Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2022, Quarter 1

(July - September 2021)

Performance Data

Published December 2021

Department of HUMAN SERVICES

Contents

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

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

Executive Summary

This report is based on Quarter 1 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)

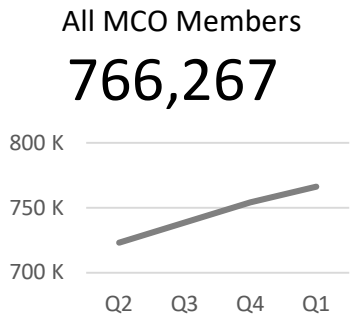
Notes about the reported data:

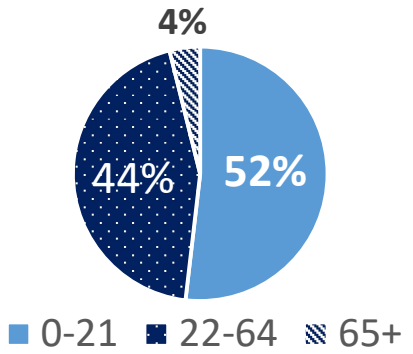
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period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

MCO Member Summary - All MCO Counts

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

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





+ 12,164 Members
1.61% Increase

All MCO Enrollment (by Age)

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

	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1	Average	Distinct
MCO Member Summary - *Overall Counts*	723,211	738,739	754,103	**766,267**	745,580	**809,207**
0-21	383,041	388,655	393,703	397,383	390,696	425,728
22-64	311,554	321,248	330,873	338,971	325,662	361,015
65+	28,616	28,836	29,527	29,913	29,223	36,492
Fee-For-Service (FFS) - *Non MCO Enrollees*	41,375	42,216	43,938	**45,062**	43,148	**60,434**

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

If Yes, explain:

Iowa Medicaid Population 1 year distinct count: **855,887**

o Disenrollment increased between Q4 and Q1 because of Open Enrollment

MCO Member Summary

Amerigroup An Anthem Company

	SFY21 Q4	SFY22 Q1
All Members - *by MCO*	439,824	445,169
Traditional Medicaid	271,198	273,370
Wellness Plan - IHAWP/Expansion	120,600	124,002
M-CHIP - Expansion	7,440	7,479
Healthy and Well Kids in Iowa (Hawki)	40,586	40,318
MCO Member Market Share	58.2%	58.1%
Disenrolled	242	1,157
Long-Term Service & Support (LTSS)	22,429	22,219
HCBS Waivers	68.8%	68.6%
Facility Based Services	31.2%	31.4%
HCBS Waivers [1]	15,428	15,237
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	7,001	6,982
ICF/ID [3]	1,012	982
Mental Health Institute (MHI)	36	38
Nursing Facilities (NF)	5,788	5,804
Nursing Facilities for Mentally Ill	73	71
Skilled	92	87

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	SFY21 Q4	SFY22 Q1
All Members - *by MCO*	315,976	321,098
Traditional Medicaid	195,343	198,160
Wellness Plan - IHAWP/Expansion	97,111	100,062
M-CHIP - Expansion	6,313	6,325
Healthy and Well Kids in Iowa (Hawki)	17,209	16,551
MCO Member Market Share	41.8%	41.9%
Disenrolled	347	914
Long-Term Service & Support (LTSS)	14,824	14,735
HCBS Waivers	65.3%	65.0%
Facility Based Services	34.7%	35.0%
HCBS Waivers [1]	9,676	9,571
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,148	5,164
ICF/ID [3]	608	594
Mental Health Institute (MHI)	27	33
Nursing Facilities (NF)	4,414	4,432
Nursing Facilities for Mentally Ill	31	36
Skilled	68	69

[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 and Psychiatric Medical Institutions for Children (PMICs).

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

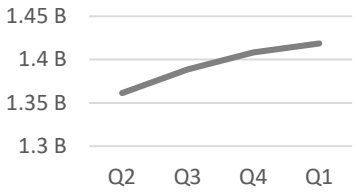
MCO Financial Summary - All MCO Counts

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

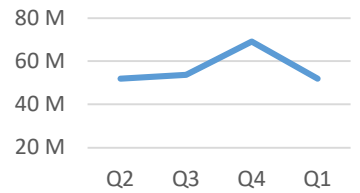
$1.42 Billion



+ $10.6 Million
0.76% Increase

Third Party Liability Recovered

$51.95 Million



- $ 17.3 Million
24.96% decrease

Data Notes: June 2021 capitation data as of July 2021. All Third Party Liability (TPL) data reported above is self-reported by MCOs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1	Average	Total
Financial Summary						
Capitation Payments	$1.36 B	$1.39 B	$1.41 B	**$1.42 B**	$1.39 B	$5.58 B
Third Party Liability (TPL) Recovered	$51.91 M	$53.73 M	$69.23 M	**$51.95 M**	$56.71 M	$226.83 M

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

If Yes, explain:

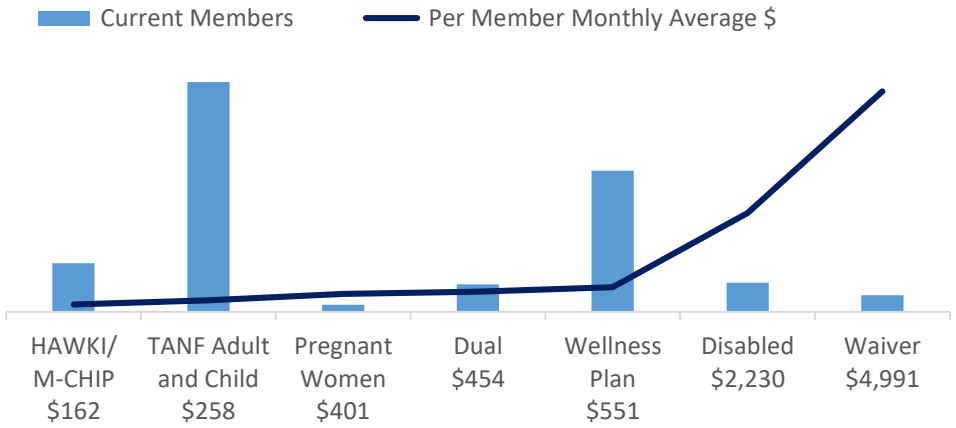
o TPL decreased by $17.3M or 24.96% between Q4 and Q1.

MCO Financial Summary

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

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

Monthly Capitation Expenditures



Amerigroup An Anthem Company

	SFY21 Q4	SFY22 Q1
Capitation Totals	$828.47 M	**$832.22 M**
Adjustments	$8.47 M	-$2.07 M
Current	$800.26 M	$814.65 M
Retro	$19.73 M	$19.64 M
Third Party Liability (TPL) Recovered	$29.29 M	**$15.35 M**
Financial Ratios		
Medical Loss Ratio (MLR)	87.0%	**90.5%**
Administrative Loss Ratio (ALR)	5.9%	5.3%
Underwriting Ratio (UR)	7.0%	4.1%
Annual MLR [4]		90.5%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

