Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2018, Quarter 1

(July- September)

Performance Data

Published December 21, 2017

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 1 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:

- 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,

[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.

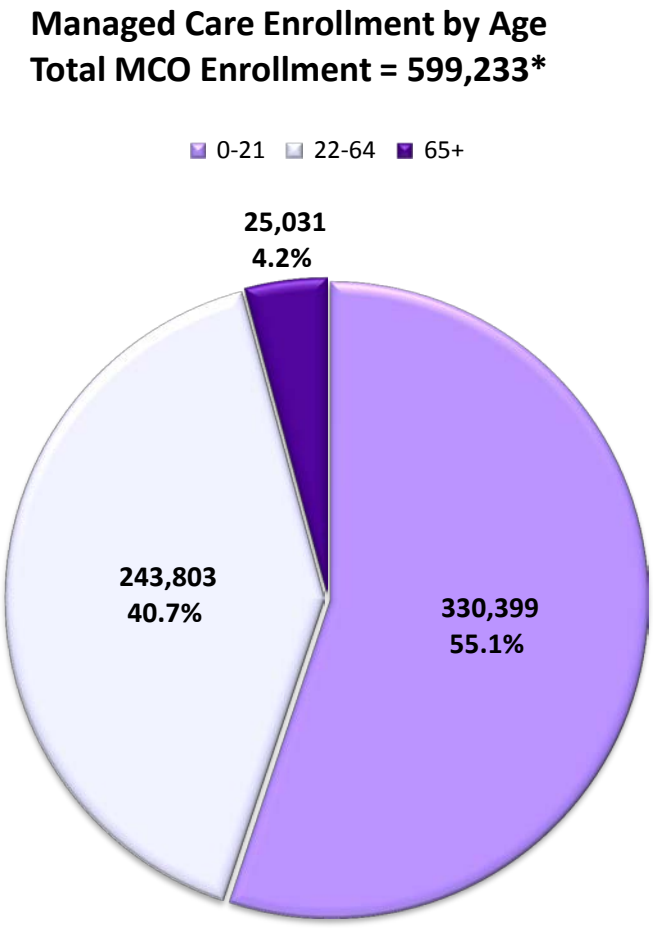
based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

- 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

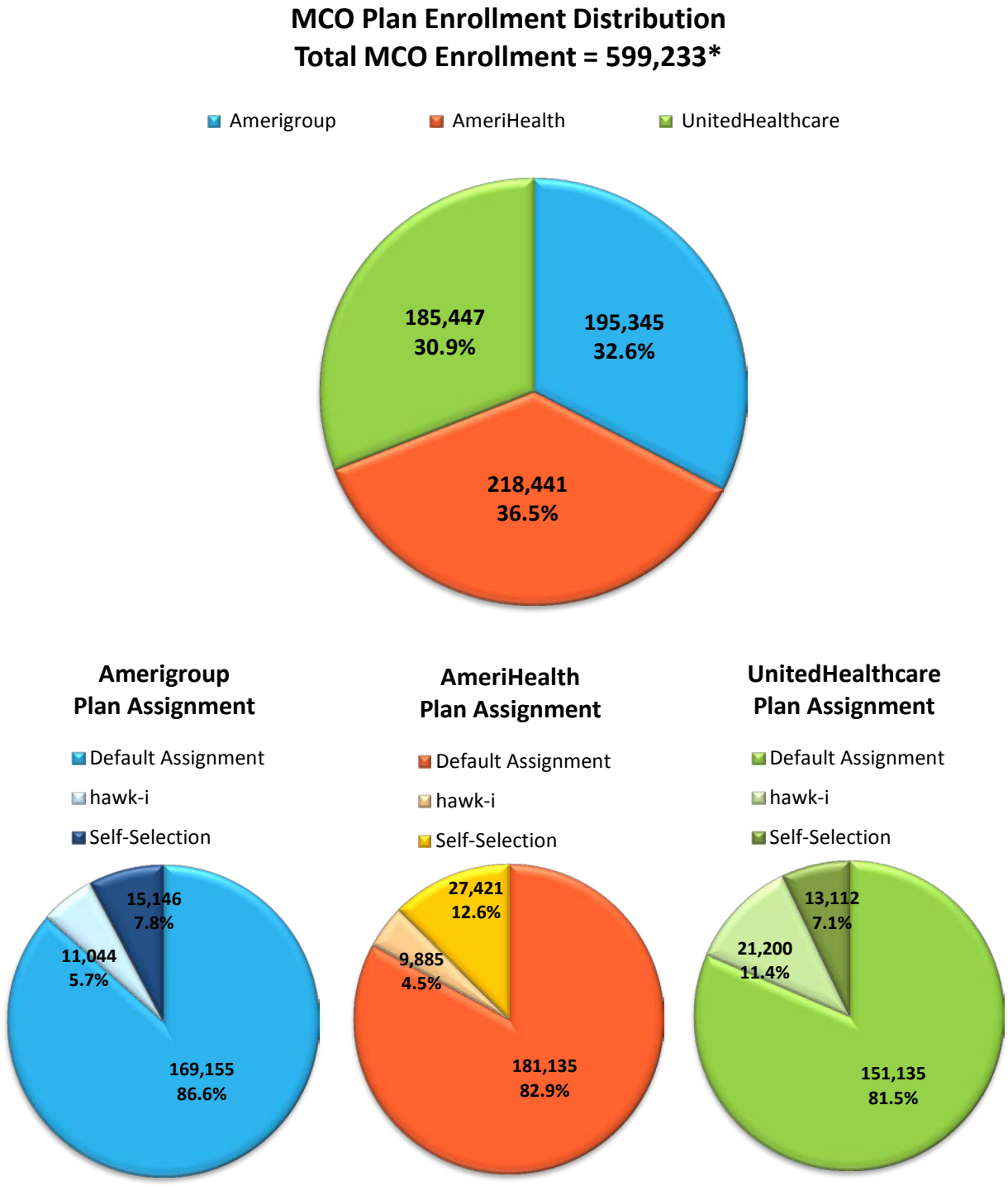
Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink

PLAN ENROLLMENT BY AGE



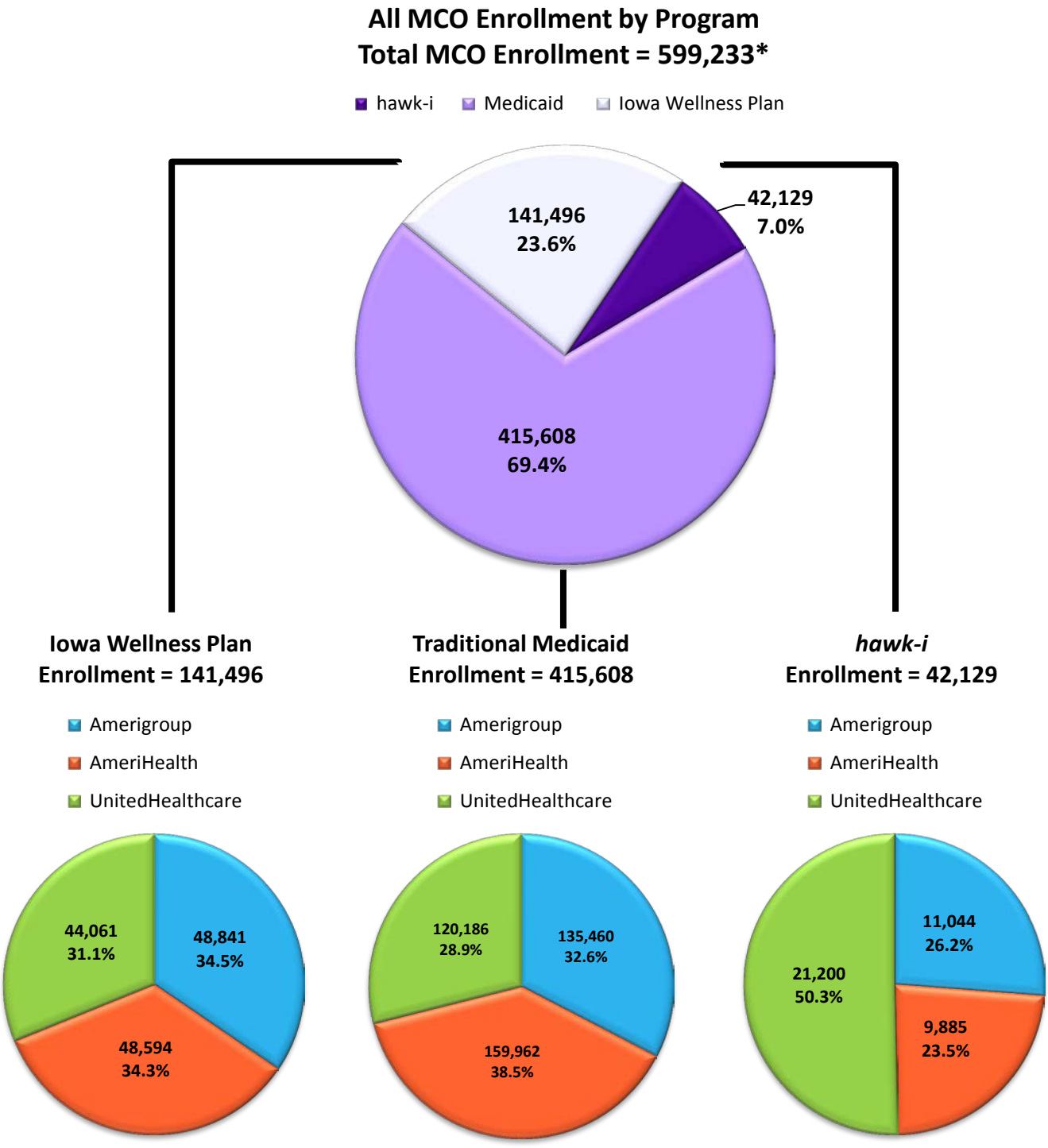
*September 2017 enrollment data as of October 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This includes ***hawk-i*** enrollees. 55,247 members remain in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY MCO



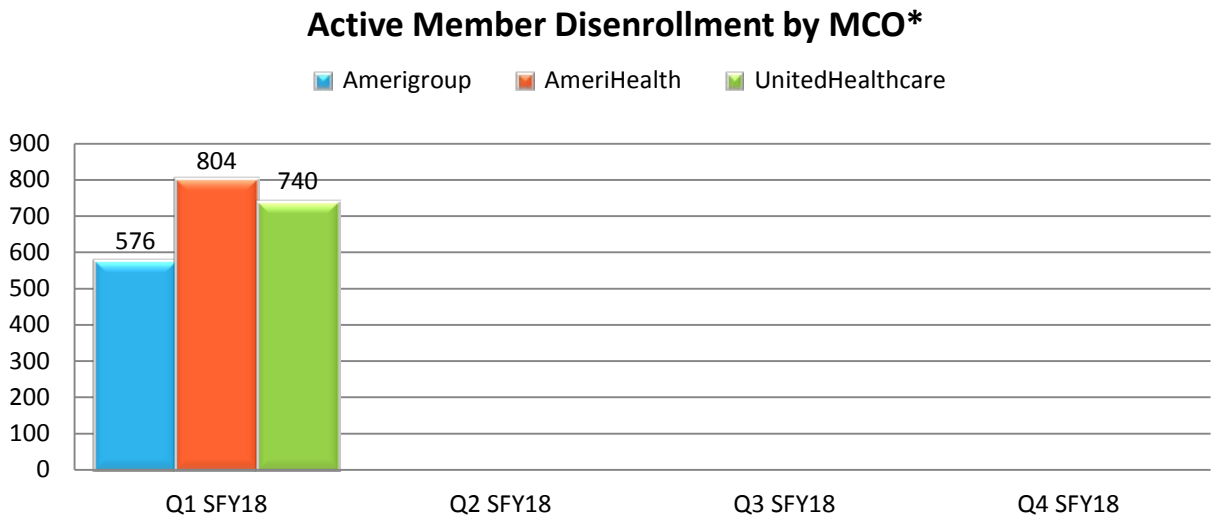
*September 2017 data as of October 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This differentiates ***hawk-i*** enrollees due to differences in *hawk-i* enrollment procedures. In most cases, *hawk-i* members select an MCO prior to beginning benefits whereas other programs have default assignment with self-selection occurring after default assignment. 55,247 members remain in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY PROGRAM



*September 2017 enrollment data as of October 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. 55,247 members remain in the Fee-for-Service (FFS) program.

PLAN DISENROLLMENT BY MCO



*Q1 SFY18 enrollment data as of September 30, 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.

Reasons for All Disenrollment for Q1 SFY18

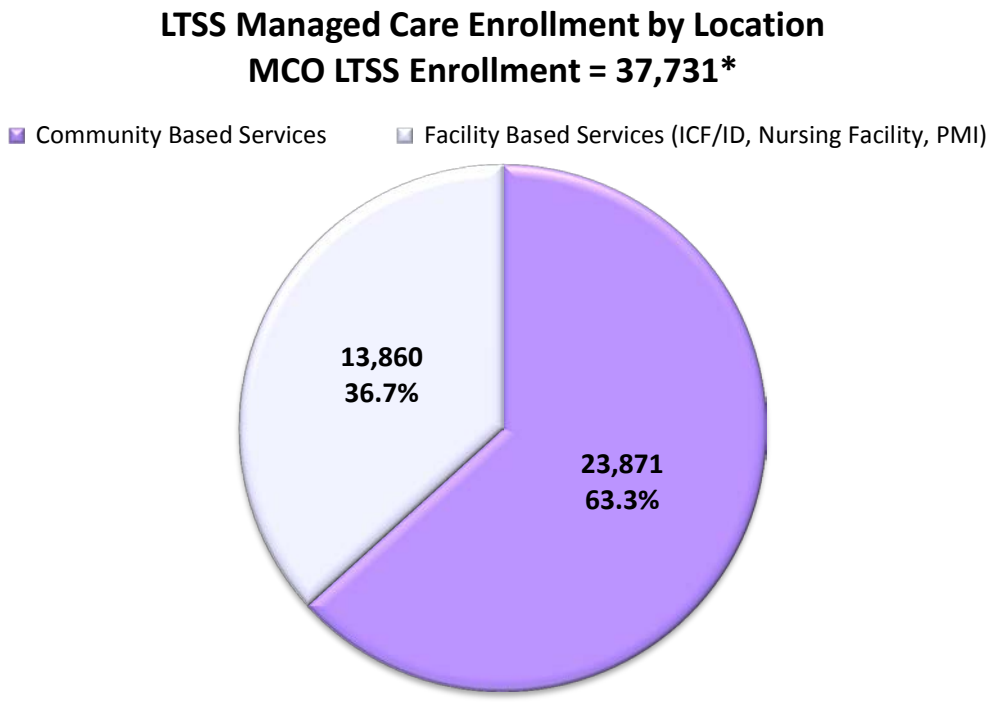
Members can disenroll for good cause any time during the year after their 90 day choice period if certain criteria are met such as:

- 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.

