Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2017, Quarter 4

(April - June)

Performance Data

Published October 18, 2017

CONTENTS

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
- Program information 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 4 of State Fiscal Year (SFY) 2017 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 health outcome measures will not be reported with validity until after the first year of implementation. 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.

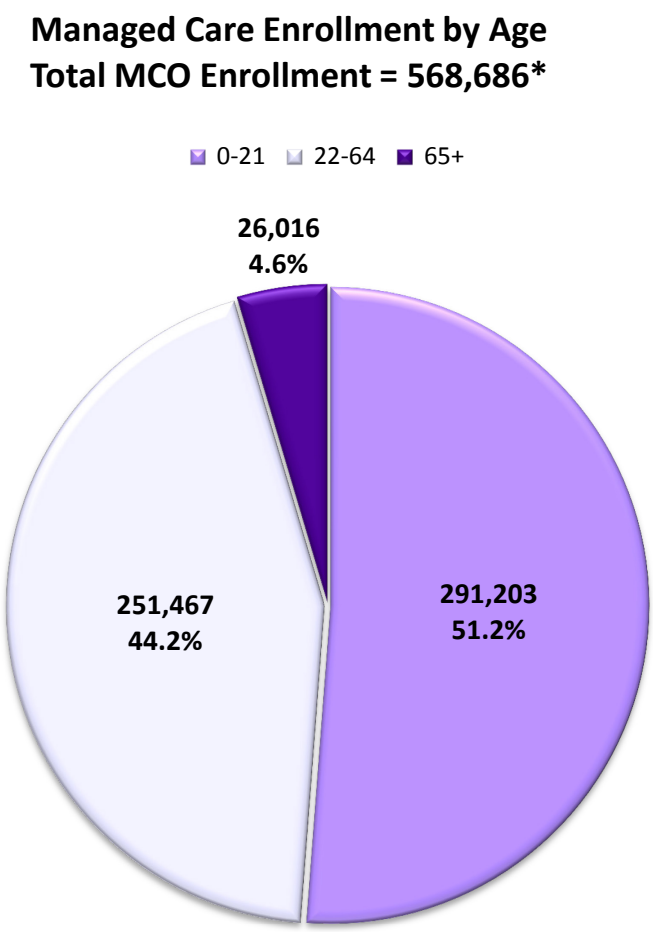
based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

- Several data elements in the quarterly reports to date have been under review, clarified, and updated in each successive report. We continue to review and fine-tune the reports to ensure that the information is presented as consistent as possible among the MCOs on a going forward basis. However, as noted in the report, accounting and reporting variances among MCOs exist and may result in variances among plans beyond the variance in medical expenses per member.
- The Department validates the data by looking at available fee-for-service historical baselines, available 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

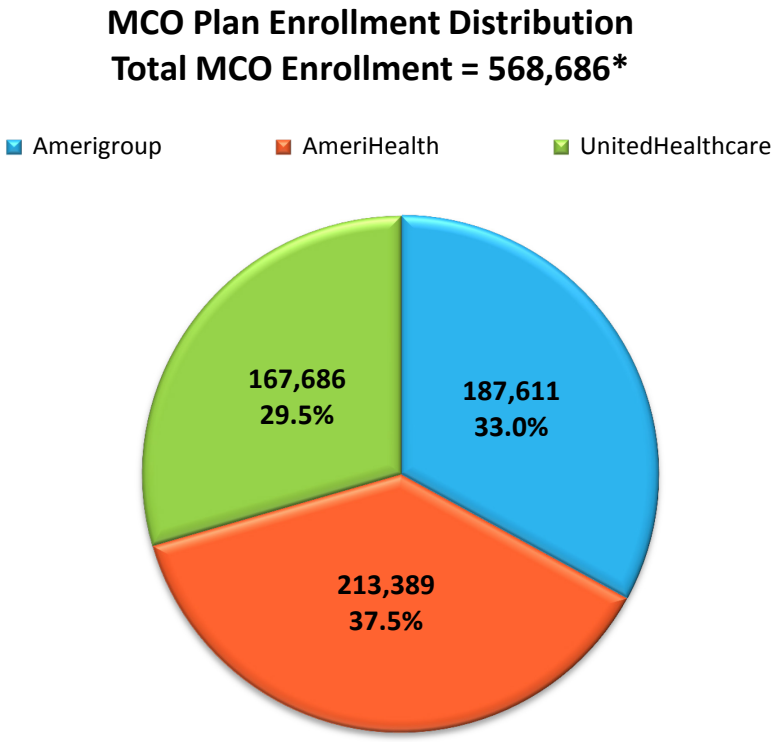
Providers and members can find more information on the IA Health Link program at http://dhs.iowa.gov/iahealthlink

