Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 3

(January - March 2021)

Performance Data

Published June 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 3 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)

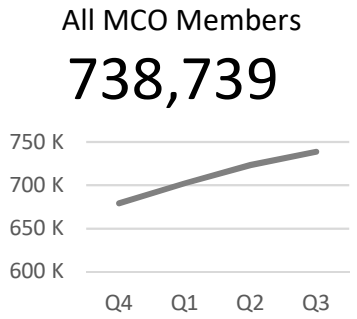
Notes about the reported data:

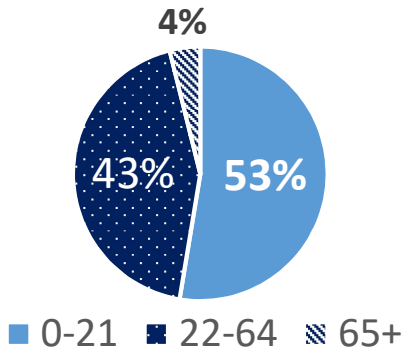
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period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





+ 15,528 Members
2.15% Increase

All MCO Enrollment (by Age)

Data Notes: March 2021 enrollment data as of May 4, 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.

	SFY20 Q4	SFY21 Q1	SFY21 Q2	SFY21 Q3	Average	Distinct
MCO Member Summary - *Overall Counts*	679,048	702,432	723,211	**738,739**	710,858	**748,900**
0-21	366,686	375,723	383,041	388,655	378,526	392,571
22-64	285,200	298,168	311,554	321,248	304,043	325,713
65+	27,162	28,541	28,616	28,836	28,289	30,616
Fee-For-Service (FFS) - *Non MCO Enrollees*	38,979	40,370	41,375	**42,216**	40,735	**43,783**

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

If Yes, explain:

Iowa Medicaid Population **792,683**
1 year distinct count

o MCO enrollment increased by 15,528 members (or 2.15% increase)
o Since March 2020, all MCO disenrollment has been suspended because of COVID-19

MCO Member Summary

Amerigroup	SFY21 Q2	SFY21 Q3
All Members - *by MCO*	423,312	432,718
MCO Member Market Share	58.5%	58.4%
Disenrolled	0	0
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	50,059	50,468
Long-Term Service & Support (LTSS)	22,802	22,367
HCBS Waivers	68.9%	69.4%
Facility Based Services	31.1%	30.6%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	15,705	15,515
Facility Based Services [4]	7,097	6,852
ICF/ID [5]	1,028	1,014
Mental Health Institute (MHI)	34	23
Nursing Facilities (NF)	5,875	5,649
Nursing Facilities for Mentally Ill	71	73
Skilled	89	93

iowa total care	SFY21 Q2	SFY21 Q3
All Members - *by MCO*	299,899	308,767
MCO Member Market Share	41.5%	41.6%
Disenrolled	0	0
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	24,980	24,544
Long-Term Service & Support (LTSS)	14,934	14,714
HCBS Waivers	61.3%	65.7%
Facility Based Services	38.7%	34.3%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	9,746	9,667
Facility Based Services [4]	5,188	5,047
ICF/ID [5]	609	607
Mental Health Institute (MHI)	18	18
Nursing Facilities (NF)	4,460	4,316
Nursing Facilities for Mentally Ill	29	32
Skilled	72	74

[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)

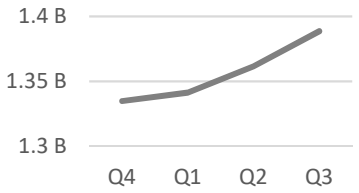
MCO Financial Summary - All MCO Counts

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

$1.39 Billion

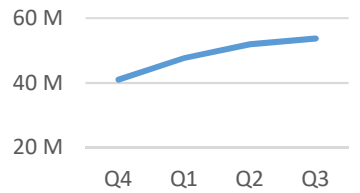


+ $27.0 Million

1.98% Increase

Third Party Liability Recovered

$ 53.73 Million



+ $ 1.8 Million

3.5% increase

Data Notes: March 2021 capitation data as of April 16, 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.

	SFY20 Q4	SFY21 Q1	SFY21 Q2	SFY21 Q3	Average	Total
Financial Summary						
Capitation Payments	$1.33 B	$1.34 B	$1.36 B	**$1.39 B**	$1.36 B	$5.43 B
Third Party Liability (TPL) Recovered	$41.63 M	$47.65 M	$51.91 M	**$53.73 M**	$48.73 M	$194.93 M

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

If Yes, explain:

o Medical Loss Ratio (MLR) - The MLR is contractually set at 88% for the time period of January 1, 2021 through June 30, 2021.

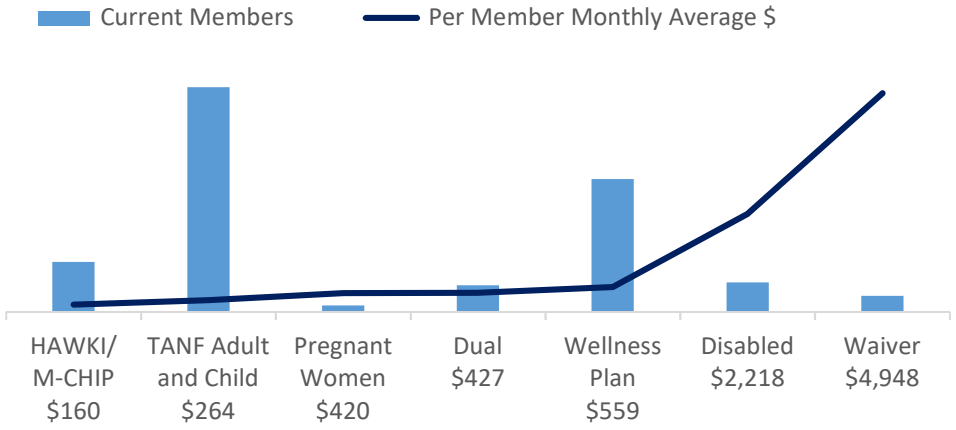
o In SFY 2020, the Department withheld $44M from ITC due to internal claims payments issues. In Q3 SFY2021, ITC met it's first set of audit milestones and was returned $14M (March 26, 2021). The Department will continue to return withheld amounts as the claims audit progresses.

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 Q2	SFY21 Q3
Capitation Totals	$811.95 M	**$818.12 M**
Adjustments	-$2.3 M	-$4.18 M
Current	$793.35 M	$800.26 M
Retro	$20.9 M	$22.04 M
Third Party Liability (TPL) Recovered	$22.40 M	**$24.32 M**
Financial Ratios		
Medical Loss Ratio (MLR)	88.8%	**91.5%**
Administrative Loss Ratio (ALR)	6.3%	5.6%
Underwriting Ratio (UR)	5.8%	2.9%
Annual MLR [6]		88.5%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

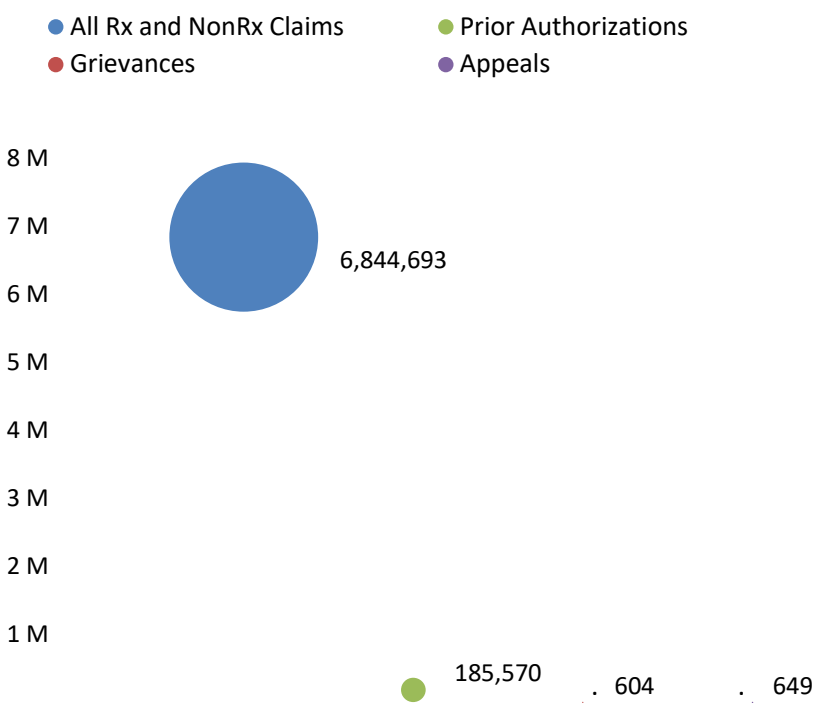
	SFY21 Q2	SFY21 Q3
Capitation Totals	$549.7 M	**$570.55 M**
Adjustments	-$1.34 M	$1.59 M
Current	$531.3 M	$548.53 M
Retro	$19.74 M	$20.43 M
Third Party Liability (TPL) Recovered	**$29.52 M**	**$29.41 M**
Financial Ratios		
Medical Loss Ratio (MLR)	88.8%	**94.0%**
Administrative Loss Ratio (ALR)	5.5%	5.6%
Underwriting Ratio (UR)	5.7%	0.4%
Annual MLR [6]		92.5%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[6] 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	2.71%
Grievances	0.01%
Appeals	0.01%

