

Iowa Medicaid Enterprise (IME)



Managed Care Organization (MCO)

Report: SFY 2022, Quarter 2

(October - December 2021)

Performance Data

Published March 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 2 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)

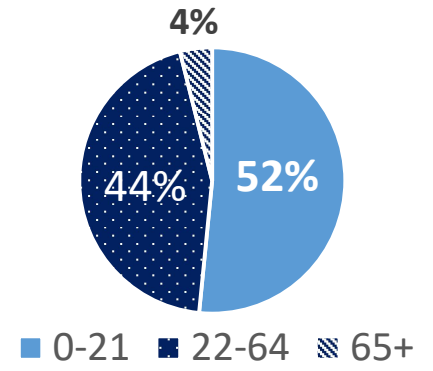
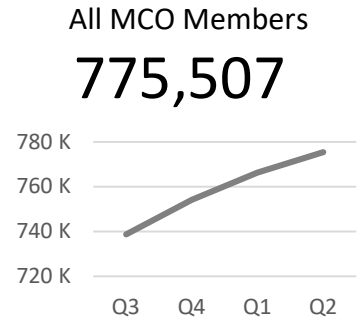
Notes about the reported data:

- 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>

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.



+ 9,240 Members
1.21% Increase

All MCO Enrollment
(by Age)

Data Notes: December 2021 enrollment data as of February 2022. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

| | SFY21 Q3 | SFY21 Q4 | SFY22 Q1 | SFY22 Q2 | Average | Distinct |
|---|--|----------|------------------------------|----------------|--|-----------------------|
| MCO Member Summary - Overall Counts | 738,739 | 754,103 | 766,267 | 775,507 | 758,654 | 811,293 |
| 0-21 | 388,655 | 393,703 | 397,383 | 400,213 | 394,989 | 417,320 |
| 22-64 | 321,248 | 330,873 | 338,971 | 345,001 | 334,023 | 360,102 |
| 65+ | 28,836 | 29,527 | 29,913 | 30,293 | 29,642 | 33,871 |
| Fee-For-Service (FFS) - Non MCO Enrollees | 42,216 | 43,938 | 45,062 | 46,254 | 44,368 | 50,005 |
| Significant Change in Data? (+/-) | No <input checked="" type="checkbox"/> | | Yes <input type="checkbox"/> | | Iowa Medicaid Population 861,298 | |
| <i>If Yes, explain:</i> | | | | | | 1 year distinct count |
| <p>o Disenrollment decreased from Q1 to Q2 due to the end of open enrollment.</p> | | | | | | |

MCO Member Summary



SFY22 Q1 SFY22 Q2

| | | |
|---------------------------------------|---------|----------------|
| All Members - by MCO | 445,169 | 447,581 |
| Traditional Medicaid | 273,370 | 274,834 |
| Wellness Plan - IHAWP/Expansion | 124,002 | 126,843 |
| M-CHIP - Expansion | 7,479 | 7,833 |
| Healthy and Well Kids in Iowa (Hawki) | 40,318 | 38,071 |
| | | |
| MCO Member Market Share | 58.1% | 57.7% |
| Disenrolled | 1,157 | 599 |



SFY22 Q1 SFY22 Q2

| | | |
|---------------------------------------|---------|----------------|
| All Members - by MCO | 321,098 | 327,926 |
| Traditional Medicaid | 198,160 | 201,591 |
| Wellness Plan - IHAWP/Expansion | 100,062 | 103,988 |
| M-CHIP - Expansion | 6,325 | 6,587 |
| Healthy and Well Kids in Iowa (Hawki) | 16,551 | 15,760 |
| | | |
| MCO Member Market Share | 41.9% | 42.3% |
| Disenrolled | 914 | 403 |

| | | |
|--|--------|---------------|
| Long-Term Service & Support (LTSS) | 22,219 | 21,662 |
| HCBS Waivers | 68.6% | 69.2% |
| Facility Based Services | 31.4% | 30.8% |
| | | |
| HCBS Waivers ¹ | 15,237 | 14,985 |
| - Reference p. 23-24 for HCBS waiver and service plan enrollment | | |
| | | |
| Facility Based Services ² | 6,982 | 6,677 |
| ICF/ID ³ | 982 | 967 |
| Mental Health Institute (MHI) | 38 | 36 |
| Nursing Facilities (NF) | 5,804 | 5,534 |
| Nursing Facilities for Mentally Ill | 71 | 58 |
| Skilled | 87 | 82 |

| | | |
|--|--------|---------------|
| Long-Term Service & Support (LTSS) | 14,735 | 14,551 |
| HCBS Waivers | 65.0% | 65.7% |
| Facility Based Services | 35.0% | 34.3% |
| | | |
| HCBS Waivers ¹ | 9,571 | 9,561 |
| - Reference p. 23-24 for HCBS waiver and service plan enrollment | | |
| | | |
| Facility Based Services ² | 5,164 | 4,990 |
| ICF/ID ³ | 594 | 572 |
| Mental Health Institute (MHI) | 33 | 23 |
| Nursing Facilities (NF) | 4,432 | 4,298 |
| Nursing Facilities for Mentally Ill | 36 | 32 |
| Skilled | 69 | 65 |

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 (689) and Psychiatric Medical Institutions for Children (PMICs - 300).

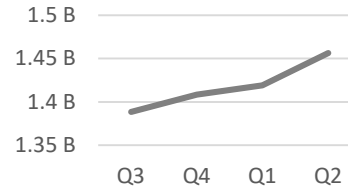
³ Intermediate Care Facilities for the Intellectually Disabled (ICF/ID).

MCO Financial Summary - All MCO Counts

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

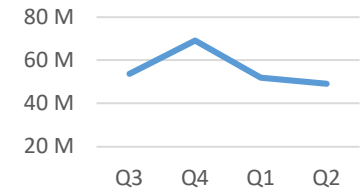
The MCOs are responsible for recovering Medicaid dollars when it is determined that other insurance coverage is available (e.g. health, auto, worker's comp, or even Medicare). This process is known as Third Party Liability (TPL). The MCO retains all recovered TPL funds: however, these funds are then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

All Capitation Payments
\$1.46 Billion



+ \$37.7 Million
2.66% Increase

Third Party Liability Recovered
\$49.17 Million



- \$ 2.9 Million
5.35% decrease

Data Notes: December 2021 capitation data as of February 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.

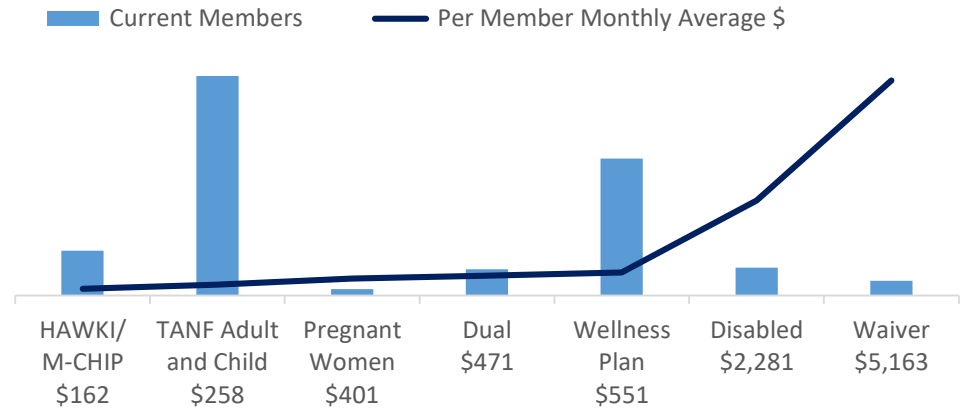
| | SFY21 Q3 | SFY21 Q4 | SFY22 Q1 | SFY22 Q2 | Average | Total |
|--|--|-----------|------------------------------|------------------|-----------|------------|
| Financial Summary | | | | | | |
| Capitation Payments | \$1.39 B | \$1.41 B | \$1.42 B | \$1.46 B | \$1.42 B | \$5.67 B |
| Third Party Liability (TPL) Recovered | \$53.73 M | \$69.23 M | \$51.95 M | \$49.17 M | \$56.02 M | \$224.08 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 decreased by \$2.9M or 5.35% between Q1 and Q2.</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 Q1 SFY22 Q2



SFY22 Q1 SFY22 Q2

| | | |
|---|-------------------------------|-------------------|
| Capitation Totals | \$832.22 M | \$851.01 M |
| Adjustments | -\$2.07 M | \$5.38 M |
| Current | \$814.65 M | \$825.03 M |
| Retro | \$19.64 M | \$20.61 M |
| Third Party Liability (TPL) Recovered | \$15.35 M | \$16.51 M |
| Financial Ratios | | |
| Medical Loss Ratio (MLR) | 90.5% | 85.8% |
| Administrative Loss Ratio (ALR) | 5.3% | 5.4% |
| Underwriting Ratio (UR) | 4.1% | 8.9% |
| | Annual MLR⁴ | 88.2% |
| Reported Reserves | | |
| Acceptable Quarterly Reserves per Iowa Insurance Division (IID) | Y | Y |

| | | |
|---|-------------------------------|-------------------|
| Capitation Totals | \$586.7 M | \$605.63 M |
| Adjustments | -938,683 | \$5.46 M |
| Current | \$568.86 M | \$580.67 M |
| Retro | \$18.78 M | \$19.5 M |
| Third Party Liability (TPL) Recovered | \$36.59 M | \$32.66 M |
| Financial Ratios | | |
| Medical Loss Ratio (MLR) | 93.2% | 90.9% |
| Administrative Loss Ratio (ALR) | 4.3% | 4.5% |
| Underwriting Ratio (UR) | 2.5% | 4.6% |
| | Annual MLR⁴ | 91.9% |
| Reported Reserves | | |
| Acceptable Quarterly Reserves per Iowa Insurance Division (IID) | Y | Y |

