**Managed Care Organization** (**MCO**)
**Report**: **SFY 2022, Quarter 4**
(Apr-Jun 2022)

## Executive Summary

The SFY22 Q4 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 795,507 members
  - Enrollment has increased by **8,320** members or **1.06%** between Q3 & Q4 (787,187 to 795,507)

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

- **Third Party Liability** (**TPL**):
  - Total TPL increased by **$8.7M** or **14.83%** between Q3 and Q4

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

- **AGP – June**: Completed 9,128 of 9,129 = **99.9%**
- **ITC - May**: Completed 6,826 of 6,832 = **99.9%**
- **ITC - June**: Completed 7,018 of 7,022 = **99.9%**

**Grievances and Appeals** (**p. 15 and 16**):

- **AGP - Appeals**: Increase of **24.9%** from Q3 (362) to Q4 (452)
- **ITC - Appeals**: Increase of **53.1%** from Q3 (196) to Q4 (300)
- Both MCOs stated that their increase in appeals primarily was an increase in pharmacy appeals due to a change in the Preferred Drug List

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

- **Secret Shopper:** surveys were put on hold for April May, and June 2022 due to temporary reassignment of DHHS staff.

STATE OF IOWA DEPARTMENT OF
Health AND Human
SERVICES

# Managed Care Organization (MCO) Quarterly Performance Report

SFY2022, Quarter 4

(April - June 2022)

Published September 2022

# Contents

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

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

# Executive Summary

This report is based on Quarter 4 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**:

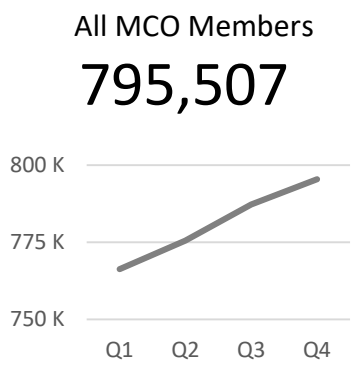
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period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

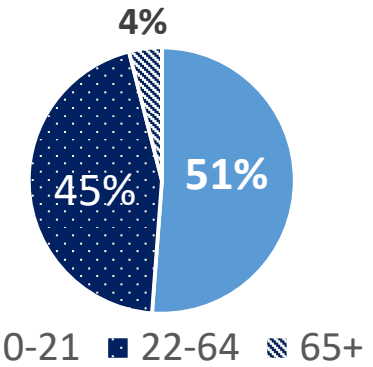
**Mission/Vision Statement**: Iowa Medicaid is committed to ensuring that all members have access to high quality services that promote dignity, removing barriers to increase health engagement, and improving whole person health. Our vision is operating a sustainable Medicaid program that improves the lives of its members through effective internal and external collaboration, innovative solutions to identified challenges, and data driven program improvement.

# **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.




**+ 8,320 Members**
1.06% Increase

**All MCO Enrollment (by Age)**

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

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 | Average | Distinct |
|---|---|---|---|---|---|---|
| **MCO Member Summary** - *Overall Counts* | 766,267 | 775,507 | 787,187 | **795,507** | 781,117 | **832,477** |
| 0-21 | 397,383 | 400,213 | 404,569 | 407,098 | 402,316 | 423,377 |
| 22-64 | 338,971 | 345,001 | 351,867 | 356,845 | 348,171 | 373,361 |
| 65+ | 29,913 | 30,293 | 30,751 | 31,564 | 30,630 | 35,739 |
| **Fee-For-Service (FFS)** - *Non MCO Enrollees* | 45,062 | 46,254 | 46,896 | **47,940** | 46,538 | **51,721** |

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

*If Yes, explain:*

**Iowa Medicaid Population** **884,198**
1 year distinct count

# MCO Member Summary

| Amerigroup | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **All Members** - *by MCO* | 451,600 | 455,273 |
| Traditional Medicaid | 278,594 | 280,403 |
| Wellness Plan - IHAWP/Expansion | 128,223 | 129,728 |
| M-CHIP - Expansion | 8,051 | 35,300 |
| Healthy and Well Kids in Iowa (Hawki) | 36,732 | 9,842 |
| MCO Member Market Share | 57.4% | 57.2% |
| Disenrolled | 401 | 517 |
| **Long-Term Service & Support (LTSS)** | 21,502 | 21,436 |
| HCBS Waivers | 68.7% | 69.0% |
| Facility Based Services | 31.3% | 31.0% |
| **HCBS Waivers** [1] | 14,778 | 14,785 |
| - Reference p. 23-24 for HCBS waiver and service plan enrollment | | |
| **Facility Based Services** [2] | 6,724 | 6,651 |
| ICF/ID [3] | 912 | 849 |
| Mental Health Institute (MHI) | 36 | 43 |
| Nursing Facilities (NF) | 5,436 | 5,411 |
| Nursing Facilities for Mentally Ill | 54 | 59 |
| Skilled | 87 | 88 |
| PMIC [4] | 199 | 201 |

| iowa total care | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **All Members** - *by MCO* | 335,587 | 340,234 |
| Traditional Medicaid | 206,374 | 210,236 |
| Wellness Plan - IHAWP/Expansion | 106,807 | 108,181 |
| M-CHIP - Expansion | 6,924 | 6,779 |
| Healthy and Well Kids in Iowa (Hawki) | 15,482 | 15,038 |
| MCO Member Market Share | 42.6% | 42.8% |
| Disenrolled | 461 | 334 |
| **Long-Term Service & Support (LTSS)** | 14,667 | 14,669 |
| HCBS Waivers | 65.0% | 65.3% |
| Facility Based Services | 35.0% | 34.7% |
| **HCBS Waivers** [1] | 9,540 | 9,583 |
| - Reference p. 23-24 for HCBS waiver and service plan enrollment | | |
| **Facility Based Services** [2] | 5,127 | 5,086 |
| ICF/ID [3] | 524 | 503 |
| Mental Health Institute (MHI) | 29 | 30 |
| Nursing Facilities (NF) | 4,340 | 4,339 |
| Nursing Facilities for Mentally Ill | 30 | 31 |
| Skilled | 76 | 67 |
| PMIC [4] | 128 | 116 |

[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 (AGP 419; ITC 388). [3] Intermediate Care Facilities for the Intellectually Disabled (ICF/ID). [4] Psychiatric Medical Institutions for Children (PMIC)

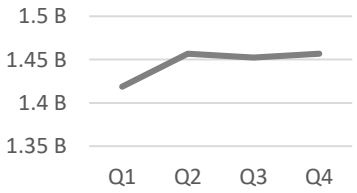
# **MCO Financial Summary** - All MCO Counts

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

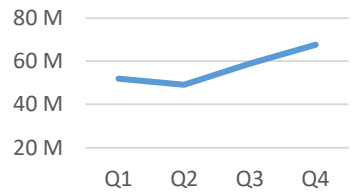
## $1.45 Billion




**+ $4.6 Million**
0.32% Increase

Third Party Liability Recovered

## $58.94 Million




**+ $ 8.7 Million**
14.83% increase

**Data Notes**: June 2022 enrollment data as of August 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.

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 | Average | Total |
|---|---|---|---|---|---|---|
| **Financial Summary** | | | | | | |
| Capitation Payments | $1.42 B | $1.46 B | $1.45 B | **$1.46 B** | $1.45 B | $5.79 B |
| Third Party Liability (TPL) Recovered | $51.95 M | $49.17 M | $58.94 M | **$67.67 M** | $56.93 M | $227.73 M |

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

*If Yes, explain:*

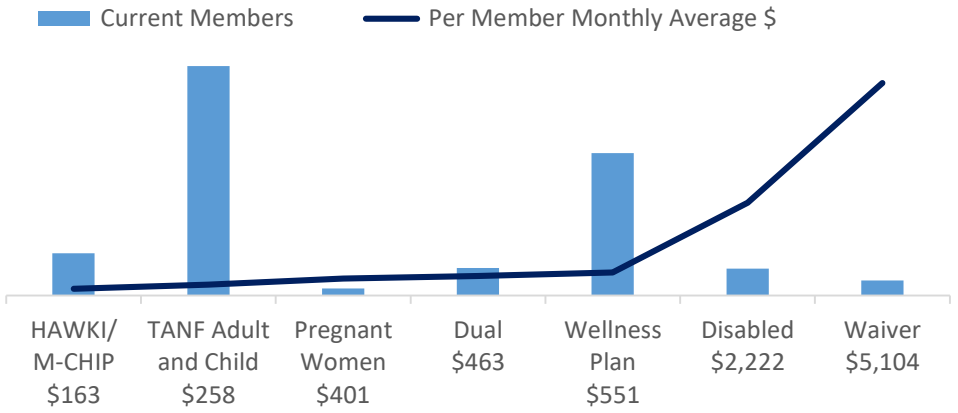
o TPL increased by $8.7M or 14.83% between Q3 and Q4.

# MCO Financial Summary

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

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

## Monthly Capitation Expenditures




Amerigroup An Anthem Company

| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **Capitation Totals** | $841.06 M | **$843.74 M** |
| Adjustments | -$.22 M | $.57 M |
| Current | $822.18 M | $823.45 M |
| Retro | $19.1 M | $19.72 M |
| **Third Party Liability (TPL) Recovered** | $22.91 M | **$28.23 M** |
| **Financial Ratios** | | |
| Medical Loss Ratio (MLR) | 89.9% | **93.9%** |
| Administrative Loss Ratio (ALR) | 5.4% | 5.5% |
| Underwriting Ratio (UR) | 4.7% | 0.6% |
| **Annual MLR [5]** | | 90.0% |
| **Reported Reserves** | | |
| Acceptable Quarterly Reserves per Iowa Insurance Division (IID) | Y | **Y** |