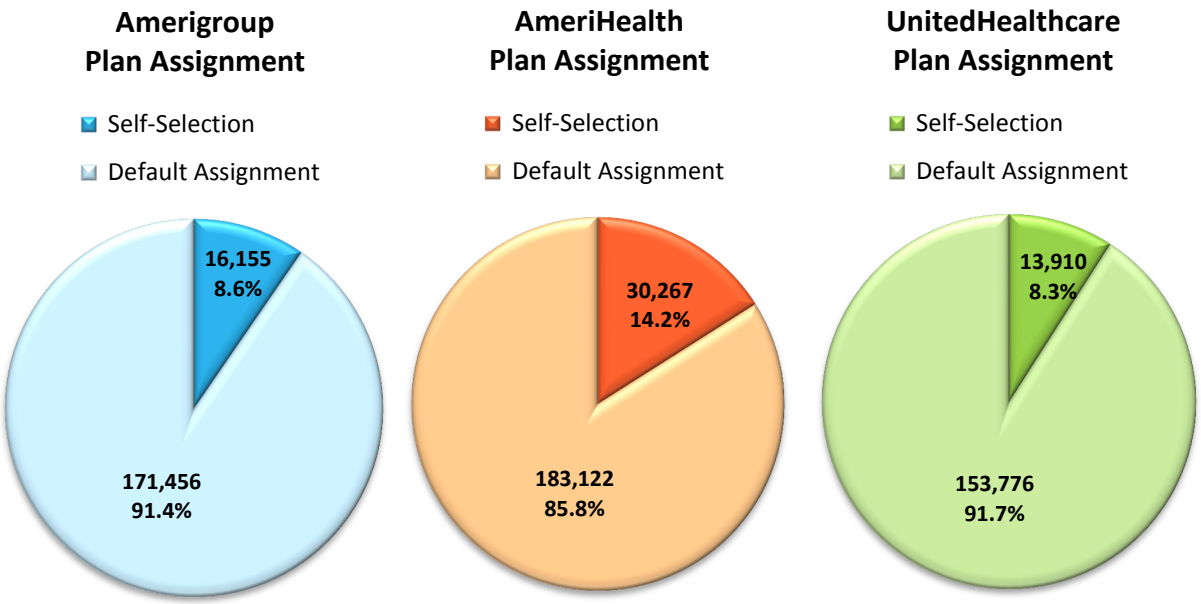
PLAN ENROLLMENT BY AGE



*June 2017 enrollment data as of July 10, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This does not include ***hawk-i*** enrollees. This does not include approximately 50,000 members that remain in the Fee-for-Service (FFS) program.

PLAN ENROLLMENT BY MCO





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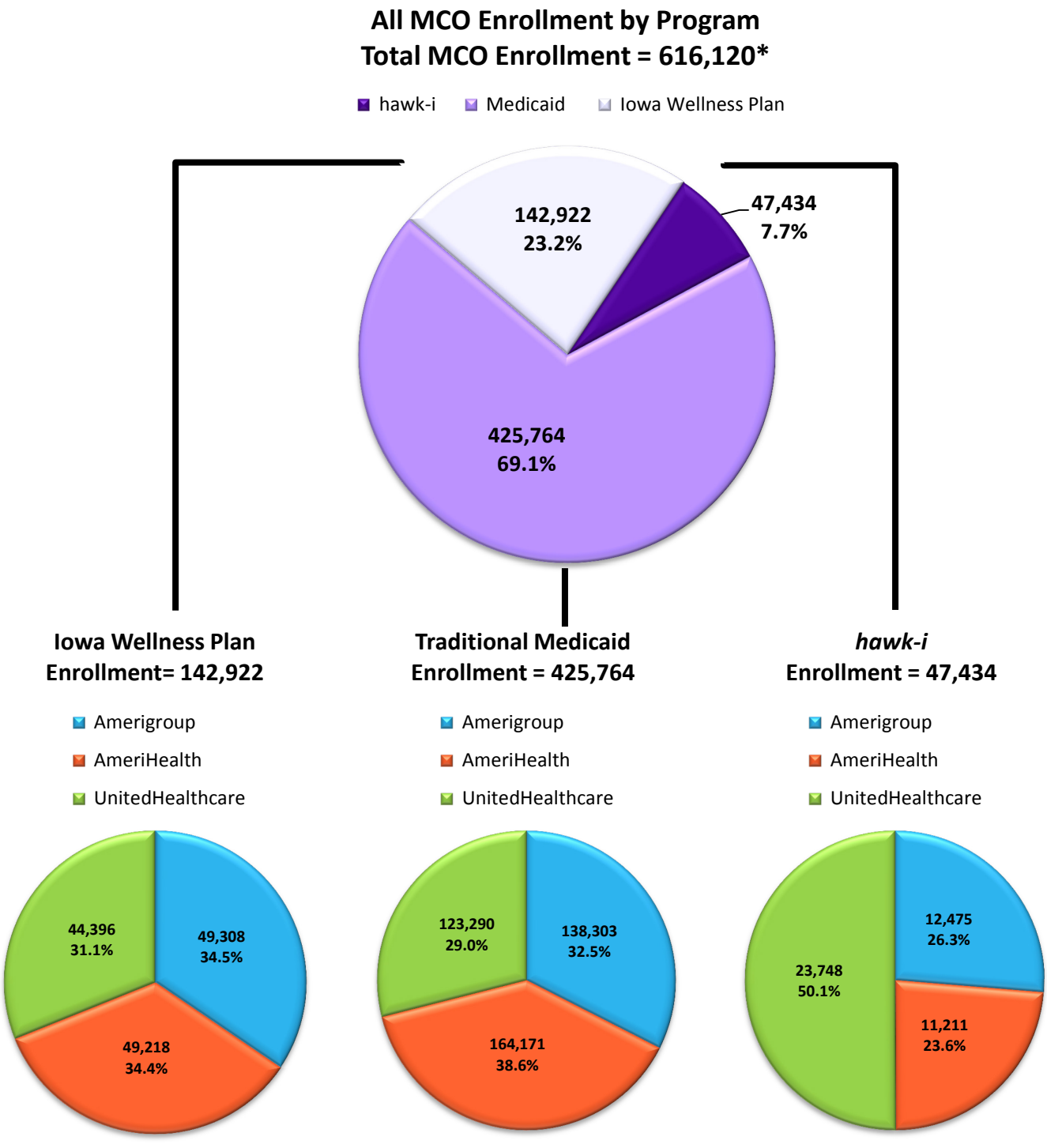
PLAN ENROLLMENT BY PROGRAM