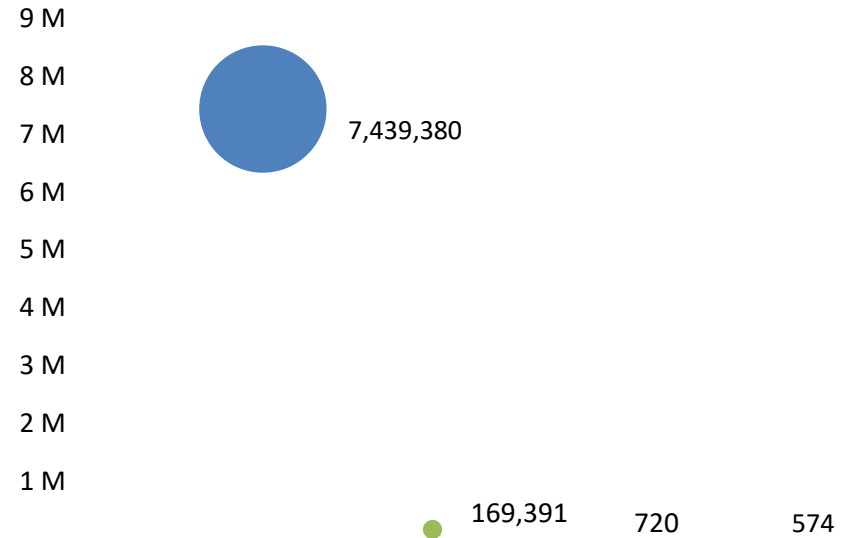
⁴ Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

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 | 2.28% |
| Grievances | 0.01% |
| Appeals | 0.01% |

| | SFY21 Q3 | SFY21 Q4 | SFY22 Q1 | SFY22 Q2 | Average | Total |
|---|----------|----------|----------|----------------|---------|---------|
| Claim Counts - All Paid & Denied (p. 9-12) | 6.84 M | 7.13 M | 7.10 M | 7.44 M | 7.13 M | 28.52 M |
| Non-Pharmacy | 4.00 M | 4.21 M | 4.21 M | 4.46 M | 4.22 M | 16.88 M |
| Pharmacy | 2.84 M | 2.92 M | 2.90 M | 2.98 M | 2.91 M | 11.64 M |
| Prior Authorization Summary (p. 13-14) | 185,570 | 180,026 | 171,159 | 169,391 | 176,537 | 706,146 |
| Non-Rx - Standard PAs Submitted | 139,780 | 138,319 | 127,869 | 124,736 | 132,676 | 530,704 |
| Pharmacy - Standard PAs Submitted | 45,790 | 41,707 | 43,290 | 44,655 | 43,861 | 175,442 |
| Grievances & Appeals Summary (p. 15-16) | | | | | | |
| Standard Grievances | 604 | 583 | 587 | 720 | 624 | 2,494 |
| Standard Appeals | 649 | 750 | 701 | 574 | 669 | 2,674 |

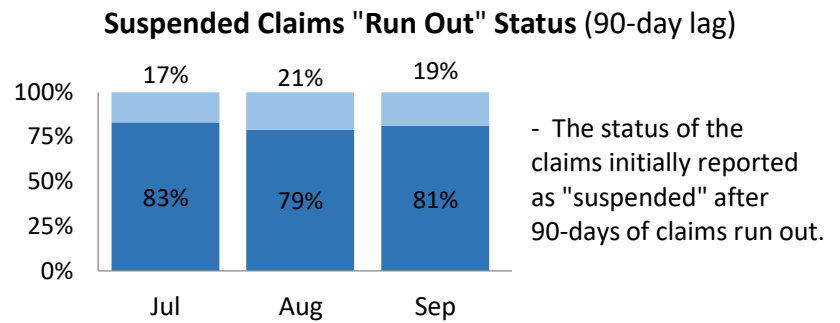
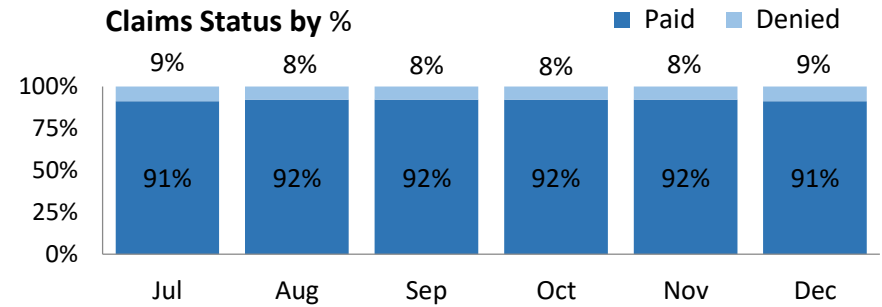
Claims Summary (Non-Pharmacy)

2.55 Million
Claims Paid & Denied



| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| All Claims | | | |
|---|---------|---------|---------|
| Paid | 759,097 | 836,841 | 731,569 |
| Denied | 67,837 | 76,822 | 73,911 |
| Suspended | 211,699 | 135,711 | 146,910 |
| Clean Claims Processed | | | |
| in 30-days (Requirement 90%) | 98% | 98% | 99% |
| in 45-days (Requirement 95%) | 99% | 100% | 100% |
| Average Days to Pay | | | |
| | 8 | 8 | 7 |
| Provider Adjustment Requests & Errors Reprocessed in 30-days | | | |
| | 100% | 100% | 100% |



| Top 10 Reasons for Claims Denials (Non-Pharmacy) | | |
|---|-----|---|
| | % | |
| 1. | 13% | Prior processing information appears incorrect |
| 2. | 11% | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement |
| 3. | 10% | Duplicate claim/service |
| 4. | 7% | Precertification/authorization/notification absent Claim/service lacks information or has submission/billing error(s) |
| 5. | 7% | Expenses incurred after coverage terminated |
| 6. | 6% | Claim/service lacks information or has submission/billing error(s) - primary payer information required |
| 7. | 6% | Claim/service lacks information or has submission/billing error(s) - lateral diagnosis required |
| 8. | 6% | The impact of prior payer(s) adjudication including payments and/or adjustments. |
| 9. | 5% | The time limit for filing has expired |
| 10. | 4% | Service not payable per managed care contract |

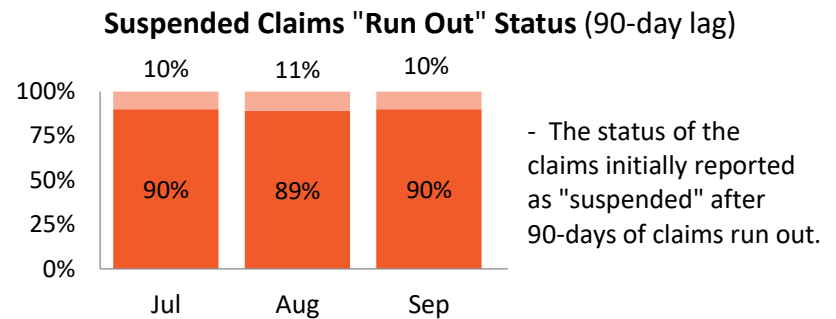
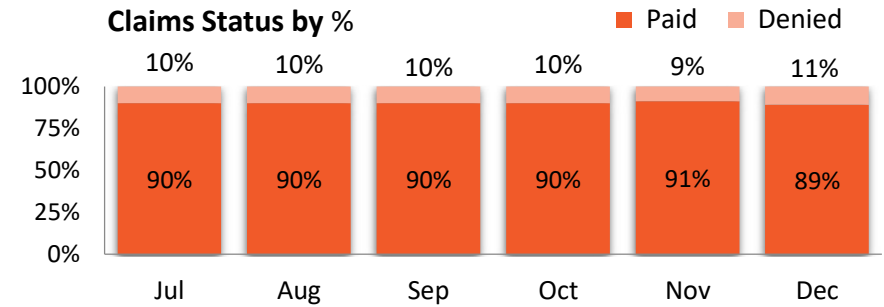
Claims Summary (Non-Pharmacy)

1.91 Million
Claims Paid & Denied



| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| All Claims | | | |
|---|---------|---------|---------|
| Paid | 556,353 | 513,597 | 653,235 |
| Denied | 59,015 | 49,865 | 82,359 |
| Suspended | 152,045 | 164,284 | 113,057 |
| Clean Claims Processed | | | |
| in 30-days (Requirement 90%) | 100% | 99% | 99% |
| in 45-days (Requirement 95%) | 100% | 100% | 99% |
| Average Days to Pay | | | |
| | 8 | 8 | 9 |
| Provider Adjustment Requests & Errors Reprocessed in 30-days | | | |
| | 98% | 99% | 99% |



| Top 10 Reasons for Claims Denials (Non-Pharmacy) | | |
|---|-----|---|
| | % | |
| 1. | 14% | Duplicate claim service |
| 2. | 10% | Service can not be combined with other service on same day |
| 3. | 7% | Reimbursed as lower complexity per payment policy |
| 4. | 6% | Bill primary insurer first; resubmit with explanation of benefits (EOB) |
| 5. | 5% | No authorization on file that matches service(s) billed |
| 6. | 5% | Service is not covered |
| 7. | 4% | Ace claim level return to provider (review claim remarks) |
| 8. | 3% | Diagnosis code incorrectly coded per ICD10 manual |
| 9. | 3% | Void adjustment |
| 10. | 3% | Billing NPI not registered with IA DHS/Iowa Medicaid |