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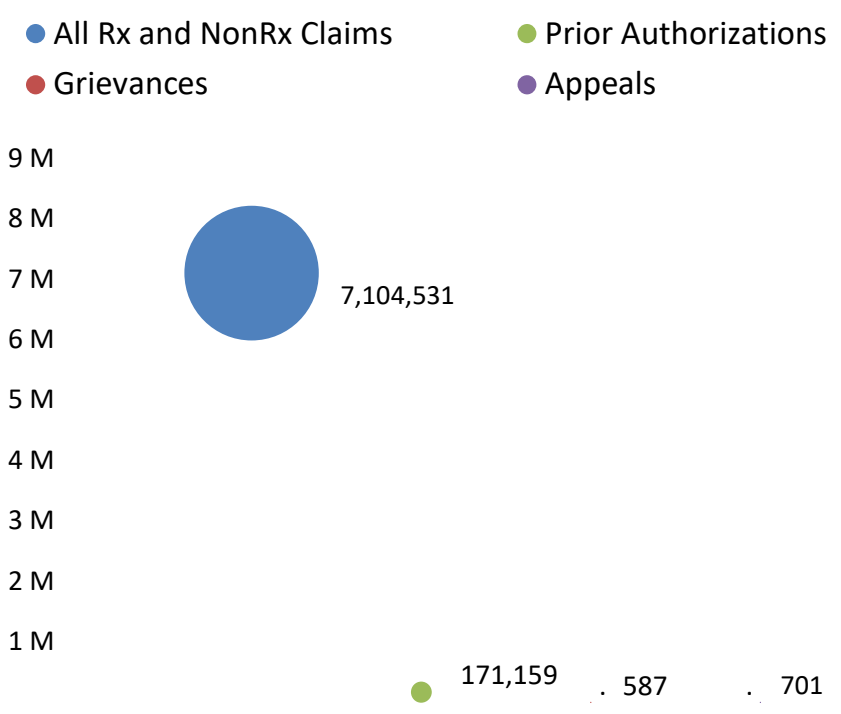
	SFY21 Q4	SFY22 Q1
Capitation Totals	$570.55 M	**$586.7 M**
Adjustments	$12.58 M	-938,683
Current	$548.53 M	$568.86 M
Retro	$18.71 M	$18.78 M
Third Party Liability (TPL) Recovered	**$39.94 M**	**$36.59 M**
Financial Ratios		
Medical Loss Ratio (MLR)	91.8%	**93.2%**
Administrative Loss Ratio (ALR)	4.4%	4.3%
Underwriting Ratio (UR)	3.7%	2.5%
Annual MLR [4]		93.2%
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



	% of Claims Universe
Prior Authorizations	2.41%
Grievances	0.01%
Appeals	0.01%

	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	6.77 M	6.84 M	7.13 M	**7.10 M**	6.96 M	27.85 M
Non-Pharmacy	3.96 M	4.00 M	4.21 M	4.21 M	4.09 M	16.38 M
Pharmacy	2.81 M	2.84 M	2.92 M	2.90 M	2.87 M	11.47 M
Prior Authorization Summary (p. 13-14)	176,060	185,570	180,026	**171,159**	178,204	712,815
Non-Rx - Standard PAs Submitted	133,643	139,780	138,319	127,869	134,903	539,611
Pharmacy - Standard PAs Submitted	42,417	45,790	41,707	43,290	43,301	173,204
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	629	604	583	**587**	601	2,403
Standard Appeals	592	649	750	**701**	673	2,692

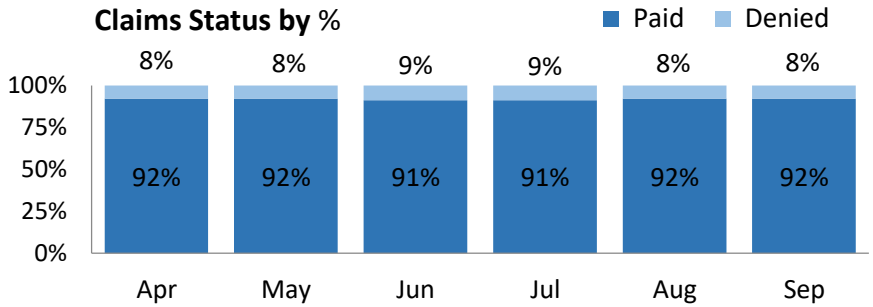
Claims Summary (Non-Pharmacy)

2.43 Million
Claims Paid & Denied

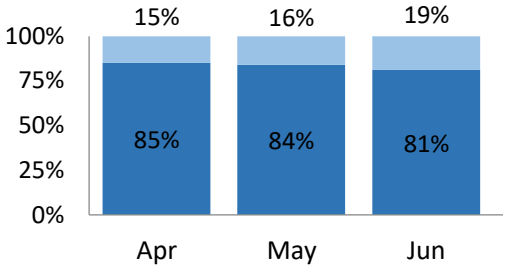
Amerigroup
An Anthem Company

	July	Aug	Sept
All Claims			
Paid	678,917	788,575	765,102
Denied	70,298	64,685	63,511
Suspended	205,369	198,484	234,018
Clean Claims Processed			
in 30-days (Requirement 90%)	98%	97%	95%
in 45-days (Requirement 95%)	100%	98%	98%
Average Days to Pay	8	9	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%

Claims Status by %



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



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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	23%	Duplicate claim service
2.	14%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Expenses incurred after coverage terminated
4.	7%	Claim/service lacks information or has submission/billing error(s)
5.	7%	The impact of prior payer(s) adjudication including payments and/or adjustments.
6.	6%	At least one remark code must be provided
7.	5%	Precertification/authorization/notification absent
8.	5%	Service not payable per managed care contract
9.	3%	An attachment/other documentation is required to adjudicate this claim/service.
10.	3%	The time limit for filing has expired

Claims Summary (Non-Pharmacy)

1.78 Million
Claims Paid & Denied

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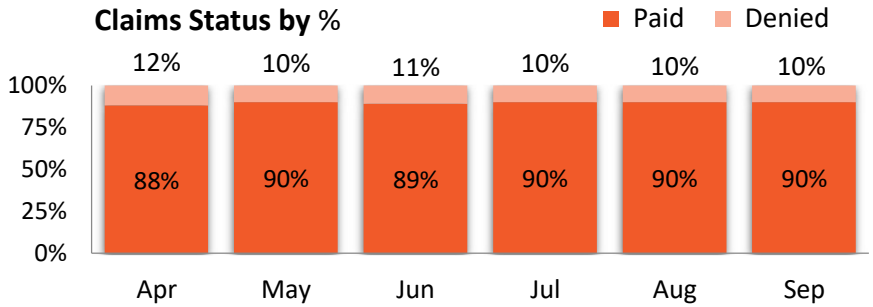
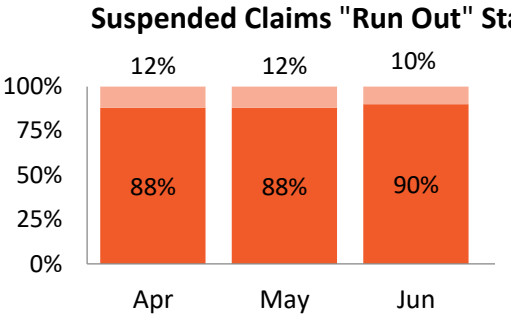
	July	Aug	Sept
All Claims			
Paid	492,557	587,021	522,786
Denied	54,886	64,088	56,243
Suspended	137,184	80,348	109,535
Clean Claims Processed			
in 30-days (Requirement 90%)	97%	98%	99%
in 45-days (Requirement 95%)	98%	99%	99%
Average Days to Pay	10	8	8
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	98%	99%





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

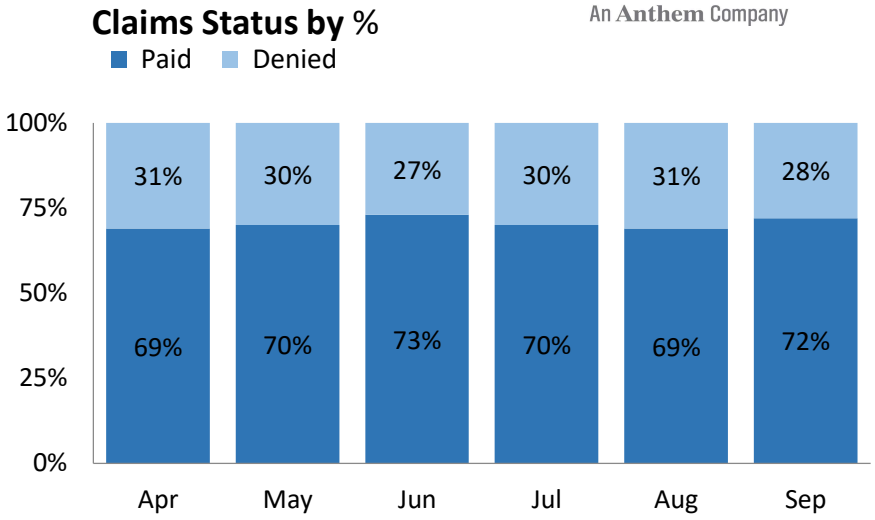
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	
1.	26%	Duplicate claim service
2.	17%	Service can not be combined with other service on same day
3.	10%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	9%	Ace claim level return to provider (review claim remarks)
5.	9%	Service is not covered
6.	7%	No authorization on file that matches service(s) billed
7.	5%	Diagnosis code incorrectly coded per ICD10 manual
8.	5%	Procedure coverage not defined by Medicaid
9.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
10.	4%	Billing NPI not registered with IA DHS/Iowa Medicaid

