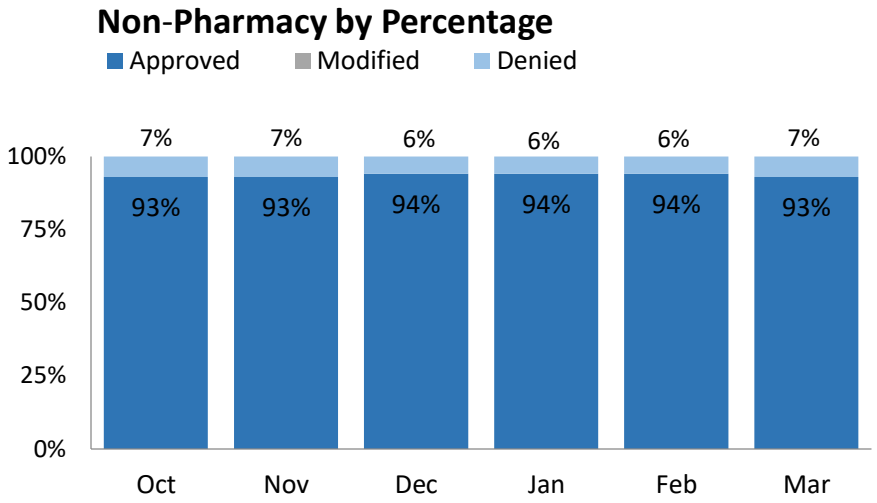
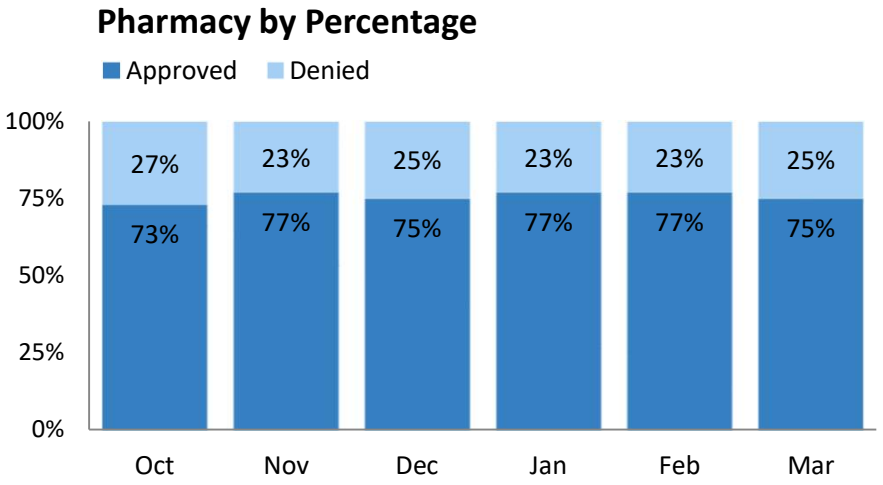
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	17,048	18,341	21,756
Denied	1,125	1,204	1,592
Modified	0	0	0
Average Days to Process	3	4	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	7,388	7,104	7,300
Denied	2,206	2,139	2,410
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	100%



[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

88,451
All PAs Submitted [6]

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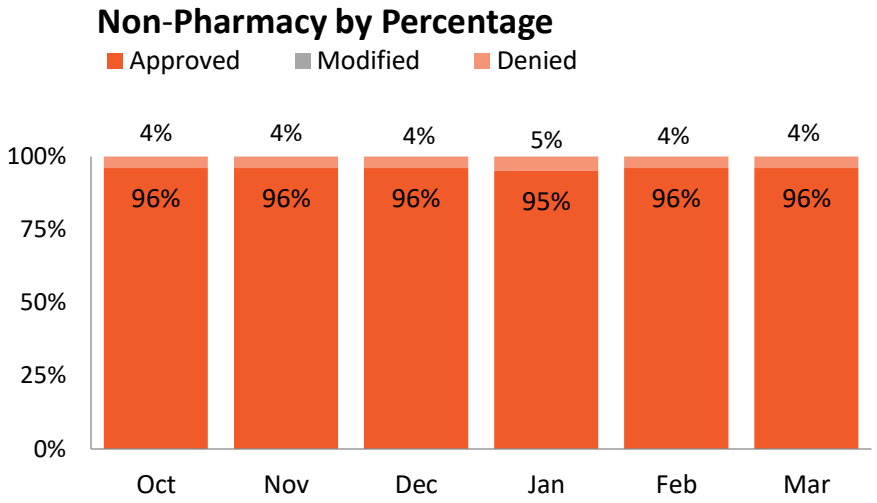
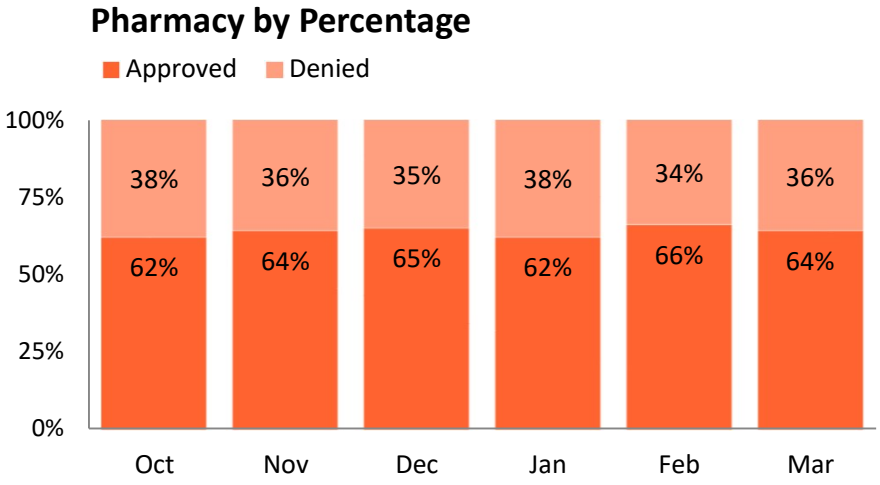
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	20,672	22,797	26,428
Denied	982	973	1,048
Modified	0	0	0
Average Days to Process	4	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	3,588	4,512	5,341
Denied	2,155	2,278	3,020
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	100%