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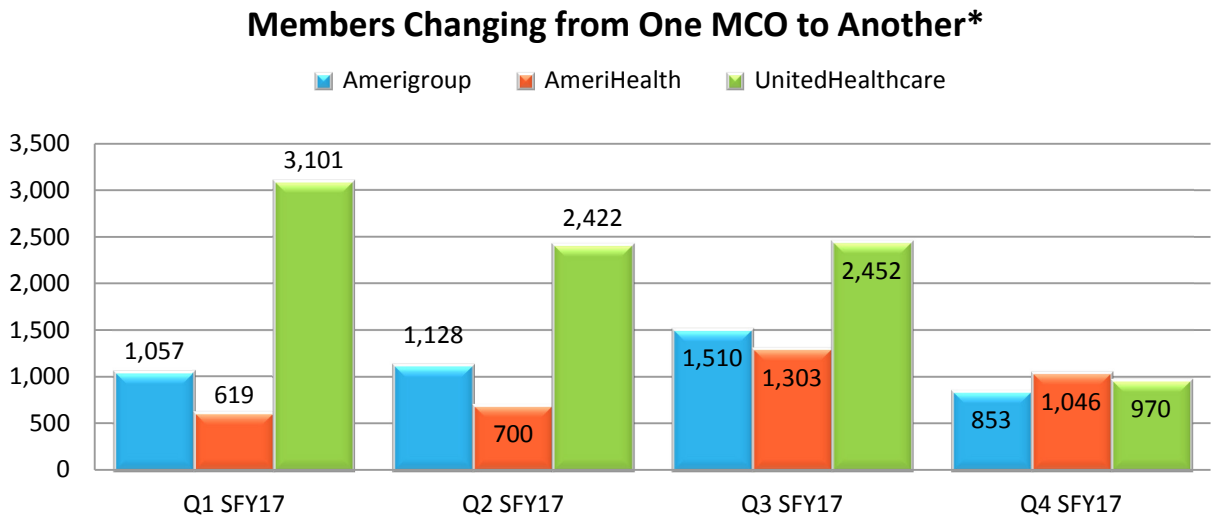


*Q4 SFY17 enrollment data as of July 10, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

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.

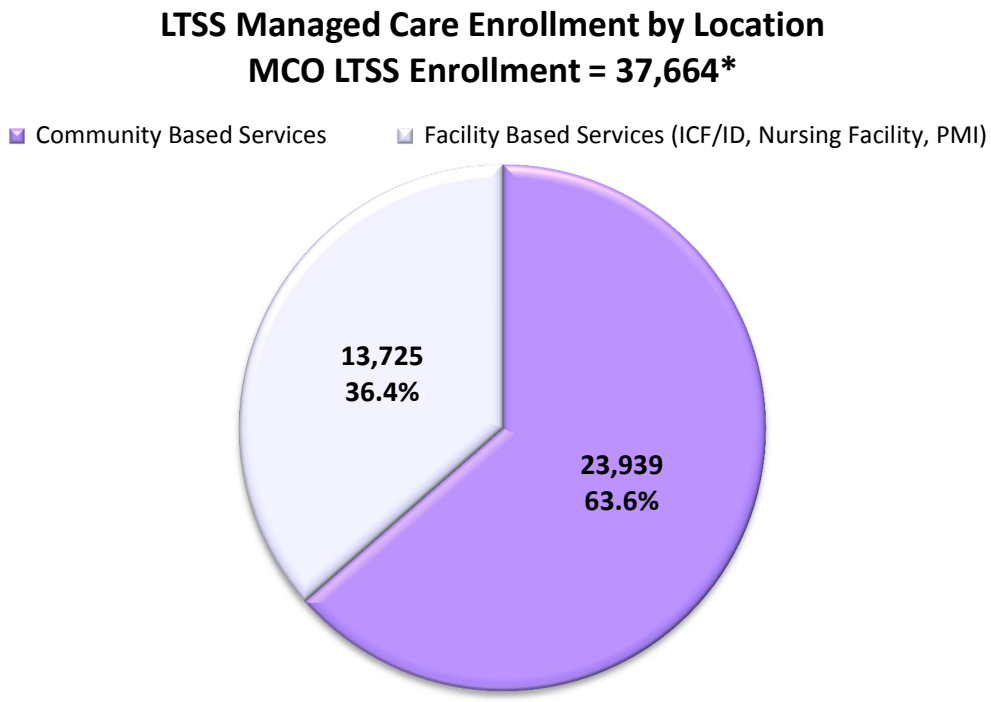
Reasons for "Good Cause" Disenrollment for Q4 SFY17