	SFY20 Q4	SFY21 Q1	SFY21 Q2	SFY21 Q3	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	5.95 M	7.02 M	6.77 M	**6.84 M**	6.65 M	26.59 M
Non-Pharmacy	3.17 M	4.02 M	3.96 M	4.00 M	3.79 M	15.15 M
Pharmacy	2.79 M	3.00 M	2.81 M	2.84 M	2.86 M	11.44 M
Prior Authorization Summary (p. 13-14)	145,452	172,937	176,060	**185,570**	170,005	680,019
Non-Pharmacy - All PAs Submitted	115,665	133,417	133,643	139,780	130,626	522,505
Pharmacy - All PAs Submitted	29,787	39,520	42,417	45,790	39,379	157,514
Grievances & **Appeals Summary** (p. 15-16)						
Grievances	422	718	629	**604**	593	2,373
Appeals	577	613	592	**649**	608	2,431

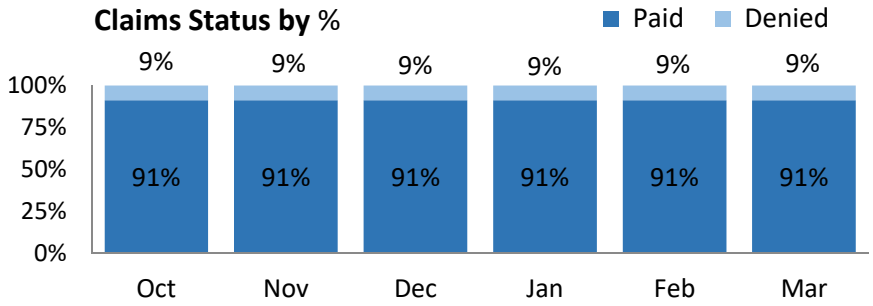
Claims Summary (Non-Pharmacy)

2.25 Million
Claims Paid & Denied

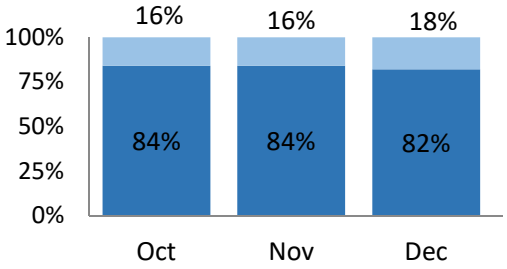
Amerigroup
An Anthem Company

	Jan	Feb	Mar
All Claims			
Paid	562,384	692,349	799,393
Denied	55,256	65,915	78,931
Suspended	144,252	177,137	144,115
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	6	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	100%	95%

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.	26%	Duplicate claim service
2.	11%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Expenses incurred after coverage terminated
4.	7%	Service not payable per managed care contract
5.	7%	Claim/service lacks information or has submission/billing error(s)
6.	5%	Precertification/authorization/notification absent
7.	5%	The impact of prior payer(s) adjudication including payments and/or adjustments.
8.	4%	The time limit for filing has expired
9.	4%	An attachment/other documentation is required to adjudicate this claim/service.
10.	3%	Benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated

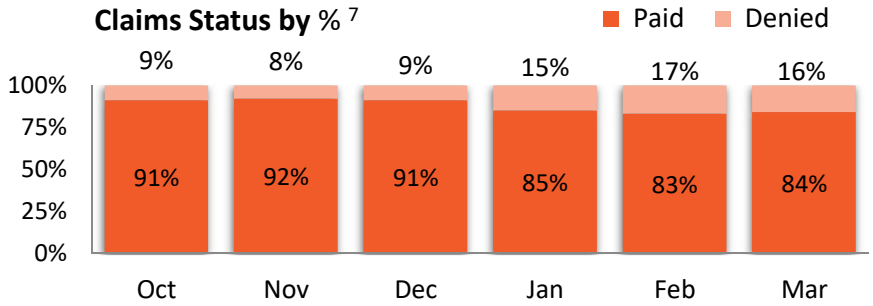
Claims Summary (Non-Pharmacy)

1.75 Million
Claims Paid & Denied

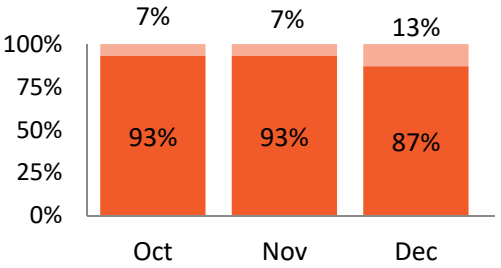
iowa total care

	Jan	Feb	Mar
All Claims			
Paid	427,592	461,945	578,311
Denied	76,872	94,209	106,544
Suspended	123,810	125,690	101,613
Clean Claims Processed [7]			
in 30-days (Requirement 90%)	96%	95%	98%
in 45-days (Requirement 95%)	98%	97%	99%
Average Days to Pay [7]	13	14	10
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	96%	97%

Claims Status by % [7]



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.	20%	Duplicate claim service
2.	11%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
3.	9%	Service can not be combined with other service on same day
4.	6%	Service is not covered
5.	5%	Advanced claim edits (ACE) claim level return to provider
6.	5%	No authorization on file that matches service(s) billed
7.	4%	Provider Medicaid ID required
8.	4%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
9.	2%	Submit to vision vendor for processing
10.	2%	Will be reprocessed after state reviews new code

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

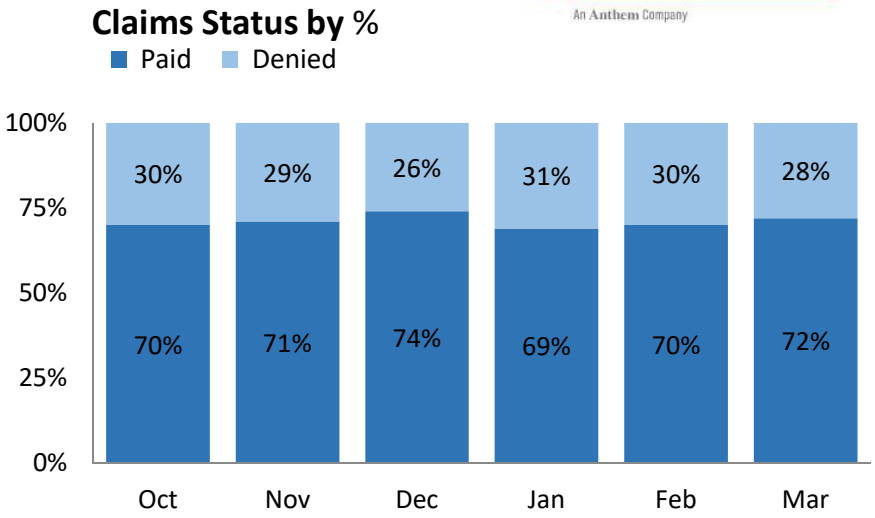
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **January**: 11,771
- **February**: 19,923
- **March**: 19,945

Claims Summary (Pharmacy)