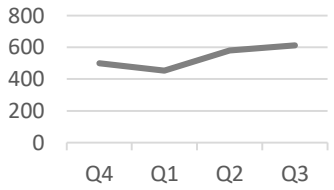


[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

Standard Grievances

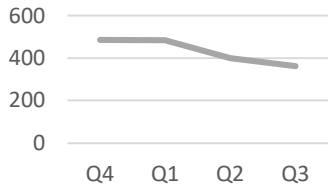
613



Resolved in 30-days 100%

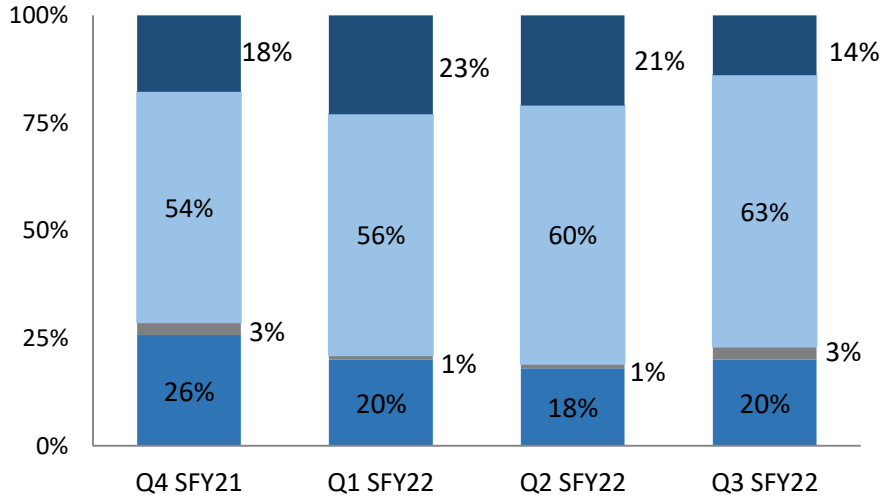
Standard Appeals

362



Resolved in 30-days 100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	34%	Voluntary disenrollment
2.	20%	Provider balance billed
3.	6%	Poor Customer Service
4.	6%	Provider Dissatisfaction
5.	6%	Effective Dates of Coverage
6.	5%	Transportation - Driver no-show
7.	5%	Treatment Dissatisfaction
8.	3%	Inadequate benefit access
9.	3%	Transportation - Driver Delay
10.	2%	Provider Attitude/Rudeness

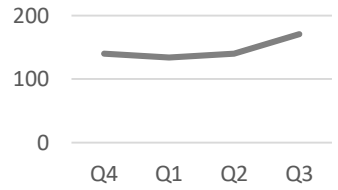
%	Top 10 Reasons for Appeals [7]
32%	Pharmacy - Non Injectable
24%	DME
14%	Radiology
13%	Outpatient Services - Medical
13%	Pharmacy - Injectable
8%	Inpatient - Medical
3%	Pain Management
3%	Surgery
3%	BH - Op Service
2%	Other

[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

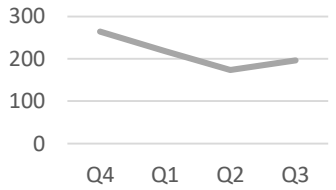
171



Resolved in 30-days 100%

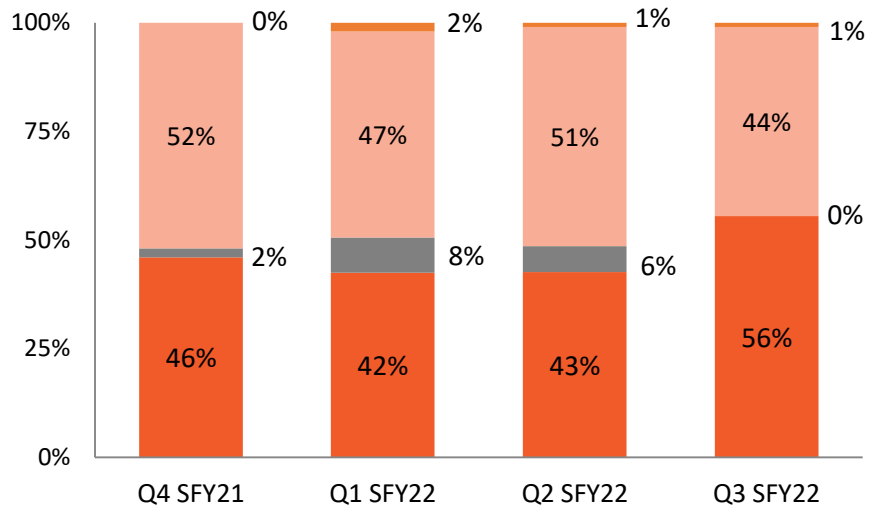
Standard Appeals

196



Resolved in 30-days 100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [7]
1.	22%	Access to Care - Network Availability
2.	19%	Voluntary Disenrollment - Unhappy with Benefits
3.	10%	Transportation - Missed Appointment
4.	8%	Transportation - General Complaint Vendor
5.	7%	Lack of Caring/Concern
6.	5%	Transportation - Driver no-show
7.	3%	Provider
8.	3%	Transportation - General Complaint Vendor CSR
9.	3%	Case Management Complaint
10.	2%	Transportation - Late appointment

%	Top 10 Reasons for Appeals [7]
26%	RX - Does Not Meet PriorAuth Guidelines
13%	Therapy - Physical Therapy
6%	Injections - Epidural Injections
5%	Diagnostic - MRI
5%	Other - Mental Health Service
5%	Therapy - Speech Therapy
4%	Therapy - Occupational Therapy
3%	DME - Wheelchair
3%	RX - No Prior Auth Denial
2%	Outpatient - Home Health Visits

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

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.

