

Iowa Medicaid Enterprise (IME)



Managed Care Organization (MCO)

Report: SFY 2021, Quarter 1

(July - September)

Performance Data

Published December 2020



Contents

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

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

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Executive Summary

This report is based on Quarter 1 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)

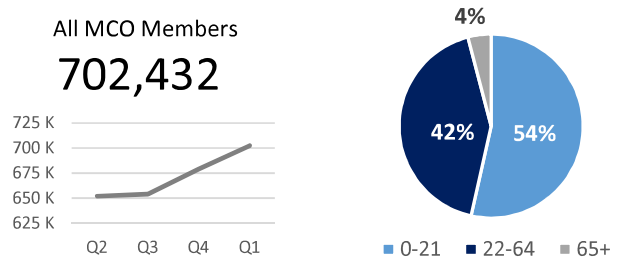
Notes about the reported data:

- 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.




+ 23,384 Members
3.44% Increase


All MCO Enrollment
(by Age)

Data Notes: September 2020 enrollment data as of October 28, 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 Q2	SFY20 Q3	SFY20 Q4	SFY21 Q1	Average	Distinct
MCO Member Summary	652,005	653,929	679,048	702,432	671,854	771,482
0-21	352,083	353,122	366,686	375,723	361,903	405,455
22-64	273,842	274,650	285,200	298,168	282,965	331,853
65+	26,080	26,157	27,162	28,541	26,985	34,174
Fee-For-Service (FFS) - Non MCO Enrollees	38,306	38,172	38,979	40,370	38,957	44,763
Significant Change in Data? (+/-) <i>If Yes, explain:</i>	No <input type="checkbox"/>	Yes <input checked="" type="checkbox"/>	Iowa Medicaid Population 816,245 1 year distinct count			
<ul style="list-style-type: none"> o MCO enrollment increased by 23,384 members (or 3.44% increase) o Since March 2020, all MCO disenrollment has been suspended because of COVID-19 						

MCO Member Summary

 Amerigroup <small>An Anthem Company</small>		SFY20 Q4	SFY21 Q1
Members		400,127	412,180
MCO Member Market Share		58.9%	58.7%
Disenrolled		-	-
Healthy and Well Kids in Iowa (Hawki) including M-CHIP (Expansion)		49,370	49,052
Long-Term Service & Support (LTSS)		23,575	23,418
HCBS Waivers		67.8%	68.0%
Facility Based Services		32.2%	32.0%
HCBS Waivers³		15,990	15,918
- Reference p. 21-22 for HCBS waiver and service plan enrollment			
Facility Based Services⁴		7,585	7,500
ICF/ID ⁵		1,033	1,041
Mental Health Institute (MHI)		10	23
Nursing Facilities (NF)		6,379	6,278
Nursing Facilities for Mentally Ill		67	69
Skilled		96	89

 iowa total care		SFY20 Q4	SFY21 Q1
Members		278,921	290,252
MCO Member Market Share		41.1%	41.3%
Disenrolled		-	-
Healthy and Well Kids in Iowa (Hawki) including M-CHIP (Expansion)		25,519	24,897
Long-Term Service & Support (LTSS)		15,405	15,294
HCBS Waivers		61.3%	64.1%
Facility Based Services		38.7%	35.9%
HCBS Waivers³		9,809	9,811
- Reference p. 21-22 for HCBS waiver and service plan enrollment			
Facility Based Services⁴		5,596	5,483
ICF/ID ⁵		620	612
Mental Health Institute (MHI)		12	12
Nursing Facilities (NF)		4,860	4,750
Nursing Facilities for Mentally Ill		29	32
Skilled		75	77

³ Home- and Community-Based Service (HCBS) totals listed above exclude Habilitation (Hab) enrollment; however, member participation in Hab services is captured on pages 21-22.

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)

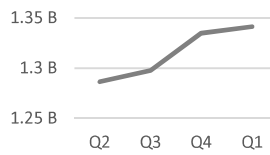
MCO Financial Summary - All MCO Counts

The MCOs receive capitation payments for the payment of 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

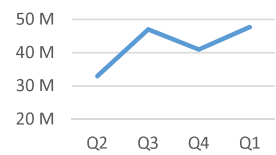
\$1.34 Billion



+ \$6 Million
0.49% Increase

Third Party Liability Recovered

\$ 47.65 Million



\$ 7 Million
16.23% increase

Data Notes: September 2020 capitation data as of October 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 Q2 SFY20 Q3 SFY20 Q4 SFY21 Q1 Average Total

Financial Summary

Capitation Payments	\$1.29 B	\$1.3 B	\$1.33 B	\$1.34 B	\$1.32 B	\$5.26 B
Third Party Liability (TPL) Recovered	\$33.12 M	\$46.41 M	\$41.63 M	\$47.65 M	\$42.20 M	\$168.81 M

Significant Change in Data? (+/-)

No Yes

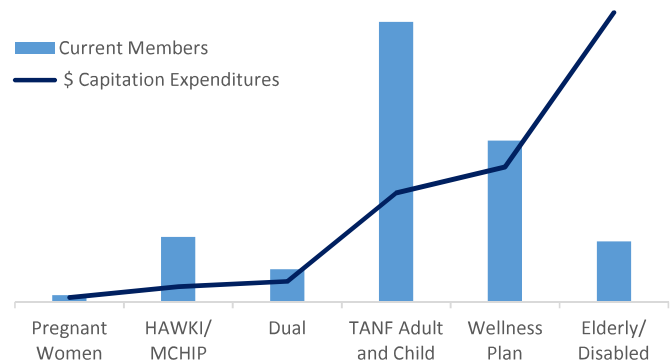
If Yes, explain:

- 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 December 2020, this withhold has 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.



SFY20 Q4 | SFY21 Q1

Capitation Totals	\$801.01 M	\$802.56 M
Adjustments	-\$709 k	-\$2.2 M
Current	\$765.46 M	\$783.29 M
Retro	\$36.26 M	\$21.48 M
Third Party Liability (TPL) Recovered	\$15.45 M	\$23.26 M
Financial Ratios		
Medical Loss Ratio (MLR)	80.5%	86.2%
Administrative Loss Ratio (ALR)	5.7%	6.7%
Underwriting Ratio (UR)	13.8%	7.1%
	Annual MLR⁶	86.2%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	Y



SFY20 Q4 | SFY21 Q1

Capitation Totals	\$533.87 M	\$538.8 M
Adjustments	-\$986 k	-\$2.04 M
Current	\$505.02 M	\$520.41 M
Retro	\$29.83 M	\$20.44 M
Third Party Liability (TPL) Recovered	\$26.18 M	\$24.40 M
Financial Ratios		
Medical Loss Ratio (MLR)	90.8%	94.8%
Administrative Loss Ratio (ALR)	5.0%	5.1%
Underwriting Ratio (UR)	4.2%	0.1%
	Annual MLR⁶	94.8%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	Y