1.62 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	333,816	349,172	451,808
Denied	152,871	150,363	179,681
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



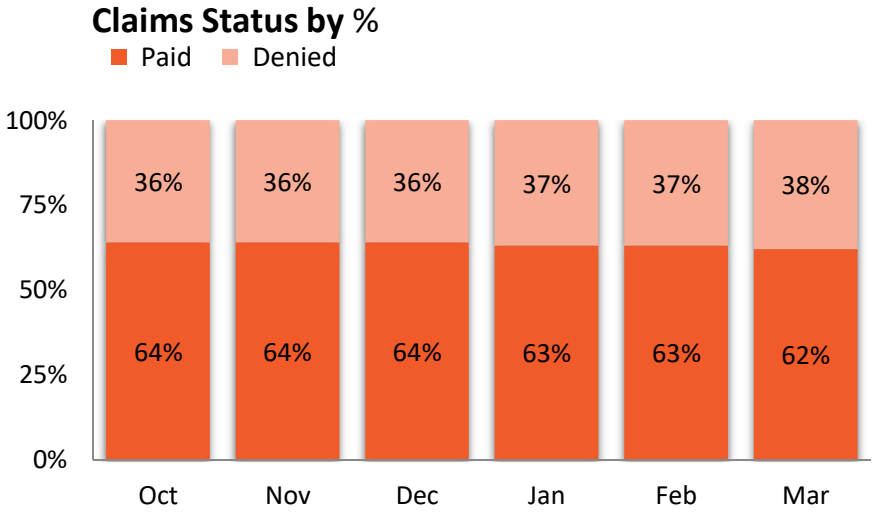
Top 10 Reasons for Claims Denials (Pharmacy)

	%	
1.	42%	Refill too soon
2.	15%	Submit bill to other processor or primary payer
3.	14%	Prior authorization required
4.	9%	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.	1%	Filled after coverage terminated
9.	1%	Pharmacy not enrolled in State Medicaid program
10.	1%	Discrepancy between other coverage code and other coverage information on file

Claims Summary (Pharmacy)

1.23 Million
Claims Paid & Denied

	Jan	Feb	Mar
All Claims (Pharmacy)			
Paid	250,352	242,037	279,080
Denied	144,672	143,151	167,989
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	4	5	4



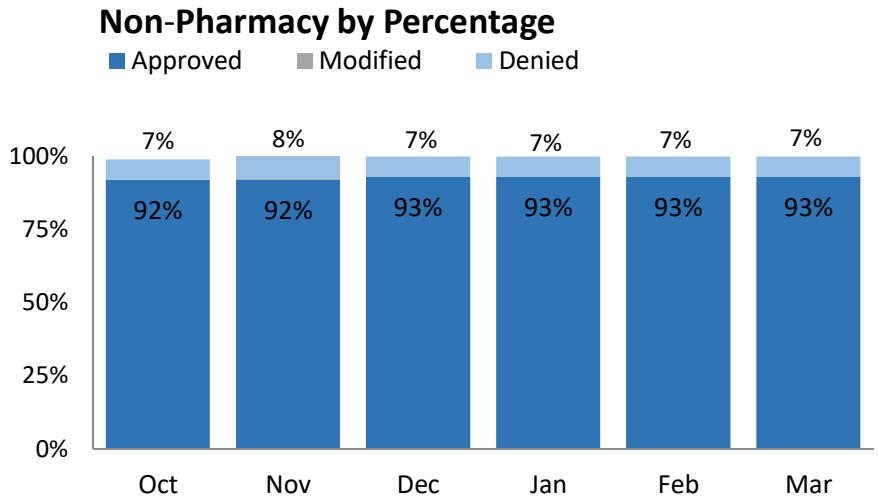
	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	29%	Refill too soon
2.	10%	Prior authorization required
3.	4%	Quantity dispensed exceeds maximum allowed
4.	3%	Submit bill to other processor or primary payer
5.	3%	Product not on formulary
6.	3%	Claim not processed
7.	2%	National Drug Code (NDC) not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

Prior Authorization Summary

86,482
All PAs Submitted [8]

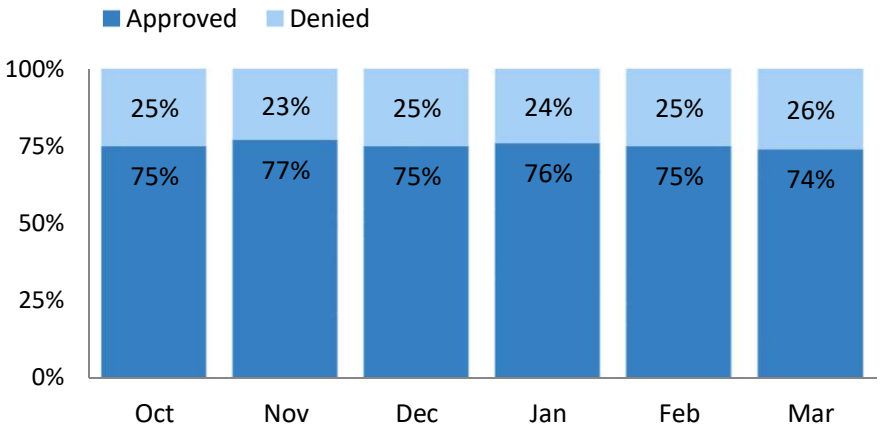
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	17,607	17,808	20,918
Denied	1,225	1,334	1,504
Modified	30	48	54
Average Days to Process	4	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	7,175	5,963	6,322
Denied	2,221	2,005	2,252
PAs Completed in 24-hours (Requirement 100%)	99.9%	100%	99.9%



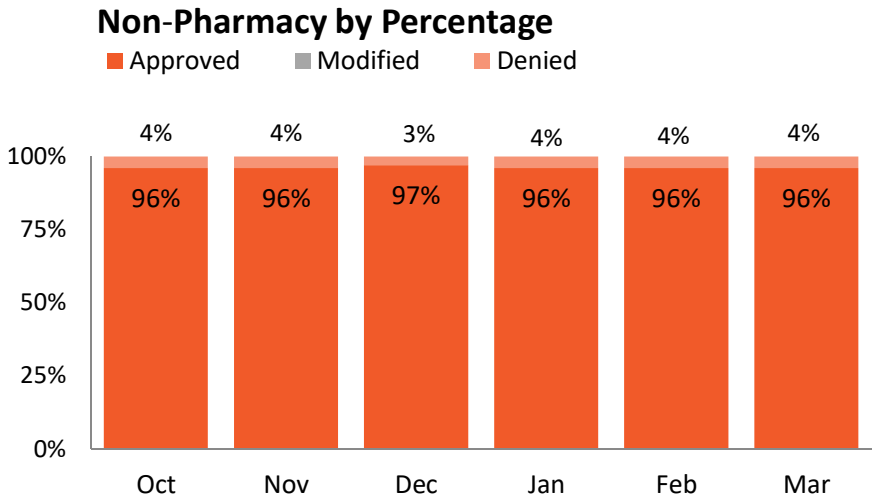
[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

99,088
All PAs Submitted [8]

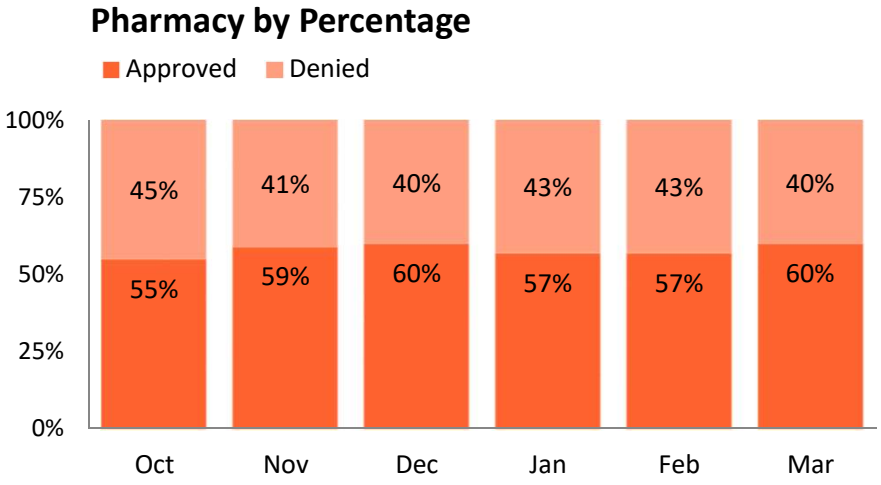
Non-Pharmacy

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	24,450	24,240	28,356
Denied	887	947	1,072
Modified	0	0	0
Average Days to Process	4	3	3
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Jan	Feb	Mar
Prior Authorizations			
Approved	3,198	3,288	4,017
Denied	2,402	2,436	2,654
PAs Completed in 24-hours (Requirement 100%)	100%	100%	100%