Claims Summary (Pharmacy)

1.64 Million
Claims Paid & Denied

	July	Aug	Sept
All Claims (Pharmacy)			
Paid	350,374	352,465	450,425
Denied	153,326	160,093	171,275
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	11	12

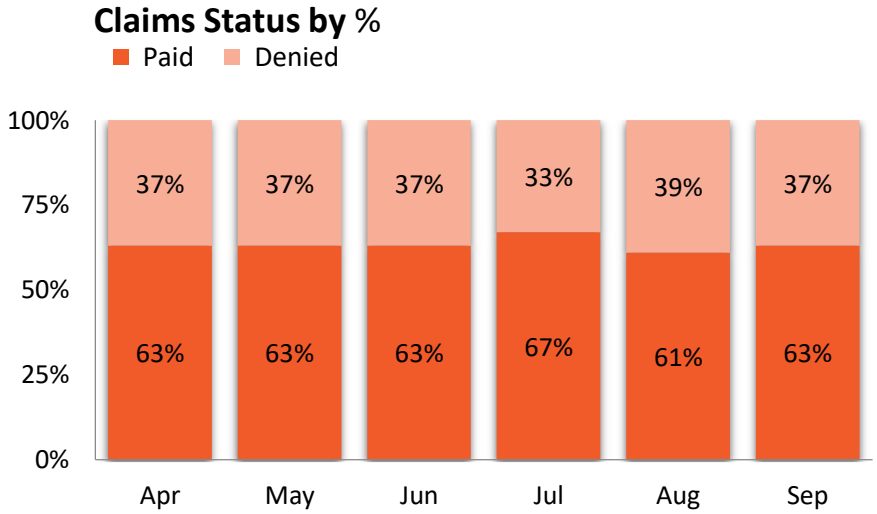


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	38%	Refill too soon
2.	14%	Prior authorization required
3.	13%	Submit bill to other processor or primary payer
4.	11%	National Drug Code (NDC) not covered
5.	6%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	3%	Non matched prescriber ID
8.	2%	Filled after coverage terminated
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	M/I other coverage code

Claims Summary (Pharmacy)

1.27 Million
Claims Paid & Denied

	July	Aug	Sept
All Claims (Pharmacy)			
Paid	265,579	272,886	272,034
Denied	133,719	171,904	156,384
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	3	10	10



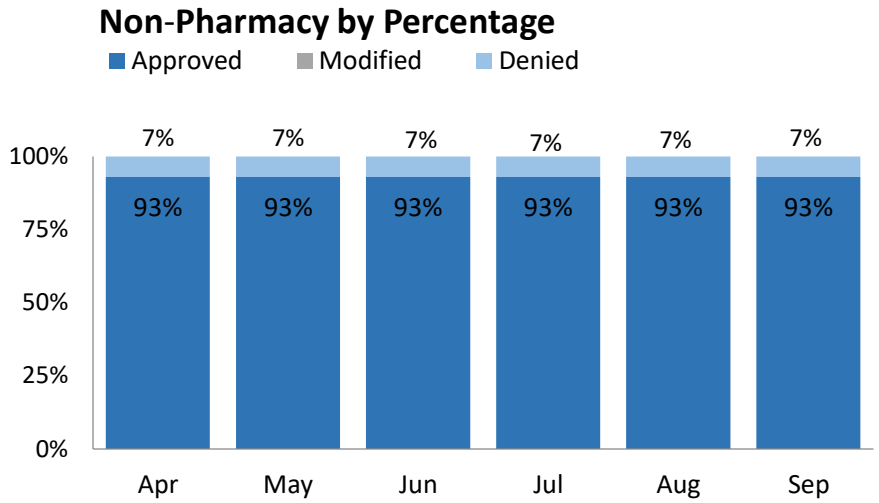
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	26%	Refill too soon
2.	11%	National Drug Code (NDC) not covered
3.	9%	Prior authorization required
4.	5%	Plan limitations exceeded
5.	3%	Submit bill to other processor or primary payer
6.	2%	Prescriber is not enrolled in State Medicaid program
7.	2%	Drug 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

80,861
All PAs Submitted [5]

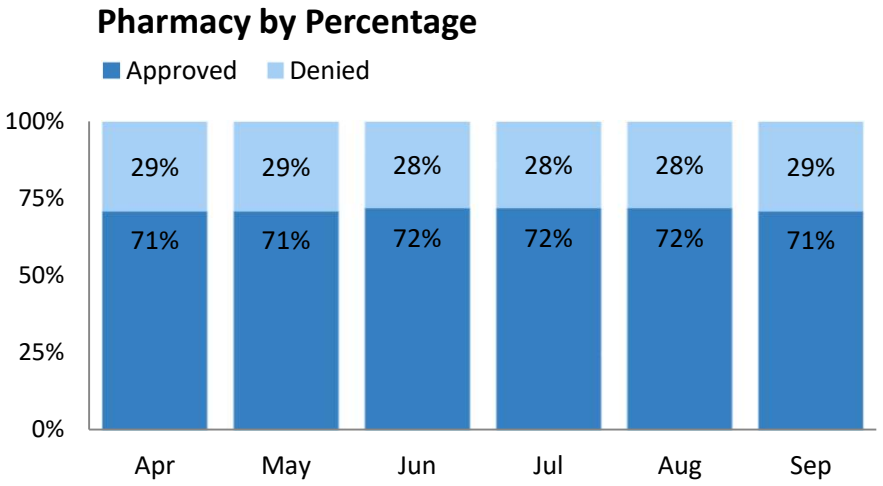
Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	17,052	17,526	17,564
Denied	1,274	1,303	1,247
Modified	1	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%)	98%	98%	99%



Pharmacy

	July	Aug	Sept
Prior Authorizations			
Approved	5,718	6,198	5,980
Denied	2,216	2,356	2,402
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	99.9%



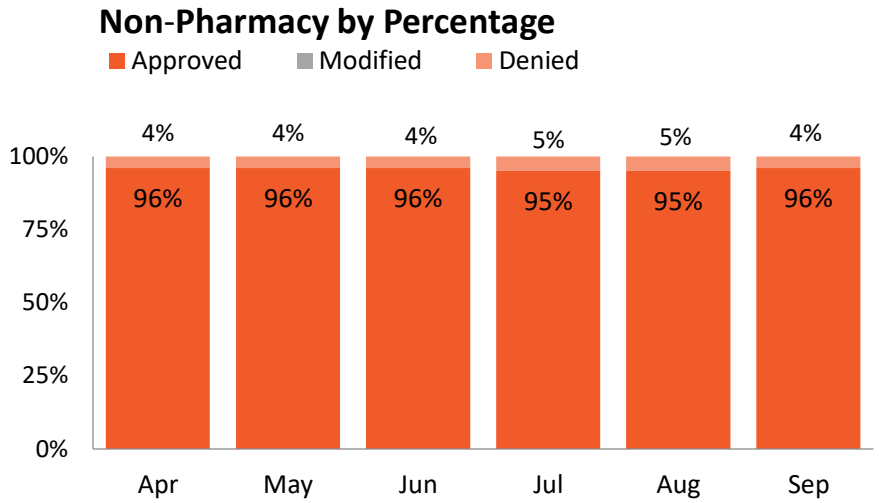
[5] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