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

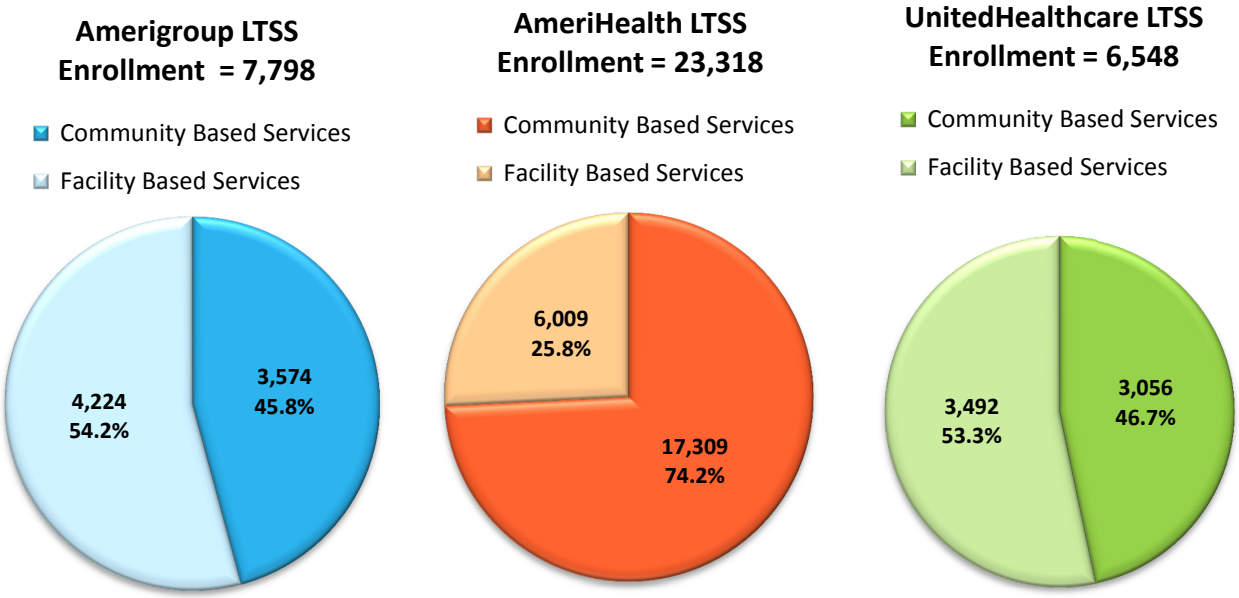
- The member needs related services to be performed at the same time; not all related services are available within the network; and the member's primary care provider or another provider determines that receiving the services separately would subject the member to unnecessary risk.
- Other reasons,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

Summary Reason	Count
Established provider in another MCO network	1,118
Continuity of care	119
Lack of access to services covered under the contract	108
Lack of access to providers experienced in dealing with the member's health care needs	23
Quality of care	21

All MCO Long Term Services and Supports (LTSS) Enrollment



Total MCO LTSS Enrollment by Plan



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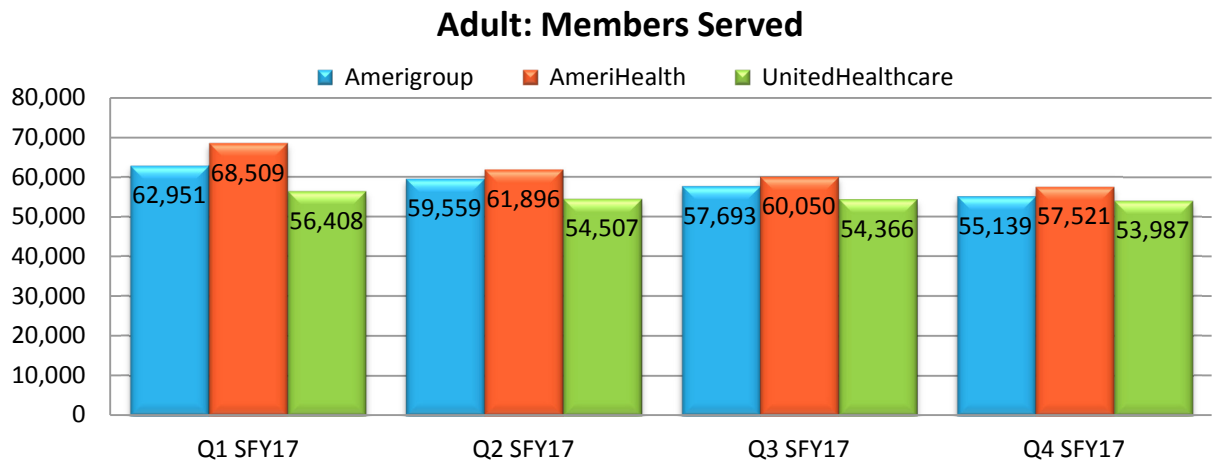
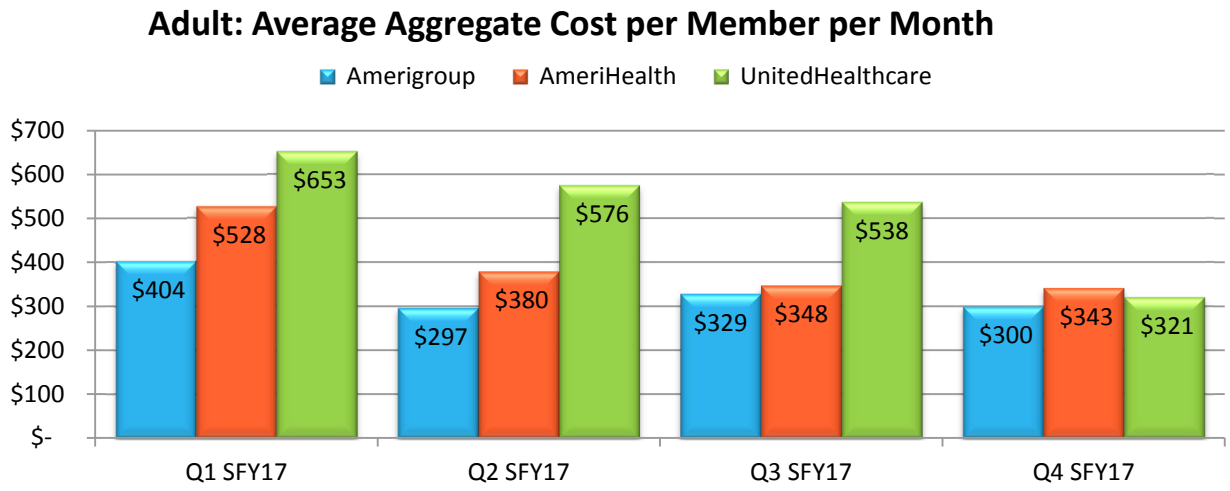
Adult General Population Reporting

Adults included in this report are members between the ages of 18 and 64 as determined at the end of the quarter, who require basic health care services and do not have needs that require long term services and supports or behavioral health services. These members are low income and also include those on the Iowa Health and Wellness Plan.

