Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 4

(April - June 2021)

Performance Data

Published September 2021

Department of
HUMAN SERVICES

Contents

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

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

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Executive Summary

This report is based on Quarter 4 of State Fiscal Year (SFY) 2021 and includes the information for the Iowa Medicaid Managed Care Organizations (MCOs): Amerigroup (AGP) and Iowa Total Care (ITC)

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However, based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.
- Data pulled on other dates may not reflect the same numbers due to reinstatements and eligibility changes.
- All encounter data is provided "as is". The IME takes measures to attempt to ensure the accuracy, completeness, and reliability of the data. However, users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.
- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- The Department validates the data by looking at available fee-for-service historical baselines, encounter data, and by reviewing the source data provided by the MCOs.
- Providers and members can find more information on the IA Health Link program at: http://dhs.iowa.gov/iahealthlink

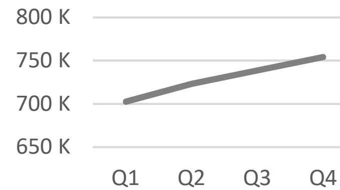
MCO Member Summary - All MCO Counts

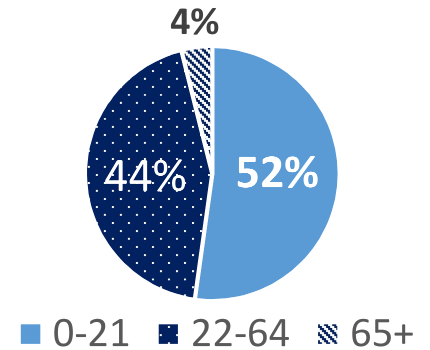
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

All MCO Members

754,103





+ 15,364 Members
2.08% Increase

All MCO Enrollment
(by Age)

Data Notes: June 2021 enrollment data as of July, 2021. The "Average" column below represents a four-quarter rolling average while the "Distinct" column represents the total number of unique individuals appearing within populations at least once during the past four-quarters.

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

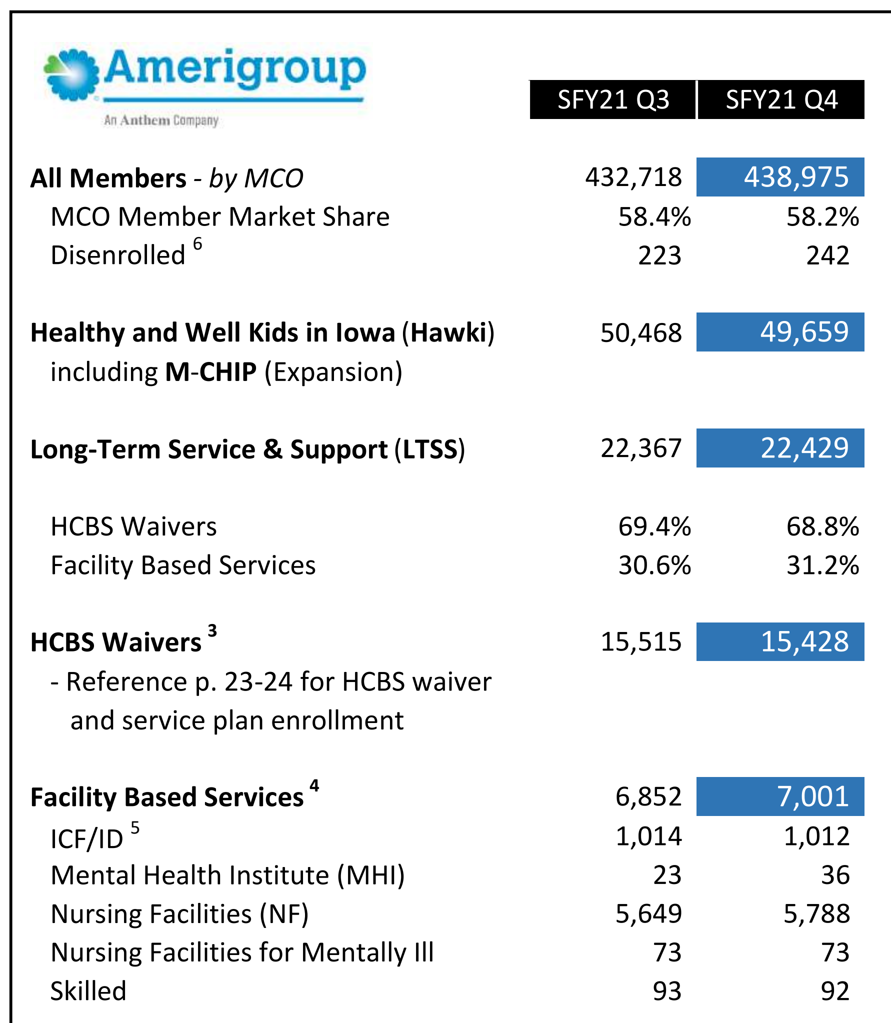
Significant Change in Data? (+/-) No [ ] Yes [X]

If Yes, explain:

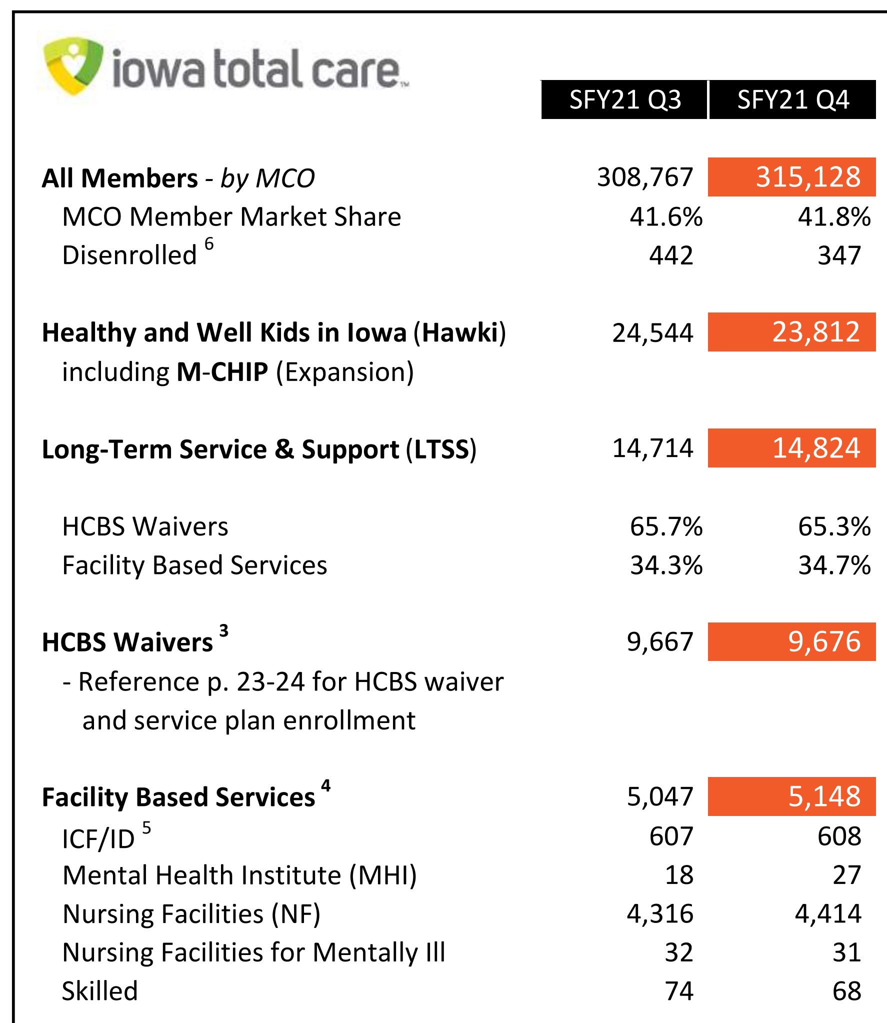
Iowa Medicaid Population **829,659**
1 year distinct count

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

MCO Member Summary



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



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

[3] Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 23-24.