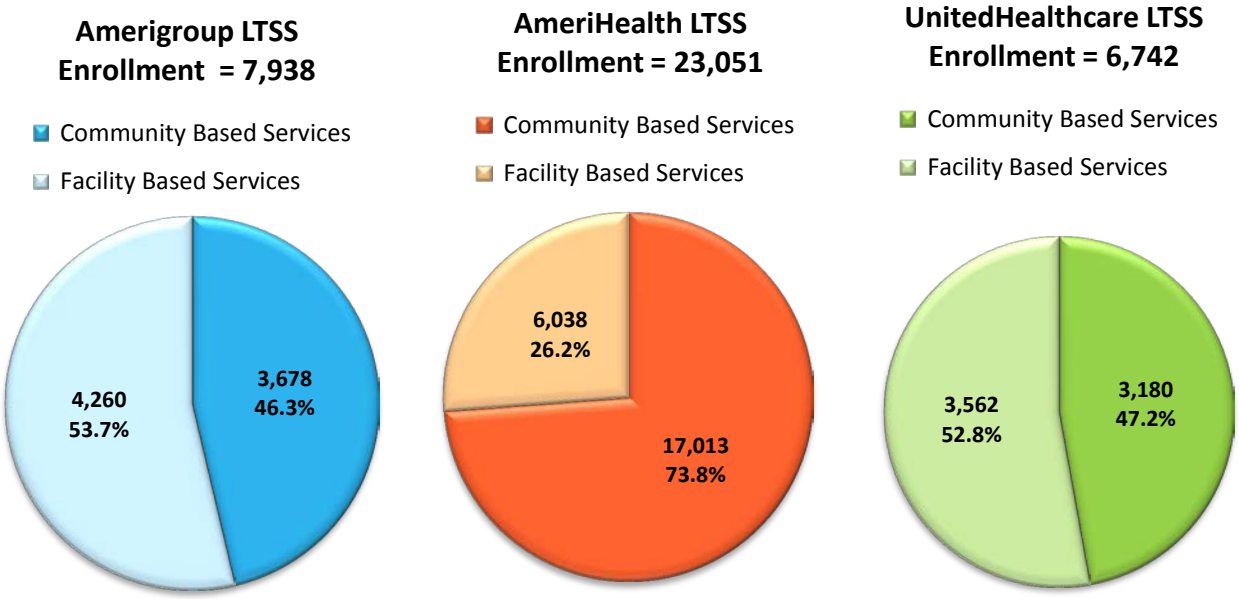
Summary Reason	Count
Established provider in another MCO network	2,041
Quality of care	570
Lack of access to services covered under the contract	146
Lack of access to providers experienced in dealing with the member's health care needs	54
Continuity of care	9

*Data includes members who chose to switch during open enrollment. The IME is investigating disenrollment reporting as there may be coding issues.

All MCO Long Term Services and Supports (LTSS) Enrollment



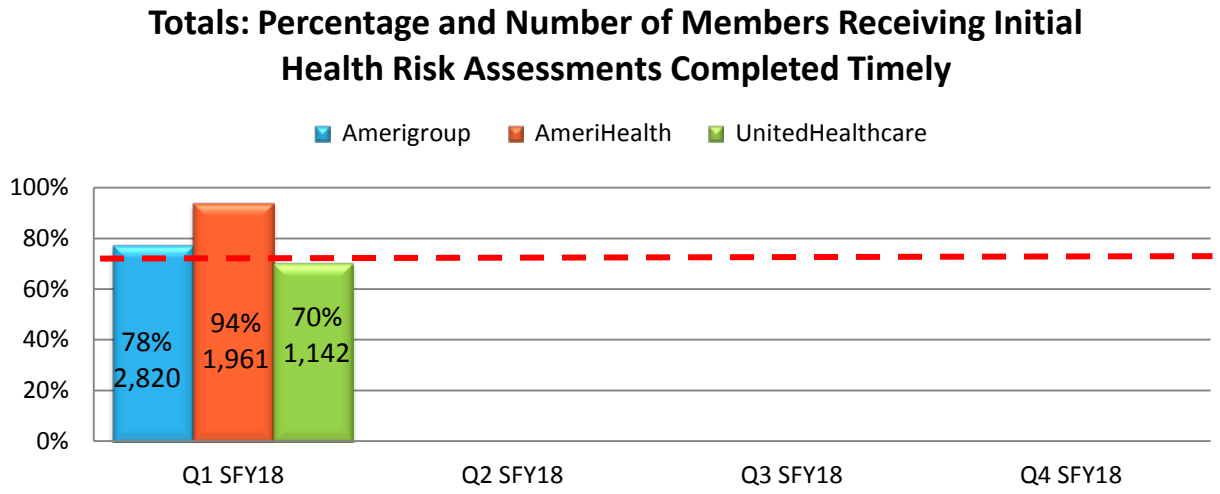
Total MCO LTSS Enrollment by Plan



*September 2017 enrollment data as of October 31, 2017 – 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.

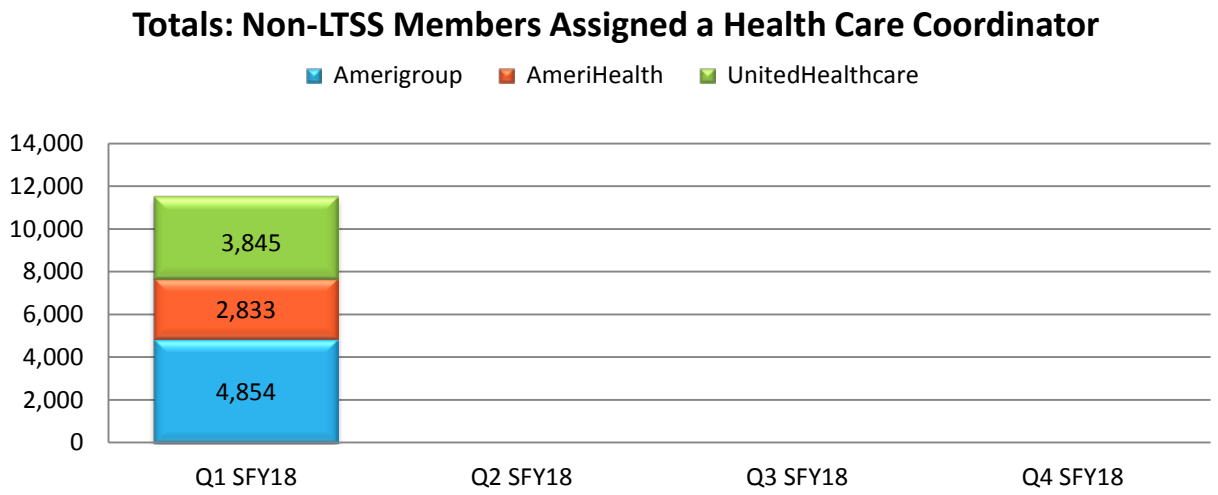


Population-Specific Supporting Data						
	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
	Count	%	Count	%	Count	%
Initial HRAs Completed Timely for Seniors (Ages 65& Up)	312	94%	338	100%	271	99%
Initial HRAs Completed Timely for Adults(Ages 18-64)	1,247	88%	889	99%	528	82%
Initial HRAs Completed Timely for Children (Under Age 18)	1,261	66%	734	87%	343	48%

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.

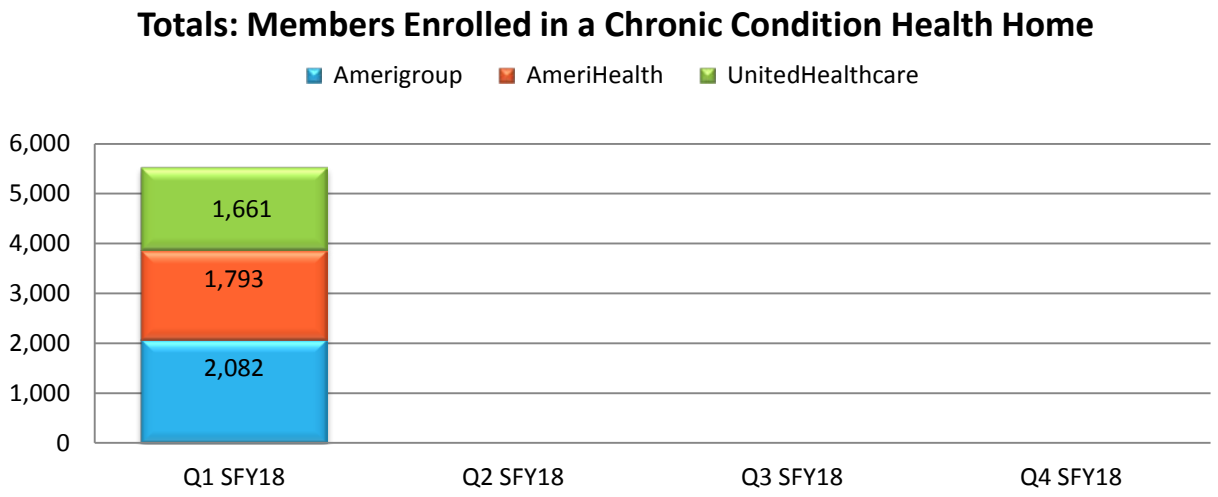
Members identified as having a special health care need through the initial health risk assessment or other means may be assigned a care coordinator with an MCO Care Coordination Program, a Chronic Condition Health Home, or an Integrated Health Home. This data element does not have a direct benchmark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



Population-Specific Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Assigned a Health Care Coordinator	292	764	96
Count of Non-LTSS Adults (Ages 18-64) Assigned a Health Care Coordinator	3,134	1,461	2,702
Count of Non-LTSS Children (Under Age 18) Assigned a Health Care Coordinator	1,428	608	1,047

Chronic Condition Health Home Assignment

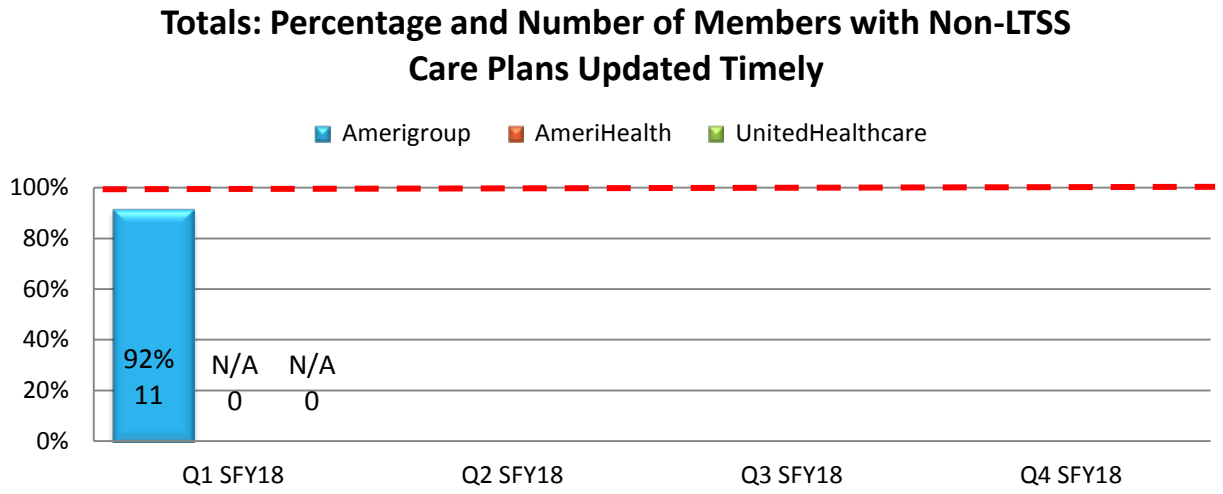
Alternatives to MCO Health Care Coordinators are Chronic Condition Health Home care coordination and Integrated Health Home care coordination. This section focuses on Chronic Condition Health Homes. Chronic Condition Health Homes are medical offices that provide care coordination services on behalf of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



Population-Specific Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Count of Non-LTSS Seniors (Ages 65& Up) Enrolled in a Chronic Condition Health Home	210	267	127
Count of Non-LTSS Adults(Ages 18-64) Enrolled in a Chronic Condition Health Home	1,425	1,124	1,112
Count of Non-LTSS Children (Under Age 18) Enrolled in a Chronic Condition Health Home	447	402	422

Non-LTSS Update of Care Plans

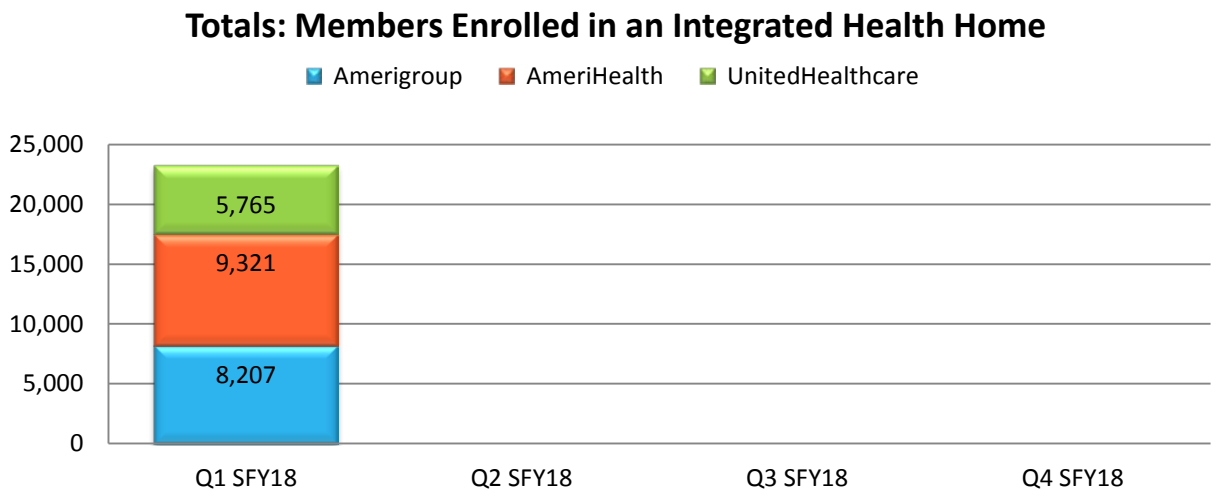
Non-LTSS Members identified as having special health care needs and requiring ongoing care coordination have care plans developed and managed by the MCO. Federal regulations require that revisions to care plans for these members occur at least annually. This measure does not have a fee for service benchmark. 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						
	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
	Count	%	Count	%	Count	%
Non-LTSS Care Plans Updated Timely for Seniors (Ages 65& Up)	9	90%	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)	1	100%	0	N/A	0	N/A

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.

