STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

Prepaid Ambulatory Health Plan (PAHP)
Dental Wellness Plan (DWP)
Quarterly Performance Report

SFY2023, Quarter 3

(January - March 2023)

Published June 2023

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

Oral disease, including tooth decay and gum disease, is the most common, chronic disease among adults and children in Iowa. Prevention and treatment of oral disease are key to improving overall health outcomes and reducing the cost of dental and medical care. The Dental Dashboard monitors the services provided to Iowa Medicaid recipients, reviewing utilization, performance, network adequacy, among other metrics to assure quality service and dental care for Iowa Medicaid members.

Delivery System: Medicaid dental benefits are largely provided by a managed care delivery system via Prepaid Ambulatory Health Plans (PAHPs). Less than 2% of Dental Wellness Plan members continue to receive care under fee for services managed by Iowa Medicaid. The State is currently contracted with two PAHP's to deliver DWP dental benefits to the Medicaid population:

- Delta Dental of Iowa (DDIA)
- Managed Care of North America (MCNA)

Background: Federal requirements for dental benefits vary by age and eligibility. For individuals under the age of 21, dental services are a mandatory benefit as part of the Early and Periodic Screening, Diagnostic and Treatment services. However, under the federal Medicaid program, dental services are an "optional" category of service for adults 21 years and older. As an optional service, states choosing to provide adult dental benefits under their Medicaid program may determine the amount, duration, and scope of dental services they will furnish.

Beginning on May 2014, the Centers for Medicaid and Medicare Services (CMS) approved Iowa's request to offer adult dental benefits to Iowa Health and Wellness Plan (IHAWP) members through the Dental Wellness Plan (DWP). The DWP plan was unique and offered tiered dental benefits to the state's Medicaid expansion population (ages 19 to 64). The DWP used a Pre-Ambulatory Health Plan (PAHP), Delta Dental of Iowa (DDIA), to manage dental services to these members.

On July, 2017, the State of Iowa proposed a Medicaid State Plan Amendment (SPA), to redesign DWP as an integrated dental program for all Medicaid enrollees aged 19 and over. With this amendment, the State proposed to offer a single, unified adult dental program for adult Medicaid populations (Fee for Service (FFS) and Medicaid Expansion). At this time another PAHP, Managed Care of North America (MCNA) contracted with Iowa Medicaid to provide services to the new increased adult population.

Monitoring and Oversight: Like all states, Iowa's Medicaid program must comply with all applicable federal program requirements. In addition to meeting requirements, states are granted considerable flexibility to tailor their Medicaid program to meet the specific priorities, demographics and constraints they face.

Executive Summary

Performance monitoring and data analysis are critical components in assessing how well the PAHP is improving the quality of care delivered to members. All dental plans submit monthly and quarterly data reports, which provide a snapshot of information on major contract compliance areas and member enrollment. Iowa Medicaid analyzes collected data to better understand service utilization, claim denials and appeals, and the impact current policies have on access to care. The data is stratified (race, ethnicity, etc.) to better understand the dental pattern of different populations to serve them better. Iowa Medicaid is also monitoring perspectives and experiences with feedback from Medicaid enrollees, providers and grassroot community leaders to work towards quality improvement with the PAHP's as issues are identified.

These reports are due to be replaced by a dashboard that is currently under development. Once completed, the dashboard will provide both medical and dental Medicaid data to the public.

Additional program related information can be found at https://hhs.iowa.gov/dental-wellness-plan/who-qualifies

Member Summary - Dental Wellness Plan (DWP)

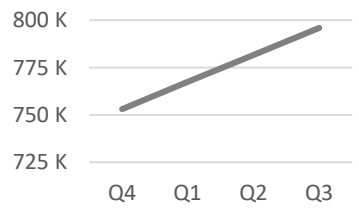
Prepaid Ambulatory Health Plans (PAHP) offer dental insurance benefits for those adults and families that qualify for the Dental Wellness Plan (DWP) Adult & Children programs.

In Iowa, almost 99% of the Medicaid population is covered by an PAHP. Populations not covered by MCOs are provided coverage through the state's Fee-For-Service (FFS) program.

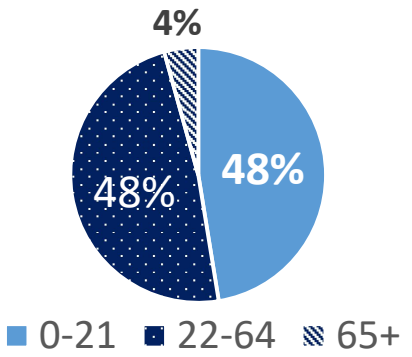
Program activity for the Healthy and Well Kids in Iowa (Hawki) plan is separately reported; However enrollment counts are captured below.

All DWP Members

796,063



+14,561 Members
1.86% Increase



PAHP Enrollment
(by Age)

Data Notes: March 2023 enrollment data as of May 2023. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters. Because of the capitation structure, M-CHIP is categorized under DWP.

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Distinct
Dental Wellness Plan (DWP) - *Overall Counts*	753,135	767,406	781,502	**796,063**	774,527	**796,063**
0-21	360,206	366,469	371,712	377,701	369,022	377,701
22-64	361,246	368,334	376,377	384,239	372,549	384,239
65+	31,683	32,603	33,413	34,123	32,956	34,123
Fee-For-Service (FFS) - *Non PAHP Enrollees*	10,979	10,689	10,557	**11,008**	10,808	**11,008**
Hawki Member Summary - *Overall Counts*	56,911	54,854	53,636	**52,833**	54,559	**52,833**
Iowa Medicaid Total - *All Dental Counts*	821,025	832,949	845,695	859,904	839,893	**859,904**