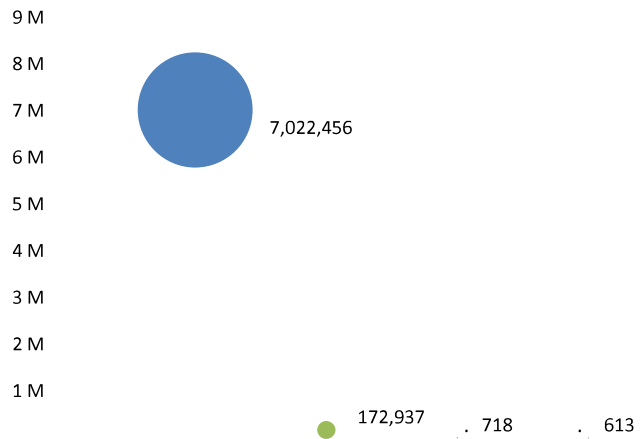
⁶ Year-to-date average that follows state fiscal year. All amounts listed are unaudited. The MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

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

● All Rx and NonRx Claims ● Prior Authorizations
● Grievances ● Appeals



	% of Claims Universe
Prior Authorizations	2.46%
Grievances	0.01%
Appeals	0.01%

	SFY20 Q2	SFY20 Q3	SFY20 Q4	SFY21 Q1	Average	Total
Claim Counts - All Paid & Denied (p. 9-12)	6.78 M	7.79 M	5.95 M	7.02 M	6.89 M	27.55 M
Non-Pharmacy	3.99 M	4.62 M	3.17 M	4.02 M	3.95 M	15.80 M
Pharmacy	2.79 M	3.17 M	2.79 M	3.00 M	2.94 M	11.75 M
Prior Authorization Summary (p. 13-14)	217,007	178,919	145,452	172,937	178,579	714,315
Non-Pharmacy - All PAs Submitted	159,522	137,044	115,665	133,417	136,412	545,648
Pharmacy - All PAs Submitted	57,485	41,875	29,787	39,520	42,167	168,667
Grievances & Appeals Summary (p. 15-16)						
Grievances	1,066	936	422	718	786	3,142
Appeals	554	612	577	613	589	2,356

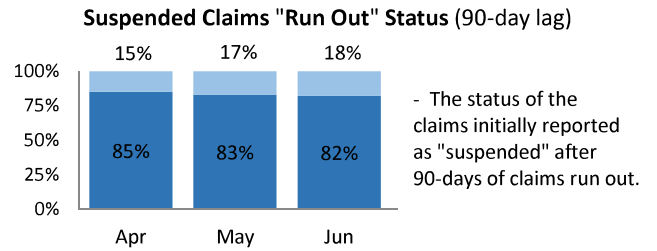
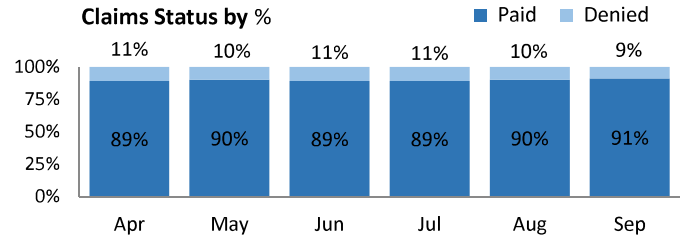
Claims Summary (Non-Pharmacy)

2.11 Million
Claims Paid & Denied



	July	Aug	Sept
--	------	-----	------

	July	Aug	Sept
All Claims			
Paid	605,261	590,456	700,395
Denied	71,964	67,844	73,076
Suspended	155,641	154,521	129,102
Clean Claims Processed			
in 30-days (Requirement 90%)	99%	98%	99%
in 45-days (Requirement 95%)	99%	99%	100%
Average Days to Pay	8	9	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%



Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
1.	26%	Duplicate claim service
2.	11%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	8%	Expenses incurred after coverage terminated
4.	8%	Service not payable per managed care contract
5.	7%	Precertification/authorization/notification absent
6.	6%	The impact of prior payer(s) adjudication including payments and/or adjustments.
7.	5%	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication.
8.	5%	An attachment/other documentation is required to adjudicate this claim/service
9.	5%	The time limit for filing has expired
10.	2%	Claim/service lacks information or has submission/billing error(s) which is needed for adjudication

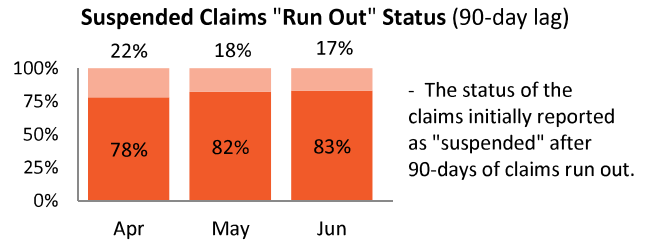
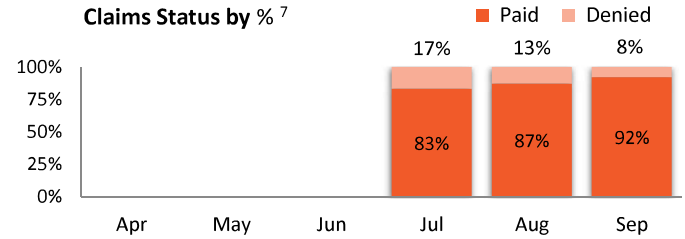
Claims Summary (Non-Pharmacy)

1.91 Million
Claims Paid & Denied



July Aug Sept

All Claims	July	Aug	Sept
Paid	541,872	387,852	744,650
Denied	114,298	57,113	66,183
Suspended	144,265	144,367	83,099
Clean Claims Processed ⁷			
in 30-days (Requirement 90%)	86%	95%	96%
in 45-days (Requirement 95%)	92%	97%	98%
Average Days to Pay ⁷	18	14	12
Provider Adjustment Requests & Errors Reprocessed in 30-days	90%	97%	99%



Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
1.	27%	Duplicate claim service
2.	11%	No authorization on file that matches service(s) billed
3.	8%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
4.	5%	Procedure coverage not defined by Medicaid; Provider to resubmit
5.	5%	National Drug Code (NDC) missing/invalid or not appropriate for procedure
6.	5%	CMS Medicaid National Correct Coding Initiative (NCCI) unbundling
7.	4%	Advanced claim edits (ACE) claim level return to provider
8.	3%	Referring provider not registered with IA DHS/Iowa Medicaid
9.	3%	ACE line item denial
10.	3%	Ancillary charges not separately Payable

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

As of **Q1 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.

