Managed Care Organization (MCO)
Report: SFY 2022, Quarter 2
(Oct – Dec 2021)

Executive Summary

The SFY22 Q2 report is a comprehensive review of key metrics focused on consumer protection, outcome achievement, and program integrity.

Member Summary (**p. 4-5**):

- **Enrollment**:
  - Current MCO enrollment is 775,507 members
  - Enrollment has increased by **9,240** members or **1.21%** between Q1 & Q2 (766,267 to 775,507)
- **Disenrollment**:
  - Disenrollment stabilized between Q1 and Q2 because open enrollment ended
  - The Department resumed some Medicaid eligibility processes currently suspended under the PHE. See DHS website for additional information.

Financial Summary (**p. 6-7**):

- **Third Party Liability** (**TPL**):
  - TPL decreased by **$2.9M** or **5.35%** between Q1 and Q2
- **Medical Loss Ratio** (**MLR**):
  - The projected timeframe to complete the final MLR reconciliation for last year's data (SFY21) is September 2022

Pharmacy Prior Authorization (**PA**) **Summary** (**p. 14**): Federal requirement to be completed within 24 hours and at 100% (No rounding).

- **AGP – December**: Completed 8,399 of 8,404 = **99.9%**
- **ITC - October**: Completed 4,880of 4,882 = **99.9%**
- **ITC - November**: Completed 5,606 of 5,613 = **99.8%**
  - In November it was determined that there were insufficient staffing levels to address the workload. ITC has since increased and rededicated staff to prevent this going forward.

Value Added Services (**p.17**):

- The Flu Program: increased from 759 to 14,683 due to ITC outreach to remind members of the importance of getting a flu shot.

Call Center Performance Metrics (**p. 25-26**):

- **AGP – NEMT Helpline:**:
  - **October – service level at 47.7%, abandonment rate reported at 6.56% -** due to increase in average absentee rate during the month (absenteeism across A2C was up 3% from Sept. to Oct.)
- **ITC** - **NEMT Helpline**:
  - **October service level at 45.36% -**The root cause is tied to high turnover and absenteeism of member service associates, high call volumes and increased handle times, the loss of agents to state run COVID call centers, and an increase in transportation demands due to an improved COVID situation.
  - To address the missed metrics, ITC sent A2C a notice of noncompliance, requested a remediation plan, and issued a penalty. A2c's remedies included continued hiring, re-instituting a regional service model, reinforcing quality, re-training staff, and developing incentive programs to encourage attendance and boost productivity. The level metric was met in November and December 2021.

Iowa Medicaid Enterprise (IME)

Managed Care Organization (MCO)

Report: SFY 2022, Quarter 2

(October - December 2021)

Performance Data

Published March 2022

Department of HUMAN SERVICES

Contents

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

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

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Executive Summary

This report is based on Quarter 2 of State Fiscal Year (SFY) 2022 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.
- 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: https://dhs.iowa.gov/iahealthlink

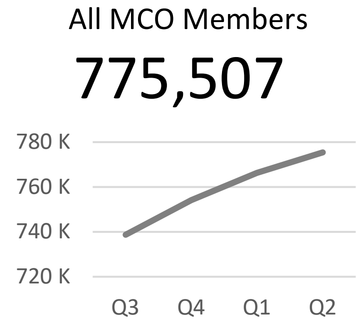
MCO Member Summary - All MCO Counts

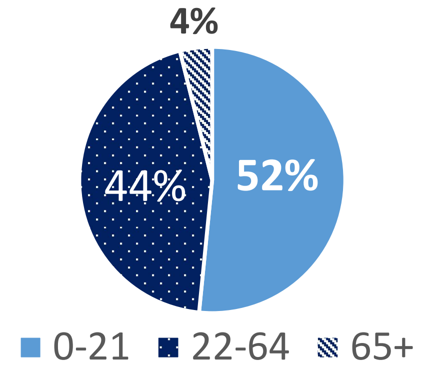
Managed Care Organizations (MCOs) offer health insurance benefits for those adults and families that qualify for the IA Health Link (Medicaid) and the Healthy and Well Kids in Iowa (Hawki) programs.

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

All MCO Members

775,507





+ 9,240 Members
1.21% Increase

All MCO Enrollment
(by Age)

Data Notes: December 2021 enrollment data as of February 2022. The "Distinct" column represents the total number of unique individuals appearing at least once during the past four-quarters.

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2	Average	Distinct
MCO Member Summary - *Overall Counts*	738,739	754,103	766,267	**775,507**	758,654	**811,293**
0-21	388,655	393,703	397,383	400,213	394,989	417,320
22-64	321,248	330,873	338,971	345,001	334,023	360,102
65+	28,836	29,527	29,913	30,293	29,642	33,871
Fee-For-Service (FFS) - *Non MCO Enrollees*	42,216	43,938	45,062	**46,254**	44,368	**50,005**

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

If Yes, explain:

Iowa Medicaid Population **861,298**
1 year distinct count

o Disenrollment decreased from Q1 to Q2 due to the end of open enrollment.

MCO Member Summary

	SFY22 Q1	SFY22 Q2
All Members - *by MCO*	445,169	447,581
Traditional Medicaid	273,370	274,834
Wellness Plan - IHAWP/Expansion	124,002	126,843
M-CHIP - Expansion	7,479	7,833
Healthy and Well Kids in Iowa (Hawki)	40,318	38,071
MCO Member Market Share	58.1%	57.7%
Disenrolled	1,157	599

	SFY22 Q1	SFY22 Q2
Long-Term Service & Support (LTSS)	22,219	21,662
HCBS Waivers	68.6%	69.2%
Facility Based Services	31.4%	30.8%
HCBS Waivers [1]	15,237	14,985
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	6,982	6,677
ICF/ID [3]	982	967
Mental Health Institute (MHI)	38	36
Nursing Facilities (NF)	5,804	5,534
Nursing Facilities for Mentally Ill	71	58
Skilled	87	82

	SFY22 Q1	SFY22 Q2
All Members - *by MCO*	321,098	327,926
Traditional Medicaid	198,160	201,591
Wellness Plan - IHAWP/Expansion	100,062	103,988
M-CHIP - Expansion	6,325	6,587
Healthy and Well Kids in Iowa (Hawki)	16,551	15,760
MCO Member Market Share	41.9%	42.3%
Disenrolled	914	403

	SFY22 Q1	SFY22 Q2
Long-Term Service & Support (LTSS)	14,735	14,551
HCBS Waivers	65.0%	65.7%
Facility Based Services	35.0%	34.3%
HCBS Waivers [1]	9,571	9,561
- Reference p. 23-24 for HCBS waiver and service plan enrollment		
Facility Based Services [2]	5,164	4,990
ICF/ID [3]	594	572
Mental Health Institute (MHI)	33	23
Nursing Facilities (NF)	4,432	4,298
Nursing Facilities for Mentally Ill	36	32
Skilled	69	65

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

[2] 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 (689) and Psychiatric Medical Institutions for Children (PMICs - 300).

[3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID).

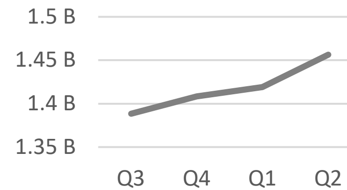
MCO Financial Summary - All MCO Counts

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

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

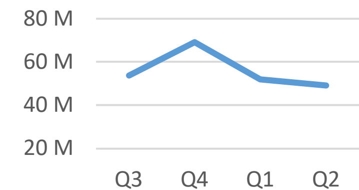
All Capitation Payments

$1.46 Billion



Third Party Liability Recovered

$49.17 Million



+ $37.7 Million
2.66% Increase

- $ 2.9 Million
5.35% decrease

Data Notes: December 2021 capitation data as of February 2022. All Third Party Liability (TPL) data reported above is self-reported by MCOs. The "Average" column below represents a four-quarter rolling average while the "Total" column represents the sum of the past four-quarters.

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2	Average	Total
Financial Summary						
Capitation Payments	$1.39 B	$1.41 B	$1.42 B	**$1.46 B**	$1.42 B	$5.67 B
Third Party Liability (TPL) Recovered	$53.73 M	$69.23 M	$51.95 M	**$49.17 M**	$56.02 M	$224.08 M

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

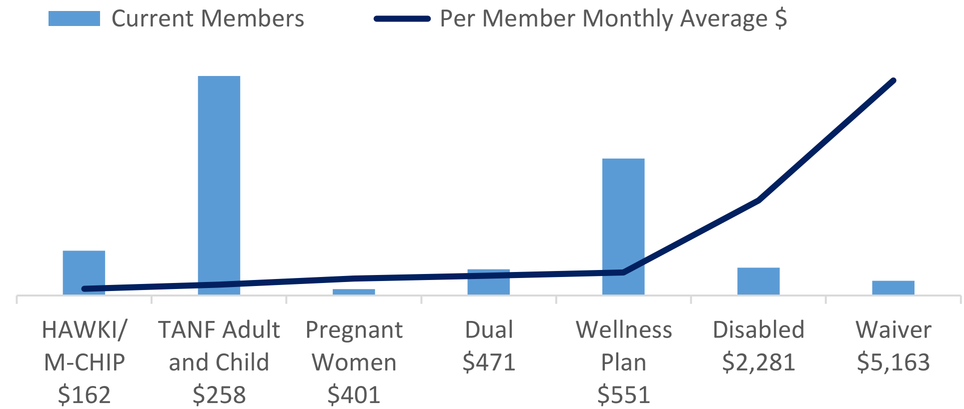
If Yes, explain:

o TPL decreased by $2.9M or 5.35% between Q1 and Q2.