Member Summary - DWP

DELTA DENTAL

	SFY23 Q2	SFY23 Q3
All DWP Members - *by PAHP*	486,348	494,972
PAHP Member Market Share	62.2%	62.2%
Disenrolled	357	299
Adult Dental Wellness Plan (**DWP**) 19+	284,043	289,360
Traditional Medicaid [1]	125,621	127,068
Iowa Health and Wellness Plan	158,422	162,292
Child Dental Wellness Plan (**DWP**) 0-18	202,305	205,612
Traditional Medicaid[1]		

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	SFY23 Q2	SFY23 Q3
All DWP Members - *by PAHP*	295,154	301,091
PAHP Member Market Share	37.8%	37.8%
Disenrolled	2,924	2,220
Adult Dental Wellness Plan (**DWP**) 19+	168,346	172,543
Traditional Medicaid [1]	73,976	75,096
Iowa Health and Wellness Plan	94,370	97,447
Child Dental Wellness Plan (**DWP**) 0-18	126,808	128,548
Traditional Medicaid[1]		

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

If Yes, explain:

- Due to disenrollment limitations related to the Public Health Emergency, overall dental enrollment continues to increase. For additional information reference the HHS website: http://hhs.iowa.gov/ime/members.
- PAHP enrollment increased by 14,561 members or 1.86%.

[1] Includes MCHIP

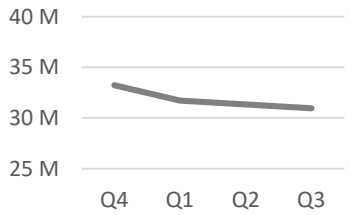
Financial Summary - DWP

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

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

All Capitation Payments

$31.0 Million

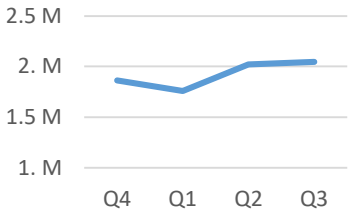


- $368 Thousand

-1.2% Decrease

Third Party Liability Recovered

$2.0 Million



+ $25 Thousand

1.2% Increase

Data Notes: March 2023 capitation data as of May 2023. All Third Party Liability (TPL) data reported above is self-reported by PAHPs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Financial Summary						
Capitation Payments	$33.3 M	$31.7 M	$31.3 M	**$31.0 M**	$31.82 M	$127.28 M
Third Party Liability (TPL) Recovered	$1.9 M	$1.8 M	$2.0 M	**$2.0 M**	$1923 K	$7.69 M

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

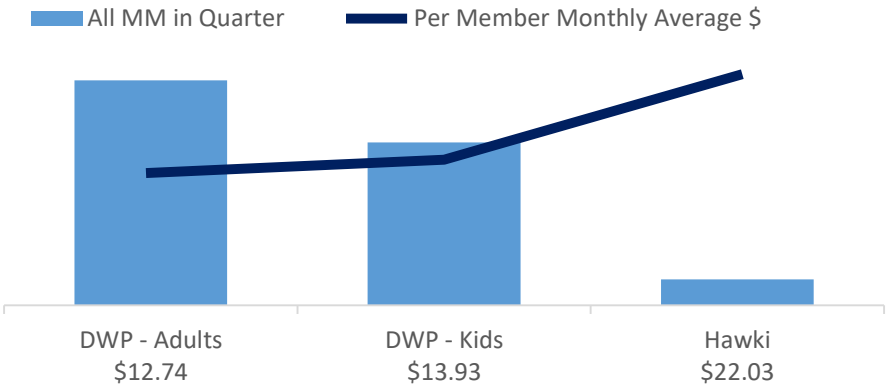
If Yes, explain:

Financial Summary - DWP

Per member Medicaid capitation is determined by the members eligibility group, the applicable provider fee schedule and annual benefit maximums (ABM).

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

Monthly Capitation Expenditures



DELTA DENTAL

	SFY23 Q2	SFY23 Q3
Capitation Totals	$20.71 M	**$20.71 M**
Adjustments	-$17 K	-$17 K
Current	$20.44 M	$20.44 M
Retro	$288 K	$288 K
Third Party Liability (TPL) Recovered	$1.92 M	**$1.94 M**
Financial Ratios		
Medical Loss Ratio (MLR)	87.1%	**85.6%**
Administrative Loss Ratio (ALR)	11.4%	10.1%
Underwriting Ratio (UR)	1.5%	4.4%
Unreconciled SFY MLR [2]		85.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

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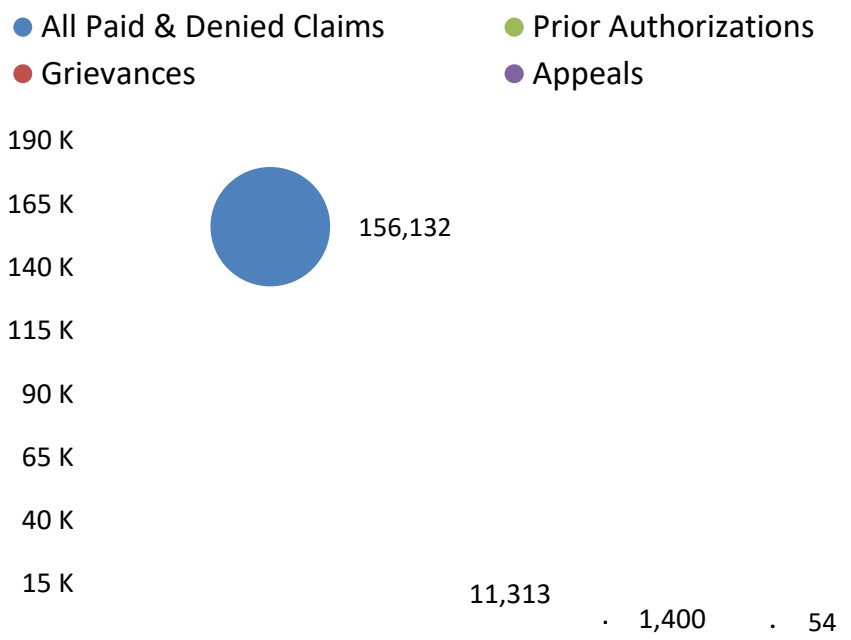
	SFY23 Q2	SFY23 Q3
Capitation Totals	$10.63 M	**$10.63 M**
Adjustments	-$8 K	-$8 K
Current	$10.42 M	$10.42 M
Retro	$220 K	$220 K
Third Party Liability (TPL) Recovered	$104 K	**$107 K**
Financial Ratios		
Medical Loss Ratio (MLR)	88.9%	**83.8%**
Administrative Loss Ratio (ALR)	11.9%	15.8%
Underwriting Ratio (UR)	-0.9%	0.4%
Unreconciled SFY MLR [2]		83.1%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