- o **July:** 8,985
- o **August:** 13,108
- o **September:** 7,827

Claims Summary (Pharmacy)

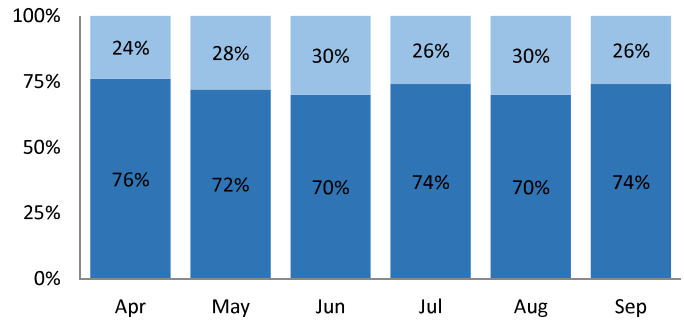


1.68 Million
Claims Paid & Denied

	July	Aug	Sept
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All Claims (Pharmacy)			
Paid	435,473	342,230	442,664
Denied	154,247	146,088	154,474
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay			
	12	11	12

Claims Status by %
■ Paid ■ Denied



Top 10 Reasons for Claims Denials (Pharmacy)

	%	Reason
1.	43%	Refill too soon
2.	15%	Submit bill to other processor or primary payer
3.	14%	Prior authorization required
4.	8%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	2%	M/I other payer reject code
7.	2%	Filled after coverage terminated
8.	2%	Non matched prescriber ID
9.	2%	MA not covered; Plan exclusion
10.	1%	Discontinued National Drug Code (NDC)

Claims Summary (Pharmacy)



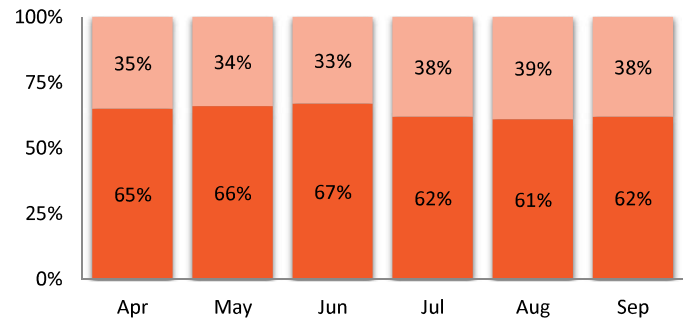
1.33 Million
Claims Paid & Denied

	July	Aug	Sept
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All Claims (Pharmacy)			
Paid	274,930	280,805	265,686
Denied	166,492	177,877	160,526
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	3

Claims Status by %

■ Paid ■ Denied



Top 10 Reasons for Claims Denials (Pharmacy)

	%	Reason
1.	26%	Refill too soon
2.	10%	Prior authorization required
3.	3%	Quantity dispensed exceeds maximum allowed
4.	3%	Claim not processed
5.	3%	Product not on formulary
6.	2%	Submit bill to other processor or primary payer
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Filled after coverage expired
9.	2%	Drug not covered for patient age
10.	1%	National Drug Code (NDC) not covered

Prior Authorization Summary

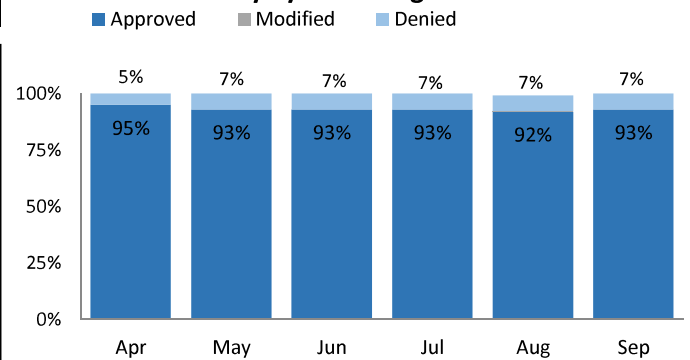
79,407
All PAs Submitted⁸



Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	17,959	15,898	18,318
Denied	1,369	1,269	1,353
Modified	40	52	48
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%	99.3%

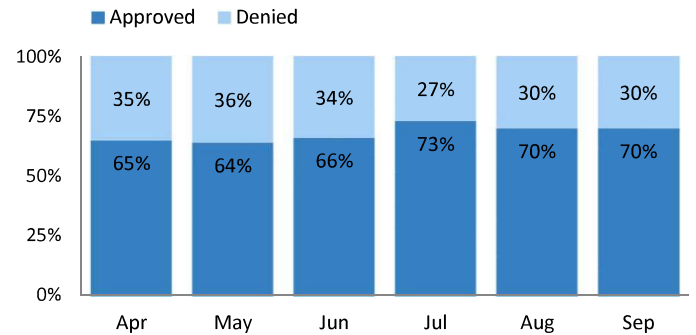
Non-Pharmacy by Percentage



Pharmacy

	July	Aug	Sept
Prior Authorizations			
Approved	6,148	5,117	5,110
Denied	309	2,164	2,232
PAs Completed in 24-hours (Requirement 100%)	100%	99.9%	100%

Pharmacy by Percentage



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

93,530

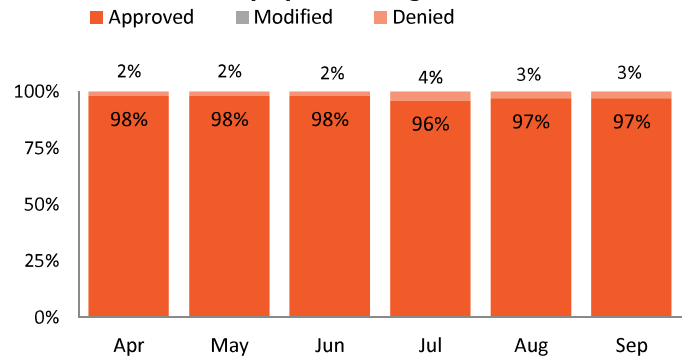
All PAs Submitted⁸



Non-Pharmacy

	July	Aug	Sept
Standard Prior Authorizations (PAs)			
Approved	23,294	23,820	26,906
Denied	876	783	858
Modified	0	0	0
Average Days to Process	3	3	3
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%