MCO Financial Summary

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

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



	SFY22 Q1	SFY22 Q2
Capitation Totals	$832.22 M	**$851.01 M**
Adjustments	-$2.07 M	$5.38 M
Current	$814.65 M	$825.03 M
Retro	$19.64 M	$20.61 M
Third Party Liability (TPL) Recovered	$15.35 M	**$16.51 M**
Financial Ratios		
Medical Loss Ratio (MLR)	90.5%	**85.8%**
Administrative Loss Ratio (ALR)	5.3%	5.4%
Underwriting Ratio (UR)	4.1%	8.9%
Annual MLR [4]		88.2%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

	SFY22 Q1	SFY22 Q2
Capitation Totals	**$586.7 M**	**$605.63 M**
Adjustments	-938,683	$5.46 M
Current	$568.86 M	$580.67 M
Retro	$18.78 M	$19.5 M
Third Party Liability (TPL) Recovered	**$36.59 M**	**$32.66 M**
Financial Ratios		
Medical Loss Ratio (MLR)	93.2%	**90.9%**
Administrative Loss Ratio (ALR)	4.3%	4.5%
Underwriting Ratio (UR)	2.5%	4.6%
Annual MLR [4]		91.9%
Reported Reserves		
Acceptable Quarterly Reserves per Iowa Insurance Division (IID)	Y	**Y**

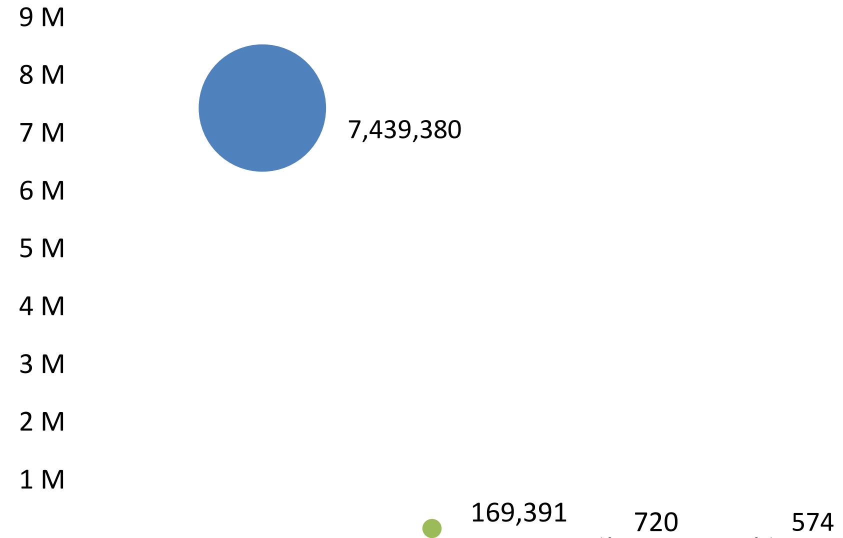
[4] Annual MLR converts IID reported data on a calendar year basis into an average that follows state fiscal year. All amounts listed are unaudited. MCOs are required to submit data as prescribed within 30 days following the six (6) month claims run-out period for final determination of SFY MLR.

MCO Claims Universe - All MCO Counts

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

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

	% of Claims Universe
Prior Authorizations	2.28%
Grievances	0.01%
Appeals	0.01%

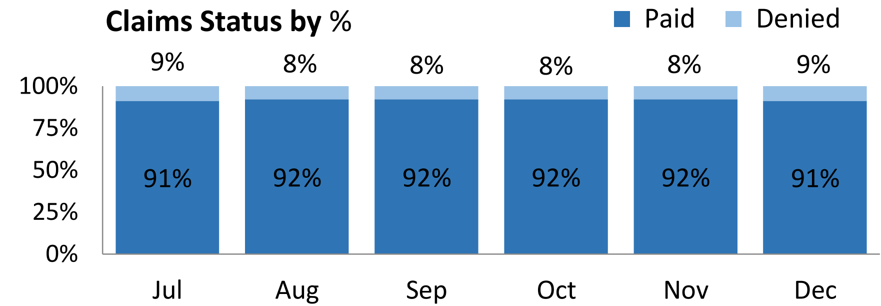


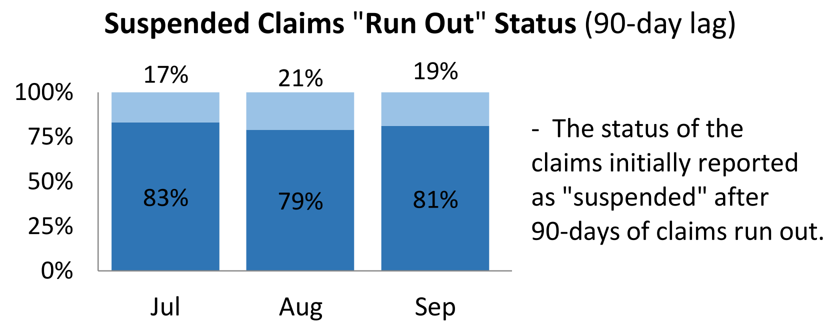
	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2	Average	Total
Claim Counts - All Paid & **Denied** (p. 9-12)	6.84 M	7.13 M	7.10 M	**7.44 M**	7.13 M	28.52 M
Non-Pharmacy	4.00 M	4.21 M	4.21 M	4.46 M	4.22 M	16.88 M
Pharmacy	2.84 M	2.92 M	2.90 M	2.98 M	2.91 M	11.64 M
Prior Authorization Summary (p. 13-14)	185,570	180,026	171,159	**169,391**	176,537	706,146
Non-Rx - Standard PAs Submitted	139,780	138,319	127,869	124,736	132,676	530,704
Pharmacy - Standard PAs Submitted	45,790	41,707	43,290	44,655	43,861	175,442
Grievances & **Appeals Summary** (p. 15-16)						
Standard Grievances	604	583	587	**720**	624	2,494
Standard Appeals	649	750	701	**574**	669	2,674

Claims Summary (Non-Pharmacy)

2.55 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	759,097	836,841	731,569
Denied	67,837	76,822	73,911
Suspended	211,699	135,711	146,910
Clean Claims Processed			
in 30-days (Requirement 90%)	98%	98%	99%
in 45-days (Requirement 95%)	99%	100%	100%
Average Days to Pay	8	8	7
Provider Adjustment Requests & Errors Reprocessed in 30-days	100%	100%	100%





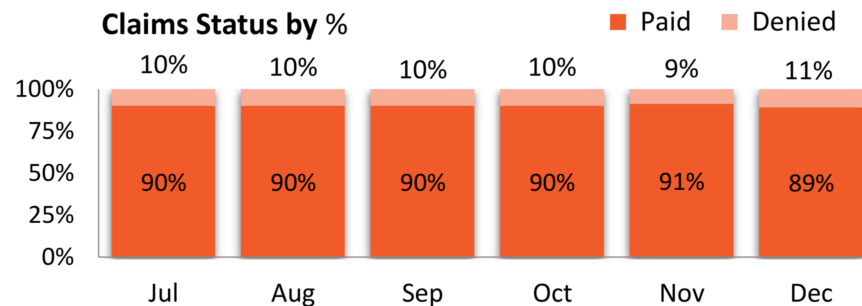
- The status of the claims initially reported as "suspended" after 90-days of claims run out.

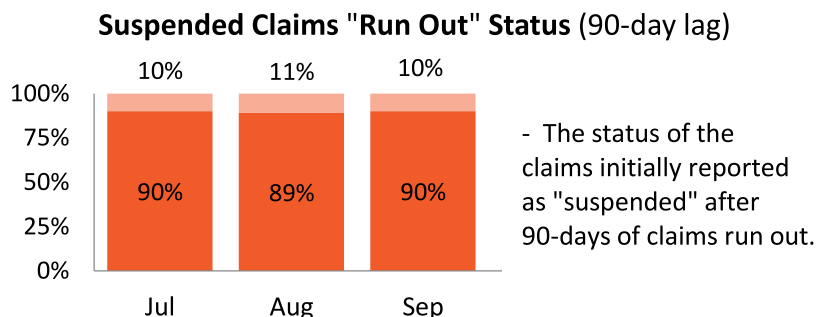
	%	Top 10 Reasons for Claims Denials (Non-Pharmacy)
1.	13%	Prior processing information appears incorrect
2.	11%	Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement
3.	10%	Duplicate claim/service
4.	7%	Precertification/authorization/notification absent Claim/service lacks information or has submission/billing error(s)
5.	7%	Expenses incurred after coverage terminated
6.	6%	Claim/service lacks information or has submission/billing error(s) - primary payer inforation required
7.	6%	Claim/service lacks information or has submission/billing error(s) - lateral diagnosis required
8.	6%	The impact of prior payer(s) adjudication including payments and/or adjustments.
9.	5%	The time limit for filing has expired
10.	4%	Service not payable per managed care contract

Claims Summary (Non-Pharmacy)

1.91 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims			
Paid	556,353	513,597	653,235
Denied	59,015	49,865	82,359
Suspended	152,045	164,284	113,057
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	99%	99%
in 45-days (Requirement 95%)	100%	100%	99%
Average Days to Pay	8	8	9
Provider Adjustment Requests & Errors Reprocessed in 30-days	98%	99%	99%





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

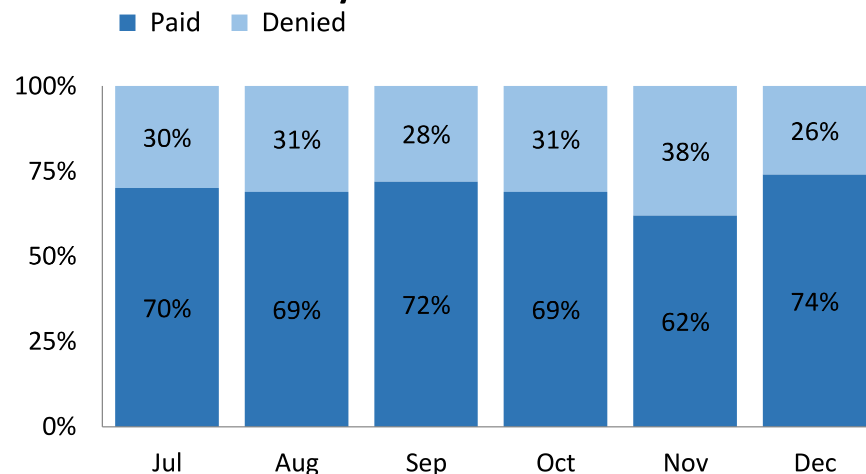
Top 10 Reasons for Claims Denials (Non-Pharmacy)