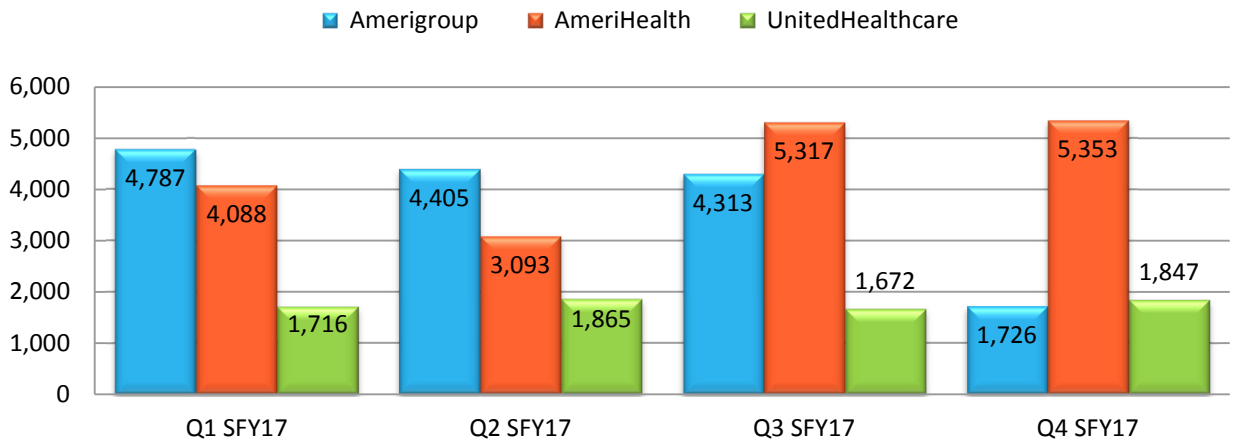


Adult: Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

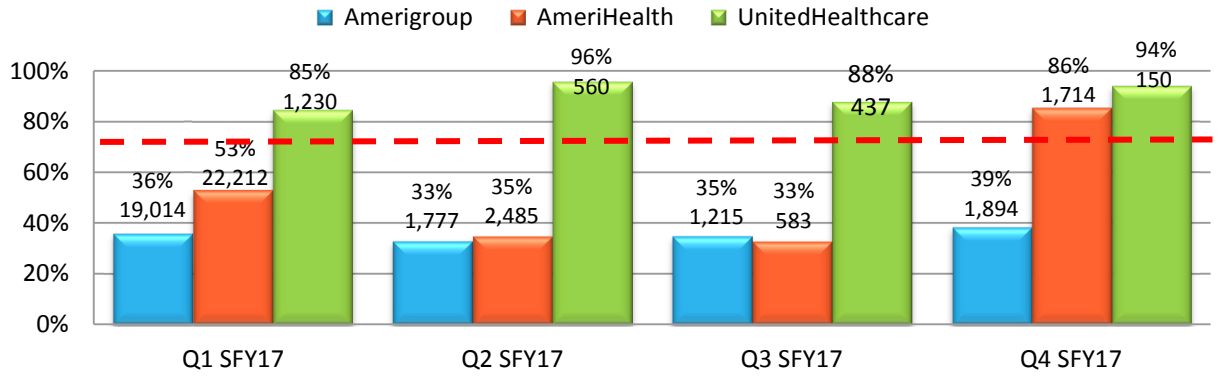
Adult: Members Assigned a Health Care Coordinator



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. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service. It is anticipated that the number of members assigned to a care coordinator will increase over the first several quarters and then remain stable.

Numbers may vary across the MCOs due to the scope of care coordination services reported.

Adult: Percentage and Number of Members Receiving Initial Health Risk Assessments Completed Timely



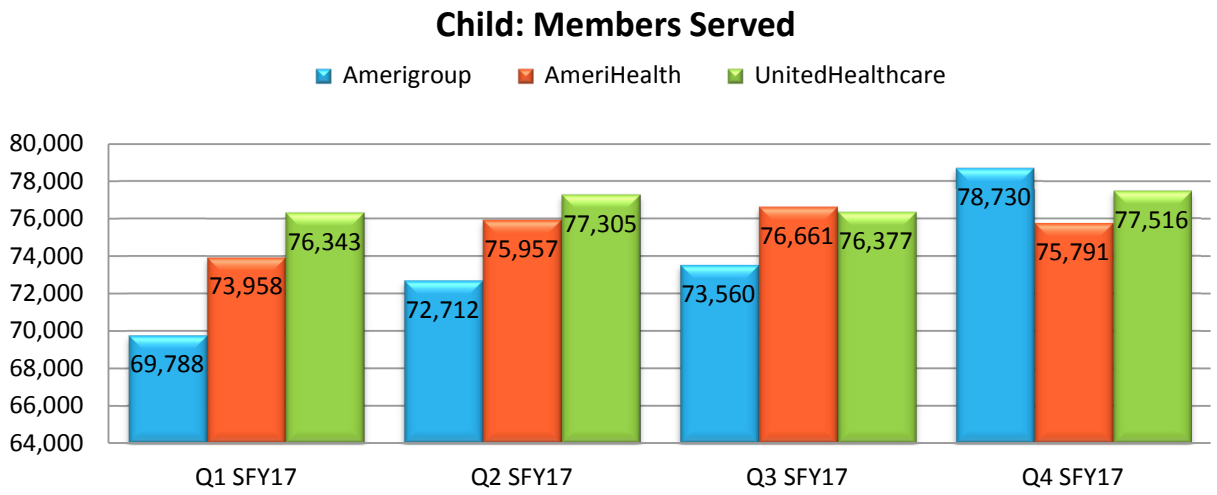
At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days and the MCO has been able to reach within three attempts, will have health risk assessments completed. The department has issued remedies for this performance metric and continues to monitor the MCO work towards this goal.

