Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2021, Quarter 2

(October - December 2020)

Performance Data

Published March 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 2 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)

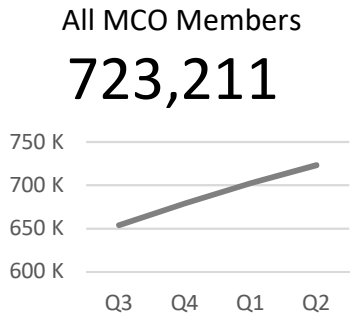
Notes about the reported data:

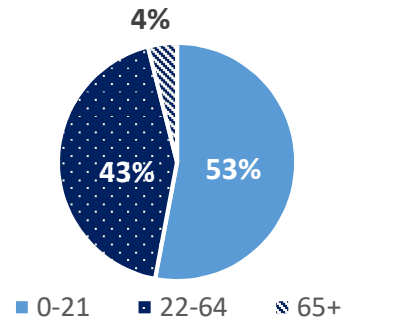
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period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





+ 20,779 Members
2.96% Increase

All MCO Enrollment (by Age)

Data Notes: December 2020 enrollment data as of February 9, 2020. 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 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Distinct
MCO Member Summary	653,929	679,048	702,432	**723,211**	689,655	**727,293**
0-21	353,122	366,686	375,723	383,041	369,643	384,577
22-64	274,650	285,200	298,168	311,554	292,393	312,711
65+	26,157	27,162	28,541	28,616	27,619	30,005
Fee-For-Service (FFS) - Non MCO Enrollees	38,172	38,979	40,370	**41,375**	39,724	**42,911**

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

If Yes, explain:

Iowa Medicaid Population **770,204**
1 year distinct count

o MCO enrollment increased by 20,779 members (or 2.96% increase)
o Since March 2020, all MCO disenrollment has been suspended because of COVID-19

MCO Member Summary

Amerigroup	SFY21 Q1	SFY21 Q2
All Members	412,180	423,312
MCO Member Market Share	58.7%	58.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	49,052	50,059
Long-Term Service & Support (LTSS)	23,418	22,802
HCBS Waivers	68.0%	68.9%
Facility Based Services	32.0%	31.1%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	15,918	15,705
Facility Based Services [4]	7,500	7,097
ICF/ID [5]	1,041	1,028
Mental Health Institute (MHI)	23	34
Nursing Facilities (NF)	6,278	5,875
Nursing Facilities for Mentally Ill	69	71
Skilled	89	89

iowa total care	SFY21 Q1	SFY21 Q2
All Members	290,252	299,899
MCO Member Market Share	41.3%	41.5%
Disenrolled	0	0
Healthy and Well Kids in Iowa (Hawki) including **M-CHIP** (Expansion)	24,897	24,980
Long-Term Service & Support (LTSS)	15,294	14,934
HCBS Waivers	61.3%	65.3%
Facility Based Services	38.7%	34.7%
HCBS Waivers [3] - Reference p. 21-22 for HCBS waiver and service plan enrollment	9,811	9,746
Facility Based Services [4]	5,483	5,188
ICF/ID [5]	612	609
Mental Health Institute (MHI)	12	18
Nursing Facilities (NF)	4,750	4,460
Nursing Facilities for Mentally Ill	32	29
Skilled	77	72

[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)

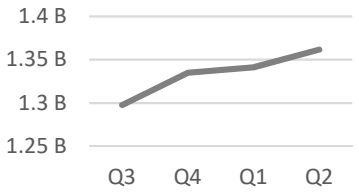
MCO Financial Summary - All MCO Counts

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

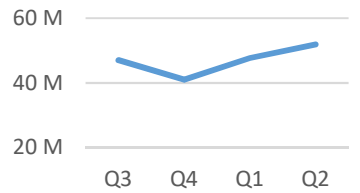
$1.36 Billion



+ $20.3 Million
1.51% Increase

Third Party Liability Recovered

$ 51.91 Million



+ $ 4.3 Million
8.94% increase

Data Notes: December 2020 capitation data as of February 5, 2020. 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 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Financial Summary						
Capitation Payments	$1.3 B	$1.33 B	$1.34 B	**$1.36 B**	$1.33 B	$5.34 B
Third Party Liability (TPL) Recovered	$46.41 M	$41.63 M	$47.65 M	**$51.91 M**	$46.90 M	$187.60 M

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

If Yes, explain:

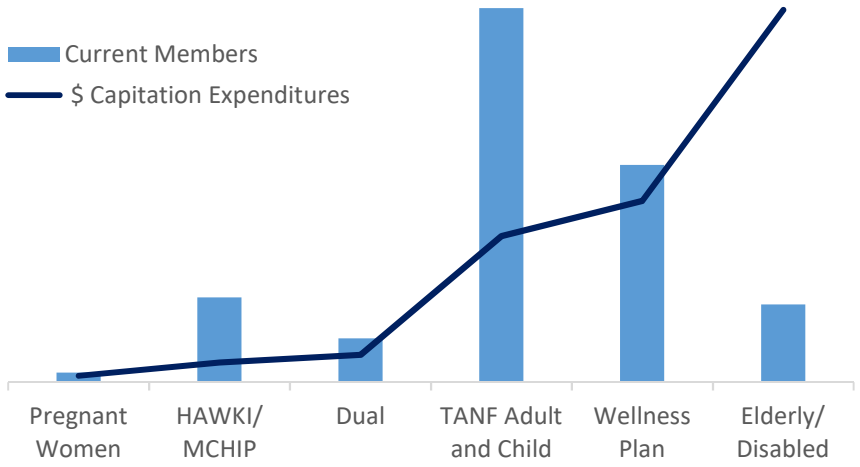
o Medical Loss Ratio (MLR) - The MLR is contractually set at 89% for the time period of July 1, 2020 through December 31, 2020.

o In Q3 SFY2020, the Department withheld $44M from ITC due to internal claims payments issues. As of the end of Q2 SFY21, this amount has still not been released.

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, over 50% of all capitation expenditures are allocated to supporting the elderly/ disabled eligibility group.

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.



Amerigroup An Anthem Company

	SFY21 Q1	SFY21 Q2
Capitation Totals	$802.56 M	**$811.95 M**
Adjustments	-$2.2 M	-$2.3 M
Current	$783.29 M	$793.35 M
Retro	$21.48 M	$20.9 M
Third Party Liability (TPL) Recovered	$23.26 M	**$22.40 M**
Financial Ratios		
Medical Loss Ratio (MLR)	86.2%	**88.8%**
Administrative Loss Ratio (ALR)	6.7%	6.3%
Underwriting Ratio (UR)	7.1%	5.8%
Annual MLR [6]		87.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

iowa total care

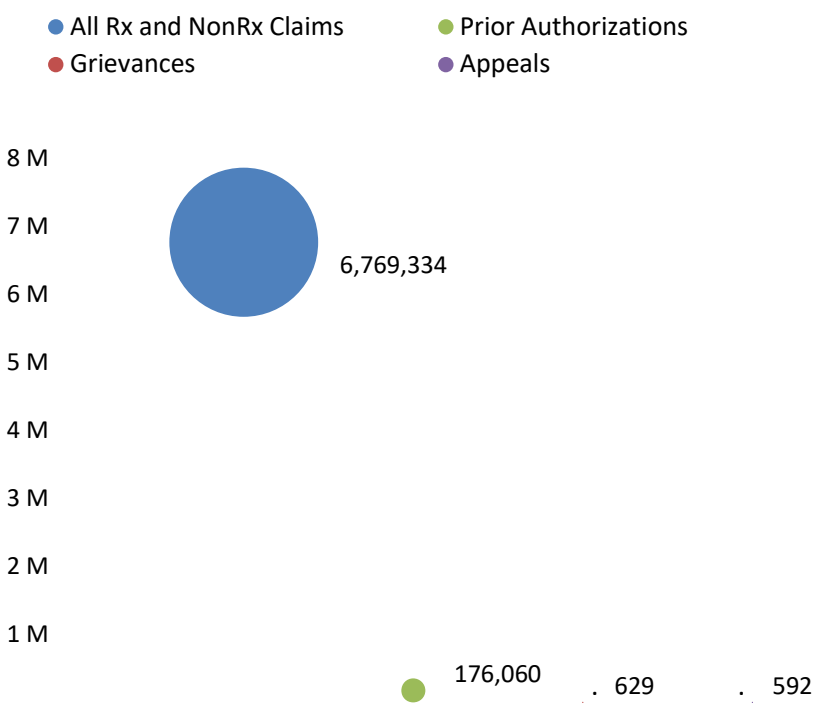
	SFY21 Q1	SFY21 Q2
Capitation Totals	$538.8 M	**$549.7 M**
Adjustments	-$2.04 M	-$1.34 M
Current	$520.41 M	$531.3 M
Retro	$20.44 M	$19.74 M
Third Party Liability (TPL) Recovered	$24.40 M	**$29.52 M**
Financial Ratios		
Medical Loss Ratio (MLR)	94.8%	**88.8%**
Administrative Loss Ratio (ALR)	5.1%	5.5%
Underwriting Ratio (UR)	0.1%	5.7%
Annual MLR [6]		91.7%
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	2.60%
Grievances	0.01%
Appeals	0.01%