	%	Reason
1.	14%	Duplicate claim service
2.	10%	Service can not be combined with other service on same day
3.	7%	Reimbursed as lower complexity per payment policy
4.	6%	Bill primary insurer first; resubmit with explanation of benefits (EOB)
5.	5%	No authorization on file that matches service(s) billed
6.	5%	Service is not covered
7.	4%	Ace claim level return to provider (review claim remarks)
8.	3%	Diagnosis code incorrectly coded per ICD10 manual
9.	3%	Void adjustment
10.	3%	Billing NPI not registered with IA DHS/Iowa Medicaid

Claims Summary (Pharmacy)

1.69 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	361,379	274,372	535,002
Denied	162,262	168,290	186,455
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	11	10	11



Top 10 Reasons for Claims Denials (Pharmacy)

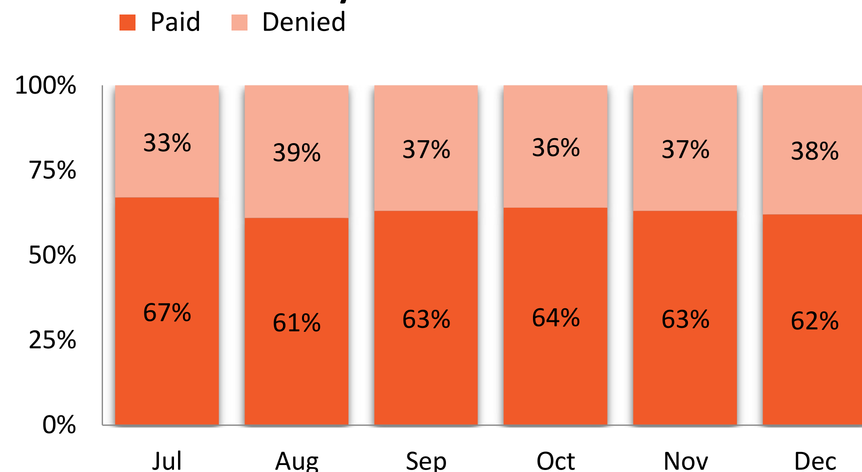
	%	Reason
1.	38%	Refill too soon
2.	16%	Prior authorization required
3.	11%	Submit bill to other processor or primary payer
4.	10%	National Drug Code (NDC) not covered
5.	5%	Plan limitations exceeded
6.	4%	M/I other payer reject code
7.	2%	M/I processor control number
8.	2%	Prescriber is not covered
9.	2%	Filled after coverage terminated
10.	1%	Pharmacy not enrolled in State Medicaid program M/I other coverage code

Claims Summary (Pharmacy)

1.29 Million
Claims Paid & Denied

	Oct	Nov	Dec
All Claims (Pharmacy)			
Paid	267,441	271,031	274,826
Denied	152,668	158,074	167,079
Clean Claims Processed			
in 30-days (Requirement 90%)	100%	100%	100%
in 45-days (Requirement 95%)	100%	100%	100%
Average Days to Pay	10	10	10

Claims Status by %



	%	Top 10 Reasons for Claims Denials (Pharmacy)
1.	27%	Refill too soon
2.	12%	Prior authorization required
3.	10%	National Drug Code (NDC) not covered
4.	5%	Plan limitations exceeded
5.	4%	Submit bill to other processor or primary payer
6.	2%	Prescriber is not enrolled in State Medicaid program
7.	2%	Drug Utilization Review (DUR) reject error
8.	2%	Pharmacy not enrolled in State Medicaid program
9.	1%	Drug not covered for patient age
10.	1%	Discrepancy other coverage code & other payer amount paid

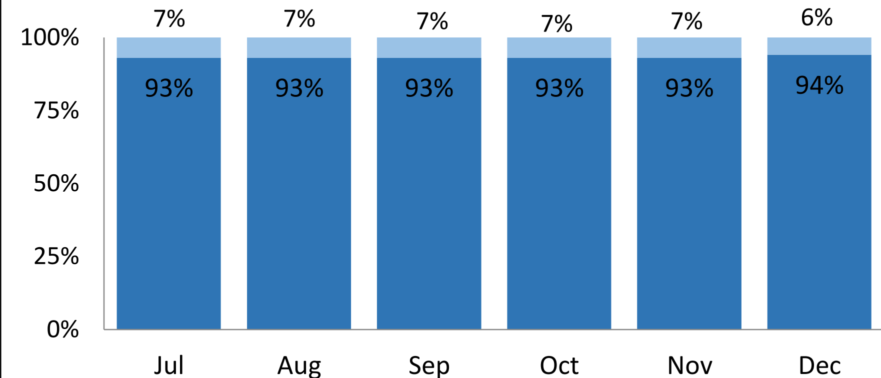
Prior Authorization Summary

80,940

All PAs Submitted [5]

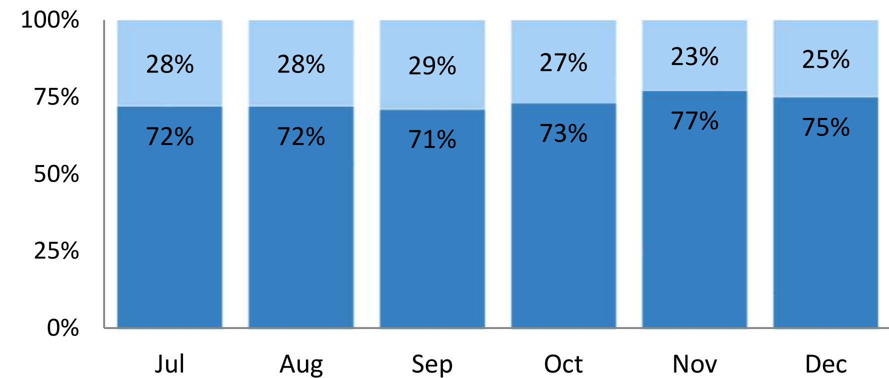
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	17,554	16,408	16,723
Denied	1,235	1,219	1,147
Modified	0	1	0
Average Days to Process	4	4	4
Standard PAs Completed in 14-days (Requirement 99%)	99%	99%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	99%	99%	99%



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	6,239	7,452	6,264
Denied	2,301	2,249	2,140
PAs Completed in 24-hours (Requirement 100%)	100%	100%	99.9%



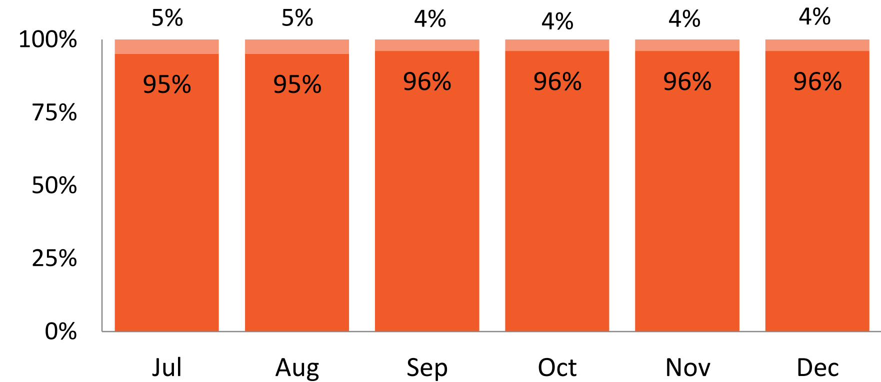
[5] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Prior Authorization Summary

88,451
All PAs Submitted [5]

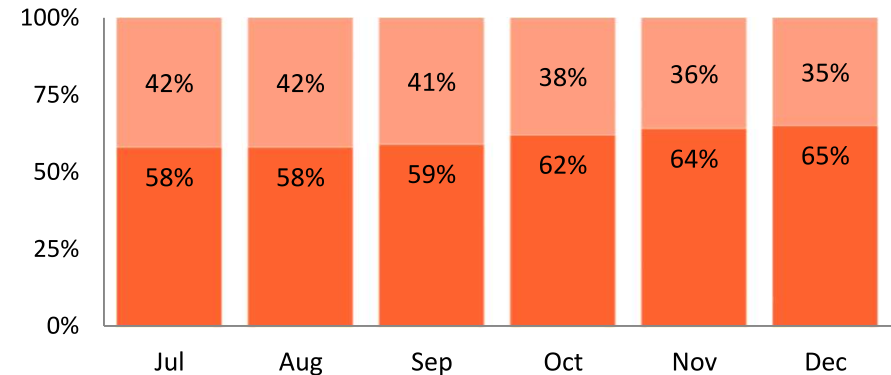
Non-Pharmacy

	Oct	Nov	Dec
Standard Prior Authorizations (PAs)			
Approved	24,286	22,373	22,039
Denied	1,104	1,024	991
Modified	0	0	0
Average Days to Process	4	4	4
Standard PAs Completed in 14-days (Requirement 99%)	100%	100%	100%
Expedited PAs Completed in 72-hours (Requirement 99%)	100%	100%	100%



Pharmacy

	Oct	Nov	Dec
Prior Authorizations			
Approved	3,047	3,572	3,460
Denied	1,835	2,042	1,867
PAs Completed in 24-hours (Requirement 100%)	99.9%	99.8%	100%