iowa total care

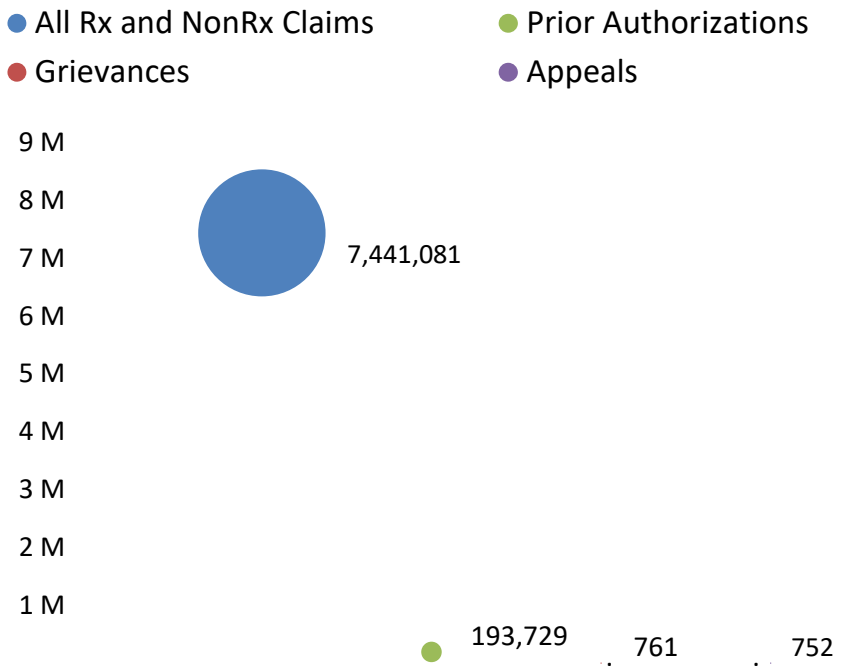
| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **Capitation Totals** | **$611.36 M** | **$613.33 M** |
| Adjustments | -$.82 M | -$.02 M |
| Current | $588.32 M | $594.66 M |
| Retro | $23.87 M | $18.68 M |
| **Third Party Liability (TPL) Recovered** | $36.03 M | **$39.45 M** |
| **Financial Ratios** | | |
| Medical Loss Ratio (MLR) | 95.1% | **94.2%** |
| Administrative Loss Ratio (ALR) | 3.8% | 7.6% |
| Underwriting Ratio (UR) | 1.1% | -1.8% |
| **Annual MLR [5]** | | 93.3% |
| **Reported Reserves** | | |
| Acceptable Quarterly Reserves per Iowa Insurance Division (IID) | Y | **Y** |

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

# **MCO Claims Universe** - All MCO Counts

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

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




| | % of Claims Universe |
|---|---|
| Prior Authorizations | 2.60% |
| Grievances | 0.01% |
| Appeals | 0.01% |

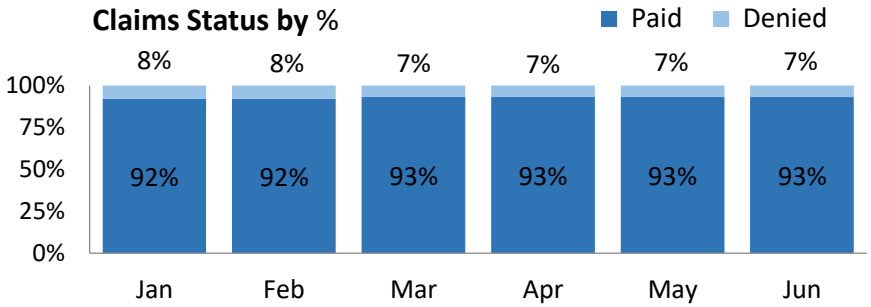
| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 | Average | Total |
|---|---|---|---|---|---|---|
| **Claim Counts - All Paid** & **Denied** (p. 9-12) | 7.10 M | 7.44 M | 7.69 M | **7.44 M** | 7.42 M | 29.67 M |
| Non-Pharmacy | 4.21 M | 4.46 M | 4.39 M | 4.41 M | 4.37 M | 17.48 M |
| Pharmacy | 2.90 M | 2.98 M | 3.29 M | 3.03 M | 3.05 M | 12.19 M |
| **Prior Authorization Summary** (p. 13-14) | 171,159 | 169,391 | 186,524 | **193,729** | 180,201 | 720,803 |
| Non-Rx - Standard PAs Submitted | 127,869 | 124,736 | 134,628 | 142,964 | 132,549 | 530,197 |
| Pharmacy - Standard PAs Submitted | 43,290 | 44,655 | 51,896 | 50,765 | 47,652 | 190,606 |
| **Grievances** & **Appeals Summary** (p. 15-16) | | | | | | |
| Standard Grievances | 587 | 720 | 784 | **761** | 713 | 2,852 |
| Standard Appeals | 701 | 574 | 558 | **752** | 646 | 2,585 |

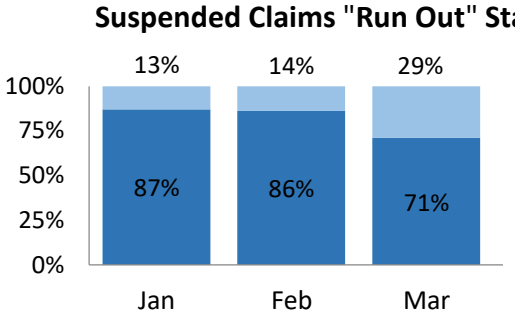
# Claims Summary (Non-Pharmacy)

**2.49 Million**
Claims Paid & Denied

Amerigroup
An Anthem Company

| | Apr | May | Jun |
|---|---|---|---|
| **All Claims** | | | |
| Paid | 720,421 | 819,395 | 781,608 |
| Denied | 50,975 | 58,023 | 63,333 |
| Suspended | 189,166 | 137,951 | 205,419 |
| **Clean Claims Processed** | | | |
| in 30-days (Requirement 90%) | 100% | 99% | 100% |
| in 45-days (Requirement 95%) | 100% | 100% | 100% |
| **Average Days to Pay** | 7 | 7 | 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)

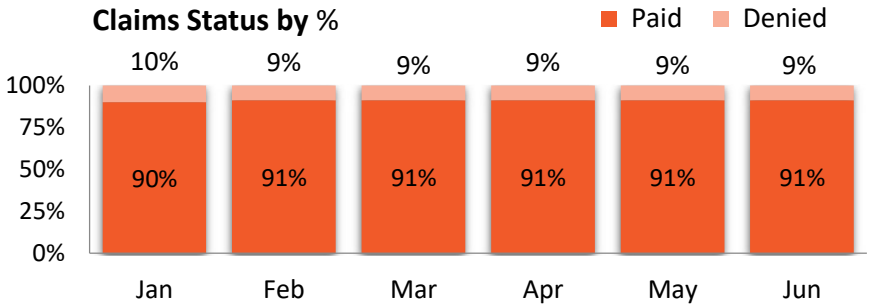
| | % | |
|---|---|---|
| 1. | 15% | Duplicate claim/service |
| 2. | 13% | Expenses incurred after coverage terminated |
| 3. | 12% | Service not payable per managed care contract |
| 4. | 10% | Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement |
| 5. | 7% | The impact of prior payer(s) adjudication including payments and/or adjustments. |
| 6. | 4% | Claim/service lacks information or has submission/billing error(s) - primary payer information required |
| 7. | 4% | Precertification/authorization/notification absent |
| 8. | 4% | Attachment/Other Documentation Required |
| 9. | 4% | The time limit for filing has expired |
| 10. | 3% | Procedure code is inconsistent with modifier used or required modifier is missing |

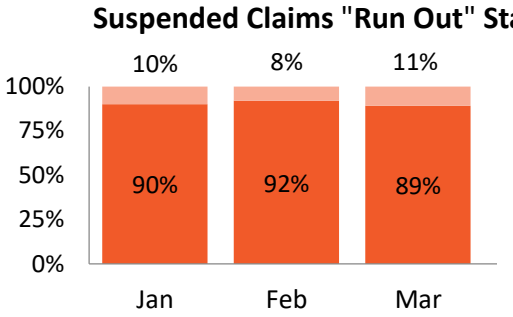
# Claims Summary (Non-Pharmacy)

**1.92 Million**
Claims Paid & Denied

iowa total care

| | Apr | May | Jun |
|---|---|---|---|
| **All Claims** | | | |
| Paid | 601,176 | 556,175 | 587,114 |
| Denied | 59,981 | 56,290 | 59,730 |
| Suspended | 162,188 | 183,954 | 127,262 |
| **Clean Claims Processed** | | | |
| in 30-days (Requirement 90%) | 98% | 98% | 98% |
| in 45-days (Requirement 95%) | 100% | 99% | 99% |
| **Average Days to Pay** | 9 | 11 | 10 |
| **Provider Adjustment Requests & Errors Reprocessed in 30-days** | 98% | 94% | 90% |




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

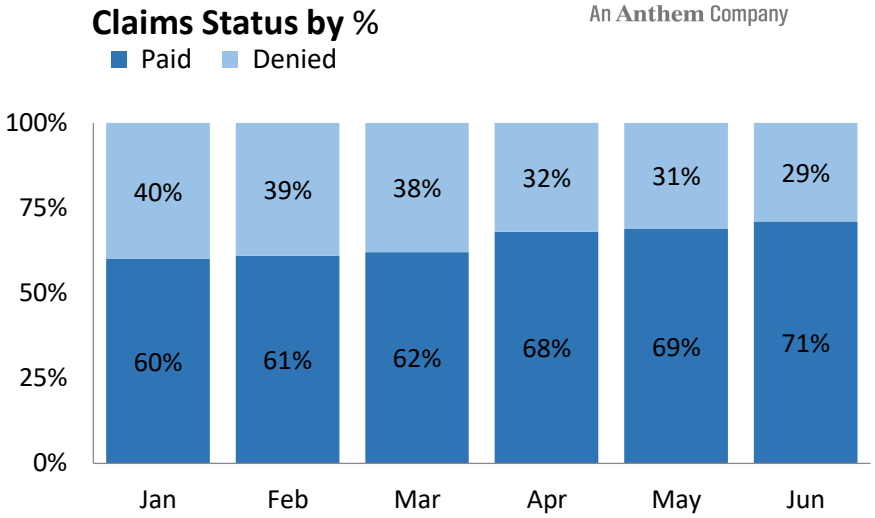
## Top 10 Reasons for Claims Denials (Non-Pharmacy)

| | % | |
|---|---|---|
| 1. | 15% | Duplicate claim/service |
| 2. | 9% | Service can not be combined with other service on same day |
| 3. | 9% | Bill primary insurer first; resubmit with explanation of benefits (EOB) |
| 4. | 6% | The time frame for filing a claim reconsideration has expired |
| 5. | 5% | Service is not covered |
| 6. | 5% | No authorization on file that matches service(s) billed |
| 7. | 4% | ACE claim level return to provider Diagnosis code incorrectly coded per ICD10 manual |
| 8. | 3% | Void Adjustment |
| 9. | 3% | Diagnosis code incorrectly coded per ICD10 manual |
| 10. | 2% | Referring Provider not registered with IA DHHS/IA Medicaid |