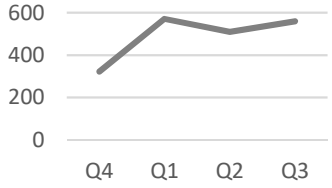


[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

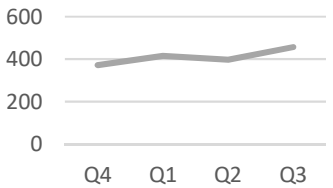
Grievances

560



Appeals

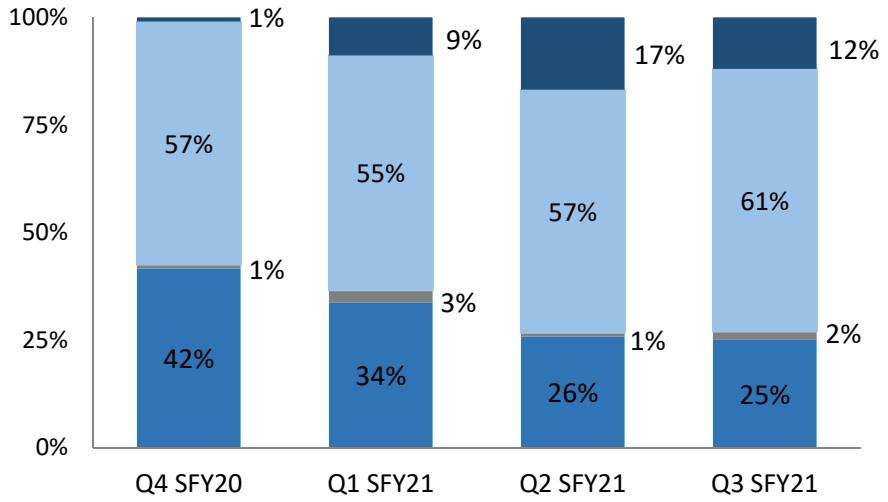
457



Resolved in 30-days
100%

Resolved in 30-days
100%

Appeal Outcome Percentages



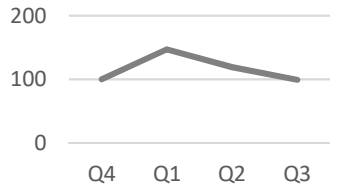
	%	Top 10 Reasons for Grievances
1.	43%	Voluntary Disenrollment
2.	15%	Provider balance billed
3.	6%	Availability of appointments
4.	6%	Transportation - Driver no-show
5.	4%	Transportation - Driver Delay
6.	4%	Adequacy of treatment record keeping
7.	4%	Provider attitude/rudeness
8.	3%	Treatment Dissatisfaction
9.	2%	Access to Case Management
10.	2%	Delay in obtaining Authorization/Referral

%	Top 10 Reasons for Appeals
29%	DME
20%	Pharmacy - Non Injectable
11%	Radiology
7%	Pharmacy - Injectable
7%	Therapy - PT
6%	BH - Op Service
6%	Surgery
3%	Outpatient Services - Medical
3%	BH - Inpatient
3%	Personal Care Services Self- Directed

Grievances and Appeals

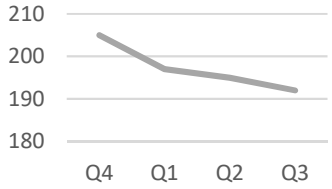
Grievances

99



Appeals

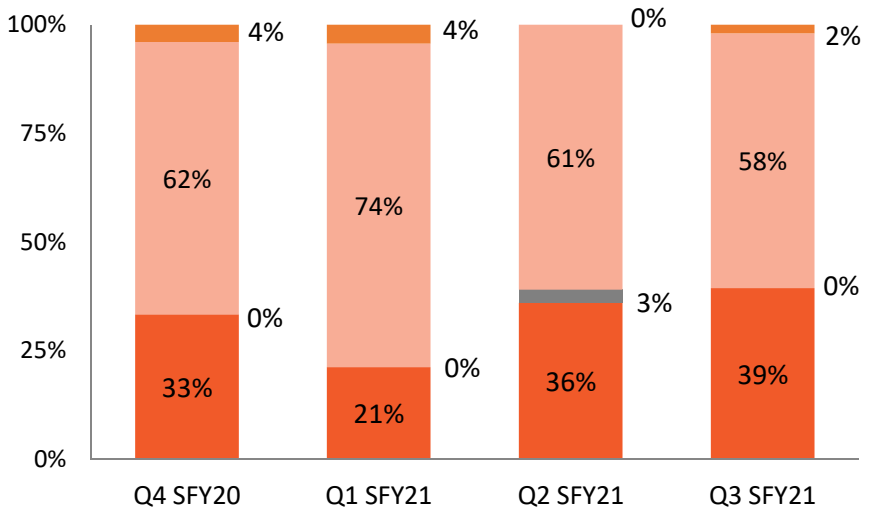
192



Resolved in 30-days
99%

Resolved in 30-days
100%

Appeal Outcome Percentages



	%	Top 10 Reasons for Grievances
1.	34%	Access to Care - Network Availability
2.	20%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	4%	Lack of Caring/Concern
5.	4%	Provider
6.	3%	Transportation - Driver no-show
7.	3%	Claim Dispute
8.	3%	Transportation - Late Appointment
9.	3%	Transportation - Missed Appointment
10.	3%	Transportation - Unsafe Driving

%	Top 10 Reasons for Appeals
27%	RX - Does Not Meet Prior AuthGuidelines
16%	Other - Mental Health Service
4%	Vendor Related - Radiology
3%	Therapy - Physical Therapy
3%	DME - Other
3%	DME - Blood Glucose Monitor
3%	Therapy - Speech Therapy
3%	RX - No Prior Authorization Denial
2%	Diagnostic - MRI
2%	Consultation - Neurology

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	SFY21 Q2	SFY21 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)[9]	58%	59%

iowa total care	SFY21 Q2	SFY21 Q3
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)[9]	84%	89%

Top 5 - Value Added Services (VAS)

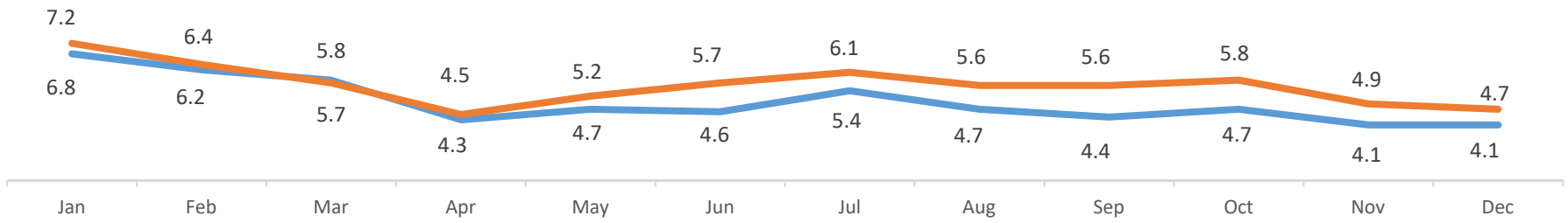
Value Added Services (VAS) are optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

Amerigroup	SFY21 Q2	SFY21 Q3
Healthy Rewards	1,408	5,633
Taking Care of Baby and Me	2,482	2,654
Community Resource Link	2,989	1,028
Dental Hygiene Kit	711	844
Exercise Kit	579	631