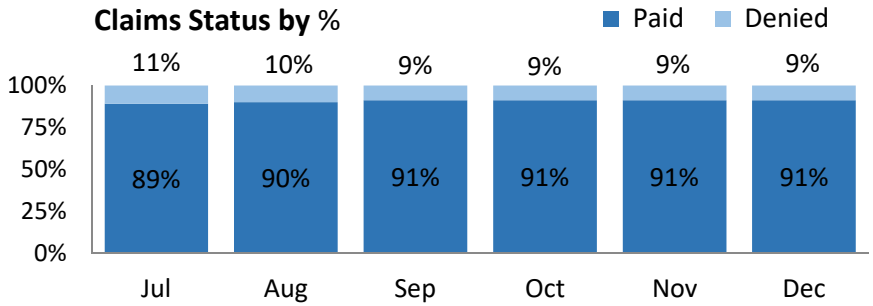
	SFY20 Q3	SFY20 Q4	SFY21 Q1	SFY21 Q2	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	7.79 M	5.95 M	7.02 M	**6.77 M**	6.88 M	27.54 M
Non-Pharmacy	4.62 M	3.17 M	4.02 M	3.96 M	3.94 M	15.77 M
Pharmacy	3.17 M	2.79 M	3.00 M	2.81 M	2.94 M	11.77 M
Prior Authorization Summary (p. 13-14)	178,919	145,452	172,937	**176,060**	168,342	673,368
Non-Pharmacy - All PAs Submitted	137,044	115,665	133,417	133,643	129,942	519,769
Pharmacy - All PAs Submitted	41,875	29,787	39,520	42,417	38,400	153,599
Grievances & **Appeals Summary** (p. 15-16)						
Grievances	936	422	718	**629**	676	2,705
Appeals	612	577	613	**592**	599	2,394

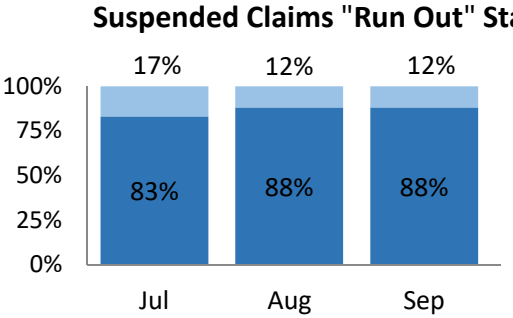
Claims Summary (Non-Pharmacy)

2.14 Million
Claims Paid & Denied

Amerigroup
An Anthem Company

	Oct	Nov	Dec
All Claims			
Paid	658,610	602,325	686,521
Denied	63,876	62,327	65,588
Suspended	139,459	151,215	115,585
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	99%	99%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7	7	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	100%	97%





- 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.	33%	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.	5%	Precertification/authorization/notification absent
5.	5%	Service not payable per managed care contract
6.	5%	An attachment/other documentation is required to adjudicate this claim/service.
7.	5%	The time limit for filing has expired
8.	3%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	3%	Claim/Service denied. At least one Remark Code must be provided
10.	2%	Expenses incurred after coverage terminated

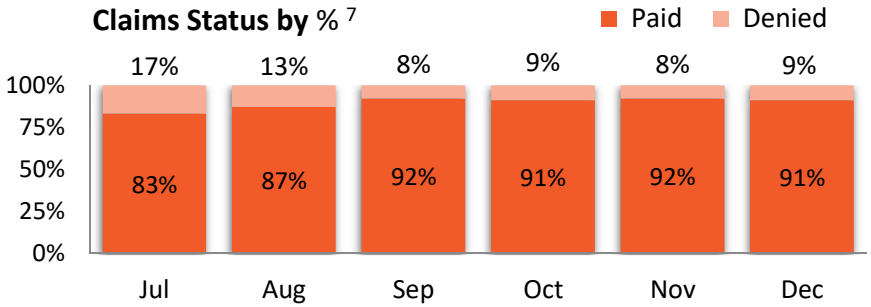
Claims Summary (Non-Pharmacy)

1.82 Million
Claims Paid & Denied

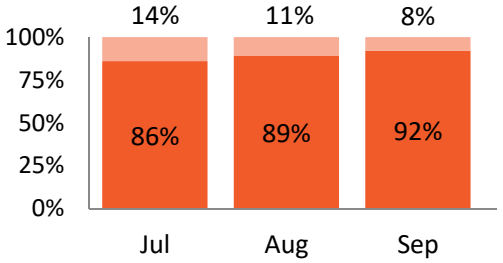
iowa total care

	Oct	Nov	Dec
All Claims			
Paid	503,711	576,638	584,590
Denied	52,838	47,853	57,720
Suspended	173,513	218,331	82,791
Clean Claims Processed [7]			
in 30-days (Requirement 90%)	98%	97%	98%
in 45-days (Requirement 95%)	99%	99%	99%
Average Days to Pay [7]	10	10	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	99%	100%	100%

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.	15%	Duplicate claim service
2.	10%	National Drug Code (NDC) missing/invalid or not appropriate for procedure
3.	9%	Service can not be combined with other service on same day
4.	8%	No authorization on file that matches service(s) billed
5.	7%	Advanced claim edits (ACE) claim level return to provider
6.	7%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
7.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
8.	4%	Procedure coverage not defined by Medicaid; Provider to resubmit
9.	3%	Provider Medicaid ID required
10.	3%	ACE line item denial

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

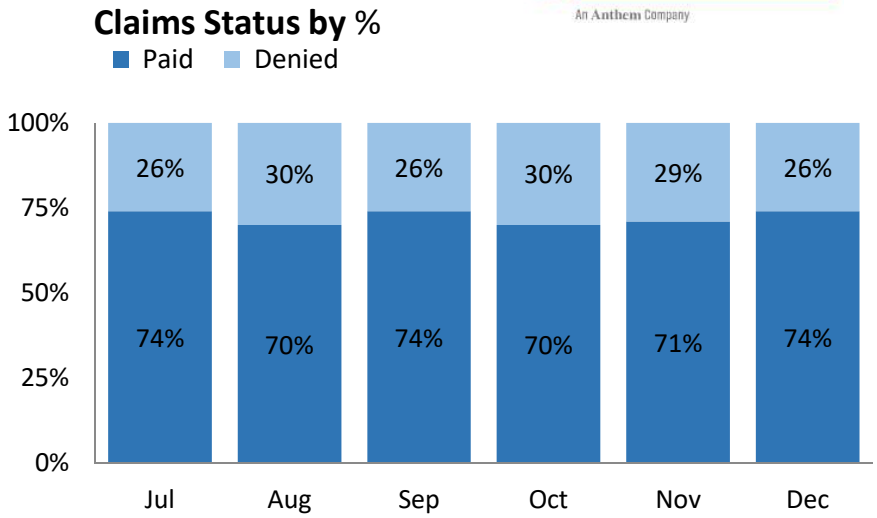
As of **SFY21**, the amount of claims being withheld significantly decreased allowing the department to resume standardized reporting while noting the number of claims withheld each month by ITC.