# Claims Summary (Pharmacy)

**1.69 Million**
Claims Paid & Denied

| | Apr | May | Jun |
|---|---|---|---|
| **All Claims (Pharmacy)** | | | |
| Paid | 363,560 | 366,186 | 446,919 |
| Denied | 169,000 | 166,472 | 178,971 |
| **Clean Claims Processed** | | | |
| in 30-days (Requirement 90%) | 100% | 100% | 100% |
| in 45-days (Requirement 95%) | 100% | 100% | 100% |
| **Average Days to Pay** | 11 | 11 | 11 |



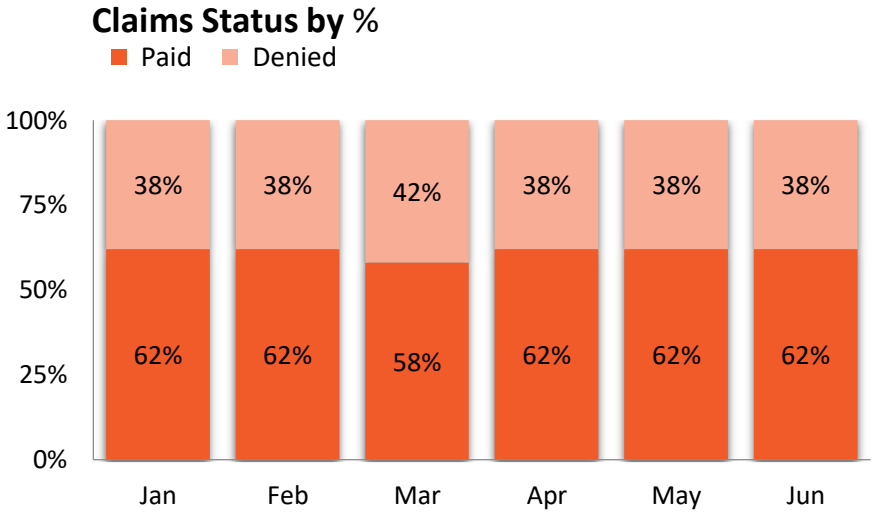

## Top 10 Reasons for Claims Denials (Pharmacy)

| | % | |
|---|---|---|
| 1. | 38% | Refill too soon |
| 2. | 16% | Prior authorization required |
| 3. | 13% | Submit bill to other processor or primary payer |
| 4. | 9% | National Drug Code (NDC) not covered |
| 5. | 6% | Plan limitations exceeded |
| 6. | 4% | M/I other payer reject code |
| 7. | 3% | M/I processor control number |
| 8. | 2% | Pharmacy not enrolled in State Medicaid program |
| 9. | 1% | Filled after coverage terminated |
| 10. | 1% | Prescriber is not enrolled in State Medicaid program |

# Claims Summary (Pharmacy)

**1.34 Million**
Claims Paid & Denied

| | Apr | May | Jun |
|---|---|---|---|
| **All Claims (Pharmacy)** | | | |
| Paid | 271,629 | 280,090 | 274,424 |
| Denied | 169,873 | 169,765 | 169,970 |
| **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 |




## Top 10 Reasons for Claims Denials (Pharmacy)

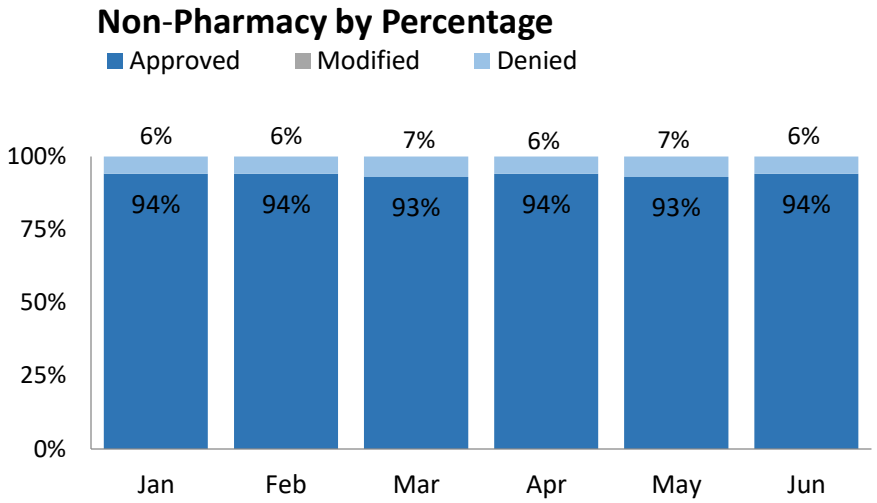
| | % | |
|---|---|---|
| 1. | 26% | Refill too soon |
| 2. | 12% | Prior authorization required |
| 3. | 9% | National Drug Code (NDC) not covered |
| 4. | 5% | Submit bill to other processor or primary payer |
| 5. | 5% | Plan limitations exceeded |
| 6. | 3% | Product not covered - non-participating manufacturer |
| 7. | 2% | Drug Utilization Review (DUR) reject error |
| 8. | 2% | Discrepancy - other coverage code & other payer amount paid |
| 9. | 1% | Pharmacy not enrolled in State Medicaid program |
| 10. | 1% | Drug not covered for patient age |

# Prior Authorization Summary

**93,082**
All PAs Submitted [6]

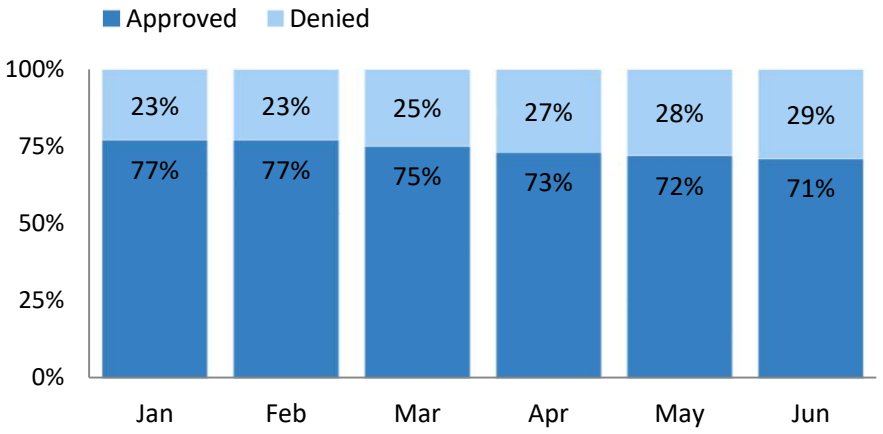
## Non-Pharmacy

| | Apr | May | Jun |
|---|---|---|---|
| **Standard Prior Authorizations (PAs)** | | | |
| Approved | 21,221 | 19,966 | 20,727 |
| Denied | 1,436 | 1,414 | 1,386 |
| Modified | 0 | 0 | 0 |
| Average Days to Process | 5 | 5 | 5 |
| **Standard PAs Completed** in 14-days (Requirement 99%) | 100% | 100% | 100% |
| **Expedited PAs Completed** in 72-hours (Requirement 99%) | 100% | 100% | 100% |




## Pharmacy

| | Apr | May | Jun |
|---|---|---|---|
| **Prior Authorizations** | | | |
| Approved | 6,384 | 6,503 | 6,516 |
| Denied | 2,376 | 2,507 | 2,613 |
| **PAs Completed** in 24-hours (Requirement 100%) | 100.0% | 100.0% | 99.9% |



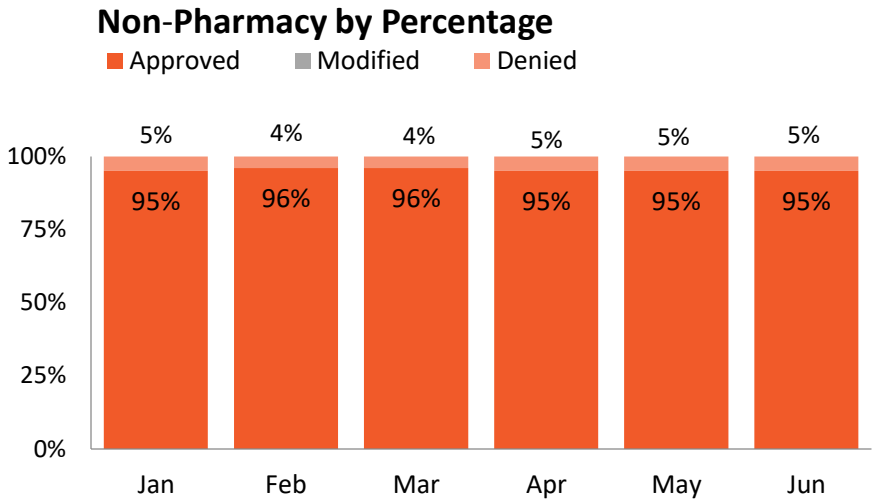

[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

# Prior Authorization Summary

**100,647**
All PAs Submitted [6]

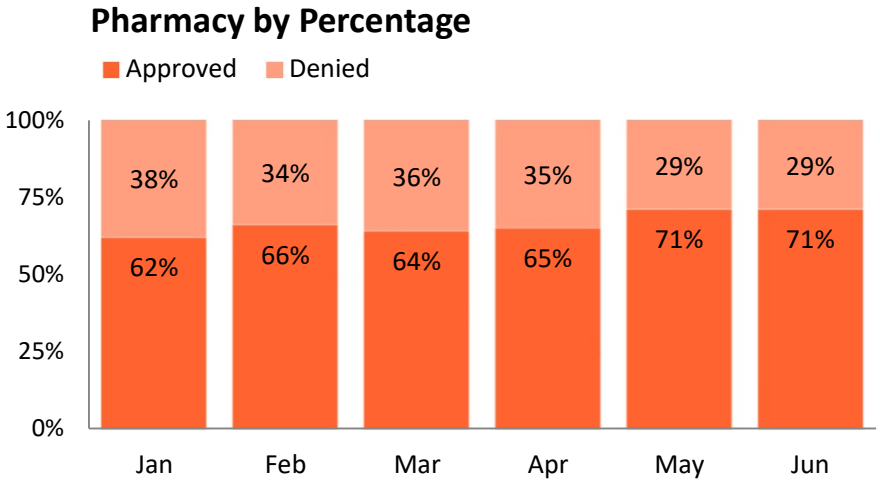
## Non-Pharmacy

| | Apr | May | Jun |
|---|---|---|---|
| **Standard Prior Authorizations (PAs)** | | | |
| Approved | 25,364 | 24,417 | 25,482 |
| Denied | 1,259 | 1,237 | 1,280 |
| Modified | 0 | 0 | 0 |
| Average Days to Process | 3 | 2 | 2 |
| **Standard PAs Completed** in 14-days (Requirement 99%) | 100% | 100% | 100% |
| **Expedited PAs Completed** in 72-hours (Requirement 99%) | 100% | 100% | 100% |




## Pharmacy

| | Apr | May | Jun |
|---|---|---|---|
| **Prior Authorizations** | | | |
| Approved | 4,695 | 4,884 | 4,960 |
| Denied | 2,506 | 1,948 | 2,062 |
| **PAs Completed** in 24-hours (Requirement 100%) | 100% | 99.9% | 99.9% |

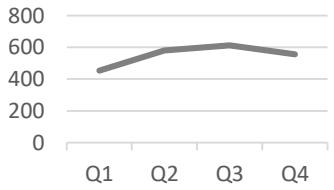



[6] Totals capture all standard non-pharmacy and pharmacy PA counts. In addition to approved, denied, or modified the submitted totals will also include PA's received, but not yet processed.