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	SFY22 Q2	SFY22 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	63%

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	SFY22 Q2	SFY22 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	96%	99%

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

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	SFY22 Q2	SFY22 Q3
Healthy Rewards	3,800	8,502
Taking Care of Baby and Me	2,513	2,829
SafeLink Mobile Phone	845	1,222
Community Resource Link	1,170	1,140
Dental Hygiene Kit	480	657

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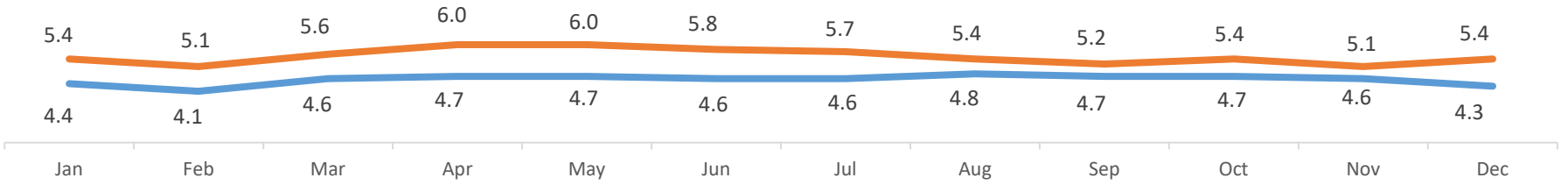
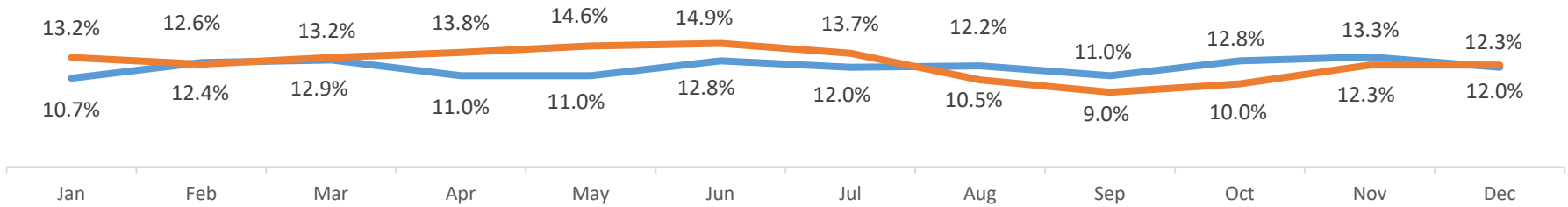
	SFY22 Q2	SFY22 Q3
My Health Pays Program	12,136	8,719
The Flu Program	14,683	6,011
Start Smart for Your Baby	1,416	1,638
Mobile App	1,017	1,072
Breast Pumps	462	553

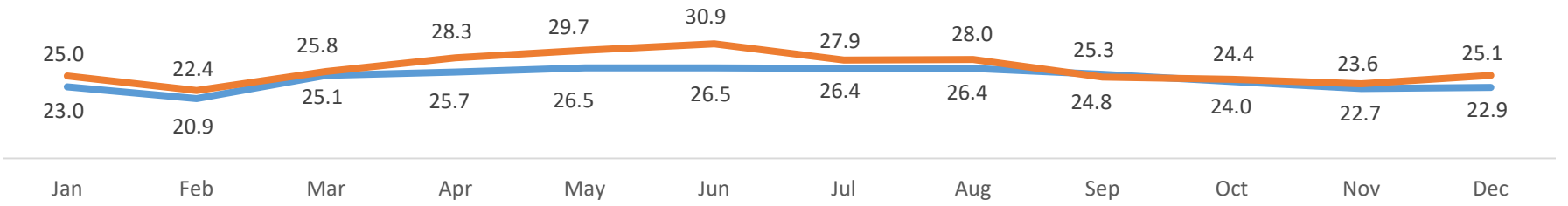
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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.*

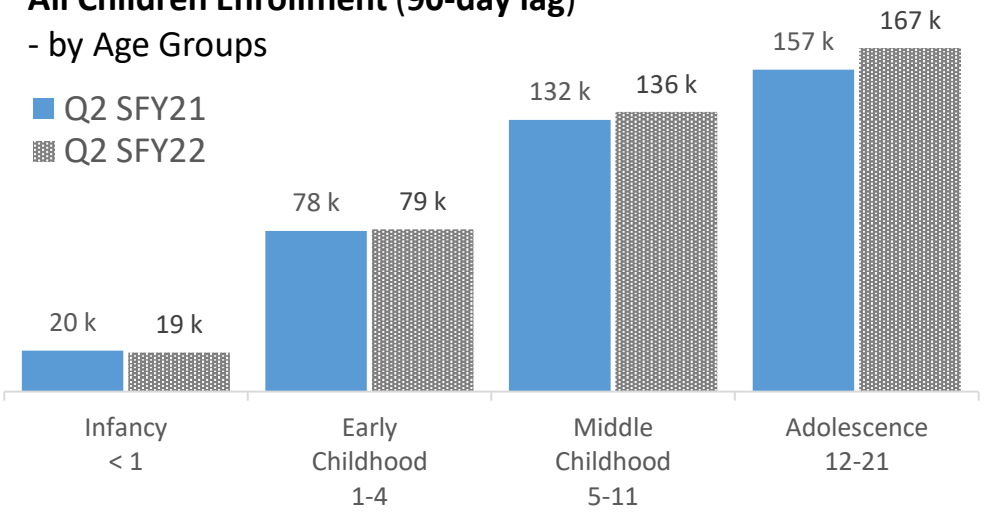
[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