[2] MLR is unaudited and is now reported to include changes with additional quarters of information during the SFY. Primary drivers that influence changes in the MLR include: 1) estimates for unpaid claims liability, 2) estimates for the impact of the risk corridor and 3) financial review process that may result in expenditure reclassifications.

Claims Universe - All DWP 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	7.25%
Grievances	0.90%
Appeals	0.03%

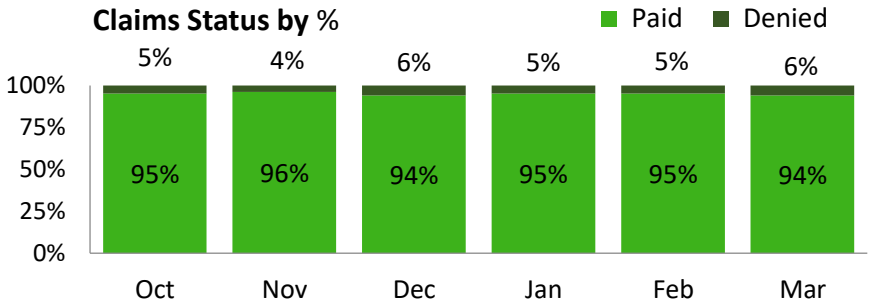
	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Claim Counts - All Paid & **Denied** (p. 10-11)	164,815	149,991	165,028	**156,132**	158,992	635,966
Delta Dental of Iowa	121,806	114,004	124,178	118,711	119,675	478,699
MCNA Dental	43,009	35,987	40,850	37,421	39,317	157,267
Prior Authorization Summary (p. 12-13)	10,953	11,061	11,038	**11,313**	11,091	44,365
Delta Dental of Iowa	8,092	8,478	8,471	8,744	8,446	33,785
MCNA Dental	2,861	2,583	2,567	2,569	2,645	10,580
Grievances & **Appeals Summary** (p. 14-15)						
All Grievances	1,757	862	1,101	**1,400**	1,280	5,120
All Appeals	54	59	45	**54**	53	212

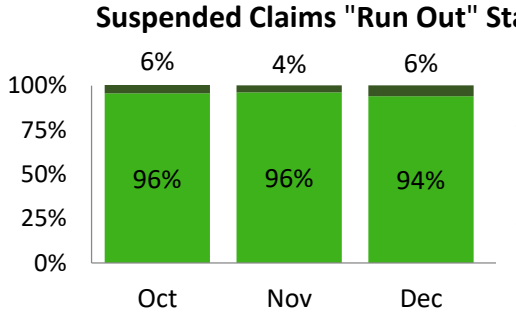
Claims Summary - DWP Counts

118,711
Claims Paid & Denied

DELTA DENTAL

	Jan	Feb	Mar
All Claims			
Paid	30,828	36,640	44,897
Denied	1,704	1,773	2,869
Suspended	47	64	68
Clean Claims Processed			
in 14-days (Requirement 90%)	100%	100%	100%
in 21-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	8	7.5	7.5
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

	%	Top 10 Reasons for Claims Denials
1.	30%	Information submitted does not support this many/frequency of services
2.	20%	The benefit of this service is included for another service
3.	19%	Exact duplicate claim/service
4.	17%	Program guidelines were not met
5.	14%	Services not provided by network/primary care providers
6.	0.1%	Expenses incurred after coverage termination
7.		
8.		
9.		
10.		

Claims Summary - DWP Counts

37,421
Claims Paid & Denied

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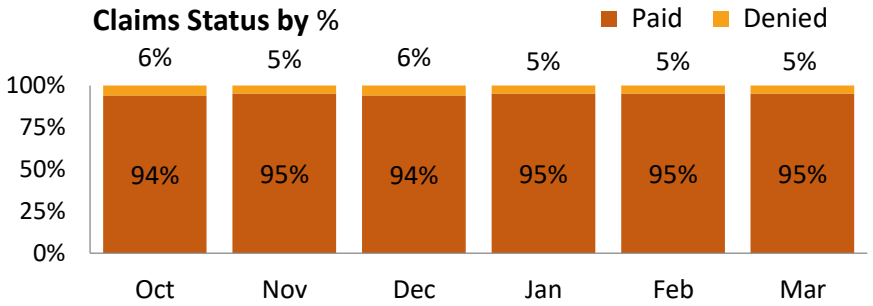
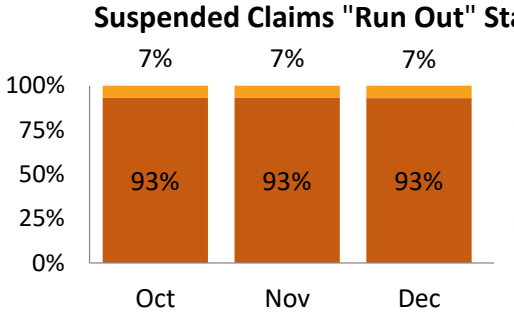
	Jan	Feb	Mar
All Claims			
Paid	9,806	11,714	14,040
Denied	528	613	720
Suspended	2,811	2,760	2,802
Clean Claims Processed			
in 14-days (Requirement 90%)	99%	100%	100%
in 21-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	7.6	7.8	8.3
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