[4] Facility Based Services listed above only include the institutional groups where members are most likely to have an option to transition to an HCBS setting. Excluded institution types include Hospice and Psychiatric Medical Institutions for Children (PMICs).

[5] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [6] Measure previously reported zeros for disenrollment during COVID incorrectly; While disenrollment under COVID was "suspended" reporting zeros failed to capture member "reassignments" between MCOs.

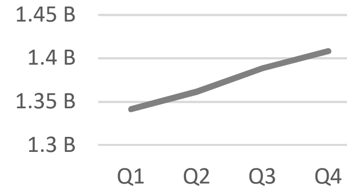
MCO Financial Summary - All MCO Counts

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

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

All Capitation Payments

$1.41 Billion

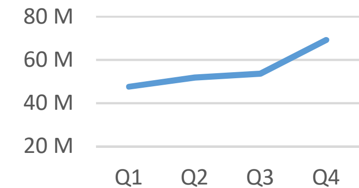


+ $19.6 Million

1.41% Increase

Third Party Liability Recovered

$69.23 Million



+ $ 15.5 Million

28.85% increase

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

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

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

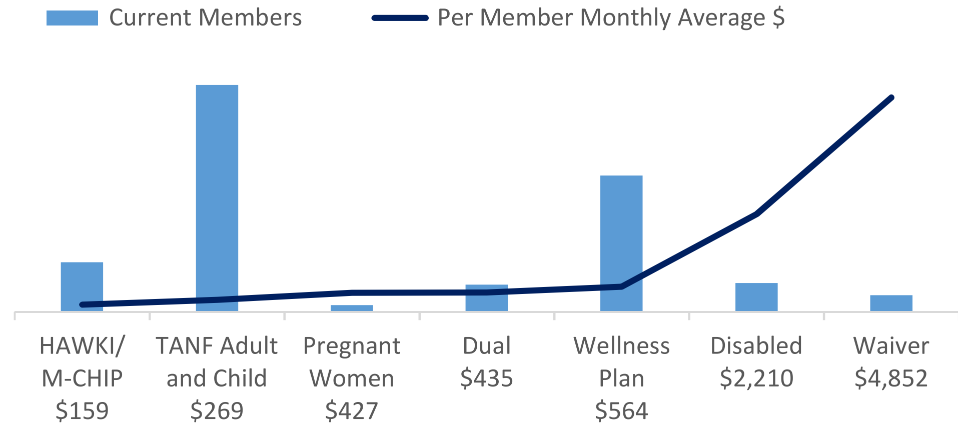
If Yes, explain:

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

MCO Financial Summary

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

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



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

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

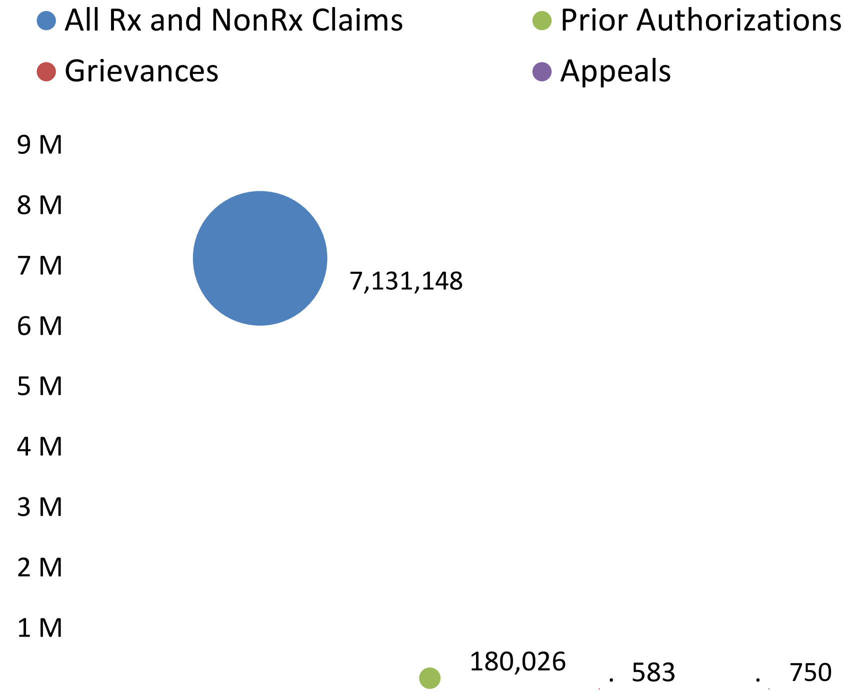
[7] Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

MCO Claims Universe - All MCO Counts

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

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

	% of Claims Universe
Prior Authorizations	2.52%
Grievances	0.01%
Appeals	0.01%

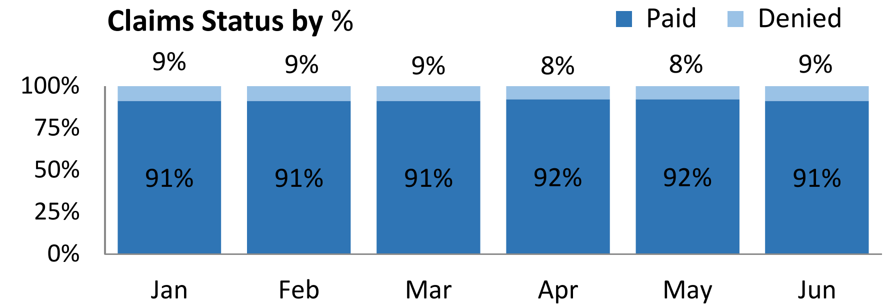


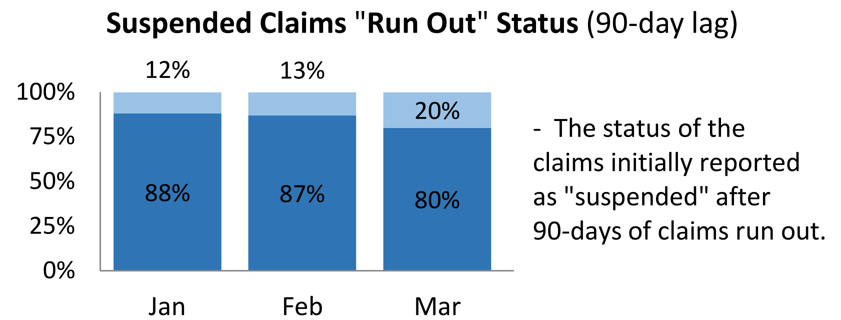
	SFY21 Q1	SFY21 Q2	SFY21 Q3	SFY21 Q4	Average	Total
Claim Counts - All Paid & Denied (p. 9-12)	7.02 M	6.77 M	6.84 M	**7.13 M**	6.94 M	27.77 M
Non-Pharmacy	4.02 M	3.96 M	4.00 M	4.21 M	4.05 M	16.19 M
Pharmacy	3.00 M	2.81 M	2.84 M	2.92 M	2.89 M	11.58 M
Prior Authorization Summary (p. 13-14)	172,937	176,060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