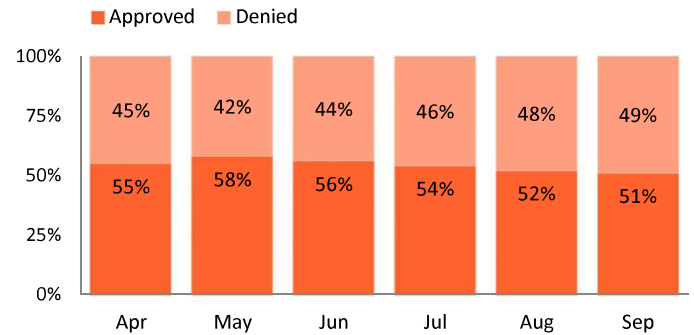
Non-Pharmacy by Percentage



Pharmacy

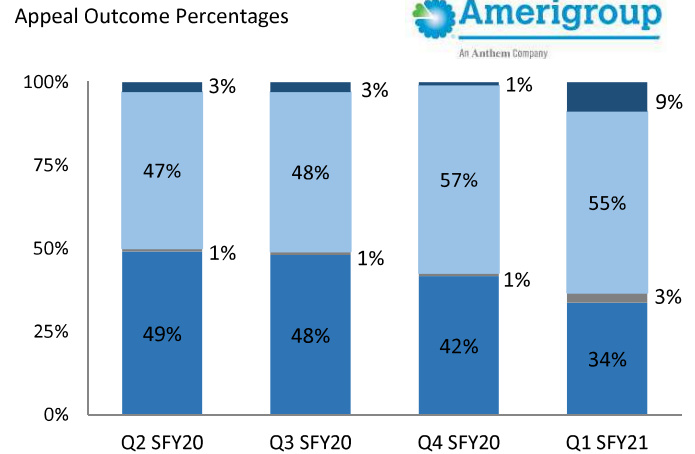
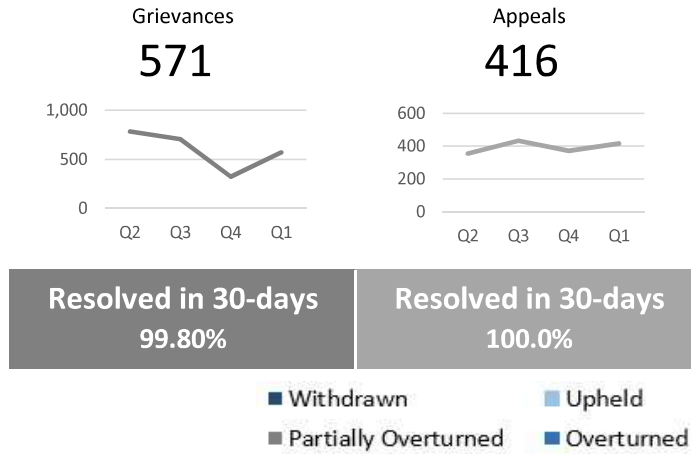
	July	Aug	Sept
Prior Authorizations			
Approved	2,801	2,348	2,492
Denied	2,351	2,136	2,407
PAs Completed in 24-hours (Requirement 100%)	100%	100%	100%

Pharmacy by Percentage



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



		Top 10 Reasons for Grievances	
	%		
1.	37%	Voluntary Disenrollment	
2.	13%	Provider balance billed	
3.	12%	Transportation - Driver no-show	
4.	9%	Transportation - Driver Delay	
5.	5%	Treatment Dissatisfaction	
6.	5%	Adequacy of treatment record keeping	
7.	4%	Provider attitude/rudeness	
8.	3%	Transportation - Unsafe Driving	
9.	2%	Availability of appointments	
10.	2%	Inadequate benefit access	

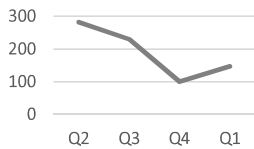
		Top 10 Reasons for Appeals	
	%		
	21%	Durable Medical Equipment (DME)	
	16%	Pharmacy - Non Injectable	
	12%	Radiology	
	9%	Pharmacy - Injectable	
	7%	Surgery	
	7%	Behavioral Health (BH) - Op Service	
	7%	Therapy - Physical Therapy	
	3%	BH - Inpatient	
	3%	Other	
	3%	Outpatient Services - Medical	