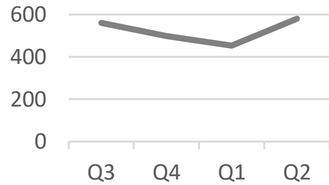


[5] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

Grievances and Appeals

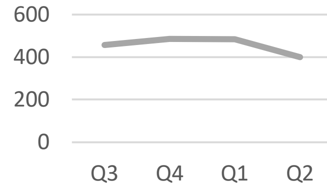
Standard Grievances

580



Standard Appeals

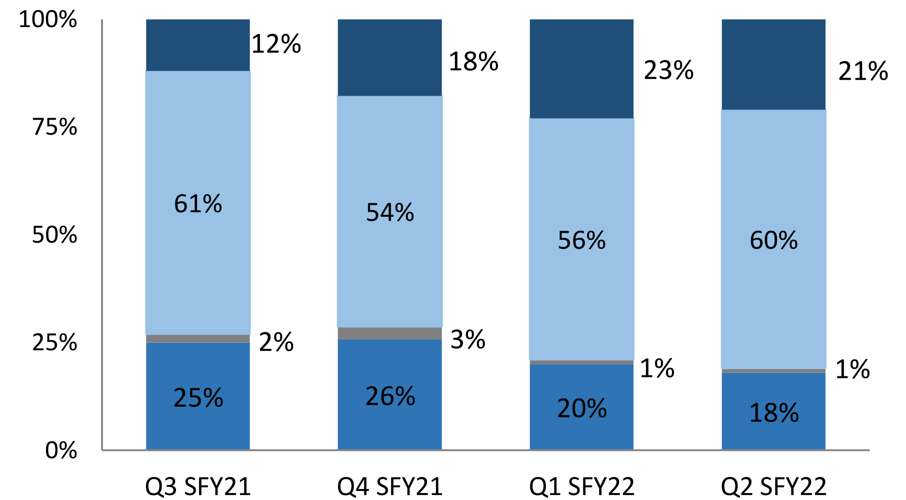
400



Resolved in 30-days
100%

Resolved in 30-days
100%

Standard Appeal Outcome %



	%	Top 10 Reasons for Grievances [6]
1.	41%	Voluntary disenrollment
2.	14%	Provider balance billed
3.	8%	Transportation - Driver no-show
4.	7%	Poor Customer Service
5.	5%	Provider dissatisfaction
6.	5%	Treatment dissatisfaction
7.	3%	Transportation - Driver delay
8.	2%	Inadequate benefit access
9.	2%	Access to Case Management
10.	2%	Too Many Phone Inquiries

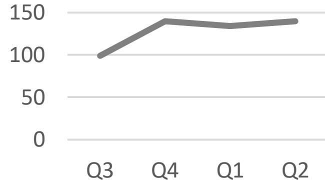
%	Top 10 Reasons for Appeals [6]
27%	DME
24%	Pharmacy - Non Injectable
9%	Radiology
8%	Pharmacy - Injectable
6%	BH - Op Service
4%	Surgery
3%	Inpatient - Medical
3%	Therapy - PT
3%	Pain Management
2%	BH - Inpatient

[6] Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Grievances and Appeals

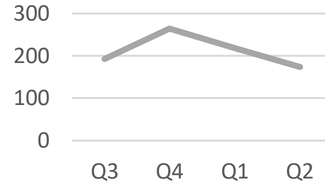
Standard Grievances

140



Standard Appeals

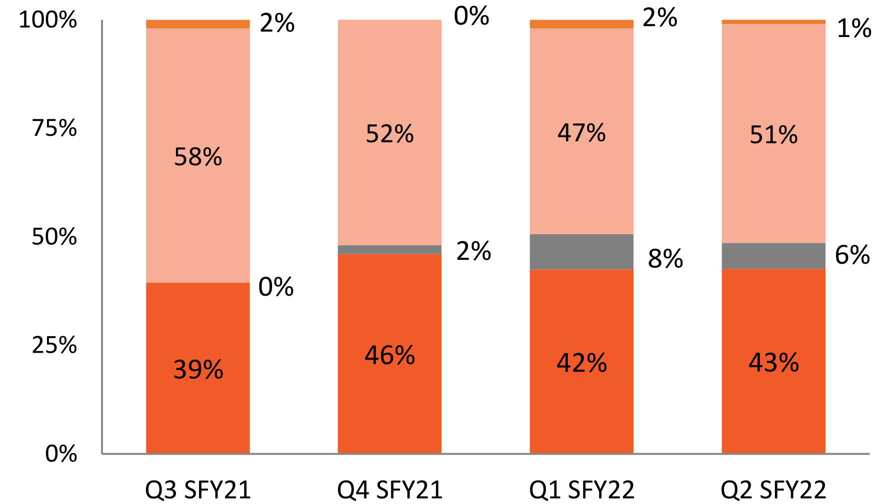
174



Resolved in 30-days
100%

Resolved in 30-days
100%

Standard Appeal Outcome %



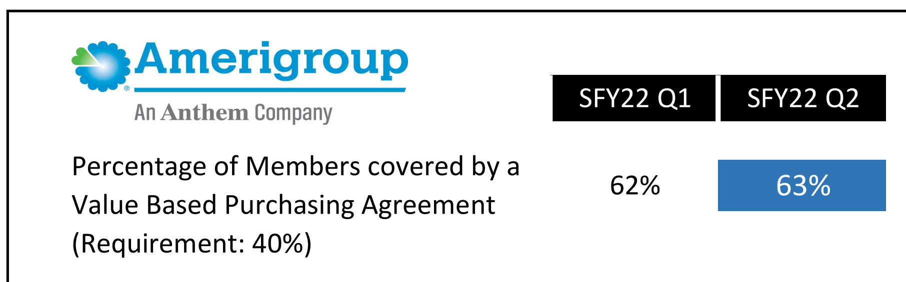
	%	Top 10 Reasons for Grievances [6]
1.	20%	Unhappy with Benefits
2.	20%	Access to Care - Network Availability
3.	11%	Transportation - Missed Appointment
4.	10%	Transportation - General Complaint Vendor
5.	6%	Lack of Caring/Concern
6.	3%	Transportation - Unsafe Driving
7.	3%	Provider
8.	3%	Transportation - Driver no-show
9.	2%	Transportation - Late appointment
10.	2%	Transportation - General Complaint Vendor CSR

%	Top 10 Reasons for Appeals [6]
34%	RX - Does Not Meet PriorAuth Guidelines
7%	Diagnostic - MRI
6%	Diagnostic - Test
5%	Vendor Related - Home Care
5%	Other - Mental Health Service
3%	DME - Other
3%	Vendor Related - Home Care
3%	Outpatient - Procedure
2%	DME - Pneumatic compressor/Appliance
2%	DME - Wheelchair

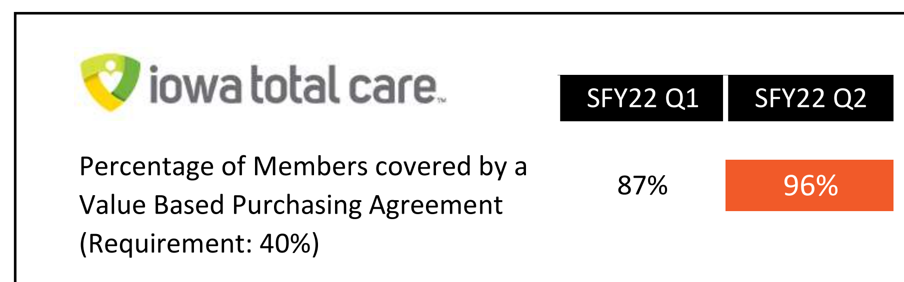
[6] Top 10 reasons for grievances and appeals includes both standard and expedited counts. All percentages listed are based on quarterly totals.

Value Based Purchasing (VBP) Agreement

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



Amerigroup (An Anthem Company)	SFY22 Q1	SFY22 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	62%	63%



iowa total care	SFY22 Q1	SFY22 Q2
Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%)	87%	96%

Top 5 - Value Added Services (VAS)

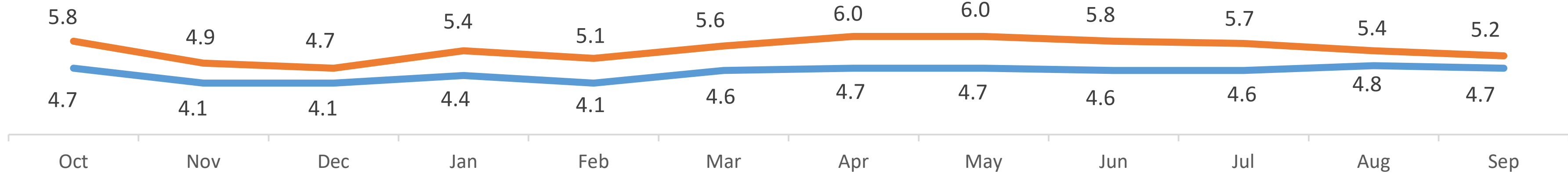
Value Added Services (VAS) are optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

Amerigroup (An Anthem Company)	SFY22 Q1	SFY22 Q2
Healthy Rewards	3,613	3,800
Taking Care of Baby and Me	2,310	2,513
Community Resource Link	2,046	1,170
SafeLink Mobile Phone	558	845
Dental Hygiene Kit	414	480