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



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	SFY21 Q2	SFY22 Q2
Member Enrollment	231,588	237,998
Infancy < 1	10,159	9,842
Early Childhood 1 - 4	47,354	46,275
Middle Childhood 5 - 11	79,742	81,778
Adolescence 12 - 21	94,333	100,103
Well Child Exams (Preventive Visits)	41,104	39,572
Infancy < 1	11,231	11,043
Early Childhood 1 - 4	12,242	11,242
Middle Childhood 5 - 11	9,351	8,865
Adolescence 12 - 21	8,280	8,422
Lead Screenings	4,279	3,445
Infancy < 1	90	77
Early Childhood 1 - 4	3,834	3,059
Middle Childhood 5 - 11	309	269
Adolescence 12 - 21	46	40

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	SFY21 Q2	SFY22 Q2
Member Enrollment	154,855	162,215
Infancy < 1	9,615	9,062
Early Childhood 1 - 4	30,738	32,560
Middle Childhood 5 - 11	52,334	54,062
Adolescence 12 - 21	62,168	66,531
Well Child Exams (Preventive Visits)	32,551	34,244
Infancy < 1	11,412	11,719
Early Childhood 1 - 4	8,367	9,329
Middle Childhood 5 - 11	6,795	6,994
Adolescence 12 - 21	5,977	6,202
Lead Screenings	3,119	3,200
Infancy < 1	72	104
Early Childhood 1 - 4	2,794	2,815
Middle Childhood 5 - 11	231	245
Adolescence 12 - 21	22	36

MCO Children Summary

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	SFY21 Q2	SFY22 Q2
Hearing Screenings	1,649	2,200
Infancy < 1	111	172
Early Childhood 1 - 4	754	1,111
Middle Childhood 5 - 11	541	660
Adolescence 12 - 21	243	257
Vision Screenings	914	1,871
Infancy < 1	10	47
Early Childhood 1 - 4	376	854
Middle Childhood 5 - 11	352	626
Adolescence 12 - 21	176	344
Vaccination Totals	91,582	80,580
COVID-19 Dose 1	9	2,212
COVID-19 Dose 2	0	2,005
COVID-19 Single-Dose	0	26
DTaP (Diphtheria, Tetanus, Pertussis)	10,223	9,220
Influenza (FLU)	40,027	31,194
HepA (Hepatitis A)	5,029	4,027
HepB (Hepatitis B)	957	878
Haemophilus Influenza Type B (Hib)	5,364	4,786
Human Papillomavirus (HPV)	3,234	2,656
Meningococcal ACWY (MenACWY)	3,132	2,714
Meningococcal B - (MenB)	1,442	1,216
MMR (Measles, Mumps, Rubella)	4,397	3,687
Pneumococcal (PCV13)	7,811	7,090
Pneumococcal (PPSV23)	71	57
Polio (IPV)	297	239
RV (Rotavirus)	4,946	4,696
Tetanus and diphtheria (Td)	38	29
TDAP (Tetanus, Diphtheria, Pertussis)	2,236	1,949
Varicella Virus Vaccine (VAR)	2,369	1,899

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	SFY21 Q2	SFY22 Q2
Hearing Screenings	1,108	1,462
Infancy < 1	82	166
Early Childhood 1 - 4	437	674
Middle Childhood 5 - 11	403	444
Adolescence 12 - 21	186	178
Vision Screenings	711	1,421
Infancy < 1	22	36
Early Childhood 1 - 4	306	718
Middle Childhood 5 - 11	255	483
Adolescence 12 - 21	128	184
Vaccination Totals	62,820	59,378
COVID-19 Dose 1	6	1,388
COVID-19 Dose 2	0	1,243
COVID-19 Single-Dose	0	15
DTaP (Diphtheria, Tetanus, Pertussis)	8,206	7,934
Influenza (FLU)	26,104	21,629
HepA (Hepatitis A)	3,264	3,267
HepB (Hepatitis B)	872	749
Haemophilus Influenza Type B (Hib)	1,410	1,612
Human Papillomavirus (HPV)	2,223	1,870
Meningococcal ACWY (MenACWY)	2,101	1,810
Meningococcal B - (MenB)	921	772
MMR (Measles, Mumps, Rubella)	3,115	3,034
Pneumococcal (PCV13)	6,595	6,361
Pneumococcal (PPSV23)	55	61
Polio (IPV)	237	200
RV (Rotavirus)	4,354	4,287
Tetanus and diphtheria (Td)	15	34
TDAP (Tetanus, Diphtheria, Pertussis)	1,551	1,405
Varicella Virus Vaccine (VAR)	1,791	1,707