- **October**: 9,680
- **November**: 5,232
- **December**: 11,576

Claims Summary (Pharmacy)

1.6 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	357,245	353,842	437,935
Denied	153,240	142,138	151,481
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

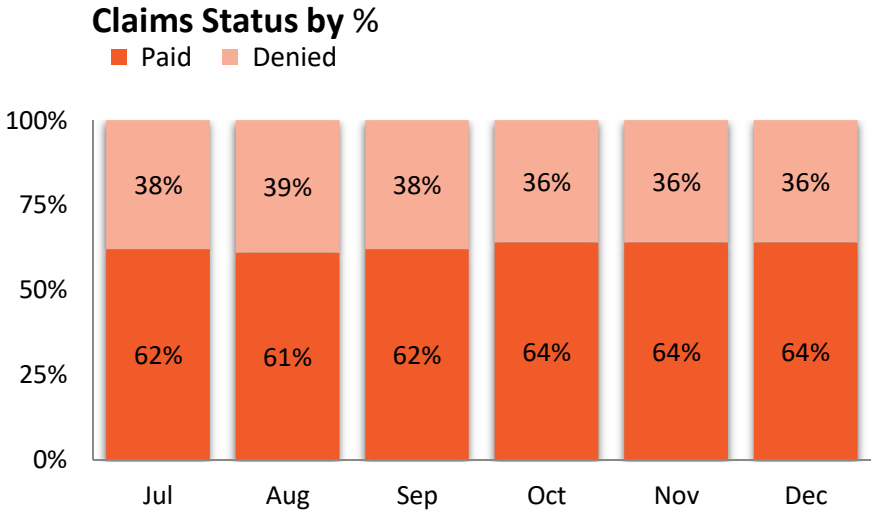


	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	45%	Refill too soon
2.	15%	Prior authorization required
3.	14%	Submit bill to other processor or primary payer
4.	9%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	3%	M/I other payer reject code
7.	2%	Filled after coverage terminated
8.	2%	Non matched prescriber ID
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)

1.21 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	264,239	249,688	260,731
Denied	150,970	141,568	143,660
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)

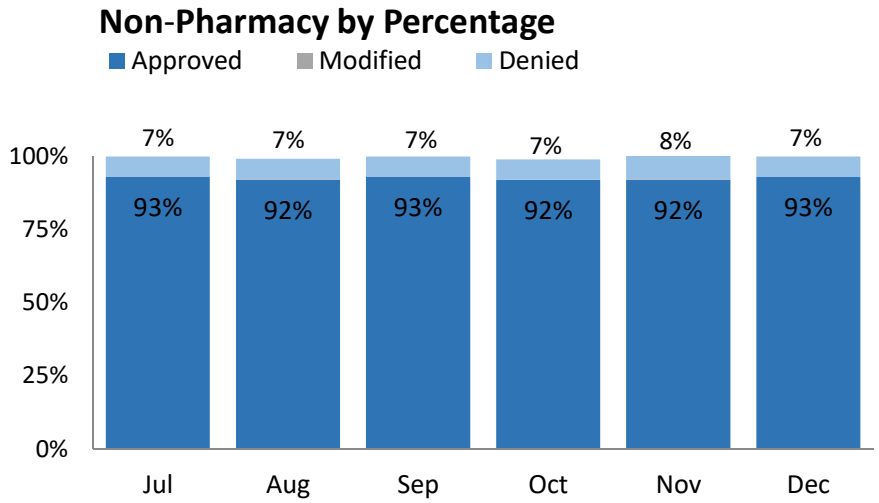
	%	
1.	31%	Refill too soon
2.	10%	Prior authorization required
3.	4%	Quantity dispensed exceeds maximum allowed
4.	3%	Claim not processed
5.	3%	Product not on formulary
6.	3%	Submit bill to other processor or primary payer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Drug not covered for patient age
9.	2%	Filled after coverage expired
10.	2%	National Drug Code (NDC) not covered

Prior Authorization Summary

81,521
All PAs Submitted [8]

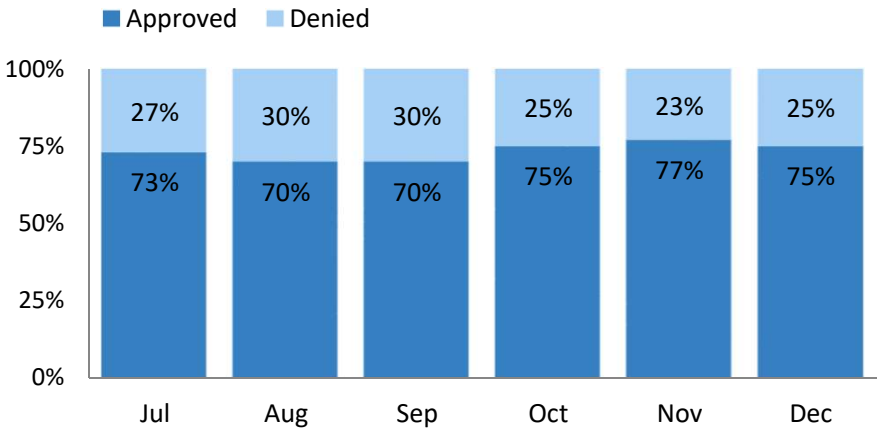
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	18,750	16,279	17,911
Denied	1,481	1,324	1,273
Modified	47	34	48
Average Days to Process	5	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

	Oct	Nov	Dec
Prior Authorizations			
Approved	6,921	5,940	5,490
Denied	2,354	1,773	1,873
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.9%	99.9%



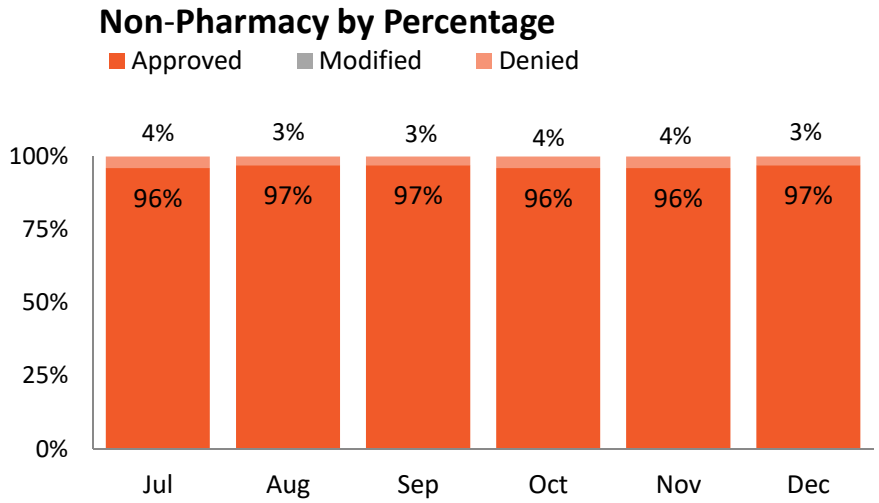
[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

94,539
All PAs Submitted [8]

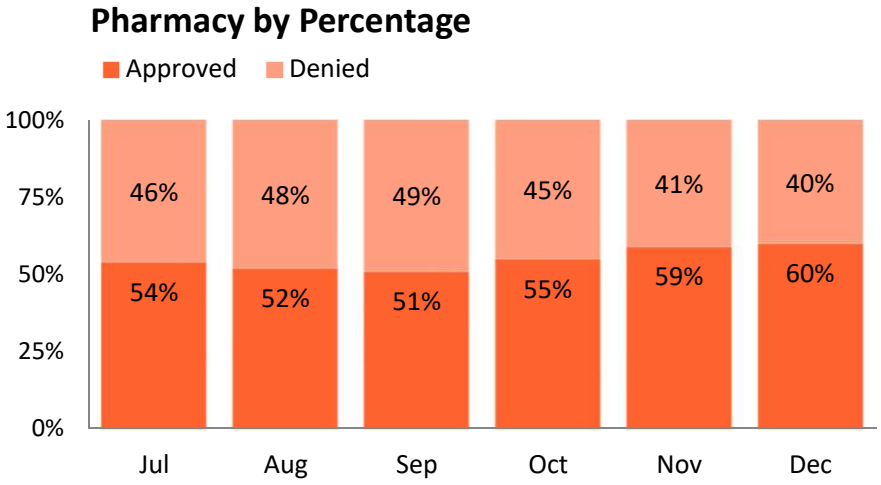
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	24,444	21,508	26,148
Denied	1,055	903	947
Modified	0	0	0
Average Days to Process	3	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