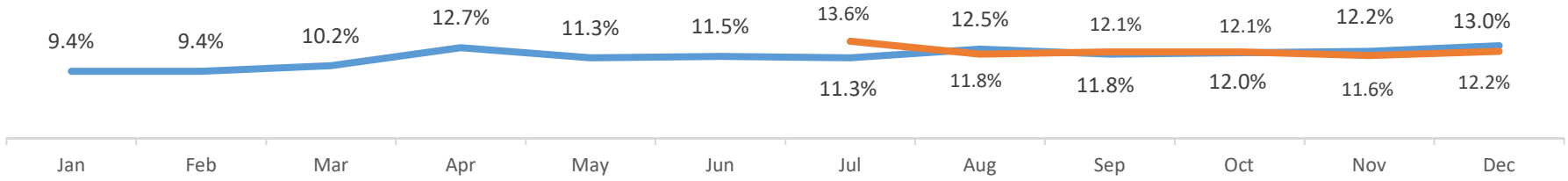
iowa total care	SFY21 Q2	SFY21 Q3
My Health Pays Program	13,222	11,284
The Flu Program	3,427	4,715
Start Smart for Your Baby	1,215	1,529
Mobile App	989	666
SafeLink Phones	116	159

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

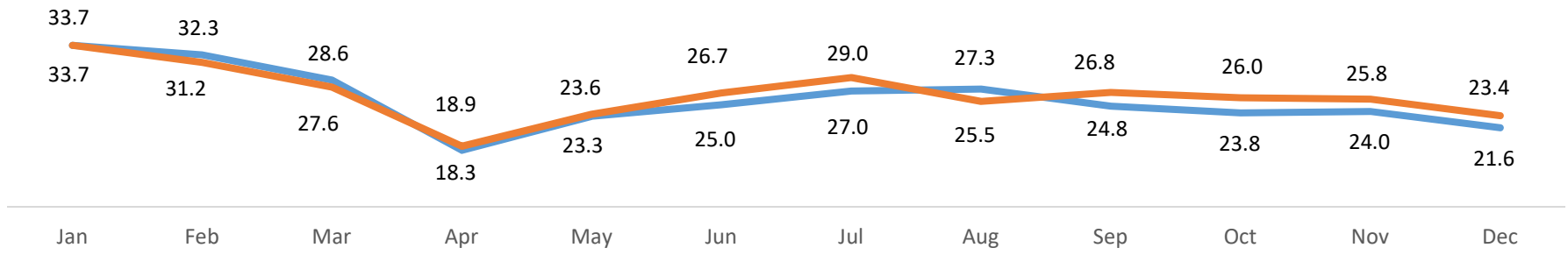
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [10]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [11]



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

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

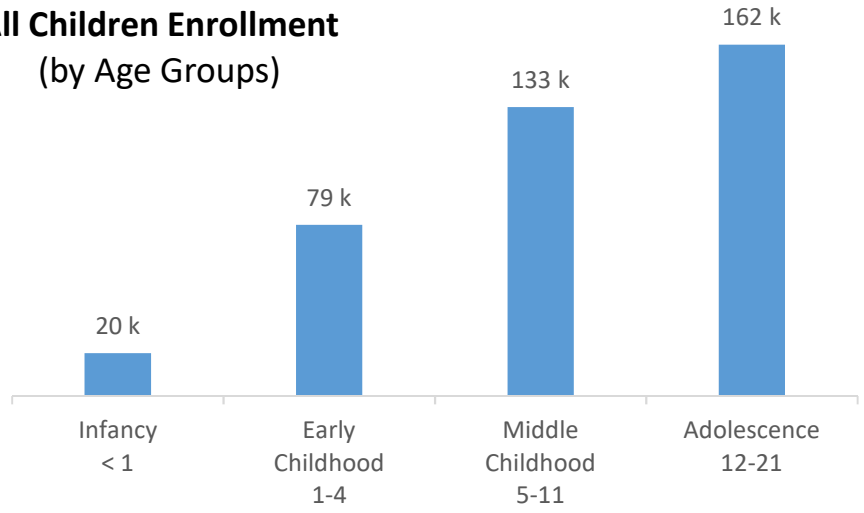
MCO Children Summary

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

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 Hawki eligible.

Data Note: MCO Enrollment, Well Child Exams, Screenings, and Immunizations are compared using the same quarter 1-year apart.

All Children Enrollment
(by Age Groups)



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	SFY20 Q3	SFY21 Q3
Member Enrollment	**225,565**	**235,816**
Infancy < 1	12,723	10,208
Early Childhood 1 - 4	46,440	47,404
Middle Childhood 5 - 11	78,139	80,518
Adolescence 12 - 21	88,263	97,686
Well Child Exams (Preventive Visits)	38,491	38,064
Infancy < 1	13,480	3,356
Early Childhood 1 - 4	13,013	19,273
Middle Childhood 5 - 11	6,406	7,780
Adolescence 12 - 21	5,592	7,655
Lead Screenings	5,584	4,362
Infancy < 1	272	0
Early Childhood 1 - 4	4,945	3,739
Middle Childhood 5 - 11	324	592
Adolescence 12 - 21	43	31

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	SFY20 Q3	SFY21 Q3
Member Enrollment	**148,445**	**158,103**
Infancy < 1	9,423	9,409
Early Childhood 1 - 4	29,589	31,562
Middle Childhood 5 - 11	51,077	52,767
Adolescence 12 - 21	58,356	64,365
Well Child Exams (Preventive Visits)	26,229	29,139
Infancy < 1	11,246	10,544
Early Childhood 1 - 4	7,354	8,877
Middle Childhood 5 - 11	4,062	4,991
Adolescence 12 - 21	3,567	4,727
Lead Screenings	2,881	3,146
Infancy < 1	72	74
Early Childhood 1 - 4	2,611	2,802
Middle Childhood 5 - 11	174	249
Adolescence 12 - 21	24	21

MCO Children Summary

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	SFY20 Q3	SFY21 Q3
Hearing Screenings	2,995	1,969
Infancy < 1	265	4
Early Childhood 1 - 4	1,357	770
Middle Childhood 5 - 11	1,020	811
Adolescence 12 - 21	353	384
Vision Screenings	763	1,463
Infancy < 1	51	0
Early Childhood 1 - 4	399	769
Middle Childhood 5 - 11	218	504
Adolescence 12 - 21	95	190

Immunization Summary - 21 & Under

Vaccination Totals	53,995	55,677
COVID-19 Dose 1	-	397
COVID-19 Dose 2	-	76
COVID-19 Single-Dose	-	5
DTaP (Diphtheria, Tetanus, Pertussis)	10,426	9,984
Influenza (FLU)	12,029	8,710
HepA (Hepatitis A)	5,275	4,639
HepB (Hepatitis B)	1,113	959
Haemophilus Influenza Type B (Hib)	6,019	5,242
Human Papillomavirus (HPV)	2,694	2,799
Meningococcal ACWY (MenACWY)	1,920	2,302
MMR (Measles, Mumps, Rubella)	4,176	3,759
Pneumococcal (PCV13)	74	7,801
Polio (IPV)	319	231
RV (Rotavirus)	5,621	5,024
TDAP (Tetanus, Diphtheria, Pertussis)	1,668	1,672
Varicella Virus Vaccine (VAR)	2,661	2,077

iowa total care

	SFY20 Q3	SFY21 Q3
Hearing Screenings	1,605	1,127
Infancy < 1	122	107
Early Childhood 1 - 4	716	489
Middle Childhood 5 - 11	584	381
Adolescence 12 - 21	183	150
Vision Screenings	526	1,039
Infancy < 1	30	16
Early Childhood 1 - 4	270	660
Middle Childhood 5 - 11	146	271
Adolescence 12 - 21	80	92

Immunization Summary - 21 & Under

Vaccination Totals	37,341	43,199
COVID-19 Dose 1	-	197
COVID-19 Dose 2	-	50
COVID-19 Single-Dose	-	6
DTaP (Diphtheria, Tetanus, Pertussis)	7,199	7,741
Influenza (FLU)	7,443	6,252
HepA (Hepatitis A)	2,882	3,493
HepB (Hepatitis B)	914	852
Haemophilus Influenza Type B (Hib)	1,376	4,464
Human Papillomavirus (HPV)	1,668	1,854
Meningococcal ACWY (MenACWY)	1,129	1,422
MMR (Measles, Mumps, Rubella)	2,028	2,859
Pneumococcal (PCV13)	5,966	6,580
Polio (IPV)	232	210
RV (Rotavirus)	4,192	4,255
TDAP (Tetanus, Diphtheria, Pertussis)	1,096	1,158
Varicella Virus Vaccine (VAR)	1,216	1,806