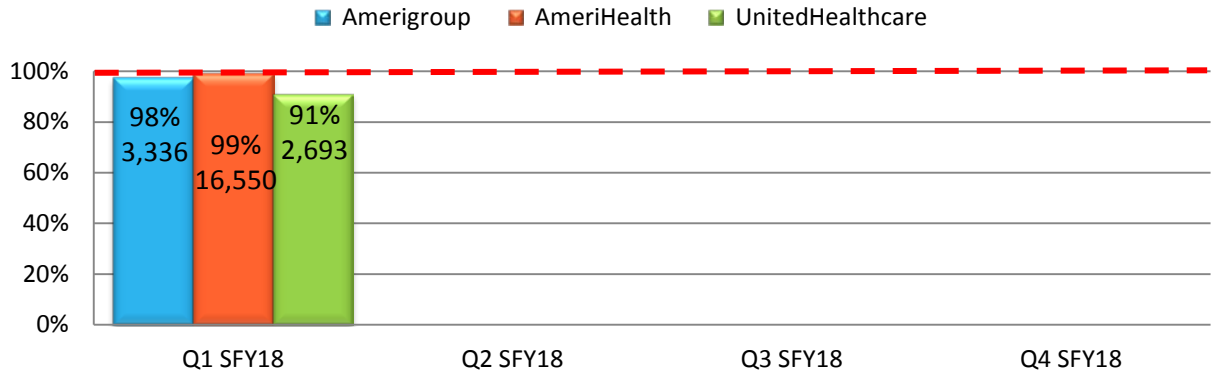


Population-Specific Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Count of Seniors (Ages 65& Up) Enrolled in an Integrated Health Home	131	128	74
Count of Adults(Ages 18-64) Enrolled in an Integrated Health Home	4,822	5,663	3,398
Count of Children (Under Age 18) Enrolled in an Integrated Health Home	3,254	3,530	2,293

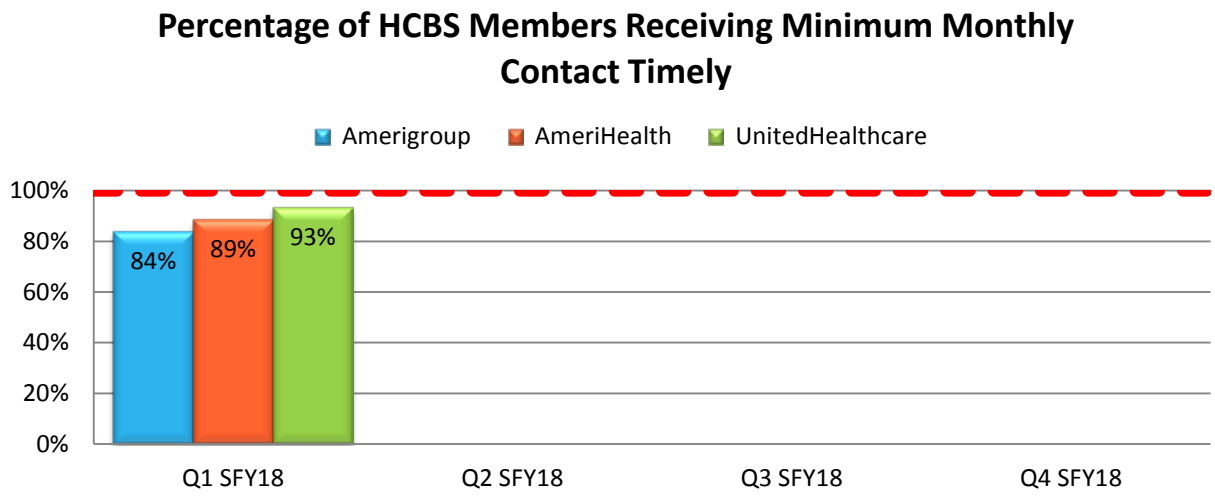
SPECIAL NEEDS: LTSS HOME AND COMMUNITY-BASED CARE COORDINATION

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.

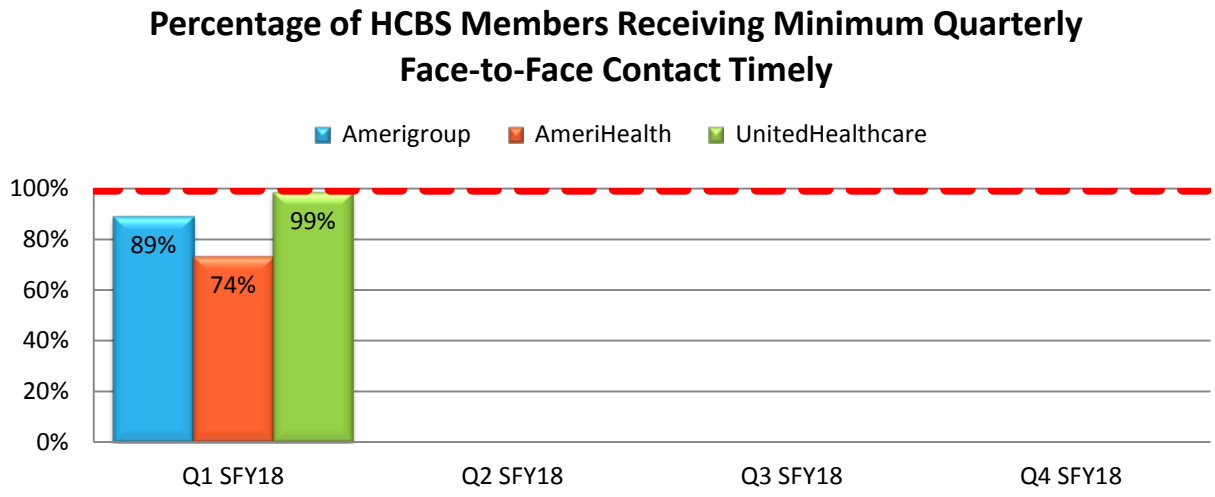
Totals: Percentage and Number of HCBS Members Assigned a Community-Based Case Manager



HCBS Waiver-Specific Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Brain Injury Members Assigned a CBCM	205	928	154
Elderly Members Assigned a CBCM	1,248	5,347	1,043
Health and Disability Members Assigned a CBCM	538	712	450
HIV/ AIDS Members Assigned a CBCM	14	12	9
Intellectual Disability Members Assigned a CBCM	1,015	9,197	783
Physical Disability Members Assigned a CBCM	316	354	254



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.



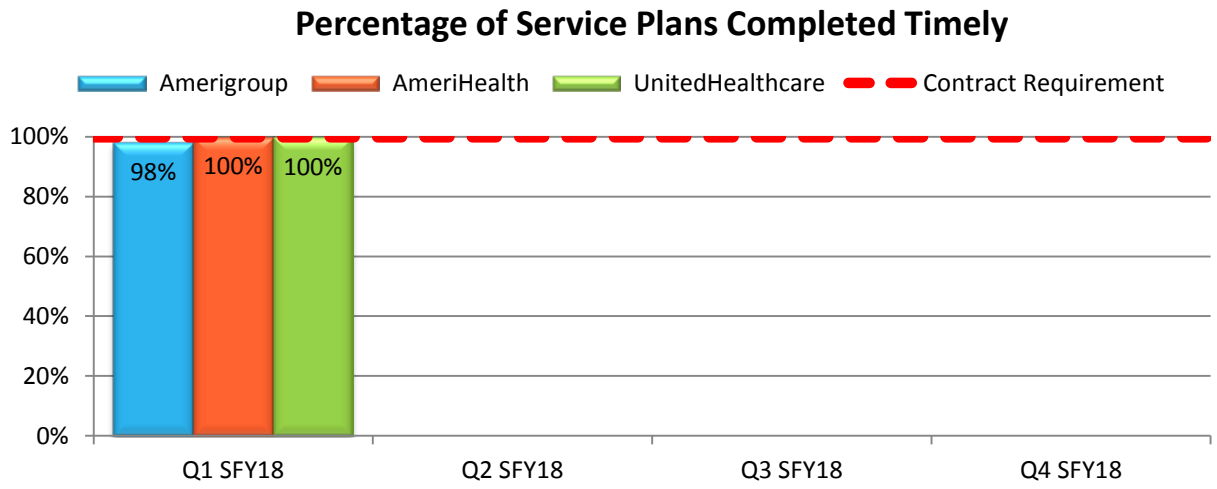
At a minimum, community-based case managers must visit members in their residence face-to-face quarterly with an interval of at least 60 calendar days between visits. HCBS Members Receiving Quarterly Face-to-Face Contact monitors the count of members

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.

Community-Based Case Management Ratios			
The ratios below reflect combined adult and child populations for these settings where applicable.			
Data Reported as of October 30,2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Members in Facility per Community-Based Case Manager	57	36	32
Members in Community per Community-Based Case Manager	37	27	27
Unduplicated LTSS Members per Community-Based Case Manager	57	27	59

Service Plans

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

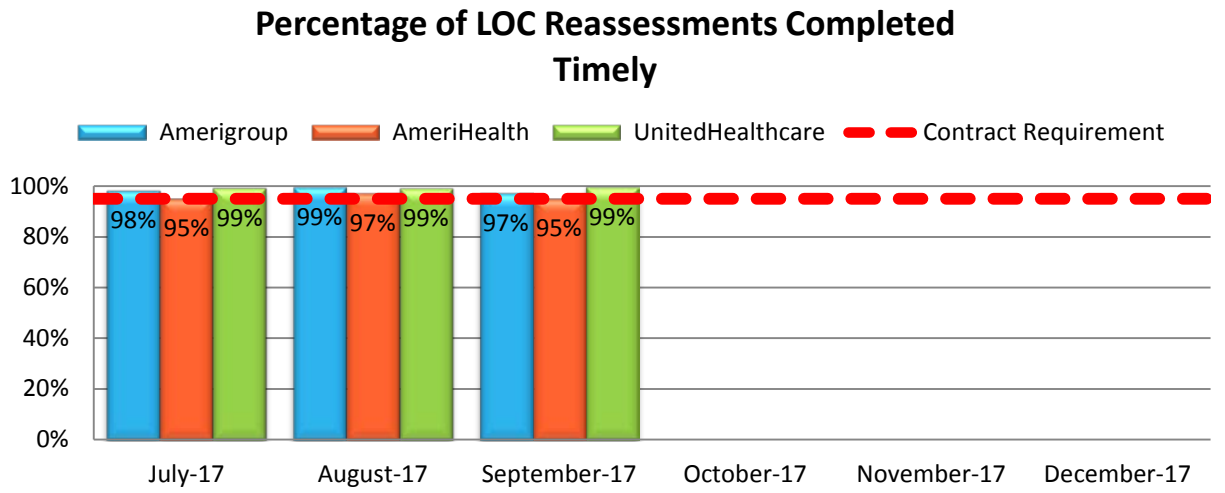


Members will continue to receive the same level of services regardless of whether service plan has been updated timely.

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

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.