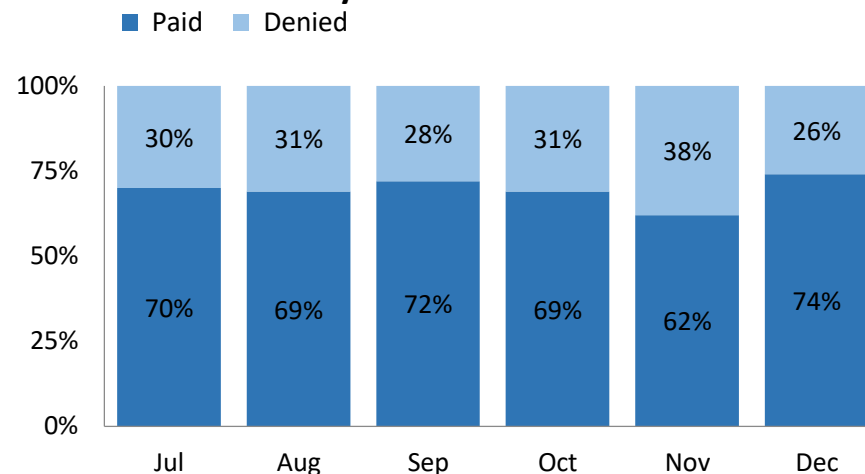
Claims Summary (Pharmacy)



1.69 Million
Claims Paid & Denied

| | Oct | Nov | Dec |
|-------------------------------|---------|---------|---------|
| All Claims (Pharmacy) | | | |
| Paid | 361,379 | 274,372 | 535,002 |
| Denied | 162,262 | 168,290 | 186,455 |
| 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 |

Claims Status by %



Top 10 Reasons for Claims Denials (Pharmacy)

| | % | Reason |
|-----|-----|---|
| 1. | 38% | Refill too soon |
| 2. | 16% | Prior authorization required |
| 3. | 11% | Submit bill to other processor or primary payer |
| 4. | 10% | National Drug Code (NDC) not covered |
| 5. | 5% | Plan limitations exceeded |
| 6. | 4% | M/I other payer reject code |
| 7. | 2% | M/I processor control number |
| 8. | 2% | Prescriber is not covered |
| 9. | 2% | Filled after coverage terminated |
| 10. | 1% | Pharmacy not enrolled in State Medicaid program M/I other coverage code |

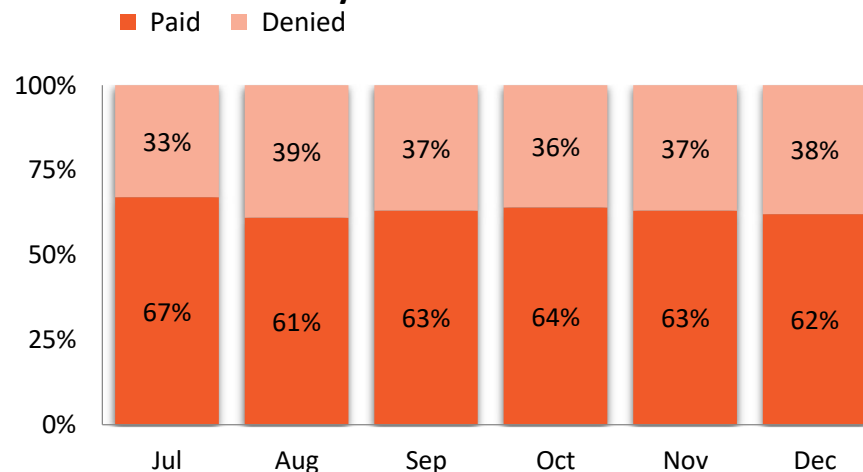
Claims Summary (Pharmacy)



1.29 Million
Claims Paid & Denied

| | Oct | Nov | Dec |
|-------------------------------|---------|---------|---------|
| All Claims (Pharmacy) | | | |
| Paid | 267,441 | 271,031 | 274,826 |
| Denied | 152,668 | 158,074 | 167,079 |
| 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 |

Claims Status by %



Top 10 Reasons for Claims Denials (Pharmacy)

| | % | Reason |
|-----|-----|---|
| 1. | 27% | Refill too soon |
| 2. | 12% | Prior authorization required |
| 3. | 10% | National Drug Code (NDC) not covered |
| 4. | 5% | Plan limitations exceeded |
| 5. | 4% | Submit bill to other processor or primary payer |
| 6. | 2% | Prescriber is not enrolled in State Medicaid program |
| 7. | 2% | Drug Utilization Review (DUR) reject error |
| 8. | 2% | Pharmacy not enrolled in State Medicaid program |
| 9. | 1% | Drug not covered for patient age |
| 10. | 1% | Discrepancy other coverage code & other payer amount paid |

Prior Authorization Summary



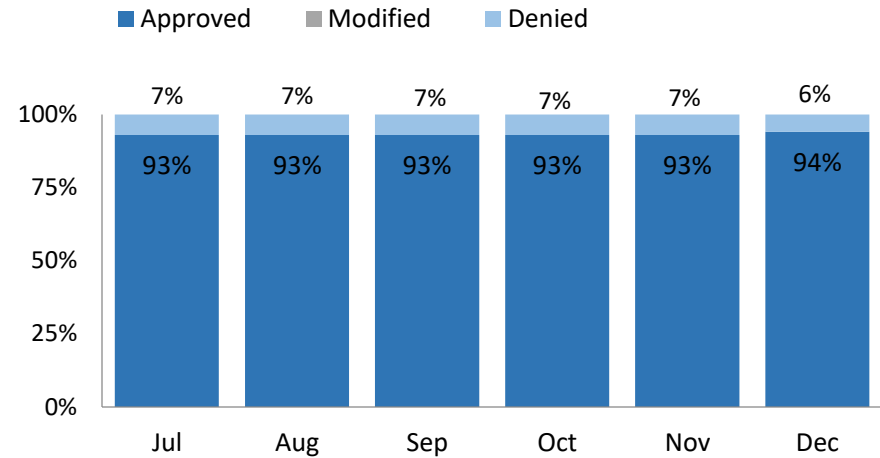
80,940
All PAs Submitted ⁵

Non-Pharmacy

| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | | | |
|---|--------|--------|--------|
| Standard Prior Authorizations (PAs) | | | |
| Approved | 17,554 | 16,408 | 16,723 |
| Denied | 1,235 | 1,219 | 1,147 |
| Modified | 0 | 1 | 0 |
| Average Days to Process | 4 | 4 | 4 |
| Standard PAs Completed in 14-days (Requirement 99%) | 99% | 99% | 100% |
| Expedited PAs Completed in 72-hours (Requirement 99%) | 99% | 99% | 99% |

Non-Pharmacy by Percentage

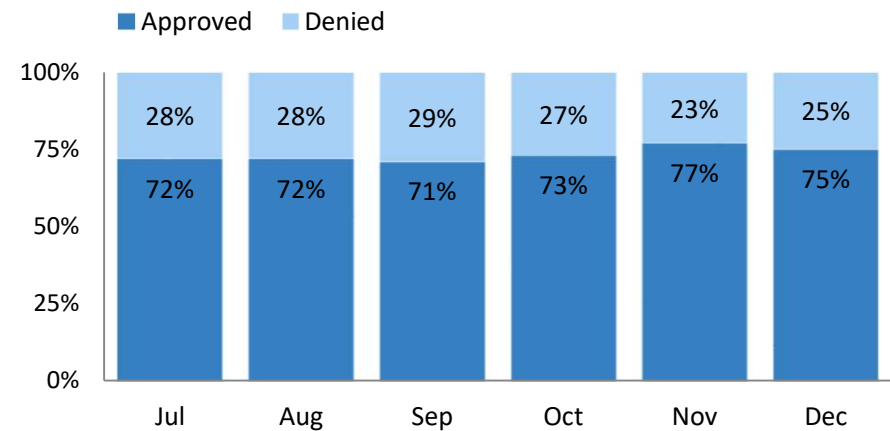


Pharmacy

| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | | | |
|--|-------|-------|-------|
| Prior Authorizations | | | |
| Approved | 6,239 | 7,452 | 6,264 |
| Denied | 2,301 | 2,249 | 2,140 |
| PAs Completed in 24-hours (Requirement 100%) | 100% | 100% | 99.9% |

Pharmacy by Percentage



⁵ 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 ⁵

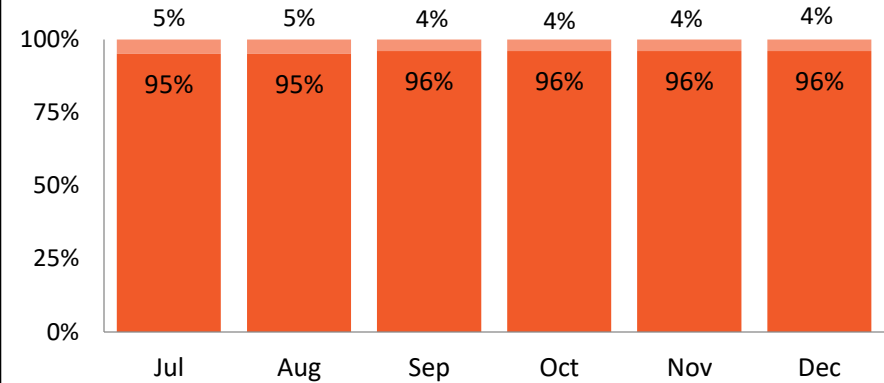
Non-Pharmacy

| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | Oct | Nov | Dec |
|---|--------|--------|--------|
| Standard Prior Authorizations (PAs) | | | |
| Approved | 24,286 | 22,373 | 22,039 |
| Denied | 1,104 | 1,024 | 991 |
| 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% |