# Grievances and Appeals

Standard Grievances

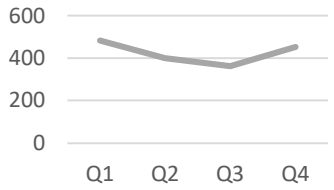
555




**Resolved in 30-days 100%**

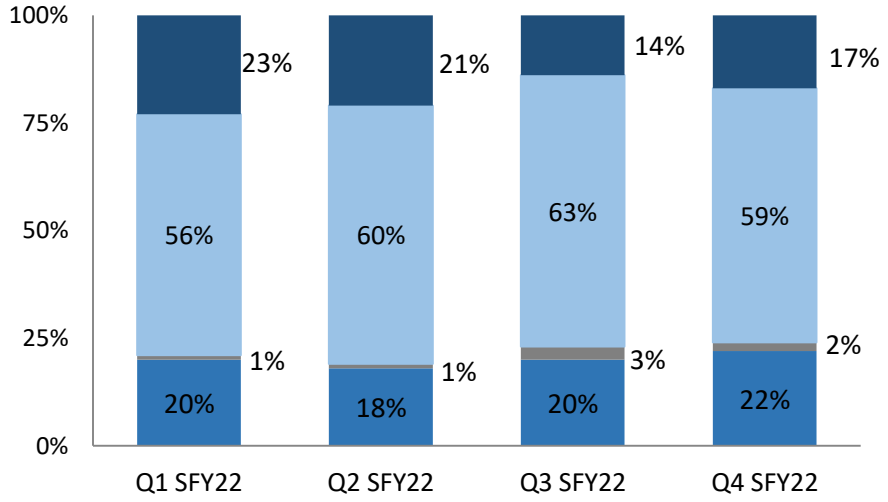
Standard Appeals/ 1st Level Review

452




**Resolved in 30-days 100%**


Standard Appeal Outcome %




| | % | Top 10 Reasons for Grievances [7] |
|---|---|---|
| 1. | 34% | Voluntary disenrollment |
| 2. | 24% | Provider balance billed |
| 3. | 9% | Provider Dissatisfaction |
| 4. | 6% | Treatment Dissatisfaction |
| 5. | 4% | Transportation - No Show |
| 6. | 3% | Transportation Delay |
| 7. | 3% | Transportation - Driver no-show |
| 8. | 3% | Access to Case Management |
| 9. | 3% | Poor Customer Service |
| 10. | 3% | Transportation - Unsafe Driving |

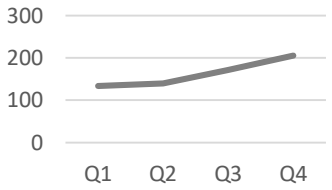
| % | Top 10 Reasons for Appeals [7] |
|---|---|
| 35% | Pharmacy - Non Injectable |
| 24% | DME |
| 13% | Outpatient Services - Medical |
| 12% | Radiology |
| 8% | Pharmacy - Injectable |
| 6% | Inpatient - Medical |
| 5% | Surgery |
| 3% | Pain Management |
| 3% | BH - Op Service |
| 2% | Personal Care Services - Self |

[7] 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

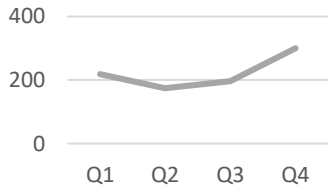
206




**Resolved in 30-days 100%**

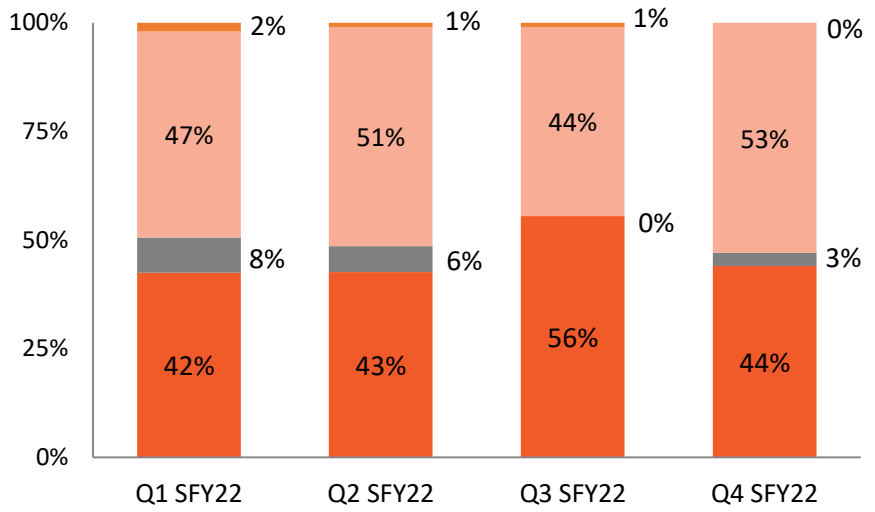
Standard Appeals/ 1st Level Review

300




**Resolved in 30-days 100%**

Standard Appeal Outcome %




## Top 10 Reasons for Grievances [7]

| | % | |
|---|---|---|
| 1. | 18% | Provider Not in Network |
| 2. | 11% | Unhappy with Benefits |
| 3. | 9% | Transportation - Driver no-show |
| 4. | 8% | Lack of Caring/Concern |
| 5. | 7% | Transportation - Missed Appointment |
| 6. | 6% | General Complaint Vendor |
| 7. | 4% | Case Management Complaint |
| 8. | 4% | Transportation - Late appointment |
| 9. | 3% | Provider |
| 10. | 3% | Benefit Concern |

## Top 10 Reasons for Appeals [7]

| % | |
|---|---|
| 30% | RX - Does Not Meet PriorAuth Guidelines |
| 6% | Therapy - Speech Therapy |
| 6% | Other - Mental Health Service |
| 5% | DME - Other |
| 4% | Injections - Epidural Injections |
| 4% | Therapy - Occupational Therapy |
| 3% | Outpatient - Procedure |
| 3% | DME - Blood Glucose Monitor |
| 3% | Diagnostic - MRI |
| 2% | DME - Wheelchair |

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

# MCO Care Quality and Outcomes

## Value Based Purchasing (VBP) Agreement

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

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| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%) | 63% | 63% |

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| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| Percentage of Members covered by a Value Based Purchasing Agreement (Requirement: 40%) | 99% | 100% |

## Top 5 - Value Added Services (VAS)

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

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| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| Healthy Rewards | 8,502 | 3,295 |
| Taking Care of Baby and Me | 2,829 | 2,661 |
| Community Resource Link | 1,140 | 1,242 |
| SafeLink Mobile Phone | 1,222 | 928 |
| Breast Pump | 474 | 543 |

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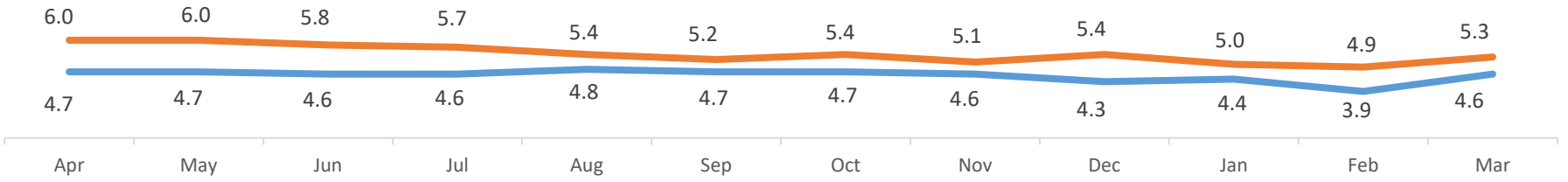
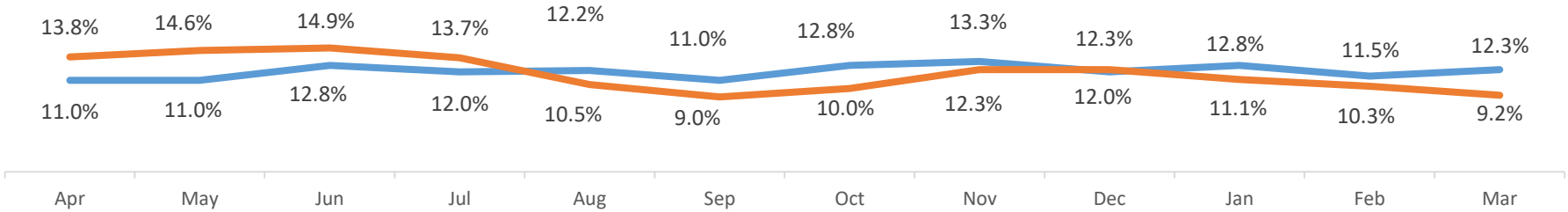
| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| My Health Pays Program | 8,719 | 7,400 |
| Start Smart for Your Baby | 1,638 | 1,638 |
| Mobile App | 1,072 | 1,148 |
| The Flu Program | 6,011 | 885 |
| Breast Pump | 553 | 564 |