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 September 2017	3,678		17,013		3,180	
Critical Incident Q1 SFY18 Resolution						
Program	Received	Resolved	Received	Resolved	Received	Resolved
Aids/HIV Waiver Critical Incidents Received in Q1 SFY18	0	N/A	0	N/A	0	N/A
Brain Injury Critical Incidents Received in Q1 SFY18	4	100%	42	100%	14	100%
Children's Mental Health Critical Incidents Received in Q1 SFY18	27	100%	16	100%	25	100%
Elderly Critical Incidents Received in Q1 SFY18	31	100%	172	100%	43	100%
Habilitation Critical Incidents Received in Q1 SFY18	494	100%	457	100%	251	100%
Health Disability Critical Incidents Received in Q1 SFY18	10	100%	17	100%	22	100%
Intellectual Disability Critical Incidents Received in Q1 SFY18	126	100%	685	100%	103	100%
Money Follows the Person Critical Incidents Received in Q1 SFY18	16	100%	0	N/A	6	100%
Physical Disability Critical Incidents Received in Q1 SFY18	0	N/A	13	100%	12	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 Q1 SFY18			
Aids/HIV	0	0	1
Brain Injury	1	2	4
Children's Mental Health	3	0	0
Elderly	24	11	36
Habilitation	7	0	6
Health Disability	0	1	19
Intellectual Disability	4	17	9
Money Follows the Person	0	0	0
Physical Disability	0	4	14
Iowa Participant Experience Survey Aggregated Responses Q1 SFY18			
Members Reporting They Feel They Have Been a Part of Planning Their Waiver Services	90%	89%	89%
Members Reporting Talking About Health Issues When Their Plan Was Being Developed	72%	89%	90%
Members Reporting Services Include All the Things They Told Their Team They Needed and Wanted	85%	81%	91%
Members Reporting They Feel Safe Where They Live	97%	94%	97%
Members Reporting it was Easy to Make Contact with Service Staff	79%	83%	89%
Members Reporting Their Services and Providers Make Their Life Better	100%	94%	93%
Members Receiving Employment Services that Report They Like Their Job	Not Reportable	48%	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 April 30, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Individual Jobs Services Outcomes			
Brain Injury Waiver Members Served	8	55	1
Habilitation Members Served	139	345	79
Intellectual Disability Waiver Members Served	125	1,493	60
Small Group Employment Services Outcomes			
Brain Injury Waiver Members Served	1	17	2
Habilitation Members Served	52	98	16
Intellectual Disability Waiver Members Served	41	479	40
Facility-Based Services Outcomes			
Brain Injury Waiver Members Served	2	34	2
Habilitation Members Served	123	249	31
Intellectual Disability Waiver Members Served	99	1,091	46

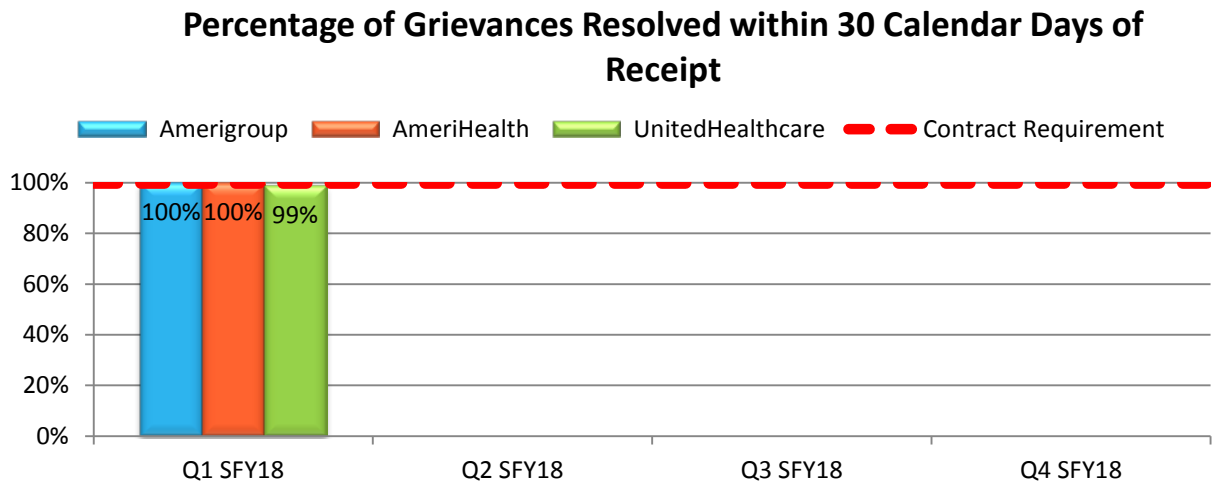
MCO Member Grievances and Appeals

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.

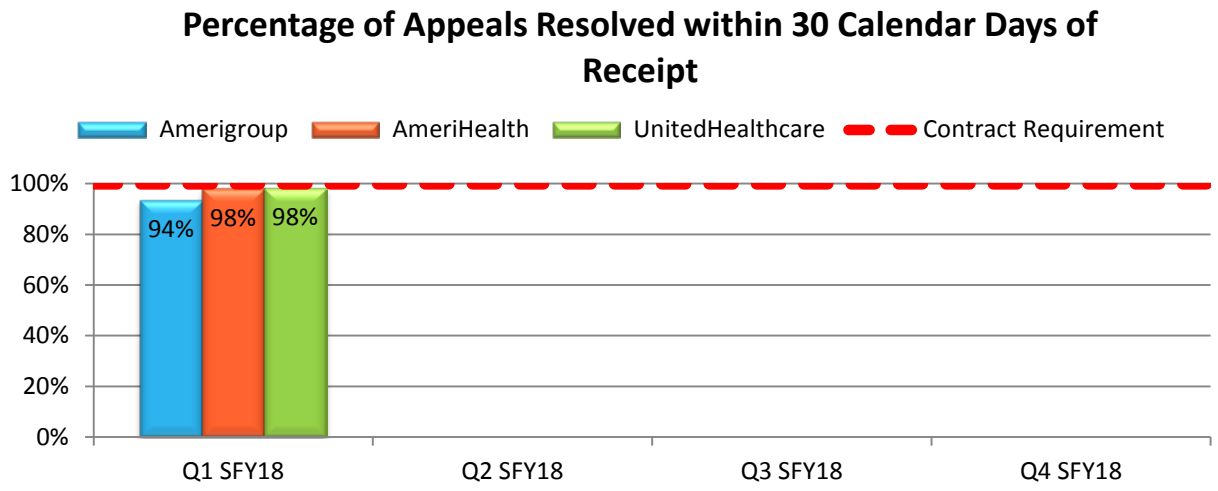
Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Grievances Received in Q1 SFY18	260	638	104

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 Q1 SFY18

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	80	Type of Grievance - Provider-Member Received Bill	439	Benefit-Other - Ambulance / Transportation - Dispute regarding non-ambulance methods of transportation	50
2	Provider balance billed	43	Type of Grievance - Administrative/MCO-Exception Decisions	32	Benefit-Other - Balance Billing	25
3	Provider attitude/rudeness	24	Type of Grievance - Administrative/MCO-Plan Policies and Procedures	30	Quality of Care	10
4	Adequacy of treatment record keeping	13	Type of Grievance - Hospital-Member Received Bill	27	Administration - Service Concerns - Members unhappy with high risk case management or transitional care management	2
5	Treatment Dissatisfaction	13	Type of Grievance - Provider-Dissatisfied with Treatment or Service	25	Administration - Service Concerns - Caller not recontacted or called back in a timely manner. Letter not sent.	2

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



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 this 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

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 Q1 SFY18

	Amerigroup		**AmeriHealth**		**UnitedHealthcare**	
#	**Appeals**	**Count**	**Appeals**	**Count**	**Appeals**	**Count**
1	Pharmacy - Non Injectable	152	Pharmacy	89	Pharmacy - Dispute of drugs that require clinical coverage review.	81
2	Skilled Nursing	53	Skilled Care/Nursing	72	Utilization Review Determination - Dispute over the medical necessity of a service or treatment.	41
3	BH - Op Service	38	Durable Medical Equipment	63	Pharmacy - Dispute of coverage of non-preferred drugs.	25

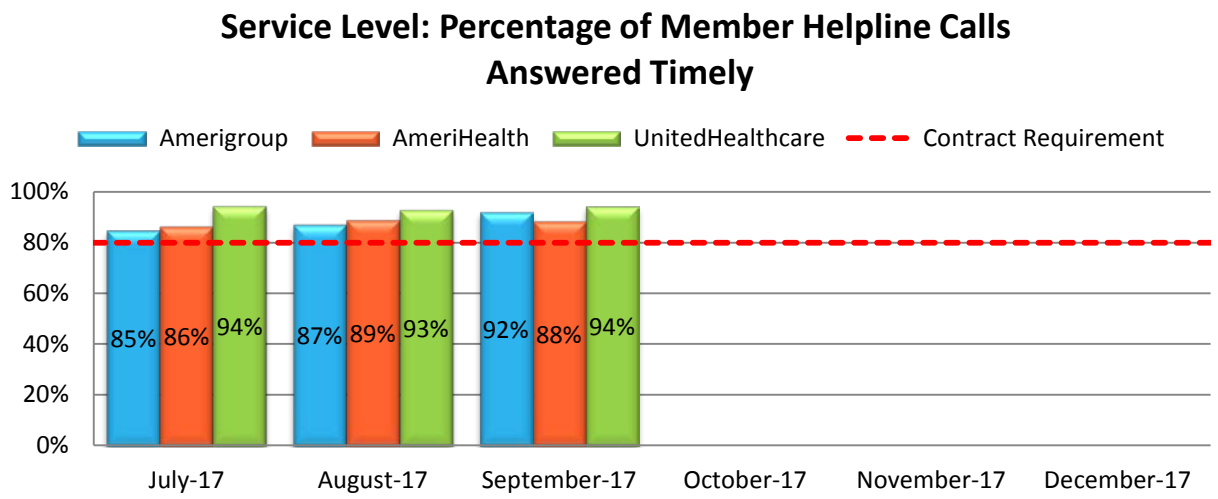
	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Appeals	Count	Appeals	Count	Appeals	Count
4	Pharmacy - Injectable	35	LTSS - Long-term Support Services	53	Durable Medical Equipment (DME)	18
5	Therapy - PT	29	Prior Authorization	34	Pharmacy - Dispute of excluded medication or new prescription drug product not added to PDL	11

State Fair Hearing Summary for Members in Managed Care Q1SFY18

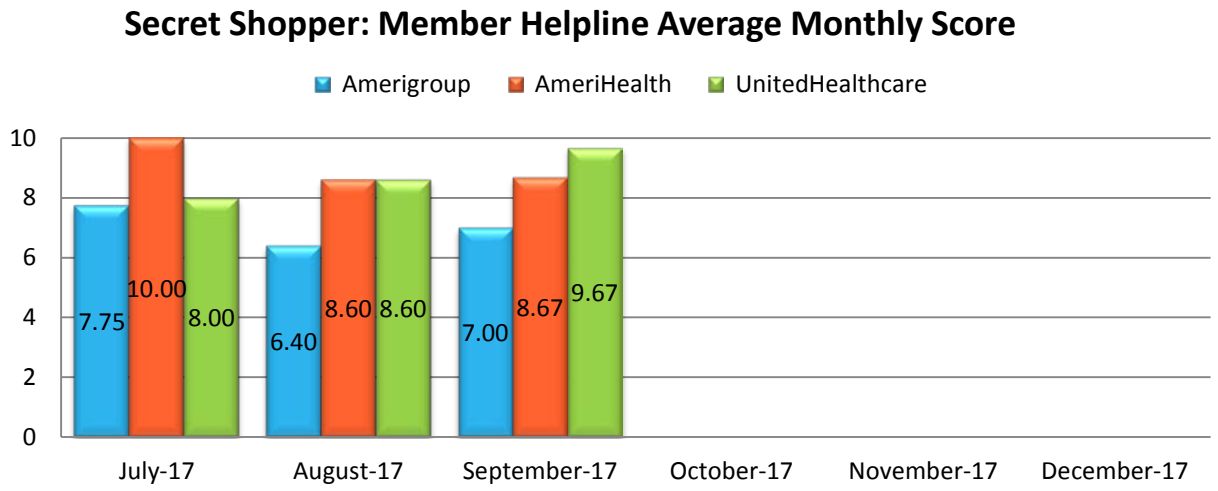
Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Level of Care	0	0	0
Medical Service Denial/Reduction	71	64	14
Pharmacy Denial/Reduction	6	2	2
Durable Medical Equipment Denial/Reduction	6	4	10

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.

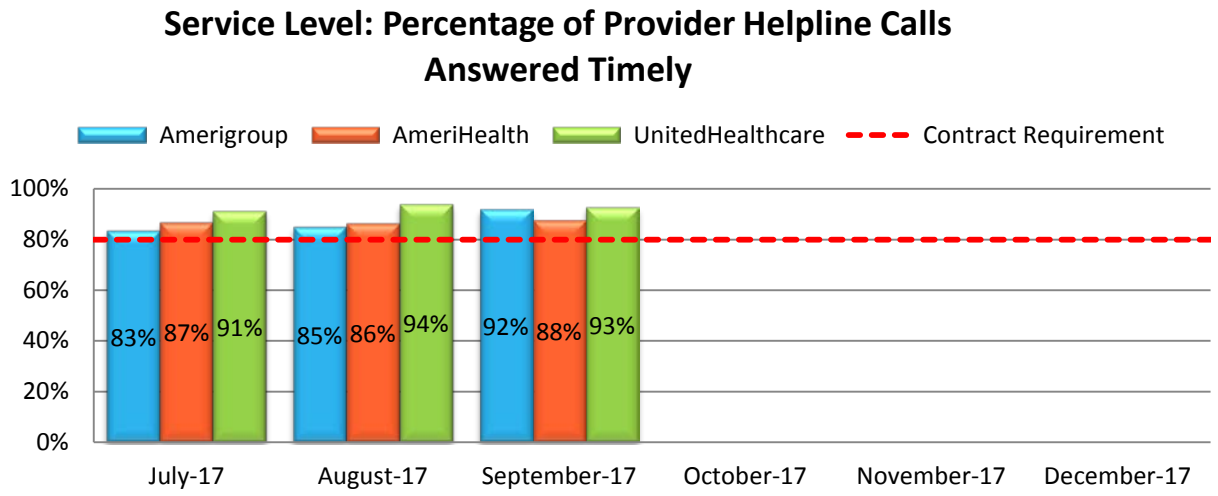
Scores are aggregated for each day to achieve a daily score with a maximum of ten points. All results are provided to MCOs so they can address any training needs. The focus of these activities is continuous quality improvement, with topics changing based on current issues. In July, member helpline secret shopper topics focused on Iowa Health and Wellness Plan Ombudsman referrals, member grievance processes, and translation services. In August, topics included ombudsman referrals, grievance processes, translation services, guardianship, case manager processes for guardianship, HIPAA compliance, and member fraud. In September, topics included pharmacy benefits, transportation services, and durable medical equipment.