Non-LTSS Care Coordination and HCBS Case Management

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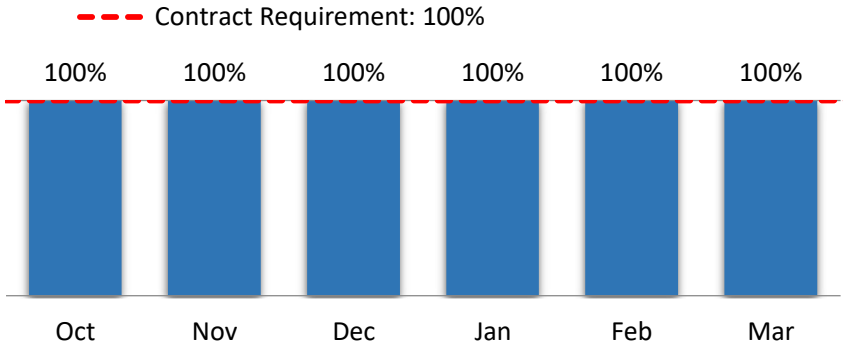
Average Number of Contacts Per Month	SFY22 Q2	SFY22 Q3
by Care Coordinators	0.8	**0.8**
by Case Managers	1.1	**1.1**
"Members to" Ratios		
Members to Care Coordinators	20	**15**
HCBS Members to Case Managers	72	**56**

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.

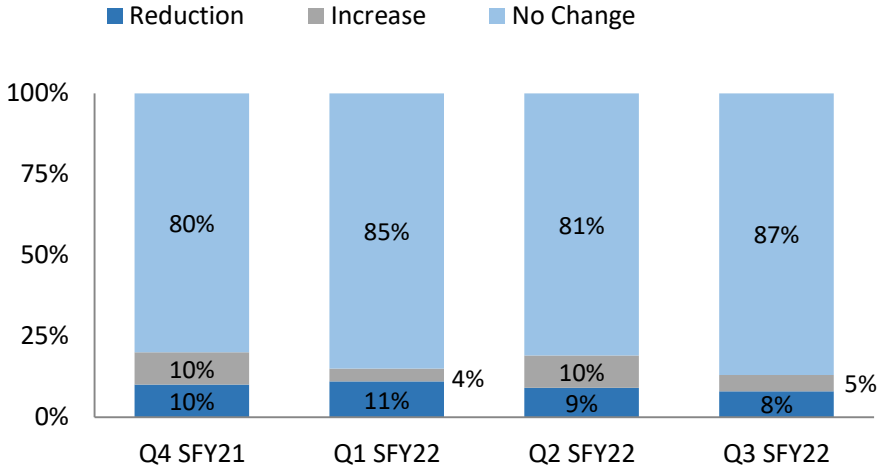
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY22 Q2	SFY22 Q3
They were part of service planning.	I don't know	0.0%	0.4%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	99.6%
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	0.5%	0.8%
	No	0.0%	0.0%
	Sometimes	0.0%	0.4%
	Yes	99.5%	98.8%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

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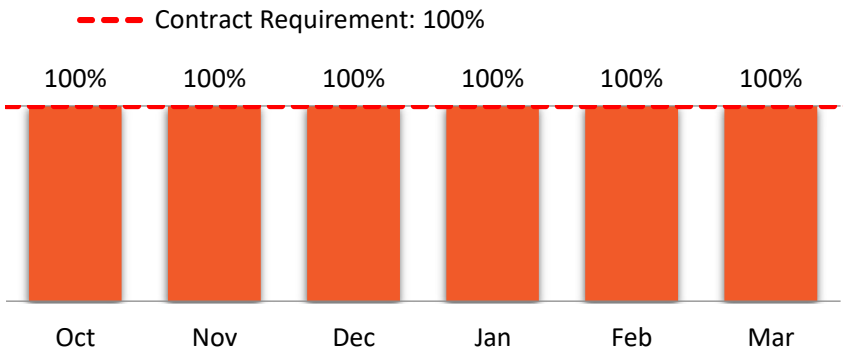
Average Number of Contacts Per Month	SFY22 Q2	SFY22 Q3
by Care Coordinators	1.0	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	50	**57**
HCBS Members to Case Managers	40	**40**

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

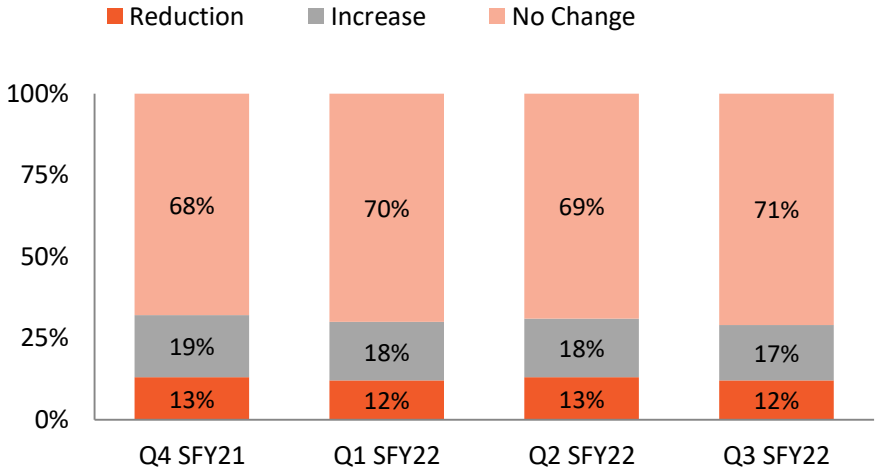
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY22 Q2	SFY22 Q3
They were part of service planning.	I don't know	0.7%	0.0%
	No	1.4%	2.6%
	Sometimes	1.1%	0.8%
	Yes	96.7%	95.9%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.7%	0.8%
	Sometimes	1.5%	1.5%
	Yes	97.8%	97.4%
Their services make their lives better.	I don't know	0.4%	0.0%
	No	2.2%	1.5%
	Sometimes	2.2%	1.9%
	Yes	95.2%	96.2%