Non-LTSS Care Coordination and HCBS Case Management

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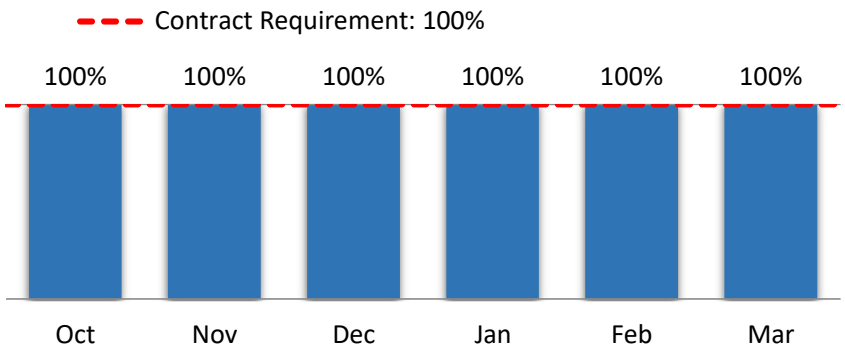
Average Number of Contacts Per Month	SFY21 Q2	SFY21 Q3
by Care Coordinators	0.8	**0.8**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	24	**27**
HCBS Members to Case Managers	65	**67**

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.

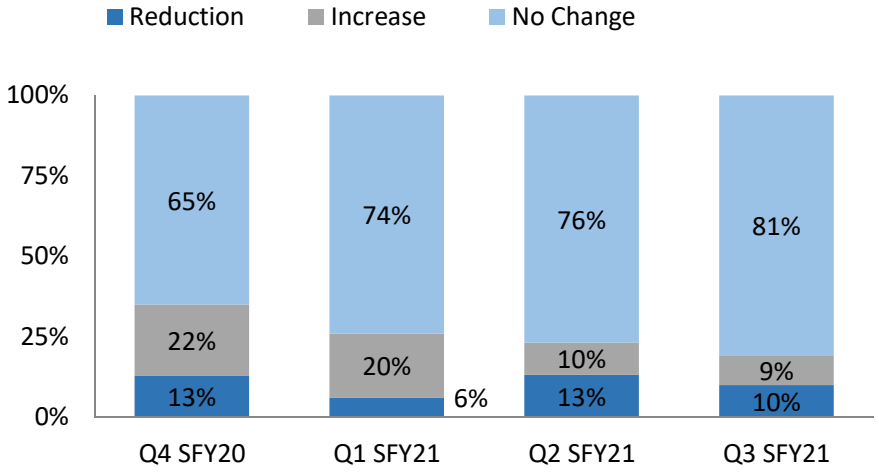
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q2	SFY21 Q3
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%	0.6%
	Sometimes	0.6%	0.0%
	Yes	99.4%	99.4%
Their services make their lives better.	I don't know	0.0%	0.3%
	No	0.0%	0.6%
	Sometimes	0.0%	2.3%
	Yes	100.0%	96.8%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

iowa total care

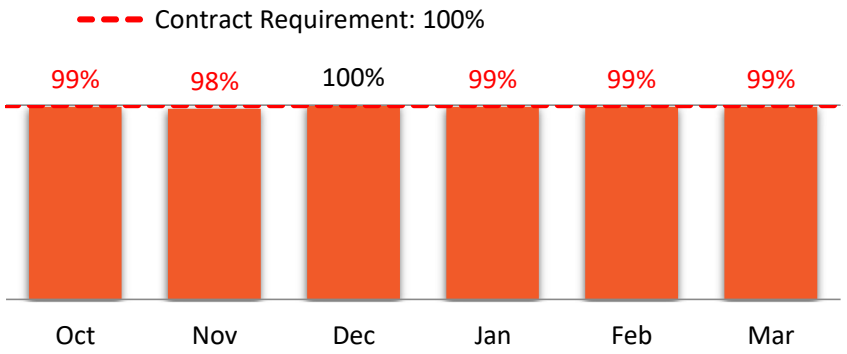
Average Number of Contacts Per Month	SFY21 Q2	SFY21 Q3
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	20	**25**
HCBS Members to Case Managers	41	**41**

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

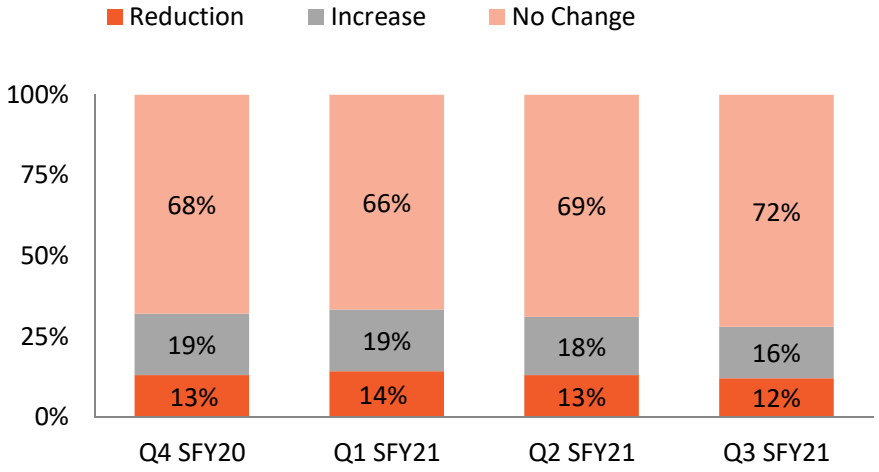
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q2	SFY21 Q3
They were part of service planning.	I don't know	0.4%	0.4%
	No	1.1%	1.8%
	Sometimes	1.9%	1.8%
	Yes	96.7%	96.0%
They feel safe where they live.	I don't know	0.4%	0.0%
	No	0.4%	0.4%
	Sometimes	1.5%	1.1%
	Yes	97.8%	98.5%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.7%	0.4%
	Sometimes	2.6%	2.6%
	Yes	96.7%	97.1%

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 Q2	SFY21 Q3
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	18	16
CDAC (individual) by 15 minute units	1	4
Homemaker (by 15 minute units)	2	2
CDAC (agency) by 15 minute units	1	1
Brain Injury (BI) Waivers	821	818
Financial Management Services	245	233
Supported Community Living (by unit)	215	197
Respite (by 15 minute units)	172	163
Personal Emergency Response	167	158
Supported Community Living (daily)	103	101
Children's Mental Health (CMH)	876	863
Respite (by 15 minute units)	482	434
Respite (Hos/NF) - 15 minute units	261	233
Family and Community Support	254	219
Respite (Resident Camp) by units	13	12
Home Delivered Meals	13	7
Elderly Waivers	4,795	4,703
Home Delivered Meals	3,271	2,995
Personal Emergency Response	3,220	2,969
Assisted Living Services	442	422
CDAC (agency) by 15 minute units	357	382
Personal Emergency Response (install)	388	297

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	SFY21 Q2	SFY21 Q3
Habilitation (Hab)	4,696	4,578
Home-based Habilitation	3,997	3,928
Long Term Job Coaching	358	373
Day Habilitation (units by day)	333	335
Individual Supported Employment	187	150
Day Habilitation (by 15 minute units)	283	130
Health & Disability (HD)	1,359	1,353
Financial Management Services	368	354
Respite (by 15 minute units)	368	352
Personal Emergency Response	353	327
Home Delivered Meals	361	327
Respite (Hos/NF) - 15 minute units	73	63
Intellectual Disability (ID)	7,111	7,065
Supported Community Living (by unit)	1,928	1,793
Supported Community Living (daily)	1,590	1,413
Day Habilitation (units by day)	1,573	1,412
Financial Management Services	1,420	1,377
Supported Community Living (RCF)	1,202	1,099
Physical Disability (PD)	724	694
Personal Emergency Response	400	366
CDAC (agency) by 15 minute units	75	77
CDAC (individual) by 15 minute units	57	69
Personal Emergency Response (install)	73	50
Home Delivered Meals	57	48