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

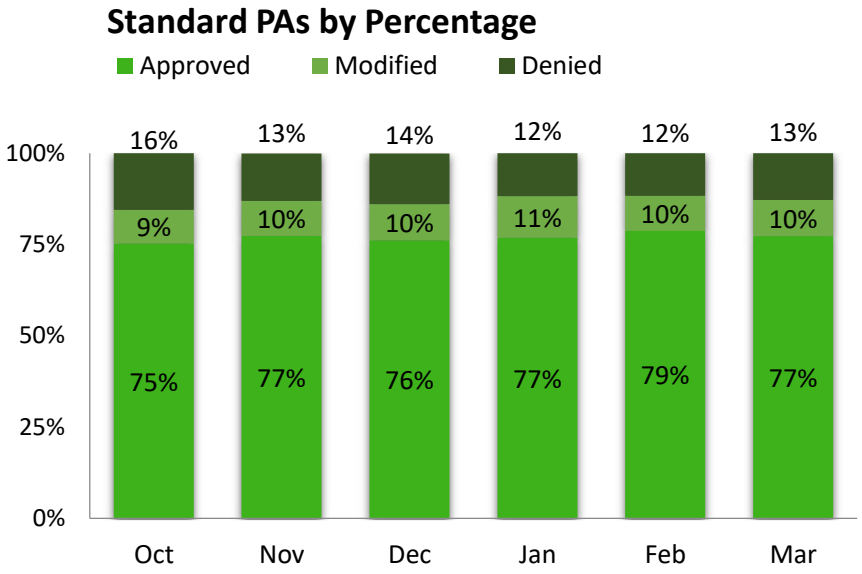
Top 10 Reasons for Claims Denials

	%	
1.	20%	Charges for radiographs combined into a full mouth series
2.	16%	Denied missing prior authorization/missing documentation for post PA review
3.	14%	Request has been previously reported and an approval or denial was issued
4.	13%	Non-covered service
5.	8%	Submit the primary carrier's explanation of benefits
6.	8%	Coverage limited to once in a twelve month period
7.	5%	Coverage limited to once in a five year period
8.	5%	Coverage limited to once in a six month period
9.	5%	Submit x-ray(s) and documentation of medical necessity
10.	4%	Services performed by a non-participating provider not covered

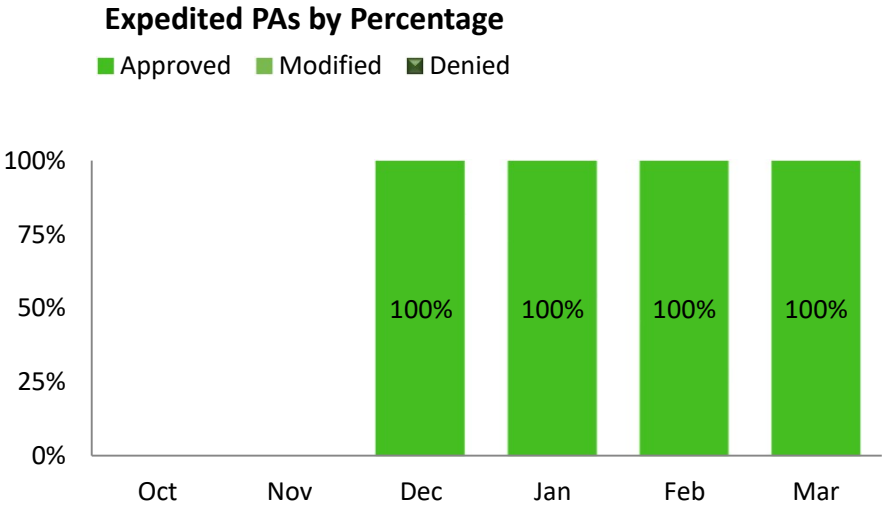
Prior Authorization Summary - DWP Counts

8,744
All PAs Submitted

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	2,259	2,077	2,440
Denied	347	310	405
Modified	335	254	314
Average Days to Process	1	3	3
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%



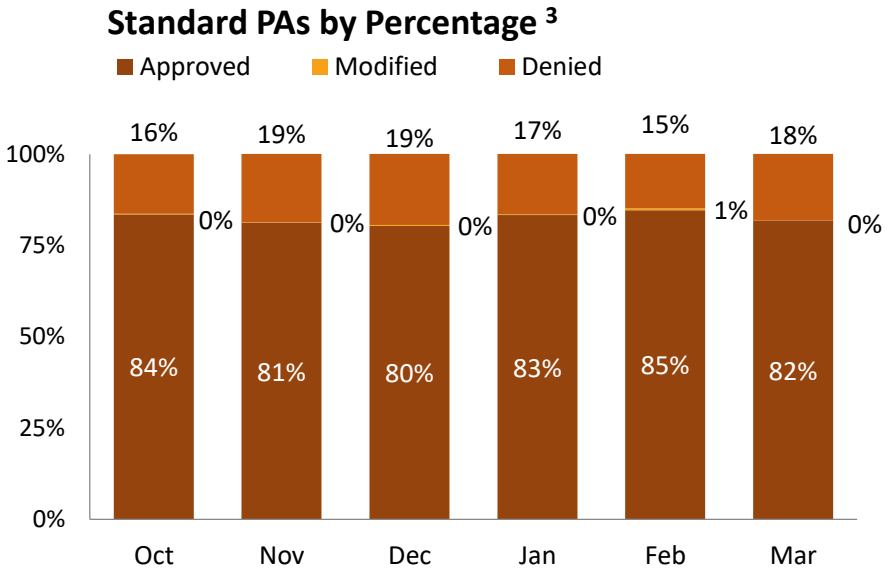
	Jan	Feb	Mar
Expedited Prior Authorizations (PAs)			
Approved	1	1	1
Denied	0	0	0
Modified	0	0	0
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



