Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2018, Quarter 2

(October-December 2017)

Performance Data

Published March 28, 2018

Iowa Department of Human Services

CONTENTS

EXECUTIVE SUMMARY

Legislative Requirements:
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
- 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 will flow in the following way:

- Eligibility and demographic information associated with members assigned to managed care
- Care coordination related to specific population groupings (General, Special Needs, Behavioral Health, and Elderly)
- Consumer protections and support information
- Managed care organization program information related to operations
- Network access and continuity of providers
- Financial reporting
- Program integrity actions and recoveries
- Health care outcomes for Medicaid members
- Appendices with supporting information

This report is based on Quarter 2 of State Fiscal Year (SFY) 2018 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

- Amerigroup Iowa, Inc. (Amerigroup, AGP)
- AmeriHealth Caritas Iowa, Inc. (AmeriHealth, ACIA)
- UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare, UHC)

Notes about the reported data:

- AmeriHealth Caritas Iowa, Inc. did not have members enrolled in December 2017.
    - Measures that provide a snapshot of the last months of the quarter, including but not limited to demographic information and case management assignment, will be reported as 0 (zero) or N/A.
    - Measures with November snapshots or aggregate data for the reported period will still include AmeriHealth Caritas Iowa, Inc. data.
- For this reporting period, it is noteworthy to consider how transition of AmeriHealth Caritas members to UnitedHealthcare or Fee-for-Service may have impacted reporting.
- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized, aggregate health outcome measures are reported

annually. This will include measures associated with HEDIS®[1] CAHPS[2], and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).

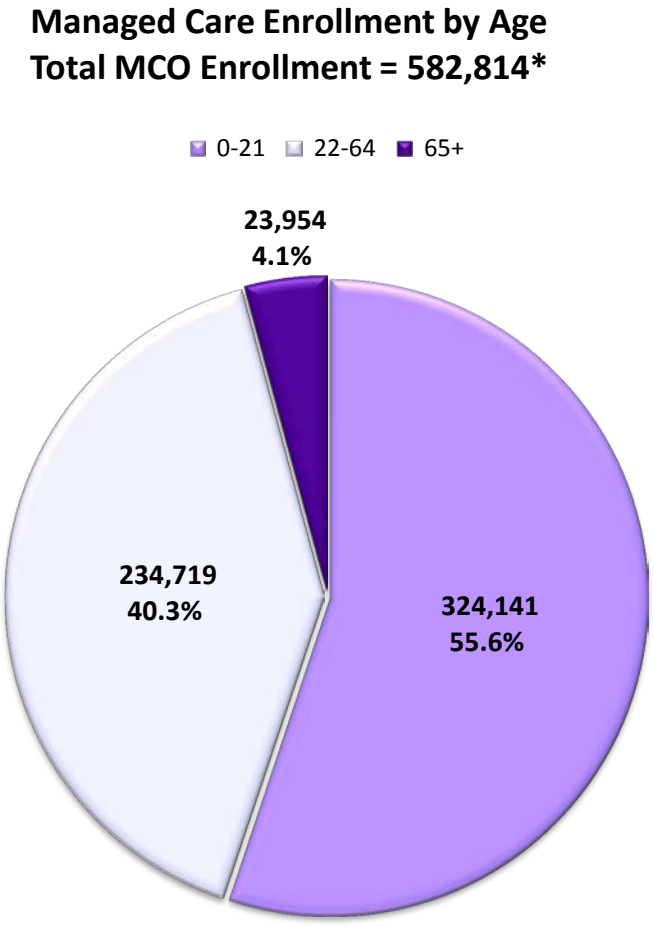
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However, based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.
- 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.

More information on the move to managed care is available at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink

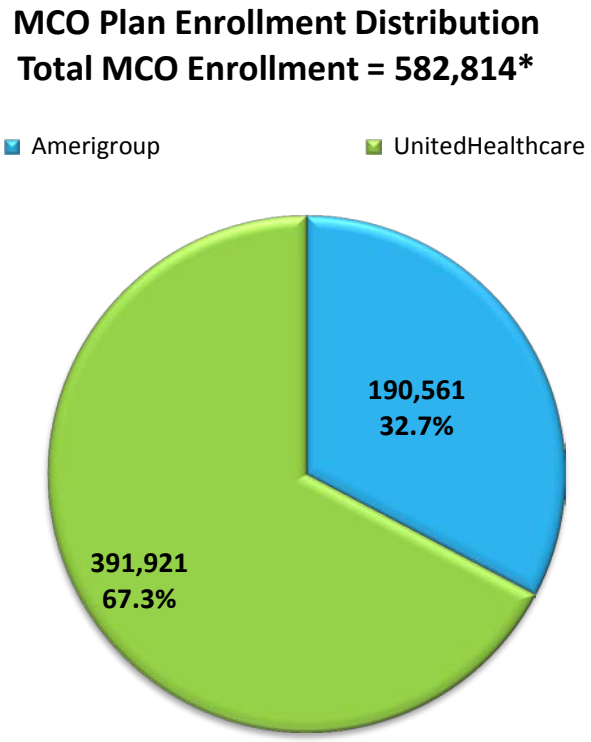
[1] The Healthcare Effectiveness Data and Information Set (HEDIS®) is a standardized, nationally-accepted set of performance measures that assess health plan performance and quality.
[2] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized, nationally-accepted survey that assesses health plan member satisfaction.

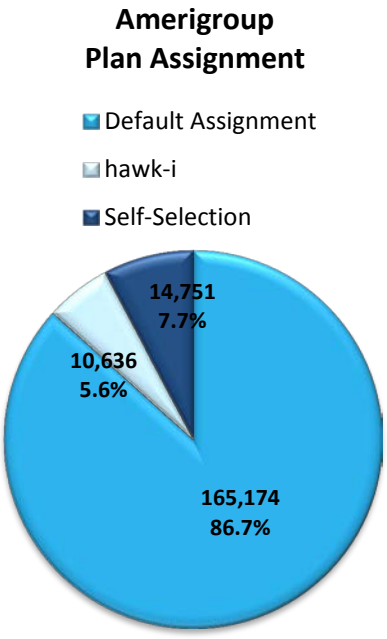
PLAN ENROLLMENT BY AGE

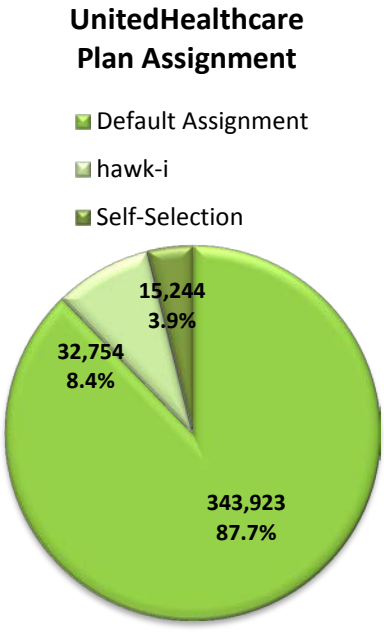


*December 2017 enrollment data as of January 31, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes ***hawk-i*** enrollees. 75,417 members are in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY MCO

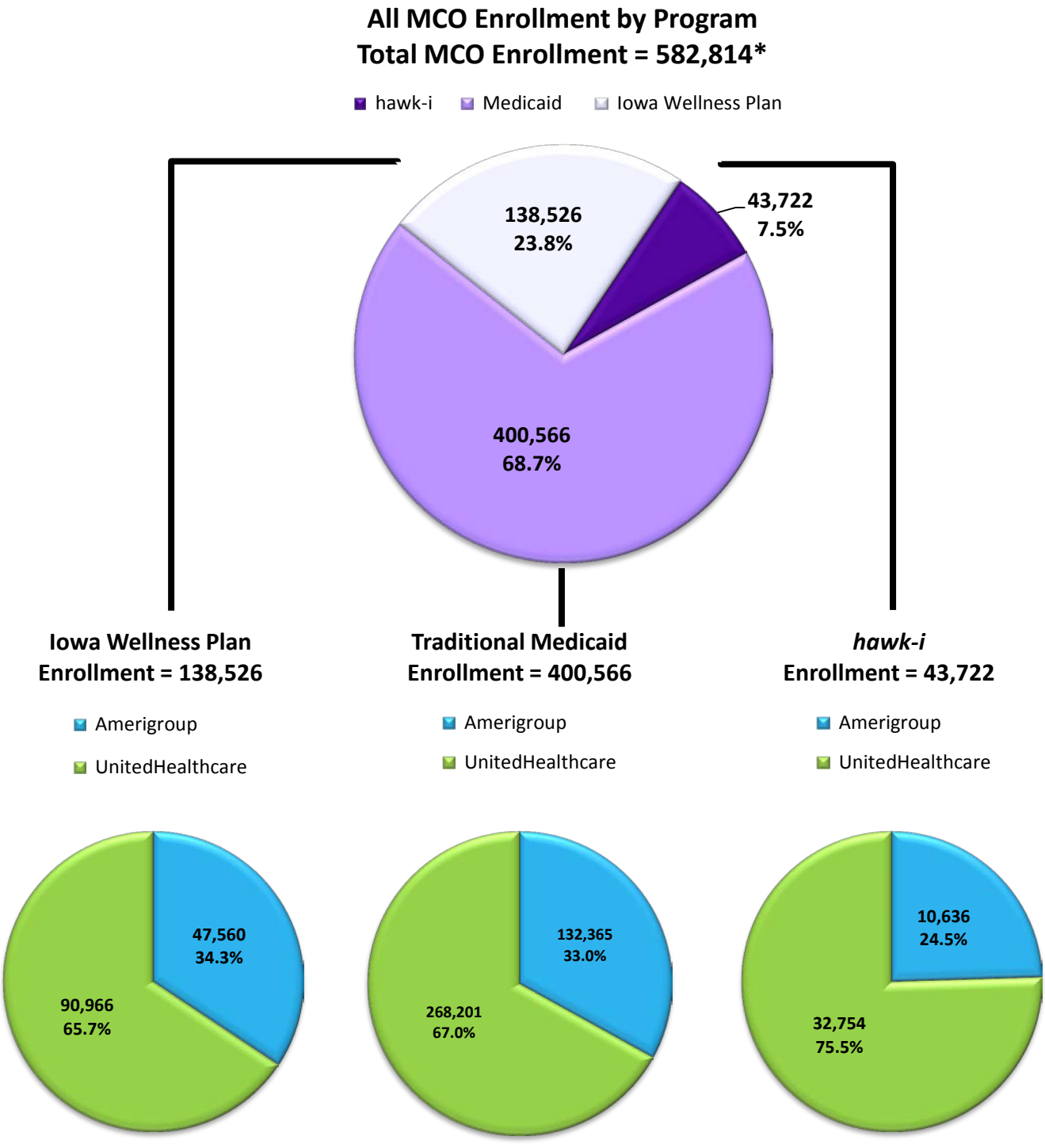






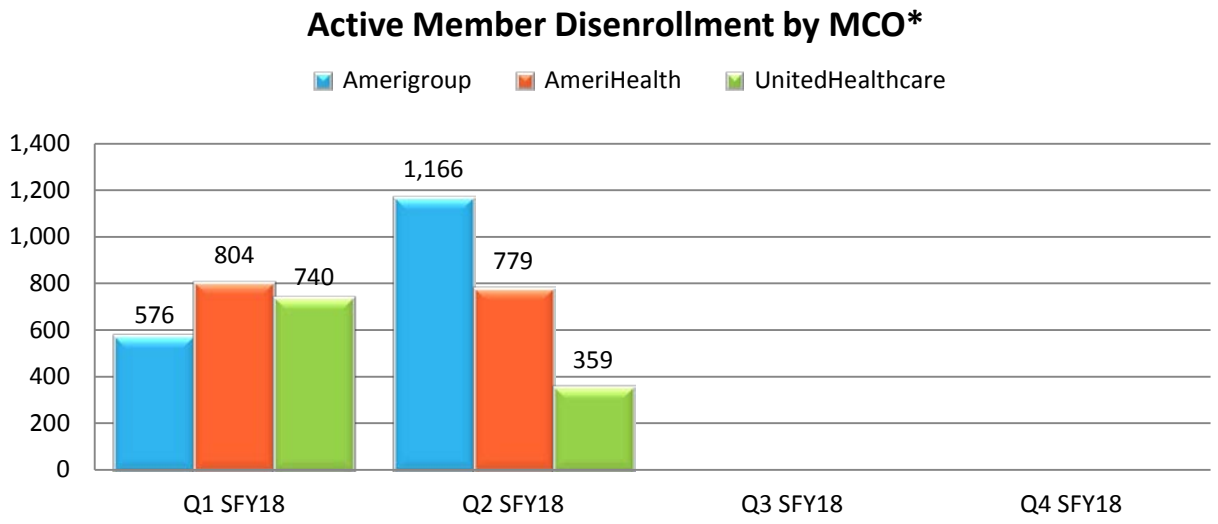
*December 2017 data as of January 31, 201 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This differentiates ***hawk-i*** enrollees due to differences in *hawk-i* enrollment procedures. In most cases, *hawk-i* members select an MCO prior to beginning benefits whereas other programs have default assignment with self-selection occurring after default assignment. 75,417 members are in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY PROGRAM



*December 2017 enrollment data as of January 31, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. 75,417 members are in the Fee-for-Service (FFS) program.

PLAN DISENROLLMENT BY MCO



*Q2 SFY18 enrollment data as of December 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. Disenrollment does not include members in the *hawk-i* program.

Disenrollment refers to members who have chosen to change their enrollment with one MCO to an alternate MCO. The chart above indicates the number of members disenrolling from the MCO to another MCO. This includes members changing MCOs within the 90 day "choice period" that they can change for any reason as well as "good cause" disenrollments after the 90 day choice period. Members leaving AmeriHealth in November and December are not being counted because there was not member choice.

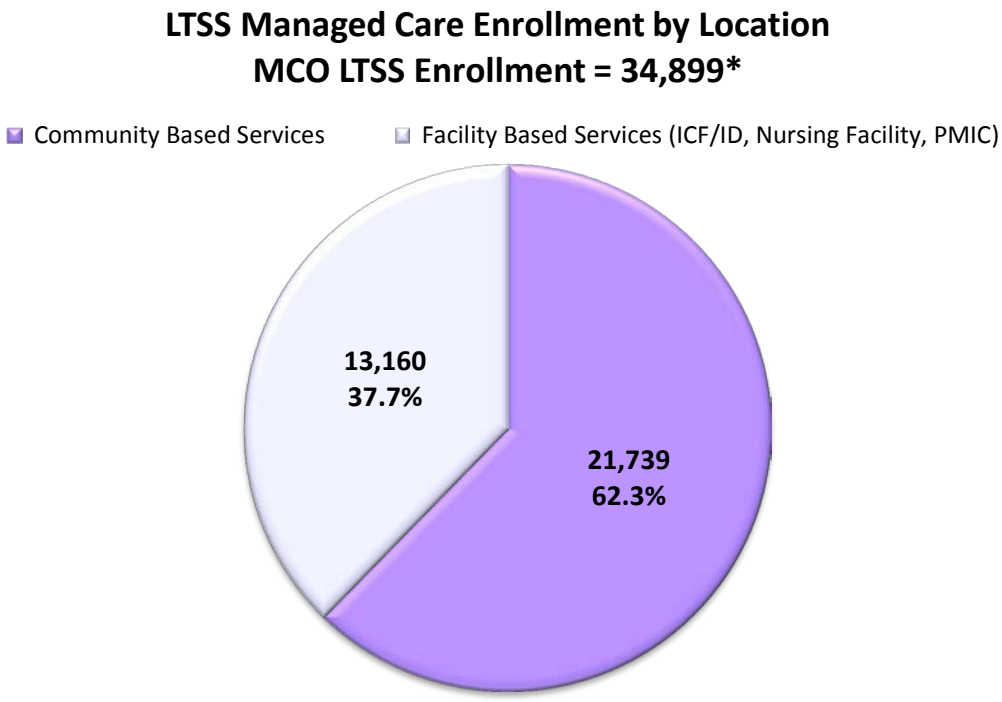
Reasons for "Good Cause" Disenrollment for Q2 SFY18

Members can disenroll for good cause any time during the year after their 90 day choice period if certain criteria are met such as:

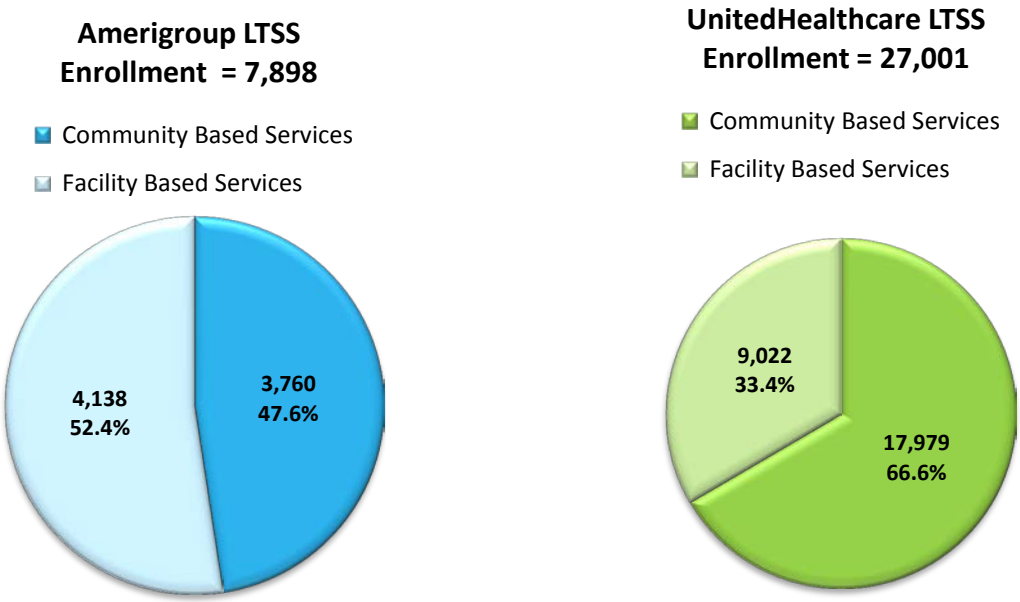
- The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- Other reasons, including but not limited to, poor quality of care, lack of access to services covered under the contract, lack of access to providers experienced in dealing with the member's health care needs, or eligibility and choice to participate in a program not available in managed care (i.e. PACE).
- MCO does not, because of moral or religious objections, cover the service the member seeks.