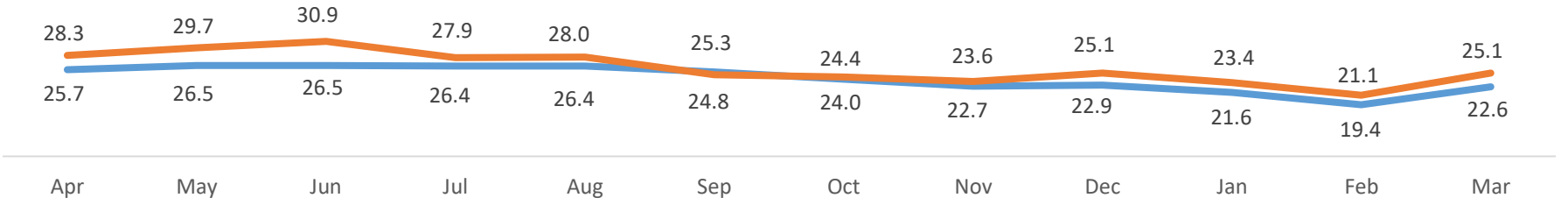
## Inpatient Admissions per 1,000 Members per Month (90-day lag)




## All Cause Readmissions within 30-days (90-day lag) [8]




## Adult Non-Emergent Use Per 1,000 ED Visits (90-day lag) [9]




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

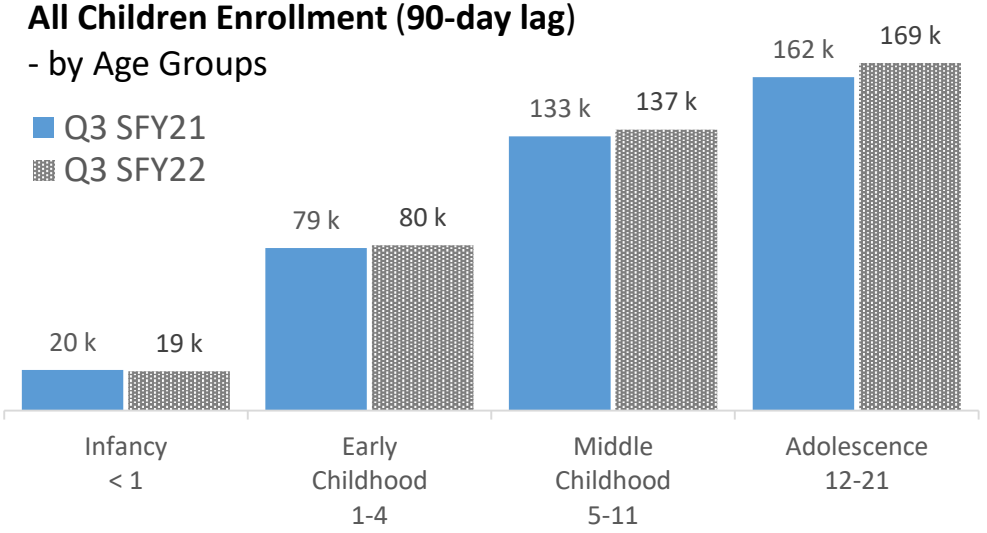
[9] *Effective January 1, 2020, the list of emergent diagnosis codes used to determine this measure was updated.*

# 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).

**All Children Enrollment (90-day lag)**
- by Age Groups

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| | SFY21 Q3 | SFY22 Q3 |
|---|---|---|
| **Member Enrollment** | 235,816 | 239,362 |
| Infancy < 1 | 10,208 | 9,778 |
| Early Childhood 1 - 4 | 47,404 | 46,510 |
| Middle Childhood 5 - 11 | 80,518 | 81,881 |
| Adolescence 12 - 21 | 97,686 | 101,193 |
| **Well Child Exams** (Preventive Visits) | 39,279 | 37,091 |
| Infancy < 1 | 11,844 | 11,533 |
| Early Childhood 1 - 4 | 12,642 | 11,573 |
| Middle Childhood 5 - 11 | 7,507 | 7,029 |
| Adolescence 12 - 21 | 7,286 | 6,956 |
| **Lead Screenings** | 4,509 | 3,899 |
| Infancy < 1 | 97 | 111 |
| Early Childhood 1 - 4 | 4,050 | 3,396 |
| Middle Childhood 5 - 11 | 333 | 334 |
| Adolescence 12 - 21 | 29 | 58 |

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| | SFY21 Q3 | SFY22 Q3 |
|---|---|---|
| **Member Enrollment** | 158,103 | 165,207 |
| Infancy < 1 | 9,409 | 9,262 |
| Early Childhood 1 - 4 | 31,562 | 33,643 |
| Middle Childhood 5 - 11 | 52,767 | 54,686 |
| Adolescence 12 - 21 | 64,365 | 67,616 |
| **Well Child Exams** (Preventive Visits) | 31,819 | 32,931 |
| Infancy < 1 | 11,555 | 12,181 |
| Early Childhood 1 - 4 | 9,797 | 10,294 |
| Middle Childhood 5 - 11 | 5,302 | 5,306 |
| Adolescence 12 - 21 | 5,165 | 5,150 |
| **Lead Screenings** | 3,540 | 3,929 |
| Infancy < 1 | 92 | 143 |
| Early Childhood 1 - 4 | 3,129 | 3,455 |
| Middle Childhood 5 - 11 | 289 | 271 |
| Adolescence 12 - 21 | 30 | 60 |

# MCO Children Summary

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| | SFY21 Q3 | SFY22 Q3 |
|---|---|---|
| **Hearing Screenings** | 1,835 | 2,466 |
| Infancy < 1 | 132 | 177 |
| Early Childhood 1 - 4 | 799 | 1,267 |
| Middle Childhood 5 - 11 | 588 | 758 |
| Adolescence 12 - 21 | 316 | 264 |
| **Vision Screenings** | 1,517 | 1,993 |
| Infancy < 1 | 19 | 55 |
| Early Childhood 1 - 4 | 898 | 1,056 |
| Middle Childhood 5 - 11 | 425 | 567 |
| Adolescence 12 - 21 | 175 | 315 |
| **Vaccination Totals** | 59,215 | 57,417 |
| COVID-19 Dose 1 | 944 | 957 |
| COVID-19 Dose 2 | 196 | 1,003 |
| COVID-19 Single-Dose | 13 | 49 |
| DTaP (Diphtheria, Tetanus, Pertussis) | 10,237 | 9,543 |
| Influenza (FLU) | 8,961 | 9,801 |
| HepA (Hepatitis A) | 4,790 | 4,246 |
| HepB (Hepatitis B) | 1,003 | 939 |
| Haemophilus Influenza Type B (Hib) | 5,371 | 5,160 |
| Human Papillomavirus (HPV) | 2,901 | 2,452 |
| Meningococcal ACWY (MenACWY) | 2,365 | 1,986 |
| Meningococcal B - (MenB) | 1,108 | 988 |
| MMR (Measles, Mumps, Rubella) | 3,860 | 3,656 |
| Pneumococcal (PCV13) | 8,014 | 7,717 |
| Pneumococcal (PPSV23) | 67 | 57 |
| Polio (IPV) | 236 | 218 |
| RV (Rotavirus) | 5,138 | 4,975 |
| Tetanus and diphtheria (Td) | 33 | 26 |
| TDAP (Tetanus, Diphtheria, Pertussis) | 1,844 | 1,638 |
| Varicella Virus Vaccine (VAR) | 2,134 | 2,006 |

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| | SFY21 Q3 | SFY22 Q3 |
|---|---|---|
| **Hearing Screenings** | 1,130 | 1,709 |
| Infancy < 1 | 126 | 169 |
| Early Childhood 1 - 4 | 522 | 461 |
| Middle Childhood 5 - 11 | 342 | 908 |
| Adolescence 12 - 21 | 140 | 171 |
| **Vision Screenings** | 1,098 | 1,334 |
| Infancy < 1 | 19 | 41 |
| Early Childhood 1 - 4 | 693 | 704 |
| Middle Childhood 5 - 11 | 290 | 367 |
| Adolescence 12 - 21 | 96 | 222 |
| **Vaccination Totals** | 47,547 | 49,205 |
| COVID-19 Dose 1 | 606 | 887 |
| COVID-19 Dose 2 | 160 | 923 |
| COVID-19 Single-Dose | 17 | 22 |
| DTaP (Diphtheria, Tetanus, Pertussis) | 8,284 | 8,578 |
| Influenza (FLU) | 6,617 | 7,569 |
| HepA (Hepatitis A) | 3,733 | 3,670 |
| HepB (Hepatitis B) | 921 | 958 |
| Haemophilus Influenza Type B (Hib) | 4,737 | 4,656 |
| Human Papillomavirus (HPV) | 2,019 | 1,651 |
| Meningococcal ACWY (MenACWY) | 1,547 | 1,317 |
| Meningococcal B - (MenB) | 766 | 648 |
| MMR (Measles, Mumps, Rubella) | 3,070 | 3,043 |
| Pneumococcal (PCV13) | 7,034 | 7,139 |
| Pneumococcal (PPSV23) | 46 | 47 |
| Polio (IPV) | 233 | 276 |
| RV (Rotavirus) | 4,543 | 4,721 |
| Tetanus and diphtheria (Td) | 17 | 42 |
| TDAP (Tetanus, Diphtheria, Pertussis) | 1,276 | 1,207 |
| Varicella Virus Vaccine (VAR) | 1,921 | 1,851 |

## Non-LTSS Care Coordination and HCBS Case Management

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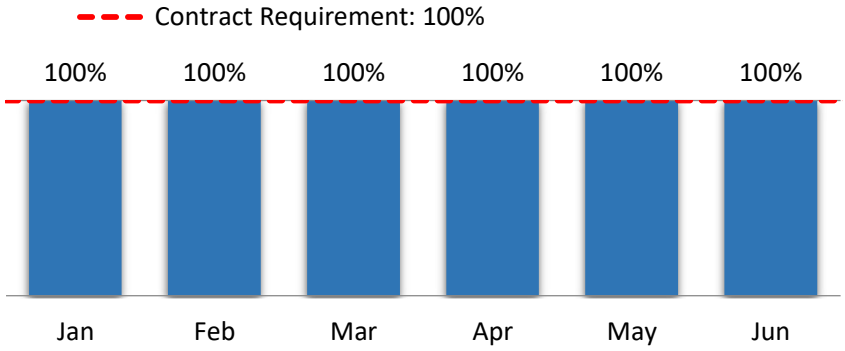
| Average Number of Contacts Per Month | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| by Care Coordinators | 0.8 | **2.2** |
| by Case Managers | 1.1 | **1.0** |
| **"Members to" Ratios** | | |
| Members to Care Coordinators | 15 | **16** |
| HCBS Members to Case Managers | 56 | **62** |

There are no current MCO contract standards for ratios of members to care coordinators or community based case managers. However, MCO contracts do state that members are to be visited in their residence face-to-face by their care coordinator at least quarterly with an interval of at least 60 days between visits.