90,298
All PAs Submitted [5]

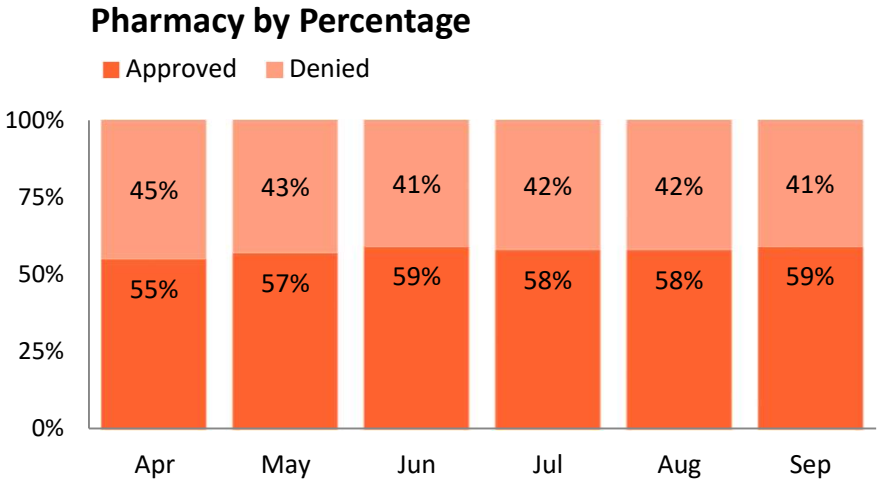
Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	21,629	24,009	23,141
Denied	1,061	1,283	1,062
Modified	0	0	0
Average Days to Process	5	4	5
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	99%



Pharmacy

	July	Aug	Sept
Prior Authorizations			
Approved	3,144	3,400	3,150
Denied	2,242	2,452	2,153
PAs Completed in 24-hours (Requirement 100%)	99.8%	99.3%	99.9%

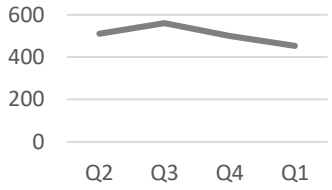


[5] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

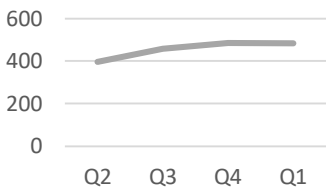
Standard Grievances

453



Standard Appeals

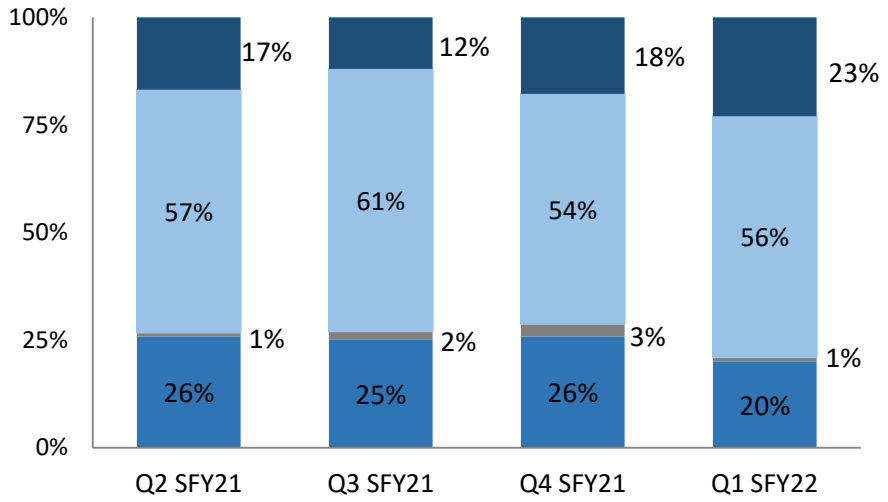
483



Resolved in 30-days 100%

Resolved in 30-days 100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [6]
1.	46%	Voluntary disenrollment
2.	15%	Provider balance billed
3.	6%	Transportation - Driver delay
4.	6%	Poor Customer Service
5.	5%	Transportation - Driver no-show
6.	5%	Treatment dissatisfaction
7.	4%	Provider dissatisfaction
8.	2%	Inadequate benefit access
9.	2%	Provider attitude/rudeness
10.	2%	Delay in obtaining Authorization/Referral

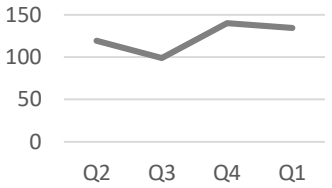
%	Top 10 Reasons for Appeals [6]
22%	DME
20%	Pharmacy - Non Injectable
11%	Radiology
9%	Pharmacy - Injectable
6%	BH - Op Service
6%	Surgery
5%	Inpatient - Medical
4%	Therapy - PT
3%	Anesthesia for Dental Surgery
3%	Outpatient Services - Medical

[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

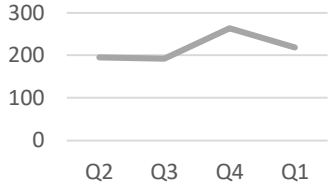
134



Resolved in 30-days
100%

Standard Appeals

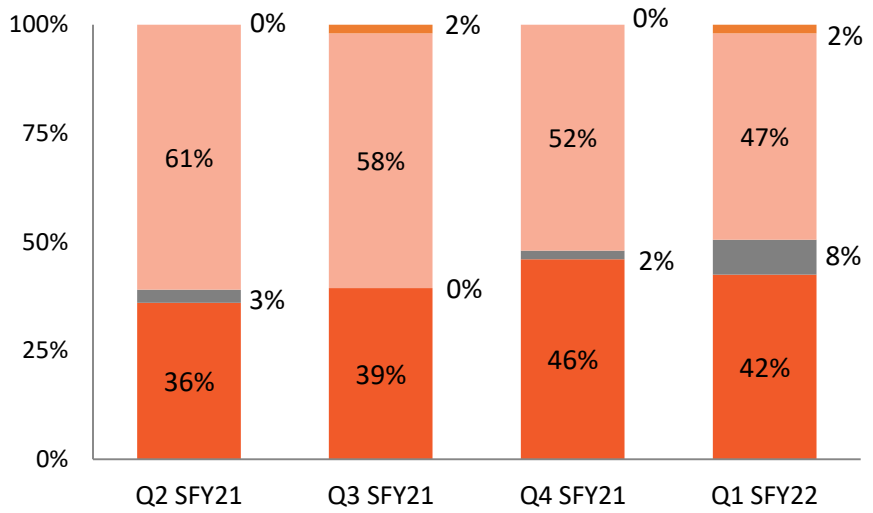
218



Resolved in 30-days
100%

Withdrawn
Upheld
Partially Overturned
Overturned

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [6]
1.	15%	Unhappy with Benefits
2.	11%	Access to Care - Network Availability
3.	10%	Transportation - Missed Appointment
4.	9%	Transportation - General Complaint Vendor
5.	8%	Transportation - Late Appointment
6.	7%	Transportation - Driver no-show
7.	4%	Provider Staff
8.	4%	Provider
9.	3%	Transportation - Unsafe Driving
10.	3%	Lack of Caring/Concern

%	Top 10 Reasons for Appeals [6]
33%	RX - Does Not Meet PriorAuth Guidelines
9%	Diagnostic - MRI
7%	Other - Mental Health Service
5%	Vendor Related - HomeCare
4%	Outpatient - Home Health Visits
3%	Injection - Self Injectables
3%	Special Services - PainManagement
3%	DME - Insulin Pump
3%	DME - Other
3%	Other - Self Injectable Medication