Summary Reason	Count
Established provider in another MCO network	1,398
Continuity of care	112
Lack of access to services covered under the contract	32
Lack of access to providers experienced in dealing with the member's health care needs	27
Quality of care	9

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



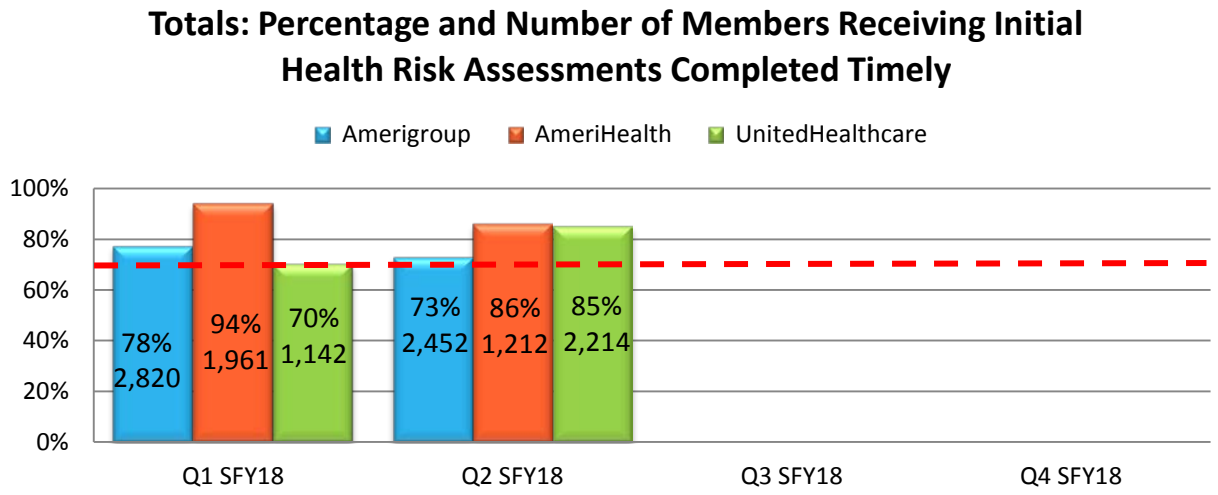
Total MCO LTSS Enrollment by Plan



*December 2017 enrollment data as of January 30, 2018 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

CARE COORDINATION REPORTING

Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. Special health care needs may be identified through the initial health risk assessment, standard industry predictive modeling, claims review, or physician referral. Care coordination can also occur at the request of the member or caregiver. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service.

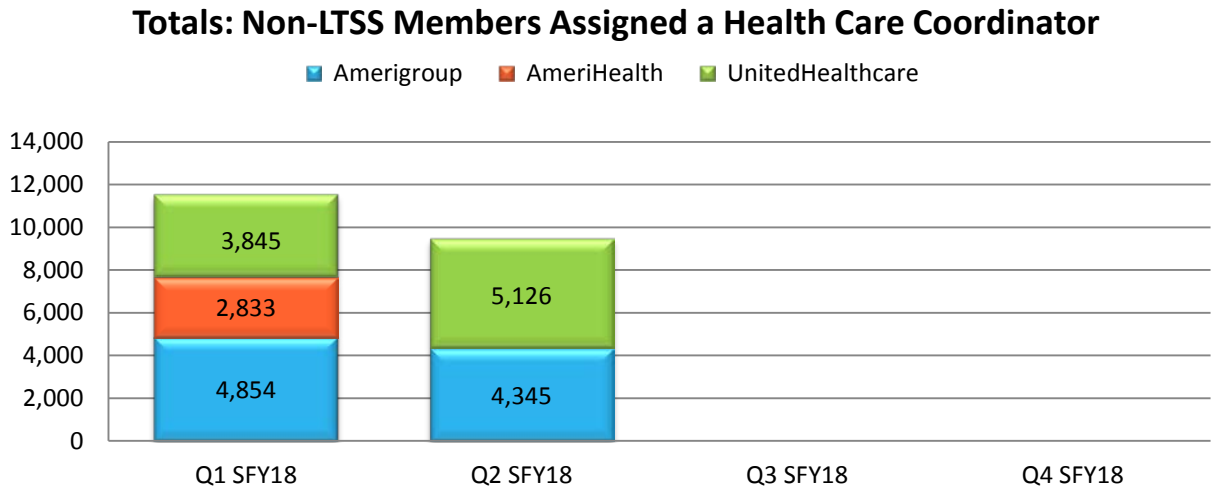


Population-Specific Supporting Data for Q2 SFY18						
Data are cumulative for the quarter	**Amerigroup**		**AmeriHealth**		**UnitedHealthcare**	
	Count	%	Count	%	Count	%
Initial HRAs Completed Timely for Seniors (Ages 65& Up)	276	90%	191	99%	333	89%
Initial HRAs Completed Timely for Adults(Ages 18-64)	1,057	86%	504	94%	1,071	94%
Initial HRAs Completed Timely for Children (Under Age 18)	1,119	61%	517	75%	810	74%

At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days and the MCO has been able to reach within three attempts, must receive an initial health risk assessment. This data includes all MCO populations. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed.

Members identified as having a special health care need through the initial health risk assessment or other means may be assigned a care coordinator with an MCO Care Coordination Program, a Chronic Condition Health Home, or an Integrated Health Home. This data element does not have a direct benchmark to compare to historical fee-for-service data.

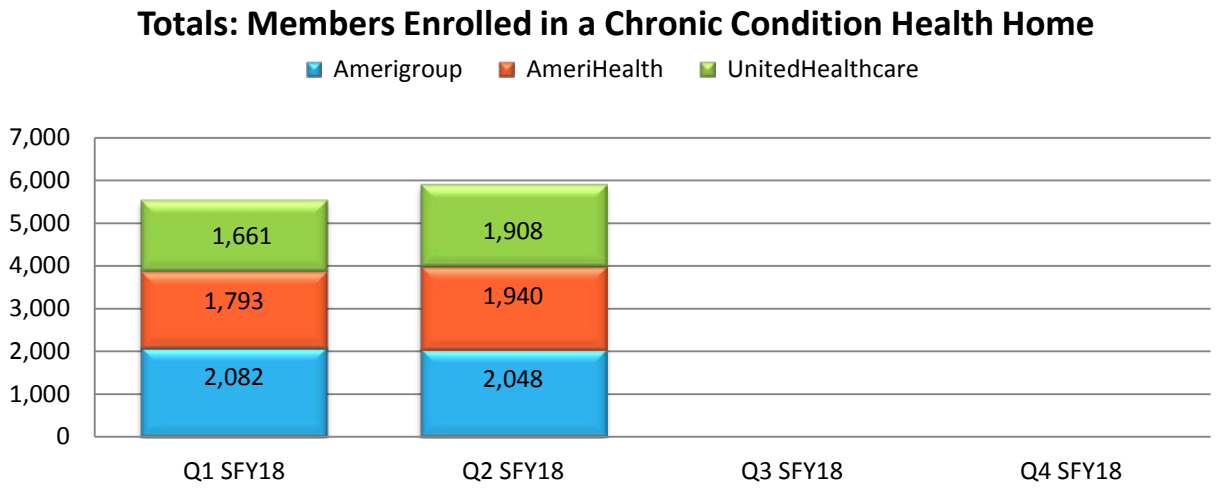


Data is as of December 2017. AmeriHealth did not have any members enrolled in December 2017.

Population-Specific Supporting Data for Q2 SFY18			
Data Reported as of December 31, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator	197	0	140
Count of Non-LTSS Adults (Ages 18-64) Assigned a Health Care Coordinator	2,945	0	3,167
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator	1,203	0	1,819

CHRONIC CONDITION HEALTH HOME ASSIGNMENT

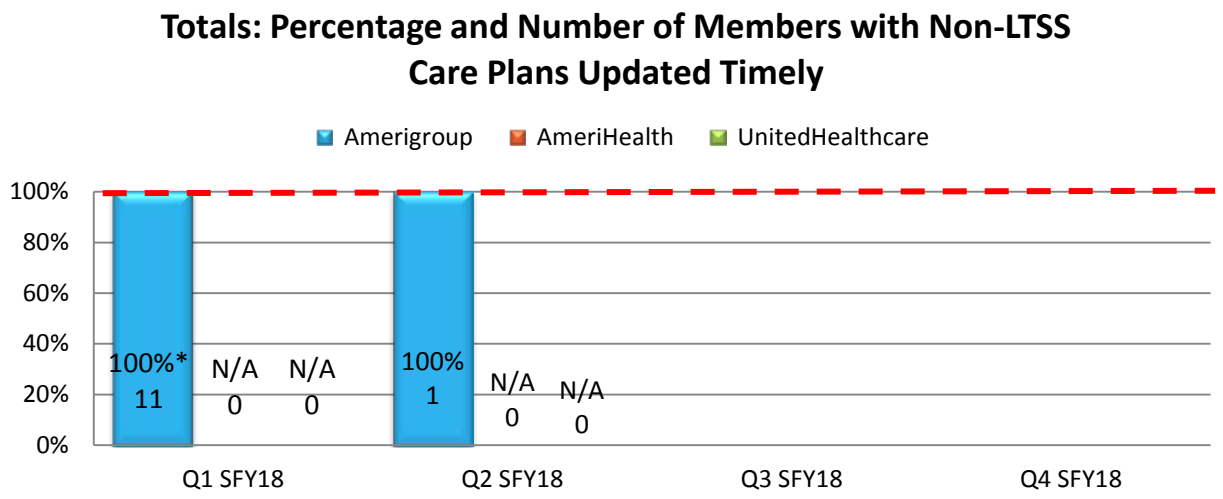
Alternatives to MCO Health Care Coordinators are Chronic Condition Health Home care coordination and Integrated Health Home care coordination. This section focuses on Chronic Condition Health Homes. Chronic Condition Health Homes are medical offices that provide care coordination services on behalf of the Managed Care Organization.



Population-Specific Supporting Data for Q2 SFY18			
Data Reported as of November 30, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home	205	272	143
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home	1,427	1,284	1,270
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home	416	384	495

Non-LTSS Update of Care Plans

Non-LTSS Members identified as having special health care needs and requiring ongoing care coordination have care plans developed and managed by the MCO. Federal regulations require that revisions to care plans for these members occur at least annually. This measure does not have a fee for service benchmark. All plans have indicated that their care coordination works to provide health care coordination such that members are prepared to discharge within twelve months, which is why the data reported indicates that few or zero care plans have been updated.

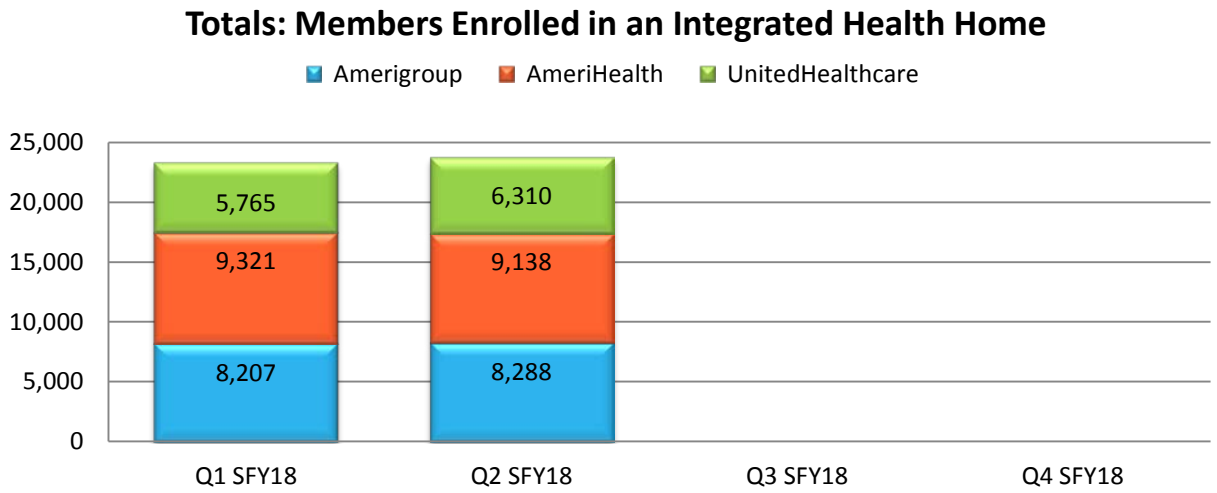


Population-Specific Supporting Data for Q2 SFY18						
Data are cumulative for the quarter	**Amerigroup**		**AmeriHealth**		**UnitedHealthcare**	
	Count	%	Count	%	Count	%
Non-LTSS Care Plans Updated Timely for Seniors (Ages 65& Up)	0	N/A	0	N/A	0	N/A
Non-LTSS Care Plans Updated Timely for Adults(Ages 18-64)	1	100%	0	N/A	0	N/A
Non-LTSS Care Plans Updated Timely for Children (Under Age 18)	0	N/A	0	N/A	0	N/A

*Amerigroup data percentage for Q1 has been updated to reflect a correction identified after the publication of last quarter's report.

Behavioral Health: Integrated Health Home Enrollment

Integrated Health Homes specialize in the coordinated care of members with serious and persistent mental illness and serious emotional disturbances. Members receiving Habilitation program services and Children's Mental Health Waiver services may receive care coordination through the Integrated Health Home instead of from MCO care coordinators or community-based case managers.

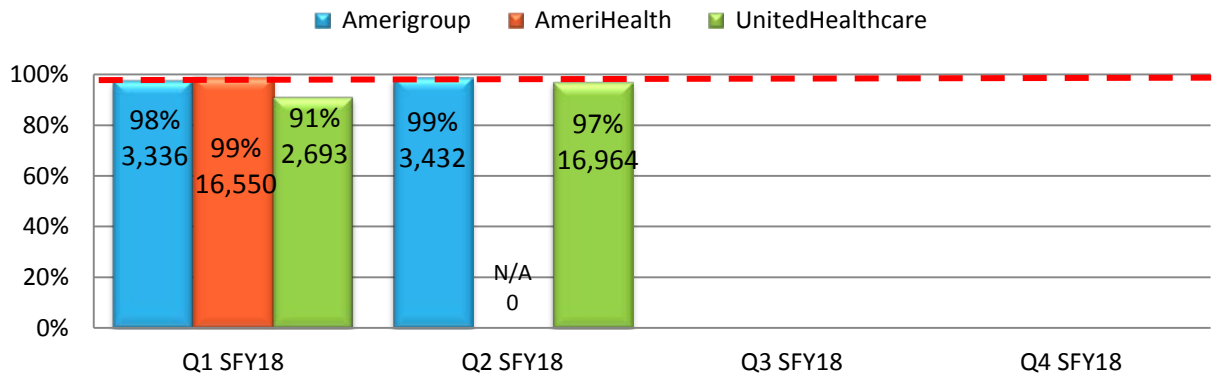


Population-Specific Supporting Data for Q2 SFY18			
Data Reported as of November 30, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home	124	123	89
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home	4,898	5,540	3,756
Count of Children (Under Age 18) Enrolled in an Integrated Health Home	3,266	3,475	2,465

Special Needs: LTSS Home and Community-Based Care Coordination

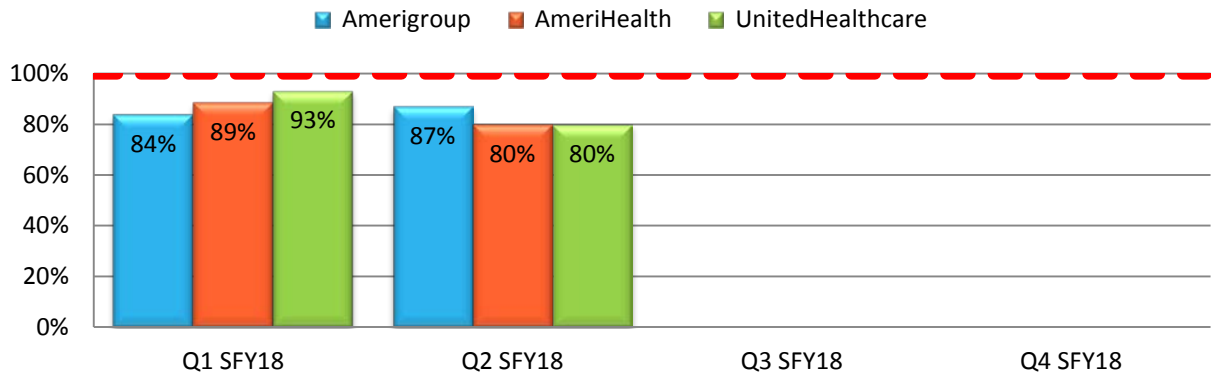
Community-based case management is a service that is specifically-designed to manage members receiving long term services and supports (LTSS). This is a new and more comprehensive case management strategy than was available in fee-for-service. Key components of community-based case management include person-centered care planning, addressing member's care and treatment needs, providing assurances for health and safety, and addressing potential risks related to members' desire to live as independently as possible. The count of Members Assigned a Community-Based Case Manager represents unduplicated count of members assigned a community-based case manager (CBCM) on the last day of the quarter. 100% of members receiving Home- and Community-Based Services (HCBS) should be assigned a community-based case manager. The IME is working to resolve data timing issues that may be impacting reported assignment.