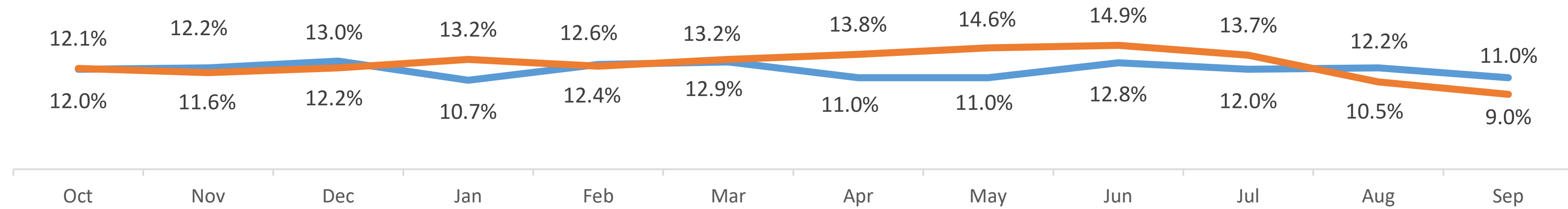
iowa total care	SFY22 Q1	SFY22 Q2
The Flu Program	759	14,683
My Health Pays Program	14,419	12,136
Start Smart for Your Baby	1,431	1,416
Mobile App	834	1,017
Breast Pumps	406	462

MCO Care Quality and Outcomes

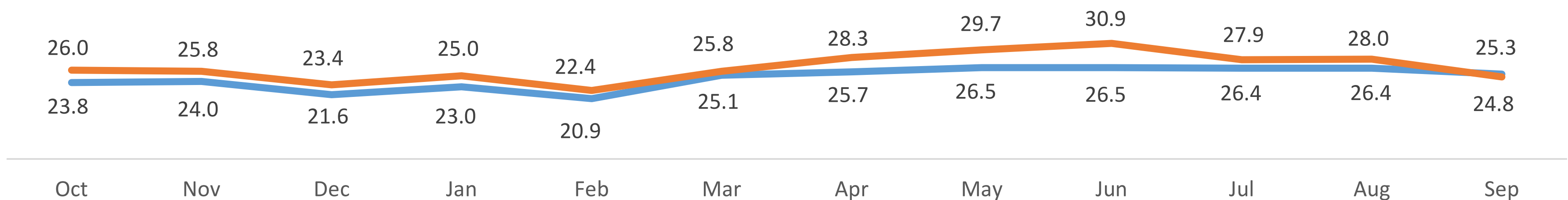
Inpatient Admissions per 1,000 Members per Month (90-day lag)



All Cause Readmissions within 30-days (90-day lag) [7]



Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [8]



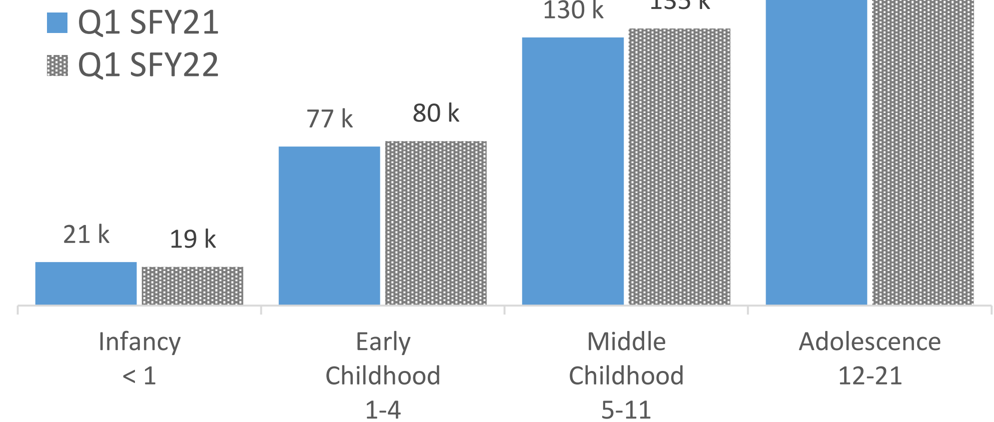
[7] *This measure requires 12 months of continuous enrollment with the MCO. Q2 SFY2021 is the first quarter that ITC is reporting data.*

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

MCO Children Summary

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

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



	SFY21 Q1	SFY22 Q1
Member Enrollment	228,223	237,586
Infancy < 1	11,020	9,827
Early Childhood 1 - 4	46,976	47,425
Middle Childhood 5 - 11	78,663	81,514
Adolescence 12 - 21	91,564	98,820
Well Child Exams (Preventive Visits)	59,780	59,597
Infancy < 1	11,496	11,307
Early Childhood 1 - 4	15,485	14,077
Middle Childhood 5 - 11	15,528	15,916
Adolescence 12 - 21	17,271	18,297
Lead Screenings	5,244	5,050
Infancy < 1	103	129
Early Childhood 1 - 4	4,460	4,184
Middle Childhood 5 - 11	647	676
Adolescence 12 - 21	34	61

	SFY21 Q1	SFY22 Q1
Member Enrollment	152,472	159,797
Infancy < 1	10,058	8,899
Early Childhood 1 - 4	30,256	32,520
Middle Childhood 5 - 11	51,634	53,211
Adolescence 12 - 21	60,524	65,167
Well Child Exams (Preventive Visits)	44,048	46,033
Infancy < 1	11,568	11,533
Early Childhood 1 - 4	9,769	11,119
Middle Childhood 5 - 11	10,772	10,871
Adolescence 12 - 21	11,939	12,510
Lead Screenings	3,843	4,064
Infancy < 1	72	130
Early Childhood 1 - 4	3,284	3,473
Middle Childhood 5 - 11	464	424
Adolescence 12 - 21	23	37

MCO Children Summary

	SFY21 Q1	SFY22 Q1
Hearing Screenings	1,942	2,009
Infancy < 1	131	147
Early Childhood 1 - 4	790	926
Middle Childhood 5 - 11	690	647
Adolescence 12 - 21	331	289
Vision Screenings	1,753	2,332
Infancy < 1	12	32
Early Childhood 1 - 4	599	944
Middle Childhood 5 - 11	652	849
Adolescence 12 - 21	490	507
Vaccination Totals	79,511	80,402
COVID-19 Dose 1	0	5,839
COVID-19 Dose 2	0	5,271
COVID-19 Single-Dose	0	60
DTaP (Diphtheria, Tetanus, Pertussis)	11,994	11,091
Influenza (FLU)	11,074	5,787
HepA (Hepatitis A)	6,410	5,222
HepB (Hepatitis B)	1,011	937
Haemophilus Influenza Type B (Hib)	5,534	4,956
Human Papillomavirus (HPV)	6,953	6,338
Meningococcal ACWY (MenACWY)	7,056	7,309
Meningococcal B - (MenB)	2,517	2,500
MMR (Measles, Mumps, Rubella)	5,970	5,701
Pneumococcal (PCV13)	7,953	7,220
Pneumococcal (PPSV23)	65	50
Polio (IPV)	323	333
RV (Rotavirus)	4,739	4,498
Tetanus and diphtheria (Td)	51	43
TDAP (Tetanus, Diphtheria, Pertussis)	5,097	4,935
Varicella Virus Vaccine (VAR)	2,764	2,312

	SFY21 Q1	SFY22 Q1
Hearing Screenings	1,248	1,167
Infancy < 1	116	106
Early Childhood 1 - 4	451	499
Middle Childhood 5 - 11	460	392
Adolescence 12 - 21	221	170
Vision Screenings	1,135	1,445
Infancy < 1	17	34
Early Childhood 1 - 4	406	624
Middle Childhood 5 - 11	377	487
Adolescence 12 - 21	335	300
Vaccination Totals	56,011	49,225
COVID-19 Dose 1	0	3,205
COVID-19 Dose 2	0	2,928
COVID-19 Single-Dose	0	37
DTaP (Diphtheria, Tetanus, Pertussis)	9,100	7,611
Influenza (FLU)	7,111	3,274
HepA (Hepatitis A)	4,360	3,719
HepB (Hepatitis B)	978	681
Haemophilus Influenza Type B (Hib)	1,365	1,346
Human Papillomavirus (HPV)	4,791	3,679
Meningococcal ACWY (MenACWY)	4,902	4,108
Meningococcal B - (MenB)	1,767	1,283
MMR (Measles, Mumps, Rubella)	4,304	3,530
Pneumococcal (PCV13)	6,871	5,499
Pneumococcal (PPSV23)	49	56
Polio (IPV)	320	247
RV (Rotavirus)	4,472	3,483
Tetanus and diphtheria (Td)	34	27
TDAP (Tetanus, Diphtheria, Pertussis)	3,493	2,864
Varicella Virus Vaccine (VAR)	2,094	1,648

Non-LTSS Care Coordination and HCBS Case Management

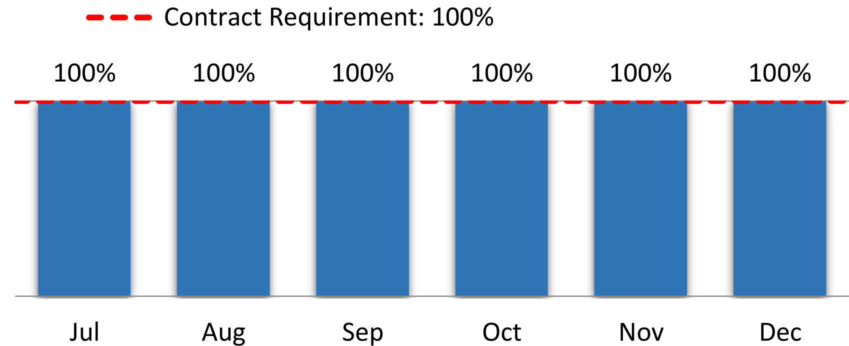
Average Number of Contacts Per Month	SFY22 Q1	SFY22 Q2
by Care Coordinators	0.8	**0.8**
by Case Managers	1.2	**1.1**
"Members to" Ratios		
Members to Care Coordinators	27	**20**
HCBS Members to Case Managers	68	**72**

Iowa Participant Experience Survey (IPES)