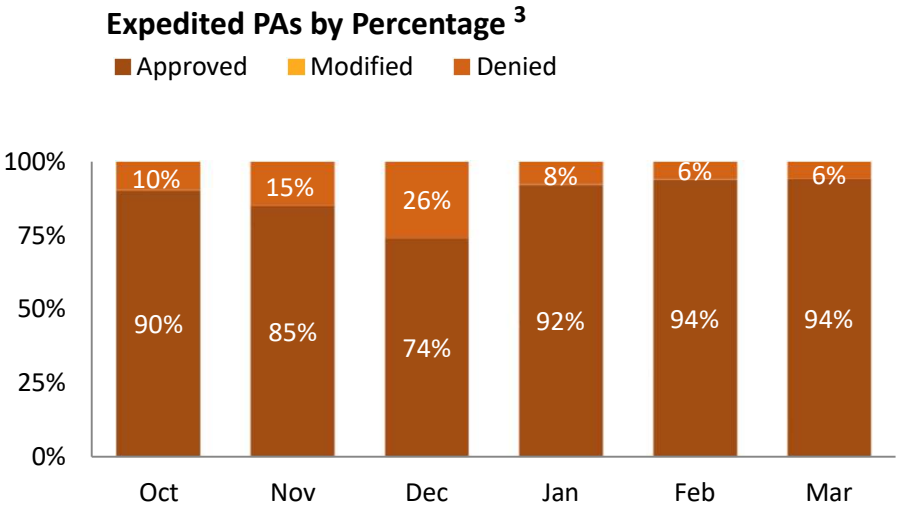
Prior Authorization Summary - DWP Counts

2,569
All PAs Submitted

	Jan	Feb	Mar
Standard Prior Authorizations (PAs)			
Approved	548	598	613
Denied	109	105	136
Modified	1	4	0
Average Days to Process	8	9	8
Standard PAs Completed in 14-days (Requirement 99%)	100%	100.0%	100%



	Jan	Feb	Mar
Expedited Prior Authorizations (PAs)			
Approved	82	92	62
Denied	7	6	4
Modified	0	0	0
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	98%	100%

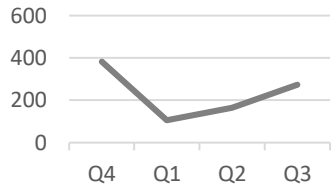


[3] Percentages previously displayed as combined standard and expedited

Grievances and Appeals - DWP Counts

Grievances

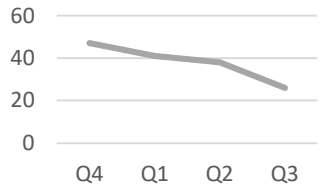
273



Resolved in 30-days
100%

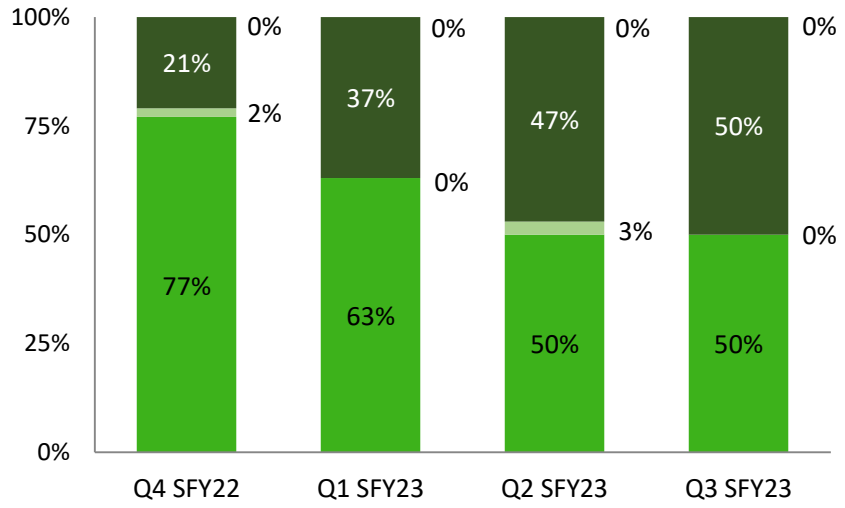
Appeals/ 1st Level Review

26



Resolved in 30-days
96%

Appeal Outcome %



Withdrawn
Partially Overturned
Upheld
Overturned

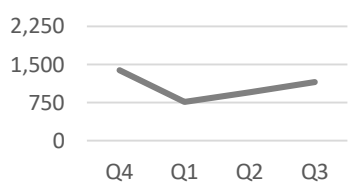
	%	Top Reasons for Grievances
1.	85%	Access to care/network adequacy
2.	12%	Quality of Care/Treatment Concerns
3.	1%	Inappropriate Dentist Action/Behavior
4.	1%	Potential Fraud and Abuse
5.	1%	Other
6.		
7.		
8.		
9.		
10.		

%	Top Reasons for Appeals
67%	Medical necessity: Orthodontia
27%	Medical Necessity: Crown/Bridge/Dentures/Implants
3%	Medical Necessity: Oral Surgery
3%	Missing Prior Authorization

Grievances and Appeals - DWP Counts

Grievances

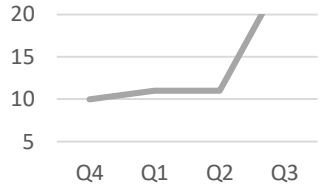
1,150



Resolved in 30-days
100%

Appeals/ 1st Level Review [4]