	Oct	Nov	Dec
Prior Authorizations			
Approved	3,024	3,087	3,258
Denied	2,459	2,122	2,200
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	99.9%

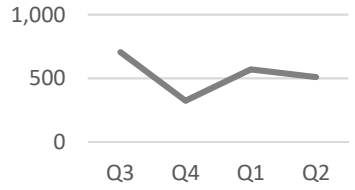


[8] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

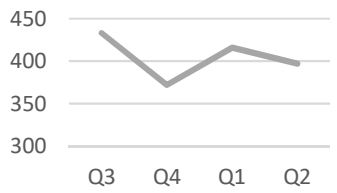
Grievances

510



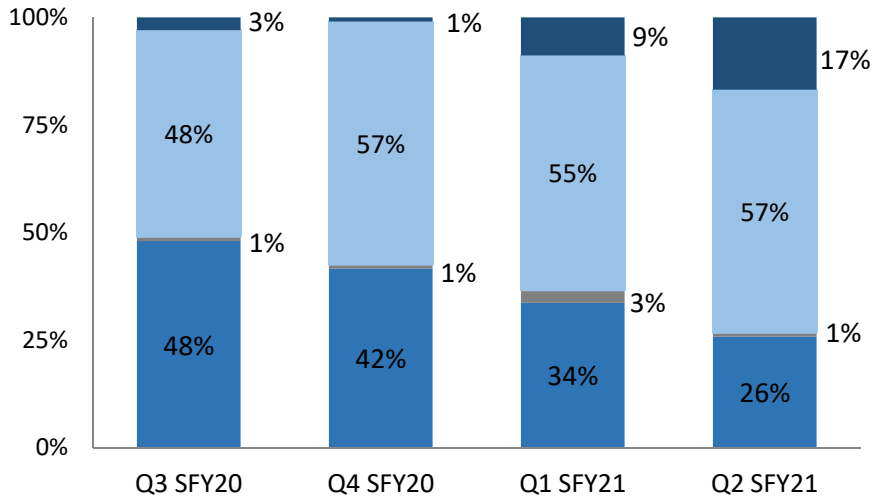
Appeals

397



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

Appeal Outcome Percentages



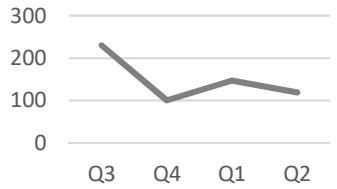
	%	Top 10 Reasons for Grievances
1.	39%	Voluntary Disenrollment
2.	18%	Provider balance billed
3.	7%	Adequacy of treatment record keeping
4.	6%	Transportation - Driver no-show
5.	4%	Availability of appointments
6.	4%	Transportation - Driver Delay
7.	4%	Treatment Dissatisfaction
8.	4%	Provider attitude/rudeness
9.	3%	Delay in Treatment
10.	3%	Inadequate benefit access

%	Top 10 Reasons for Appeals
20%	Pharmacy - Non Injectable
18%	Durable Medical Equipment (DME)
10%	Radiology
9%	Surgery
8%	Therapy - Physical Therapy
8%	Pharmacy - Injectable
4%	Inpatient Services - Medical
4%	Laboratory
3%	Behavioral Health (BH) - Op Service
3%	Behavioral Health (BH) - Inpatient

Grievances and Appeals

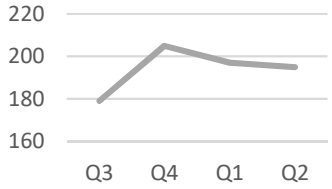
Grievances

119



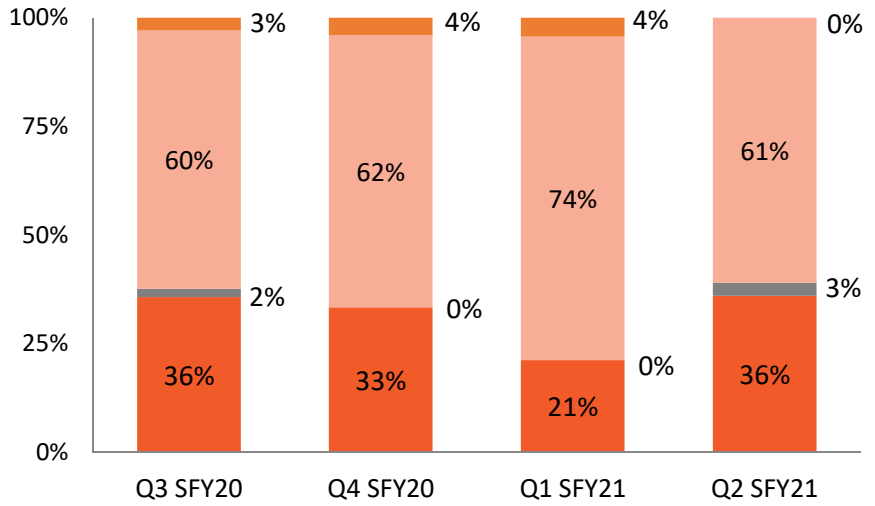
Appeals

195



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

Appeal Outcome Percentages



	%	Top 10 Reasons for Grievances
1.	27%	Access to Care - Network Availability
2.	17%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	5%	Transportation - Missed Appointment
5.	4%	Provider
6.	4%	Transportation - Late Appointment
7.	3%	Lack of Caring/Concern
8.	3%	Health Plan Staff
9.	3%	Claim Dispute
10.	2%	Transportation - Unsafe Driving

%	Top 10 Reasons for Appeals
39%	RX - Does Not Meet Prior AuthGuidelines
17%	Other - Mental Health Service
5%	Diagnostic - CAT Scan
3%	Diagnostic - MRI
3%	DME - Wheelchair
2%	DME - Other
2%	Injections - Epidural
2%	DME - Orthopedic Devices
2%	Outpatient - Home Health Visits
1%	DME - CPAP Machine

Value Based Purchasing (VBP) Agreement

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

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	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	63%	64%

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	SFY21 Q1	SFY21 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	84%	84%

Top 5 - Value Added Services (VAS)

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

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	SFY21 Q1	SFY21 Q2
Community Resource Link	841	2,989
Taking Care of Baby and Me	2,095	2,482
Healthy Rewards[9]	1,678	1,408
Dental Hygiene Kit	683	711
SafeLink Mobile Phone	723	581