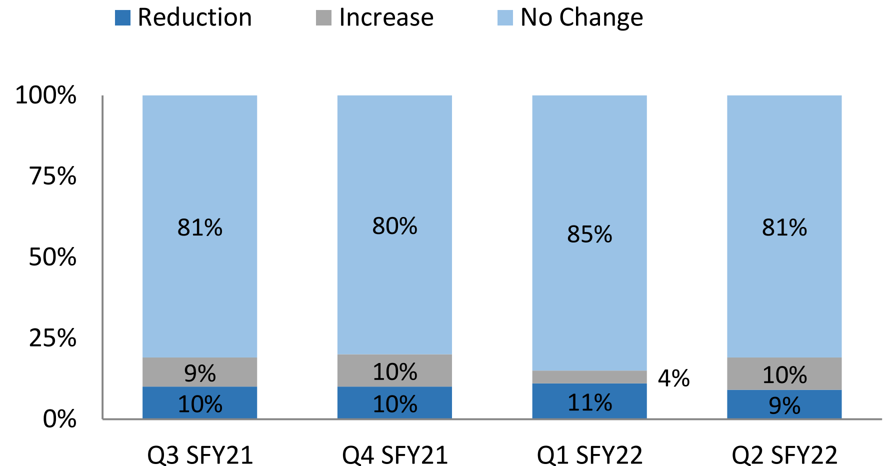
Waiver members reporting…		SFY22 Q1	SFY22 Q2
They were part of service planning.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	100.0%	100.0%
Their services make their lives better.	I don't know	0.5%	0.5%
	No	0.0%	0.0%
	Sometimes	0.0%	0.0%
	Yes	99.5%	99.5%

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



Waiver Service Plan Outcomes



Long Term Services - Care Quality and Outcomes

Non-LTSS Care Coordination and HCBS Case Management

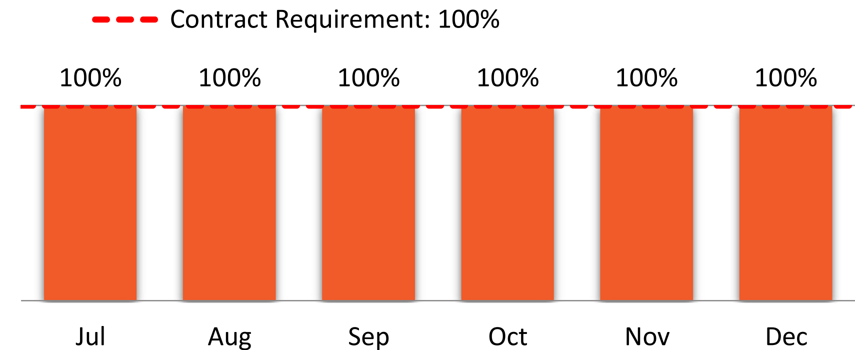
Average Number of Contacts Per Month	SFY22 Q1	SFY22 Q2
by Care Coordinators	0.8	**1.0**
by Case Managers	1.0	**1.0**
"Members to" Ratios		
Members to Care Coordinators	49	**50**
HCBS Members to Case Managers	44	**40**

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

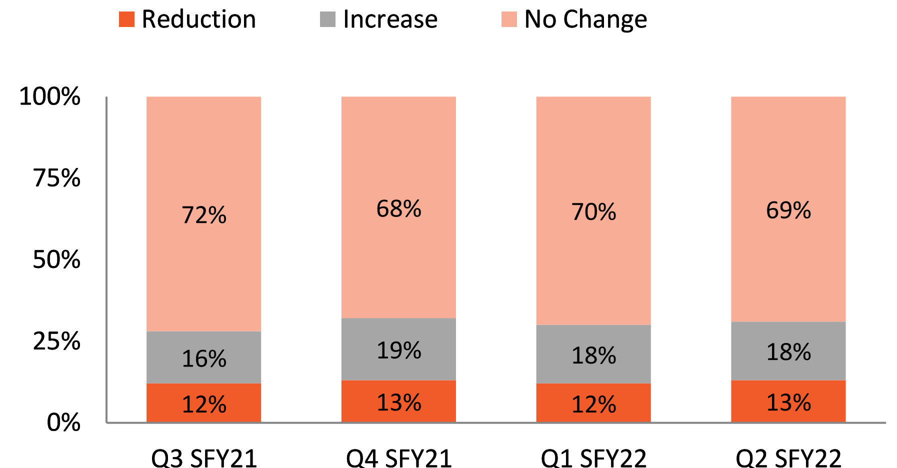
Iowa Participant Experience Survey (IPES)

Waiver members reporting…		SFY22 Q1	SFY22 Q2
They were part of service planning.	I don't know	0.4%	0.7%
	No	0.8%	1.4%
	Sometimes	0.0%	1.1%
	Yes	98.9%	96.7%
They feel safe where they live.	I don't know	0.0%	0.0%
	No	0.8%	0.7%
	Sometimes	1.1%	1.5%
	Yes	98.1%	97.8%
Their services make their lives better.	I don't know	0.4%	0.4%
	No	0.4%	2.2%
	Sometimes	0.4%	2.2%
	Yes	98.9%	95.2%

Percentage of Level of Care (LOC) Reassessments Completed Timely



Waiver Service Plan Outcomes



Long Term Services - Waiver Service Plan Participation

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

Top 5 Waiver Services

- by Member Usage

	SFY22 Q1	SFY22 Q2
AIDS/HIV - Unique Service Plans	20	19
Home Delivered Meals	14	13
CDAC (individual) by 15 minute units	0	4
CDAC (agency) by 15 minute units	0	2
Brain Injury (BI) Waivers	808	794
Financial Management Services	241	243
Supported Community Living (by unit)	187	185
Personal Emergency Response	162	161
Respite (by 15 minute units)	166	155
Supported Community Living (daily)	110	106
Children's Mental Health (CMH)	763	756
Respite (by 15 minute units)	408	400
Family and Community Support	223	205
Respite (Hos/NF) - 15 minute units	214	193
Respite (Resident Camp) by units	11	9
Home Delivered Meals	3	3
Elderly Waivers	4,581	4,487
Home Delivered Meals	2,884	2,854
Personal Emergency Response	2,895	2,844
CDAC (agency) by 15 minute units	392	409
Assisted Living Services	372	368
Personal Emergency Response (install)	302	291

	SFY22 Q1	SFY22 Q2
Habilitation (Hab)	4,346	4,238
Home-based Habilitation	3,921	3,816
Long Term Job Coaching	440	431
Day Habilitation (units by day)	402	401
Individual Supported Employment	181	197
Day Habilitation (by 15 minute units)	151	151
Health & Disability (HD)	1,375	1,340
Financial Management Services	385	391
Respite (by 15 minute units)	358	355
Personal Emergency Response	314	305
Home Delivered Meals	303	294
Respite (Hos/NF) - 15 minute units	73	68
Intellectual Disability (ID)	7,033	6,969
Supported Community Living (by unit)	1,810	1,786
Supported Community Living (RCF)	1,411	1,463
Financial Management Services	1,423	1,436
Day Habilitation (units by day)	1,448	1,432
Supported Community Living (daily)	1,207	1,171
Physical Disability (PD)	657	622
Personal Emergency Response	345	343
CDAC (agency) by 15 minute units	57	53
CDAC (individual) by 15 minute units	46	47
Home Delivered Meals	39	38
Financial Management Services	37	38

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 to include wait list information and a full list of available services, reference: http://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

Top 5 Waiver Services

- by Member Usage

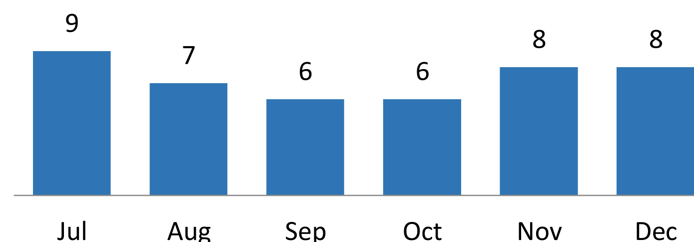
	SFY22 Q1	SFY22 Q2
AIDS/HIV - Unique Service Plans	9	9
Home Delivered Meals	7	7
CDAC (individual) by 15 minute units	4	3
CDAC (agency) by 15 minute units	1	1
Homemaker (by 15 minute units)	1	1
Personal Emergency Response	1	1
Brain Injury (BI) Waivers	526	520
Supported Community Living (by unit)	218	225
Respite (by 15 minute units)	137	134
Personal Emergency Response	131	132
Supported Community Living (daily)	103	119
Transportation (1-way trip)	81	88
Children's Mental Health (CMH)	326	327
Respite (by 15 minute units)	189	189
Respite (Hos/NF) - 15 minute units	127	124
Family and Community Support	97	96
Mental Health Service	39	38
Respite (Resident Camp) by units	2	1
Elderly Waivers	3,237	3,277
Home Delivered Meals	2,462	2,514
Personal Emergency Response	2,464	2,490
CDAC (agency) by 15 minute units	1,307	1,352
Homemaker (by 15 minute units)	812	801
CDAC (individual) by 15 minute units	649	670

	SFY22 Q1	SFY22 Q2
Habilitation (Hab)	2,300	2,356
Home-based Habilitation	1,951	1,993
Day Habilitation (by 15 minute units)	296	333
Day Habilitation (units by day)	249	286
Long Term Job Coaching	274	278
Individual Supported Employment	148	145
Health & Disability (HD)	616	594
Respite (by 15 minute units)	277	280
Home Delivered Meals	175	174
Personal Emergency Response	168	171
CDAC (agency) by 15 minute units	113	119
CDAC (individual) by 15 minute units	110	103
Intellectual Disability (ID)	4,494	4,479
Supported Community Living (by unit)	1,856	1,811
Day Habilitation (by 15 minute units)	1,466	1,660
Day Habilitation (units by day)	1,669	1,653
Supported Community Living (RCF)	1,330	1,312
Respite (by 15 minute units)	1,022	1,014
Physical Disability (PD)	363	358
Personal Emergency Response	209	194
CDAC (agency) by 15 minute units	167	170
CDAC (individual) by 15 minute units	125	121
Transportation (1-way trip)	41	37
Personal Emergency Response (install)	18	17