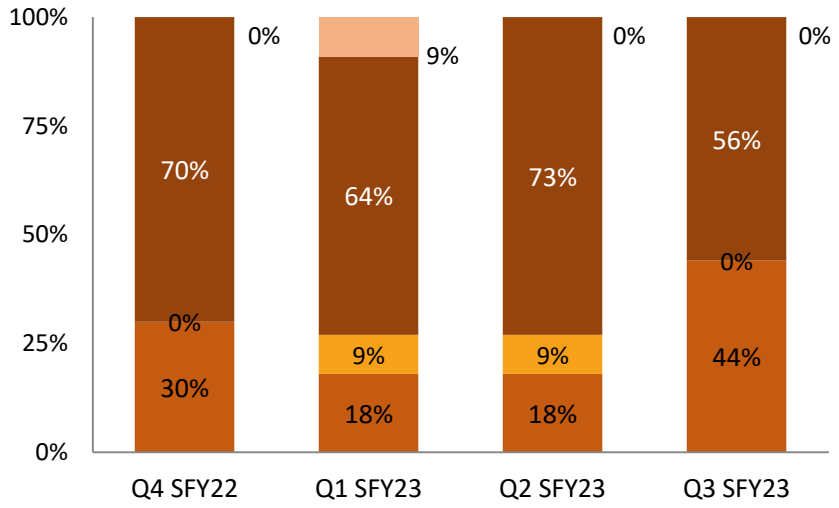
25



Resolved in 30-days
100%

Withdrawn
Partially Overturned
Upheld
Overturned

Appeal Outcome %



	%	Top Reasons for Grievances
1.	99.7%	Access to care/network adequacy
2.	0.2%	Inappropriate dentist action/behavior
3.	0.1%	Potential Fraud and Abuse
4.		
5.		
6.		
7.		
8.		
9.		
10.		

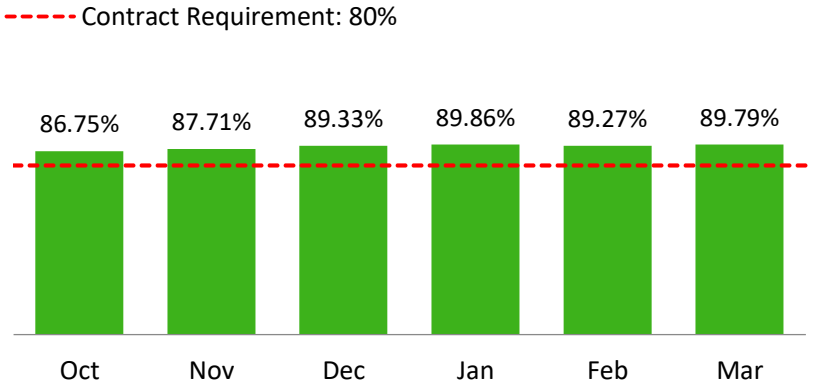
%	Top Reasons for Appeals
27%	Medical Necessity: Crown(s)/Bridge(s)/Dentures/Implants
27%	Medical necessity: Orthodontia
18%	Frequency: Restorative
18%	Medical Necessity: Oral Surgery
10%	Exceeds Benefit Maximum

[4] MCNA counts prior to SFY23 were restated due to omission of provider filed appeals

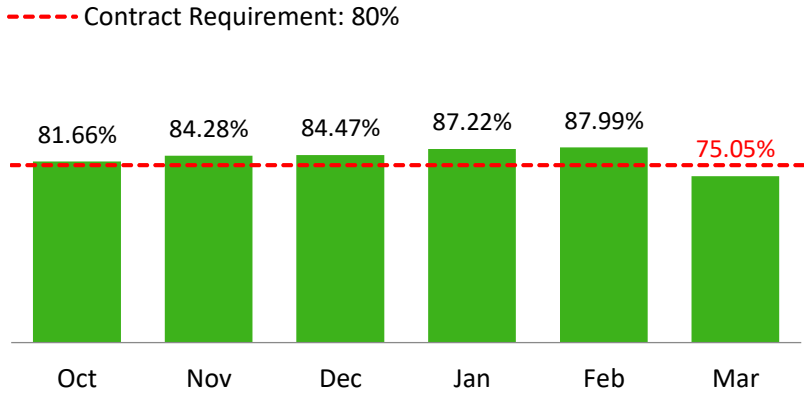
Call Center Performance Metrics

	Oct	Nov	Dec	Jan	Feb	Mar
Member Helpline						
Service Level (Requirement 80%)	86.75%	87.71%	89.33%	89.86%	89.27%	89.79%
Abandonment Rate - Must be 5% or less	0.59%	0.50%	0.83%	0.81%	0.50%	0.65%
Provider Helpline						
Service Level (Requirement 80%)	81.66%	84.28%	84.47%	87.22%	87.99%	75.05%
Abandonment Rate - Must be 5% or less	0.96%	1.08%	2.26%	1.00%	0.76%	1.00%

Member Helpline - Service Level



Provider Helpline - Service Level



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

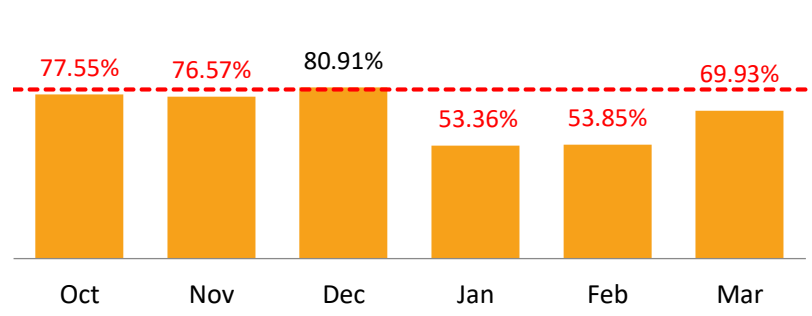
	Top 5 Call Reasons (Member Helpline) [5]	Top 5 Call Reasons (Provider Helpline) [5]
1.	Eligibility Inquiry	Claims Related
2.	Benefit Inquiry	Benefit Inquiry
3.	Provider Related	Eligibility Related
4.	ID Card Related	Risk Assessment
5.	Claims Related	Internal Transfer

[5] Delta's call center does not track calls answered via voice recognition.