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

	SFY22 Q2	SFY22 Q3
AIDS/HIV - Unique Service Plans	19	21
Home Delivered Meals	13	14
CDAC (individual) by 15 minute units	4	2
CDAC (agency) by 15 minute units	2	2
Financial Management Services	0	1
Brain Injury (BI) Waivers	794	786
Financial Management Services	243	241
Supported Community Living (by unit)	185	182
Personal Emergency Response	161	165
Respite (by 15 minute units)	155	157
Supported Community Living (daily)	106	109
Children's Mental Health (CMH)	756	739
Respite (by 15 minute units)	400	416
Family and Community Support	205	200
Respite (Hos/NF) - 15 minute units	193	198
Respite (Resident Camp) by units	9	10
Home Delivered Meals	3	2
Elderly Waivers	4,487	4,349
Personal Emergency Response	2,844	2,798
Home Delivered Meals	2,854	2,765
CDAC (agency) by 15 minute units	409	390
Assisted Living Services	368	334
Personal Emergency Response (install)	291	285

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	SFY22 Q2	SFY22 Q3
Habilitation (Hab)	4,238	4,233
Home-based Habilitation	3,816	3,681
Long Term Job Coaching	431	412
Day Habilitation (units by day)	401	380
Day Habilitation (by 15 minute units)	151	129
Individual Supported Employment	197	112
Health & Disability (HD)	1,340	1,326
Financial Management Services	391	376
Respite (by 15 minute units)	355	352
Personal Emergency Response	305	311
Home Delivered Meals	294	290
Respite (Hos/NF) - 15 minute units	68	64
Intellectual Disability (ID)	6,969	6,951
Supported Community Living (by unit)	1,786	1,775
Supported Community Living (RCF)	1,463	1,458
Financial Management Services	1,436	1,431
Day Habilitation (units by day)	1,432	1,386
Supported Community Living (daily)	1,171	1,133
Physical Disability (PD)	622	606
Personal Emergency Response	343	326
CDAC (agency) by 15 minute units	53	79
CDAC (individual) by 15 minute units	47	77
Financial Management Services	38	33
Home Delivered Meals	38	30

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 Q2	SFY22 Q3
AIDS/HIV - Unique Service Plans	9	7
Home Delivered Meals	7	8
CDAC (individual) by 15 minute units	3	2
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	1	1
Brain Injury (BI) Waivers	520	514
Supported Community Living (by unit)	225	222
Personal Emergency Response	132	132
Respite (by 15 minute units)	134	130
Supported Community Living (daily)	119	124
Transportation (1-way trip)	88	87
Children's Mental Health (CMH)	327	328
Respite (by 15 minute units)	189	192
Respite (Hos/NF) - 15 minute units	124	127
Family and Community Support	96	106
Mental Health Service	38	40
Respite (Resident Camp) by units	1	8
Elderly Waivers	3,277	3,257
Personal Emergency Response	2,490	2,542
Home Delivered Meals	2,514	2,513
CDAC (agency) by 15 minute units	1,352	1,353
Homemaker (by 15 minute units)	801	757
CDAC (individual) by 15 minute units	670	659

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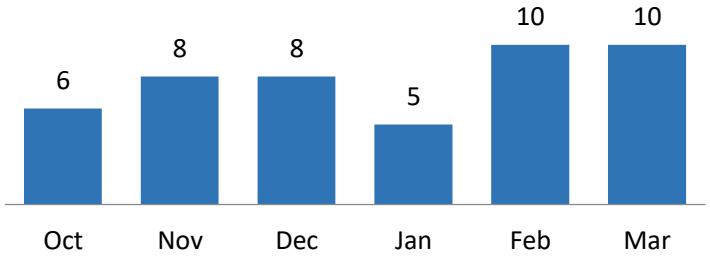
	SFY22 Q2	SFY22 Q3
Habilitation (Hab)	2,356	2,364
Home-based Habilitation	1,993	1,966
Day Habilitation (by 15 minute units)	333	343
Day Habilitation (units by day)	286	296
Long Term Job Coaching	278	285
Individual Supported Employment	145	135
Health & Disability (HD)	594	593
Respite (by 15 minute units)	280	276
Personal Emergency Response	171	159
Home Delivered Meals	174	158
CDAC (agency) by 15 minute units	119	112
CDAC (individual) by 15 minute units	103	101
Intellectual Disability (ID)	4,479	4,466
Supported Community Living (by unit)	1,811	1,823
Day Habilitation (by 15 minute units)	1,660	1,736
Day Habilitation (units by day)	1,653	1,623
Supported Community Living (RCF)	1,312	1,284
Respite (by 15 minute units)	1,014	1,019
Physical Disability (PD)	358	375
Personal Emergency Response	194	196
CDAC (agency) by 15 minute units	170	155
CDAC (individual) by 15 minute units	121	126
Transportation (1-way trip)	37	40
Personal Emergency Response (install)	17	22

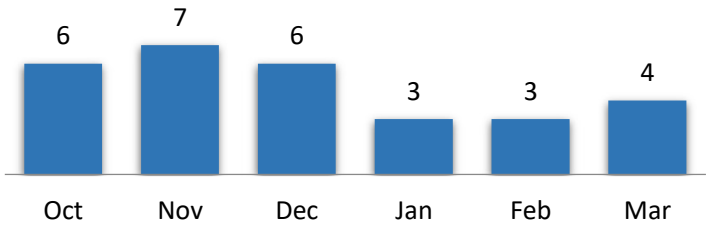
Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	96.47%	95.95%	97.07%
Abandonment Rate - Must be 5% or less	0.50%	1.01%	0.65%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.35%	98.64%	99.02%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.18%
Provider Helpline			
Service Level (Requirement 80%)	95.18%	92.42%	95.50%
Abandonment Rate - Must be 5% or less	0.32%	1.31%	0.52%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	97.50%	97.54%	95.93%
Abandonment Rate - Must be 5% or less	0.04%	0.41%	0.19%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	86.51%	86.73%	89.25%
Abandonment Rate - Must be 5% or less	1.68%	2.16%	1.84%

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.