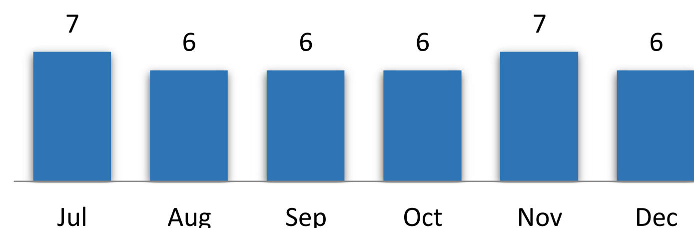
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	93.23%	97.18%	96.90%
Abandonment Rate - Must be 5% or less	0.43%	0.95%	2.13%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	94.29%	92.81%	98.19%
Abandonment Rate - Must be 5% or less	0.66%	0.34%	0.00%
Provider Helpline			
Service Level (Requirement 80%)	86.83%	95.44%	96.69%
Abandonment Rate - Must be 5% or less	0.56%	1.20%	1.78%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.42%	96.82%	95.91%
Abandonment Rate - Must be 5% or less	0.36%	0.10%	0.65%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	47.70%	82.38%	93.32%
Abandonment Rate - Must be 5% or less	6.56%	1.59%	2.43%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

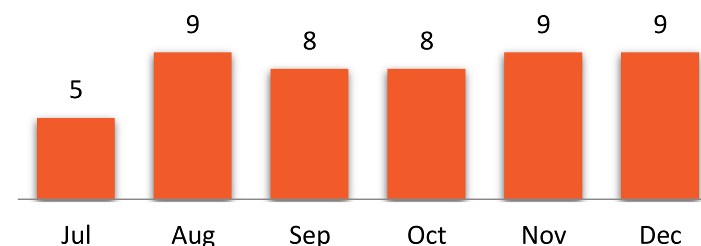
	Top 5 Call Reasons (Member Helpline)
1.	Benefit Inquiry
2.	Enrollment Information
3.	ID Card Request or Inquiry
4.	Claim Inquiry
5.	Transportation Inquiry

Top 5 Call Reasons (Provider Helpline)
Benefit Inquiry
Authorization Status
Claim Status
Claim Payment Question or Dispute
Authorization New

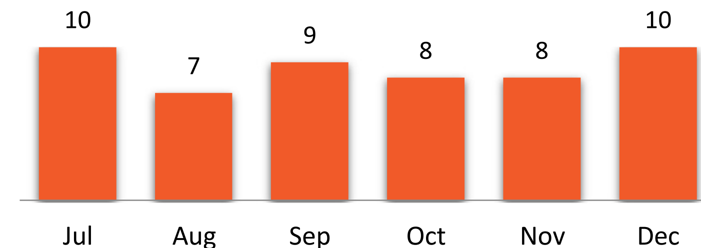
Call Center Performance Metrics

	Oct	Nov	Dec
Member Helpline			
Service Level (Requirement 80%)	84.41%	86.71%	89.12%
Abandonment Rate - Must be 5% or less	3.84%	3.34%	2.48%
Member Pharmacy Helpline			
Service Level (Requirement 80%)	88.75%	92.71%	94.16%
Abandonment Rate - Must be 5% or less	2.83%	2.40%	1.42%
Provider Helpline			
Service Level (Requirement 80%)	86.24%	85.69%	84.15%
Abandonment Rate - Must be 5% or less	2.78%	2.74%	3.50%
Provider Pharmacy Helpline			
Service Level (Requirement 80%)	96.76%	93.69%	89.08%
Abandonment Rate - Must be 5% or less	0.46%	0.81%	0.42%
Non-Emergency Medical Transportation (NEMT) Helpline			
Service Level (Requirement 80%)	45.36%	81.76%	93.95%
Abandonment Rate - Must be 5% or less	4.83%	0.99%	0.95%

Secret Shopper Scores
- Member Helpline



Secret Shopper Scores
- Provider Helpline



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

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

Provider Network Access Summary

Primary Care Providers (PCP)

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2
Adults PCP				
Provider Count	6,672	6,632	6,589	6,688
Members with Access	219,428	224,574	228,637	231,146
Average Distance (Miles)	1.9	1.8	1.8	1.8
Pediatric PCP				
Provider Count	6,707	6,666	6,621	6,719
Members with Access	209,553	211,406	213,136	212,453
Average Distance (Miles)	2.0	2.0	2.0	1.9

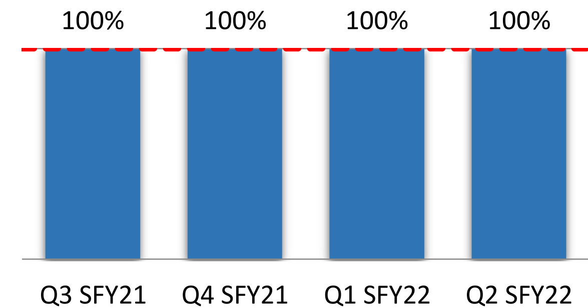
Specialty Care & Behavioral Health (BH)

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2
OB/GYN Adult				
Provider Count	403	402	401	405
Members with Access	142,865	146,051	148,670	150,083
Average Distance (Miles)	5.7	5.6	5.6	5.6
Outpatient - Behavioral Health				
Provider Count	4,137	4,205	4,305	4,456
Members with Access	428,981	435,980	441,773	443,599
Average Distance (Miles)	2.3	2.3	2.3	2.2
Inpatient - Behavioral Health				
Provider Count	48	50	50	51
Rural Members				
Members with Access	175,907	178,368	180,629	181,008
Average Distance (Miles)	21.4	21.4	21.4	18.5
Urban Members				
Members with Access	253,074	257,612	261,144	262,591
Average Distance (Miles)	5.8	5.8	5.8	5.8

Adult PCP - Standards

30 minutes or 30 miles

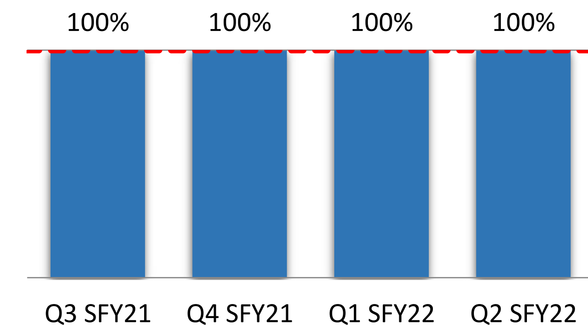
Contract Requirement: 100%



Pediatric PCP - 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)

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2
Adults PCP				
Provider Count	9,085	9,704	9,894	9,894
Members with Access	166,971	171,647	175,634	180,087
Average Distance (Miles)	2.0	2.0	2.0	2.0
Pediatric PCP				
Provider Count	9,820	10,472	10,658	10,658
Members with Access	138,828	140,406	141,050	143,484
Average Distance (Miles)	2.1	2.1	2.1	2.1

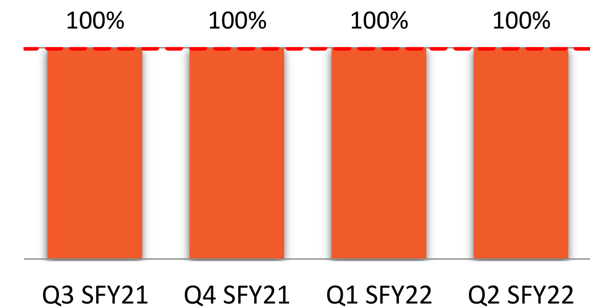
Specialty Care & Behavioral Health (BH)

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2
OB/GYN Adult				
Provider Count	1,234	1,286	1,298	1,298
Members with Access	110,381	113,317	115,394	118,135
Average Distance (Miles)	5.4	5.4	5.4	5.4
Outpatient - Behavioral Health				
Provider Count	8,737	9,476	9,688	9,688
Members with Access	305,799	312,053	316,684	323,571
Average Distance (Miles)	2.5	2.5	2.4	2.4
Inpatient - Behavioral Health				
Provider Count	36	36	36	36
Rural Members				
Members with Access	218,902	223,411	226,908	231,823
Average Distance (Miles)	24.6	24.6	24.6	24.5
Urban Members				
Members with Access	86,897	88,642	89,776	91,748
Average Distance (Miles)	8.4	8.4	8.4	8.4

Adult PCP - Standards

30 minutes or 30 miles

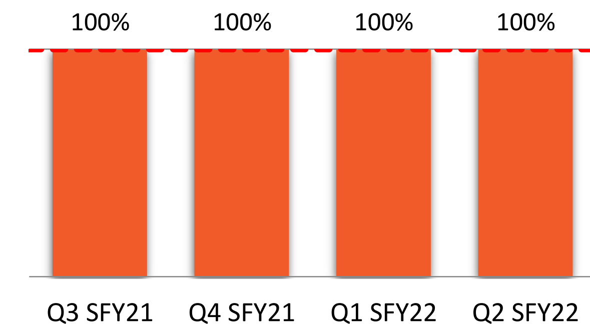
Contract Requirement: 100%



Pediatric PCP - Standards

30 minutes or 30 miles

Contract Requirement: 100%



Link to Geo Access Reports:

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

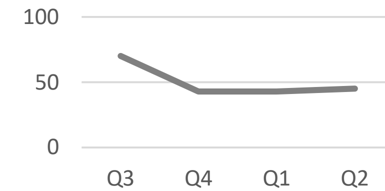
MCO Program Integrity

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 in SFY22 Q2

45



7 Total Cases

Referred to MCFU Q2

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2	Average	Total
Investigations opened	42	33	28	31	34	134
Overpayments identified	10	23	14	25	18	72
Member concerns referred to IME	4	2	2	5	3	13
Cases referred to the Medicaid Fraud Control Unit (MCFU)	2	6	6	4	5	18

	SFY21 Q3	SFY21 Q4	SFY22 Q1	SFY22 Q2	Average	Total
Investigations opened	28	10	15	12	16	65
Overpayments identified	0	6	12	17	9	35
Member concerns referred to IME	6	10	10	5	8	31
Cases referred to the Medicaid Fraud Control Unit (MCFU)	2	12	16	3	8	33

Appendix: Glossary

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

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

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

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

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

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

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

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

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

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

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

Capitation Expenditures (continued...):

- **Retro**: Payments for months prior to the current month for member months not previously paid for
  - Member months are counted if request is to provide member months within a specific date range for more than one month
  - Data is not pulled by paid date, but by eligibility month

Care Coordinator: A person who helps manage the health of members with chronic health conditions.