Grievances and Appeals



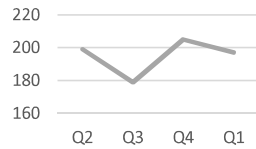
Grievances

147



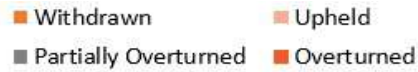
Appeals

197

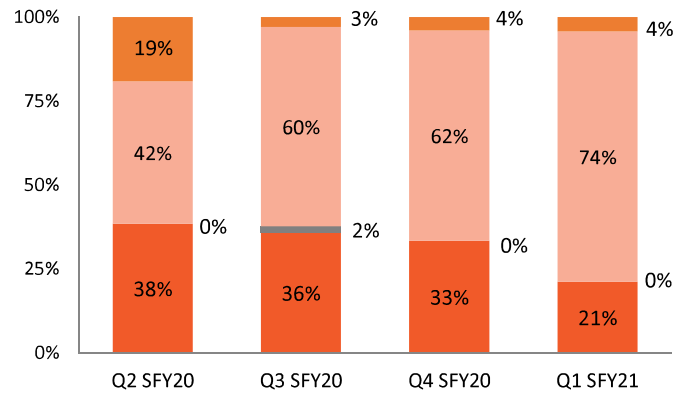


Resolved in 30-days
100%

Resolved in 30-days
100.0%



Appeal Outcome Percentages



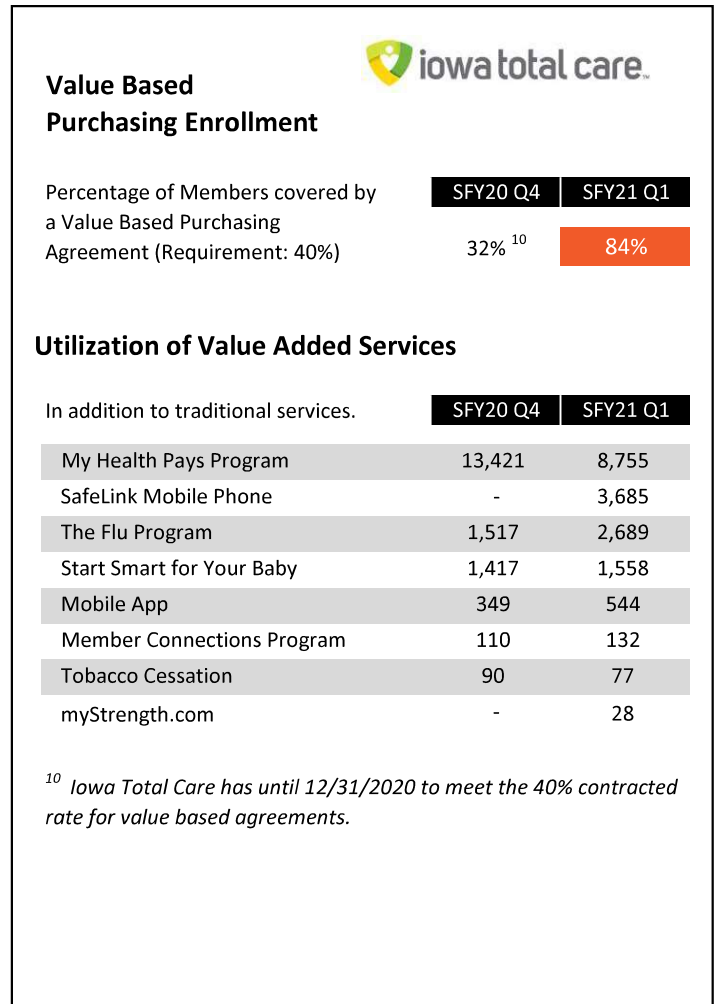
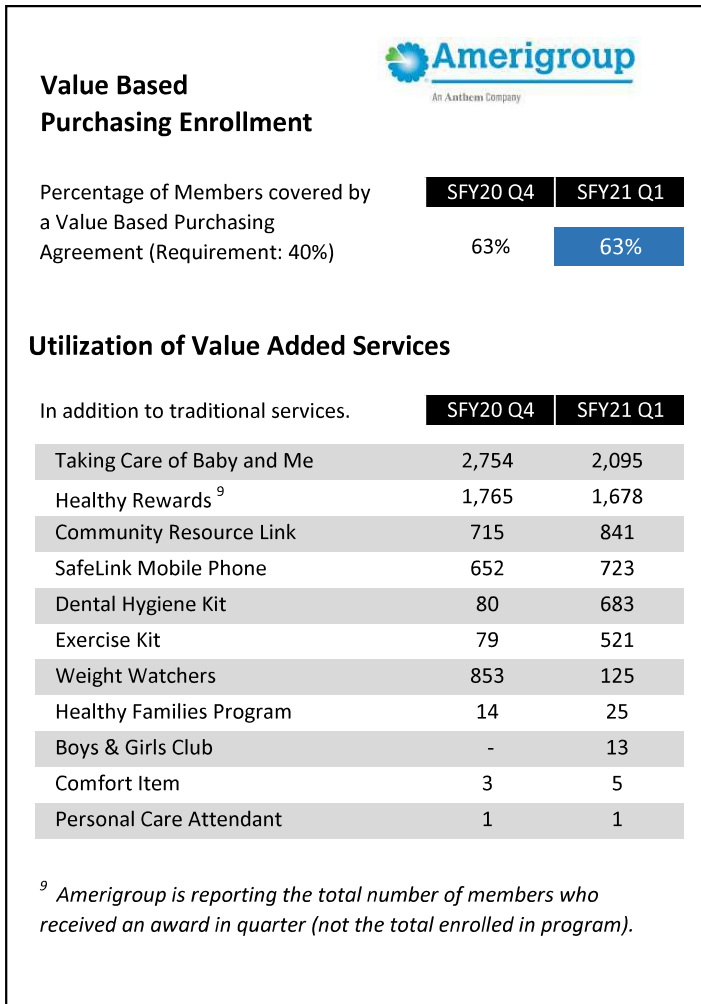
Top 10 Reasons for Grievances

	%	Reason
1.	25%	Access to Care - Network Availability
2.	20%	Unhappy with Benefits
3.	8%	Transportation - General Complaint Vendor
4.	5%	Provider
5.	4%	Transportation - Unsafe Driving
6.	4%	Health Plan Staff
7.	4%	Transportation - Missed Appointment
8.	3%	Lack of Caring/Concern
9.	3%	Transportation - General Complaint Vendor/CSR
10.	2%	Transportation - Driver did not show

Top 10 Reasons for Appeals

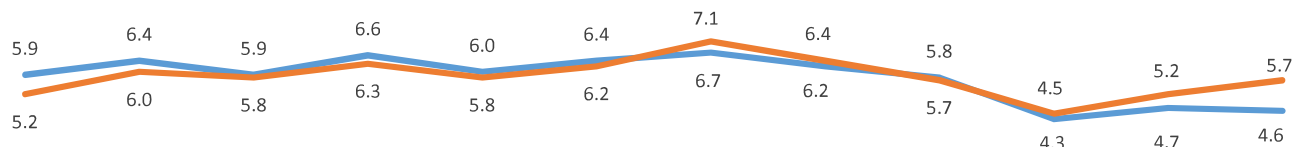
	%	Reason
	28%	RX - Does Not Meet Prior Auth Guidelines
	17%	Other - Mental Health Service
	5%	DME - Other
	4%	DME - Wheelchair
	3%	DME - Orthopedic Devices
	3%	DME - Wheelchair Accessories
	3%	Diagnostic - CAT Scan
	2%	Therapy - Physical Therapy
	2%	DME - Pneumatic Compressor/Appliance
	2%	Diagnostic - MRI

MCO Care Quality and Outcomes

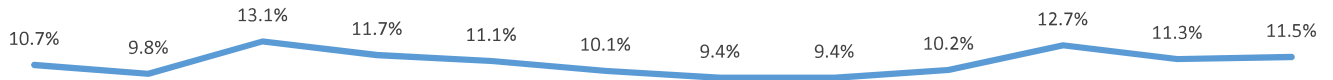


MCO Care Quality and Outcomes

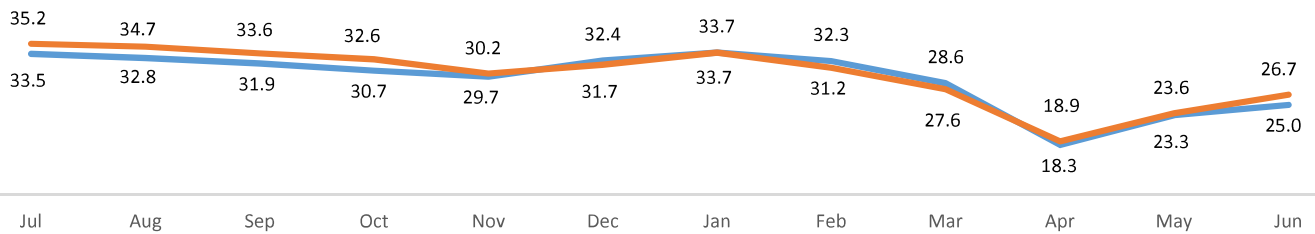
Inpatient Admissions per 1,000 Members per Month (90-day lag)



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



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



¹¹ This measure requires 12 months of continuous enrollment with the MCO. ITC data will first be available Q2 SFY2021.