Top Five Reasons for Members Contacting Helplines for Q1 SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2017						
1.	Transportation Questions	8138	Member Inquiries-Plan Policy/Procedure Education	6471	PCP Inquiry	4422
2.	Benefit Inquiry/Issue	1657	Member Changes-Demographic Changes	5605	Eligibility Inquiry	3689
3.	Enrollment Inquiry/Issue	1004	Member Request-ID Card Request	2689	Benefits	3545
4.	Pharmacy Inquiry/Issue	944	Eligibility/Enrollment-Member Eligibility	2232	COB Information	1775
5.	Provider-Find/Change/Verify PCP	675	Member Inquiries-General Benefit	1646	General Inquiry	777
August 2017						
1.	Transportation Questions	9270	Member Inquiries-Plan Policy/Procedure Education	7164	PCP Inquiry	4857
2.	Benefit Inquiry/Issue	953	Member Changes-Demographic Changes	6320	Benefits	3963
3.	Provider Find/Change/Verify PCP	947	Member Request-ID Card Request	3170	Eligibility Inquiry	3017
4.	Benefit Inquiry	921	Eligibility/Enrollment-Member Eligibility	2378	COB Information	1429
5.	Pharmacy Inquiry/Issue	892	Member Changes-PCP Change	1683	Claims Inquiry	813
September 2017						
1.	Transportation Questions	9561	Member Inquiries-Plan Policy/Procedure Education	6700	PCP Inquiry	4355
2.	Benifit Inquiry	845	Member Changes-Demographic Changes	5520	Benefits	3168
3.	Provider Find/Change/Verify	780	Member Request-ID Card Request	2599	Eligibility Inquiry	2453

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
	PCP					
4.	Pharmacy Inquiry/Issue	778	Eligibility/Enrollment-Member Eligibility	2116	COB Information	1451
5.	Benefit Inquiry/Issue	696	Member Changes-PCP Change	1522	Claims Inquiry	769

Provider Helpline



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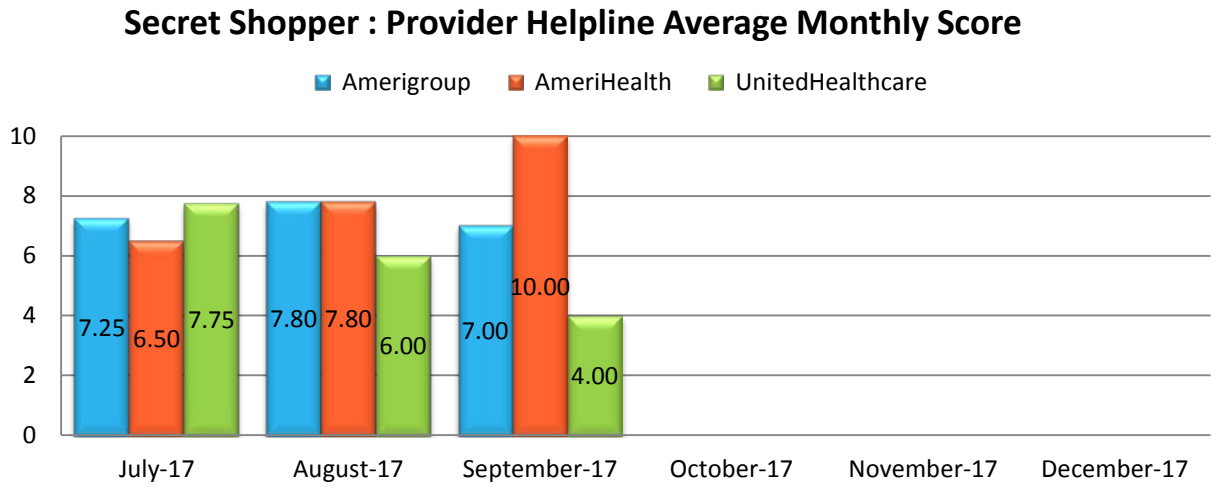


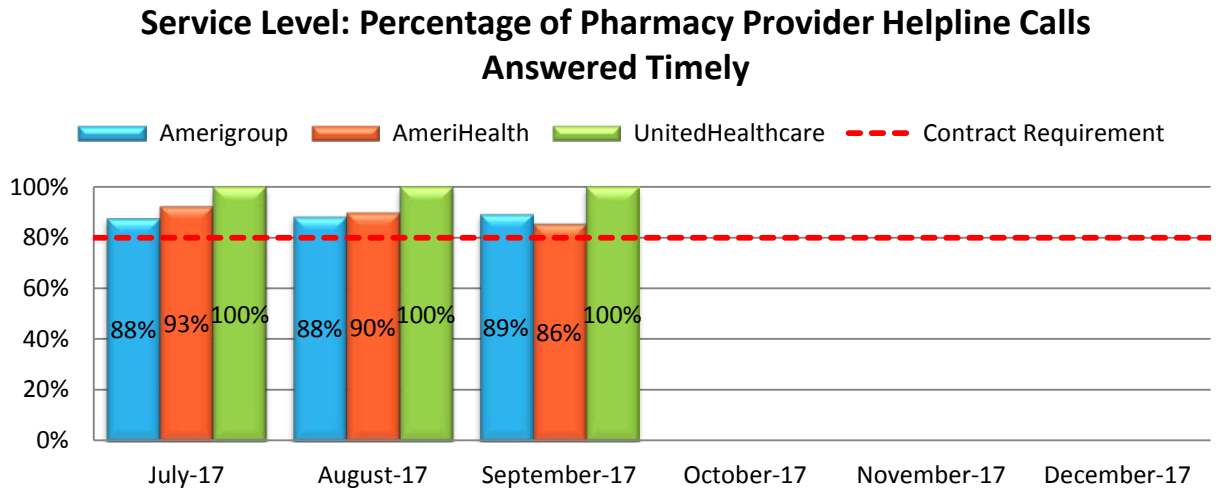
Secret shopper calls are conducted by the Iowa Medicaid Enterprise at least weekly and assess MCO customer service representative soft skills and policy knowledge. For each day that call monitoring occurs, five questions are asked of provider helpline representatives to be monitored and scored. Each 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 July, provider helpline secret shopper topics focused exclusively on family planning services. In August, topics included family planning services, prior authorizations, claim denial processes, vaccines for children, and retroactive eligibility. In September, topics included hearing aids for durable medical equipment, retroactive eligibility, and vaccines for children.

Top Five Reasons for Providers Contacting Helplines for Q1 SFY18

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2017						
1.	Claim Status Inquiry	3,015	Claims-Claim Status	13,574	Claims Inquiry	13,664
2.	Claim Rejected	1,635	Provider Requests-Check Remittance Advice	7,180	Benefits	4,280
3.	Claims Inquiry	1,366	Provider Inquiries-Plan Policy/Procedure Education	5,652	COB Information	1,693
4.	Claim Denial Inquiry	981	Eligibility/Enrollment-Member Eligibility	2,344	Authorization Related	953
5.	Benefits Inquiry	862	Claims-Claim Issues	1,823	Membership Record	665
August 2017						
1.	Claim Status Inquiry	3,113	Claims-Claim Status	16,335	Claims Inquiry	11,063
2.	Claims Inquiry	1,496	Provider Requests-Check Remittance Advice	6,750	Benefits	3,709
3.	Claim Rejected	1,492	Provider Inquiries-Plan Policy/Procedure Education	5,352	COB Information	981
4.	Claim Denial Inquiry	1,240	Eligibility/Enrollment-Member Eligibility	2,665	Authorization Related	824
5.	Benefits Inquiry	1,084	Claims-Claim Issues	2,324	Membership Record	667
September 2017						
1.	Claim Status Inquiry	2,962	Claims-Claim Status	14,239	Claims Inquiry	15,536
2.	Claim Rejected	1,336	Provider Requests-Check Remittance Advice	7,550	Benefits	4,577
3.	Claims Inquiry	1,313	Provider Inquiries-Plan Policy/Procedure	5,248	COB Information	1,211

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			Education			
4.	Claim Denial Inquiry	1,013	Eligibility/Enrollment-Member Eligibility	2,407	Membership Record	912
5.	Benefits Inquiry	876	Claims-Claim Issues	1,975	Authorization Related	1,180

Pharmacy Services Helpline

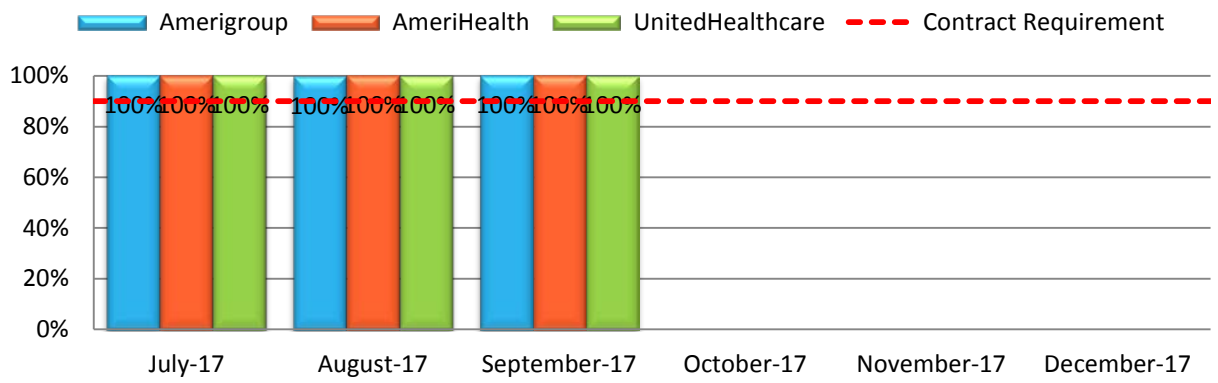


This performance target measures the timeliness of answering the helpline calls. The department defines “timely” answers as calls answered in 30 seconds or less. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure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

Medical Claims Payment

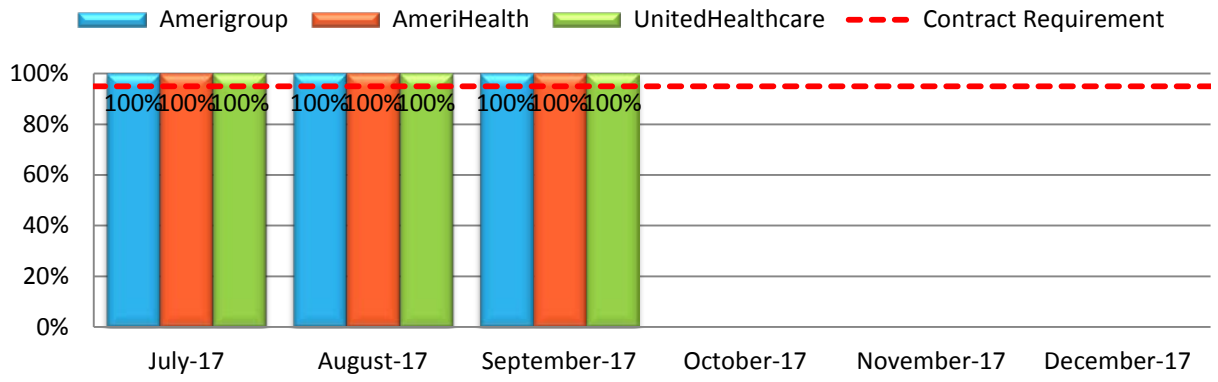
Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

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

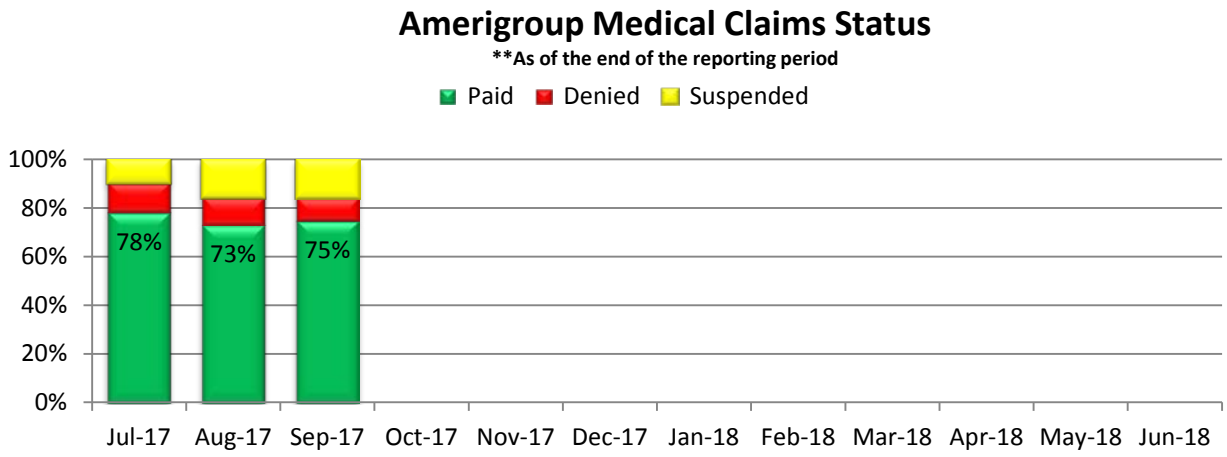


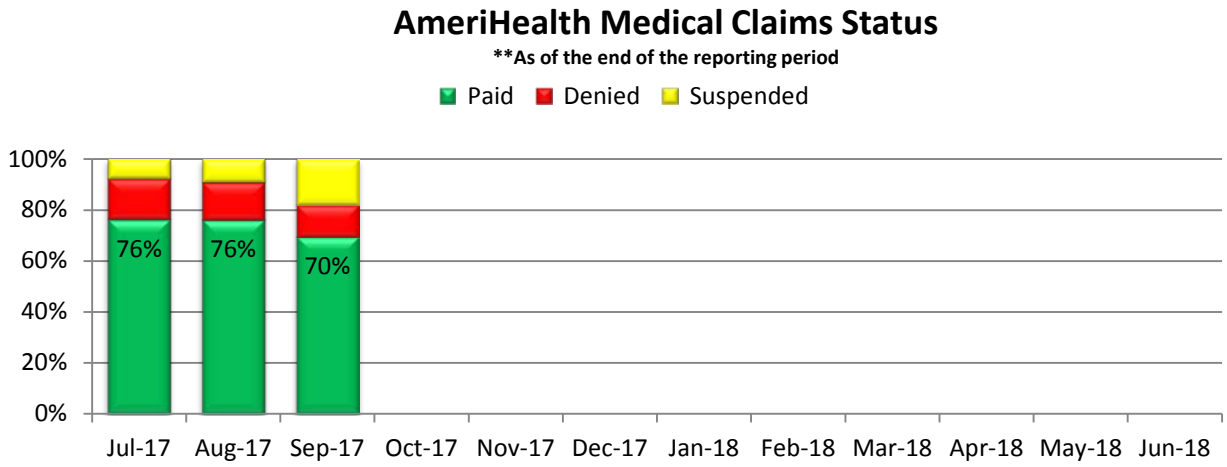
This measure is a measure of timeliness of adjudication and does not represent the accuracy of payment by the MCOs. The department continues to monitor reimbursement accuracy through analysis, collaborative validation projects with the MCOs, as well as investigation and follow up when the department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