Non-Pharmacy by Percentage

Approved Modified Denied



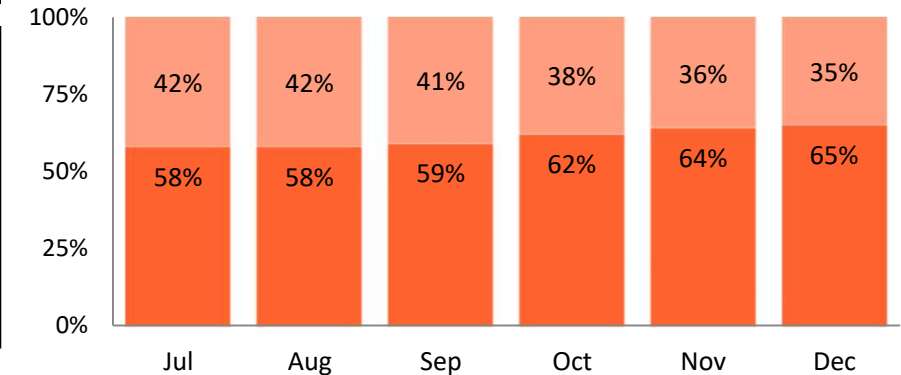
Pharmacy

| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | Oct | Nov | Dec |
|--|-------|-------|-------|
| Prior Authorizations | | | |
| Approved | 3,047 | 3,572 | 3,460 |
| Denied | 1,835 | 2,042 | 1,867 |
| PAs Completed in 24-hours (Requirement 100%) | 99.9% | 99.8% | 100% |

Pharmacy by Percentage

Approved Denied



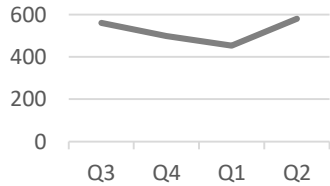
⁵ Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals



Standard Grievances

580



Standard Appeals

400

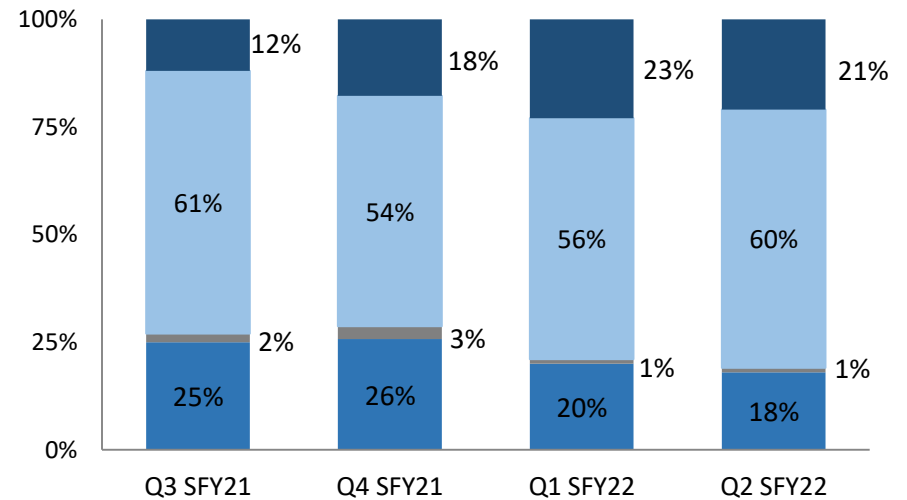


Resolved in 30-days
100%

Resolved in 30-days
100%



Standard Appeal Outcome %



Top 10 Reasons for Grievances ⁶

| | % | Reason |
|-----|-----|---------------------------------|
| 1. | 41% | Voluntary disenrollment |
| 2. | 14% | Provider balance billed |
| 3. | 8% | Transportation - Driver no-show |
| 4. | 7% | Poor Customer Service |
| 5. | 5% | Provider dissatisfaction |
| 6. | 5% | Treatment dissatisfaction |
| 7. | 3% | Transportation - Driver delay |
| 8. | 2% | Inadequate benefit access |
| 9. | 2% | Access to Case Management |
| 10. | 2% | Too Many Phone Inquiries |

Top 10 Reasons for Appeals ⁶

| | % | Reason |
|--|-----|---------------------------|
| | 27% | DME |
| | 24% | Pharmacy - Non Injectable |
| | 9% | Radiology |
| | 8% | Pharmacy - Injectable |
| | 6% | BH - Op Service |
| | 4% | Surgery |
| | 3% | Inpatient - Medical |
| | 3% | Therapy - PT |
| | 3% | Pain Management |
| | 2% | BH - Inpatient |

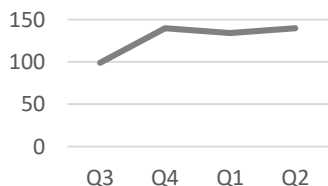
⁶ Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Grievances and Appeals



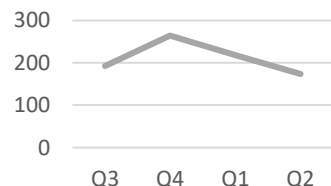
Standard Grievances

140



Standard Appeals

174

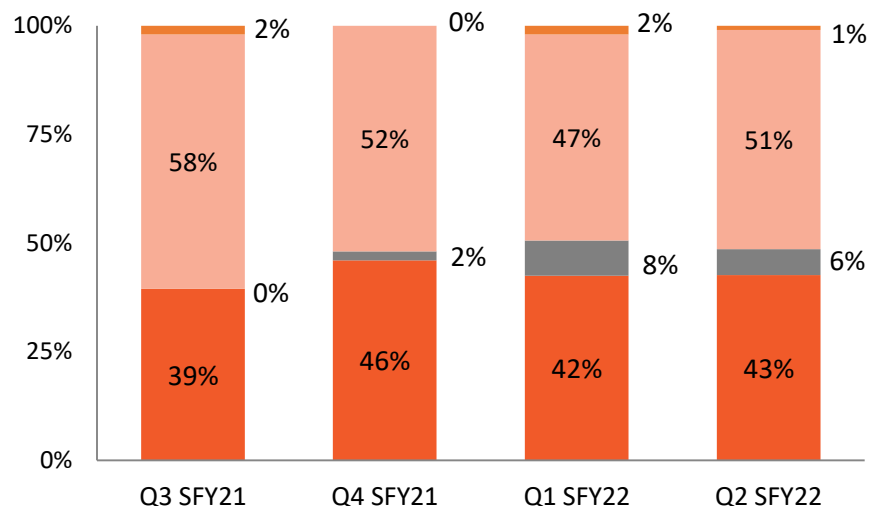


Resolved in 30-days
100%

Resolved in 30-days
100%



Standard Appeal Outcome %



Top 10 Reasons for Grievances ⁶

| | % | Reason |
|-----|-----|---|
| 1. | 20% | Unhappy with Benefits |
| 2. | 20% | Access to Care - Network Availability |
| 3. | 11% | Transportation - Missed Appointment |
| 4. | 10% | Transportation - General Complaint Vendor |
| 5. | 6% | Lack of Caring/Concern |
| 6. | 3% | Transportation - Unsafe Driving |
| 7. | 3% | Provider |
| 8. | 3% | Transportation - Driver no-show |
| 9. | 2% | Transportation - Late appointment |
| 10. | 2% | Transportation - General Complaint Vendor CSR |

Top 10 Reasons for Appeals ⁶

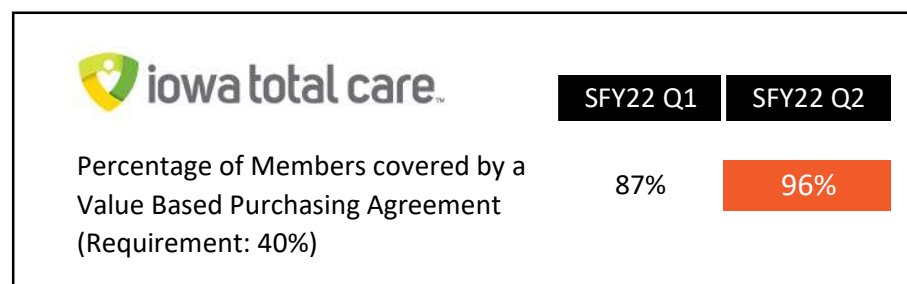
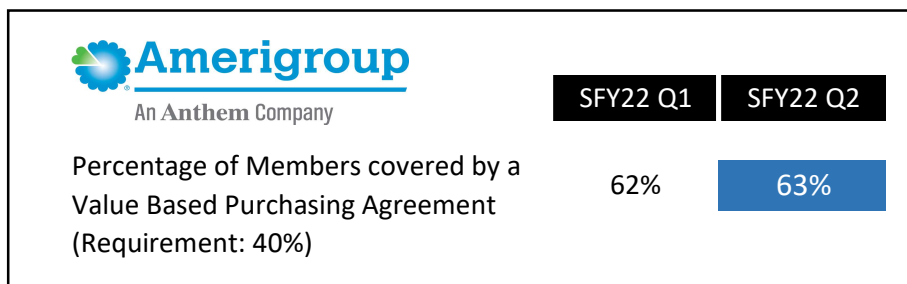
| | % | Reason |
|--|-----|---|
| | 34% | RX - Does Not Meet PriorAuth Guidelines |
| | 7% | Diagnostic - MRI |
| | 6% | Diagnostic - Test |
| | 5% | Vendor Related - Home Care |
| | 5% | Other - Mental Health Service |
| | 3% | DME - Other |
| | 3% | Vendor Related - Home Care |
| | 3% | Outpatient - Procedure |
| | 2% | DME - Pneumatic compressor/Appliance |
| | 2% | DME - Wheelchair |