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

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

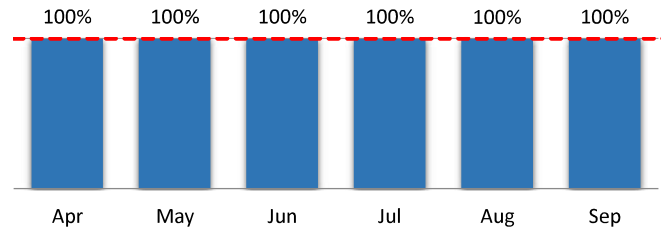


Average Number of Contacts Per Month	SFY20 Q4	SFY21 Q1
by Care Coordinators	0.9	0.8
by Case Managers	1.3	1.2
"Members to" Ratios		
Members to Care Coordinators	14	16
HCBS Members to Case Managers	65	65

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.

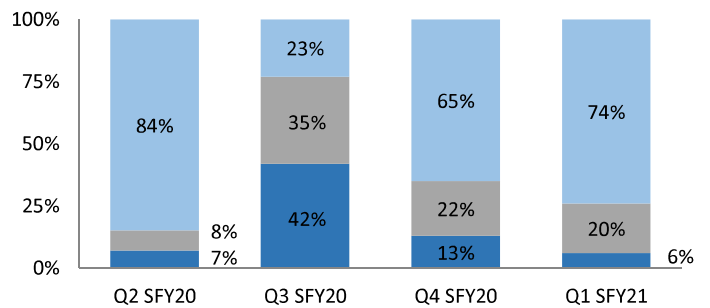
Percentage of Level of Care (LOC) Reassessments Completed Timely

--- Contract Requirement: 100%



Waiver Service Plan Outcomes

■ Reduction ■ Increase ■ No Change



Iowa Participant Experience Survey (IPES)			
Waiver members reporting...		SFY20 Q4	SFY21 Q1
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	1.5%	0.3%
	Sometimes	0.0%	0.0%
	Yes	98.5%	99.7%
Their services make their lives better.	I don't know	0.0%	0.0%
	No	0.3%	0.3%
	Sometimes	0.6%	0.0%
	Yes	99.1%	99.7%

Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

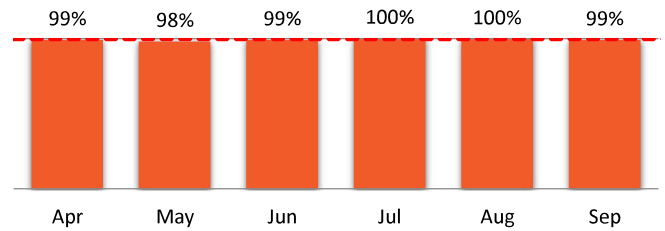


Average Number of Contacts Per Month	SFY20 Q4	SFY21 Q1
by Care Coordinators	0.8	0.8
by Case Managers	1.0	1.0
"Members to" Ratios		
Members to Care Coordinators	75	36
HCBS Members to Case Managers	38	38

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

Percentage of Level of Care (LOC) Reassessments Completed Timely

--- Contract Requirement: 100%

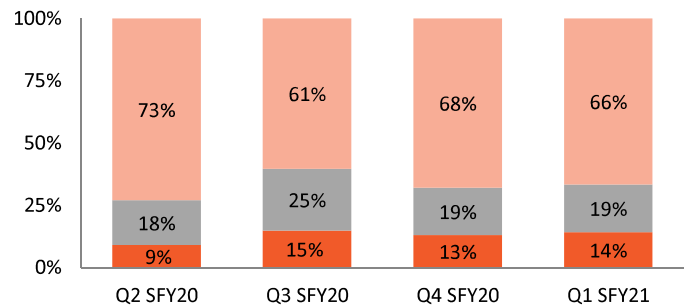


Iowa Participant Experience Survey (IPES)

Waiver members reporting...		SFY20 Q4	SFY21 Q1
They were part of service planning.	I don't know	1.1%	0.4%
	No	4.3%	5.2%
	Sometimes	2.1%	1.1%
	Yes	92.6%	93.3%
They feel safe where they live.	I don't know	3.2%	0.8%
	No	2.1%	2.3%
	Sometimes	3.2%	1.9%
	Yes	91.5%	95.1%
Their services make their lives better.	I don't know	1.1%	1.1%
	No	1.1%	1.9%
	Sometimes	4.3%	2.6%
	Yes	93.6%	94.4%

Waiver Service Plan Outcomes

■ Reduction ■ Increase ■ No Change



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



	SFY20 Q4	SFY21 Q1		SFY20 Q4	SFY21 Q1
AIDS/HIV - Unique Service Plans	19	19	Habilitation (Hab)	4,837	4,786
Home Delivered Meals	15	16	Supported Community Living (daily)	3,676	3,816
Supported Community Living (daily)	3	1	Home Health Aide	791	593
CDAC (agency) by 15 minute units	1	1	Long Term Job Coaching	474	403
CDAC (individual) by 15 minute units	3	-	Day Habilitation	161	213
-	-	-	Individual Supported Employment	188	184
Brain Injury (BI) Waivers	833	831	Health & Disability (HD)	1,412	1,394
Financial Management Services	240	236	Financial Management Services	379	374
Supported Community Living (by unit)	218	224	Home Delivered Meals	376	370
Respite (by 15 minute units)	178	174	Respite (by 15 minute units)	359	364
Personal Emergency Response	164	162	Personal Emergency Response	361	363
Supported Community Living (daily)	105	107	Respite (by 15 minute units)	75	67
Children's Mental Health (CMH)	894	879	Intellectual Disability (ID)	7,153	7,150
Respite (by 15 minute units)	444	441	Supported Community Living (daily)	2,133	1,965
Family and Community Support	281	271	Supported Community Living (by unit)	1,954	1,886
Respite (by 15 minute units)	253	245	Day Habilitation	1,668	1,551
Respite (Resident Camp) by units	25	18	Financial Management Services	1,376	1,376
Respite (Resident Camp) by day	11	12	Long Term Job Coaching	1,006	980
Elderly Waivers	4,904	4,886	Physical Disability (PD)	775	759
Home Delivered Meals	3,244	3,213	Personal Emergency Response	398	402
Personal Emergency Response	3,131	3,144	Personal Emergency Response (install)	101	75
Assisted Living Services	439	437	CDAC (agency) by 15 minute units	135	70
Personal Emergency Response (install)	388	343	Supported Community Living (daily)	58	60
CDAC (agency) by 15 minute units	601	319	Home Delivered Meals	108	55