[6] 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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	SFY21 Q4	SFY22 Q1
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	60%	62%

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	SFY21 Q4	SFY22 Q1
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	90%	87%

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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	SFY21 Q4	SFY22 Q1
Healthy Rewards	4,466	3,613
Taking Care of Baby and Me	1,514	2,310
Community Resource Link	1,007	2,046
Exercise Kit	402	662
SafeLink Mobile Phone	447	558

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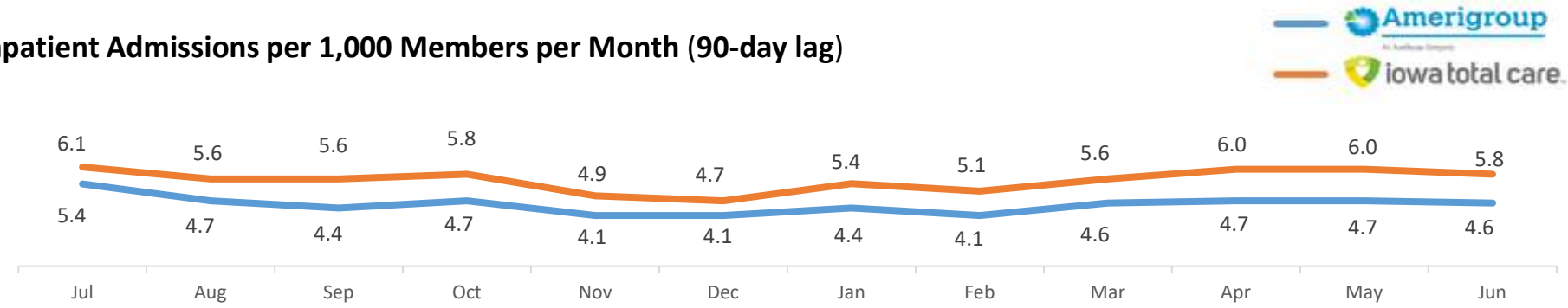
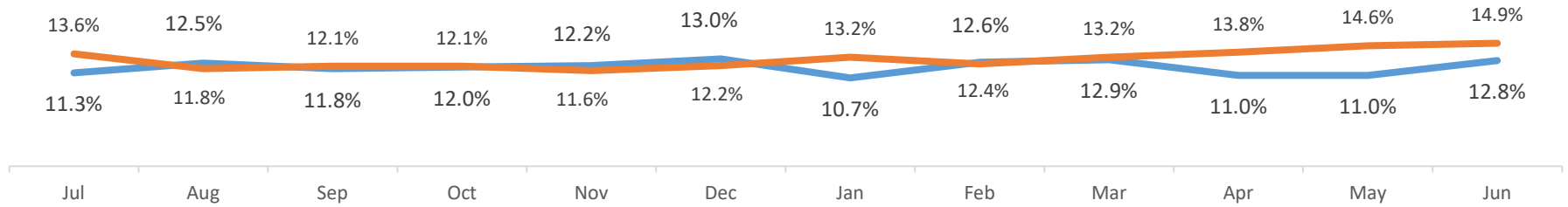
	SFY21 Q4	SFY22 Q1
My Health Pays Program	10,387	14,419
Start Smart for Your Baby	1,445	1,431
Mobile App	933	834
The Flu Program	974	759
Healthy Celebration Days	-	757

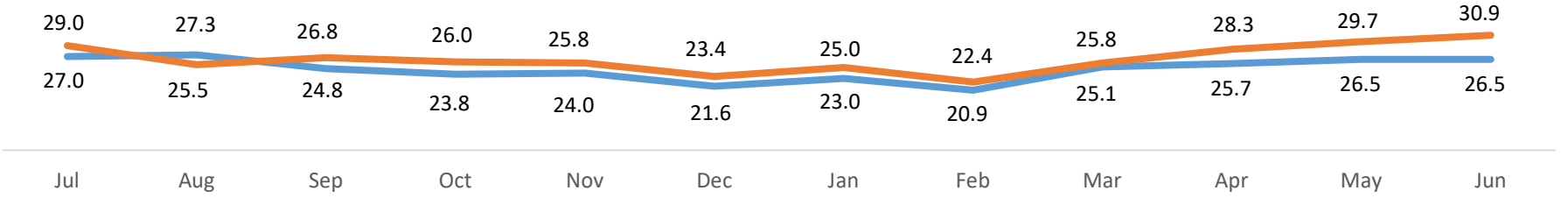
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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.*

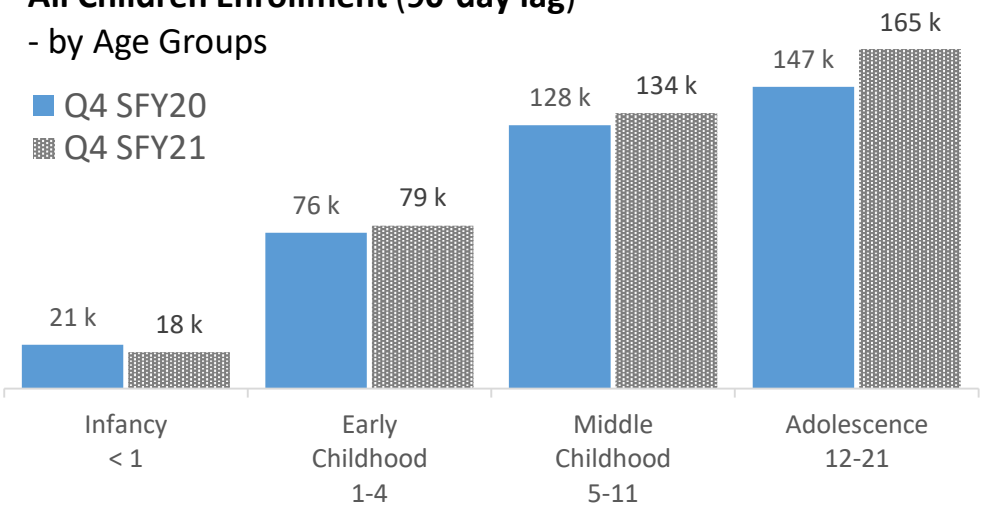
[8] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

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



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	SFY20 Q4	SFY21 Q4
Member Enrollment	223,742	236,807
Infancy < 1	11,082	9,176
Early Childhood 1 - 4	46,773	47,242
Middle Childhood 5 - 11	77,497	80,950
Adolescence 12 - 21	88,390	99,439
Well Child Exams (Preventive Visits)	29,958	36,804
Infancy < 1	10,935	11,392
Early Childhood 1 - 4	10,483	11,986
Middle Childhood 5 - 11	4,865	7,078
Adolescence 12 - 21	3,675	6,348
Lead Screenings	3,629	4,651
Infancy < 1	77	136
Early Childhood 1 - 4	3,346	4,174
Middle Childhood 5 - 11	190	295
Adolescence 12 - 21	16	46

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	SFY20 Q4	SFY21 Q4
Member Enrollment	147,722	158,536
Infancy < 1	10,164	8,480
Early Childhood 1 - 4	28,862	31,936
Middle Childhood 5 - 11	50,530	52,915
Adolescence 12 - 21	58,166	65,205
Well Child Exams (Preventive Visits)	22,277	29,353
Infancy < 1	10,728	11,207
Early Childhood 1 - 4	5,777	8,590
Middle Childhood 5 - 11	3,278	5,017
Adolescence 12 - 21	2,494	4,539
Lead Screenings	2,092	3,612
Infancy < 1	55	139
Early Childhood 1 - 4	1,864	3,182
Middle Childhood 5 - 11	144	268
Adolescence 12 - 21	29	23