Case Manager: See Community Based Case Management (CBCM)

Centers for Medicare and Medicaid Service (**CMS**): A federal agency that administers the Medicare program and works in partnership with state governments to administer Medicaid standards.

Children's Mental Health (**CMH**) **Waiver**: A HCBS waiver that offers services for children up to age 18, who have been diagnosed with a serious emotional disturbance.

Children's Health Insurance Program (**CHIP**): A federal program administered by state governments to provide health care coverage for children and families whose income is too high to qualify for Medicaid, but too low to afford individual or work-provided health care.

Claims: What providers submit to the MCOs or the Department in order to receive payment for services rendered.

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

Clean Claims: The claim is on the appropriate form, identifies the service provider that provided service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

Community: A natural setting where people live, learn, work, and socialize.

Community Based Case Management (**CBCM**): Helps LTSS members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. CBCMs make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (**CDAC**): Helps people do things that they normally would for themselves if they were able. CDAC services may include unskilled tasks such as bathing, grocery shopping, household chores or skilled tasks such as medication management, tube feeding, recording vital signs. CDAC providers are available through an agency or from an individual such as a family member, friend, or neighbor that meets eligibility requirements.

Denied Claims: See Claims

Department of Human Services (**DHS**): The state's health and social services agency.

Disabled: Group descriptions include: Age Blind Disabled (ABD), Residential Care Facility (RFC), Nursing Facility (NF), Hospice, Skilled Nursing Facility (SNF), Intermediate Care Facility (ICF), State Mental Health Hospital, and Children in Psychiatric Mental Institutions (PMIC).

Disenrollment: Refers to members who have chosen to change their enrollment with one MCO to an alternate MCO.

Dual: Members who have both Medicare and Medicaid benefits.

Durable Medical Equipment (**DME**): Reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

Elderly Waiver: A HCBS waiver that offers services for elderly persons. An applicant must be at least 65 years of age.

Financial Ratios: The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for MCOs is contractually set at 88%.

- **Administrative Loss Ratio** (**ALR**): The percent of capitated rate payments an MCO spends on administrative costs.
- **Medical Loss Ratio** (**MLR**): The percent of capitated rate payments an MCO spends on claims and expenses that improve health care quality of Medicaid members.
- **Underwriting Ratio** (**UR**): If total expenses exceed capitated rate payments, an underwriting loss occurs. If total capitated rate payments exceed total expenses, an underwriting profit occurs.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

- Member is unhappy with the quality of your care
- Doctor who the member wants to see is not in the MCO's network
- Member is not able to receive culturally competent care
- Member got a bill from a provider for a service that should be covered by the MCO

Grievance (continued…):

- Rights and dignity
- Member is commended changes in policies and services
- Any other access to care issues

Habilitation (Hab) Services: A program that provides HCBS for Iowans with the functional impairments typically associated with chronic mental illnesses.

Health & Disability (HD) Waiver: A HCBS waiver that offers services for those persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver.

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

Home Delivered Meals: Meals that are prepared outside of the member's home and delivered to the member.

Home Health Aide: Medical services that provide direct personal care. This may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompanying member to medical services, transporting member to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

Homemaker Services: Services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to essential shopping, limited house cleaning, and meal preparation.

Home and Community Based Services (HCBS): Types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.

Inpatient Admissions: A member has formally been admitted to a hospital to receive care.

Intellectual Disability (ID) Waiver: A HCBS waiver that offers services for persons who have been diagnosed with an intellectual disability.

Intermediate Care Facilities for the Intellectually Disabled (ICF/ID): The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify for Medicaid assistance financially.

Iowa Health and Wellness Plan (**IHAWP**): The Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act or Medicaid expansion.

Iowa Insurance Division (**IID**): The state regulator which supervises all insurance business transacted in the state of Iowa.

Iowa Medicaid Enterprise (**IME**): The division of DHS that administers the Iowa Medicaid Program.

Iowa Participant Experience Survey (**IPES**): A survey tool developed for use with HCBS programs that asks members about the services they receive, and where the service is provided.

Level of Care (**LOC**): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long Term Services and Supports (**LTSS**): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money.

M-CHIP: Refers to Medicaid CHIP, or Medicaid expansion. M-CHIP provides coverage to children ages 6-18 whose family income is between 122 and 167 percent of the Federal Poverty Level (FPL), and infants whose family income is between 240 and 375 percent of the FPL.

Managed Care Organization (**MCO**): A health plan contracted with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and LTSS.

Medicaid: Provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. Also known as Title XIX under the Social Security Act.

Medicaid Expansion: See Iowa Health and Wellness Plan (IHAWP) and/or M-CHIP

Medicaid Fraud Control Unit (**MFCU**): A division within the Iowa Department of Inspections & Appeals whose primary goal is to prevent abuse of taxpayer resources through professional investigation of criminal activity. MFCU staffs experienced criminal investigators, auditors, and attorneys to achieve this goal.

Medical Loss Ratio (**MLR**): See Financial Ratios

Mental Health Institute (**MHI**): Provide short term psychiatric treatment and care for severe symptoms of mental illness. Iowa has two MHIs located in **Cherokee** and **Independence**. The services at each MHI vary.

Monthly Capitation Expenditures: See Capitation Expenditures

Nursing Facility (**NF**): Provide 24-hour care for individuals who need nursing or skilled nursing care.

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

Non-Emergency Medical Transportation (**NEMT**): Services are for members with full Medicaid benefits, who need travel reimbursement or a ride to get to their medical appointments.

Physical Disability (**PD**) **Waiver**: A HCBS waiver that offers services for persons who are physically disabled. An applicant must be at least 18 years of age, but less than 65 years of age.

Prior Authorization (**PA**): Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription. Prior Authorizations for pharmaceuticals are becoming more complex and may require more specific data for approval.

Primary Care Provider (**PCP**): A physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member will see for checkups, health concerns, health screenings, and specialist referrals.

Program Integrity (**PI**): Program Integrity (PI) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Provider Adjustment Requests and Errors Reprocessed: See Claims

Provider Network Access: Each MCO has a network of providers across Iowa who their members may see for care. Members don't need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

Psychiatric Medical Institute for Children (**PMIC**): Institutions which provide more than 24-hours of continuous care involving long-term psychiatric services to three or more children in residence. The expected periods of stay for diagnosis and evaluation are fourteen days or more and for treatment the expected period of stay is 90-days or more.

Reported Reserves: Refer to an MCO's ability to pay their bills and the amount of cash they have on hand to do so.

Service Level (**SL**): In relation to call centers, service level is defined as the percentage of calls answered within a predefined amount of time.

Service Plan: Plan of services for HCBS members. A member's service plan is based on the member's needs and goals. It is created by the member and their interdisciplinary team to meet HCBS Waiver criteria.

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

Temporary Assistance for Needy Families (**TANF**) **Adult and Child**: A program to help needy families achieve self-sufficiency.

Third-Party Liability (**TPL**) **Recovered**: Third party payments include recoveries from health insurance coverage, settlements or court awards for casualty/tort (accident) claims, product liability claims (global settlements), medical malpractice, worker's compensation claims, etc. This means all other available TPL resources must meet their legal obligation to pay claims for the care of an individual eligible for Medicaid. By law, Medicaid is generally the payer of last resort, meaning that Medicaid only pays claims for covered items and services if there are no other liable payers.

Underwriting Ratio (**UR**): See Financial Ratios

Value Added Services (**VAS**): Optional benefits provided by the MCOs outside of the standard Medicaid benefit package. MCOs use value added services as an incentive to attract members to their plan. The following VAS examples, captured from each MCO's handbook, provide a description of their most active services offered. A complete listing by each MCO can also be found here: https://dhs.iowa.gov/sites/default/files/Comm504.pdf

- **Taking Care of Baby and Me®** (**AGP**): It's very important to see your primary care provider (PCP), obstetrician or gynecologist (OB/GYN) for care when you're pregnant. This kind of care is called prenatal care. It can help you have a healthy baby. Prenatal care is always important even if you've already had a baby. With our program, members receive health information and rewards for getting prenatal and postpartum care.

- **My Health Pays** (**ITC**): This program rewards members who engage in healthy behaviors with predetermined nominal dollar amounts. Members who complete plan determined healthy behaviors will receive a reloadable Visa card. This Visa card can only be used at participating retailers, such as Walmart and for additional options such as transportation, utilities, phone bills, education costs, child care and rent. This card does not allow for the purchase of tobacco, firearms, or alcohol. In addition to this, members may utilize this card for medical cost share. Should a member incur a copay for a non-emergent emergency department visit, they may use the card to pay for this copay.

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

Waivers: See Home and Community Based Services (HCBS) or reference by individual waiver descriptions (Elderly, Physical Disability, Health and Disability, AIDS/HIV, Brian Injury, Intellectual Disability, or Children's Mental Health)

Waiver Service Plan: See Service Plan