Claims Summary (Non-Pharmacy)

2.42 Million
Claims Paid & Denied

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





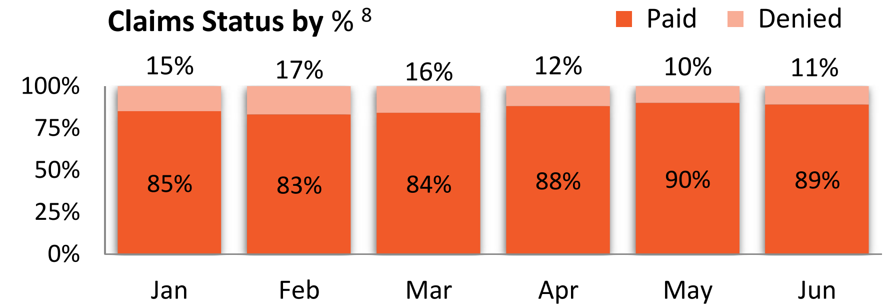
- The status of the claims initially reported as "suspended" after 90-days of claims run out.

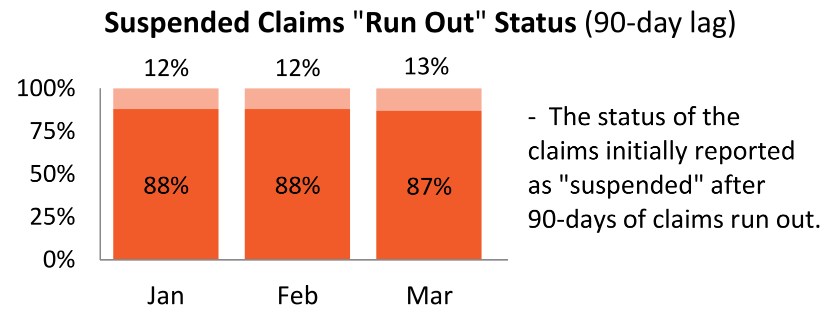
	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	25%	Duplicate claim service
2.	12%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Claim/service lacks information or has submission/billing error(s)
4.	8%	Service not payable per managed care contract
5.	8%	Expenses incurred after coverage terminated
6.	6%	Precertification/authorization/notification absent
7.	5%	An attachment/other documentation is required to adjudicate this claim/service.
8.	5%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	3%	The time limit for filing has expired
10.	3%	Benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

Claims Summary (Non-Pharmacy)

1.79 Million
Claims Paid & Denied

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





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

Top 10 Reasons for Claims Denials (Non-Pharmacy)

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

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

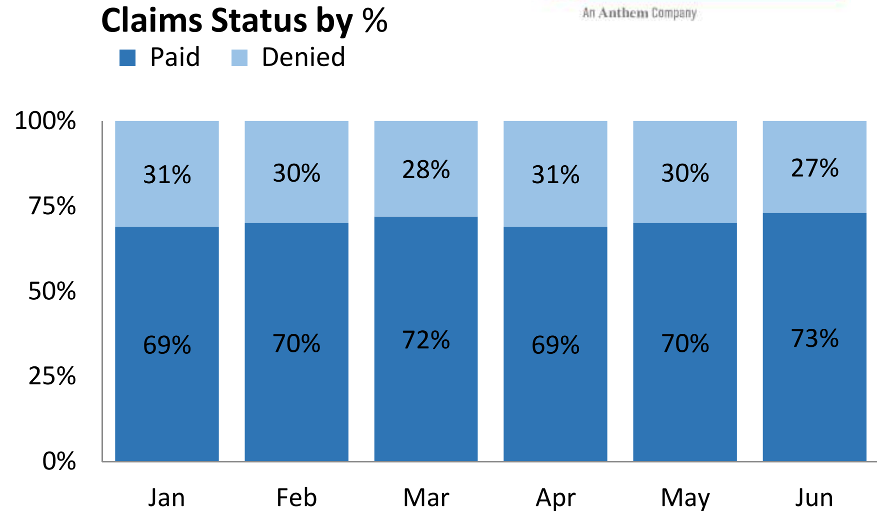
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

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

Claims Summary (Pharmacy)

1.65 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	358,521	364,932	452,424
Denied	158,320	153,504	165,144
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	11	12

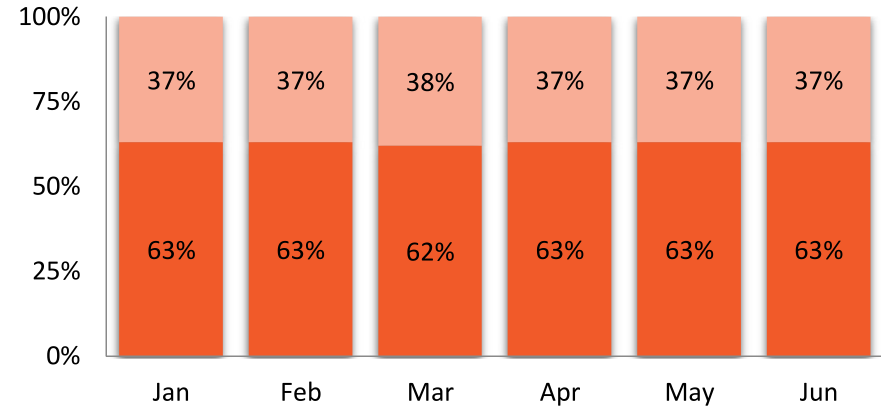


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	40%	Refill too soon
2.	14%	Submit bill to other processor or primary payer
3.	14%	Prior authorization required
4.	10%	National Drug Code (NDC) not covered
5.	5%	M/I other payer reject code
6.	5%	Plan limitations exceeded
7.	2%	Non matched prescriber ID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

Claims Summary (Pharmacy)

1.27 Million
Claims Paid & Denied

	Apr	May	Jun
All Claims (Pharmacy)			
Paid	267,219	261,365	275,964
Denied	154,512	152,130	159,420
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	3	3	4