Totals: Percentage and Number of HCBS Members Assigned a Community-Based Case Manager



HCBS Waiver-Specific Supporting Data for Q2 SFY18			
Data Reported as of December 31, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Brain Injury Members Assigned a CBCM	202	0	947
Elderly Members Assigned a CBCM	1,322	0	5,816
Health and Disability Members Assigned a CBCM	542	0	1,046
HIV/ AIDS Members Assigned a CBCM	13	0	18
Intellectual Disability Members Assigned a CBCM	1,043	0	8,562
Physical Disability Members Assigned a CBCM	310	0	575

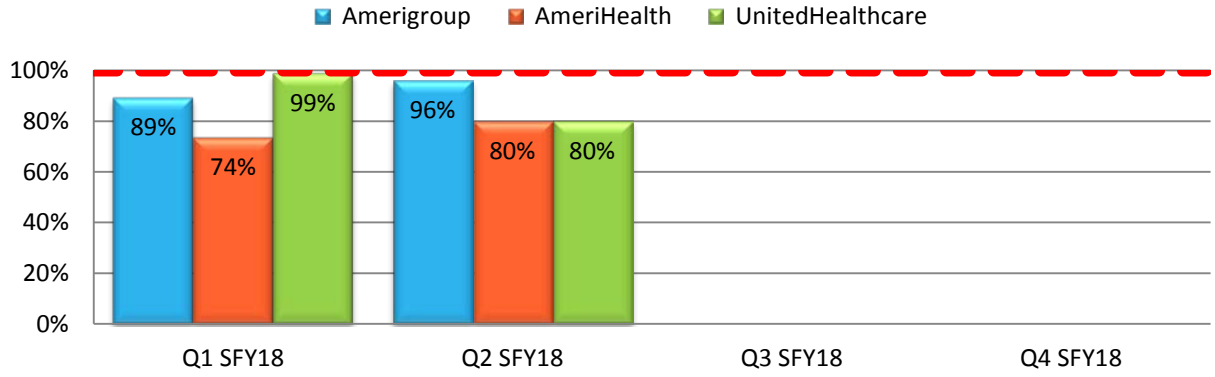
Percentage of HCBS Members Receiving Minimum Monthly Contact Timely



At a minimum, community-based case managers must contact 1915(c) HCBS waiver members at least monthly in person or by phone with an interval of at least 14 calendar days between contacts. HCBS Members Receiving Monthly Contact monitors the count of members requiring and the count of members receiving timely contact during the quarter. There may be legitimate reasons a member cannot be contacted outside MCO control. The department monitors the volume and reasons for missed contacts.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members and this effort impacted the UnitedHealthcare results for December.

Percentage of HCBS Members Receiving Minimum Quarterly Face-to-Face Contact Timely



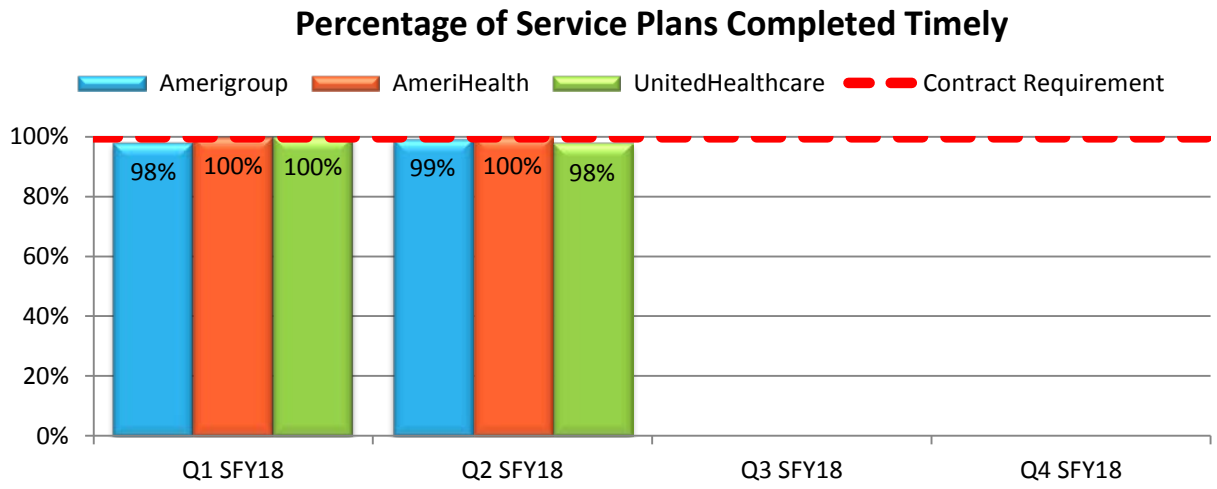
At a minimum, community-based case managers must visit members in their residence face-to-face quarterly with an interval of at least 60 calendar days between visits. HCBS Members Receiving Quarterly Face-to-Face Contact monitors the count of members requiring and the count of members receiving timely face-to-face contact during the quarter. There may be legitimate reasons a member cannot be contacted outside MCO control. The department monitors the volume and reasons for missed contacts.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members and this effort impacted the UnitedHealthcare results for December.

Community-Based Case Management Ratios			
The ratios below reflect combined adult and child populations for these settings where applicable.			
Data Reported as of December 31, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Members in Facility per Community-Based Case Manager	59	N/A	38
Members in Community per Community-Based Case Manager	40	N/A	33
Unduplicated LTSS Members per Community-Based Case Manager	67	N/A	46

Service Plans

Waiver service plans must be updated annually or as the member's needs change.



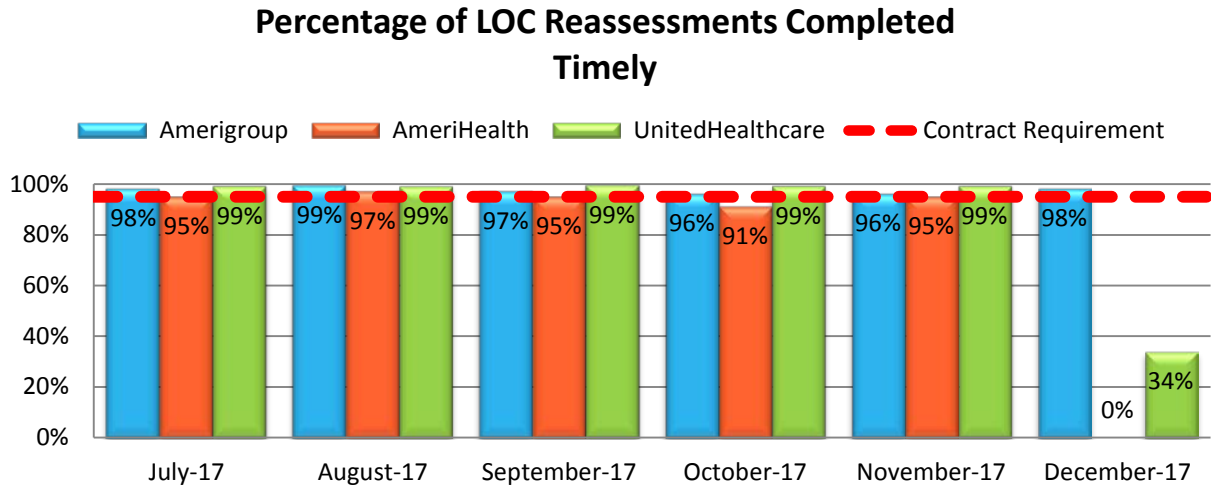
Members will continue to receive the same level of services regardless of whether service plan has been updated timely.

The department will be closely monitoring corrective actions to ensure that service plans are completed in a timely manner for all Medicaid members.

The percentage listed for AmeriHealth is as of November 30, 2017. The percentages listed for Amerigroup and United are as of December 31, 2017.

Level of Care

Level of care (LOC) and functional need assessments must be updated annually or as a member's needs change.



Ninety-five percent (95%) of needs assessments must be completed annually or as a member's needs change. There may be legitimate reasons for MCO failure to complete LOC Reassessments timely, such as member hospitalization or other extenuating member circumstances. The department requests MCO exception details for members that did not have LOC Reassessments completed timely. Exceptions are granted for one month only, with the requirement that MCOs complete the assessment in the following month, or request a new exception.

The department closely monitors these details in conjunction with corrective actions to ensure that LOC assessments are completed in a timely manner for all Medicaid members. This includes staffing contingencies implemented to ensure that adequate resources are available to perform level of care assessments for both new members as well as members that are due for their annual reassessment.

Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. UnitedHealthcare assumed these members and this effort impacted the UnitedHealthcare results for December.

Critical Incidents

Home- and Community-Based Services (HCBS) Waiver and Habilitation providers and case managers/care coordinators are required to report critical incidents to the MCOs. These critical incidents are to be reported if the reporting entity witnesses the incident or is made aware of the incident. Critical incidents are events that may affect a member's health or welfare, such incidents involving:

- Physical injury;
- Emergency mental health treatment;
- Death;
- Law enforcement intervention;
- Medication error resulting in one of the above;
- Member elopement; or,
- Reported child or dependent abuse.

Resolution indicates that the MCO has reviewed the incident and is working with the member or provider to mitigate the risk of events in the future.

Data Reported	Amerigroup		AmeriHealth		UnitedHealthcare	
HCBS and Habilitation Members as of December 2017	5,862		AmeriHealth did not have any HCBS or Habilitation members as of December 2017.		22,097	
Critical Incident Q2 SFY18 Resolution						
Program	Received	Resolved	Received	Resolved	Received	Resolved
Aids/HIV Waiver Critical Incidents Received in Q2 SFY18	0	N/A	0	N/A	1	N/A
Brain Injury Critical Incidents Received in Q2 SFY18	22	100%	73	62%	51	100%
Children's Mental Health Critical Incidents Received in Q2 SFY18	24	100%	24	46%	40	100%
Elderly Critical Incidents Received in Q2 SFY18	60	100%	139	40%	99	100%
Habilitation Critical Incidents Received in Q2 SFY18	502	100%	443	49%	419	100%
Health Disability Critical Incidents Received in Q2 SFY18	25	100%	13	62%	16	100%
Intellectual Disability Critical Incidents Received in Q2 SFY18	124	100%	745	53%	272	100%
Money Follows the Person Critical Incidents Received in Q2 SFY18	1	100%	1	100%	10	100%
Physical Disability Critical Incidents Received in Q2 SFY18	10	N/A	16	81%	16	100%

Iowa Participant Experience Survey Reporting

The data below reflect the results of Iowa Participant Experience Survey (IPES) activities and results. IPES results are one component of the Iowa Department of Human Services Home and Community Based Services quality strategy.

Data Reported	Amerigroup	AmeriHealth	UnitedHealthcare
Iowa Participant Experience Survey Count of Members Surveyed Q2 SFY18			
Aids/HIV	1	0	0
Brain Injury	7	2	4
Children's Mental Health	1	0	0
Elderly	32	12	17
Habilitation	3	0	15
Health Disability	5	1	14
Intellectual Disability	8	16	9
Money Follows the Person	0	0	0
Physical Disability	6	0	20
Iowa Participant Experience Survey Aggregated Responses Q2 SFY18			
Members Reporting They Feel They Have Been a Part of Planning Their Waiver Services	94%	87%	90%
Members Reporting Talking About Health Issues When Their Plan Was Being Developed	92%	90%	86%
Members Reporting Services Include All the Things They Told Their Team They Needed and Wanted	83%	94%	82%
Members Reporting They Feel Safe Where They Live	98%	100%	99%
Members Reporting it was Easy to Make Contact with Service Staff	94%	93%	92%
Members Reporting Their Services and Providers Make Their Life Better	98%	97%	87%
Members Receiving Employment Services that Report They Like Their Job	Not Reportable	36%	Not Reportable

Percentages reflect the number of survey responses from all applicable waivers indicating "yes". Other valid survey responses include "no," "I don't know," "I don't remember," and "No/Unclear response."

Biannual Waiver Employment Services Outcomes

Supported employment services are provided to members on home and community based service waivers for Brain Injury, Habilitation, and Intellectual Disability. As stated in the Iowa Department of Human Services Employment Outcomes Vision, "Employment in the general workforce is the first priority and the expected and preferred outcome in the provision of publically funded services for all working age Iowan's with disabilities."

In alignment with this vision, utilization and wage data for members receiving employment services is requested by case managers twice annually in April and October with a 90 day reporting lag.

Supported Employment Data

The department collects labor and wage information for members in eligible waiver programs receiving supported employment services.

Data Reported as of October 31, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Individual Jobs Services Outcomes			
Brain Injury Waiver Members Served	9	56	5
Habilitation Members Served	156	302	79
Intellectual Disability Waiver Members Served	93	1,480	80
Small Group Employment Services Outcomes			
Brain Injury Waiver Members Served	0	15	2
Habilitation Members Served	53	92	25
Intellectual Disability Waiver Members Served	32	479	39
Facility-Based Services Outcomes			
Brain Injury Waiver Members Served	2	27	2
Habilitation Members Served	70	172	34
Intellectual Disability Waiver Members Served	23	807	51

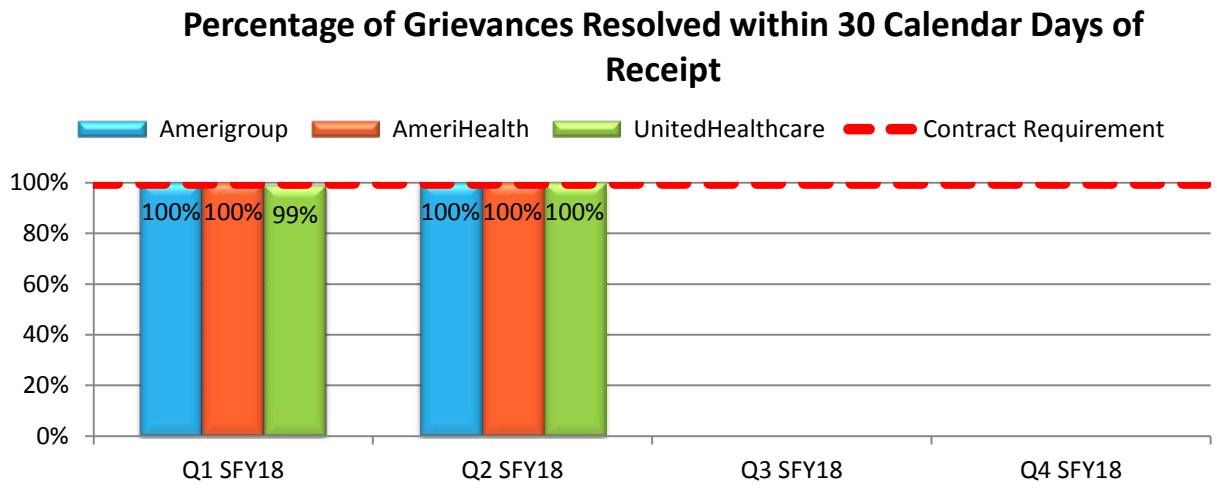
MCO Member Grievances and Appeals

Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization.

Grievance: A written or verbal expression of dissatisfaction.

Appeal: A request for a review of an MCO's denial, reduction, suspension, termination or delay of services.

Resolved: The appeal or grievance has been through the process and a disposition has been communicated to the member and member representative.