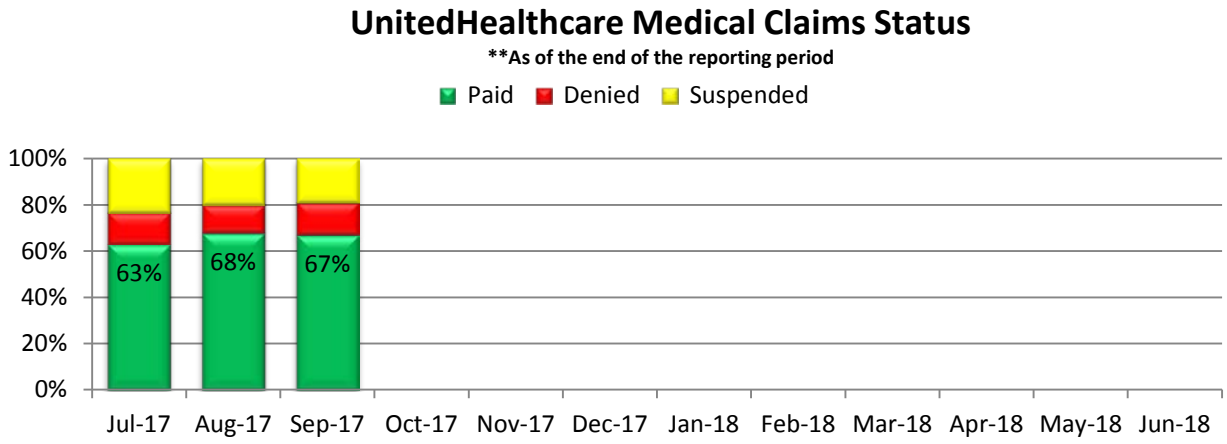
Percentage of Clean Medical Claims Paid or Denied Within 45 Calendar Days



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%
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%
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%
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-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-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.
2.	CARC-27 Expenses incurred after coverage terminated.	CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for 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-29 The time limit for filing has expired.	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 claim.	CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
4.	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-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
5.	CARC-197 Precertification/authorization/notification absent.	CARC-29 The time limit for filing has expired.	CARC-252 An attachment/other documentation is required to adjudicate this claim/ service.

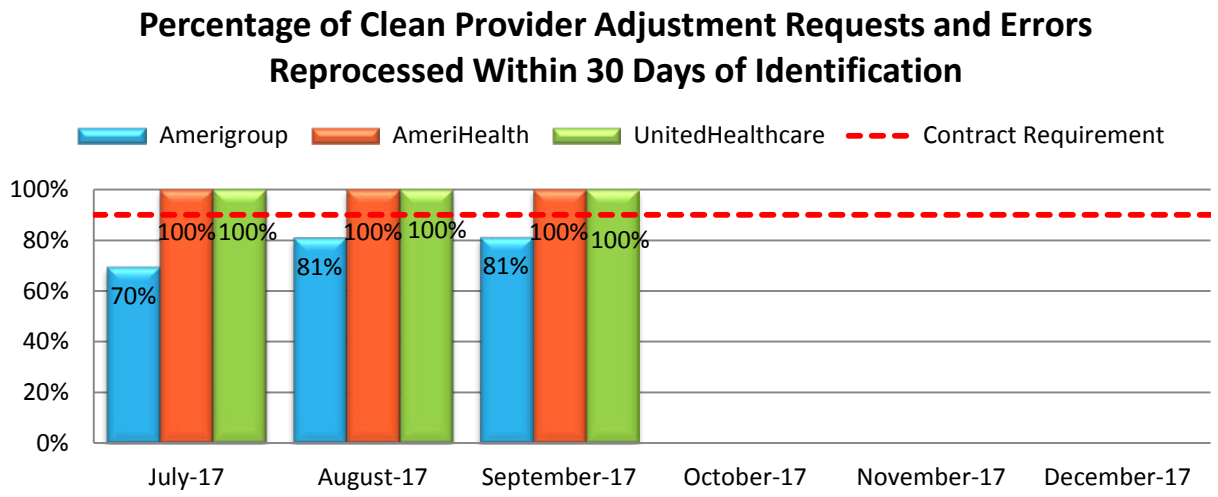
Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
			RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
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-29 The time limit for filing has expired.
7.	CARC-256 Service not payable per managed care contract.	CARC-97 The benefit for this service is included in the payment/allowance for 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. RARC-M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	CARC-97 The benefit for this service is included in the payment/allowance for another service/ procedure that has already been adjudicated. RARC-N130 Consult plan benefit documents/guidelines for information about restrictions for this service.
8.	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	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.)	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.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period			
CARC and RARC are defined below table			
#	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
	Code that is not an ALERT.) Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present. RARC-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.	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-4 The procedure code is inconsistent with the modifier used or a required modifier is missing. Note: Refer to the 835 Healthcare Policy Identification Segment (loop 2110 Service Payment Information REF), if present.	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-N329 Missing/incomplete/invalid patient birth date.	CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication RARC-N258 Missing/incomplete/invalid billing provider/supplier address
10.	CARC-242 Services not provided by network/primary care providers.	CARC-236 This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. RARC-N657 This should be billed with the appropriate code for these services.	CARC-208-National Provider Identifier - Not matched. RARC-N77 Missing/incomplete/invalid designated provider number.

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 July 2017	684,027	792,677	522,420
Total Claims Processed August 2017	665,189	821,495	584,806
Total Claims Processed September 2017	651,587	763,436	549,341
Claims Reprocessed or Adjusted July 2017	21,958	110,358	25,759
Claims Reprocessed or Adjusted August 2017	34,248	70,557	37,889
Claims Reprocessed or Adjusted September 2017	18,567	53,413	23,823

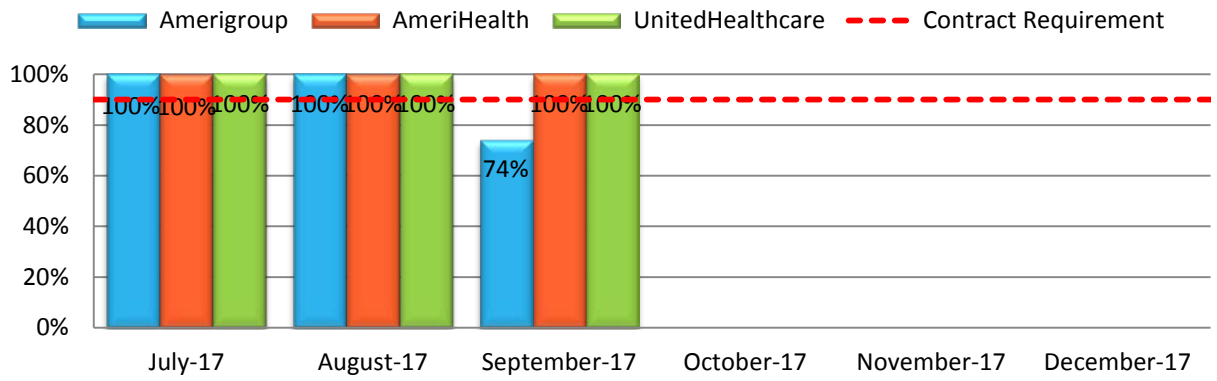


Plans have 30 days from the date of identification of an error or a clean provider adjustment request to reprocess 90% of the claims identified. Claims reprocessing projects may be processed on a different timeline with Agency approval.

Pharmacy Claims Payment

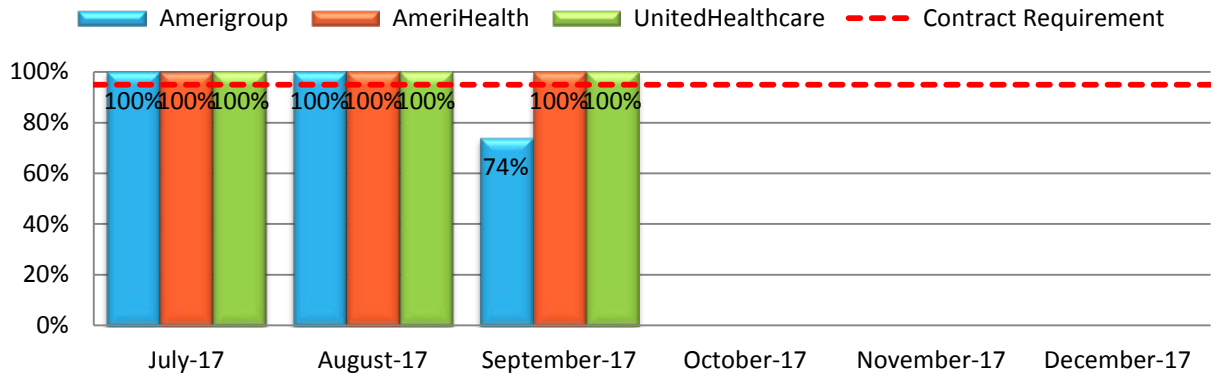
Pharmacy claims processing data is for the entire quarter.

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.

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



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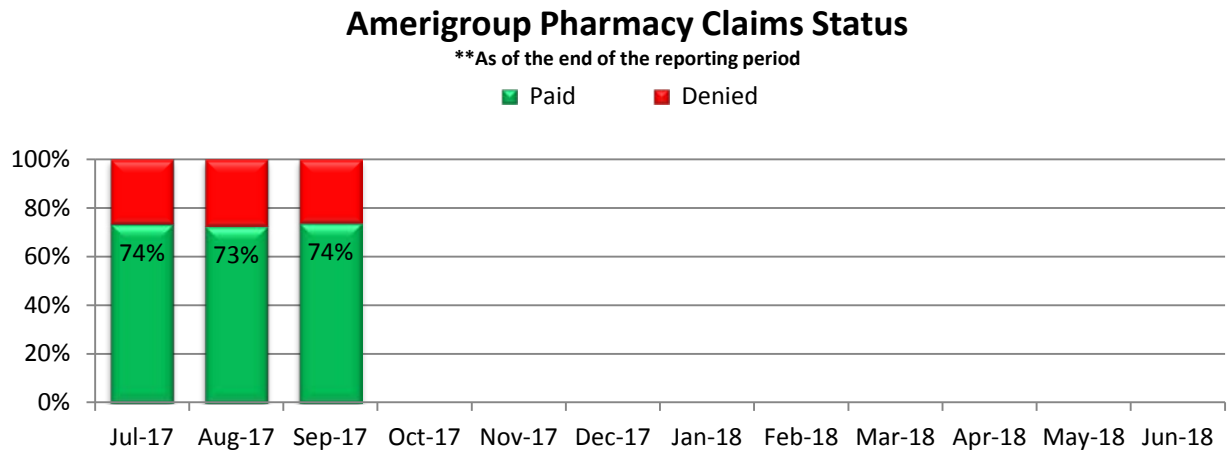
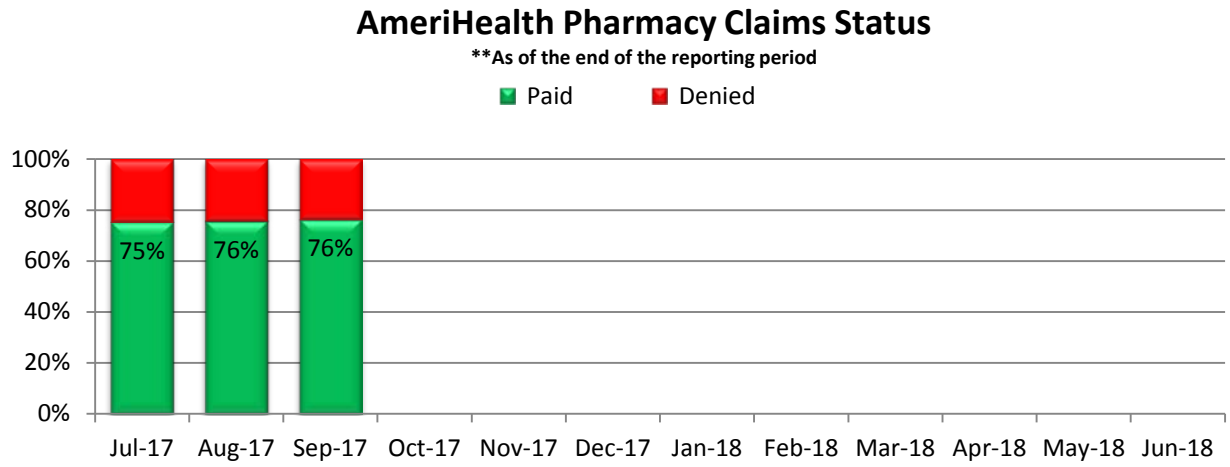
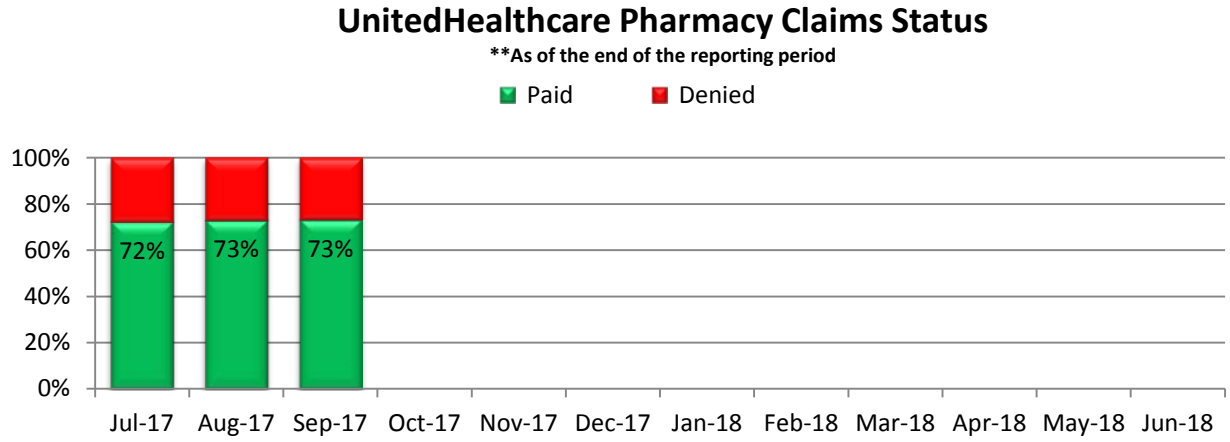