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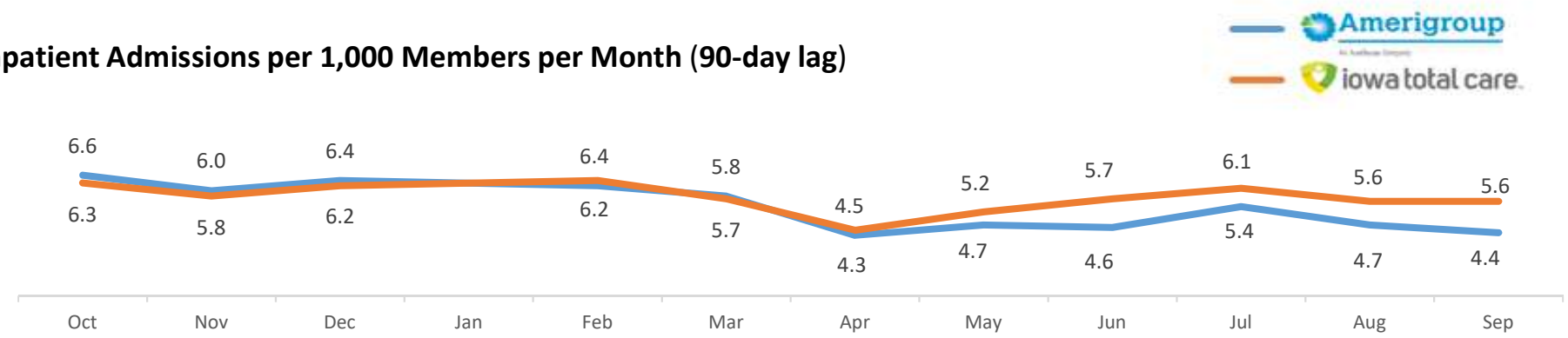
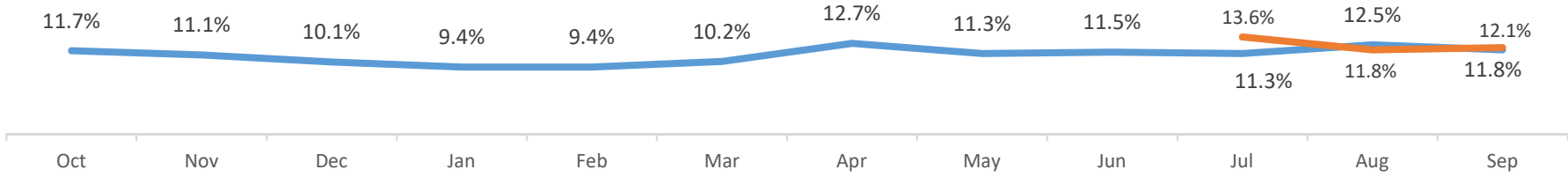
	SFY21 Q1	SFY21 Q2
My Health Pays Program	8,755	13,222
The Flu Program	2,689	3,427
Start Smart for Your Baby	1,558	1,215
Mobile App	544	989
myStrength.com	28	428

[9] *Amerigroup is reporting the total number of members who received an award in quarter (not the total enrolled in program).*

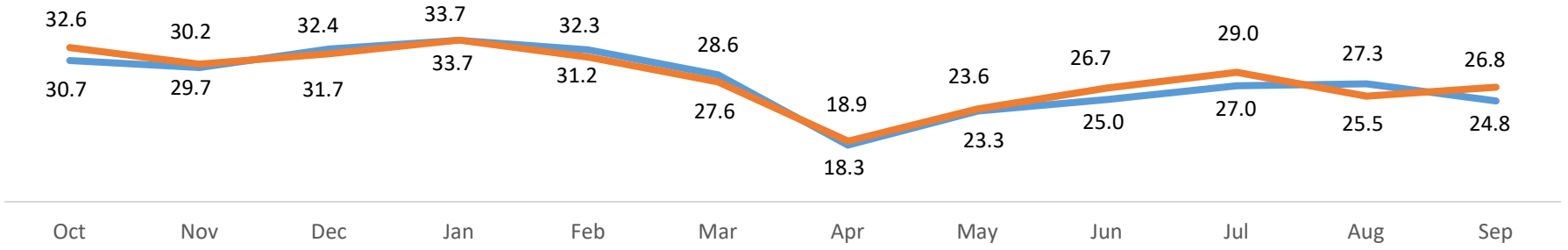
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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.*

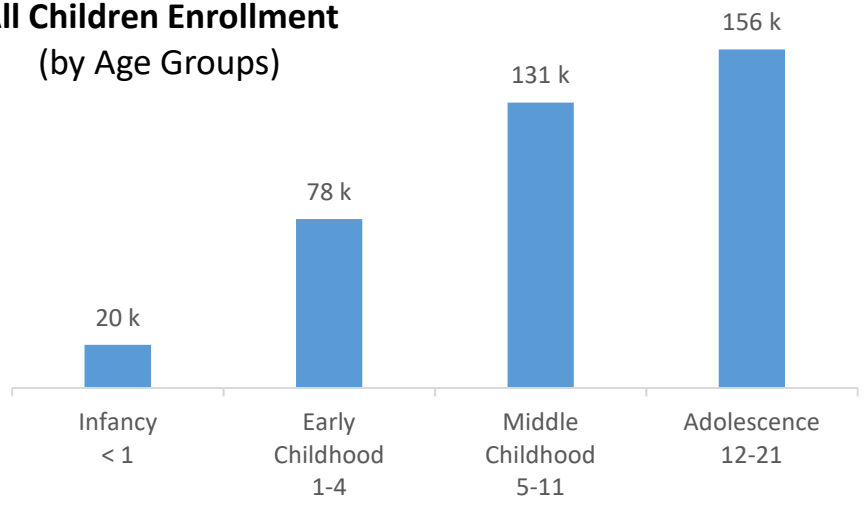
MCO Children Summary

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 Q2	SFY21 Q2
Member Enrollment	**225,398**	**231,588**
Infancy < 1	13,684	10,159
Early Childhood 1 - 4	46,178	47,354
Middle Childhood 5 - 11	78,030	79,742
Adolescence 12 - 21	87,506	94,333
Well Child Exams (Preventive Visits)	46,157	43,306
Infancy < 1	15,136	11,524
Early Childhood 1 - 4	13,674	12,993
Middle Childhood 5 - 11	9,270	9,947
Adolescence 12 - 21	8,077	8,842
Lead Screenings	5,386	4,313
Infancy < 1	228	98
Early Childhood 1 - 4	4,777	3,853
Middle Childhood 5 - 11	343	323
Adolescence 12 - 21	38	39

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	SFY20 Q2	SFY21 Q2
Member Enrollment	**150,165**	**154,855**
Infancy < 1	8,547	9,615
Early Childhood 1 - 4	30,611	30,738
Middle Childhood 5 - 11	52,051	52,334
Adolescence 12 - 21	58,956	62,168
Well Child Exams (Preventive Visits)	32,242	30,439
Infancy < 1	10,652	10,480
Early Childhood 1 - 4	9,048	7,949
Middle Childhood 5 - 11	6,801	6,423
Adolescence 12 - 21	5,741	5,587
Lead Screenings	3,921	2,961
Infancy < 1	136	69
Early Childhood 1 - 4	3,476	2,661
Middle Childhood 5 - 11	284	217
Adolescence 12 - 21	25	14

MCO Children Summary

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	SFY20 Q2	SFY21 Q2
Hearing Screenings	2,810	1,872
Infancy < 1	225	113
Early Childhood 1 - 4	1,236	830
Middle Childhood 5 - 11	1,009	654
Adolescence 12 - 21	340	275
Vision Screenings	974	901
Infancy < 1	65	10
Early Childhood 1 - 4	476	374
Middle Childhood 5 - 11	276	343
Adolescence 12 - 21	157	174

Immunization Summary - Vaccines for Children (VFC)

Vaccination Totals	104,285	91,072
DTaP (Diphtheria, Tetanus, Pertussis)	11,737	10,124
Influenza (FLU)	46,228	40,164
HepA (Hepatitis A)	5,353	4,956
HepB (Hepatitis B)	2,489	951
Haemophilus Influenza Type B (Hib)	6,169	5,238
Human Papillomavirus (HPV)	3,243	3,092
Meningococcal ACWY (MenACWY)	2,614	3,103
Meningococcal B - (MenB)	1,423	1,430
MMR (Measles, Mumps, Rubella)	4,607	4,389
Pneumococcal (PCV13)	9,284	7,727
Pneumococcal (PPSV23)	104	72
Polio (IPV)	362	297
RV (Rotavirus)	5,968	4,874
Tetanus and diphtheria (Td)	68	43
TDAP (Tetanus, Diphtheria, Pertussis)	2,093	2,247
Varicella Virus Vaccine (VAR)	2,543	2,365

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	SFY20 Q2	SFY21 Q2
Hearing Screenings	1,452	1,072
Infancy < 1	97	83
Early Childhood 1 - 4	614	420
Middle Childhood 5 - 11	502	391
Adolescence 12 - 21	239	178
Vision Screenings	660	669
Infancy < 1	23	19
Early Childhood 1 - 4	314	281
Middle Childhood 5 - 11	212	245
Adolescence 12 - 21	111	124

Immunization Summary - Vaccines for Children (VFC)