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.

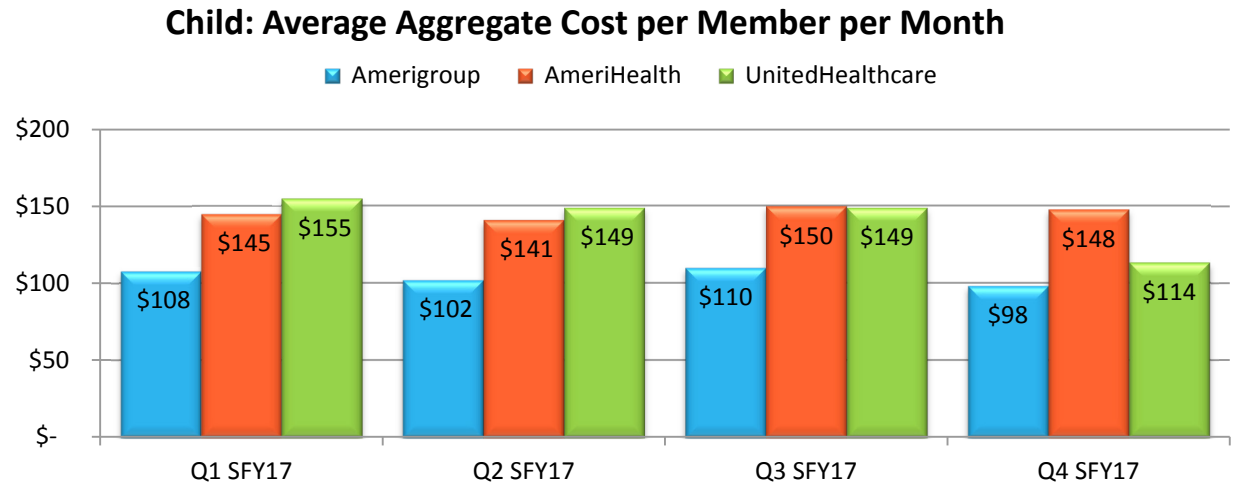
This data includes all MCO populations. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Child General Population Reporting

Children included in this report are members under the age of 18 as determined at the end of the quarter that require basic health care services and do not have needs that require long term care or supports including behavioral health services. This population includes the ***hawk-i*** and CHIP children.



Child: Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

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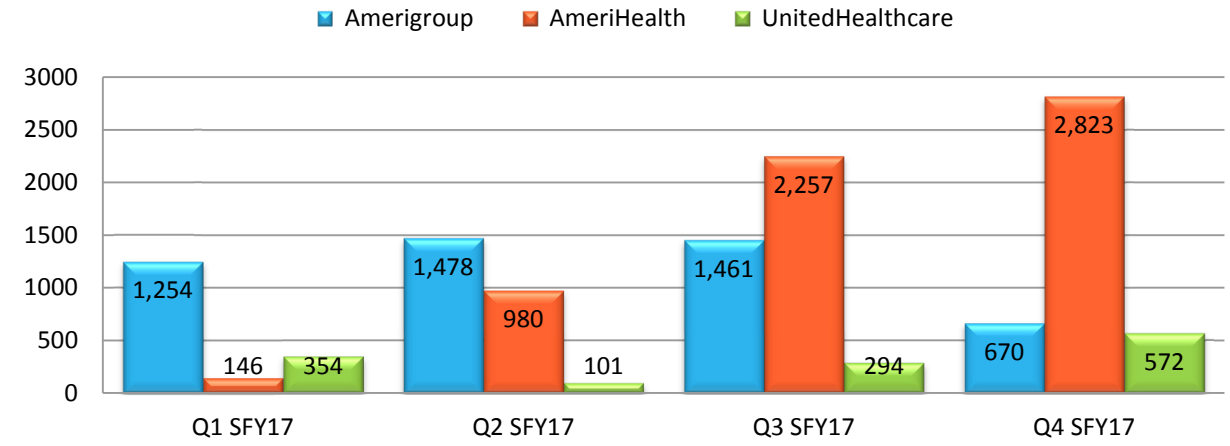

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Numbers may vary across the managed care organizations due to the scope of care coordination services reported.

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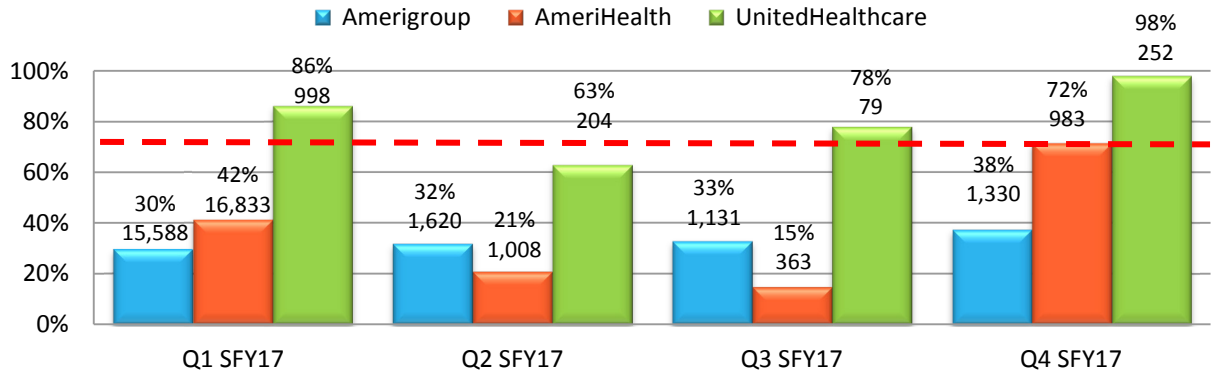