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

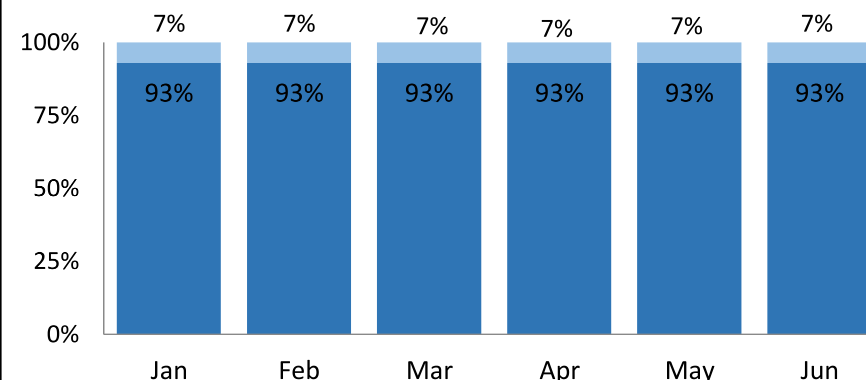
Prior Authorization Summary

83,721
All PAs Submitted [9]

Non-Pharmacy

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

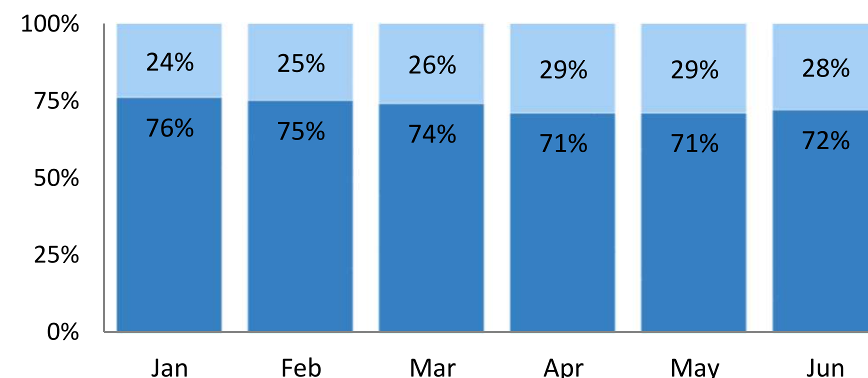
Non-Pharmacy by Percentage



Pharmacy

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

Pharmacy by Percentage



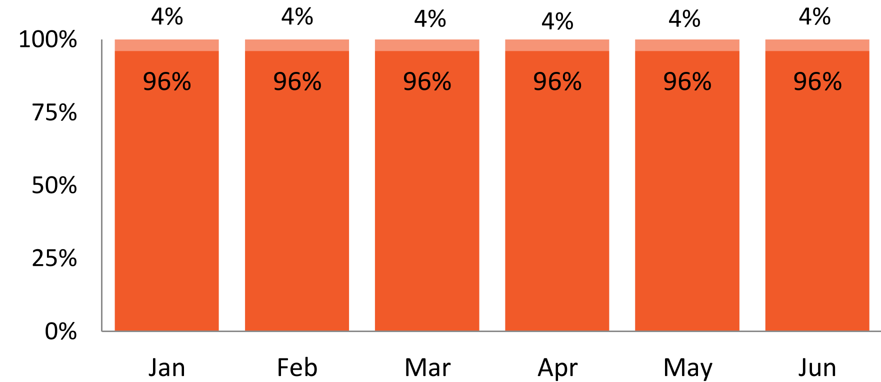
[9] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

96,305
All PAs Submitted [9]

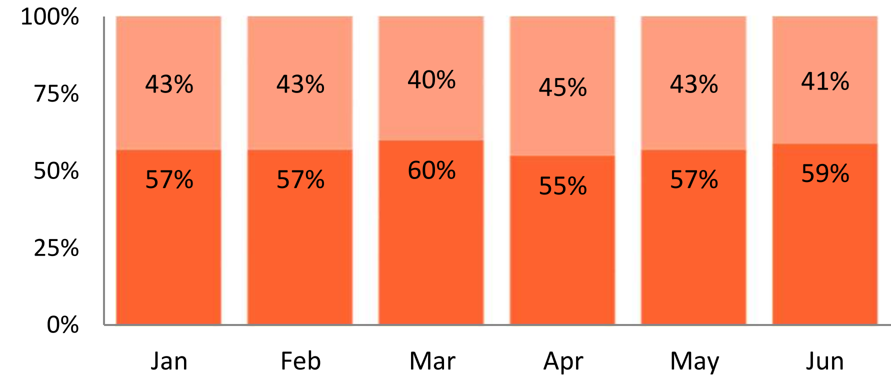
Non-Pharmacy

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



Pharmacy

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

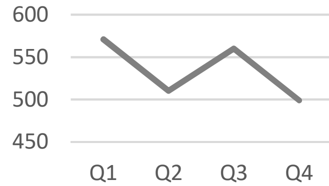


[9] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

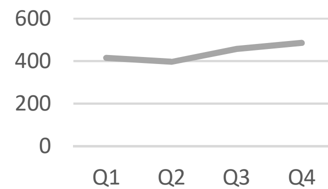
Grievances

499



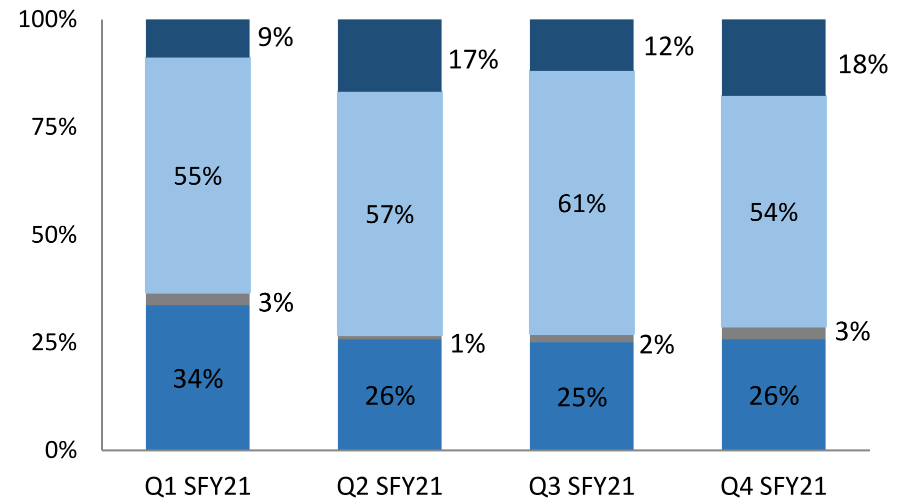
Appeals

486



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

Appeal Outcome Percentages



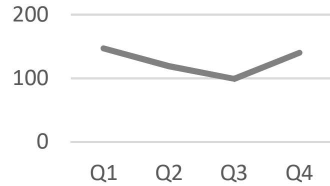
	%	Top 10 Reasons for Grievances
1.	35%	Voluntary disenrollment
2.	17%	Provider balance billed
3.	10%	Adequacy of treatment record keeping
4.	5%	Availability of appointments
5.	4%	Transportation - Driver delay
6.	4%	Provider attitude/rudeness
7.	3%	Transportation - Driver no-show
8.	3%	Treatment dissatisfaction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