⁶ 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>

Amerigroup
An Anthem Company

| | SFY22 Q1 | SFY22 Q2 |
|----------------------------|----------|----------|
| Healthy Rewards | 3,613 | 3,800 |
| Taking Care of Baby and Me | 2,310 | 2,513 |
| Community Resource Link | 2,046 | 1,170 |
| SafeLink Mobile Phone | 558 | 845 |
| Dental Hygiene Kit | 414 | 480 |

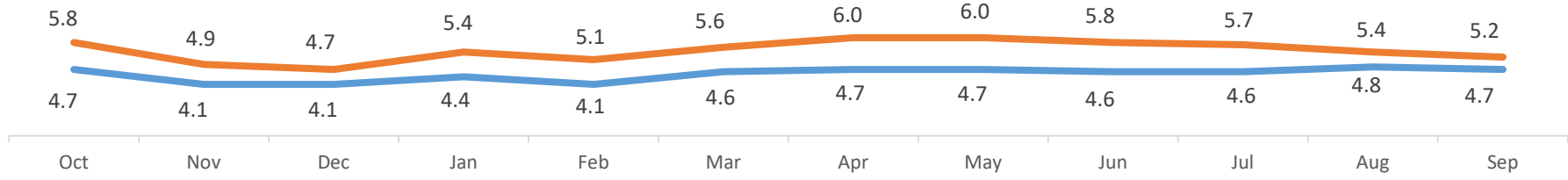
iowa total care

| | SFY22 Q1 | SFY22 Q2 |
|---------------------------|----------|----------|
| The Flu Program | 759 | 14,683 |
| My Health Pays Program | 14,419 | 12,136 |
| Start Smart for Your Baby | 1,431 | 1,416 |
| Mobile App | 834 | 1,017 |
| Breast Pumps | 406 | 462 |

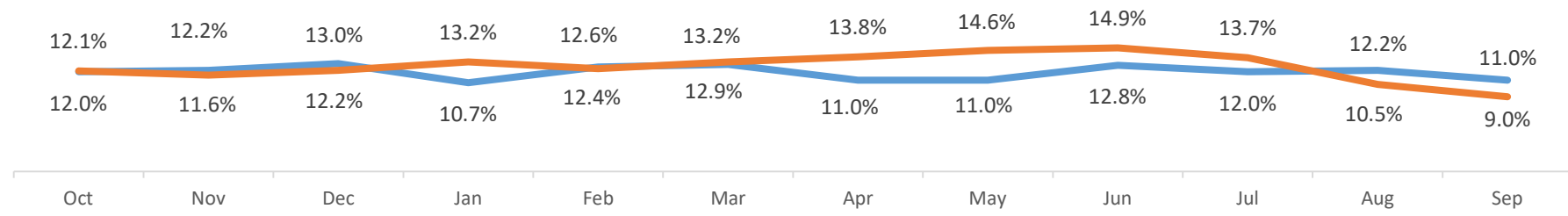
MCO Care Quality and Outcomes



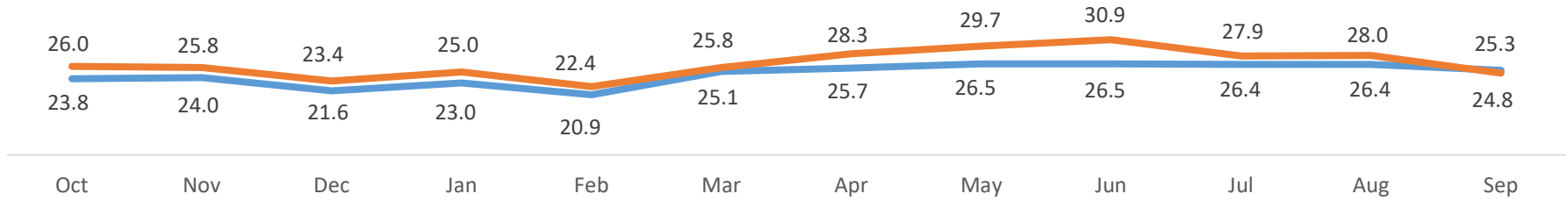
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag)⁷



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag)⁸



⁷ This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.

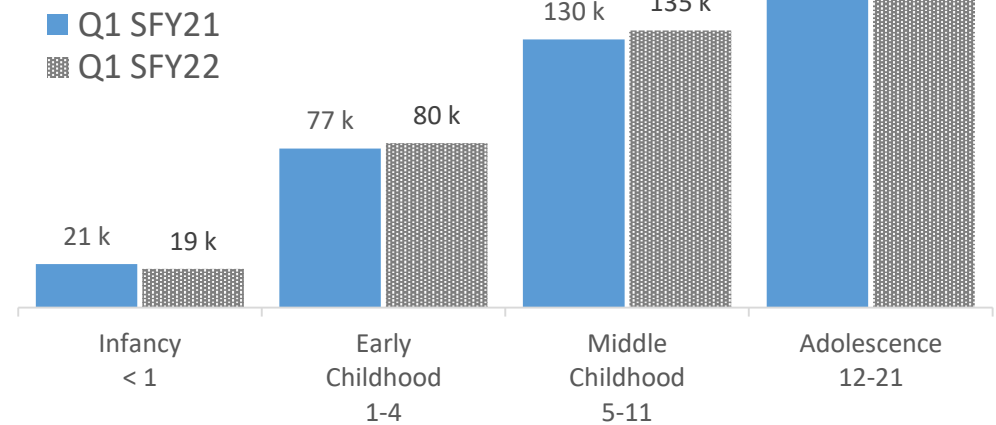
⁸ Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.

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 Q1 **SFY22 Q1**



SFY21 Q1 **SFY22 Q1**

| | | |
|---|---------|----------------|
| Member Enrollment | 228,223 | 237,586 |
| Infancy < 1 | 11,020 | 9,827 |
| Early Childhood 1 - 4 | 46,976 | 47,425 |
| Middle Childhood 5 - 11 | 78,663 | 81,514 |
| Adolescence 12 - 21 | 91,564 | 98,820 |
| Well Child Exams (Preventive Visits) | 59,780 | 59,597 |
| Infancy < 1 | 11,496 | 11,307 |
| Early Childhood 1 - 4 | 15,485 | 14,077 |
| Middle Childhood 5 - 11 | 15,528 | 15,916 |
| Adolescence 12 - 21 | 17,271 | 18,297 |
| Lead Screenings | 5,244 | 5,050 |
| Infancy < 1 | 103 | 129 |
| Early Childhood 1 - 4 | 4,460 | 4,184 |
| Middle Childhood 5 - 11 | 647 | 676 |
| Adolescence 12 - 21 | 34 | 61 |

| | | |
|---|---------|----------------|
| Member Enrollment | 152,472 | 159,797 |
| Infancy < 1 | 10,058 | 8,899 |
| Early Childhood 1 - 4 | 30,256 | 32,520 |
| Middle Childhood 5 - 11 | 51,634 | 53,211 |
| Adolescence 12 - 21 | 60,524 | 65,167 |
| Well Child Exams (Preventive Visits) | 44,048 | 46,033 |
| Infancy < 1 | 11,568 | 11,533 |
| Early Childhood 1 - 4 | 9,769 | 11,119 |
| Middle Childhood 5 - 11 | 10,772 | 10,871 |
| Adolescence 12 - 21 | 11,939 | 12,510 |
| Lead Screenings | 3,843 | 4,064 |
| Infancy < 1 | 72 | 130 |
| Early Childhood 1 - 4 | 3,284 | 3,473 |
| Middle Childhood 5 - 11 | 464 | 424 |
| Adolescence 12 - 21 | 23 | 37 |

MCO Children Summary



SFY21 Q1 **SFY22 Q1**

| | | |
|---------------------------------------|--------|---------------|
| Hearing Screenings | 1,942 | 2,009 |
| Infancy < 1 | 131 | 147 |
| Early Childhood 1 - 4 | 790 | 926 |
| Middle Childhood 5 - 11 | 690 | 647 |
| Adolescence 12 - 21 | 331 | 289 |
| Vision Screenings | 1,753 | 2,332 |
| Infancy < 1 | 12 | 32 |
| Early Childhood 1 - 4 | 599 | 944 |
| Middle Childhood 5 - 11 | 652 | 849 |
| Adolescence 12 - 21 | 490 | 507 |
| Vaccination Totals | 79,511 | 80,402 |
| COVID-19 Dose 1 | 0 | 5,839 |
| COVID-19 Dose 2 | 0 | 5,271 |
| COVID-19 Single-Dose | 0 | 60 |
| DTaP (Diphtheria, Tetanus, Pertussis) | 11,994 | 11,091 |
| Influenza (FLU) | 11,074 | 5,787 |
| HepA (Hepatitis A) | 6,410 | 5,222 |
| HepB (Hepatitis B) | 1,011 | 937 |
| Haemophilus Influenza Type B (Hib) | 5,534 | 4,956 |
| Human Papillomavirus (HPV) | 6,953 | 6,338 |
| Meningococcal ACWY (MenACWY) | 7,056 | 7,309 |
| Meningococcal B - (MenB) | 2,517 | 2,500 |
| MMR (Measles, Mumps, Rubella) | 5,970 | 5,701 |
| Pneumococcal (PCV13) | 7,953 | 7,220 |
| Pneumococcal (PPSV23) | 65 | 50 |
| Polio (IPV) | 323 | 333 |
| RV (Rotavirus) | 4,739 | 4,498 |
| Tetanus and diphtheria (Td) | 51 | 43 |
| TDAP (Tetanus, Diphtheria, Pertussis) | 5,097 | 4,935 |
| Varicella Virus Vaccine (VAR) | 2,764 | 2,312 |