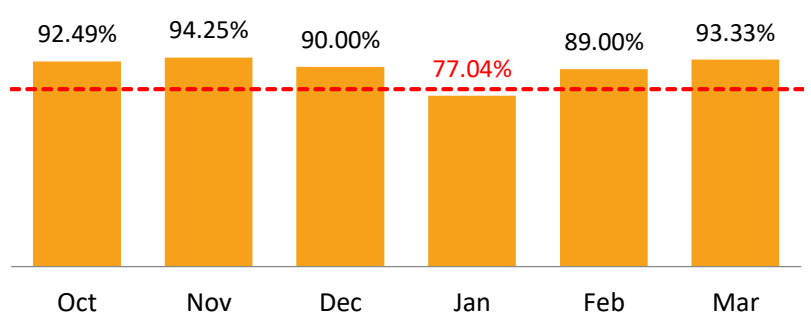
Call Center Performance Metrics

	Oct	Nov	Dec	Jan	Feb	Mar
Member Helpline						
Service Level (Requirement 80%)	77.55%	76.57%	80.91%	53.36%	53.85%	69.93%
Abandonment Rate - Must be 5% or less	4.15%	3.82%	6.31%	7.06%	9.14%	10.40%
Provider Helpline						
Service Level (Requirement 80%)	92.49%	94.25%	90.00%	77.04%	89.00%	93.33%
Abandonment Rate - Must be 5% or less	1.03%	1.14%	1.48%	3.91%	2.79%	0.39%

Member Helpline - Service Level



Provider Helpline - Service Level



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

	Top 5 Call Reasons (Member Helpline)	Top 5 Call Reasons (Provider Helpline)
1.	Provider Related	Claims Related
2.	Eligibility Inquiry	Benefit Inquiry
3.	Benefit Inquiry	Eligibility Related
4.	Value Added Services	Internal Transfer
5.	Internal Transfer	Prior Authorization

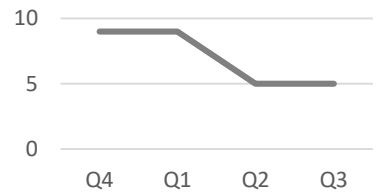
Program Integrity - DWP Counts

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 Dental Plans, 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 Dental Plan investigations, overpayment recovery, and referrals to MFCU listed in this chart would be considered pending until final determinations are made.

Total Investigations Opened in SFY23 Q3

5



0 Total Cases
Referred to MFCU Q3

DELTA DENTAL

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Investigations opened	5	4	3	5	4	17
Overpayments identified	-	1	3	1	2	5
Member concerns referred to Iowa Medicaid	0	0	0	0	0	0
Cases referred to the Medicaid Fraud Control Unit (MFCU)	0	1	1	0	1	2

mcnadental

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3	Average	Total
Investigations opened	4	5	2	0	3	11
Overpayments identified	-	2	1	0	1	3
Member concerns referred to Iowa Medicaid	0	0	0	0	0	0
Cases referred to the Medicaid Fraud Control Unit (MFCU)	0	0	0	0	0	0

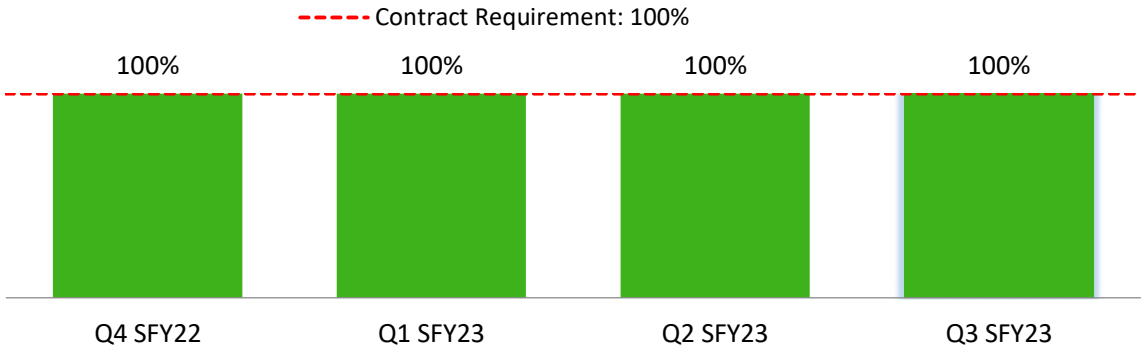
Provider Network Access Summary - DWP Counts

Access Primary Care Dentist

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
DWP				
Members with Access		471,802	484,422	490,135
Primary Care Dentists		815	809	793

General Dentist Time and Distance Standards

60 minutes or 60 miles



Link to Geo Access Reports:

https://hhs.iowa.gov/ime/about/performance-data-geoaccess

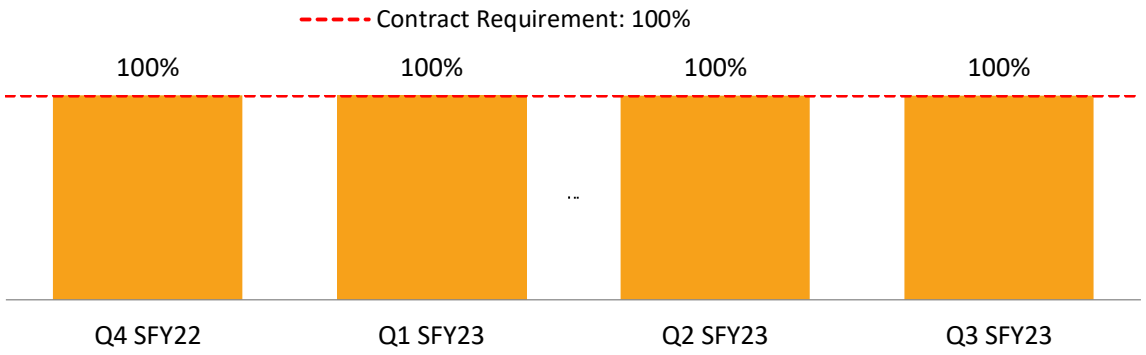
Provider Network Access Summary - DWP Counts