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



	SFY20 Q4	SFY21 Q1		SFY20 Q4	SFY21 Q1
AIDS/HIV - Unique Service Plans	12	13	Habilitation (Hab)	2,381	2,395
Home Delivered Meals	6	7	Supported Community Living (daily)	1,678	1,851
CDAC (individual) by 15 minute units	5	6	Integrated Health Home Services	1,820	1,836
Supported Community Living (daily)	2	2	Home Health Aide	364	354
Homemaker (by 15 minute units)	1	2	Day Habilitation	281	271
Day Habilitation	1	1	Long Term Job Coaching	217	233
Brain Injury (BI) Waivers	532	531	Health & Disability (HD)	644	645
Supported Community Living (by unit)	232	233	Respite (by 15 minute units)	297	297
Respite (by 15 minute units)	156	157	Home Delivered Meals	194	203
Personal Emergency Response	119	127	Personal Emergency Response	179	180
Supported Community Living (daily)	118	119	CDAC (individual) by 15 minute units	131	130
Transportation (1-way trip)	95	92	CDAC (agency) by 15 minute units	113	111
Children's Mental Health (CMH)	351	351	Intellectual Disability (ID)	4,534	4,524
Integrated Health Home Services	245	249	Supported Community Living (by unit)	1,945	1,949
Respite (by 15 minute units)	164	173	Home Health Aide	1,927	1,912
Respite (by 15 minute units)	90	96	Day Habilitation	1,792	1,778
Family and Community Support	82	85	Supported Community Living (RCF)	1,509	1,490
Respite (Resident Camp) by units	6	7	Respite (by 15 minute units)	1,067	1,075
Elderly Waivers	3,315	3,336	Physical Disability (PD)	421	411
Home Delivered Meals	2,480	2,548	Personal Emergency Response	238	244
Personal Emergency Response	2,382	2,451	CDAC (agency) by 15 minute units	199	204
CDAC (agency) by 15 minute units	1,238	1,285	CDAC (individual) by 15 minute units	138	144
Homemaker (by 15 minute units)	893	914	Transportation (1-way trip)	56	56
CDAC (individual) by 15 minute units	775	778	Personal Emergency Response (install)	49	40

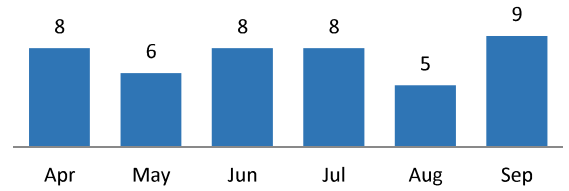
Call Center Performance Metrics



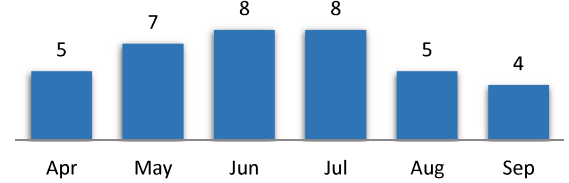
Jul Aug Sept

	Jul	Aug	Sept
Member Helpline			
Service Level (Requirement 80%)	91.51%	97.45%	98.48%
Abandonment Rate - Must be 5% or less	0.65%	1.20%	0.71%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	96.10%	97.64%	82.65%
Abandonment Rate - Must be 5% or less	0.12%	0.00%	0.06%
Provider Helpline			
Service Level (Requirement 80%)	89.06%	97.10%	97.27%
Abandonment Rate - Must be 5% or less	0.29%	0.51%	0.10%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	85.94%	91.29%	93.07%
Abandonment Rate - Must be 5% or less	1.17%	0.80%	0.47%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	80.80%	69.69%	78.81%
Abandonment Rate - Must be 5% or less	0.44%	0.60%	0.46%

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)

- Benefit Inquiry
- ID Card Request or Inquiry
- Enrollment Information
- Claim Inquiry
- Coordination of Benefits or OHI

Top 5 Call Reasons (Provider Helpline)

- Authorization Status
- Benefit Inquiry
- Claim Status
- Authorization New
- Enrollment Inquiry

Call Center Performance Metrics

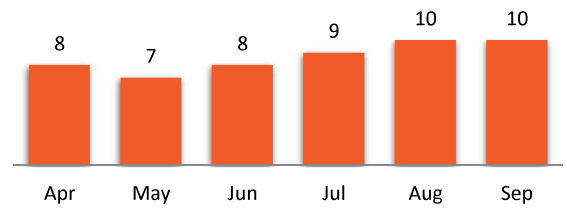


	Jul	Aug	Sept
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Member Helpline			
Service Level (Requirement 80%)	90.00%	83.21%	87.90%
Abandonment Rate - Must be 5% or less	3.28%	7.04%	3.84%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	81.34%	75.37%	78.61%
Abandonment Rate - Must be 5% or less	4.97%	7.87%	4.56%
Provider Helpline			
Service Level (Requirement 80%)	84.47%	71.25%	81.61%
Abandonment Rate - Must be 5% or less	2.37%	7.48%	2.61%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	95.49%	90.51%	85.80%
Abandonment Rate - Must be 5% or less	1.48%	2.19%	2.55%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	90.97%	86.51%	83.02%
Abandonment Rate - Must be 5% or less	1.19%	1.13%	1.69%

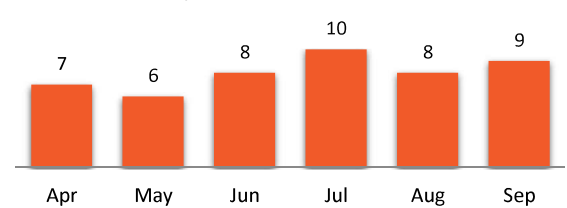
Secret Shopper Scores

- 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)

- Benefits and Eligibility for Member
- Coordination Of Benefits for Member
- Update PCP/PPG for Member
- Member Rewards for Member
- Order ID card

Top 5 Call Reasons (Provider Helpline)

- Medical Claims Inquiry for Provider
- Coordination Of Benefits for Provider
- Benefits and Eligibility for Provider
- Provider Outreach for Provider
- View Authorization for Provider

Provider Network Access Summary



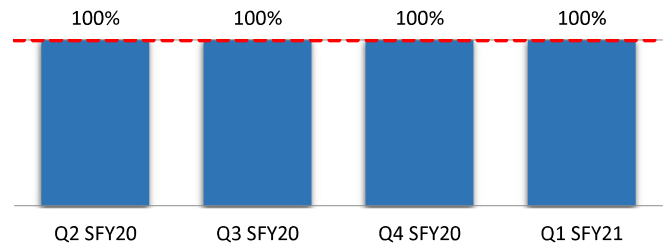
Primary Care Providers (PCP)

SFY20 Q4 | SFY21 Q1

Adults PCP		
Provider Count	-	6,591
Members with Access	-	204,945
Average Distance (Miles)	-	1.5
Pediatric PCP		
Provider Count	-	6,634
Members with Access	-	204,867
Average Distance (Miles)	-	1.6

Adult PCP - Time Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



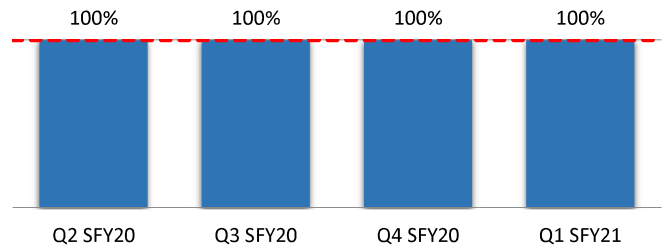
Specialty Care & Behavioral Health (BH)