This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. Grievances with contractually-allowed extensions of resolution timeframe are excluded from the numerator and denominator. If a member is not satisfied with the MCO's resolution to their grievance, the member may contact the Iowa Medicaid Enrollment Broker to disenroll if "good cause" criteria are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Grievances Received in Q1 SFY18	260	638	104
Grievances Received in Q2 SFY18	244	63	247

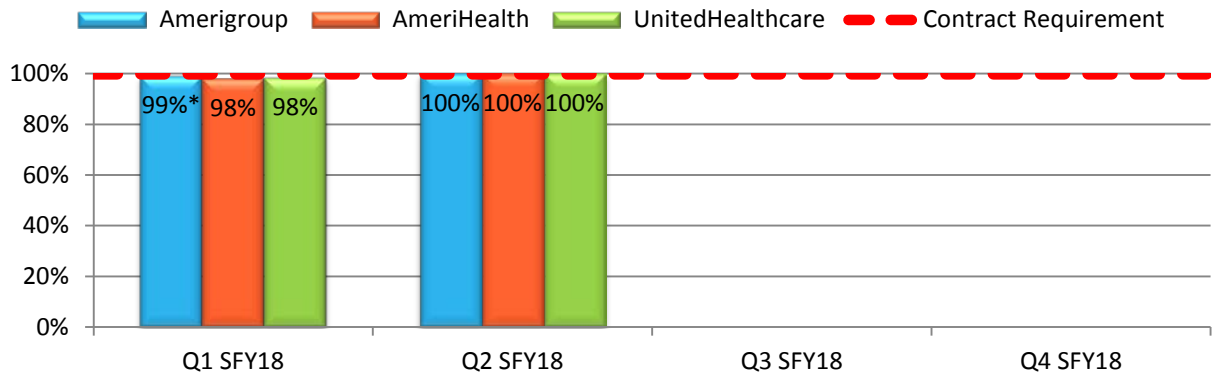
MCOs have different criteria for bucketing so the above numbers may represent each reason filed for the grievance with AmeriHealth and Amerigroup while representing unduplicated member grievances for UnitedHealthcare.

Top Five Reasons for Grievances for Q2 SFY18

	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
#	**Grievances**	**Count**	**Grievances**	**Count**	**Grievances**	**Count**
1	Out of Network	275	Type of Grievance - Provider-Dissatisfied with Treatment of Service	11	Administration – Enrollment/Member Material – Request to enroll/change benefit plan did not occur within open enrollment period	89
2	Transportation – Delay	72	Type of Grievance – Transportation – No Pick-Up	8	Enrollee Access/Availability – Provider Network Adequacy	65
3	Provider Balance Billed	40	Type of Grievance – Provider – Member Received Bill	7	Benefit-Other - Ambulance / Transportation - Dispute regarding non-ambulance methods of transportation	53
4	Provider Attitude/Rudeness	19	Type of Grievance – Transportation – Excessive Waiting	6	Benefit-Other - Balance Billing	20
5	Adequacy of Treatment Record Keeping	15	Type of Grievance – Transportation – Environment of Vehicle	4	Quality of Care	7

Members may file a grievance with the MCOs for any dissatisfaction that is not related to a clinical decision.

Percentage of Appeals Resolved within 30 Calendar Days of Receipt



*Amerigroup data percentage for Q1 has been updated to reflect a correction identified after the publication of last quarter's report.

This measure represents appeals resolved within 30 calendar days of receipt. In state fiscal year 2017, appeals required resolution within 45 days of receipt. The first quarter may include appeals resolved in the quarter that were received prior to the 30 day requirement and may have met the previous timeliness standard of 45 calendar days. If a member is not satisfied with the appeal decision, they may file a state fair hearing request with the state.

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Appeals Received in Q1 SFY18	521	430	127
Appeals Received in Q2 SFY18	499	244	154

This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care appeal process does differ from the administrative appeal process.

Top Five Reasons for Appeals for Q2 SFY18

	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
#	**Appeals**	**Count**	**Appeals**	**Count**	**Appeals**	**Count**
1	Pharmacy - Non Injectable	208	Pharmacy	49	Benefit – Other - Pharmacy - Dispute of drugs that require clinical coverage review.	102
2	BH – Op Service	50	LTSS – Long-Term Support Services	39	Benefit – Other - Pharmacy - Dispute of coverage of non-preferred drugs	39

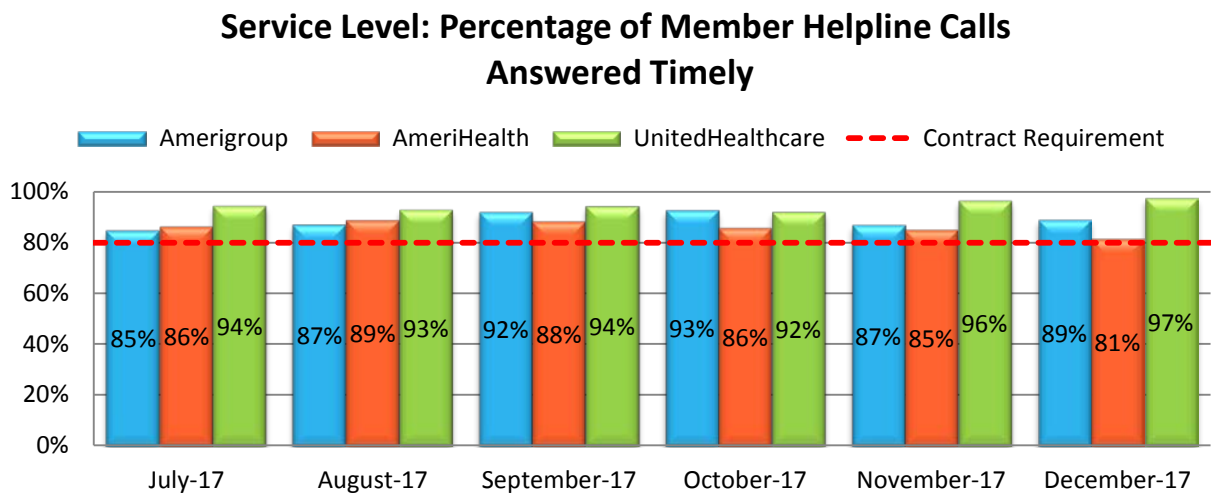
	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Appeals	Count	Appeals	Count	Appeals	Count
3	Surgery	34	Durable Medical Equipment	35	Benefit-Clinical - Utilization Review Determination - Dispute over the medical necessity of a service or treatment.	34
4	Pharmacy - Injectable	32	Skilled Care/Nursing	32	Durable Medical Equipment (DME)	18
5	DME	28	Prior Authorization	19	Benefit – Clinical - Personal Attendant Services	9

State Fair Hearing Summary for Members in Managed Care Q2 SFY18

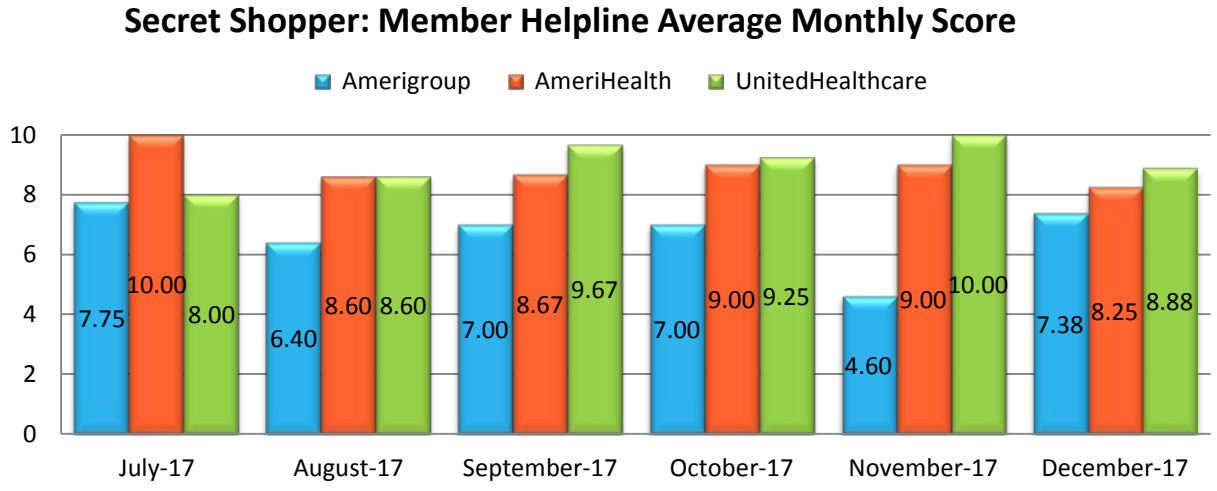
Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Level of Care	0	0	0
Medical Service Denial/Reduction	65	82	19
Pharmacy Denial/Reduction	62	3	2
Durable Medical Equipment Denial/Reduction	0	2	3

This data reflects the type of state fair hearing requests and does not reflect the disposition of the appeal. Most of the appeal requests received are dismissed or withdrawn due to resolution of the issue prior to hearing.

Member Helpline



This performance target measures the timeliness of answering the helpline calls. The department defines "timely" answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines. The CAHPS surveys conducted annually also measure member satisfaction with their health plan.



Secret shopper calls are conducted by the Iowa Medicaid Enterprise at least weekly and assess MCO customer service representative soft skills and policy knowledge. For each day that call monitoring occurs, five questions are asked of Member helpline representatives to be monitored and scored. Each question can receive a maximum of 2 points, where 2 points indicate a full and complete answer free of errors was provided. Scores are aggregated for each day to

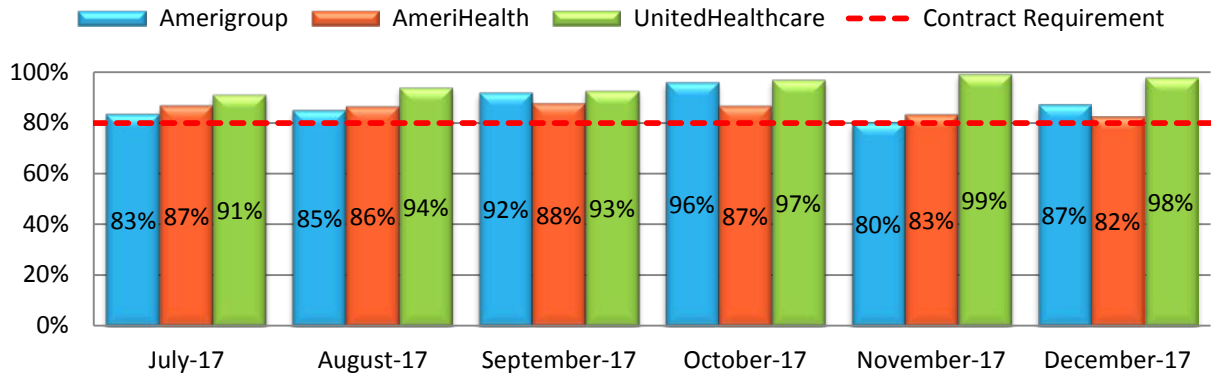
achieve a daily score with a maximum of ten points. All results are provided to MCOs so they can address any training needs. The focus of these activities is continuous quality improvement, with topics changing based on current issues. In October, member helpline secret shopper topics focused on getting authorized to receive information regarding an adult child. In November, questions dealt with receiving information regarding the appeals process. In December, topics focused on receiving information regarding MCO choice options.

Top Five Reasons for Members Contacting Helplines for Q2 SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
October 2017						
1.	Transportation Questions	9,844	Member Inquiries-Plan Policy/Procedure Education	7,270	PCP Inquiry	4,635
2.	Benefit Inquiry	1,119	Member Changes-Demographic Changes	6,265	Benefits	3,550
3.	Pharmacy Inquiry/Issue	854	Eligibility/Enrollment-Member Eligibility	2,309	Eligibility Inquiry	2,541
4.	Provider Find/Change/Verify PCP	810	Member Request – ID Card Request	2,282	COB Information	1,778
5.	Benefit Inquiry/Issue	802	Member Changes – PCP Changes	1,690	Claims Inquiry	788
November 2017						
1.	Transportation Questions	9,185	Member Inquiries-Plan Policy/Procedure Education	6,087	PCP Inquiry	5,188
2.	Benefit Inquiry	1,187	Member Changes-Demographic Changes	4,889	Benefits	3,991
3.	Enrollment Information	771	Eligibility/Enrollment-Member Eligibility	1,785	Membership Record	2,595
4.	Eligibility Inquiry	720	Member Inquiries-General Benefit	1,132	COB Information	1,167
5.	Find/Change PCP	573	Member Request – ID Card Request	735	General Inquiry	884
December 2017						
1.	Transportation Questions	8,354	Member Inquiries-Plan Policy/Procedure Education	1,539	PCP Inquiry	19,714
2.	Benefit Inquiry	1,187	Eligibility/Enrollment-Member Eligibility	824	Benefits	9,959
3.	Enrollment Information	771	Member Billing Inquiries – Par Billing issue	210	Eligibility Inquiry	4,804
4.	Eligibility Inquiry	720	Member Inquiries – General Benefit	206	Change Address/Phone #	3,801
5.	Find/Change PCP	573	Member Changes-Demographic Changes	181	General Inquiry	2,690

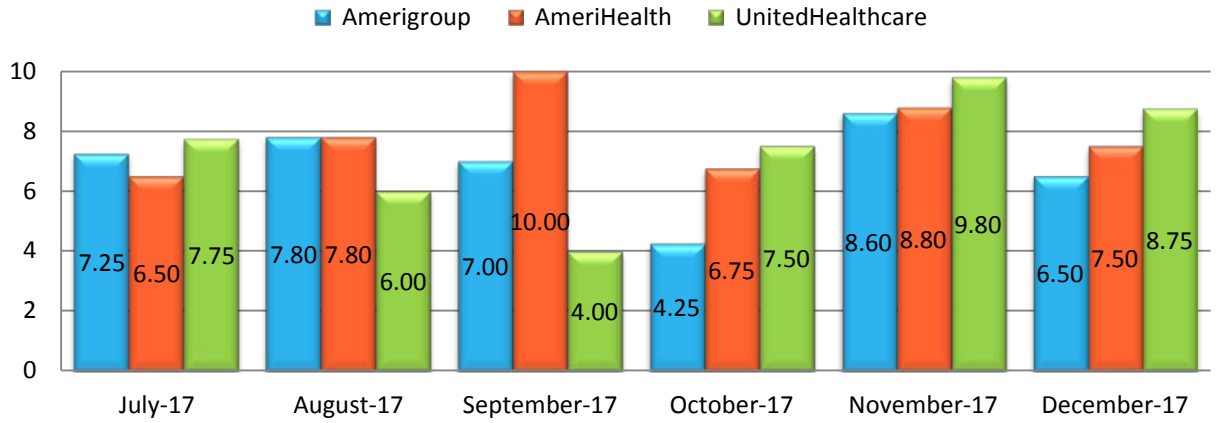
Provider Helpline

Service Level: Percentage of Provider Helpline Calls Answered Timely



This performance target measures the timeliness of answering the helpline calls. The department defines “timely” answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines.

Secret Shopper : Provider Helpline Average Monthly Score



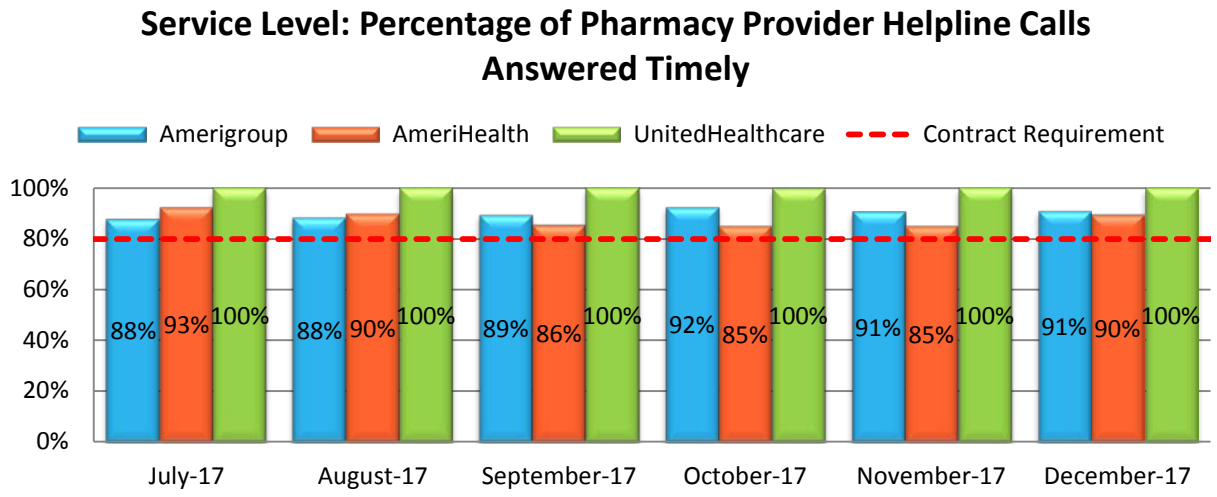
Secret shopper calls are conducted by the Iowa Medicaid Enterprise at least weekly and assess MCO customer service representative soft skills and policy knowledge. For each day that call monitoring occurs, five questions are asked of provider helpline representatives to be monitored and scored. Each question can receive a maximum of 2 points, where 2 points indicate a full and complete answer free of errors was provided. Scores are aggregated for each day to achieve a daily score with a maximum of ten points. All results are provided to MCOs so they can address any training needs. The focus of these activities is continuous quality improvement,

with topics changing based on current issues. In October, provider helpline secret shopper topics included issues with payments and authorizations, switching MCOs, and claims denial. In November, questions dealt exclusively with home health authorization. In December, topics focused on issues regarding the transition from three MCOs to two, including honoring authorizations, claims run-out, and finding out to which MCO members would be assigned.