Access Primary Care Dentist

	SFY22 Q4	SFY23 Q1	SFY23 Q2	SFY23 Q3
DWP				
Members with Access		286,691	291,228	297,115
Primary Care Dentists		552	534	529

General Dentist Time and Distance Standards

60 minutes or 60 miles



Link to Geo Access Reports:

https://hhs.iowa.gov/ime/about/performance-data-geoaccess

Annual Benefit Maximum - DWP Counts

Annual Benefit Maximum

A $ 1,000 Annual Benefit Maximum (ABM) applies to the Adult Dental Wellness Plan population. On a State-Fiscal-Year-To-Date (SFYTD) basis, the state monitors the cumulative count of members that have reached the ABM.

DELTA DENTAL

	SFYTD	
	Count	% of Total
The total number of members that have met their ABM during SFY.	261	0.05%

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	SFYTD	
	Count	% of Total
The total number of members that have met their ABM during SFY.	844	0.28%

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

Annual Benefit Maximum (**ABM**): A $1,000 maximum state fiscal year (July 1 to June 30) benefit limit that applies to every adult Medicaid member, age 21 and older, as well as the Hawki population. By program design, certain services are excluded from the ABM calculation including emergency dental services.

Appeal: An appeal is a request for a review of an adverse benefit determination. 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 PAHP to act within required time-frames.
- For a resident of a rural area with only one PAHP, the denial of services outside the network

A member or a member's authorized representative (e.g., provider or lawyer) may file an appeal directly with the PAHP (a.k.a. first level review) or with the department (HHS). If filed with the PAHP, the PAHP has 30-days to try and resolve. If the member and/or provider is not happy with the outcome of the first level review, they may request a State Fair Hearing. See https://hhs.iowa.gov/appeals

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: Program Integrity requests recoupments/adjustments based on their data pulls (date of death, incarceration based on DOC file, etc.). Those requests would process through MMIS and would either make the pay-out amounts higher or lower depending on if they were recoupments or adjustments.

- **Current**: Payments that occur within the paid month for same month

- **Retro**: Monthly mass adjustment processes look at the last 12 months and adjust capitation claims based on any eligibility changes (gender, DOB, MCO removal, Cap group changes) the member had in that timeframe. Capitation would either be adjusted or recouped and that would make the pay-out amounts higher or lower depending on if they were recoupments or adjustments.

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 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 PAHP or the Department in order to receive payment for services rendered.

- **Paid**: Claim is received and the provider is reimbursed for the service rendered
- **Denied**: Claim is received and services are not covered benefits, duplicate, or other substantial issues that prevent payment
- **Suspended**: Pending internal review for medical necessity and/or additional information must be submitted for processing
- **Run Out**: Additional time for providers to submit claims for services rendered
- **Provider Adjustment Requests and Errors Reprocessed**:
    - Claims where the provider may request a reopening to fix clerical errors or billing errors
    - Claims identified by the PAHP 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.

Delta Dental of Iowa (**Delta**): An Iowa licensed dental insurance carrier utilized by the Department of Health and Human Services to administer assigned Dental Wellness Plan and Hawki members.

Denied Claims: See Claims

Dental Plan: see PAHP

Dental Wellness Plan (**DWP**): Medicaid Dental Coverage that is not Hawki split into

- DWP-Adults (DWP-A) those non-Hawki members 19+ and older
- DWP-Kids (DWP-K) those non-Hawki members 18 and older

Department of Human Services (**DHS**): See Health and Human Services (HHS)

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 PAHP to an alternate PAHP.

Financial Ratios: Affordable Care Act requires insurance companies to spend a certain percentage of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for PAHPs is contractually set between 89.1 and 89.5% depending on PAHP and product (Dental Wellness Plan or Hawki).

- **Administrative Loss Ratio** (**ALR**): The percent of capitated rate payments an PAHP spends on administrative costs.

- **Medical Loss Ratio** (**MLR**): The percent of capitated rate payments an PAHP 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 PAHP. 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 PAHP'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 PAHP
- Rights and dignity
- Any other access to care issues

Health and Human Services (**HHS**): On June 14, 2022, House File 2578 was signed by Iowa Governor Reynolds, creating a Department of Health and Human Services by merging Public Health (IDPH) and Human Services (DHS) into one, single, department.

Healthy and Well Kids in Iowa (**Hawki**): In Iowa, CHIP is offered through the Hawki program. Hawki offers dental coverage, through a PAHP, Delta Dental of Iowa, for uninsured children of working families. A family who qualifies for Hawki may have to pay a monthly premium.

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: The division of Health and Human Services (HHS) that administers the Iowa Medicaid Program.

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 of North America (**MCNA**): An Iowa licensed dental insurance carrier utilized by the Department of Health and Human Services to administer assigned Dental Wellness Plan Members.

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

Monthly Capitation Expenditures: See Capitation Expenditures

Non-Emergent Use: Illnesses or injuries that are generally not life-threatening and do not need immediate treatment at an Emergency Department.

Prepaid Ambulatory Health Plan (**PAHP**): A dental health insurance company retained to manage care for a segment of the population and adjudicate claims funded through capitation

Prior Authorization (**PA**): Some services or prescriptions require approval from the PAHP for them to be covered. This must be done before the member gets that service or fills that prescription.

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 PAHP has a network of providers across Iowa who their members may see for care. Members don't need to call their PAHP before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the PAHP network. There may be times when a member needs to get services outside of the PAHP 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.

Reported Reserves: Refers to an PAHPs 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.

Suspended Claims: See Claims

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 PAHP outside of the standard Medicaid benefit package. PAHPs use value added services as an incentive to attract members to their plan. Historically, dental value added services have been in the form of gift cards toward dental hygiene items.