Amerigroup Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
74%
73%
74%
Jul-17
Aug-17
Sep-17
Oct-17
Nov-17
Dec-17
Jan-18
Feb-18
Mar-18
Apr-18
May-18
Jun-18


AmeriHealth Pharmacy Claims Status
**As of the end of the reporting period
Paid
Denied
100%
80%
60%
40%
20%
0%
75%
76%
76%
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%
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	Refill Too Soon	Refill Too Soon
2.	Product Not On Formulary	Product/Service Not Covered	Prior Authorization Required
3.	Submit Bill To Other Processor Or Primary Payer	Patient Is Not Covered	Filled After Coverage Term
4.	Days Supply Exceeds Plan Limitation	Prior Authorization Required	Prod/Service Not Covered
5.	Prior Authorization Required	Submit Bill To Other Processor Or Primary Payer	Plan Limitations Exceeded
6.	Product/Service Not Covered – Plan/Benefit Exclusion	Plan Limitations Exceeded	Submit Bill To Other Processor
7.	Plan Limitations Exceeded	Duplicate Paid/Captured Claim	DUR Reject Error
8.	DUR Reject Error	Non-Matched Product/Service Id Number	Prescriber is Not Covered
9.	Scheduled Downtime	DUR Reject Error	M/I Days Supply
10.	This Medicaid Patient Is Medicare Eligible	Provider Not Eligible To Perform Service/Dispense Product	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.

Q1 SFY18 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Additional Benefits	1,730	2,401	347	4,478
Family Planning and Resources	0	0	1,057	1,057
Health and Wellness	54	12,128	135	12,317
Healthy Incentives	6,310	10,375	1,809	18,494
Tobacco Cessation	127	641	375	1,143

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.

To view a list of value added services by plan, visit: https://dhs.iowa.gov/sites/default/files/ValueAddedServicesComparisonChart_2015_12_02.pdf

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.

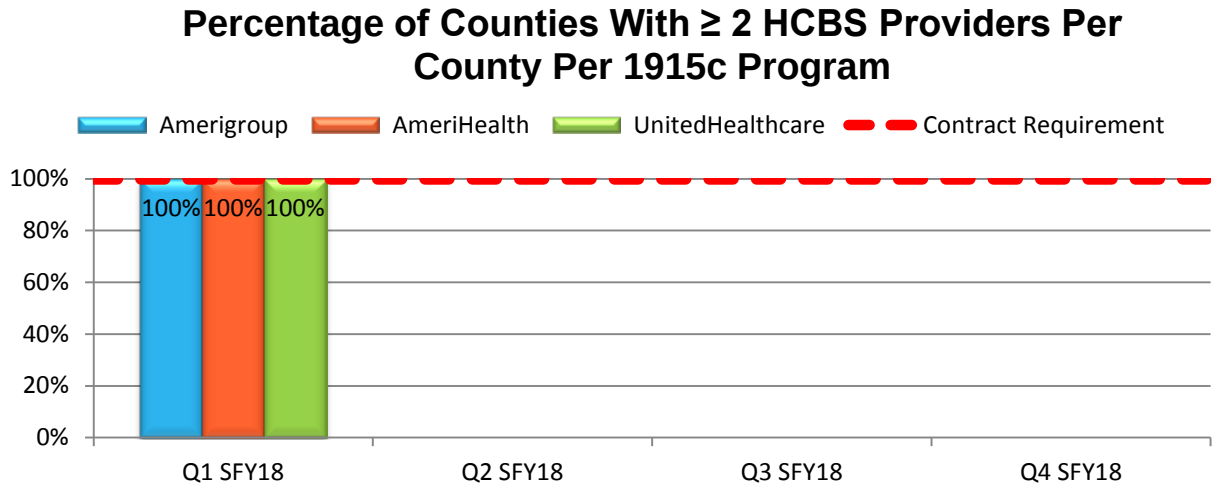
Links to time and distance reports for this reporting period can be found at:

- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-AGP-09012017.pdf
- AmeriHealth Caritas:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-ACIA-090117.pdf
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-UHC-090117.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%		91%	100%	
Behavioral Health – Inpatient		98%	100%		100%	100%		98%	100%

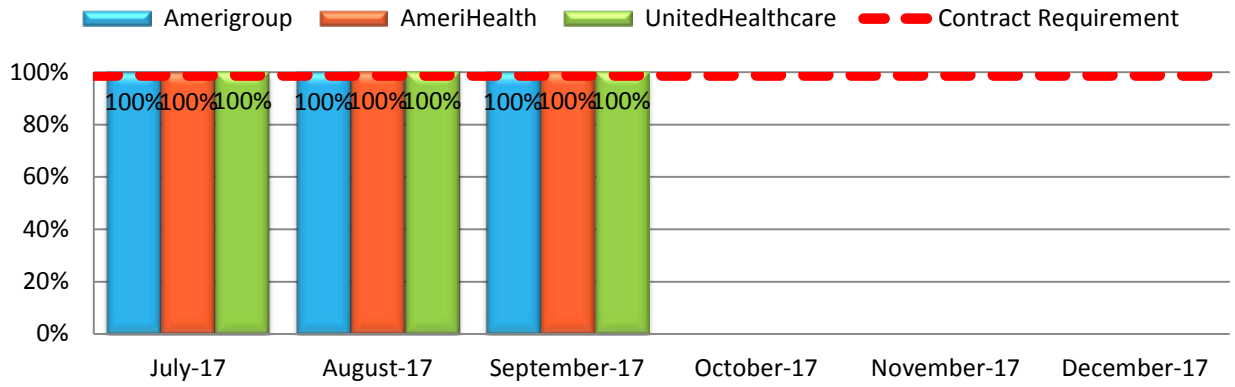


All MCOs have approved exception requests for the network standards in Exhibit B of the contract for HCBS services.

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

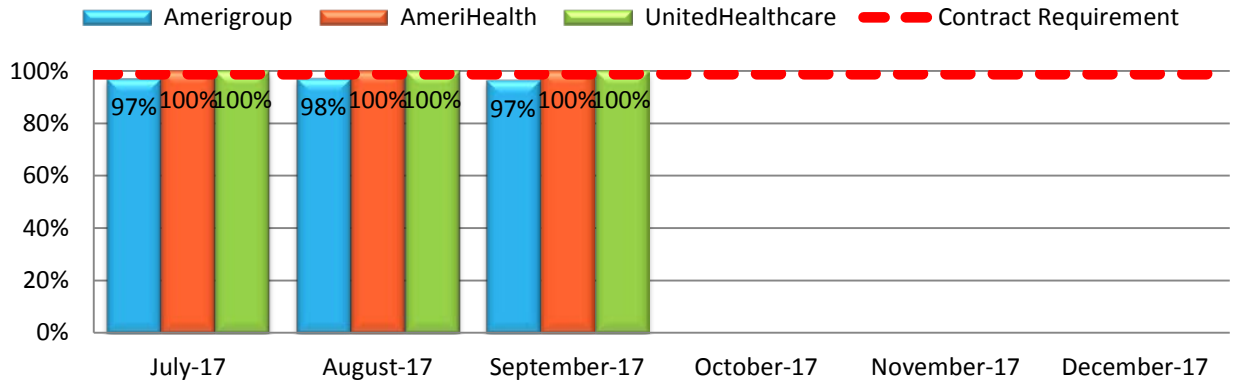
Percentage of Regular Prior Authorizations (PAs) Completed Within 14 Calendar Days of Request



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.

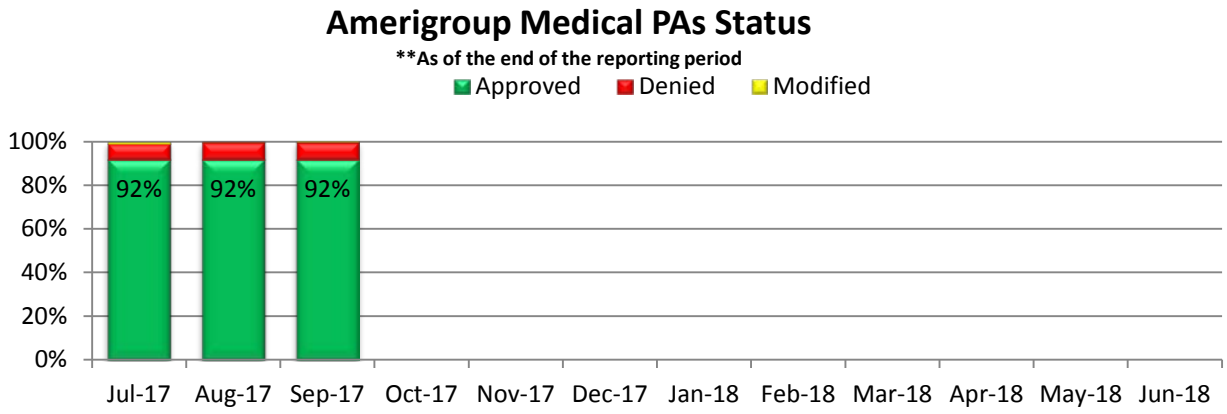
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

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

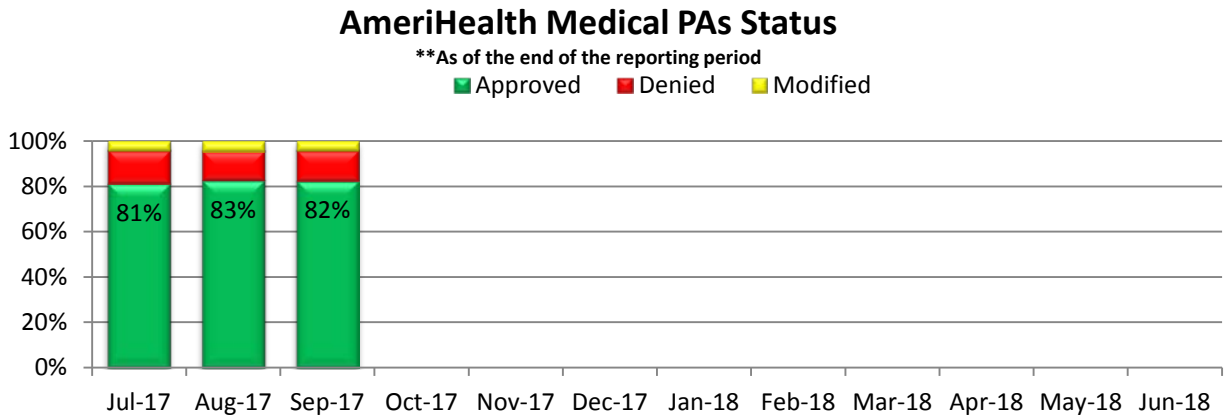


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ. 99% of PAs for expedited services must be authorized within 72 hours of request to meet performance guarantees.

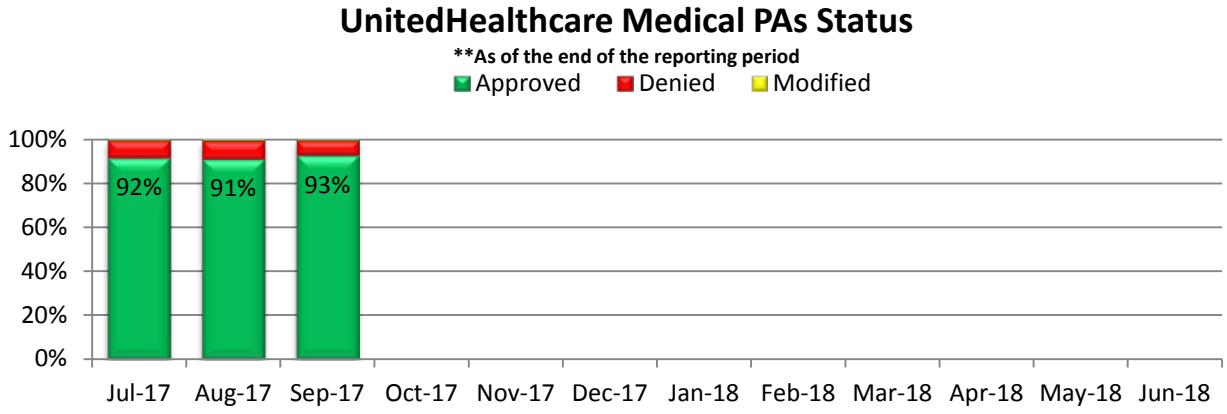
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.