Top Five Reasons for Providers Contacting Helplines for Q2 SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
October 2017						
1.	Claim Status Inquiry	3,229	Claims-Claim Status	15,141	Claims Inquiry	13,172
2.	Claims Inquiry	1,455	Provider Requests-Check Remittance Advice	7,994	Benefits	3,671
3.	Claim Denial Inquiry	1,065	Provider Inquiries-Plan Policy/Procedure Education	5,761	Authorization Related	1,093
4.	Benefits Inquiry	998	Eligibility/Enrollment-Member Eligibility	2,540	COB Information	1,032
5.	Transportation Questions	930	Claims-Claim Issues	2,159	Membership Record	573
November 2017						
1.	Claim Status Inquiry	2,676	Claims-Claim Status	14,807	Claims Inquiry	10,461
2.	Claims Inquiry	1,253	Provider Requests-Check Remittance Advice	7,250	Benefits	2,772
3.	Claim Denial Inquiry	906	Provider Inquiries-Plan Policy/Procedure Education	5,302	Authorization Related	1,019
4.	Transportation Questions	897	Claims-Claim Issues	2,204	COB Information	763
5.	Benefits Inquiry	862	Eligibility/Enrollment-Member Eligibility	2,106	Membership Record	511
December 2017						
1.	Claim Status Inquiry	2,326	Claims-Claim Status	12,975	Claims Inquiry	13,060
2.	Claims Inquiry	1,247	Provider Requests-Check Remittance Advice	6,514	Benefits	8,603
3.	Claim Denial Inquiry	804	Provider Inquiries-Plan Policy/Procedure Education	3,669	Authorization Related	2,884
4.	Transportation Questions	787	Claims-Claim Issues	1,722	COB Information	1,574
5.	Benefits Inquiry	756	Eligibility/Enrollment-Member Eligibility	1,391	Membership Record	1,400

Pharmacy Services Helpline

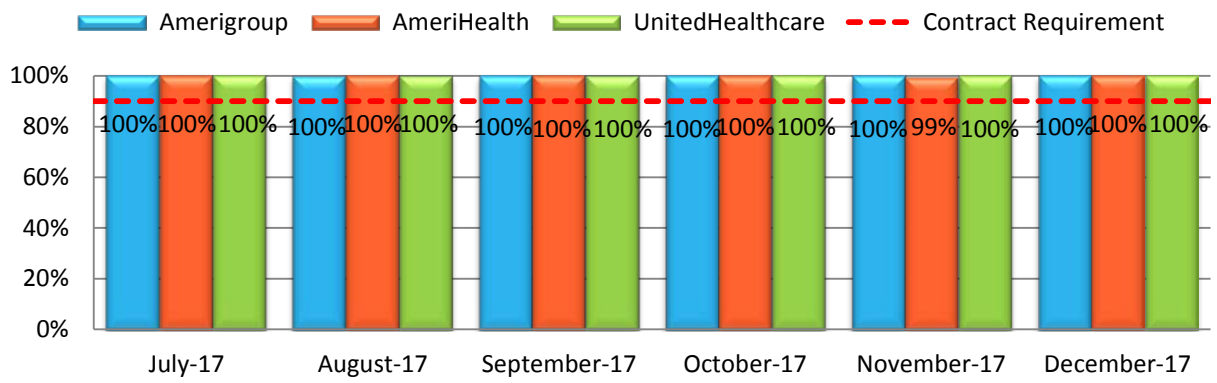


This performance target measures the timeliness of answering the helpline calls. The department defines “timely” answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines.

Medical Claims Payment

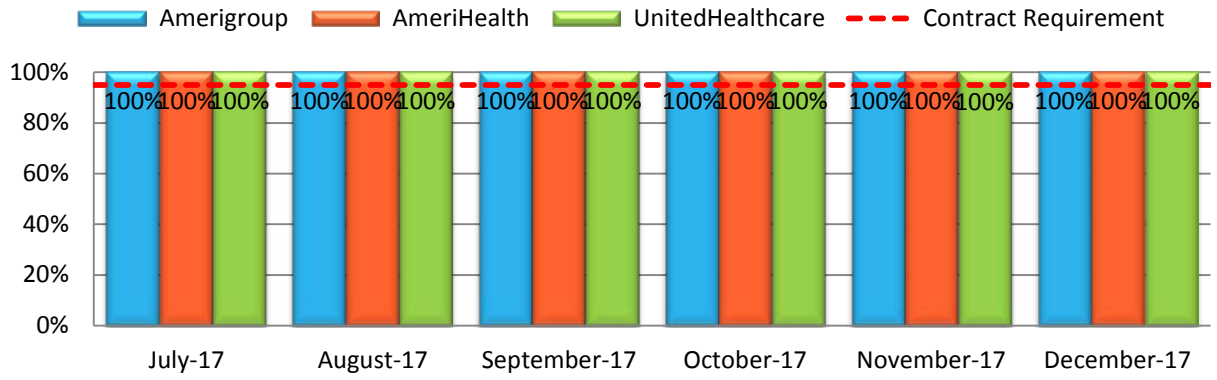
Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

Percentage of Clean Medical Claims Paid or Denied Within 30 Calendar Days

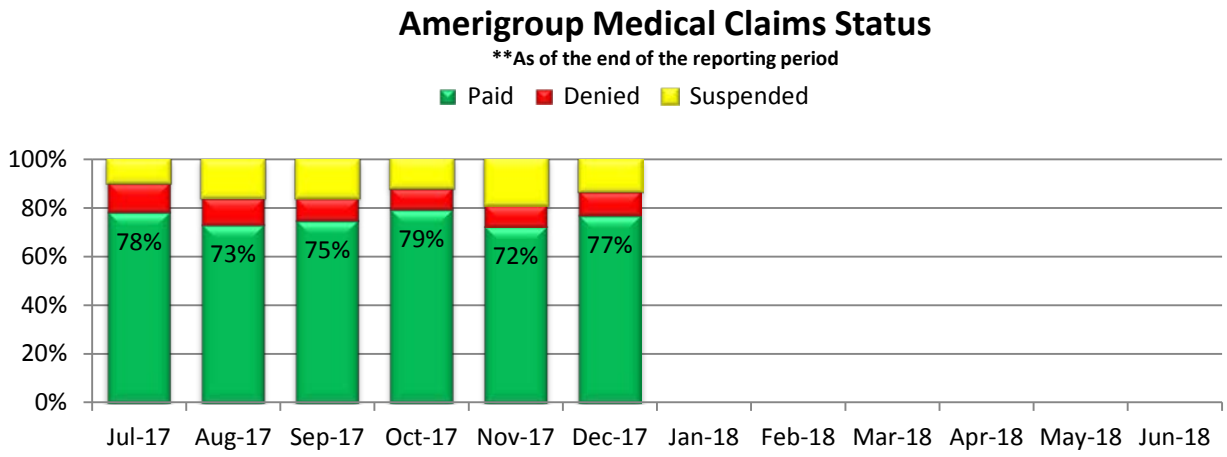


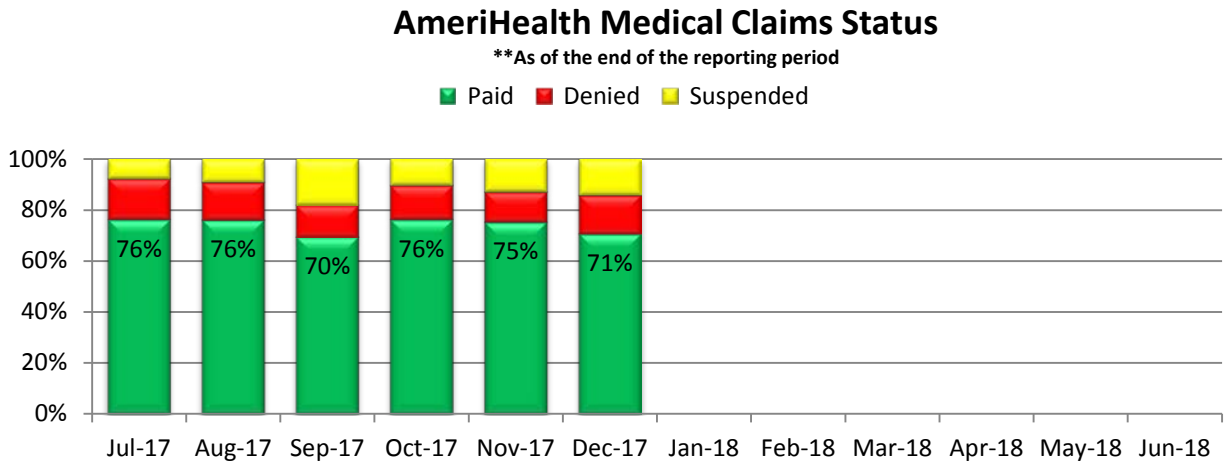
This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.

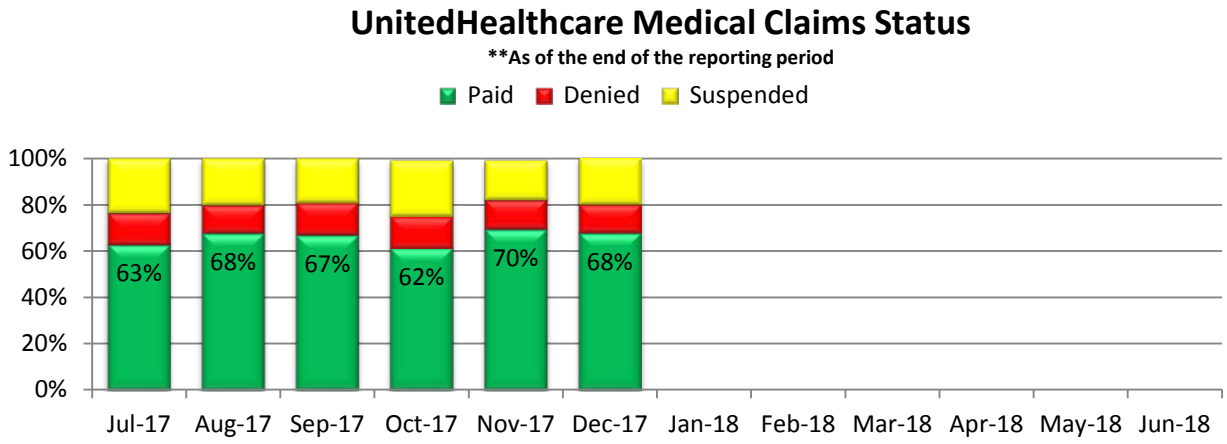
Percentage of Clean Medical Claims Paid or Denied Within 45 Calendar Days



This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.


Amerigroup Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
78%
73%
75%
79%
72%
77%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18


AmeriHealth Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
76%
76%
70%
76%
75%
71%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18


UnitedHealthcare Medical Claims Status
**As of the end of the reporting period
Paid
Denied
Suspended
100%
80%
60%
40%
20%
0%
63%
68%
67%
62%
70%
68%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
1.	CARC-18 Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO).	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service.	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
2.	CARC-27 Expenses incurred after coverage terminated.	CARC-8 The procedure code is inconsistent with the provider type/specialty (taxonomy). Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC-N95 This provider type/provider specialty may not bill this service.	CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim
3.	CARC-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement. Note: This adjustment amount cannot equal the total service or claim charge amount; and must not duplicate provider adjustment amounts (payments and contractual reductions) that have resulted from prior payer(s) adjudication. (Use only with Group Codes PR or CO depending upon liability) RARC-N381-Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	CARC-29 The time limit for filing has expired.	CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.
4.	CARC-197 Precertification/authorization /notification absent.	CARC-18 Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover	CARC-208-National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
		claim.	
5.	CARC-29 The time limit for filing has expired.	CARC-197 Precertification/authorization/notification absent. RARC-M62 Missing/incomplete/invalid treatment authorization code.	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service
6.	CARC-252 An attachment/other documentation is required to adjudicate this claim/service. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT). RARC-N479 Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	CARC-22 This care may be covered by another payer per coordination of benefits. RARC-N4 Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
7.	CARC-256 Service not payable per managed care contract.	CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC-MA 130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CARC-26 Expenses incurred prior to coverage. RARC-N30 Patient ineligible for this service.
8.	CARC-97 The benefit for this service is included in the payment/allowance for	CARC-16 Claim/service lacks information or has submission/billing error(s)	CARC-29 The time limit for filing has expired.

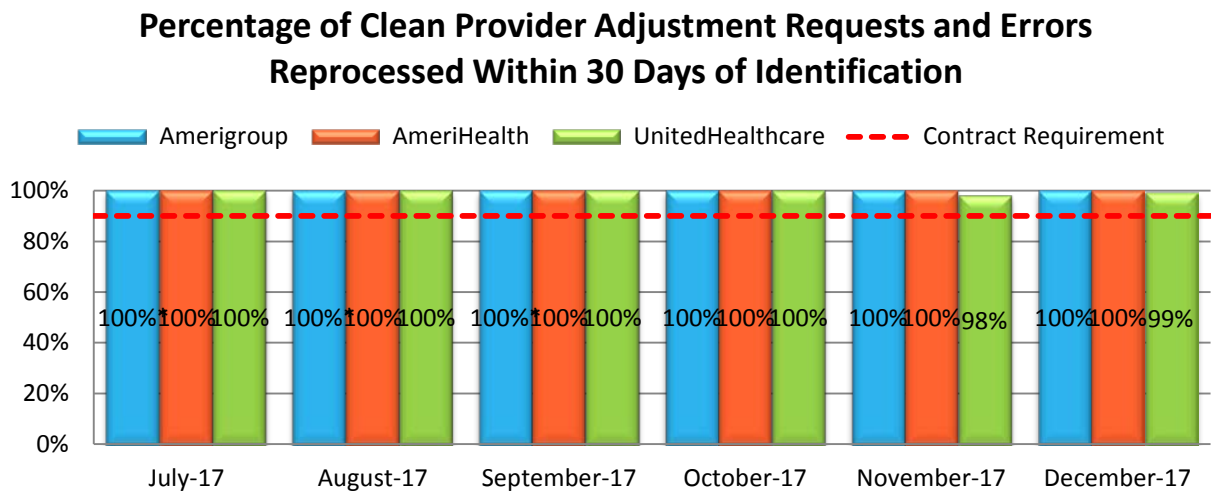
Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
	another service/procedure that has already been adjudicated. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. allowed. N432 – Alert: Adjustment based on a Recovery Audit.	which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC-N253 Missing/incomplete/invalid attending provider primary identifier.	
9.	CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. MA130 – Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable. Please submit a new claim with the complete/correct information.	CARC-109 Claim/service not covered by this payer/contractor. You must send the claim/service to the correct payer/contractor. RARC-N193 Alert: Specific federal/state/local program may cover this service through another payer.	CARC-256 Service not payable per managed care contract. RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
10.	CARC 23 – The impact of prior payer(s) adjudication including payments and/or adjustments. (Use only with Group Code OA)	CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. Do not use this code for claims	CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC-M119 Missing/incomplete/invalid/de

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
		attachment(s)/other documentation. At least one Remark Code must be provided (may be comprised of either the NCPDP Reject Reason Code, or Remittance Advice Remark Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC-N329 Missing/incomplete/invalid patient birth date.	activated/withdrawn National Drug Code (NDC).

Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

Remittance Advice Remark Codes (RARCs): A more detailed explanation for a payment adjustment used in conjunction with CARCs. http://www.wpc-edi.com/reference/codelists/healthcare/remittance-advice-remark-codes/

Claims Reprocessing and Adjustments			
The table below reflects the total count of claims processed including Rx and non-Rx claims, and the count of claims reprocessed or adjusted. Reprocessed or adjusted claims include clean provider adjustment requests, claims processing errors identified, and claims reprocessing projects.			
Period	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Total Claims Processed October 2017	721,405	859,622	563,614
Total Claims Processed November 2017	648,999	803,332	588,926
Total Claims Processed December 2017	672,010	349,186	929,966
Claims Reprocessed or Adjusted October 2017	24,817	73,675	14,373
Claims Reprocessed or Adjusted November 2017	22,326	55,042	21,187
Claims Reprocessed or Adjusted December 2017	30,188	105,093	32,699



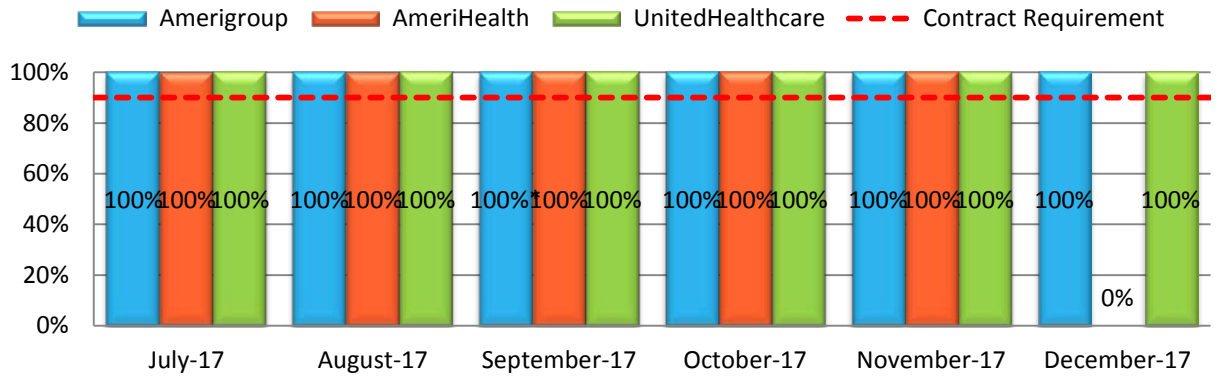
Plans have 30 days from the date of identification of an error or a clean provider adjustment request to reprocess 90% of the claims identified. Claims reprocessing projects may be processed on a different timeline with Agency approval.