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

Grievances and Appeals

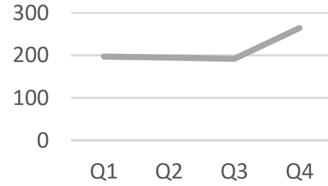
Grievances

140



Appeals

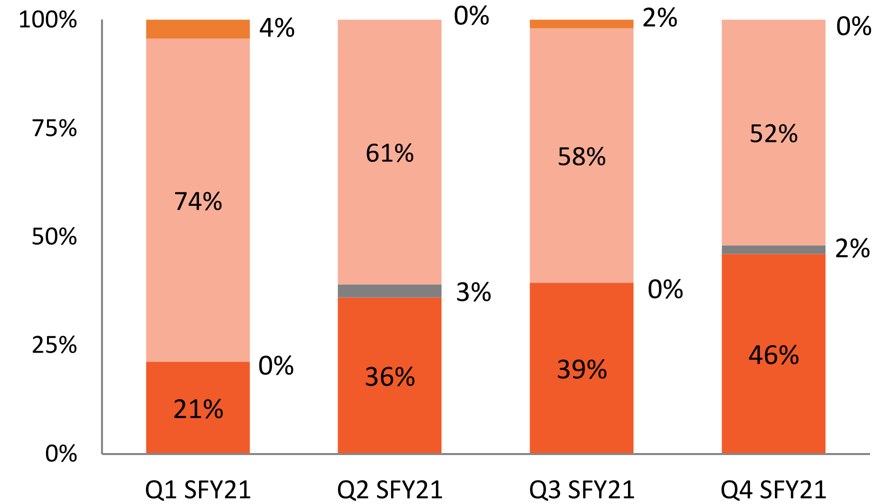
264



Resolved in 30-days
99%

Resolved in 30-days
100%

Appeal Outcome Percentages

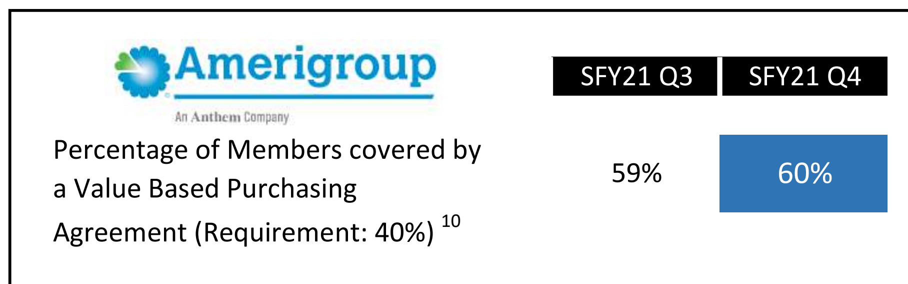


	%	Top 10 Reasons for Grievances
1.	22%	Access to Care - Network Availability
2.	17%	Unhappy with Benefits
3.	14%	Transportation - General Complaint Vendor
4.	6%	Transportation - Missed Appointment
5.	5%	Transportation - Late Appointment
6.	5%	Provider Staff
7.	4%	Provider
8.	3%	Transportation - Driver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

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

Value Based Purchasing (VBP) Agreement

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



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

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

Top 5 - Value Added Services (VAS)

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

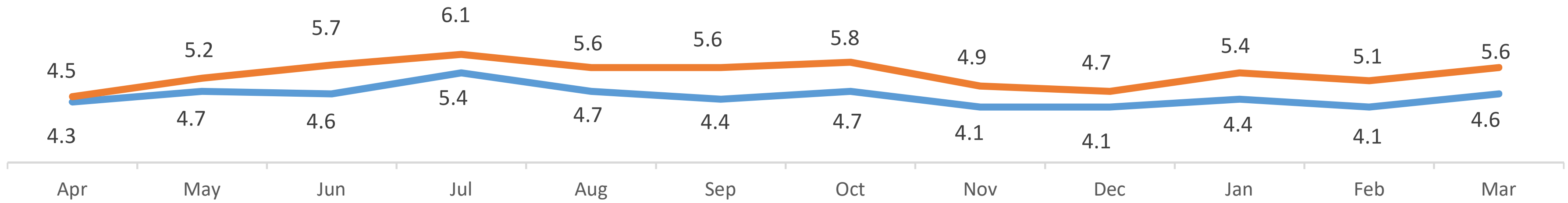
Amerigroup (An Anthem Company)	SFY21 Q3	SFY21 Q4
Healthy Rewards	5,633	4,466
Taking Care of Baby and Me	2,654	1,514
Community Resource Link	1,028	1,007
Dental Hygiene Kit	844	565
SafeLink Mobile Phone	616	447

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

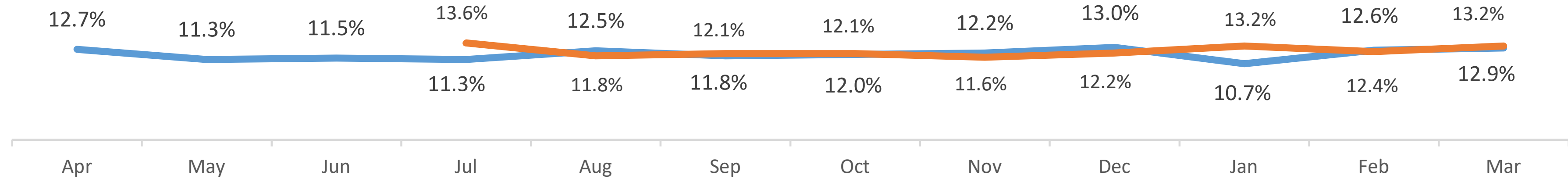
[10] *Updated "members covered" in 40% requirement to include long term care, dual eligible, Hawki, and breast cervical cancer program members*

MCO Care Quality and Outcomes

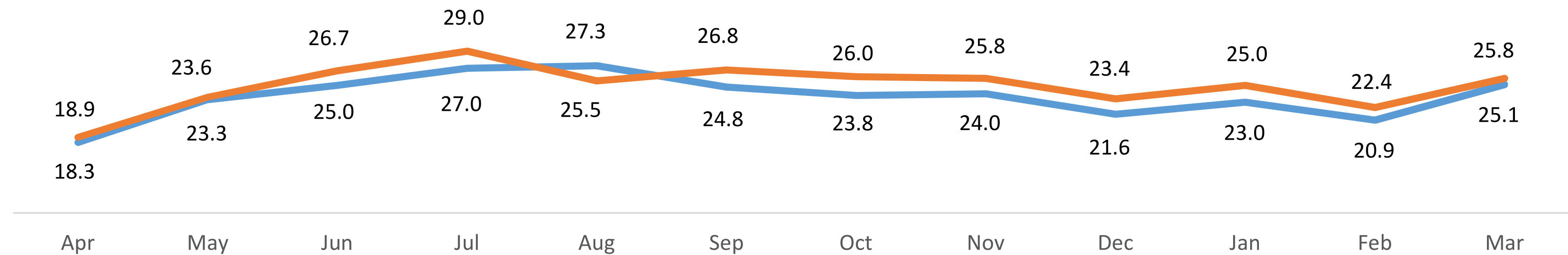
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