Vaccination Totals	70,828	62,721
DTaP (Diphtheria, Tetanus, Pertussis)	8,076	7,639
Influenza (FLU)	29,211	24,481
HepA (Hepatitis A)	3,797	3,049
HepB (Hepatitis B)	4,895	4,576
Haemophilus Influenza Type B (Hib)	2,842	2,606
Human Papillomavirus (HPV)	2,467	2,066
Meningococcal ACWY (MenACWY)	1,921	1,913
Meningococcal B - (MenB)	26	14
MMR (Measles, Mumps, Rubella)	3,021	2,909
Pneumococcal (PCV13)	6,539	6,110
Pneumococcal (PPSV23)	0	0
Polio (IPV)	342	216
RV (Rotavirus)	4,292	4,019
Tetanus and diphtheria (Td)	51	14
TDAP (Tetanus, Diphtheria, Pertussis)	1,653	1,431
Varicella Virus Vaccine (VAR)	1,695	1,678

Non-LTSS Care Coordination and HCBS Case Management

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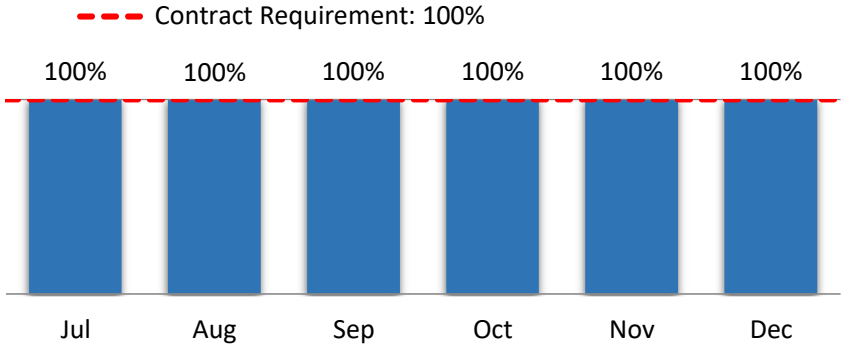
Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.2	**1.2**
"Members to" Ratios		
Members to Care Coordinators	16	**24**
HCBS Members to Case Managers	65	**65**

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.

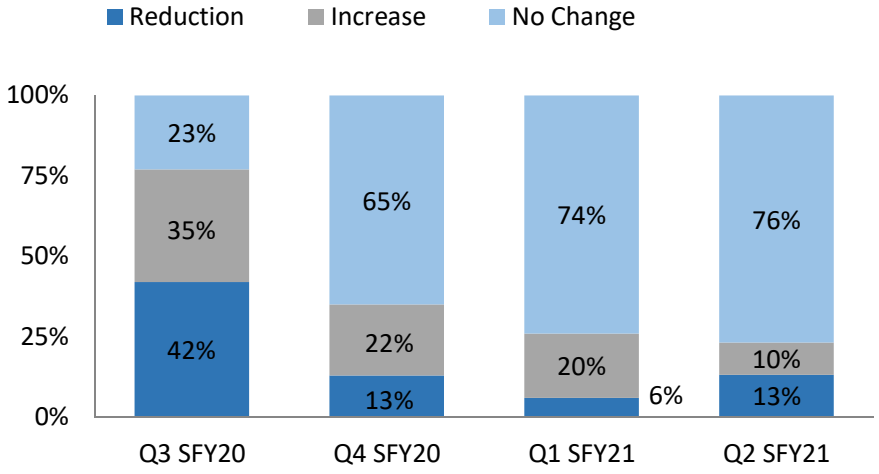
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.6%
	Yes	99.7%	99.4%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.3%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.7%	100.0%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Non-LTSS Care Coordination and HCBS Case Management

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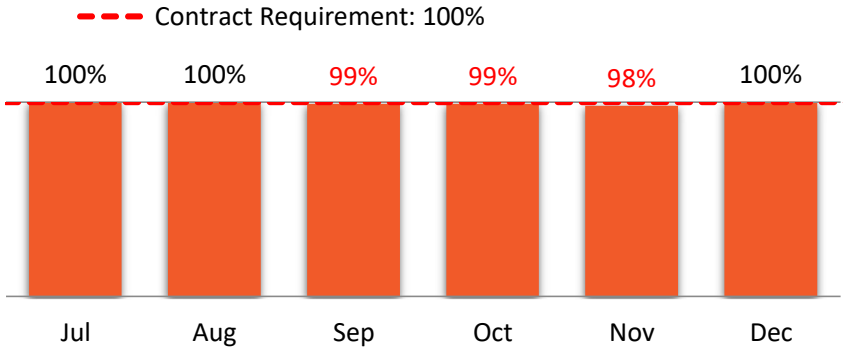
Average Number of Contacts Per Month	SFY21 Q1	SFY21 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	36	**20**
HCBS Members to Case Managers	38	**41**

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

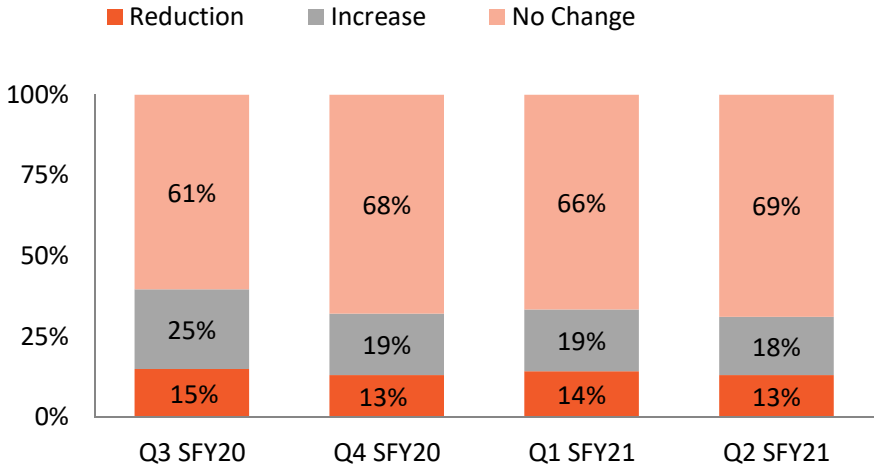
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY21 Q1	SFY21 Q2
They were part of service planning.	I don't know	0.4%	0.4%
	No	5.2%	1.1%
	Sometimes	1.1%	1.9%
	Yes	93.3%	96.7%
They feel safe where they live.	I don't know	0.8%	0.4%
	No	2.3%	0.4%
	Sometimes	1.9%	1.5%
	Yes	95.1%	97.8%
Their services make their lives better.	I don't know	1.1%	0.0%
	No	1.9%	0.7%
	Sometimes	2.6%	2.6%
	Yes	94.4%	96.7%

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 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	19	19
Home Delivered Meals	16	16
CDAC (individual) by 15 minute units	0	3
Supported Community Living (daily)	1	1
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	0	1
Brain Injury (BI) Waivers	831	821
Financial Management Services	236	239
Supported Community Living (by unit)	224	210
Respite (by 15 minute units)	174	170
Personal Emergency Response	162	163
Supported Community Living (daily)	107	107
Children's Mental Health (CMH)	879	876
Respite (by 15 minute units)	441	453
Family and Community Support	271	240
Respite (Hos/NF) - 15 minute units	245	232
Respite (Resident Camp) by units	18	14
Home Delivered Meals	8	8
Elderly Waivers	4,886	4,795
Home Delivered Meals	3,213	3,089
Personal Emergency Response	3,144	3,056
Assisted Living Services	437	412
CDAC (agency) by 15 minute units	319	349
Personal Emergency Response (install)	343	319

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	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	4,786	4,696
Home-based Habilitation	3,816	3,991
Long Term Job Coaching	403	375
Day Habilitation (units by day)	213	319
Day Habilitation (by 15 minute units)	593	282
Individual Supported Employment	184	196
Health & Disability (HD)	1,394	1,359
Financial Management Services	374	361
Home Delivered Meals	364	356
Respite (by 15 minute units)	370	350
Personal Emergency Response	363	349
Respite (Hos/NF) - 15 minute units	67	67
Intellectual Disability (ID)	7,150	7,111
Supported Community Living (by unit)	1,886	1,848
Supported Community Living (daily)	1,965	1,586
Day Habilitation (units by day)	1,551	1,498
Financial Management Services	1,376	1,385
Supported Community Living (RCF)	966	1,107
Physical Disability (PD)	759	724
Personal Emergency Response	402	384
CDAC (agency) by 15 minute units	70	72
Personal Emergency Response (install)	75	63
Home-based Habilitation	60	52
Home Delivered Meals	55	51