*Amerigroup data percentages for Q1 (July, August, and September 2017) have been updated to reflect corrections identified after the publication of last quarter's report.

Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

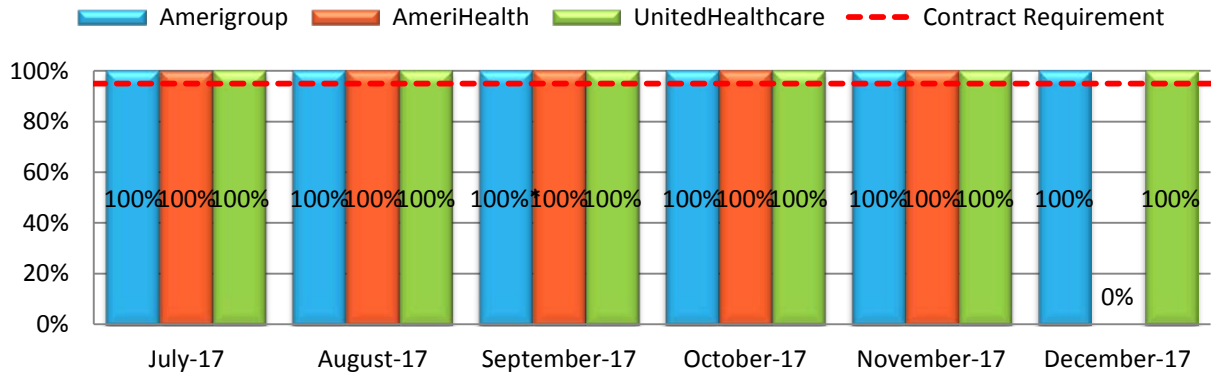
Percentage of Clean Pharmacy Claims Paid or Denied Within 30 Calendar Days



This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.

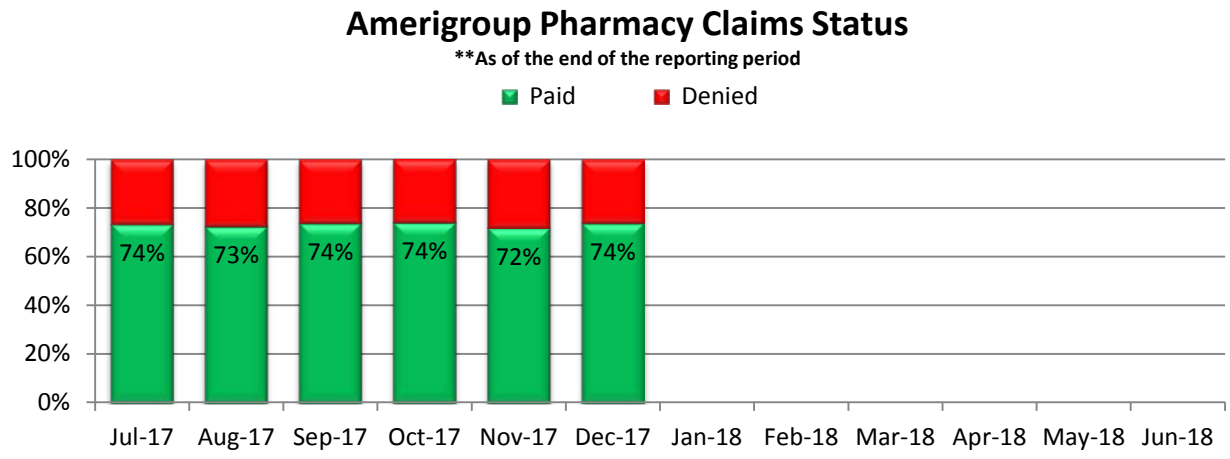
*Amerigroup data percentage for September 2017 has been updated to reflect a correction identified after the publication of last quarter's report.

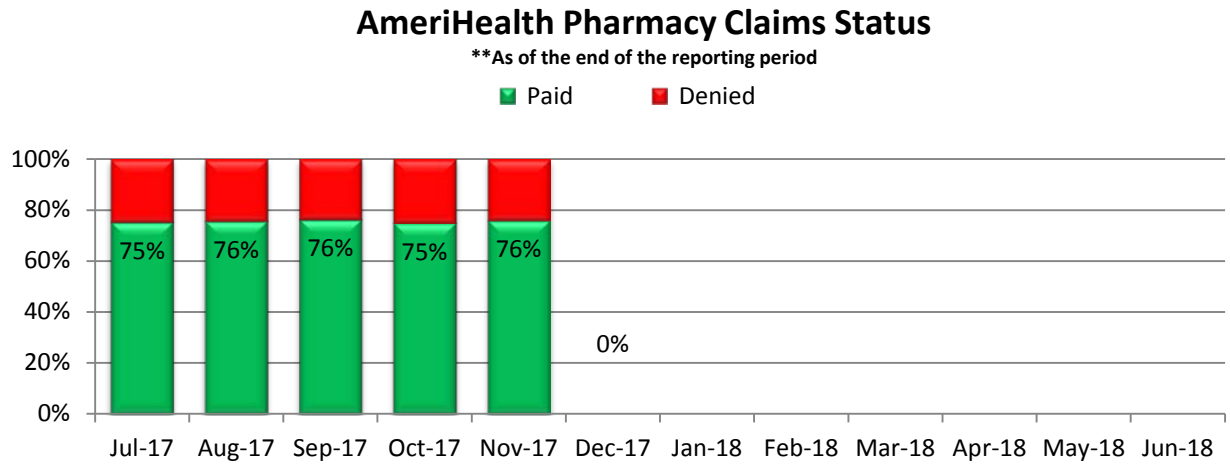
Percentage of Clean Pharmacy Claims Paid or Denied Within 45 Calendar Days

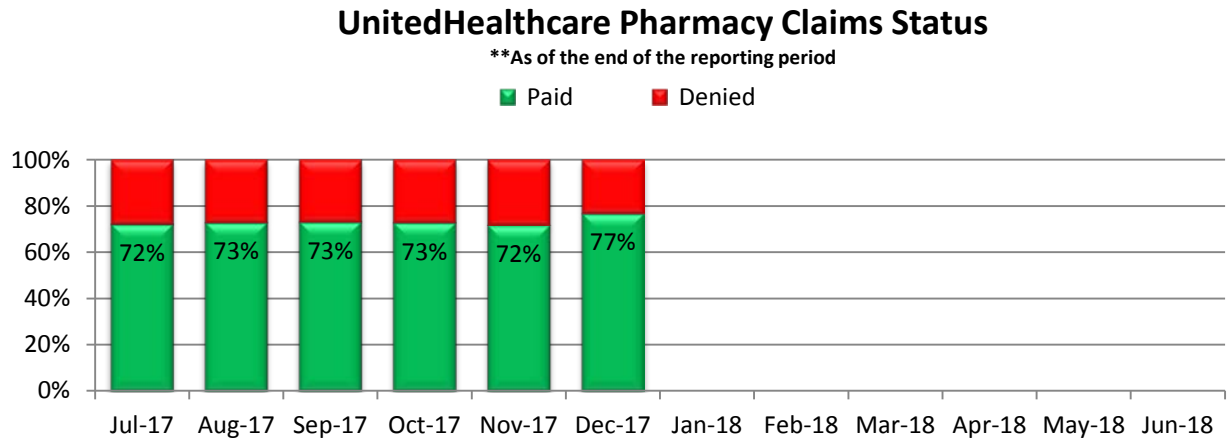


This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.

*Amerigroup data percentage for September 2017 has been updated to reflect a correction identified after the publication of last quarter's report.


Amerigroup Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
74%
73%
74%
74%
72%
74%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18


AmeriHealth Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
75%
76%
76%
75%
76%
0%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18


UnitedHealthcare Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
72%
73%
73%
73%
72%
77%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18

Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
1.	Refill Too Soon	No Pharmacy Claims processed in December 2017.	Refill Too Soon
2.	Product Not On Formulary	No Pharmacy Claims processed in December 2017.	Prod/Service Not Covered
3.	Days Supply Exceeds Plan Limitation	No Pharmacy Claims processed in December 2017.	Prior Authorization Required
4.	Product/Service Not Covered – Plan/Benefit Exclusion	No Pharmacy Claims processed in December 2017.	Filled After Coverage Term
5.	Submit Bill To Other Processor Or Primary Payer	No Pharmacy Claims processed in December 2017.	Plan Limitations Exceeded
6.	Plan Limitations Exceed	No Pharmacy Claims processed in December 2017.	Submit bill to other processor
7.	DUR Reject Error	No Pharmacy Claims processed in December 2017.	Prescriber is Not Covered
8.	Prior Authorization Required	No Pharmacy Claims processed in December 2017.	DUR Reject Error
9.	Scheduled Downtime	No Pharmacy Claims processed in December 2017.	Patient is Not Covered
10.	This Medicaid Patient Is Medicare Eligible	No Pharmacy Claims processed in December 2017.	Non-Matched Pharmacy Number

Utilization of Value Added Services Reported Count of Members

Managed care organizations may offer value added services in addition to traditional Medicaid and HCBS services. Between the plans there are 40 value added services available as part of the managed care program.

Q2 SFY18 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Additional Benefits	924	12,108	485	13,517
Family Planning and Resources	0	0	772	772
Health and Wellness	67	7,934	118	8,119
Healthy Incentives	6,120	3,842	1,818	11,780
Tobacco Cessation	78	465	623	1,166

Services that could be considered as a value add for managed care may not be reflected in this table such as enhanced care coordination, 24/7 nurse call lines, and increased access to health care information.

Provider Network Access

There are two major methods used to determine adequacy of network in the contract between the department and the MCOs:

- Member and provider ratios by provider type and by region
- Geographic access by time and distance

As there are known coverage gaps within the state for both Medicaid and other health care markets; exceptions will be granted by the department when the MCO clearly demonstrates that:

- Reasonable attempts have been made to contract with all available providers in that area; or
- There are no providers established in that area.

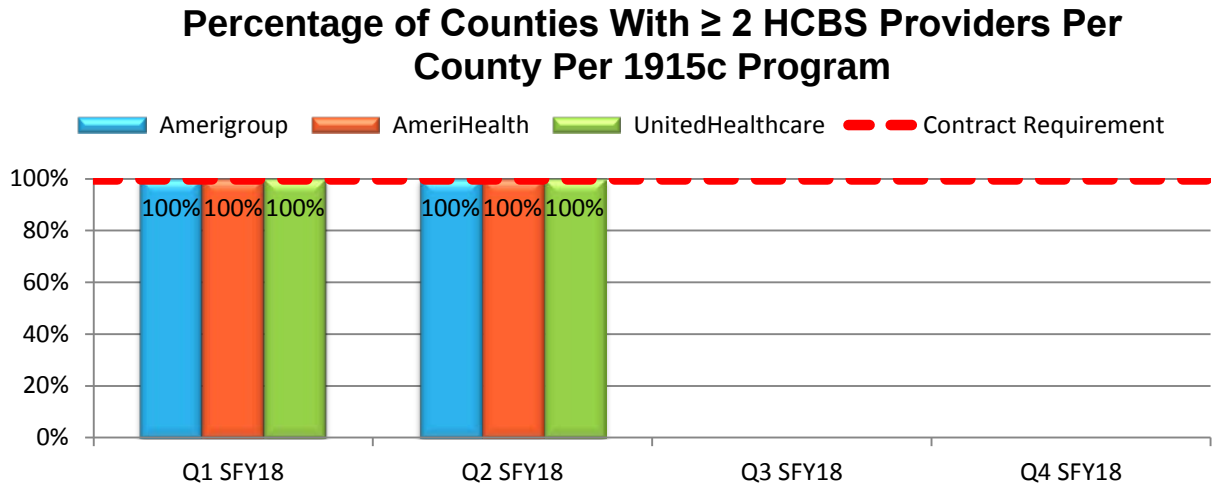
Links to time and distance reports for this reporting period can be found at:

- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-AGP-12012017.pdf
- AmeriHealth Caritas: Not in operations during the reporting period.
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-UHC-12012017.pdf

GeoAccess maps reflect traditional time and distance standards. As of the date of this publication, all MCOs have submitted exception reports to the department but not all MCO submitted exceptions have been approved.

The following table of Percentage of Members with Coverage in Time and Distance Standards provides a snapshot of available non-specialty measures (i.e., providers) for non-HCBS services across the respective regions.

Percentage of Members with Coverage in Time and Distance Standards									
MCO	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
Measure	**30 Min/ 30 Mile**			**30 Min/ 30 Mile**			**30 Min/ 30 Mile**		
Primary Care - Adult	100%			100%			100%		
Primary Care – Child	100%			100%			100%		
Hospital	100%			100%			100%		
Behavioral Health – Outpatient	100%			100%			100%		
General Optometry	100%			100%			100%		
Lab and X-ray Services	100%			100%			100%		
Pharmacy	100%			100%			100%		
MCO	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
Measure	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**	**30 Min/ 30 Mile**	**60 Min/ 60 Mile**	**90 Min/ 90 Mile**
ICF/SNF	100%	100%		100%	100%		100%	100%	
ICF/ID	100%	100%		100%	100%		90%	100%	
Behavioral Health – Inpatient		98%	100%		100%	100%		98%	100%

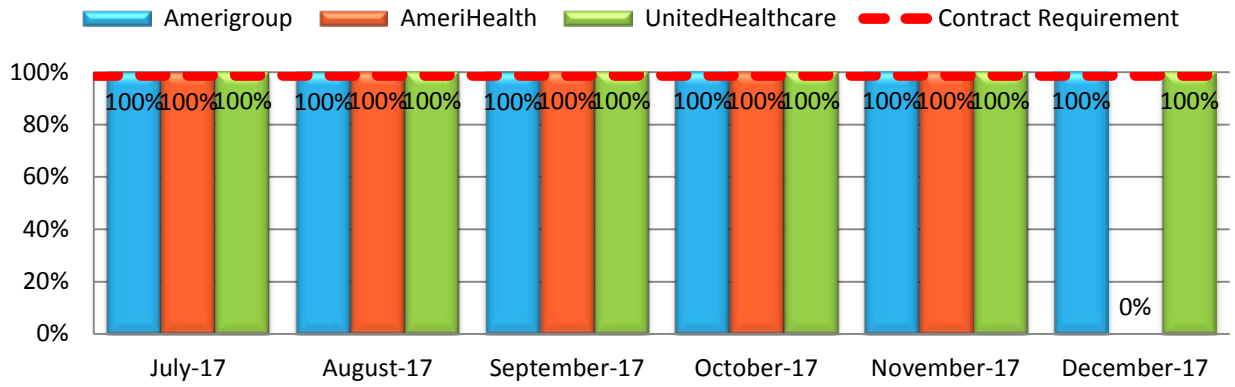


All MCOs have approved exception requests for the network standards in Exhibit B of the contract for HCBS services.

The department continues to monitor network adequacy to ensure that these contract standards are met and will take additional steps towards progressive remedies if necessary.

Prior Authorization - Medical

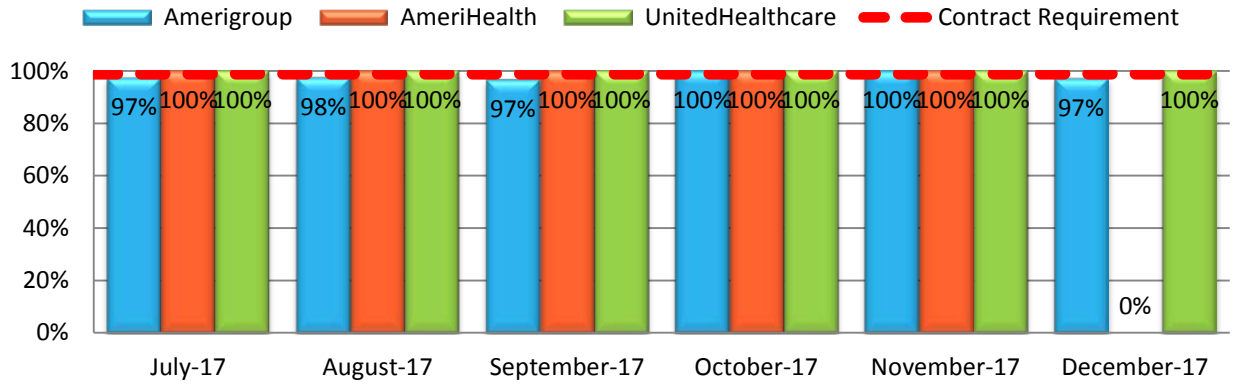
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request



This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of regular prior authorizations (PAs) must be completed within 14 calendar days of request to meet performance guarantees.