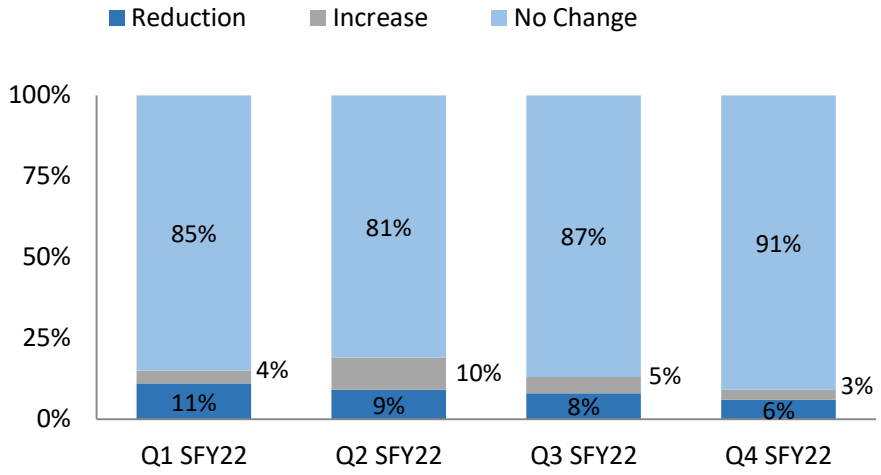
## Iowa Participant Experience Survey (IPES)

| Waiver members reporting… | | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|
| They were part of service planning. | I don't know | 0.4% | 0.0% |
| | No | 0.0% | 0.0% |
| | Sometimes | 0.0% | 0.0% |
| | **Yes** | 99.6% | 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 | 0.8% | 1.0% |
| | No | 0.0% | 0.0% |
| | Sometimes | 0.4% | 0.5% |
| | **Yes** | 98.8% | 98.5% |

## Percentage of Level of Care (LOC) Reassessments Completed Timely




## Waiver Service Plan Outcomes



## Non-LTSS Care Coordination and HCBS Case Management

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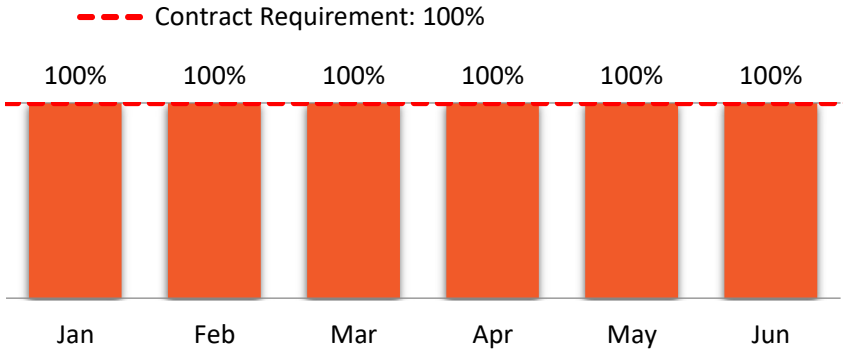
| Average Number of Contacts Per Month | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| by Care Coordinators | 1.0 | **1.0** |
| by Case Managers | 1.0 | **1.0** |
| **"Members to" Ratios** | | |
| Members to Care Coordinators | 57 | **50** |
| HCBS Members to Case Managers | 40 | **41** |

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

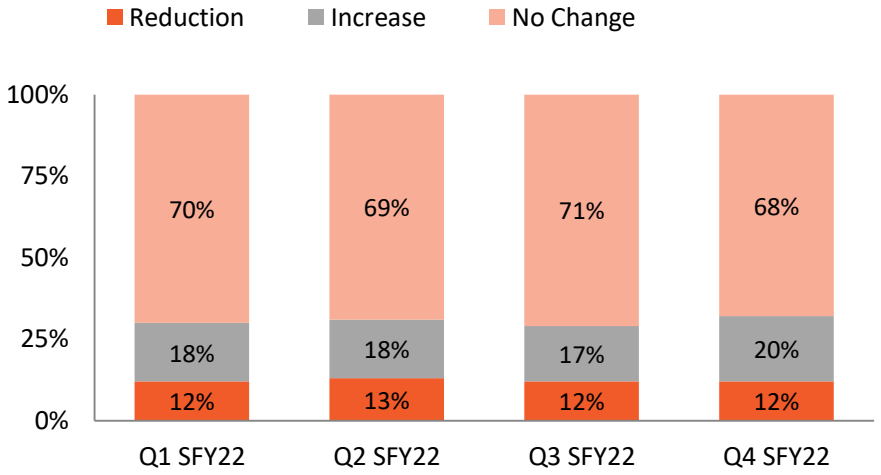
## Iowa Participant Experience Survey (IPES)

| Waiver members reporting… | | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|
| They were part of service planning. | I don't know | 0.0% | 1.9% |
| | No | 2.6% | 6.4% |
| | Sometimes | 0.8% | 3.4% |
| | **Yes** | 95.9% | 88.4% |
| They feel safe where they live. | I don't know | 0.0% | 0.0% |
| | No | 0.8% | 2.2% |
| | Sometimes | 1.5% | 4.5% |
| | **Yes** | 97.4% | 93.3% |
| Their services make their lives better. | I don't know | 0.0% | 0.4% |
| | No | 1.5% | 3.4% |
| | Sometimes | 1.9% | 3.4% |
| | **Yes** | 96.2% | 92.9% |

## 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 Q3 | SFY22 Q4 |
|---|---|---|
| **AIDS/HIV** - Unique Service Plans | 21 | 22 |
| Home Delivered Meals | 14 | 14 |
| CDAC (agency) by 15 minute units | 2 | 2 |
| Financial Management Services | 1 | 1 |
| **Brain Injury (BI) Waivers** | 786 | 769 |
| Financial Management Services | 241 | 226 |
| Supported Community Living (by unit) | 182 | 193 |
| Respite (by 15 minute units) | 157 | 164 |
| Personal Emergency Response | 165 | 160 |
| Supported Community Living (daily) | 109 | 109 |
| **Children's Mental Health (CMH)** | 739 | 783 |
| Respite (by 15 minute units) | 416 | 418 |
| Respite (Hos/NF) - 15 minute units | 198 | 216 |
| Family and Community Support | 200 | 185 |
| Respite (Resident Camp) by units | 10 | 19 |
| Home Modification | 2 | 3 |
| **Elderly Waivers** | 4,349 | 4,342 |
| Home Delivered Meals | 2,765 | 2,742 |
| Personal Emergency Response | 2,798 | 2,741 |
| CDAC (agency) by 15 minute units | 390 | 478 |
| Assisted Living Services | 334 | 330 |
| Personal Emergency Response (install) | 285 | 301 |

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| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **Habilitation (Hab)** | 4,233 | 4,201 |
| Home-based Habilitation | 3,681 | 3,448 |
| Long Term Job Coaching | 412 | 406 |
| Day Habilitation (units by day) | 380 | 354 |
| Individual Supported Employment | 112 | 141 |
| Day Habilitation (by 15 minute units) | 129 | 138 |
| **Health & Disability (HD)** | 1,326 | 1,345 |
| Respite (by 15 minute units) | 352 | 377 |
| Financial Management Services | 376 | 363 |
| Personal Emergency Response | 311 | 314 |
| Home Delivered Meals | 290 | 296 |
| CDAC (individual) by 15 minute units | 48 | 62 |
| **Intellectual Disability (ID)** | 6,951 | 6,923 |
| Supported Community Living (by unit) | 1,775 | 1,794 |
| Supported Community Living (RCF) | 1,458 | 1,489 |
| Day Habilitation (units by day) | 1,386 | 1,378 |
| Financial Management Services | 1,431 | 1,343 |
| Supported Community Living (daily) | 1,133 | 1,183 |
| **Physical Disability (PD)** | 606 | 601 |
| Personal Emergency Response | 326 | 327 |
| CDAC (agency) by 15 minute units | 79 | 84 |
| CDAC (individual) by 15 minute units | 77 | 63 |
| Financial Management Services | 30 | 35 |
| Personal Emergency Response (install) | 24 | 27 |

# **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: https://dhs.iowa.gov/ime/members/medicaid-a-to-z/hcbs/waivers.

## Top 5 Waiver Services

- by Member Usage

| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **AIDS/HIV** - Unique Service Plans | 7 | 8 |
| Home Delivered Meals | 8 | 8 |
| CDAC (individual) by 15 minute units | 2 | 1 |
| CDAC (agency) by 15 minute units | 1 | 1 |
| Homemaker (by 15 minute units) | 1 | 1 |
| **Brain Injury (BI) Waivers** | 514 | 515 |
| Supported Community Living (by unit) | 222 | 216 |
| Personal Emergency Response | 132 | 139 |
| Respite (by 15 minute units) | 130 | 125 |
| Supported Community Living (daily) | 124 | 122 |
| Transportation (1-way trip) | 87 | 93 |
| **Children's Mental Health (CMH)** | 328 | 374 |
| Respite (by 15 minute units) | 192 | 215 |
| Respite (Hos/NF) - 15 minute units | 127 | 145 |
| Family and Community Support | 106 | 106 |
| Mental Health Service | 40 | 42 |
| Respite (Resident Camp) by units | 8 | 12 |
| **Elderly Waivers** | 3,257 | 3,277 |
| Personal Emergency Response | 2,542 | 2,542 |
| Home Delivered Meals | 2,513 | 2,477 |
| CDAC (agency) by 15 minute units | 1,353 | 1,303 |
| Homemaker (by 15 minute units) | 757 | 708 |
| CDAC (individual) by 15 minute units | 659 | 648 |