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

	SFY21 Q2	SFY21 Q3
AIDS/HIV - Unique Service Plans	11	9
Home Delivered Meals	7	8
CDAC (individual) by 15 minute units	5	5
Homemaker (by 15 minute units)	3	2
Brain Injury (BI) Waivers	532	531
Supported Community Living (by unit)	236	234
Respite (by 15 minute units)	151	151
Personal Emergency Response	131	129
Supported Community Living (daily)	112	116
CDAC (agency) by 15 minute units	88	88
Children's Mental Health (CMH)	351	353
Respite (by 15 minute units)	198	197
Respite (Hos/NF) - 15 minute units	123	127
Family and Community Support	101	104
Mental Health Service	22	30
Respite (Resident Camp) by units	6	4
Elderly Waivers	3,310	3,275
Home Delivered Meals	2,649	2,618
Personal Emergency Response	2,567	2,552
CDAC (agency) by 15 minute units	1,349	1,359
Homemaker (by 15 minute units)	947	911
CDAC (individual) by 15 minute units	769	754

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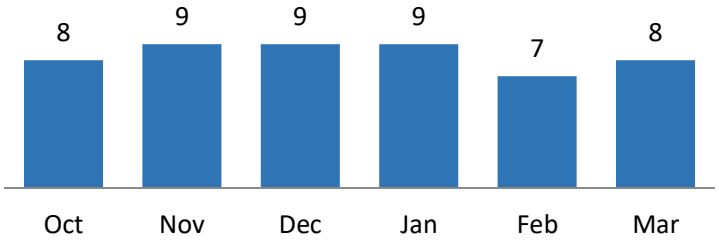
	SFY21 Q2	SFY21 Q3
Habilitation (Hab)	2,416	2,350
Home-based Habilitation	1,860	1,893
Day Habilitation (by 15 minute units)	358	340
Day Habilitation (units by day)	272	265
Long Term Job Coaching	251	248
Individual Supported Employment	157	152
Health & Disability (HD)	631	626
Respite (by 15 minute units)	296	292
Home Delivered Meals	191	179
Personal Emergency Response	177	170
CDAC (individual) by 15 minute units	131	125
CDAC (agency) by 15 minute units	113	110
Intellectual Disability (ID)	4,512	4,478
Supported Community Living (by unit)	1,949	1,918
Day Habilitation (by 15 minute units)	1,903	1,848
Day Habilitation (units by day)	1,781	1,713
Supported Community Living (RCF)	1,447	1,376
Respite (by 15 minute units)	1,081	1,071
Physical Disability (PD)	399	395
Personal Emergency Response	243	232
CDAC (agency) by 15 minute units	197	191
CDAC (individual) by 15 minute units	149	141
Transportation (1-way trip)	54	47
Personal Emergency Response (install)	27	23

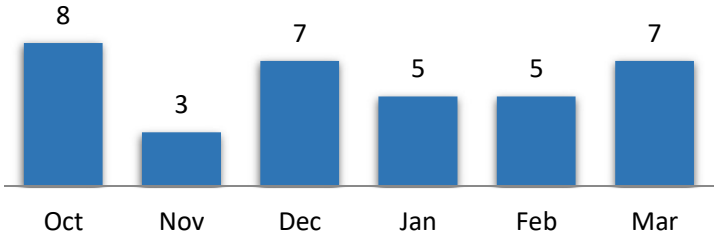
Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	96.31%	97.95%	90.60%
Abandonment Rate - Must be 5% or less	1.03%	0.84%	0.84%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	99.94%	97.42%	97.50%
Abandonment Rate - Must be 5% or less	0.00%	0.00%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	95.19%	93.57%	82.77%
Abandonment Rate - Must be 5% or less	0.24%	0.50%	0.48%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	26.62%	18.39%	27.92%
Abandonment Rate - Must be 5% or less	11.62%	22.08%	9.77%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

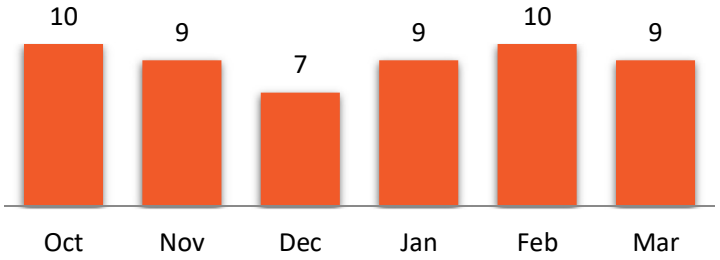
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Other
5.	Coordination of Benefits or OHI

Top 5 Call Reasons (Provider Helpline)
Authorization Status
Benefit Inquiry
Claim Status
Authorization New
Enrollment Inquiry

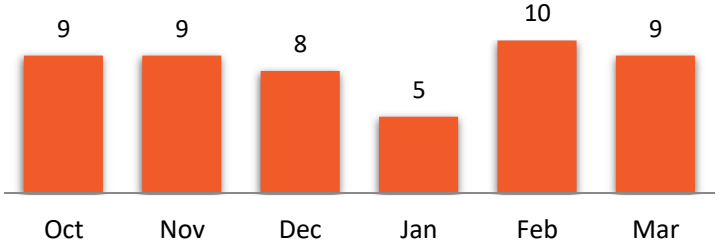
Call Center Performance Metrics

	Jan	Feb	Mar
Member Helpline			
Service Level (Requirement 80%)	85.60%	81.78%	85.45%
Abandonment Rate - Must be 5% or less	1.91%	2.38%	4.07%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	94.20%	87.40%	85.57%
Abandonment Rate - Must be 5% or less	1.44%	3.13%	2.79%
Provider Helpline			
Service Level (Requirement 80%)	80.30%	84.76%	88.06%
Abandonment Rate - Must be 5% or less	5.55%	1.85%	2.21%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	92.79%	92.74%	93.67%
Abandonment Rate - Must be 5% or less	0.56%	2.01%	1.21%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	69.43%	80.67%	47.72%
Abandonment Rate - Must be 5% or less	5.90%	2.10%	5.28%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

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

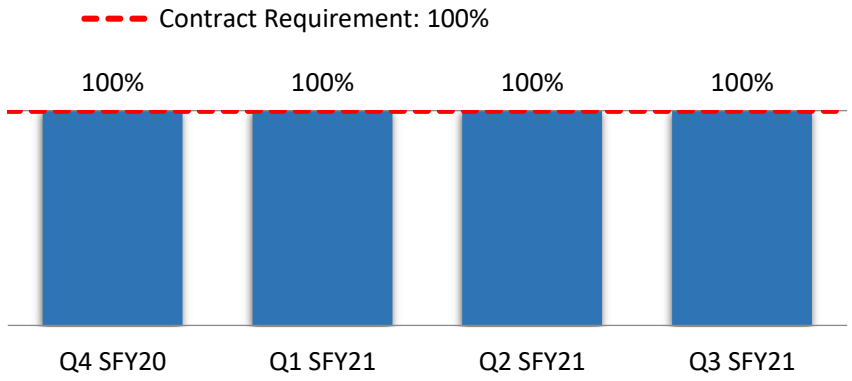
	SFY21 Q2	SFY21 Q3
Adults PCP		
Provider Count	6,641	5,723
Members with Access	210,795	217,611
Average Distance (Miles)	2	2
Pediatric PCP		
Provider Count	6,677	5,750
Members with Access	203,169	207,096
Average Distance (Miles)	2	2

Specialty Care & Behavioral Health (BH)

	SFY21 Q2	SFY21 Q3
OB/GYN Adult		
Provider Count	399	321
Members with Access	137,341	141,581
Average Distance (Miles)	6	6
Outpatient - Behavioral Health		
Provider Count	4,043	3,469
Members with Access	413,964	424,707
Average Distance (Miles)	2	2
Inpatient - Behavioral Health		
Provider Count	48	44
Rural Members		
Members with Access	169,705	174,026
Average Distance (Miles)	22	21
Urban Members		
Members with Access	244,259	250,681
Average Distance (Miles)	6	6