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 Q1	SFY21 Q2
AIDS/HIV - Unique Service Plans	13	11
Home Delivered Meals	7	7
CDAC (individual) by 15 minute units	6	5
Homemaker (by 15 minute units)	2	3
Supported Community Living (daily)	2	2
Day Habilitation (units by day)	1	1
Brain Injury (BI) Waivers	531	532
Supported Community Living (by unit)	233	234
Respite (by 15 minute units)	157	153
Personal Emergency Response	127	130
Supported Community Living (daily)	119	117
Transportation (1-way trip)	92	93
Children's Mental Health (CMH)	351	351
Respite (by 15 minute units)	173	192
Respite (Hos/NF) - 15 minute units	96	113
Family and Community Support	85	89
Mental Health Service	5	16
Respite (Resident Camp) by units	7	6
Elderly Waivers	3,336	3,310
Home Delivered Meals	2,548	2,610
Personal Emergency Response	2,451	2,526
CDAC (agency) by 15 minute units	1,285	1,330
Homemaker (by 15 minute units)	914	928
CDAC (individual) by 15 minute units	778	762

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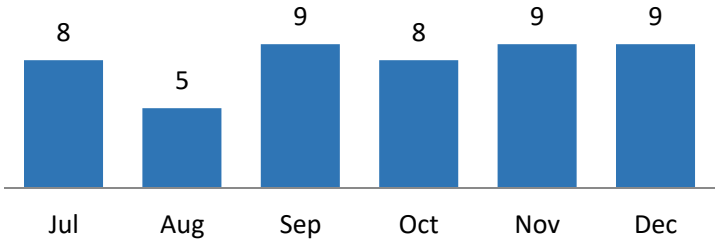
	SFY21 Q1	SFY21 Q2
Habilitation (Hab)	2,395	2,416
Home-based Habilitation	1,787	1,800
Day Habilitation (by 15 minute units)	370	350
Day Habilitation (units by day)	283	270
Long Term Job Coaching	225	240
Individual Supported Employment	145	153
Health & Disability (HD)	645	631
Respite (by 15 minute units)	297	292
Home Delivered Meals	203	190
Personal Emergency Response	180	176
CDAC (individual) by 15 minute units	130	130
CDAC (agency) by 15 minute units	111	109
Intellectual Disability (ID)	4,524	4,512
Supported Community Living (by unit)	1,949	1,939
Day Habilitation (by 15 minute units)	1,912	1,899
Day Habilitation (units by day)	1,778	1,769
Supported Community Living (RCF)	1,490	1,440
Respite (by 15 minute units)	1,075	1,079
Physical Disability (PD)	411	399
Personal Emergency Response	244	236
CDAC (agency) by 15 minute units	204	197
CDAC (individual) by 15 minute units	144	148
Transportation (1-way trip)	56	54
Personal Emergency Response (install)	40	28

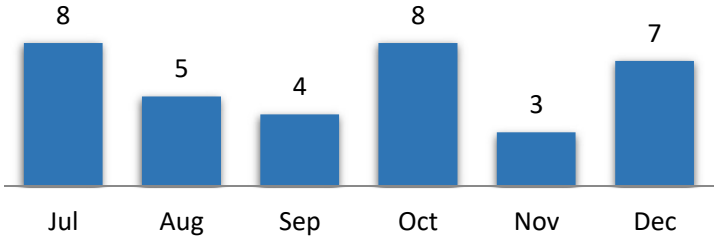
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	96.30%	96.77%	97.06%
Abandonment Rate - Must be 5% or less	1.08%	0.38%	0.50%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	90.51%	92.20%	94.57%
Abandonment Rate - Must be 5% or less	0.07%	0.07%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	90.98%	94.25%	91.36%
Abandonment Rate - Must be 5% or less	0.69%	0.19%	0.22%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	78.63%	90.80%	92.59%
Abandonment Rate - Must be 5% or less	3.25%	0.44%	0.80%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	76.62%	81.23%	94.60%
Abandonment Rate - Must be 5% or less	1.77%	1.29%	0.90%

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.

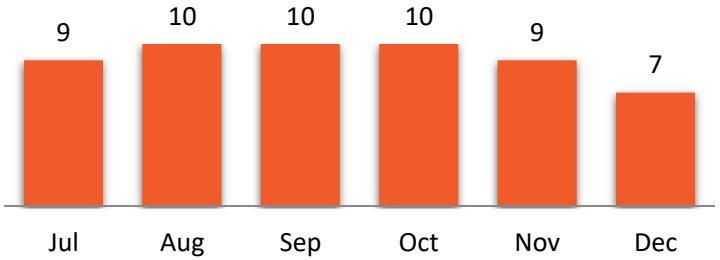
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	ID Card Request or Inquiry
3.	Enrollment Information
4.	Transportation Inquiry
5.	Claim Inquiry

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

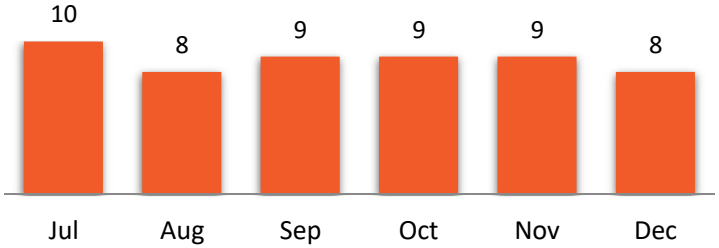
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	81.00%	72.93%	80.91%
Abandonment Rate - Must be 5% or less	4.35%	4.54%	2.87%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	89.70%	71.87%	90.18%
Abandonment Rate - Must be 5% or less	3.74%	4.92%	4.62%
Provider Helpline			
Service Level (Requirement 80%)	83.70%	79.11%	82.38%
Abandonment Rate - Must be 5% or less	2.75%	2.51%	2.95%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	92.41%	91.43%	92.33%
Abandonment Rate - Must be 5% or less	0.43%	0.22%	0.13%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	70.29%	77.73%	94.03%
Abandonment Rate - Must be 5% or less	2.01%	1.45%	1.20%

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 PCP/PPG for Member
3.	Member Rewards for Member
4.	Coordination Of Benefits for Member
5.	Order ID card

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

Provider Network Access Summary

Primary Care Providers (PCP)

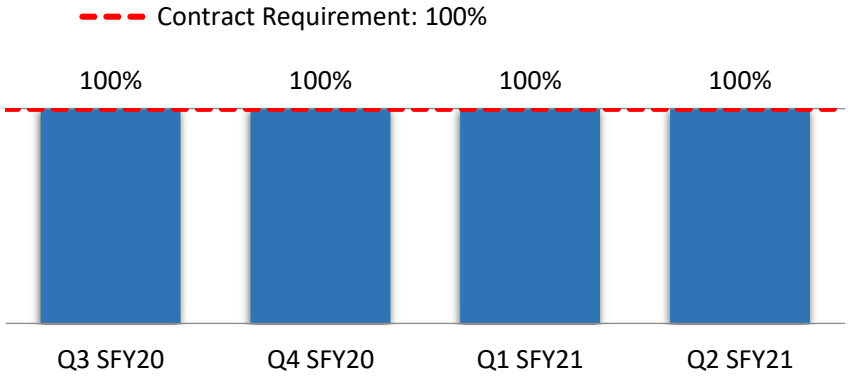
	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	6,591	6,641
Members with Access	204,945	210,795
Average Distance (Miles)	2	1.5
Pediatric PCP		
Provider Count	6,634	6,677
Members with Access	204,867	203,169
Average Distance (Miles)	2	1.6

Specialty Care & Behavioral Health (BH)