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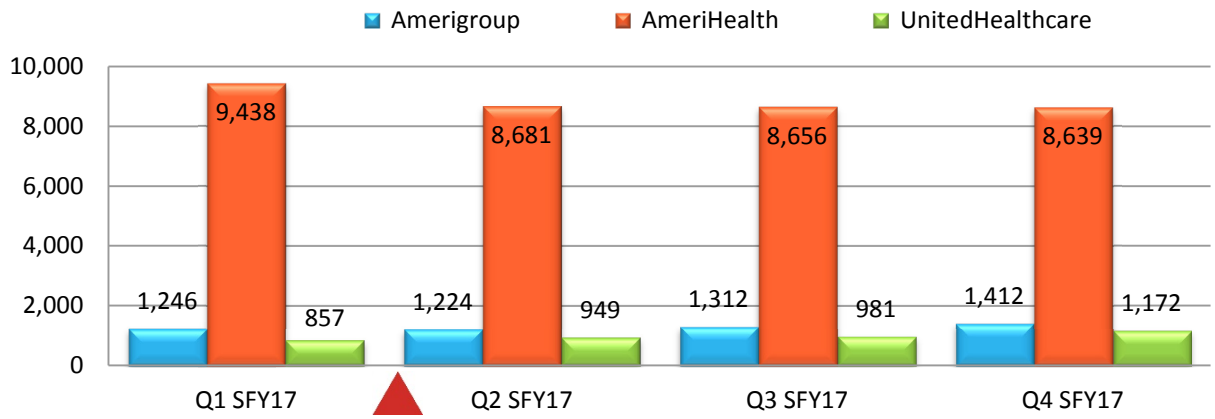
Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed.

This data is not exclusive to the general population, but includes all MCO populations including members with special needs and behavioral health conditions. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Adult Special Needs Population Reporting

Adults included in this report are members between the ages of 18 and 64 as determined at the end of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. This population report reflects home and community based members as well as facility based members. These members may also be reflected in the Behavioral Health Population.

Adult: Members Served in Community-Based Settings

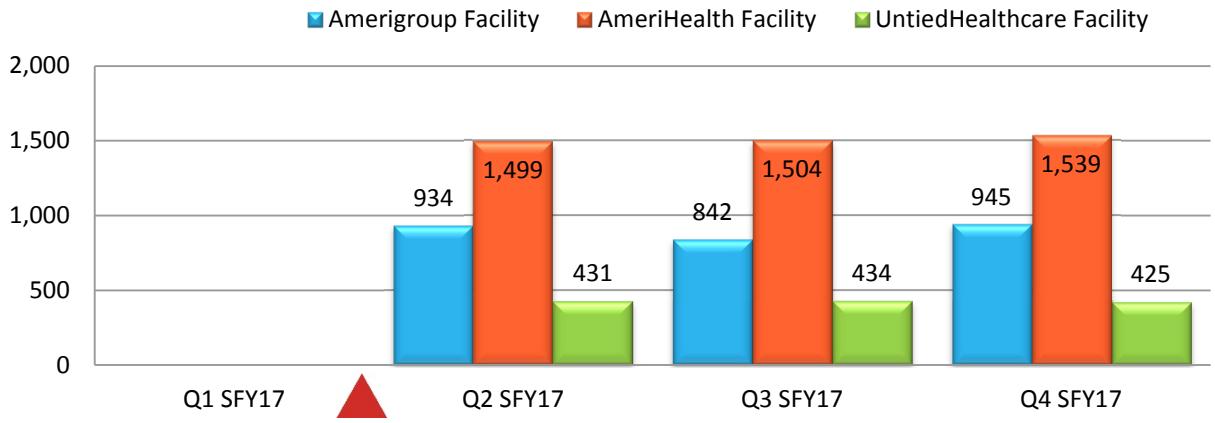


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

Adult: Members Served in a Facility



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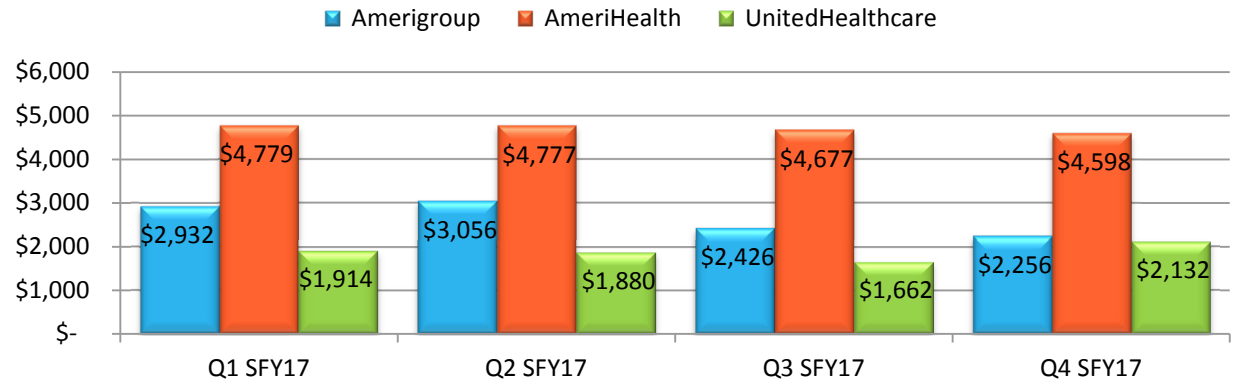
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in a facility.