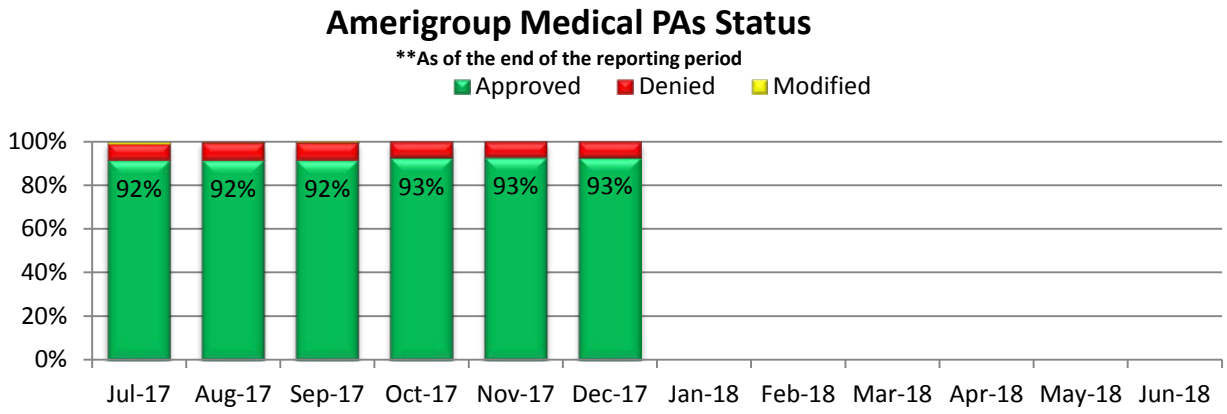
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

Percentage of PAs for Expedited Services Authorized Within 72 Hours of Request

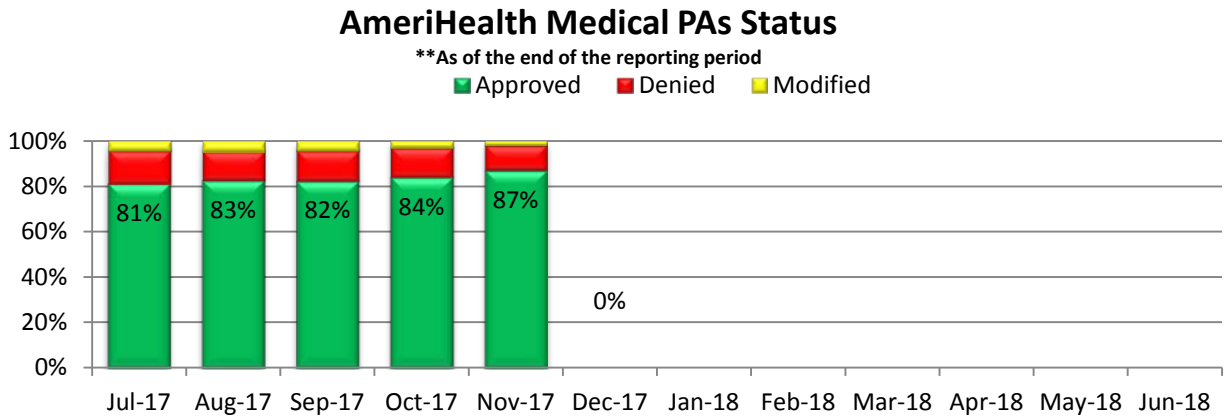


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of PAs for expedited services must be authorized within 72 hours of request to meet performance guarantees.

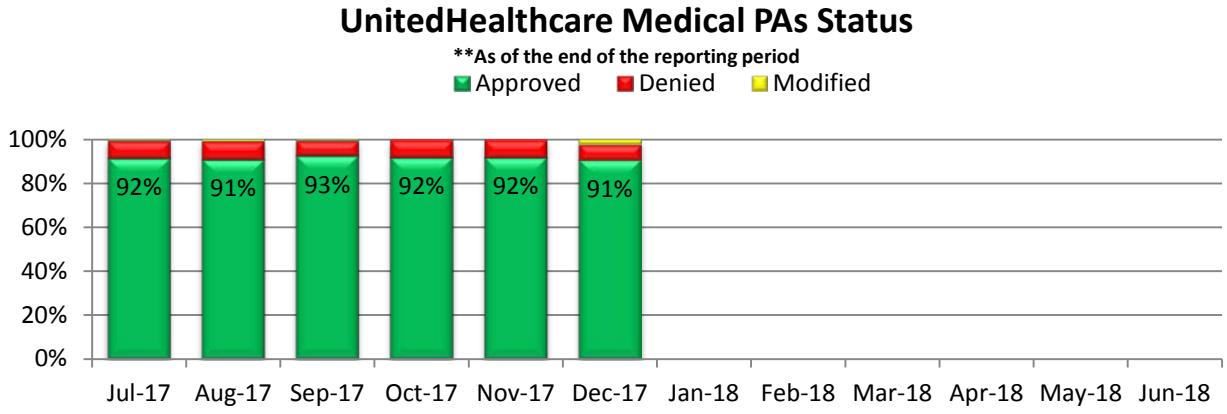
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.



This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

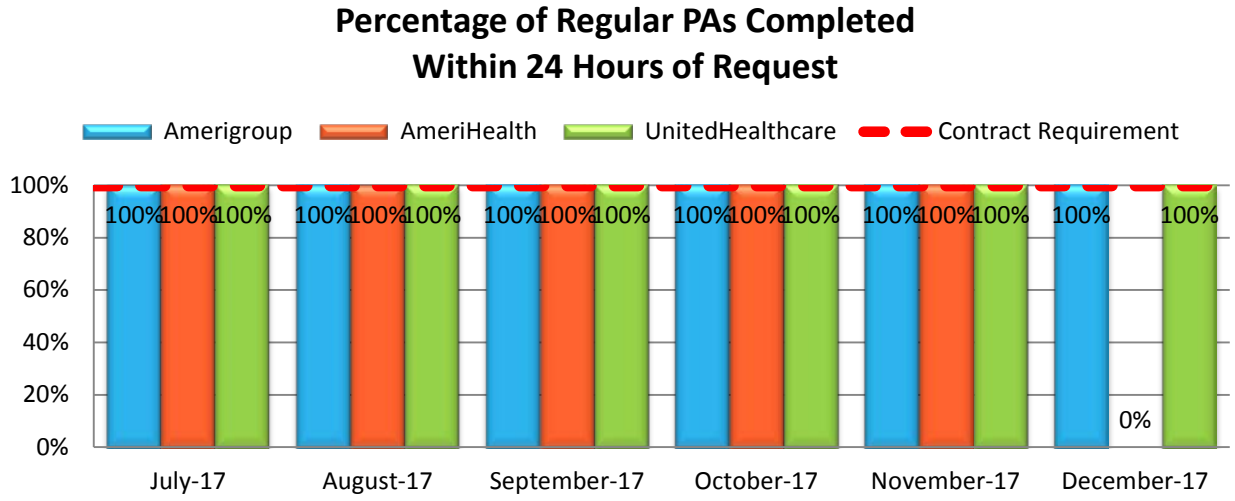


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

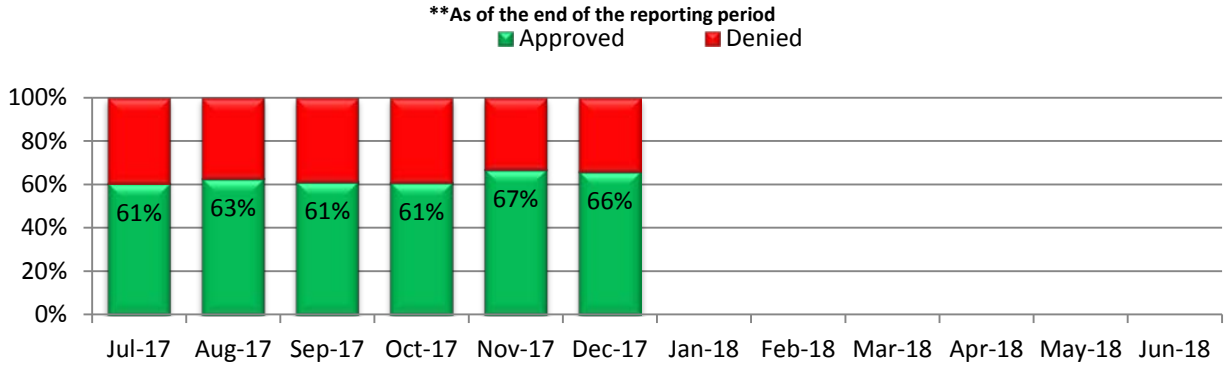
Prior Authorization - Pharmacy



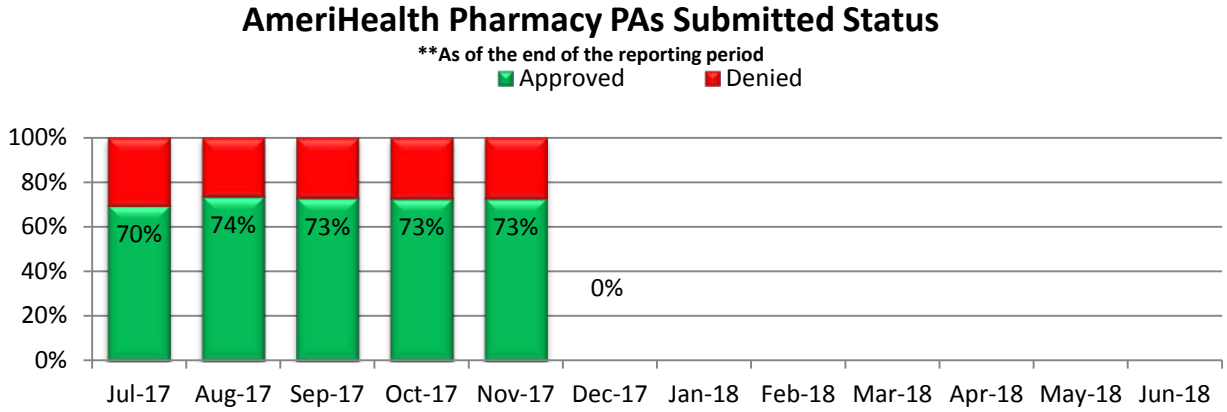
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ. 100% of regular PAs must be completed within 24 hours of request to meet performance guarantees.

The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.

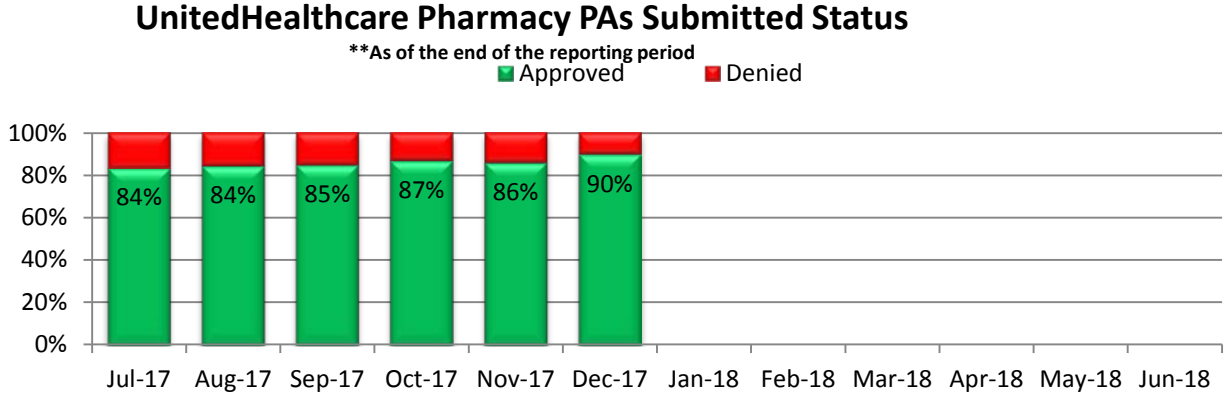
Amerigroup Pharmacy PAs Submitted Status



AmeriHealth Pharmacy PAs Submitted Status



UnitedHealthcare Pharmacy PAs Submitted Status



Encounter Data Reporting

Encounter Data are records of medically-related services rendered by a provider to a member. The department continues the process of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

Performance Measure	Amerigroup			AmeriHealth			UnitedHealthcare		
Encounter Data Submitted By 20th of the Month	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
	Y	Y	Y	Y	Y	Y	Y	Y	Y

Any errors in encounter data are expected to be corrected within contractual timeframes. The department is engaged in ongoing validation and collaboration associated with the transfer of encounter data as well as continuous evaluation of the quality of data submitted.

Value Based Purchasing Enrollment

MCOs are expected to have 40% of their population covered by a value based purchasing agreement by 2018.

Data as of December 2017	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards	20%	0%	39%

All value based contracts are currently being discussed with MCOs to ensure that all components required are included.

On October 31, 2017, AmeriHealth Caritas announced their departure from the IA Health Link program, effective November 30, 2017. Therefore, AmeriHealth had no members as of December 2017.

MLR/ALR/Underwriting

MCOs are required to meet a minimum medical loss ratio of 88% per the contract between the department and the managed care organizations.

- Medical loss ratio (MLR) reflects the percentage of capitation payments used to pay medical expenses.
- Administrative loss ratio (ALR) reflects the percentage of capitation payments used to pay administrative expenses.
- Underwriting ratio reflects profit or loss.

A minimum medical loss ratio protects the state, providers, and members from inappropriate denial of care to reduce medical expenditures. A minimum medical loss ratio also protects the state if capitation rates are significantly above the actual managed care experience, in which case the state will recoup the difference.

Q2 SFY18 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	96.0%	97.3%	95.6%
ALR	7.8%	10.9%	7.8%
Underwriting	-3.8%	-8.2%	-3.4%

The department expects quarter-to-quarter fluctuations in financial metrics while the plans' experience in the Iowa Medicaid market matures. The financial ratios presented above are common financial metrics used to assess MCO financial performance. The financial ratios presented here were reported by the MCOs and are consistent with Q4 calendar year 2017 (Q2 SFY18) financial information submitted to the Iowa Insurance Division by each MCO.

The financial metrics presented here reflect financial performance for Q2 SFY18. Premium deficiency reserves and/or changes in premium deficiency reserves are excluded from the calculations. The department believes this approach most accurately reflects financial performance for service delivery under the contract.

It is important to note that accounting and reporting differences among MCOs may result in variance among plans beyond the variance in medical expenses per member. The department is working with the MCOs to standardize financial metrics and limit or explain controllable variances for reporting purposes.

Q2 SFY18 results reported for UnitedHealthcare include the AmeriHealth transition that occurred on December 1, 2017.

As such, the reported results include one month of the AmeriHealth transitioned members.

Due to timing of expenses and revenues related to the transition, the ALR for Q2 SFY18 is lower than for prior quarters.

Member Months and Average Costs Per Member Per Month (PMPM) Q1 SFY18
July, August, September 2017

Amerigroup

Population	Member Months	Inpatient Hospital PMPM	Outpatient Hospital PMPM	Physician PMPM	Pharmacy PMPM	Ancillaries PMPM	LTSS PMPM	Total PMPM
TANF Child	291,553	$29.71	$33.03	$63.64	$23.05	$3.11	$0.02	$152.56
TANF Adult	57,888	$51.80	$115.34	$107.64	$74.16	$9.60	$0.07	$358.61
Pregnant Women	6,863	$25.64	$136.83	$144.46	$20.78	$4.82	$0.03	$332.56
Wellness Plan	147,055	$86.93	$126.28	$113.06	$100.81	$12.94	$0.09	$440.11
Disabled	28,602	$236.57	$239.87	$323.81	$286.74	$58.48	$0.23	$1,145.69
Dual	33,311	$22.88	$86.98	$231.78	$7.72	$33.64	$0.15	$383.14
LTSS Physically Disabled	5,068	$238.43	$193.33	$198.67	$205.07	$200.75	$2,929.94	$3,966.18
LTSS Elderly	12,820	$42.04	$48.40	$38.48	$4.18	$40.74	$3,092.60	$3,266.44
LTSS Intellectually Disabled	4,558	$67.73	$71.35	$240.43	$124.80	$147.01	$6,770.71	$7,422.03
LTSS Children's Mental Health	1,257	$51.33	$63.93	$430.23	$239.66	$21.54	$1,984.09	$2,790.79

Encounter Data Disclaimer: The data provided by the IME is provided "as is." The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.