MCO Children Summary

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	SFY20 Q4	SFY21 Q4
Hearing Screenings	1,328	1,779
Infancy < 1	116	140
Early Childhood 1 - 4	646	810
Middle Childhood 5 - 11	404	556
Adolescence 12 - 21	162	273
Vision Screenings	708	1,565
Infancy < 1	11	34
Early Childhood 1 - 4	378	865
Middle Childhood 5 - 11	216	452
Adolescence 12 - 21	103	214
Vaccination Totals	44,636	63,672
COVID-19 Dose 1	0	8,969
COVID-19 Dose 2	0	7,447
COVID-19 Single-Dose	0	209
DTaP (Diphtheria, Tetanus, Pertussis)	9,080	9,377
Influenza (FLU)	814	778
HepA (Hepatitis A)	4,378	4,497
HepB (Hepatitis B)	860	882
Haemophilus Influenza Type B (Hib)	5,248	5,007
Human Papillomavirus (HPV)	1,787	2,653
Meningococcal ACWY (MenACWY)	1,518	2,476
Meningococcal B - (MenB)	605	994
MMR (Measles, Mumps, Rubella)	3,619	3,682
Pneumococcal (PCV13)	7,806	7,423
Pneumococcal (PPSV23)	37	56
Polio (IPV)	128	225
RV (Rotavirus)	4,816	4,811
Tetanus and diphtheria (Td)	44	31
TDAP (Tetanus, Diphtheria, Pertussis)	1,571	2,171
Varicella Virus Vaccine (VAR)	2,325	1,984

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	SFY20 Q4	SFY21 Q4
Hearing Screenings	799	1,226
Infancy < 1	107	121
Early Childhood 1 - 4	350	506
Middle Childhood 5 - 11	247	409
Adolescence 12 - 21	95	190
Vision Screenings	438	1,075
Infancy < 1	19	30
Early Childhood 1 - 4	245	587
Middle Childhood 5 - 11	133	349
Adolescence 12 - 21	41	109
Vaccination Totals	28,114	39,098
COVID-19 Dose 1	0	2,419
COVID-19 Dose 2	0	2,092
COVID-19 Single-Dose	0	48
DTaP (Diphtheria, Tetanus, Pertussis)	6,702	7,726
Influenza (FLU)	596	691
HepA (Hepatitis A)	2,274	3,312
HepB (Hepatitis B)	772	780
Haemophilus Influenza Type B (Hib)	1,234	1,285
Human Papillomavirus (HPV)	1,223	1,794
Meningococcal ACWY (MenACWY)	1,008	1,544
Meningococcal B - (MenB)	0	618
MMR (Measles, Mumps, Rubella)	1,843	2,765
Pneumococcal (PCV13)	5,868	6,439
Pneumococcal (PPSV23)	0	33
Polio (IPV)	139	142
RV (Rotavirus)	4,255	4,256
Tetanus and diphtheria (Td)	26	19
TDAP (Tetanus, Diphtheria, Pertussis)	1,114	1,417
Varicella Virus Vaccine (VAR)	1,060	1,718

Non-LTSS Care Coordination and HCBS Case Management

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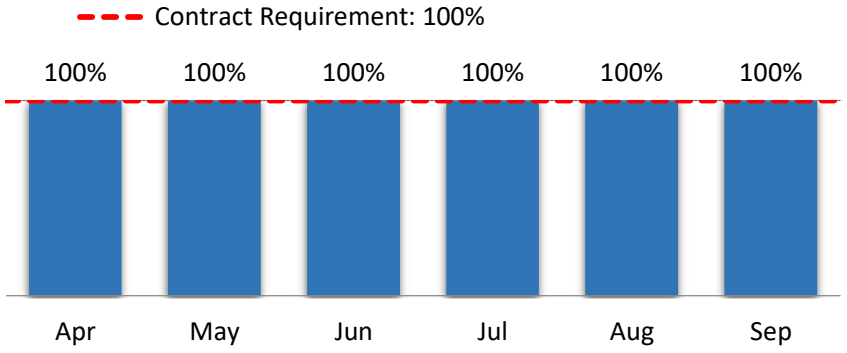
Average Number of Contacts Per Month	SFY21 Q4	SFY22 Q1
by Care Coordinators	0.9	**0.8**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	34	**27**
HCBS Members to Case Managers	65	**68**

Iowa Participant Experience Survey (IPES)

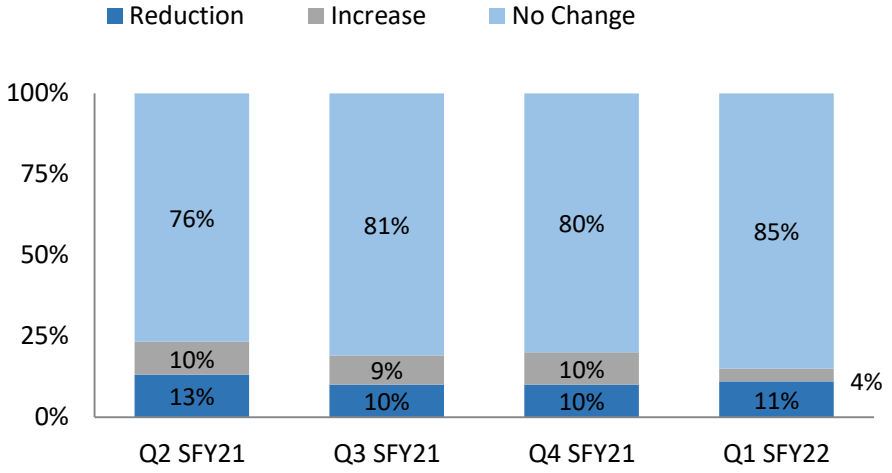
Waiver members reporting…		SFY21 Q4	SFY22 Q1
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	0.9%	0.5%
	No	0.3%	0.0%
	Sometimes	0.0%	0.0%
	Yes	98.8%	99.5%

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



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

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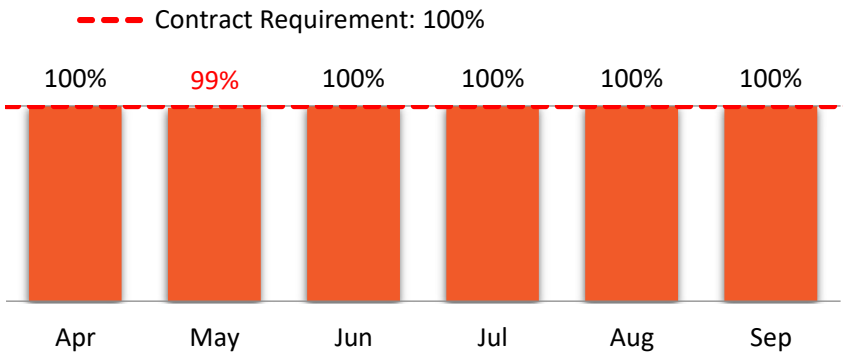
Average Number of Contacts Per Month	SFY21 Q4	SFY22 Q1
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	47	**49**
HCBS Members to Case Managers	41	**44**

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

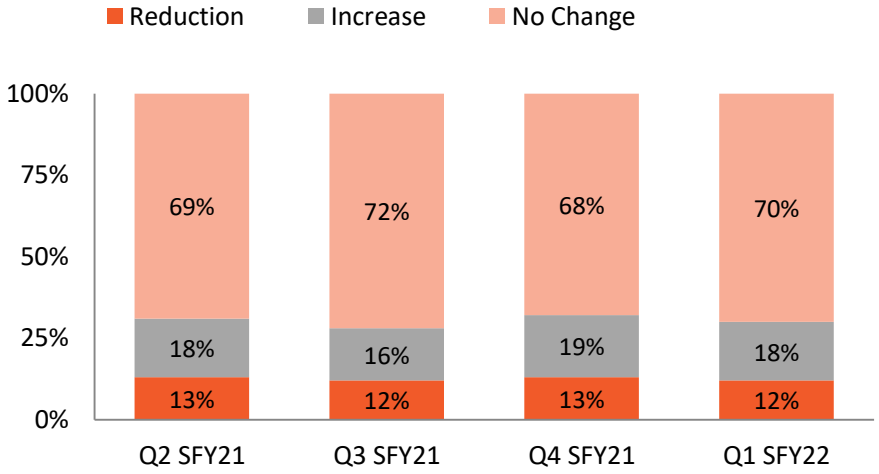
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q4	SFY22 Q1
They were part of service planning.	I don't know	0.0%	0.4%
	No	1.4%	0.8%
	Sometimes	0.4%	0.0%
	Yes	98.2%	98.9%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	1.4%	0.8%
	Sometimes	0.4%	1.1%
	Yes	98.2%	98.1%
Their services make their lives better.	I don't know	0.0%	0.4%
	No	1.4%	0.4%
	Sometimes	0.7%	0.4%
	Yes	97.8%	98.9%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