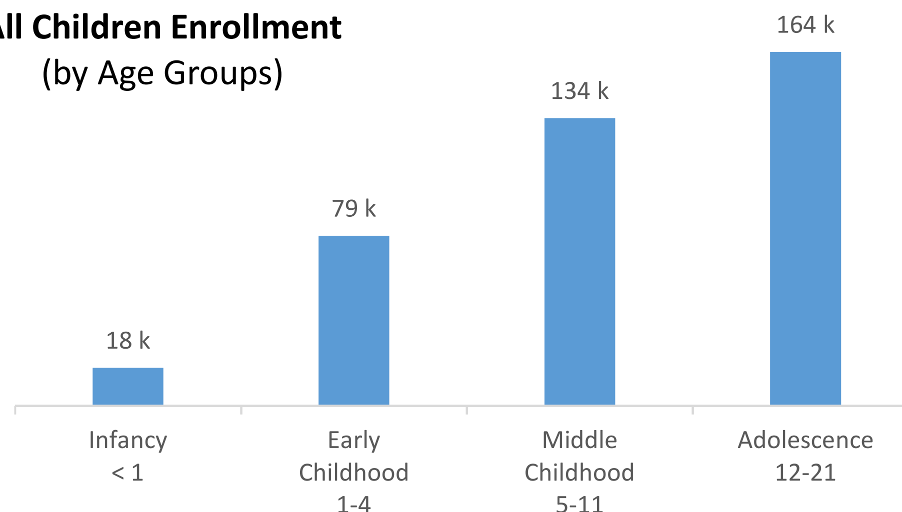
[11] *This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.*

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

MCO Children Summary

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

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



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

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

MCO Children Summary

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

Immunization Summary - 21 & Under

	SFY20 Q4	SFY21 Q4
Vaccination Totals	46,015	49,705
COVID-19 Dose 1	0	3,894
COVID-19 Dose 2	0	3,156
COVID-19 Single-Dose	0	78
DTaP (Diphtheria, Tetanus, Pertussis)	9,498	8,674
Influenza (FLU)	867	755
HepA (Hepatitis A)	4,608	4,191
HepB (Hepatitis B)	909	793
Haemophilus Influenza Type B (Hib)	5,444	4,656
Human Papillomavirus (HPV)	1,872	2,424
Meningococcal ACWY (MenACWY)	1,619	2,280
MMR (Measles, Mumps, Rubella)	3,817	3,439
Pneumococcal (PCV13)	8,128	6,871
Polio (IPV)	153	213
RV (Rotavirus)	4,998	4,462
TDAP (Tetanus, Diphtheria, Pertussis)	1,667	1,970
Varicella Virus Vaccine (VAR)	2,435	1,849

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

Immunization Summary - 21 & Under

	SFY20 Q4	SFY21 Q4
Vaccination Totals	28,088	38,900
COVID-19 Dose 1	0	2,273
COVID-19 Dose 2	0	1,939
COVID-19 Single-Dose	0	40
DTaP (Diphtheria, Tetanus, Pertussis)	6,702	7,247
Influenza (FLU)	596	673
HepA (Hepatitis A)	2,274	3,101
HepB (Hepatitis B)	772	710
Haemophilus Influenza Type B (Hib)	1,234	4,080
Human Papillomavirus (HPV)	1,223	1,702
Meningococcal ACWY (MenACWY)	1,008	1,453
MMR (Measles, Mumps, Rubella)	1,843	2,604
Pneumococcal (PCV13)	5,868	6,019
Polio (IPV)	139	132
RV (Rotavirus)	4,255	3,972
TDAP (Tetanus, Diphtheria, Pertussis)	1,114	1,346
Varicella Virus Vaccine (VAR)	1,060	1,609

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

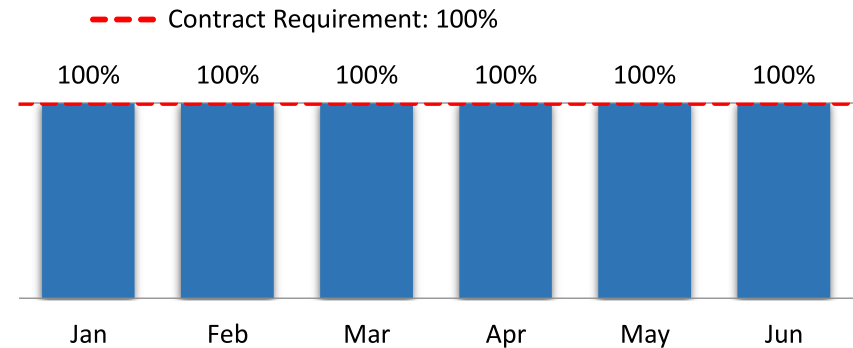
Average Number of Contacts Per Month	SFY21 Q3	SFY21 Q4
by Care Coordinators	0.8	**0.9**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	27	**34**
HCBS Members to Case Managers	67	**65**

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

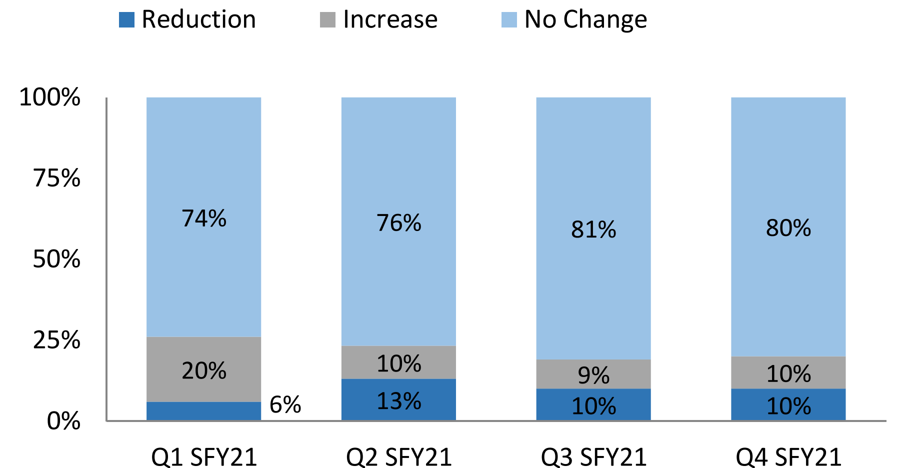
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q3	SFY21 Q4
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.6%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.4%	100.0%
Their services make their lives better.	I don't know	0.3%	0.9%
	No	0.6%	0.3%
	Sometimes	2.3%	0.0%
	Yes	96.8%	98.8%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

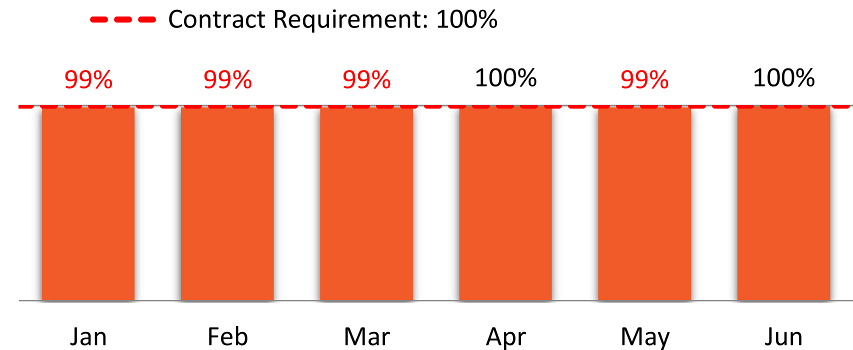
Average Number of Contacts Per Month	SFY21 Q3	SFY21 Q4
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	25	**47**
HCBS Members to Case Managers	41	**41**