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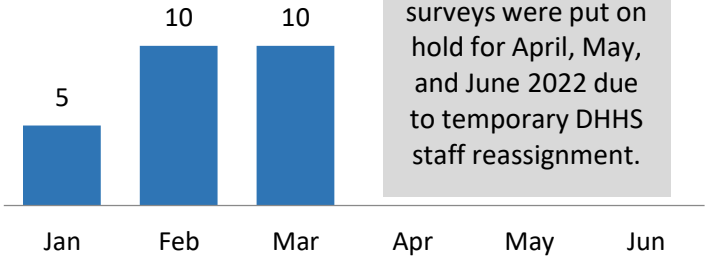
| | SFY22 Q3 | SFY22 Q4 |
|---|---|---|
| **Habilitation (Hab)** | 2,364 | 2,371 |
| Home-based Habilitation | 1,966 | 1,954 |
| Day Habilitation (by 15 minute units) | 343 | 329 |
| Day Habilitation (units by day) | 296 | 277 |
| Long Term Job Coaching | 285 | 273 |
| Individual Supported Employment | 135 | 126 |
| **Health & Disability (HD)** | 593 | 590 |
| Respite (by 15 minute units) | 276 | 276 |
| Personal Emergency Response | 159 | 152 |
| Home Delivered Meals | 158 | 149 |
| CDAC (agency) by 15 minute units | 112 | 100 |
| CDAC (individual) by 15 minute units | 101 | 95 |
| **Intellectual Disability (ID)** | 4,466 | 4,435 |
| Supported Community Living (by unit) | 1,823 | 1,751 |
| Day Habilitation (by 15 minute units) | 1,736 | 1,693 |
| Day Habilitation (units by day) | 1,623 | 1,559 |
| Supported Community Living (RCF) | 1,284 | 1,214 |
| Respite (by 15 minute units) | 1,019 | 965 |
| **Physical Disability (PD)** | 375 | 384 |
| Personal Emergency Response | 196 | 213 |
| CDAC (agency) by 15 minute units | 155 | 161 |
| CDAC (individual) by 15 minute units | 126 | 114 |
| Transportation (1-way trip) | 40 | 41 |
| Personal Emergency Response (install) | 22 | 26 |

# Call Center Performance Metrics

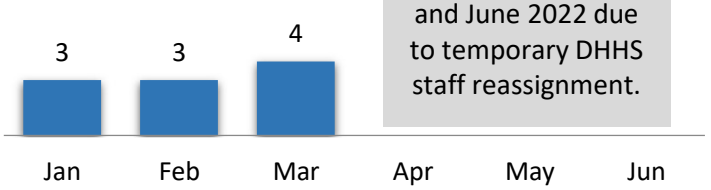
| | Apr | May | Jun |
|---|---|---|---|
| **Member Helpline** | | | |
| Service Level (Requirement 80%) | 96.39% | 97.30% | 93.13% |
| Abandonment Rate - Must be 5% or less | 0.37% | 0.30% | 0.59% |
| **Member Pharmacy Helpline** | | | |
| Service Level (Requirement 80%) | 99.81% | 99.60% | 99.14% |
| Abandonment Rate - Must be 5% or less | 0.00% | 0.00% | 0.09% |
| **Provider Helpline** | | | |
| Service Level (Requirement 80%) | 94.07% | 95.40% | 90.20% |
| Abandonment Rate - Must be 5% or less | 0.55% | 0.33% | 0.46% |
| **Non-Emergency Medical Transportation (NEMT) Helpline** | | | |
| Service Level (Requirement 80%) | 80.81% | 83.46% | 90.23% |
| Abandonment Rate - Must be 5% or less | 2.69% | 2.98% | 1.14% |

**Secret Shopper Scores**
- Member Helpline




Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.

**Secret Shopper Scores**
- Provider Helpline




Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.

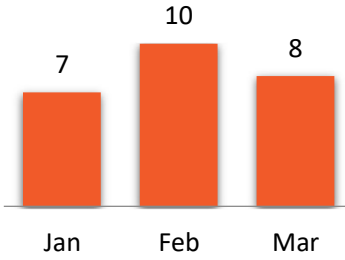
**Data Notes**: Top 5 Call Reasons are captured during the last month of the reporting period.

| | Top 5 Call Reasons (Member Helpline) | Top 5 Call Reasons (Provider Helpline) |
|---|---|---|
| 1. | Benefit Inquiry | Benefit Inquiry |
| 2. | Over the Counter | Authorization Status |
| 3. | ID Card Request or Inquiry | Claim Status |
| 4. | Enrollment Information | Claim Payment Question or Dispute |
| 5. | Transportation Inquiry | Enrollment Inquiry |

# Call Center Performance Metrics

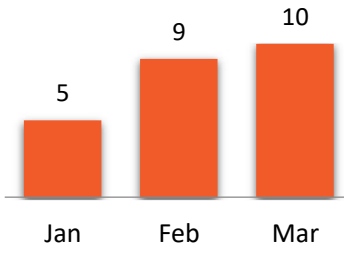
| | Apr | May | Jun |
|---|---|---|---|
| **Member Helpline** | | | |
| Service Level (Requirement 80%) | 83.54% | 86.62% | 87.92% |
| Abandonment Rate - Must be 5% or less | 4.21% | 4.29% | 4.29% |
| **Member Pharmacy Helpline** | | | |
| Service Level (Requirement 80%) | 85.60% | 86.80% | 86.80% |
| Abandonment Rate - Must be 5% or less | 0.90% | 1.00% | 1.30% |
| **Provider Helpline** | | | |
| Service Level (Requirement 80%) | 80.50% | 85.30% | 87.60% |
| Abandonment Rate - Must be 5% or less | 1.90% | 1.42% | 1.20% |
| **Non-Emergency Medical Transportation (NEMT) Helpline** | | | |
| Service Level (Requirement 80%) | 79.85% | 84.84% | 91.36% |
| Abandonment Rate - Must be 5% or less | 2.08% | 2.16% | 0.83% |

**Secret Shopper Scores - Member Helpline**




Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.

**Secret Shopper Scores - Provider Helpline**




Secret Shopper surveys were put on hold for April, May, and June 2022 due to temporary DHHS staff reassignment.

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

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

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

# Provider Network Access Summary

## Primary Care Providers (PCP)

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|---|
| **Adults PCP** | | | | |
| Provider Count | 6,589 | 6,688 | 6,768 | 6,893 |
| Members with Access | 228,637 | 231,146 | 230,958 | 237,584 |
| Average Distance (Miles) | 1.8 | 1.8 | 1.8 | 1.8 |
| **Pediatric PCP** | | | | |
| Provider Count | 6,621 | 6,719 | 6,798 | 6,924 |
| Members with Access | 213,136 | 212,453 | 214,637 | 214,390 |
| Average Distance (Miles) | 2.0 | 1.9 | 1.9 | 1.9 |

## Specialty Care & Behavioral Health (BH)

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|---|
| **OB/GYN Adult** | | | | |
| Provider Count | 401 | 405 | 409 | 423 |
| Members with Access | 148,670 | 150,083 | 150,019 | 154,186 |
| Average Distance (Miles) | 5.6 | 5.6 | 5.5 | 5.5 |
| **Outpatient - Behavioral Health** | | | | |
| Provider Count | 4,305 | 4,456 | 4,503 | 4,543 |
| Members with Access | 441,773 | 443,599 | 445,595 | 451,974 |
| Average Distance (Miles) | 2.3 | 2.2 | 2.2 | 2.2 |
| **Inpatient - Behavioral Health** | | | | |
| Provider Count | 50 | 51 | 51 | 51 |
| **Rural Members** | | | | |
| Members with Access | 180,629 | 181,008 | 181,707 | 184,359 |
| Average Distance (Miles) | 21.4 | 18.5 | 18.3 | 21.0 |
| **Urban Members** | | | | |
| Members with Access | 261,144 | 262,591 | 263,888 | 267,615 |
| Average Distance (Miles) | 5.8 | 5.8 | 5.8 | 5.8 |

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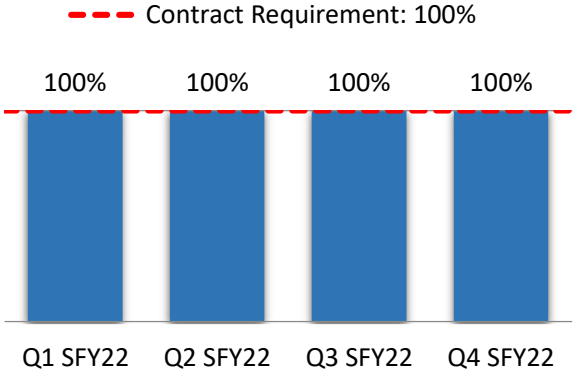
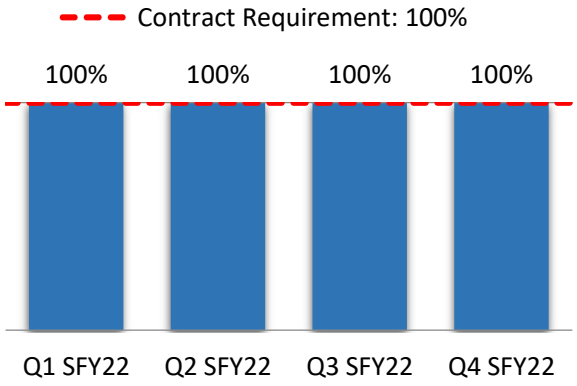
**Adult PCP - Standards**
30 minutes or 30 miles




**Pediatric PCP - Standards**
30 minutes or 30 miles




**Link to Geo Access Reports**:

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

# Provider Network Access Summary

## Primary Care Providers (PCP)

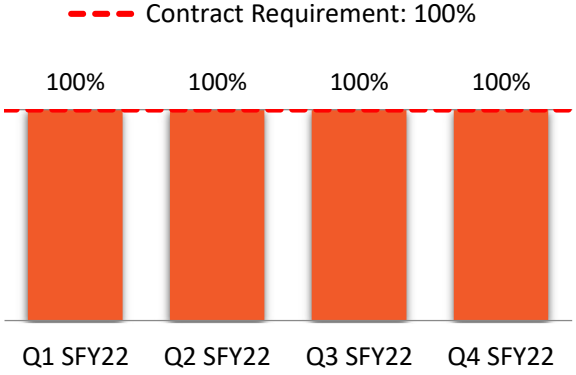
| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|---|
| **Adults PCP** | | | | |
| Provider Count | 9,894 | 9,894 | 9,894 | 9,894 |
| Members with Access | 175,634 | 180,087 | 186,041 | 189,029 |
| Average Distance (Miles) | 2.0 | 2.0 | 2.0 | 2.0 |
| **Pediatric PCP** | | | | |
| Provider Count | 10,658 | 10,658 | 10,658 | 10,658 |
| Members with Access | 141,050 | 143,484 | 146,338 | 147,665 |
| Average Distance (Miles) | 2.1 | 2.1 | 2.1 | 2.1 |