Member Months and Average Costs Per Member Per Month (PMPM) Q1 SFY18
July, August, September 2017

AmeriHealth

Population	Member Months	Inpatient Hospital PMPM	Outpatient Hospital PMPM	Physician PMPM	Pharmacy PMPM	Ancillaries PMPM	LTSS PMPM	Total PMPM
TANF Child	304,350	$38.16	$39.56	$64.02	$29.40	$3.76	$0.03	$174.93
TANF Adult	60,815	$49.00	$132.17	$110.94	$92.10	$11.65	$0.12	$395.98
Pregnant Women	7,421	$36.66	$143.46	$159.96	$25.20	$11.16	$0.05	$376.49
Wellness Plan	146,380	$89.34	$139.42	$112.90	$125.07	$15.08	$0.19	$482.00
Disabled	31,789	$240.45	$256.17	$428.23	$344.07	$59.37	$1.39	$1,329.69
Dual	39,307	$35.95	$75.71	$304.30	$8.96	$36.52	$1.61	$463.06
LTSS Physically Disabled	8,483	$168.50	$191.26	$206.03	$225.19	$147.48	$3,070.62	$4,009.08
LTSS Elderly	29,004	$44.37	$51.98	$49.76	$3.00	$42.12	$2,298.88	$2,490.11
LTSS Intellectually Disabled	30,731	$35.02	$60.59	$120.41	$117.91	$43.63	$4,893.30	$5,270.86
LTSS Children's Mental Health	1,528	$58.76	$67.11	$426.04	$302.38	$17.00	$1,695.31	$2,566.61

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Member Months and Average Costs Per Member Per Month (PMPM) Q1 SFY18
July, August, September 2017

UnitedHealthcare

Population	Member Months	Inpatient Hospital PMPM	Outpatient Hospital PMPM	Physician PMPM	Pharmacy PMPM	Ancillaries PMPM	LTSS PMPM	Total PMPM
TANF Child	297,341	$28.34	$31.39	$62.09	$27.06	$3.16	$0.00	$152.04
TANF Adult	50,189	$43.98	$117.10	$109.18	$84.50	$12.25	$0.00	$367.02
Pregnant Women	6,511	$38.91	$105.57	$155.75	$21.94	$10.80	$0.00	$332.98
Wellness Plan	132,898	$81.80	$114.65	$110.99	$118.19	$14.89	$0.00	$440.51
Disabled	24,276	$233.11	$227.72	$308.43	$360.33	$70.61	$0.00	$1,200.19
Dual	28,712	$20.35	$71.99	$186.83	$8.01	$26.62	$0.00	$313.80
LTSS Physically Disabled	4,275	$130.96	$163.28	$177.24	$211.09	$137.90	$2,621.04	$3,441.51
LTSS Elderly	11,596	$6.58	$47.18	$33.64	$6.70	$29.10	$3,086.47	$3,209.69
LTSS Intellectually Disabled	3,230	$47.84	$70.60	$232.57	$111.19	$162.70	$6,221.03	$6,845.93
LTSS Children's Mental Health	1,070	$25.60	$80.70	$418.16	$231.36	$12.45	$1,427.76	$2,196.03

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Capitation Payments Made to the Managed Care Organizations				
MCO	**Q1 SFY18**	**Q2 SFY18**	**Q3 SFY18**	**Q4 SFY18**
Amerigroup	$252,059,197	$252,496,960		
AmeriHealth	$452,572,360	$304,552,047		
UnitedHealthcare	$213,334,385	$356,479,227		

Managed Care Organization Reported Reserves			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Acceptable Quarterly Reserves per Iowa Insurance Division (IID) (Y/N)*	Y	N/A	Y

Third Party Liability Recovery for Q2 SFY18			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Amount of TPL Recovered	$9,493,182	$17,317,546	$16,846,120

Historical third party liability recoveries collected by the Iowa Medicaid Enterprise as part of payment for services was included in the capitation rates for the managed care organizations.

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.

Fraud, Waste and Abuse

Program integrity activity data demonstrates the MCO's ability to identify, investigate and prevent fraud, waste and abuse.

Q2 SFY18 Data	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	4	90	19
Overpayments Identified During the Quarter	0	71	5
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	1	9	2
Member Concerns Referred to IME	3	6	2

In prior reports, dollars recovered through Program Integrity efforts were reported on a quarterly basis. However, MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The plans have initiated 113 investigations in the second quarter and referred 12 cases to MFCU. 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 would not occur until there is sufficient evidence to implement. It is anticipated that these activities will significantly grow with ongoing claims experience to be used for analytics.

Hospital Admissions

A goal of managed care is to reduce unnecessary hospital admissions by assuring that members receive effective care coordination and preventive services.

Data reported Q2 SFY18 to allow 90 day claims lag	Amerigroup			AmeriHealth			UnitedHealthcare		
	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep
Members (from IME)*	197,851	197,577	195,345	221,264	220,952	218,441	189,009	188,569	185,447
Total Inpatient Admissions	2,492	2,276	1,240	2,241	2,403	2,218	1,167	1,596	1,576
Readmissions within 15 days of Discharge	224	217	78	148	150	147	135	136	128
Readmissions between 16 and 30 days of Discharge	128	34	53	101	112	96	85	105	77
Readmissions between 31 and 45 days of Discharge	70	63	48	84	80	96	90	63	69
Readmissions between 46 and 60 days of Discharge	27	107	25	76	81	94	73	61	76

*Member totals were calculated on the tenth day of the month following each reporting period – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

The data is based on claims paid for dates of service during the experience periods listed above and does not account for claims that have not yet been submitted. Data is pulled from encounters submitted to the IME by MCOs. Data is not risk adjusted for differences in MCO populations.

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Emergency Department*									
Data reported Q2 SFY18 to allow 90 day claims lag	**Amerigroup**			**AmeriHealth**			**UnitedHealthcare**		
	Jul	**Aug**	**Sep**	**Jul**	**Aug**	**Sep**	**Jul**	**Aug**	**Sep**
ED Visits for Non-Emergent Conditions – Adult	36	36	32	29	28	27	33	30	32
ED Visits for Non-Emergent Conditions – Child	16	16	17	16	15	17	16	14	16
Supporting Data									
Members (from IME)	197,851	197,577	195,345	221,264	220,952	218,441	189,009	188,569	185,447
Members Using ED More Than Once in 30 Days	1,185	1,219	799	1,109	1,062	800	883	845	664
Members Using ED More Than Once between 31 and 60 Days	761	541	434	746	504	413	577	388	317

*Emergency department utilization is reported using revenue code 45X. Member totals were calculated on the tenth day of the month following the reporting period – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. The data is based on claims paid for dates of service during the experience periods listed above and does not account for claims that have not yet been submitted. Data is pulled from encounters submitted to the IME by MCOs. Data is not risk adjusted for differences in MCO populations. ED Visits for Non-Emergent Conditions are reported per 1,000 member months.

Encounter Data Disclaimer: The data provided by the IME is provided "as is." The IME cannot ensure the accuracy, completeness, or reliability of the data. The encounter validation process is not yet complete and a one percent (1%) error rate has not yet been achieved. Users accept the quality of the data they receive and acknowledge that there may be errors, omissions, or inaccuracies in the data provided. Further, the IME is not responsible for the user's interpretation, misinterpretation, use or misuse of the data. The IME does not warrant that the data meets the user's needs or expectations.

Out-of-State Placement*									
Q2 SFY18 Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Members in Out-of-State PMIC	5	3	3	13	11	0	4	4	10
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	22	18	17	44	38	0	11	10	57
Members Placed in an Out-of-State ICF/ID	5	4	4	4	3	0	4	3	8

*The data provided is what has been uploaded to the Individualized Service Information System (ISIS) by income maintenance workers based on out of state case activity reports submitted. This process is important in ensuring that member eligibility is up to date and capitation rates are appropriately paid. The IME is working through encounter data validation processes, and numbers may differ from MCO placement counts. Data is not risk adjusted for differences in MCO populations.

APPENDIX

APPENDIX: HCBS WAIVER WAITLIST

HCBS Waiver Waitlist – January 2018*							
HCBS waivers have a finite number of slots budgeted and authorized by CMS. These allow members to receive services in the community instead of a facility or institution.							
Waiver	AIDS	Brain Injury	Children's Mental Health	Elderly	Health and Disability	Intellectual Disability	Physical Disability
Number of Individuals on Waiver	36	1,430	906	7,920	2,210	11,894	921
Number of Individuals on Waiver Waitlist (DHS Function)	0	1,147	1,363	0	3,036	2,958	1,453
Waitlist Increase or (Decrease)	0	72	86	0	64	32	-26

As reported in January 2018. January data represents December eligibility statistics.

APPENDIX: COMPLIANCE REMEDIES ISSUED

Type of Report with Noncompliance by MCO During this Reporting Period				
Identified Reporting or Compliance Issue	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
Care Plan Reductions Report				
Care Coordination Report	2	3	1	6
Correct Coding Initiative Report	1			1
Cost Avoidance Report				
Consumer Reports Report				
Geographic Access Report				
Grievances and Appeals	1		1	2
Health Outcomes Report				
IPES Report				
LTSS Report		1		1
NEMT Report				
Non-PI Recoveries Report				
Planned Coordination Events Report				
Program Integrity Report	3	1	2	6
Provider Credentialing Report				
Provider Incentives Report				
Revised Assessments and Care Plans Reports				
Risk Assessment Report				
Third Party Liability				
Value Added Services Report				
Waivers Report			1	1
Grand Total	**7**	**5**	**5**	**17**

Type of Noncompliance Identified by MCO During this Reporting Period				
Type of Noncompliance	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
Did not meet performance standard	3	3	3	9
Incomplete/Untimely/Inaccurate	4	2	2	8
Grand Total	**7**	**5**	**5**	**17**

Remedies are subject to change due to review of information received from the managed care organizations following publication of this report.

APPENDIX: GLOSSARY

MCO Abbreviations:

AGP: Amerigroup Iowa, Inc.
ACIA: AmeriHealth Caritas Iowa, Inc.
UHC: UnitedHealthcare Plan of the River Valley Iowa, Inc.

Glossary Terms:

Administrative Loss Ratio: The percent of capitated rate payment or premium spent on administrative costs.

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 the Department of Human Services (DHS) or they may ask to ask for a state fair hearing.

Appeal process: The MCO process for handling of appeals, which complies with:

- The procedures for a member to file an appeal
- The process to resolve the appeal
- The right to access a state fair hearing and
- The timing and manner of required notices

Calls Abandoned: Member terminates the call before a representative is connected.

Capitation Payment: Medicaid payments the Department makes on a monthly basis to 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.

CARC: Claim Adjustment Reason Code. An explanation why a claim or service line was paid differently than it was billed. A **RARC** – Readjustment Advice Remark Code provides further information.

Care Management: Care Management helps members manage their complex health care needs. It may include helping member get other social services, too.

Chronic Condition: Chronic Condition is a persistent health condition or one with long-lasting effects. The term chronic is often applied when the disease lasts for more than three months.

Chronic Condition Health Home: Chronic Condition Health Home refers to a team of people who provide coordinated care for adults and children with two chronic conditions. A Chronic Condition Health Home may provide care for members with one chronic condition if they are at risk for a second.

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.

Client Participation: Client Participation is what a Medicaid member pays for Long-Term Services and Supports (LTSS) services such as nursing home or home supports.

Community-Based Case Management (CBCM): Community-Based Case Management helps Long Term Services and Supports (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. Community-Based Care managers (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): Consumer Directed Attendant Care (CDAC) helps people do things that they normally would for themselves if they were able.
CDAC services include:

- Bathing
- Grocery Shopping
- Medication Management
- Household Chores

Critical Incidents: When a major incident has been witnessed or discovered, the HCBS provider/case manager must complete the critical incident form and submit it to

the HCBS member's MCO in a clear, legible manner, providing as much information as possible regarding the incident.

Denied Claims: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.

DHS: Iowa Department of Human Services

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

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

ED: Emergency department

Emergency Medical Condition: An Emergency Medical Condition is any condition that the member believes endangers their life or would cause permanent disability if not treated immediately. A physical or behavioral condition medical condition shown by acute symptoms of sufficient severity that a prudent layperson, who possesses an average knowledge of health and medicine, could expect the absence of medical attention right away to result in:

- Placing the health of the person (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy
- Serious impairment to bodily function
- Serious dysfunction of any bodily organ or body part

If a member has a serious or disabling emergency, they do not need to call their provider or MCO. They should go directly to the nearest hospital emergency room or call an ambulance.
The following are examples of emergencies:

- A Serious Accident
- Stroke
- Severe Shortness of Breath
- Poisoning
- Severe Bleeding
- Heart Attack
- Severe Burns

Emergency Medical Transportation: Emergency Medical Transportation provides stabilization care and transportation to the nearest emergency facility.

Emergency Room Care: Emergency Room Care is provided for Emergency Medical Conditions.

Emergency Services: Covered inpatient or outpatient services that are:

- Given by a provider who is qualified to provide these services
- Needed to assess and stabilize an emergency medical condition

Emergency Services are provided when you have an Emergency Medical Condition.

Excluded Services: Excluded services are services that Medicaid does not cover. The member may have to pay for these services.

Fee-for-Service (FFS): The payment method by which the state pays providers for each medical service given to a patient; this member handbook includes a list of services covered through fee-for-service Medicaid.

Fraud: An act by a person, which is intended to deceive or misrepresent with the knowledge that the deception could result in an unauthorized benefit to himself or some other person; it includes any act that is fraud under federal and state laws and rules; this member handbook tells members how to report fraud.

Good Cause: Members may request to change their MCO during their 12 months of closed enrollment. A request for this change, called disenrollment, will require a Good Cause reason.
Some examples of Good Cause for disenrollment include:

- A member's provider is not in the MCO's network.
- A member needs related services to be performed at the same time. Not all related services are available within the MCO's provider network. The member's primary care provider or another provider determined that receiving the services separately would subject the member to unnecessary risk.
- Lack of access to providers experienced in dealing with the member's health care needs.
- The member's provider has been terminated or no longer participates with the MCO.
- Lack of access to services covered under the contract.
- Poor quality of care given by the member's MCO.
- The MCO plan does not cover the services the member needs due to moral or religious objections.

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:

- The member is unhappy with the quality of your care.
- The doctor who the member wants to see is not an MCO doctor.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Habilitation Services: Habilitation Services are HCBS services for members with chronic mental illness.

HCBS: Home- and Community-Based Services, waiver services. Home- and Community-Based Services (HCBS) provide supports to keep Long Term Services and Supports (LTSS) members in their homes and communities.

hawk-i: A program that provides coverage to children under age 19 in families whose gross income is less than or equal to 302 percent of the FPL based on Modified Adjusted Gross Income (MAGI) methodology.

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

Health Risk Assessment (HRA): A Health Risk Assessment (HRA) is a short survey with questions about the member's health.

Historical Utilization: A measure of the percentage of assigned members whose current providers are part of the managed care network for a particular service or provider type based on claims history.

Home Health: Home Health is a program that provides services in the home. These services include visits by nurses, home health aides and therapists.

Hospital Inpatient Care: Hospital Inpatient Care, or Hospitalization, is care in a hospital that requires admission as an inpatient. This usually requires an overnight stay. These can include serious illness, surgery or having a baby. (An overnight stay for observation could be outpatient care.)

Hospital Outpatient Care: Hospital Outpatient Care is when a member gets hospital services without being admitted as an inpatient. These may include:

- Emergency services.
- Observation services.
- Outpatient surgery.
- Lab tests.
- X-rays.

ICF/ID: Intermediate Care Facility for Individuals with Intellectual Disabilities

IHAWP: 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.

IID: Iowa Insurance Division

IME: Iowa Medicaid Enterprise

Integrated Health Home: An Integrated Health Home is a team that works together to provide whole person, patient-centered, coordinated care. An Integrated Health Home is for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

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): Long Term Services and Supports (LTSS) help Medicaid members maintain quality of life and independence. LTSS are provided in the home or in a facility if needed.
Long Term Care Services:
• Home- and Community-Based Services (HCBS).
• Intermediate Care Facilities for Persons with Intellectual Disabilities.
• Nursing Facilities and Skilled Nursing Facilities.

MCO: Managed Care Organization

Medical Loss Ratio (MLR): The percent of capitated rate payment or premium spent on claims and expenses that improve health care quality.

Medically Necessary: Services or supplies needed for the diagnosis and treatment of a medical condition. They must meet the standards of good medical practice.

Network: 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.

NF: Nursing Facility

PA: Prior Authorization. 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.

PCP: Primary Care Provider. A Primary Care Provider (PCP) is either 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.

PDL: Preferred Drug List

Person-centered Plan: A Person-centered Plan is a written individual plan based on the member's needs, goals, and preferences. This is also referred to as a plan of care, care plan, individual service plan (ISP) or individual education plan (IEP).

PMIC: Psychiatric Medical Institute for Children

Rejected Claims: Claims that don't meet minimum data requirements or basic format are rejected and not sent through processing.

SMI: Serious mental illness.

SED: Serious emotional disturbance. Serious Emotional Disturbance (SED) is a mental, behavioral, or emotional disturbance. An SED impacts children. An SED may last a long time and interferes with family, school, or community activities.
SED does not include:

- Neurodevelopmental disorders.
- Substance-related disorders.
- Other conditions that may be a focus of clinical attention, unless they co-occur with another (SED).

Service Plan: A Service Plan is a 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: Nursing facilities provide 24-hour care for members who need nursing or Skilled Nursing Care. Medicaid helps with the cost of care in nursing facilities. The member must be medically and financially eligible. If the member's care needs require that licensed nursing staff be available in the facility 24 hours a day to provide direct care or make decisions regarding their care, then a skilled level of care is assigned.

Supported Employment: Supported Employment means ongoing job supports for people with disabilities. The goal is to help the person keep a job at or above minimum wage.

Suspended Claims: Claim is pending internal review for medical necessity and/or may need additional information to be submitted for processing.

TPL: Third-party liability. This is the legal obligation of third parties (e.g., certain individuals, entities, insurers, or programs) to pay part or all of the expenditures for medical assistance furnished under a Medicaid state plan.

Underwriting: A health plan accepts responsibility for paying for the health care services of covered individuals in exchange for dollars, which are usually referred to as premiums. This practice is known as underwriting. When a health insurer collects more premiums than it pays in expense for those treatments (claim costs) and the expense to run its business (administrative expenses), an underwriting gain is said to occur. If the total expenses exceed the premium dollars collected, an underwriting loss occurs.