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

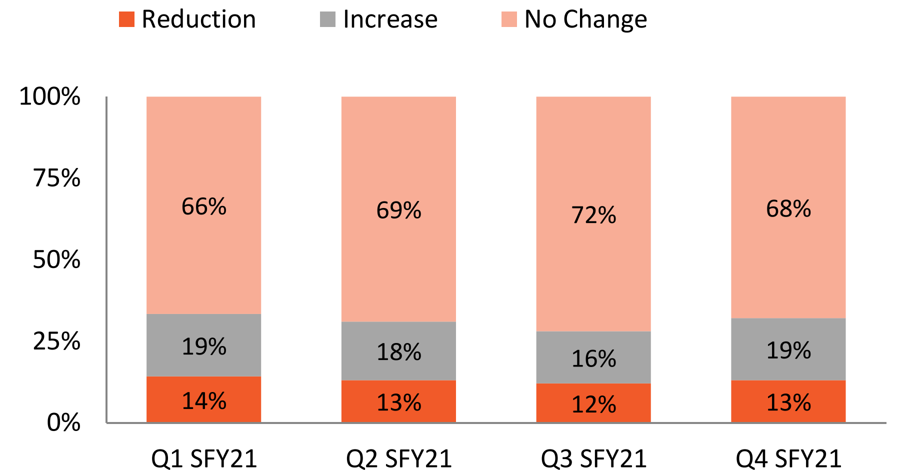
Iowa Participant Experience Survey (IPES)

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

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

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

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

Long Term Services - Waiver Service Plan Participation

All eligible members receive service coordination and a customized individual service plan. For additional information on the HCBS waiver program including a full list of available services reference our dedicated webpage: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services

- by Member Usage

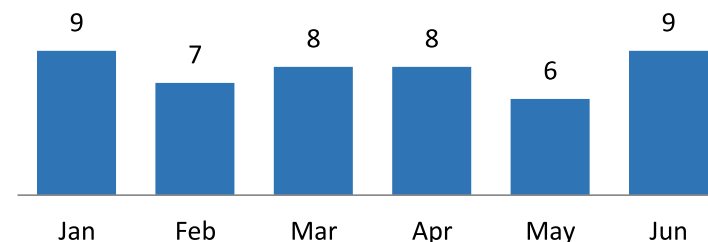
Service	SFY21 Q3	SFY21 Q4
AIDS/HIV - Unique Service Plans	9	10
Home Delivered Meals	8	7
CDAC (individual) by 15 minute units	5	4
Homemaker (by 15 minute units)	2	2
Brain Injury (BI) Waivers	531	527
Supported Community Living (by unit)	235	229
Respite (by 15 minute units)	151	145
Personal Emergency Response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

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

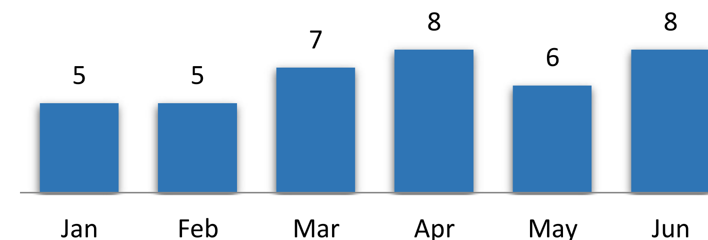
Call Center Performance Metrics

	Apr	May	Jun
Member Helpline			
Service Level (Requirement 80%)	93.10%	89.83%	95.93%
Abandonment Rate - Must be 5% or less	0.81%	0.73%	0.83%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	96.04%	96.68%	93.75%
Abandonment Rate - Must be 5% or less	0.11%	0.17%	0.34%
Provider Helpline			
Service Level (Requirement 80%)	90.05%	83.11%	83.38%
Abandonment Rate - Must be 5% or less	1.01%	1.37%	0.92%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	93.06%	93.35%	93.31%
Abandonment Rate - Must be 5% or less	0.29%	0.23%	0.11%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	80.09%	88.65%	71.06%
Abandonment Rate - Must be 5% or less	3.62%	2.53%	3.60%

Secret Shopper Scores - Member Helpline



Secret Shopper Scores - Provider Helpline



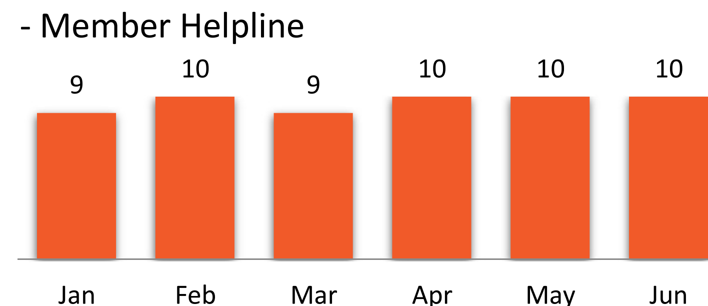
Data Notes: Top 5 Call Reasons are captured during the last month of the reporting period.

	Top 5 Call Reasons (Member Helpline)	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	Authorization New
5.	Transportation Inquiry	Claim Payment Question or Dispute

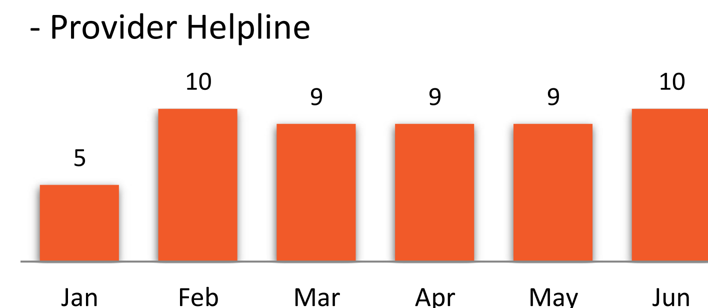
Call Center Performance Metrics

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

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

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

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

Provider Network Access Summary

Primary Care Providers (PCP)

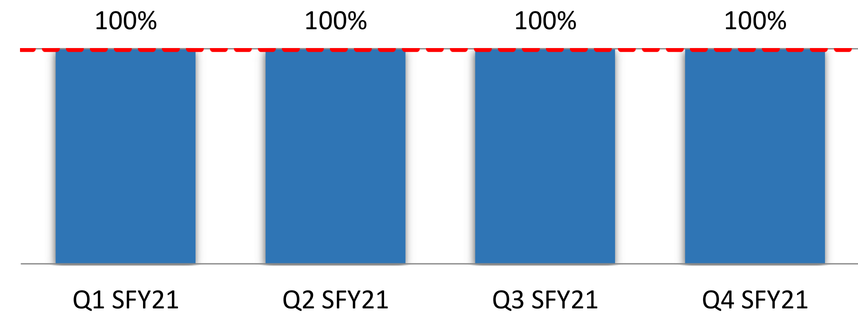
	SFY21 Q3	SFY21 Q4
Adults PCP		
Provider Count	6,672	6,632
Members with Access	219,428	224,574
Average Distance (Miles)	1.9	1.8
Pediatric PCP		
Provider Count	6,707	6,666
Members with Access	209,553	211,406
Average Distance (Miles)	2.0	2.0