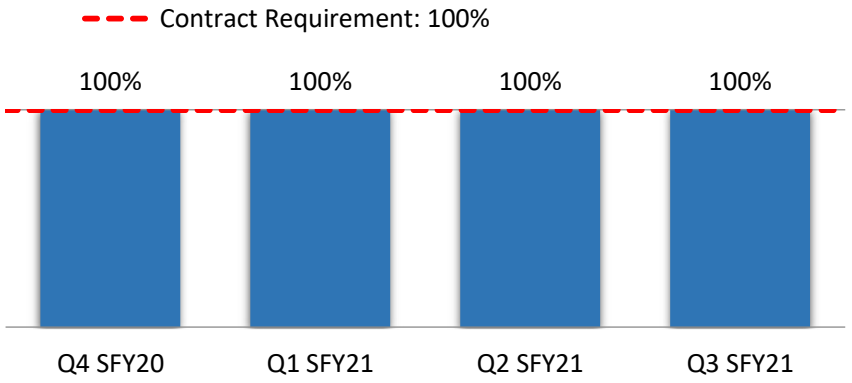
Adult PCP - Time Standards

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)

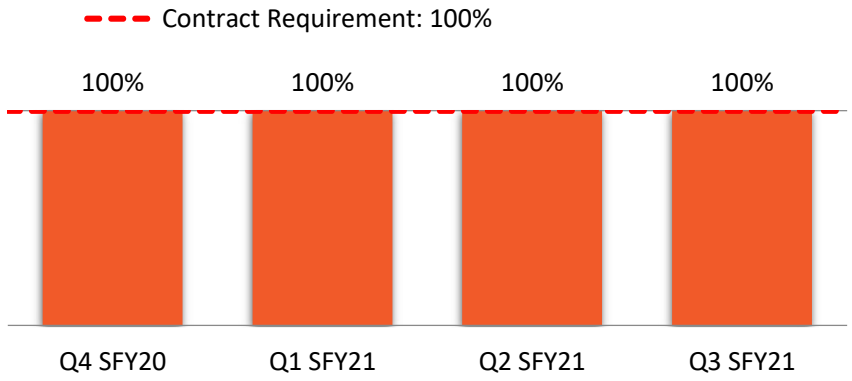
	SFY21 Q2	SFY21 Q3
Adults PCP		
Provider Count	8,548	9,085
Members with Access	160,490	166,971
Average Distance (Miles)	2	2
Pediatric PCP		
Provider Count	9,262	9,820
Members with Access	136,490	138,828
Average Distance (Miles)	2	2

Specialty Care & Behavioral Health (BH)

	SFY21 Q2	SFY21 Q3
OB/GYN Adult		
Provider Count	1,207	1,234
Members with Access	106,694	110,381
Average Distance (Miles)	5	5
Outpatient - Behavioral Health		
Provider Count	8,251	8,737
Members with Access	296,980	305,799
Average Distance (Miles)	3	3
Inpatient - Behavioral Health		
Provider Count	35	36
Rural Members		
Members with Access	212,426	218,902
Average Distance (Miles)	25	25
Urban Members		
Members with Access	84,554	86,897
Average Distance (Miles)	8	8

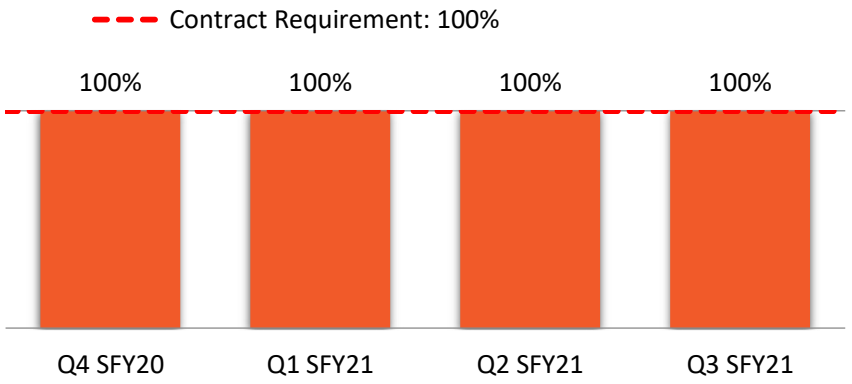
Adult PCP - Time Standards

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

MCO Program Integrity

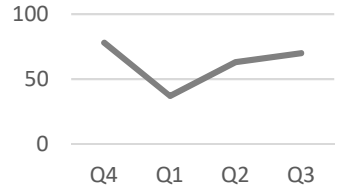
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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 Q3

70



4 Total Cases
Referred to MCFU

Amerigroup
An Anthem Company

Program Integrity
- Fraud, Waste, & Abuse

	SFY21 Q2	SFY21 Q3
Investigations opened	34	42
Overpayments identified	23	10
Member concerns referred to IME	3	4
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	2

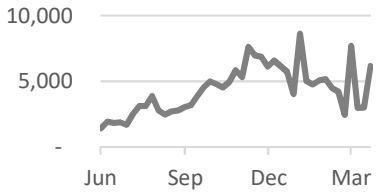
iowa total care

Program Integrity
- Fraud, Waste, & Abuse

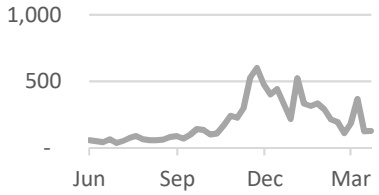
	SFY21 Q2	SFY21 Q3
Investigations opened	29	28
Overpayments identified	1	0
Member concerns referred to IME	4	6
Cases referred to the Medicaid Fraud Control Unit (MCFU)	3	2

MCO COVID-19 Summary

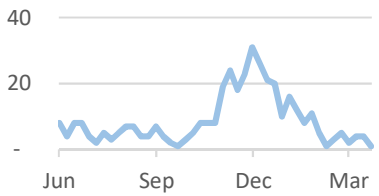
Total Individuals Tested
200,470



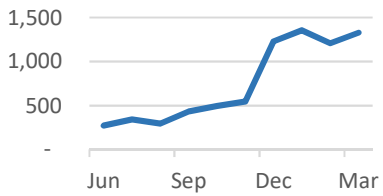
Total Tested Positive
9,295



Total COVID Deaths [12]
453



Total COVID Inpatient Stays
7,516



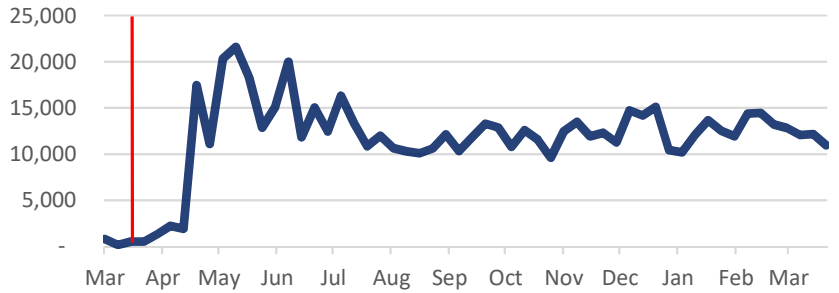
66,533 tested in Q3	4.6%	0.06%	2.09%
-12% Decrease	% Tested Positive	% of MCO Population	% of Total Inpatient Stays

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. [12]

Claims Activity During COVID-19

MCO Total Counts	SFY21 Q2	SFY21 Q3
ER Visits - Counts	**258,518**	**248,761**
Amount Paid	$55.52 M	$51.21 M
Telehealth Services - Counts	**160,529**	**161,653**
Amount Paid	$13.01 M	$13.71 M
Transportation - Counts	**212,223**	**217,383**
Amount Paid	$9.05 M	$9.29 M
Home Maker Services - Counts	**7,921**	**18,286**
Amount Paid	$878 k	$1.59 M
COVID Testing - Counts	**75,601**	**66,533**
Amount Paid	$7.23 M	$6.16 M
Meals - Counts	**18,704**	**19,899**
Amount Paid	$5.22 M	$4.88 M

Telehealth Services - All 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
  - 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