SFY21 Q1 **SFY22 Q1**

| | | |
|---------------------------------------|--------|---------------|
| Hearing Screenings | 1,248 | 1,167 |
| Infancy < 1 | 116 | 106 |
| Early Childhood 1 - 4 | 451 | 499 |
| Middle Childhood 5 - 11 | 460 | 392 |
| Adolescence 12 - 21 | 221 | 170 |
| Vision Screenings | 1,135 | 1,445 |
| Infancy < 1 | 17 | 34 |
| Early Childhood 1 - 4 | 406 | 624 |
| Middle Childhood 5 - 11 | 377 | 487 |
| Adolescence 12 - 21 | 335 | 300 |
| Vaccination Totals | 56,011 | 49,225 |
| COVID-19 Dose 1 | 0 | 3,205 |
| COVID-19 Dose 2 | 0 | 2,928 |
| COVID-19 Single-Dose | 0 | 37 |
| DTaP (Diphtheria, Tetanus, Pertussis) | 9,100 | 7,611 |
| Influenza (FLU) | 7,111 | 3,274 |
| HepA (Hepatitis A) | 4,360 | 3,719 |
| HepB (Hepatitis B) | 978 | 681 |
| Haemophilus Influenza Type B (Hib) | 1,365 | 1,346 |
| Human Papillomavirus (HPV) | 4,791 | 3,679 |
| Meningococcal ACWY (MenACWY) | 4,902 | 4,108 |
| Meningococcal B - (MenB) | 1,767 | 1,283 |
| MMR (Measles, Mumps, Rubella) | 4,304 | 3,530 |
| Pneumococcal (PCV13) | 6,871 | 5,499 |
| Pneumococcal (PPSV23) | 49 | 56 |
| Polio (IPV) | 320 | 247 |
| RV (Rotavirus) | 4,472 | 3,483 |
| Tetanus and diphtheria (Td) | 34 | 27 |
| TDAP (Tetanus, Diphtheria, Pertussis) | 3,493 | 2,864 |
| Varicella Virus Vaccine (VAR) | 2,094 | 1,648 |

Long Term Services - Care Quality and Outcomes

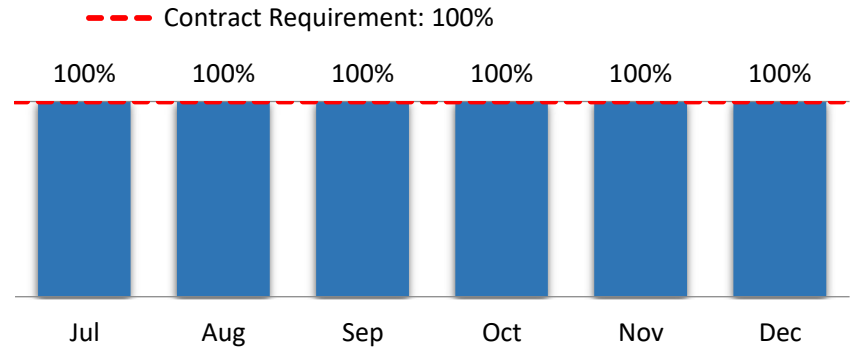
Non-LTSS Care Coordination and HCBS Case Management



| Average Number of Contacts Per Month | SFY22 Q1 | SFY22 Q2 |
|--------------------------------------|----------|------------|
| by Care Coordinators | 0.8 | 0.8 |
| by Case Managers | 1.2 | 1.1 |
| "Members to" Ratios | | |
| Members to Care Coordinators | 27 | 20 |
| HCBS Members to Case Managers | 68 | 72 |

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.

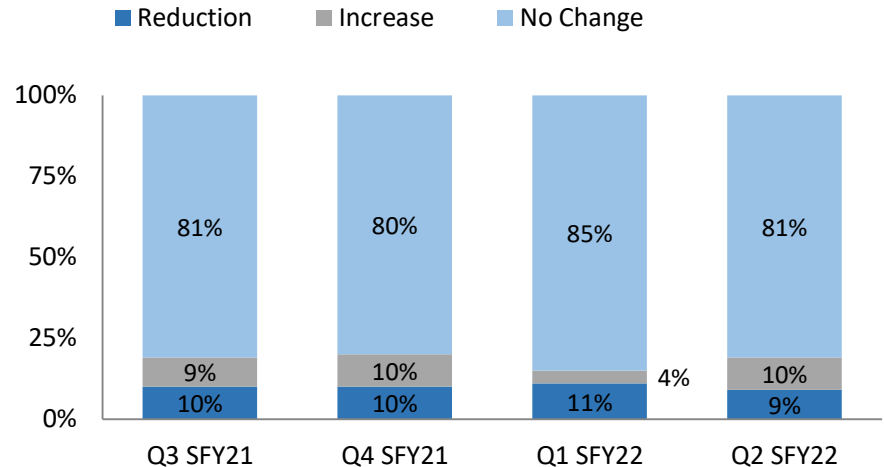
Percentage of Level of Care (LOC) Reassessments Completed Timely



Iowa Participant Experience Survey (IPES)

| Waiver members reporting... | | SFY22 Q1 | SFY22 Q2 |
|---|--------------|----------|---------------|
| They were part of service planning. | I don't know | 0.0% | 0.0% |
| | No | 0.0% | 0.0% |
| | Sometimes | 0.0% | 0.0% |
| | Yes | 100.0% | 100.0% |
| They feel safe where they live. | I don't know | 0.0% | 0.0% |
| | No | 0.0% | 0.0% |
| | Sometimes | 0.0% | 0.0% |
| | Yes | 100.0% | 100.0% |
| Their services make their lives better. | I don't know | 0.5% | 0.5% |
| | No | 0.0% | 0.0% |
| | Sometimes | 0.0% | 0.0% |
| | Yes | 99.5% | 99.5% |

Waiver Service Plan Outcomes



Long Term Services - Care Quality and Outcomes

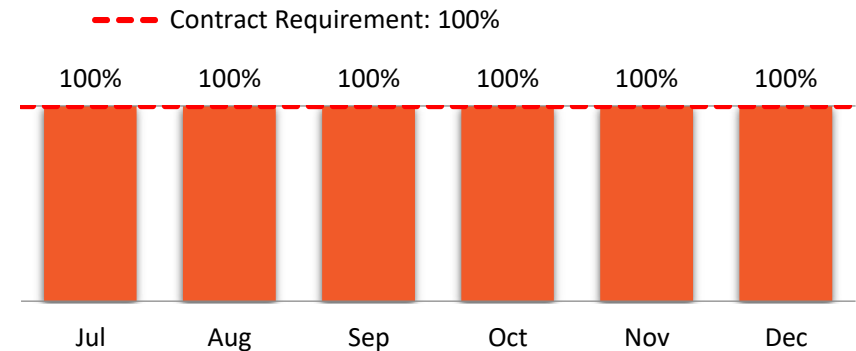
Non-LTSS Care Coordination and HCBS Case Management



| Average Number of Contacts Per Month | SFY22 Q1 | SFY22 Q2 |
|--------------------------------------|----------|------------|
| by Care Coordinators | 0.8 | 1.0 |
| by Case Managers | 1.0 | 1.0 |
| "Members to" Ratios | | |
| Members to Care Coordinators | 49 | 50 |
| HCBS Members to Case Managers | 44 | 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

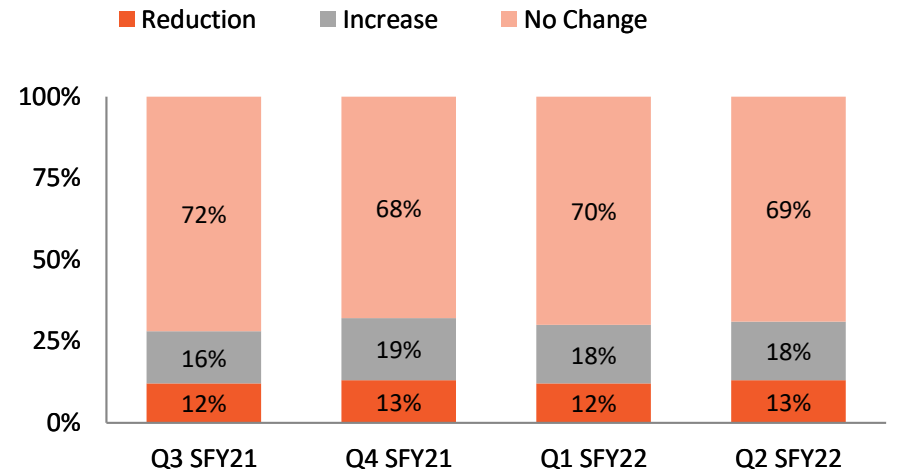
Percentage of Level of Care (LOC) Reassessments Completed Timely



Iowa Participant Experience Survey (IPES)

| Waiver members reporting... | | SFY22 Q1 | SFY22 Q2 |
|---|--------------|----------|--------------|
| They were part of service planning. | I don't know | 0.4% | 0.7% |
| | No | 0.8% | 1.4% |
| | Sometimes | 0.0% | 1.1% |
| | Yes | 98.9% | 96.7% |
| They feel safe where they live. | I don't know | 0.0% | 0.0% |
| | No | 0.8% | 0.7% |
| | Sometimes | 1.1% | 1.5% |
| | Yes | 98.1% | 97.8% |
| Their services make their lives better. | I don't know | 0.4% | 0.4% |
| | No | 0.4% | 2.2% |
| | Sometimes | 0.4% | 2.2% |
| | Yes | 98.9% | 95.2% |