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.

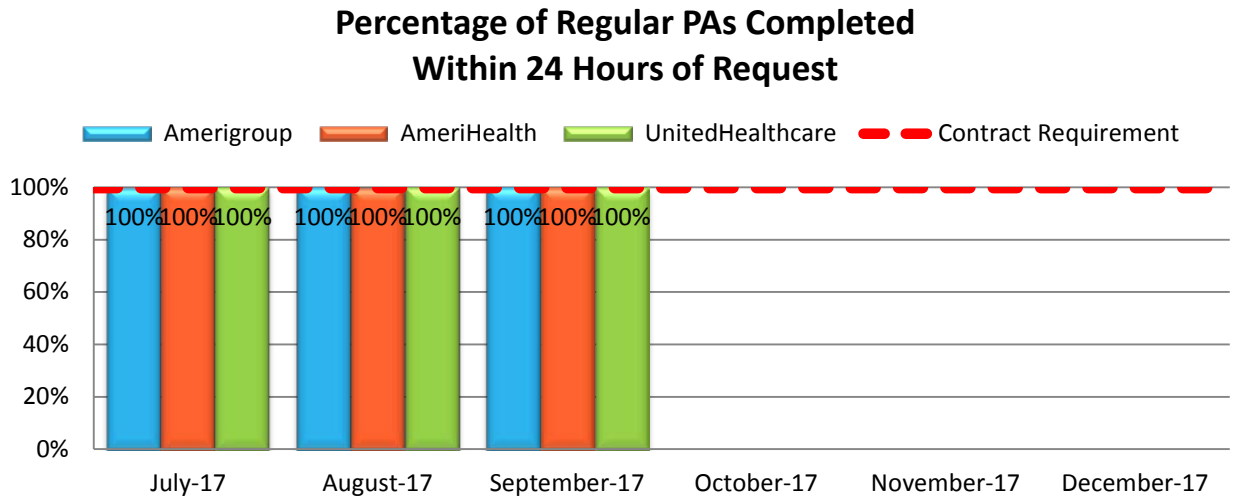


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



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.

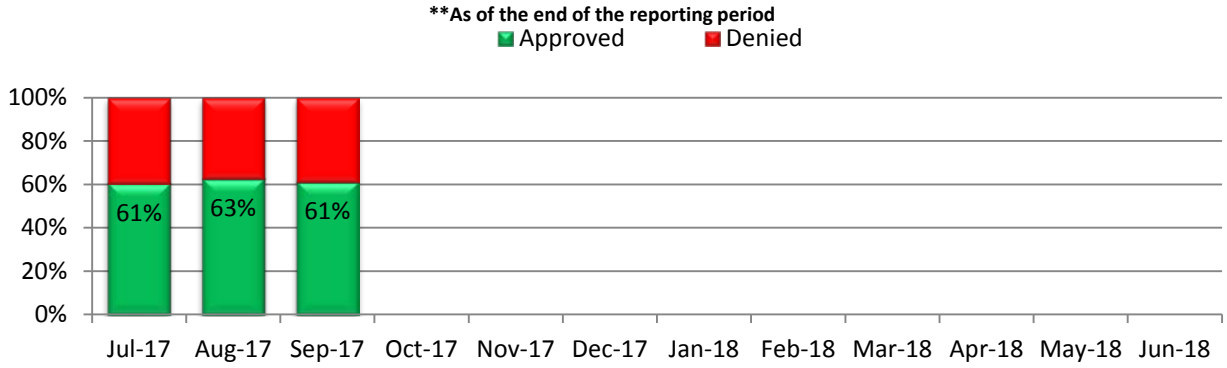
Prior Authorization - Pharmacy



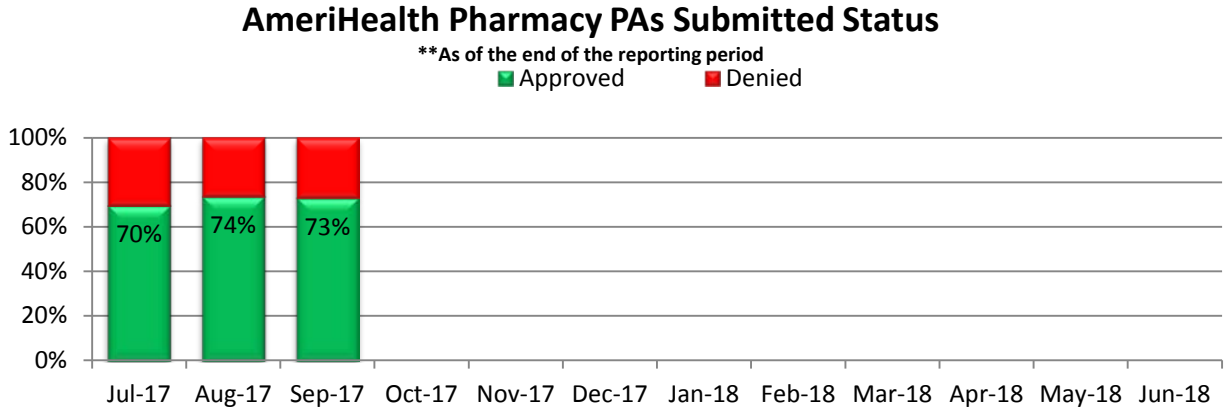
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ. 100% of regular PAs must be completed within 24 hours of request to meet performance guarantees.

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

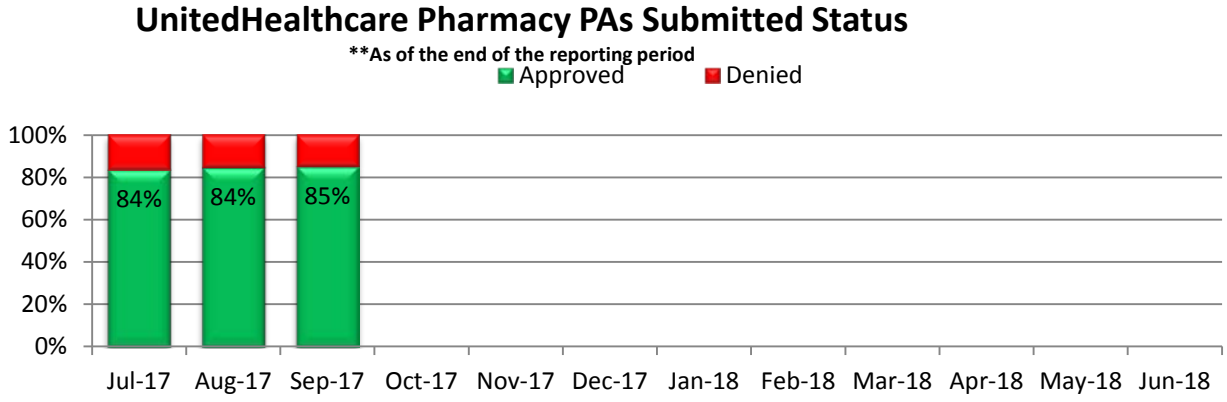
Amerigroup Pharmacy PAs Submitted Status



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	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep
	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 September 2017	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement Meeting State Standards	21%	0%	25%

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

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.

Q1 SFY18 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	116.3%	111.2%	95.5%
ALR	8.6%	9.4%	11.5%
Underwriting	-24.9%	-20.6%	-7.0%

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 Q3 calendar year 2017 (Q1 SFY18) financial information submitted to the Iowa Insurance Division by each MCO.

The financial metrics presented here reflect financial performance for Q1 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.

Program Cost Savings (Annual)			
Data	**Projected State Spend Without Managed Care**	**Actual State Spend with Managed Care**	**Program Cost Savings (State)**
Program Cost Savings (State)**	$1,550,068,000	$1,502,968,000	$47,100,000

▲ Because Medicaid expenditures and revenues fluctuate on a quarterly basis due to a variety of factors (timing of retrospective rate adjustments, timing of performance withhold payments, collection of drug rebates, etc.) savings are being reported on an annual basis.

Annual savings from managed care are estimated at $47.1 million.

When calculating savings, the Department is comparing what we believe we would have spent for medical assistance had the FFS system continued to what the Department is spending for medical assistance with the implementation of the IA Health Link managed care program. Speaking in broad terms, savings result from the difference between:

- The managed care adjustment (a decrease in per member per month expenditures)
- And the administrative load paid on the capitation rates.

The calculation does not consider what the MCOs have paid in claims or MCO profit/loss; rather it is a calculation of what the state has paid the MCOs versus estimated payments under the FFS system.

Savings reported are inclusive of the performance withhold. It is anticipated that all or a portion of this withhold will be paid out to the managed care organizations at the end of the first performance measurement period. The managed care payments are inclusive of long term care mix (mix of institutional and waiver members) and emerging trend adjustments that have not yet been paid.

**Savings are based on a comparison between the expected costs for the Medicaid managed care population and what that same population would have cost had the managed care transition not occurred. Claims for members not covered by managed care and non-claim costs are excluded because they are not impacted by the IA Health Link program. An example of an excluded cost is Medicare Part B premium payments.

Member Months and Average Costs Per Member Per Month Q1 SFY18

*Data to be reported in Q2 SFY18 to allow 90 day claims lag

Amerigroup

Population	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Pharmacy	Ancillaries	LTSS	Total
TANF Child								$ 0.00
TANF Adult								-
Pregnant Women								-
Wellness Plan								-
Family Planning Waiver								-
Disabled								-
Dual								-
LTSS Physically Disabled								-
LTSS Elderly								
LTSS Intellectually Disabled								
LTSS Children's Mental Health								
Maternity Case Rate	-							-

Data will be reported next quarter to allow 90 day lag.

Member Months and Average Costs Per Member Per Month Q1 SFY18

*Data to be reported in Q2 SFY18 to allow 90 day claims lag

AmeriHealth

Population	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Pharmacy	Ancillaries	LTSS	Total
TANF Child								$ 0.00
TANF Adult								-
Pregnant Women								-
Wellness Plan								-
Family Planning Waiver								-
Disabled								-
Dual								-
LTSS Physically Disabled								-
LTSS Elderly								
LTSS Intellectually Disabled								
LTSS Children's Mental Health								
Maternity Case Rate								-

Data will be reported next quarter to allow 90 day lag.

Member Months and Average Costs Per Member Per Month Q1 SFY18

*Data to be reported in Q2 SFY18 to allow 90 day claims lag

UnitedHealthcare

Population	Member Months	Inpatient Hospital	Outpatient Hospital	Physician	Pharmacy	Ancillaries	LTSS	Total
TANF Child	-							$ 0.00
TANF Adult								-
Pregnant Women								-
Wellness Plan								-
Family Planning Waiver								-
Disabled								-
Dual								-
LTSS Physically Disabled								-
LTSS Elderly								
LTSS Intellectually Disabled								
LTSS Children's Mental Health								
Maternity Case Rate	-							-

Data will be reported next quarter to allow 90 day lag.

Capitation Payments Made to the Managed Care Organizations				
MCO	**Q1 SFY18**	**Q2 SFY18**	**Q3 SFY18**	**Q4 SFY18**
Amerigroup	$252,059,197			
AmeriHealth	$452,572,360			
UnitedHealthcare	$213,334,385			

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

Third Party Liability Recovery for Q1 SFY18			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Amount of TPL Recovered	$10,370,140	$21,561,935	$18,513,369

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.

Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	123	10	65
Overpayments Identified During the Quarter	6	7	14
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	4	28	5
Member Concerns Referred to IME	0	16	6

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 MCOs have attended more than nine meetings or on-site visits with regulators during this quarter. The plans have initiated 198 investigations in the second quarter and referred 37 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 to be 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									
Readmissions within 15 days of Discharge									
Readmissions between 16 and 30 days of Discharge									
Readmissions between 31 and 45 days of Discharge									
Readmissions between 46 and 60 days of Discharge									

Data will be reported next quarter to allow 90 day lag.

*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.

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.

Emergency Department									
Data to be 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	**Data will be reported next quarter to allow 90 day lag.**								
ED Visits for Non-Emergent Conditions – Child									
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	**Data will be reported next quarter to allow 90 day lag.**								
Members Using ED More Than Once between 31 and 60 Days**									

*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.

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*									
Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	Jul	Aug	Sep	Jul	Aug	Sep	Jul	Aug	Sep
Members in Out-of-State PMIC	10	11	11	9	13	12	3	2	5
Members in Out-of-State Nursing Facilities and Skilled Nursing Facilities	14	16	16	37	37	35	10	10	9
Members Placed in an Out-of-State ICF/ID	4	4	4	5	3	3	3	3	3

*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 – October 2017*							
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	35	1,460	961	7,999	2,186	11,939	949
Number of Individuals on Waiver Waitlist (DHS Function)	0	1,075	1,277	0	2,972	2,926	1,479
Waitlist Increase or (Decrease)	0	122	210	0	202	166	265

As reported in October 2017. October data represents September 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	1	6	1	8
Correct Coding Initiative Report	1			1
Cost Avoidance Report	1			1
Consumer Reports Report	6	1	1	8
Geographic Access Report	5			5
Grievances and Appeals	1		1	2
Health Outcomes Report	1			1
IPES Report				
LTSS Report				
NEMT Report				
Non-PI Recoveries Report		1		1
Planned Coordination Events Report			1	1
Program Integrity Report	1	3	1	5
Provider Credentialing Report				
Provider Incentives Report	1	1		2
Revised Assessments and Care Plans Reports				
Risk Assessment Report				
Third Party Liability				
Value Added Services Report				
Waivers Report	1			1
Grand Total	**19**	**12**	**5**	**36**

Type of Noncompliance Identified by MCO During this Reporting Period				
Type of Noncompliance	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
Did not meet performance standard	6	2	3	11
Incomplete/Untimely/Inaccurate	13	10	2	25
Grand Total	**19**	**12**	**5**	**36**

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.