Specialty Care & Behavioral Health (BH)

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

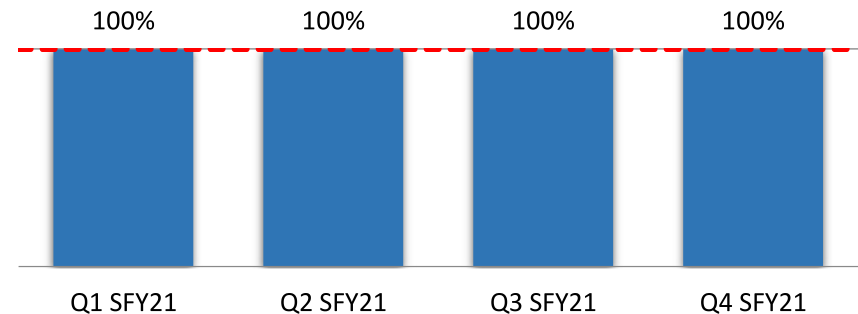
Adult PCP - Time Standards

30 minutes or 30 miles



Pediatric PCP - Time Standards

30 minutes or 30 miles



Link to Geo Access Reports:
https://dhs.iowa.gov/ime/about/performance-data-geoaccess

Provider Network Access Summary

Primary Care Providers (PCP)

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

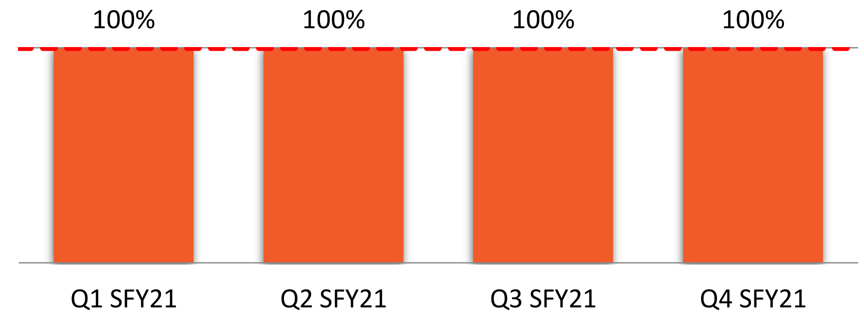
Specialty Care & Behavioral Health (BH)

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

Adult PCP - Time Standards

30 minutes or 30 miles

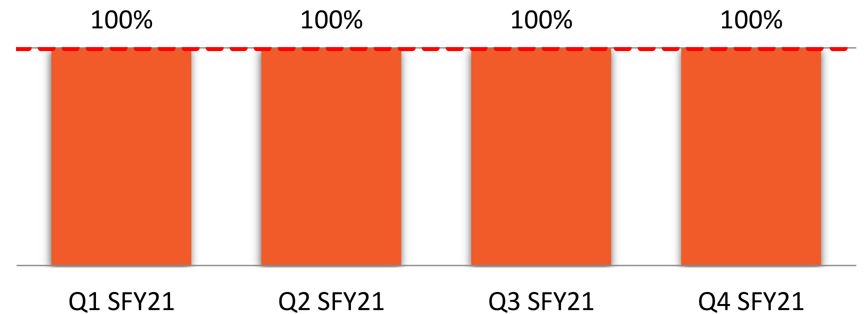
Contract Requirement: 100%



Pediatric PCP - Time 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

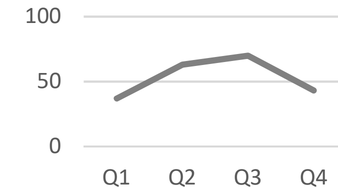
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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 - SFY21 Q4

43



18 Total Cases Referred to MCFU

Program Integrity

- Fraud, Waste, & Abuse

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

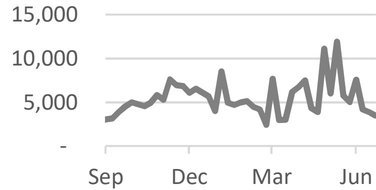
Program Integrity

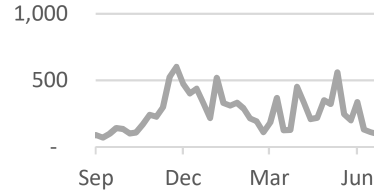
- Fraud, Waste, & Abuse

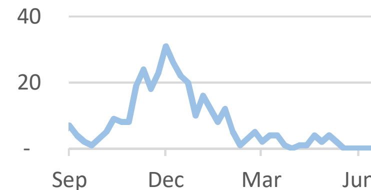
	SFY21 Q3	SFY21 Q4
Investigations opened	28	10
Overpayments identified	0	6
Member concerns referred to IME	6	10
Cases referred to the Medicaid Fraud Control Unit (MCFU)	2	12

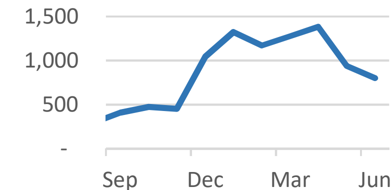
MCO COVID-19 Summary

Total Individuals Tested	Total Tested Positive	Total COVID Deaths [13]	Total COVID Inpatient Stays
277,746	12,449	470	10,156









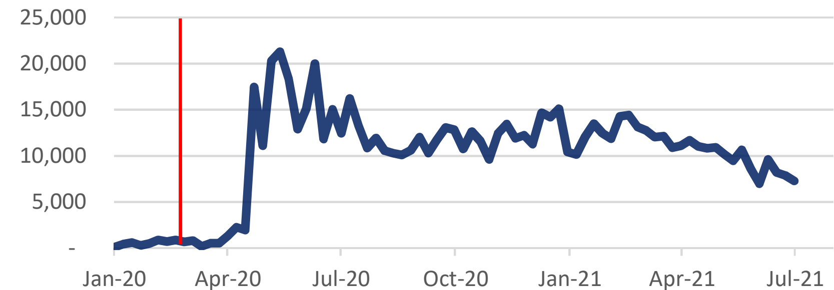
78,246 tested in Q4	4.5%	0.06%	2.24%
18% Increase	% Tested Positive	% of MCO Population	% of Total Inpatient Stays

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

Claims Activity During COVID-19

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

Telehealth Services - Weekly MCO Counts



- o In March 2020, IL 2115-MC-FFS and IL 2119-MC-FFS authorized the expansion of telehealth services in Iowa.
- o Since March, the Managed Care Organizations have reported a significant increase in telehealth services.
- o IME is currently reviewing the continuation of telehealth service expansion once the public health emergency is lifted.

Appendix: Glossary

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

Administrative Loss Ratio (**ALR**): See Financial Ratios

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

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

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

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO. Actions that a member may choose to appeal:

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

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

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

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

- **Adjustments**: Monetary only payments/adjustments that can occur within the paid month for same month or prior months
    - Example - Recoup and repay when rate changes occur
- **Current**: Payments that occur within the paid month for same month

Capitation Expenditures (continued...):

- **Retro**: Payments for months prior to the current month for member months not previously paid for
  - Member months are counted if request is to provide member months within a specific date range for more than one month
  - 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**:
  - Claims where the provider may request a reopening to fix clerical errors or billing errors
  - 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