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 Q1 | SFY22 Q2 |
|--|----------|----------|
| AIDS/HIV - Unique Service Plans | 20 | 19 |
| Home Delivered Meals | 14 | 13 |
| CDAC (individual) by 15 minute units | 0 | 4 |
| CDAC (agency) by 15 minute units | 0 | 2 |
| Brain Injury (BI) Waivers | 808 | 794 |
| Financial Management Services | 241 | 243 |
| Supported Community Living (by unit) | 187 | 185 |
| Personal Emergency Response | 162 | 161 |
| Respite (by 15 minute units) | 166 | 155 |
| Supported Community Living (daily) | 110 | 106 |
| Children's Mental Health (CMH) | 763 | 756 |
| Respite (by 15 minute units) | 408 | 400 |
| Family and Community Support | 223 | 205 |
| Respite (Hos/NF) - 15 minute units | 214 | 193 |
| Respite (Resident Camp) by units | 11 | 9 |
| Home Delivered Meals | 3 | 3 |
| Elderly Waivers | 4,581 | 4,487 |
| Home Delivered Meals | 2,884 | 2,854 |
| Personal Emergency Response | 2,895 | 2,844 |
| CDAC (agency) by 15 minute units | 392 | 409 |
| Assisted Living Services | 372 | 368 |
| Personal Emergency Response (install) | 302 | 291 |

| | SFY22 Q1 | SFY22 Q2 |
|---------------------------------------|----------|----------|
| Habilitation (Hab) | 4,346 | 4,238 |
| Home-based Habilitation | 3,921 | 3,816 |
| Long Term Job Coaching | 440 | 431 |
| Day Habilitation (units by day) | 402 | 401 |
| Individual Supported Employment | 181 | 197 |
| Day Habilitation (by 15 minute units) | 151 | 151 |
| Health & Disability (HD) | 1,375 | 1,340 |
| Financial Management Services | 385 | 391 |
| Respite (by 15 minute units) | 358 | 355 |
| Personal Emergency Response | 314 | 305 |
| Home Delivered Meals | 303 | 294 |
| Respite (Hos/NF) - 15 minute units | 73 | 68 |
| Intellectual Disability (ID) | 7,033 | 6,969 |
| Supported Community Living (by unit) | 1,810 | 1,786 |
| Supported Community Living (RCF) | 1,411 | 1,463 |
| Financial Management Services | 1,423 | 1,436 |
| Day Habilitation (units by day) | 1,448 | 1,432 |
| Supported Community Living (daily) | 1,207 | 1,171 |
| Physical Disability (PD) | 657 | 622 |
| Personal Emergency Response | 345 | 343 |
| CDAC (agency) by 15 minute units | 57 | 53 |
| CDAC (individual) by 15 minute units | 46 | 47 |
| Home Delivered Meals | 39 | 38 |
| Financial Management Services | 37 | 38 |

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: <http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers>.

Top 5 Waiver Services

- by Member Usage



| | SFY22 Q1 | SFY22 Q2 |
|--|----------|----------|
| AIDS/HIV - Unique Service Plans | 9 | 9 |
| Home Delivered Meals | 7 | 7 |
| CDAC (individual) by 15 minute units | 4 | 3 |
| CDAC (agency) by 15 minute units | 1 | 1 |
| Homemaker (by 15 minute units) | 1 | 1 |
| Personal Emergency Response | 1 | 1 |
| Brain Injury (BI) Waivers | 526 | 520 |
| Supported Community Living (by unit) | 218 | 225 |
| Respite (by 15 minute units) | 137 | 134 |
| Personal Emergency Response | 131 | 132 |
| Supported Community Living (daily) | 103 | 119 |
| Transportation (1-way trip) | 81 | 88 |
| Children's Mental Health (CMH) | 326 | 327 |
| Respite (by 15 minute units) | 189 | 189 |
| Respite (Hos/NF) - 15 minute units | 127 | 124 |
| Family and Community Support | 97 | 96 |
| Mental Health Service | 39 | 38 |
| Respite (Resident Camp) by units | 2 | 1 |
| Elderly Waivers | 3,237 | 3,277 |
| Home Delivered Meals | 2,462 | 2,514 |
| Personal Emergency Response | 2,464 | 2,490 |
| CDAC (agency) by 15 minute units | 1,307 | 1,352 |
| Homemaker (by 15 minute units) | 812 | 801 |
| CDAC (individual) by 15 minute units | 649 | 670 |

| | SFY22 Q1 | SFY22 Q2 |
|---------------------------------------|----------|----------|
| Habilitation (Hab) | 2,300 | 2,356 |
| Home-based Habilitation | 1,951 | 1,993 |
| Day Habilitation (by 15 minute units) | 296 | 333 |
| Day Habilitation (units by day) | 249 | 286 |
| Long Term Job Coaching | 274 | 278 |
| Individual Supported Employment | 148 | 145 |
| Health & Disability (HD) | 616 | 594 |
| Respite (by 15 minute units) | 277 | 280 |
| Home Delivered Meals | 175 | 174 |
| Personal Emergency Response | 168 | 171 |
| CDAC (agency) by 15 minute units | 113 | 119 |
| CDAC (individual) by 15 minute units | 110 | 103 |
| Intellectual Disability (ID) | 4,494 | 4,479 |
| Supported Community Living (by unit) | 1,856 | 1,811 |
| Day Habilitation (by 15 minute units) | 1,466 | 1,660 |
| Day Habilitation (units by day) | 1,669 | 1,653 |
| Supported Community Living (RCF) | 1,330 | 1,312 |
| Respite (by 15 minute units) | 1,022 | 1,014 |
| Physical Disability (PD) | 363 | 358 |
| Personal Emergency Response | 209 | 194 |
| CDAC (agency) by 15 minute units | 167 | 170 |
| CDAC (individual) by 15 minute units | 125 | 121 |
| Transportation (1-way trip) | 41 | 37 |
| Personal Emergency Response (install) | 18 | 17 |

Call Center Performance Metrics

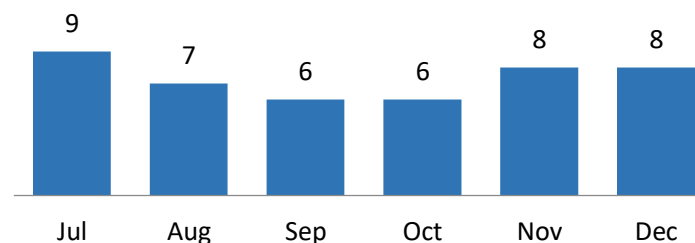


| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | Oct | Nov | Dec |
|---|--------|--------|--------|
| Member Helpline | | | |
| Service Level (Requirement 80%) | 93.23% | 97.18% | 96.90% |
| Abandonment Rate - Must be 5% or less | 0.43% | 0.95% | 2.13% |
| Member Pharmacy Helpline | | | |
| Service Level (Requirement 80%) | 94.29% | 92.81% | 98.19% |
| Abandonment Rate - Must be 5% or less | 0.66% | 0.34% | 0.00% |
| Provider Helpline | | | |
| Service Level (Requirement 80%) | 86.83% | 95.44% | 96.69% |
| Abandonment Rate - Must be 5% or less | 0.56% | 1.20% | 1.78% |
| Provider Pharmacy Helpline | | | |
| Service Level (Requirement 80%) | 96.42% | 96.82% | 95.91% |
| Abandonment Rate - Must be 5% or less | 0.36% | 0.10% | 0.65% |
| Non-Emergency Medical Transportation (NEMT) Helpline | | | |
| Service Level (Requirement 80%) | 47.70% | 82.38% | 93.32% |
| Abandonment Rate - Must be 5% or less | 6.56% | 1.59% | 2.43% |

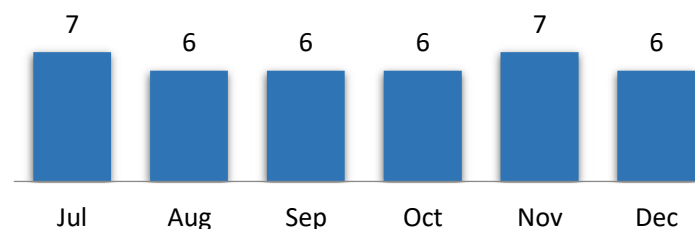
Secret Shopper Scores

- 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)

- Benefit Inquiry
- Enrollment Information
- ID Card Request or Inquiry
- Claim Inquiry
- Transportation Inquiry

Top 5 Call Reasons (Provider Helpline)

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

Call Center Performance Metrics

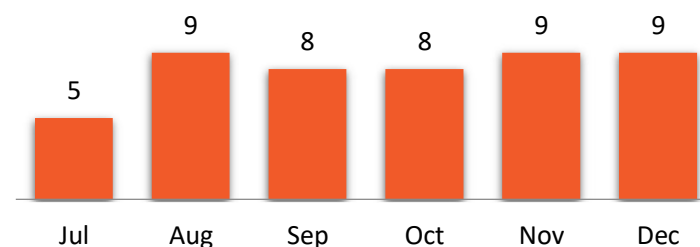


| | Oct | Nov | Dec |
|--|-----|-----|-----|
|--|-----|-----|-----|

| | Oct | Nov | Dec |
|---|--------|--------|--------|
| Member Helpline | | | |
| Service Level (Requirement 80%) | 84.41% | 86.71% | 89.12% |
| Abandonment Rate - Must be 5% or less | 3.84% | 3.34% | 2.48% |
| Member Pharmacy Helpline | | | |
| Service Level (Requirement 80%) | 88.75% | 92.71% | 94.16% |
| Abandonment Rate - Must be 5% or less | 2.83% | 2.40% | 1.42% |
| Provider Helpline | | | |
| Service Level (Requirement 80%) | 86.24% | 85.69% | 84.15% |
| Abandonment Rate - Must be 5% or less | 2.78% | 2.74% | 3.50% |
| Provider Pharmacy Helpline | | | |
| Service Level (Requirement 80%) | 96.76% | 93.69% | 89.08% |
| Abandonment Rate - Must be 5% or less | 0.46% | 0.81% | 0.42% |
| Non-Emergency Medical Transportation (NEMT) Helpline | | | |
| Service Level (Requirement 80%) | 45.36% | 81.76% | 93.95% |
| Abandonment Rate - Must be 5% or less | 4.83% | 0.99% | 0.95% |