	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	400	399
Members with Access	134,256	137,341
Average Distance (Miles)	5.7	5.6
Outpatient - Behavioral Health		
Provider Count	4,000	4,043
Members with Access	409,812	413,964
Average Distance (Miles)	2	2.1
Inpatient - Behavioral Health		
Provider Count	49	48
Rural Members		
Members with Access	168,321	169,705
Average Distance (Miles)	21	21.6
Urban Members		
Members with Access	241,491	244,259
Average Distance (Miles)	6	5.7

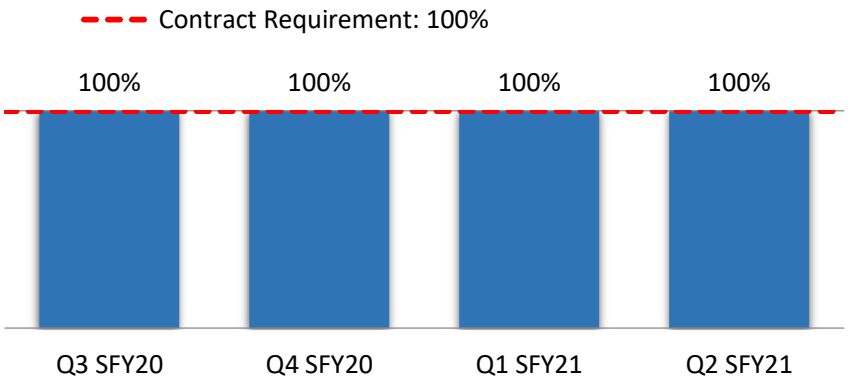
Adult PCP - Time Standards

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

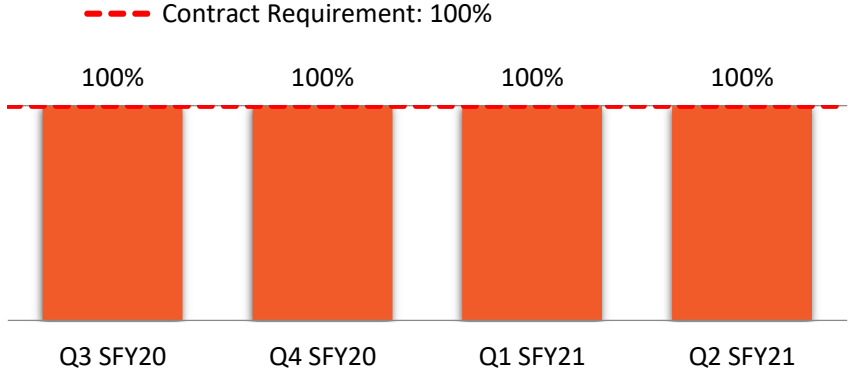
Provider Network Access Summary

Primary Care Providers (PCP)	SFY21 Q1	SFY21 Q2
Adults PCP		
Provider Count	8,301	8,548
Members with Access	153,137	160,490
Average Distance (Miles)	2.0	2.0
Pediatric PCP		
Provider Count	8,986	9,262
Members with Access	133,933	136,490
Average Distance (Miles)	2.1	2.1

Specialty Care & Behavioral Health (BH)	SFY21 Q1	SFY21 Q2
OB/GYN Adult		
Provider Count	1,183	1,207
Members with Access	102,412	106,694
Average Distance (Miles)	5.4	5.4
Outpatient - Behavioral Health		
Provider Count	7,842	8,251
Members with Access	287,070	296,980
Average Distance (Miles)	2.6	2.5
Inpatient - Behavioral Health		
Provider Count	35	35
Rural Members		
Members with Access	205,468	212,426
Average Distance (Miles)	25	24.7
Urban Members		
Members with Access	81,602	84,554
Average Distance (Miles)	8	8.4

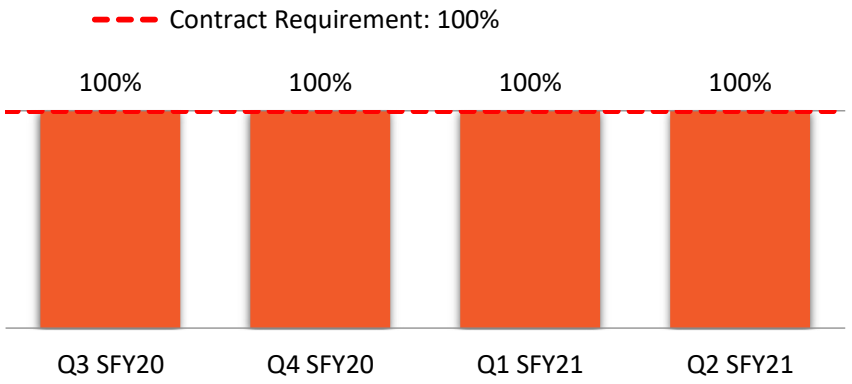
Adult PCP - Time Standards

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

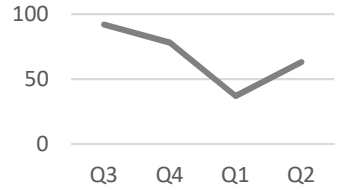
Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated 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 Q2

63



9 Total Cases
Referred to MCFU

Amerigroup
An Anthem Company

Program Integrity
- Fraud, Waste, & Abuse

	SFY21 Q1	SFY21 Q2
Investigations opened	28	34
Overpayments identified	23	23
Member concerns referred to IME	6	3
Cases referred to the Medicaid Fraud Control Unit (MCFU)	6	6

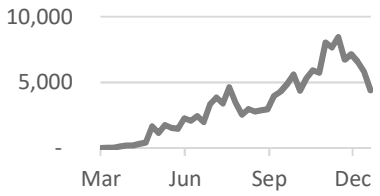
iowa total care

Program Integrity
- Fraud, Waste, & Abuse

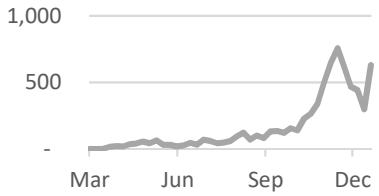
	SFY21 Q1	SFY21 Q2
Investigations opened	9	29
Overpayments identified	0	1
Member concerns referred to IME	8	4
Cases referred to the Medicaid Fraud Control Unit (MCFU)	1	3

MCO COVID-19 Summary

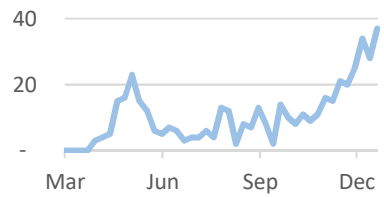
Total Individuals Tested
146,288



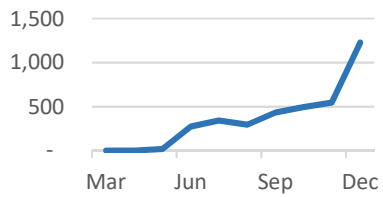
Total Tested Positive
7,098



Total COVID Deaths
462



Total COVID Inpatient Stays [12]
3,625



81,802 tested in Q2	4.9%	0.06%	1.38%
78% 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 Q2, ITC updated logic used to evaluate inpatient stays which lead to the adjustment of previously reported COVID Inpatient Stays. [12]

Claims Activity During COVID-19

MCO Total Counts	Q1 SFY21	Q2 SFY21
ER Visits - Counts	**298,300**	**255,268**
Amount Paid	$63.77 M	$64.17 M
Telehealth Services - Counts	**156,254**	**162,046**
Amount Paid	$14.08 M	$14.42 M
Transportation - Counts	**200,464**	**213,932**
Amount Paid	$9.35 M	$9.61 M
Home Maker Services - Counts	**6,283**	**7,921**
Amount Paid	$1.18 M	$1.26 M
COVID Testing - Counts	**46,040**	**81,802**
Amount Paid	$6.02 M	$9.72 M
Meals - Counts	**12,817**	**12,594**
Amount Paid	$6.44 M	$6.05 M

Telehealth Services - All MCO Counts

o In March, 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.

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 89%.

- **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
- 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.

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.

Run Out: See Claims

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 specific waivers listed above.

Waiver Service Plan: See Service Plan