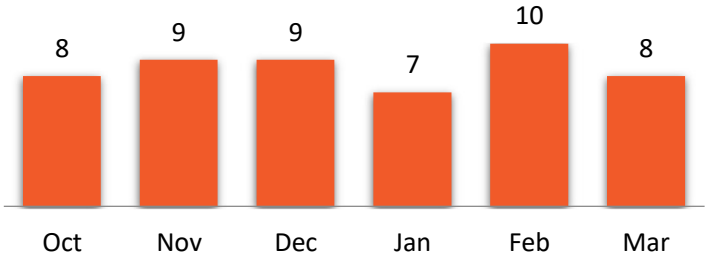
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Over the Counter
5.	Claim Inquiry

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

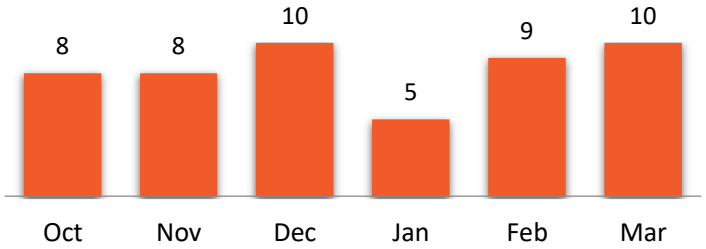
Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	84.25%	85.39%	85.26%
Abandonment Rate - Must be 5% or less	2.58%	2.65%	4.17%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	93.40%	87.70%	87.77%
Abandonment Rate - Must be 5% or less	1.10%	1.20%	2.18%
Provider Helpline			
Service Level (Requirement 80%)	87.80%	82.90%	82.30%
Abandonment Rate - Must be 5% or less	4.00%	2.27%	3.15%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	87.50%	95.10%	95.00%
Abandonment Rate - Must be 5% or less	1.33%	0.90%	0.99%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	86.30%	87.09%	89.84%
Abandonment Rate - Must be 5% or less	1.03%	1.58%	1.54%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

	Top 5 Call Reasons (Member Helpline)
1.	Benefits and Eligibility for Member
2.	Coordination Of Benefits for Member
3.	Update PCP/PPG for Member
4.	Member Rewards for Member
5.	Order ID card

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

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3
Adults PCP				
Provider Count	6,632	6,589	6,688	6,768
Members with Access	224,574	228,637	231,146	230,958
Average Distance (Miles)	1.8	1.8	1.8	1.8
Pediatric PCP				
Provider Count	6,666	6,621	6,719	6,798
Members with Access	211,406	213,136	212,453	214,637
Average Distance (Miles)	2.0	2.0	1.9	1.9

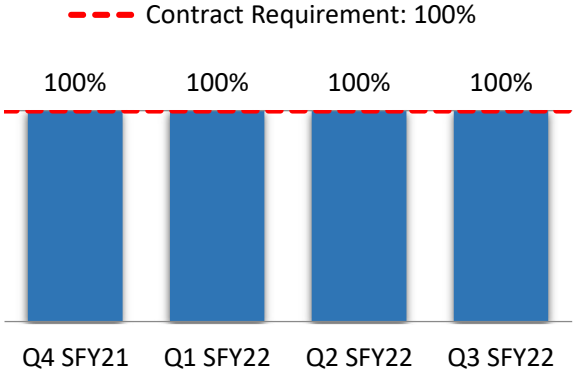
Specialty Care & Behavioral Health (BH)

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3
OB/GYN Adult				
Provider Count	402	401	405	409
Members with Access	146,051	148,670	150,083	150,019
Average Distance (Miles)	5.6	5.6	5.6	5.5
Outpatient - Behavioral Health				
Provider Count	4,205	4,305	4,456	4,503
Members with Access	435,980	441,773	443,599	445,595
Average Distance (Miles)	2.3	2.3	2.2	2.2
Inpatient - Behavioral Health				
Provider Count	50	50	51	51
Rural Members				
Members with Access	178,368	180,629	181,008	181,707
Average Distance (Miles)	21.4	21.4	18.5	18.3
Urban Members				
Members with Access	257,612	261,144	262,591	263,888
Average Distance (Miles)	5.8	5.8	5.8	5.8

Amerigroup
An Anthem Company

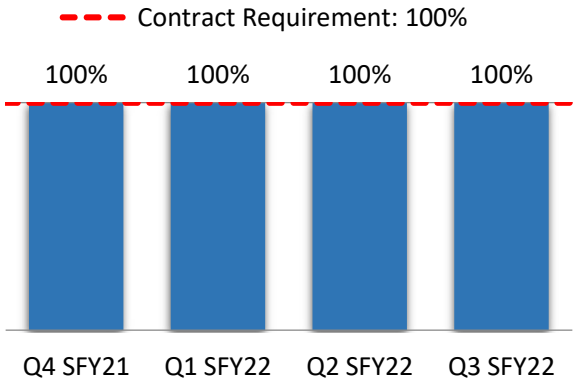
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

Provider Network Access Summary

Primary Care Providers (PCP)