SFY20 Q4 | SFY21 Q1

OB/GYN Adult		
Provider Count	-	400
Members with Access	-	134,256
Average Distance (Miles)	-	5.7
Outpatient - Behavioral Health		
Provider Count	-	4,000
Members with Access	-	409,812
Average Distance (Miles)	-	2.1
Inpatient - Behavioral Health		
Provider Count	-	49
Rural Members		
Members with Access	-	168,321
Average Distance (Miles)	-	21.4
Urban Members		
Members with Access	-	241,491
Average Distance (Miles)	-	5.7

Pediatric PCP - Time Standards 30 minutes or 30 miles

--- Contract Requirement: 100%



Link to Geo Access Reports:

<https://dhs.iowa.gov/ime/about/performance-data-geoaccess>

Provider Network Access Summary

Primary Care Providers (PCP)

SFY20 Q4 | SFY21 Q1

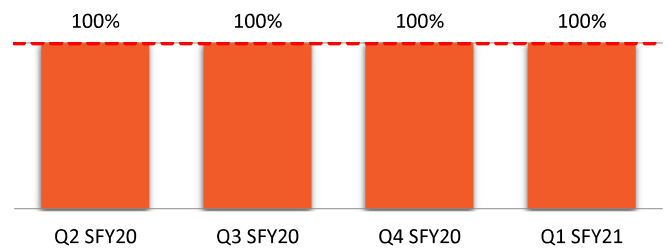


Adults PCP	
Provider Count	- 8,301
Members with Access	- 212,044
Average Distance (Miles)	- 2.0
Pediatric PCP	
Provider Count	- 8,986
Members with Access	- 75,020
Average Distance (Miles)	- 2.2

Adult PCP - Time Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



Specialty Care & Behavioral Health (BH)

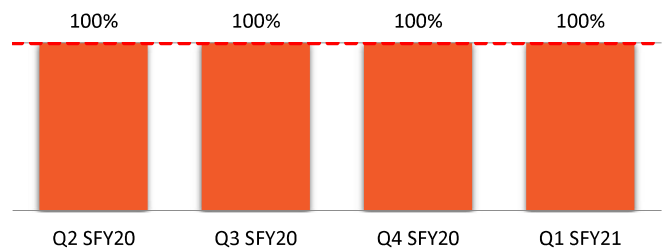
SFY20 Q4 | SFY21 Q1

OB/GYN Adult	
Provider Count	- 1,183
Members with Access	- 131,186
Average Distance (Miles)	- 5.5
Outpatient - Behavioral Health	
Provider Count	- 7,842
Members with Access	- 287,070
Average Distance (Miles)	- 2.6
Inpatient - Behavioral Health	
Provider Count	- 35
Rural Members	
Members with Access	- 205,468
Average Distance (Miles)	- 24.7
Urban Members	
Members with Access	- 81,602
Average Distance (Miles)	- 8.3

Pediatric PCP - Time Standards

30 minutes or 30 miles

--- Contract Requirement: 100%



Link to Geo Access Reports:

<https://dhs.iowa.gov/ime/about/performance-data-geoaccess>

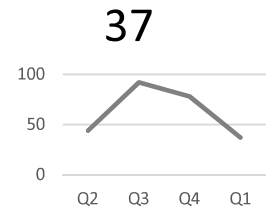
MCO Program Integrity

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

Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

The billing process generates the core information for program integrity activities. Claims payment and claims history provide information leading to the identification of potential fraud, waste, and abuse. Therefore MCO investigations, overpayment recovery, and referrals to MFCU listed in this chart would be considered pending until final determinations are made.

Total Investigations Opened



7 Total Cases
Referred to MCFU



Program Integrity

- Fraud, Waste, & Abuse

	SFY20 Q4	SFY21 Q1
Investigations opened	72	28
Overpayments identified	14	23
Member concerns referred to IME	5	6
Cases referred to the Medicaid Fraud Control Unit (MCFU)	4	6



Program Integrity

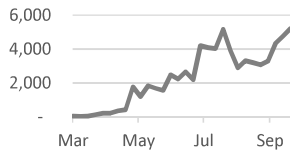
- Fraud, Waste, & Abuse

	SFY20 Q4	SFY21 Q1
Investigations opened	6	9
Overpayments identified	2	0
Member concerns referred to IME	4	8
Cases referred to the Medicaid Fraud Control Unit (MCFU)	3	1

MCO COVID-19 Summary

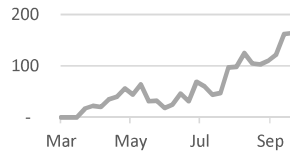
Total Individuals Tested

70,984



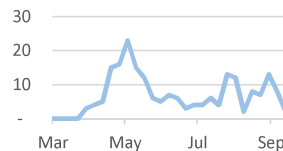
Total Tested Positive

1,787



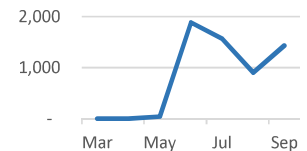
Total COVID Deaths

217



Total COVID Inpatient Stays¹³

5,826



+ 51,387 Tested
174% Increase

2.5%
% Tested Positive

0.03%
% of MCO Population

3.31%
% 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.¹³ Reported counts include patients initially hospitalized as "expected positive", but may have never tested positive.

Claims Activity During COVID-19

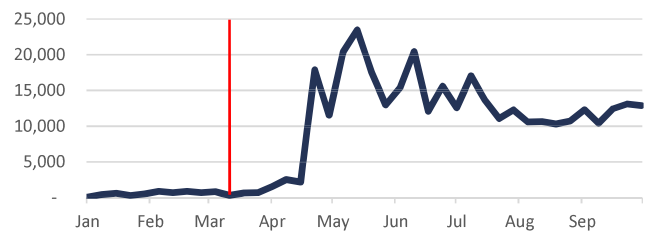
MCO Total Counts

Q4 SFY20

Q1 SFY21

ER Visits - Counts	195,982	318,723
Amount Paid	\$39.05 M	\$66.78 M
Telehealth Services - Counts	184,528	157,524
Amount Paid	\$14.97 M	\$14.17 M
Transportation Claims - Counts	145,130	188,835
Amount Paid	\$6.7 M	\$9.46 M
Home Maker Services - Counts	6,260	6,301
Amount Paid	\$940 k	\$1.18 M
COVID Testing - Counts	18,770	51,387
Amount Paid	\$1.25 M	\$6.02 M
Meals - Counts	20,940	21,277
Amount Paid	\$4.57 M	\$6.53 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/ID 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/ID 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