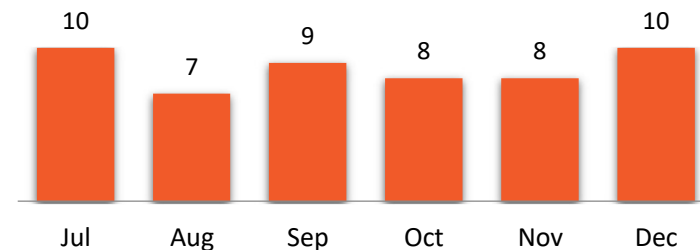
Secret Shopper Scores

- 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)

- Benefits and Eligibility for Member
- Update Address for Member
- Coordination Of Benefits for Member
- Update PCP/PPG for Member
- Member Rewards for Member

Top 5 Call Reasons (Provider Helpline)

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

Provider Network Access Summary



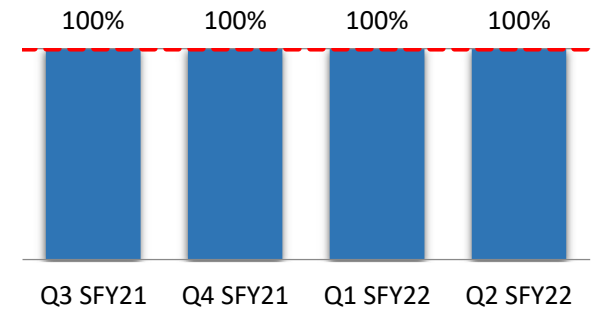
Primary Care Providers (PCP)

SFY21 Q3 SFY21 Q4 SFY22 Q1 SFY22 Q2

| Adults PCP | | | | |
|--------------------------|---------|---------|---------|---------|
| Provider Count | 6,672 | 6,632 | 6,589 | 6,688 |
| Members with Access | 219,428 | 224,574 | 228,637 | 231,146 |
| Average Distance (Miles) | 1.9 | 1.8 | 1.8 | 1.8 |
| Pediatric PCP | | | | |
| Provider Count | 6,707 | 6,666 | 6,621 | 6,719 |
| Members with Access | 209,553 | 211,406 | 213,136 | 212,453 |
| Average Distance (Miles) | 2.0 | 2.0 | 2.0 | 1.9 |

Adult PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Specialty Care &

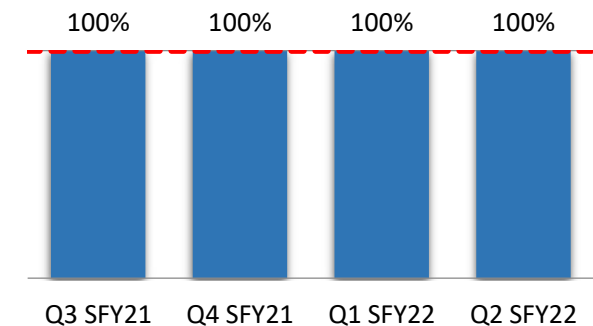
Behavioral Health (BH)

SFY21 Q3 SFY21 Q4 SFY22 Q1 SFY22 Q2

| OB/GYN Adult | | | | |
|---------------------------------------|---------|---------|---------|---------|
| Provider Count | 403 | 402 | 401 | 405 |
| Members with Access | 142,865 | 146,051 | 148,670 | 150,083 |
| Average Distance (Miles) | 5.7 | 5.6 | 5.6 | 5.6 |
| Outpatient - Behavioral Health | | | | |
| Provider Count | 4,137 | 4,205 | 4,305 | 4,456 |
| Members with Access | 428,981 | 435,980 | 441,773 | 443,599 |
| Average Distance (Miles) | 2.3 | 2.3 | 2.3 | 2.2 |
| Inpatient - Behavioral Health | | | | |
| Provider Count | 48 | 50 | 50 | 51 |
| Rural Members | | | | |
| Members with Access | 175,907 | 178,368 | 180,629 | 181,008 |
| Average Distance (Miles) | 21.4 | 21.4 | 21.4 | 18.5 |
| Urban Members | | | | |
| Members with Access | 253,074 | 257,612 | 261,144 | 262,591 |
| 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)

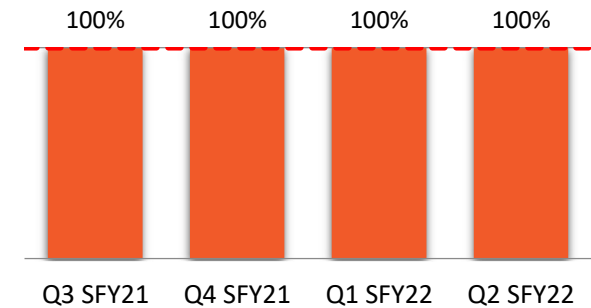
SFY21 Q3 SFY21 Q4 SFY22 Q1 SFY22 Q2

| Adults PCP | | | | |
|--------------------------|---------|---------|---------|---------|
| Provider Count | 9,085 | 9,704 | 9,894 | 9,894 |
| Members with Access | 166,971 | 171,647 | 175,634 | 180,087 |
| Average Distance (Miles) | 2.0 | 2.0 | 2.0 | 2.0 |
| Pediatric PCP | | | | |
| Provider Count | 9,820 | 10,472 | 10,658 | 10,658 |
| Members with Access | 138,828 | 140,406 | 141,050 | 143,484 |
| Average Distance (Miles) | 2.1 | 2.1 | 2.1 | 2.1 |



Adult PCP - Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Specialty Care &

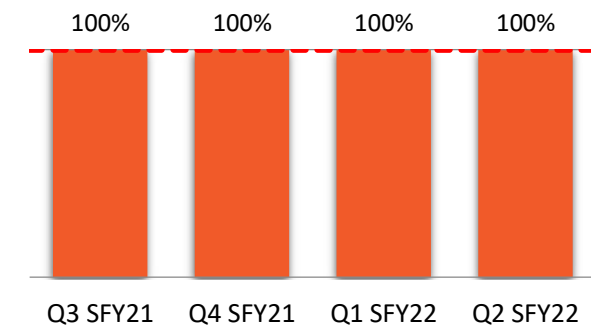
Behavioral Health (BH)

SFY21 Q3 SFY21 Q4 SFY22 Q1 SFY22 Q2

| OB/GYN Adult | | | | |
|---------------------------------------|---------|---------|---------|---------|
| Provider Count | 1,234 | 1,286 | 1,298 | 1,298 |
| Members with Access | 110,381 | 113,317 | 115,394 | 118,135 |
| Average Distance (Miles) | 5.4 | 5.4 | 5.4 | 5.4 |
| Outpatient - Behavioral Health | | | | |
| Provider Count | 8,737 | 9,476 | 9,688 | 9,688 |
| Members with Access | 305,799 | 312,053 | 316,684 | 323,571 |
| Average Distance (Miles) | 2.5 | 2.5 | 2.4 | 2.4 |
| Inpatient - Behavioral Health | | | | |
| Provider Count | 36 | 36 | 36 | 36 |
| Rural Members | | | | |
| Members with Access | 218,902 | 223,411 | 226,908 | 231,823 |
| Average Distance (Miles) | 24.6 | 24.6 | 24.6 | 24.5 |
| Urban Members | | | | |
| Members with Access | 86,897 | 88,642 | 89,776 | 91,748 |
| 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>

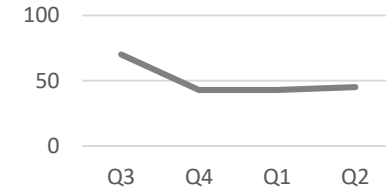
MCO Program Integrity

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 Q2

45



7 Total Cases
Referred to MCFU Q2



| | SFY21 Q3 | SFY21 Q4 | SFY22 Q1 | SFY22 Q2 | Average | Total |
|--|----------|----------|----------|----------|---------|-------|
| Investigations opened | 42 | 33 | 28 | 31 | 34 | 134 |
| Overpayments identified | 10 | 23 | 14 | 25 | 18 | 72 |
| Member concerns referred to IME | 4 | 2 | 2 | 5 | 3 | 13 |
| Cases referred to the Medicaid Fraud Control Unit (MCFU) | 2 | 6 | 6 | 4 | 5 | 18 |



| | SFY21 Q3 | SFY21 Q4 | SFY22 Q1 | SFY22 Q2 | Average | Total |
|--|----------|----------|----------|----------|---------|-------|
| Investigations opened | 28 | 10 | 15 | 12 | 16 | 65 |
| Overpayments identified | 0 | 6 | 12 | 17 | 9 | 35 |
| Member concerns referred to IME | 6 | 10 | 10 | 5 | 8 | 31 |
| Cases referred to the Medicaid Fraud Control Unit (MCFU) | 2 | 12 | 16 | 3 | 8 | 33 |

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 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.

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, Brain Injury, Intellectual Disability, or Children's Mental Health)

Waiver Service Plan: See Service Plan