	SFY21 Q4	SFY22 Q1
AIDS/HIV - Unique Service Plans	19	20
Home Delivered Meals	15	14
CDAC (individual) by 15 minute units	3	0
CDAC (agency) by 15 minute units	3	0
Brain Injury (BI) Waivers	814	808
Financial Management Services	234	241
Supported Community Living (by unit)	178	187
Respite (by 15 minute units)	167	166
Personal Emergency Response	162	162
Supported Community Living (daily)	107	110
Children's Mental Health (CMH)	840	763
Respite (by 15 minute units)	415	408
Family and Community Support	218	223
Respite (Hos/NF) - 15 minute units	223	214
Respite (Resident Camp) by units	11	11
Respite (Resident Camp) by day	3	5
Elderly Waivers	4,637	4,581
Personal Emergency Response	2,920	2,895
Home Delivered Meals	2,903	2,884
CDAC (agency) by 15 minute units	461	392
Assisted Living Services	363	372
Personal Emergency Response (install)	285	302

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	SFY21 Q4	SFY22 Q1
Habilitation (Hab)	4,498	4,346
Home-based Habilitation	3,870	3,921
Long Term Job Coaching	393	440
Day Habilitation (units by day)	373	402
Individual Supported Employment	165	181
Day Habilitation (by 15 minute units)	131	151
Health & Disability (HD)	1,384	1,375
Financial Management Services	353	385
Respite (by 15 minute units)	345	358
Personal Emergency Response	318	314
Home Delivered Meals	306	303
Respite (Hos/NF) - 15 minute units	66	73
Intellectual Disability (ID)	7,053	7,033
Supported Community Living (by unit)	1,785	1,810
Day Habilitation (units by day)	1,363	1,448
Financial Management Services	1,388	1,423
Supported Community Living (RCF)	1,249	1,411
Supported Community Living (daily)	1,242	1,207
Physical Disability (PD)	681	657
Personal Emergency Response	355	345
CDAC (agency) by 15 minute units	88	57
CDAC (individual) by 15 minute units	58	46
Home Delivered Meals	42	39
Financial Management Services	35	37

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

	SFY21 Q4	SFY22 Q1
AIDS/HIV - Unique Service Plans	10	9
Home Delivered Meals	7	7
CDAC (individual) by 15 minute units	4	4
Homemaker (by 15 minute units)	2	1
CDAC (agency) by 15 minute units	0	1
Personal Emergency Response	0	1
Brain Injury (BI) Waivers	527	526
Supported Community Living (by unit)	229	218
Respite (by 15 minute units)	145	137
Personal Emergency Response	129	131
Supported Community Living (daily)	124	103
CDAC (agency) by 15 minute units	87	89
Children's Mental Health (CMH)	352	326
Respite (by 15 minute units)	201	189
Respite (Hos/NF) - 15 minute units	131	127
Family and Community Support	102	97
Mental Health Service	38	39
Respite (Resident Camp) by days	1	5
Elderly Waivers	3,285	3,237
Personal Emergency Response	2,393	2,464
Home Delivered Meals	2,432	2,462
CDAC (agency) by 15 minute units	1,284	1,307
Homemaker (by 15 minute units)	830	812
CDAC (individual) by 15 minute units	695	649

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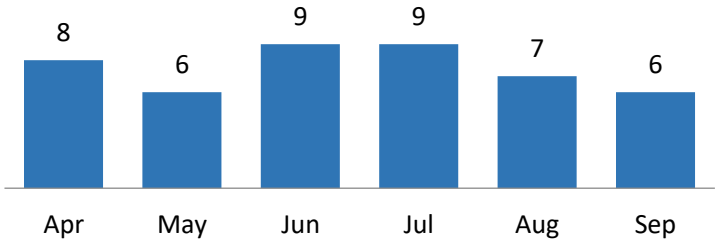
	SFY21 Q4	SFY22 Q1
Habilitation (Hab)	2,353	2,300
Home-based Habilitation	1,906	1,951
Day Habilitation (by 15 minute units)	341	296
Long Term Job Coaching	256	274
Day Habilitation (units by day)	276	249
Individual Supported Employment	140	148
Health & Disability (HD)	639	616
Respite (by 15 minute units)	286	277
Home Delivered Meals	169	175
Personal Emergency Response	154	168
CDAC (agency) by 15 minute units	112	113
CDAC (individual) by 15 minute units	118	110
Intellectual Disability (ID)	4,488	4,494
Supported Community Living (by unit)	1,854	1,856
Day Habilitation (units by day)	1,673	1,669
Day Habilitation (by 15 minute units)	1,828	1,466
Supported Community Living (RCF)	1,325	1,330
Respite (by 15 minute units)	1,039	1,022
Physical Disability (PD)	375	363
Personal Emergency Response	212	209
CDAC (agency) by 15 minute units	176	167
CDAC (individual) by 15 minute units	132	125
Transportation (1-way trip)	41	41
Personal Emergency Response (install)	15	18

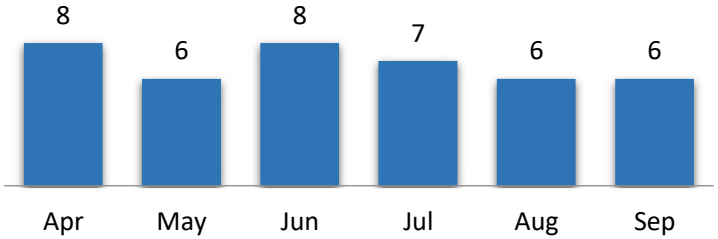
Call Center Performance Metrics

	July	Aug	Sept
Member Helpline			
Service Level (Requirement 80%)	91.84%	88.86%	94.88%
Abandonment Rate - Must be 5% or less	1.16%	1.08%	0.54%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	91.66%	89.11%	92.63%
Abandonment Rate - Must be 5% or less	0.51%	0.26%	0.55%
Provider Helpline			
Service Level (Requirement 80%)	85.32%	80.98%	89.92%
Abandonment Rate - Must be 5% or less	0.76%	0.78%	0.37%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	90.41%	79.64%	33.04%
Abandonment Rate - Must be 5% or less	1.53%	2.13%	16.33%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



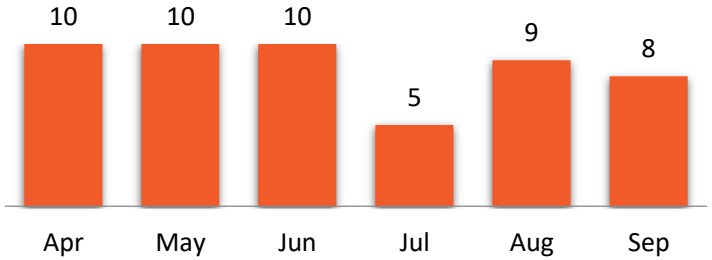
Data Notes: Top 5 Call Reasons are captured during the last month of the reporting period.