## Specialty Care & Behavioral Health (BH)

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 |
|---|---|---|---|---|
| **OB/GYN Adult** | | | | |
| Provider Count | 1,298 | 1,298 | 1,298 | 1,298 |
| Members with Access | 115,394 | 118,135 | 121,417 | 123,122 |
| Average Distance (Miles) | 5.4 | 5.4 | 5.3 | 5.4 |
| **Outpatient - Behavioral Health** | | | | |
| Provider Count | 9,688 | 9,688 | 9,688 | 9,688 |
| Members with Access | 316,684 | 323,571 | 332,379 | 336,694 |
| Average Distance (Miles) | 2.4 | 2.4 | 2.4 | 2.5 |
| **Inpatient - Behavioral Health** | | | | |
| Provider Count | 36 | 36 | 36 | 36 |
| **Rural Members** | | | | |
| Members with Access | 226,908 | 231,823 | 238,027 | 241,452 |
| Average Distance (Miles) | 24.6 | 24.5 | 24.5 | 24.5 |
| **Urban Members** | | | | |
| Members with Access | 89,776 | 91,748 | 94,352 | 95,242 |
| Average Distance (Miles) | 8.4 | 8.4 | 8.4 | 8.4 |

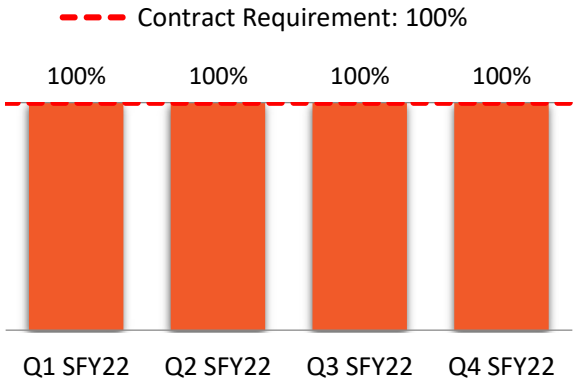
**Adult PCP - Standards**

30 minutes or 30 miles




**Pediatric PCP - Standards**

30 minutes or 30 miles




**Link to Geo Access Reports**:

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

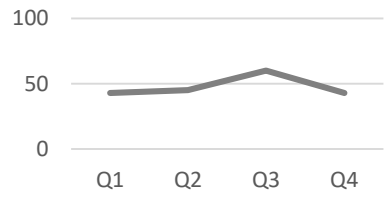
# MCO Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems, which have a series of edits that reject inaccurate or duplicate claims. Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

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

Total Investigations Opened in SFY22 Q4

43




2 Total Cases
Referred to MFCU Q4

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| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 | Average | Total |
|---|---|---|---|---|---|---|
| Investigations opened | 28 | 31 | 44 | 25 | 32 | 128 |
| Overpayments identified | 14 | 25 | 28 | 10 | 19 | 77 |
| Member concerns referred to IME | 2 | 5 | 0 | 4 | 3 | 11 |
| Cases referred to the Medicaid Fraud Control Unit (MFCU) | 6 | 4 | 3 | 2 | 4 | 15 |

iowa total care

| | SFY22 Q1 | SFY22 Q2 | SFY22 Q3 | SFY22 Q4 | Average | Total |
|---|---|---|---|---|---|---|
| Investigations opened | 15 | 12 | 16 | 18 | 15 | 61 |
| Overpayments identified | 12 | 17 | 9 | 6 | 11 | 44 |
| Member concerns referred to IME | 10 | 5 | 6 | 4 | 6 | 25 |
| Cases referred to the Medicaid Fraud Control Unit (MFCU) | 16 | 3 | 3 | 0 | 6 | 22 |

# 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. 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

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

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

**Capitation Expenditures** (continued...):

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

**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**): See Health and Human Services (HHS)

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

**Disenrollment**: Refers to members who have chosen to change their enrollment with one 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.

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

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

**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**: The division of Health and Human Services (HHS) 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

# **Appendix: Oversight Entities** - Healthy and Well Kids in Iowa (Hawki) Board

The Hawki Board is a group of people and directors of other state agencies who are appointed by the Governor or who are members of the Legislature. The Hawki Board was established to provide direction to the Iowa Department of Human Services on the development, implementation, and ongoing administration of the Hawki program. The Hawki Board is required by law to meet at least six times per year and usually meets on the third Monday of every other month. Anyone may attend and observe a Board meeting. During the meeting, there is time for the public to make comments and ask questions.

See DHS website for all future and historical meeting information: https://dhs.iowa.gov/hawki/hawkiboard

**Hawki Board of Directors Member List**

**Public Members**
MaryNelle Trefz, Chair
Mary Scieszinski, Vice Chair
Shawn Garrington
Mike Stopulos

**Statutory Members**

**Iowa Insurance Division**
Doug Ommen - Commissioner
Angela Burke Boston - Designee

**Iowa Department of Education**
Dr. Ann Lebo - Director
Jim Donoghue - Designee

**Iowa Department of Public Health**
Kelly Garcia - Interim Director
Angie Doyle Scar - Designee

**Department of Human Services (DHS) Staff**
Elizabeth (Liz) Matney - Iowa Medicaid Director

**Legislative Members - Ex Officio**
Senator Nate Boulton
Senator Mark Costello
Representative Shannon Lundgren

# **Appendix: Oversight Entities** - Medical Assistance Advisory Council (MAAC)

The purpose of the Medical Assistance Advisory Council (MAAC) is to "Advise the Director about health and medical care services under the medical assistance program." The Council is mandated by federal law and further established in Iowa Code. MAAC meets quarterly.

See DHS website for all future and historical meeting information: https://dhs.iowa.gov/ime/about/advisory_groups/maac

**MAAC Council Member List**

**Co-Chairpersons**
Angela Doyle-Scar, Public Health
Jason Haglund, Public Member

**Voting Members**: Public Representatives
John Dooley, Public Member
Dee Sandquist, Public Member
Amy Shriver, Public Member
Marcie Strouse, Public Member

**Voting Members**: Professional and Business Entities
Brett Barker, Iowa Pharmacy Association
Erin Cubit, Iowa Hospital Association
Brandon Hagen, Iowa Health Care Association
Shelly Chandler, Iowa Association of Community Providers
Dennis Tibben, Iowa Medical Society

**Members of the General Assembly**
Senator Bolkcom
Senator Mark Costello
Representative John Forbes
Representative Ann Meyer

**Other Statutory Members**
VACANT, Des Moines University-Osteopathic Medical Center
Angela Van Pelt, Iowa Department of Aging
Cynthia Pedersen, Long-Term Care Ombudsman
Jennifer Harbison, University of Iowa College of Medicine
Angela Doyle Scar, Iowa Department of Public Health
Mary Nelle Trefz, Hawki Board

**Professional and Business Entities**
Anthony Carroll, AARP
Doug Cunningham, the ARC of Iowa
Kristie Oliver, Coalition for Family and Children's Services in Iowa
Wendy Gray, Free Clinics of Iowa
David Carlyle, Iowa Academy of Family Physicians
Patricia Hildebrand, Iowa Academy of Nutrition and Dietetics
Maria Jordan, Iowa Adult Day Services Association
Dan Royer, Iowa Alliance in Home Care
Helen Royer, Iowa Hearing Association
Cheryll Jones, Iowa Association of Nurse Practitioners
Edward Friedmann, Iowa Association of Rural Health Clinics
Di Findley, Iowa CareGivers
**Continued**…

# **Appendix: Oversight Entities** - Medical Assistance Advisory Council (MAAC)

**MAAC Council Member List** continued...

**Professional and Business Entities**

Flora Schmidt, Iowa Behavioral Health Association
Marianka Pille, Iowa Chapter of the American Academy of Pediatrics
Denise Rathman, Iowa Chapter of the National Association of Social Workers
Molly Lopez, Iowa Chiropractic Society
Josh Carpenter, Iowa Dental Association
Laurie Traetow, Iowa Dental Association
Brooke Lovelace, Iowa Developmental Disabilities Council
Bill Kallestad, Iowa Developmental Disabilities Council
Sue Whitty, Iowa Nurses Association
Sherry Buske, Iowa Nurse Practitioner Society
Steve Bowen, Iowa Occupational Therapy Association
Gary Ellis, Iowa Optometric Association
VACANT, Iowa Osteopathic Medical Association
Kate Walton, Iowa Physical Therapy Association
Kevin Kruse, Iowa Podiatric Medical Society
Erica Shannon, Iowa Primary Care Association
Sara Stramel Brewer, Iowa Psychiatric Society
Dave Beeman, Iowa Psychological Association
Barbara Nebel, Iowa Speech-Language-Hearing Association
Deb Eckerman Slack, Iowa State Association of Counties
Matt Blake, Leading Age Iowa
Matt Flatt, Midwest Association for Medical Equipment Services
Peggy Huppert, National Alliance on Mental Illness
Kay Vanags, Iowa Association of Area Agencies on Aging
Lynn Boes, Iowa Nurses Association
Marc Doobay, Iowa Physician Assistant Society
Cindy Baddeloo, Iowa Health Care Association/Iowa Center for Assisted Living
VACANT, Opticians Association of Iowa
Kady Reese, Iowa Medical Society
Susan Horras, Iowa Hospital Association

# **Appendix: Oversight Entities** - Council on Human Services

There is created within the Department of Human Services a council on human services which shall act in a policymaking and advisory capacity on matters within the jurisdiction of the department. The council shall consist of seven voting members appointed by the governor subject to confirmation by the senate. Appointments shall be made on the basis of interest in public affairs, good judgement, and knowledge and ability in the field of human services. Appointments shall be made to provide a diversity of interest and point of view in the membership and without regard to religious opinions or affiliations. The voting members of the council shall serve for six-year staggered terms.

See DHS website for all future and historical meeting information: https://dhs.iowa.gov/about/dhs-council

**Council on Human Services Member List**

**Iowa Council on Human Services Members**

Rebecca Peterson, Clive - Chair
Kimberly Kudej, Swisher - Vice Chair
Sam Wallace, Des Moines
Skylar Mayberry-Mayes, Des Moines
John (Jack) Willey, Maquoketa
Kay Fisk, Mt. Vernon, IA
Monika Jindal, Tiffin, IA

**Legislative Members - Ex Officio**

Senator Amanda Ragan
Senator Mark Costello
Representative Joel Fry
Representative Timi Brown-Powers