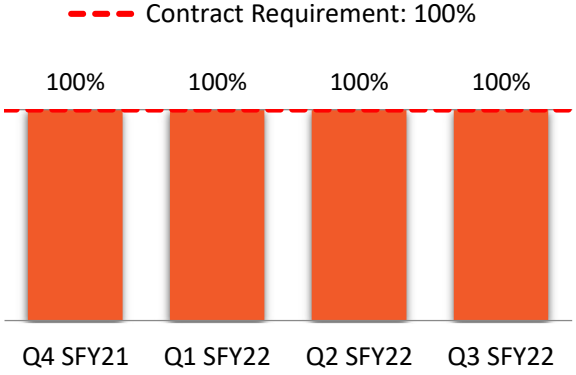
	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3
Adults PCP				
Provider Count	9,704	9,894	9,894	9,894
Members with Access	171,647	175,634	180,087	186,041
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	10,472	10,658	10,658	10,658
Members with Access	140,406	141,050	143,484	146,338
Average Distance (Miles)	2.1	2.1	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3
OB/GYN Adult				
Provider Count	1,286	1,298	1,298	1,298
Members with Access	113,317	115,394	118,135	121,417
Average Distance (Miles)	5.4	5.4	5.4	5.3
Outpatient - Behavioral Health				
Provider Count	9,476	9,688	9,688	9,688
Members with Access	312,053	316,684	323,571	332,379
Average Distance (Miles)	2.5	2.4	2.4	2.4
Inpatient - Behavioral Health				
Provider Count	36	36	36	36
Rural Members				
Members with Access	223,411	226,908	231,823	238,027
Average Distance (Miles)	24.6	24.6	24.5	24.5
Urban Members				
Members with Access	88,642	89,776	91,748	94,352
Average Distance (Miles)	8.4	8.4	8.4	8.4

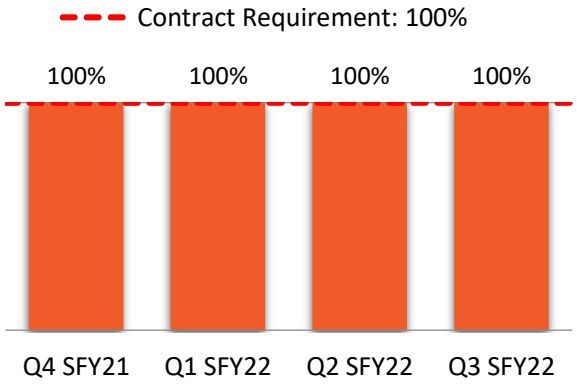
Adult PCP - Standards

30 minutes or 30 miles



Pediatric PCP - Standards

30 minutes or 30 miles



Link to Geo Access Reports:

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

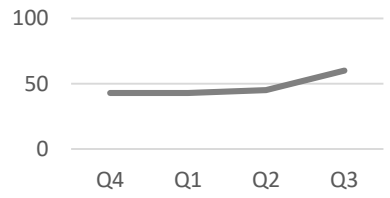
MCO Program Integrity

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 Q3

60



6 Total Cases
Referred to MCFU Q3

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	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3	Average	Total
Investigations opened	33	28	31	44	34	136
Overpayments identified	23	14	25	28	23	90
Member concerns referred to IME	2	2	5	0	2	9
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	6	4	3	5	19

iowa total care

	SFY21 Q4	SFY22 Q1	SFY22 Q2	SFY22 Q3	Average	Total
Investigations opened	10	15	12	16	13	53
Overpayments identified	6	12	17	9	11	44
Member concerns referred to IME	10	10	5	6	8	31
Cases referred to the Medicaid Fraud Control Unit (MCFU)	12	16	3	3	9	34

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

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

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

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

Hawki Board of Directors Member List

Public Members
- MaryNelle Trefz, Chair
- Mary Scieszinski, Vice Chair
- Shawn Garrington
- Mike Stopulos

Statutory Members

Iowa Insurance Division
- Doug Ommen - Commissioner
- Angela Burke Boston - Designee

Iowa Department of Education
- Dr. Ann Lebo - Director
- Jim Donoghue - Designee

Iowa Department of Public Health
- Kelly Garcia - Interim Director
- Angie Doyle Scar - Designee

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

Legislative Members - Ex Officio
- Senator Nate Boulton
- Senator Mark Costello
- Representative Shannon Lundgren

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

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

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

MAAC Council Member List

Co-Chairpersons
Angela Doyle-Scar, Public Health
Jason Haglund, Public Member

Voting Members: Public Representatives
John Dooley, Public Member
Dee Sandquist, Public Member
Amy Shriver, Public Member
Marcie Strouse, Public Member

Voting Members: Professional and Business Entities
Brett Barker, Iowa Pharmacy Association
Erin Cubit, Iowa Hospital Association
Brandon Hagen, Iowa Health Care Association
Shelly Chandler, Iowa Association of Community Providers
Dennis Tibben, Iowa Medical Society

Members of the General Assembly
Senator Bolkcom
Senator Mark Costello
Representative John Forbes
Representative Ann Meyer

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

Professional and Business Entities
Anthony Carroll, AARP
Doug Cunningham, the ARC of Iowa
Kristie Oliver, Coalition for Family and Children's Services in Iowa
Wendy Gray, Free Clinics of Iowa
David Carlyle, Iowa Academy of Family Physicians
Patricia Hildebrand, Iowa Academy of Nutrition and Dietetics
Maria Jordan, Iowa Adult Day Services Association
Dan Royer, Iowa Alliance in Home Care
Helen Royer, Iowa Hearing Association
Cheryll Jones, Iowa Association of Nurse Practitioners
Edward Friedmann, Iowa Association of Rural Health Clinics
Di Findley, Iowa CareGivers
Continued…

MAAC Council Member List continued...

Professional and Business Entities

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

Appendix: Oversight Entities - Council on Human Services

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

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

Council on Human Services Member List

Iowa Council on Human Services Members

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

Legislative Members - Ex Officio

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