	Top 5 Call Reasons (Member Helpline)	Top 5 Call Reasons (Provider Helpline)
1.	Benefit Inquiry	Benefit Inquiry
2.	ID Card Request or Inquiry	Authorization Status
3.	Enrollment Information	Claim Status
4.	Claim Inquiry	Claim Payment Question or Dispute
5.	Transportation Inquiry	Authorization New

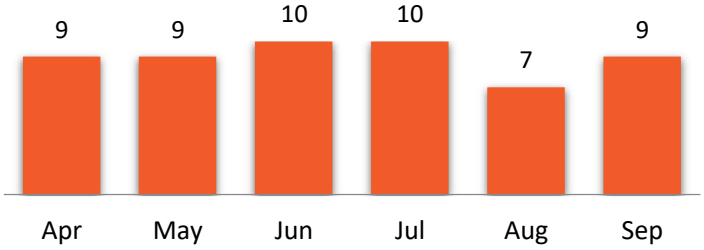
Call Center Performance Metrics

	July	Aug	Sept
Member Helpline			
Service Level (Requirement 80%)	82.81%	82.99%	84.44%
Abandonment Rate - Must be 5% or less	3.80%	3.96%	4.45%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	89.58%	93.23%	82.64%
Abandonment Rate - Must be 5% or less	5.85%	2.77%	5.06%
Provider Helpline			
Service Level (Requirement 80%)	84.35%	81.79%	86.48%
Abandonment Rate - Must be 5% or less	2.84%	3.24%	3.70%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	87.19%	93.23%	94.11%
Abandonment Rate - Must be 5% or less	0.20%	0.00%	0.38%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	93.37%	81.09%	29.41%
Abandonment Rate - Must be 5% or less	1.28%	1.95%	16.04%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

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

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

Provider Network Access Summary

Primary Care Providers (PCP)

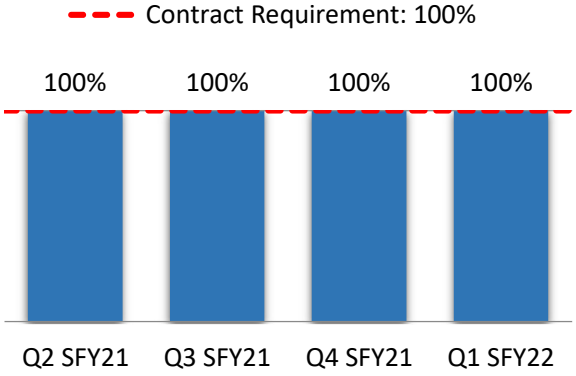
	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1
Adults PCP				
Provider Count	6,641	6,672	6,632	6,589
Members with Access	210,795	219,428	224,574	228,637
Average Distance (Miles)	1.5	1.9	1.8	1.8
Pediatric PCP				
Provider Count	6,677	6,707	6,666	6,621
Members with Access	203,169	209,553	211,406	213,136
Average Distance (Miles)	1.6	2.0	2.0	2.0

Specialty Care & Behavioral Health (BH)

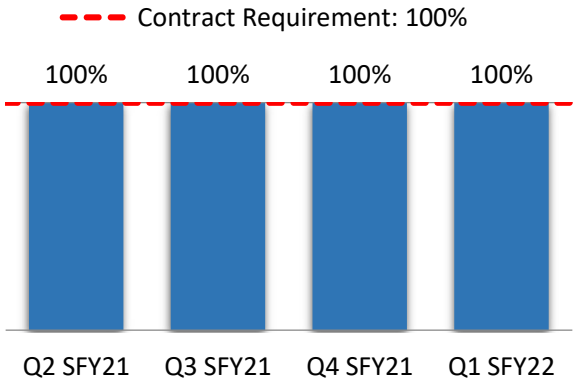
	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1
OB/GYN Adult				
Provider Count	399	403	402	401
Members with Access	137,341	142,865	146,051	148,670
Average Distance (Miles)	5.6	5.7	5.6	5.6
Outpatient - Behavioral Health				
Provider Count	4,043	4,137	4,205	4,305
Members with Access	413,964	428,981	435,980	441,773
Average Distance (Miles)	2.1	2.3	2.3	2.3
Inpatient - Behavioral Health				
Provider Count	48	48	50	50
Rural Members				
Members with Access	169,705	175,907	178,368	180,629
Average Distance (Miles)	21.6	21.4	21.4	21.4
Urban Members				
Members with Access	244,259	253,074	257,612	261,144
Average Distance (Miles)	5.7	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)

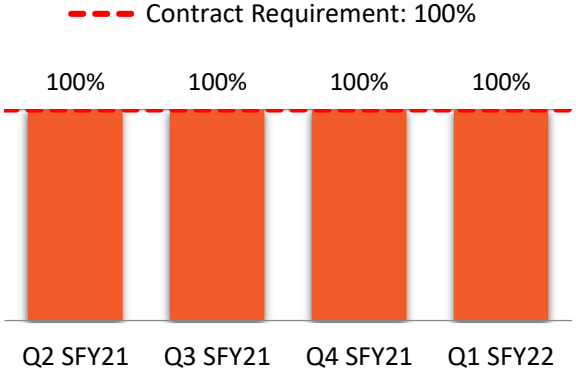
	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1
Adults PCP				
Provider Count	8,548	9,085	9,704	9,894
Members with Access	160,490	166,971	171,647	175,634
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	9,262	9,820	10,472	10,658
Members with Access	136,490	138,828	140,406	141,050
Average Distance (Miles)	2.1	2.1	2.1	2.1

Specialty Care & Behavioral Health (BH)

	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1
OB/GYN Adult				
Provider Count	1,207	1,234	1,286	1,298
Members with Access	106,694	110,381	113,317	115,394
Average Distance (Miles)	5.4	5.4	5.4	5.4
Outpatient - Behavioral Health				
Provider Count	8,251	8,737	9,476	9,688
Members with Access	296,980	305,799	312,053	316,684
Average Distance (Miles)	2.5	2.5	2.5	2.4
Inpatient - Behavioral Health				
Provider Count	35	36	36	36
Rural Members				
Members with Access	212,426	218,902	223,411	226,908
Average Distance (Miles)	24.7	24.6	24.6	24.6
Urban Members				
Members with Access	84,554	86,897	88,642	89,776
Average Distance (Miles)	8.4	8.4	8.4	8.4

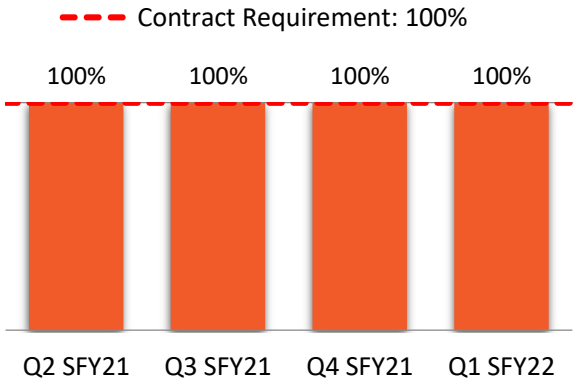
Adult PCP - Standards

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

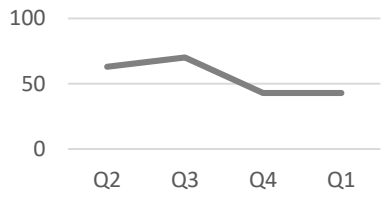
MCO Program Integrity

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 Q1

43



22 Total Cases Referred to MCFU Q1

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	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1	Average	Total
Investigations opened	34	42	33	28	34	137
Overpayments identified	23	10	23	14	18	70
Member concerns referred to IME	3	4	2	2	3	11
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	2	6	6	5	20

iowa total care

	SFY21 Q2	SFY21 Q3	SFY21 Q4	SFY22 Q1	Average	Total
Investigations opened	29	28	10	15	21	82
Overpayments identified	1	0	6	12	5	19
Member concerns referred to IME	4	6	10	10	8	30
Cases referred to the Medicaid Fraud Control Unit (MCFU)	3	2	12	16	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 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