Special Needs Adults in Community: Average Aggregate Cost per Member per Month



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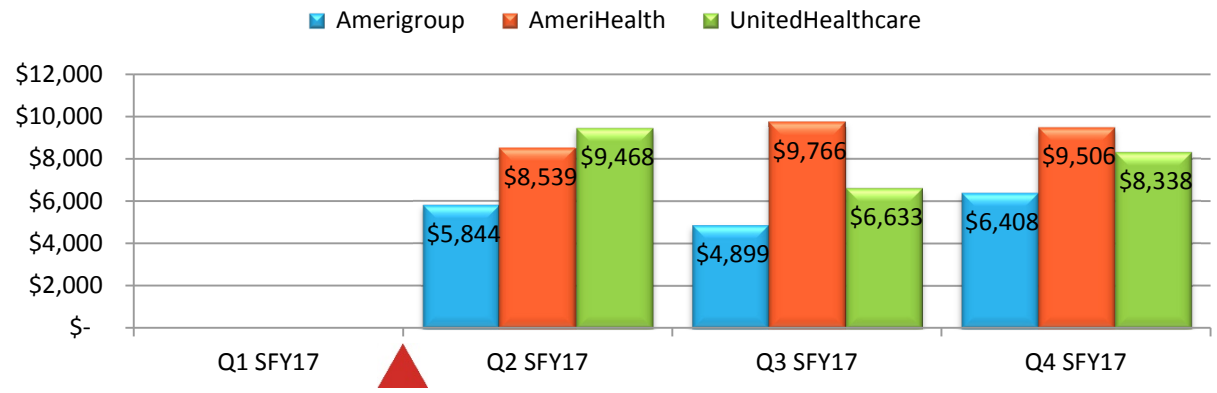
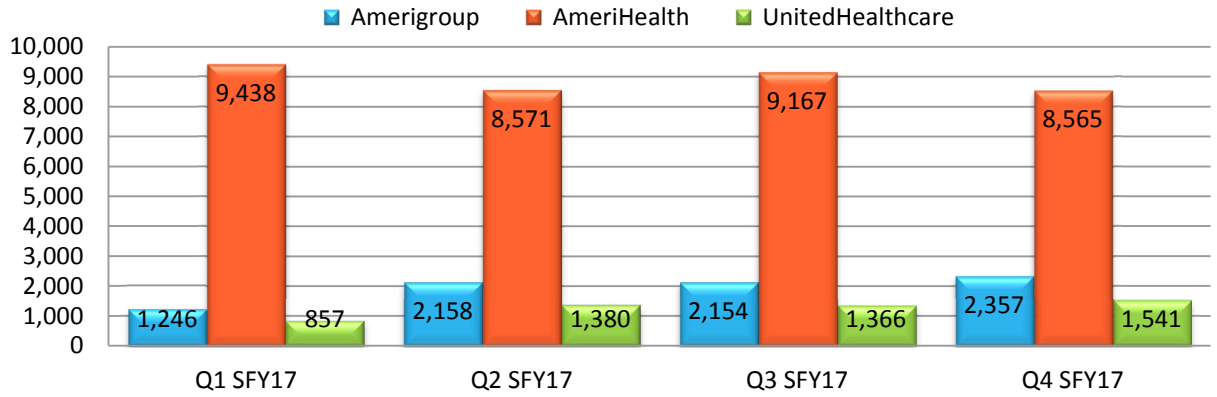
Special Needs Adults in Facility Settings: Average Aggregate Cost per Member per Month



This data element is new as of Q2 SFY17. The aggregate average cost includes health care and pharmacy services for members in facility settings. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

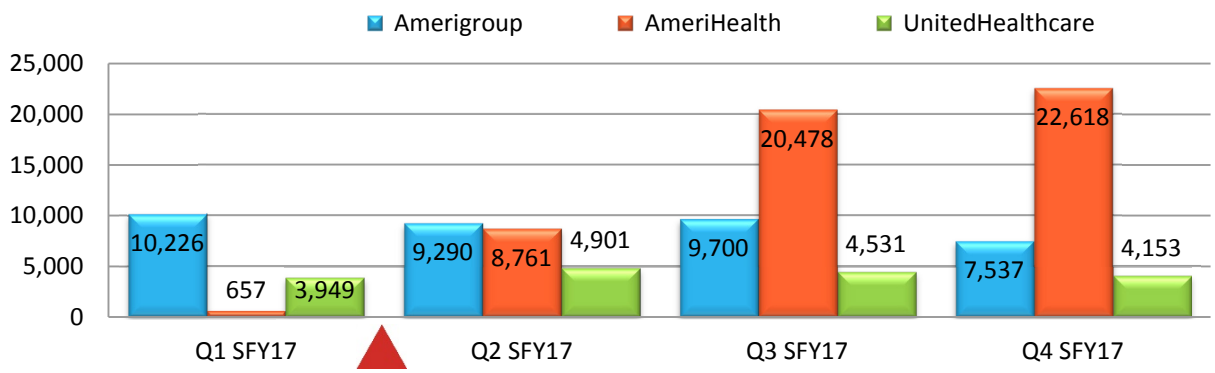
Adult: Members Assigned a Community-Based Case Manager



While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

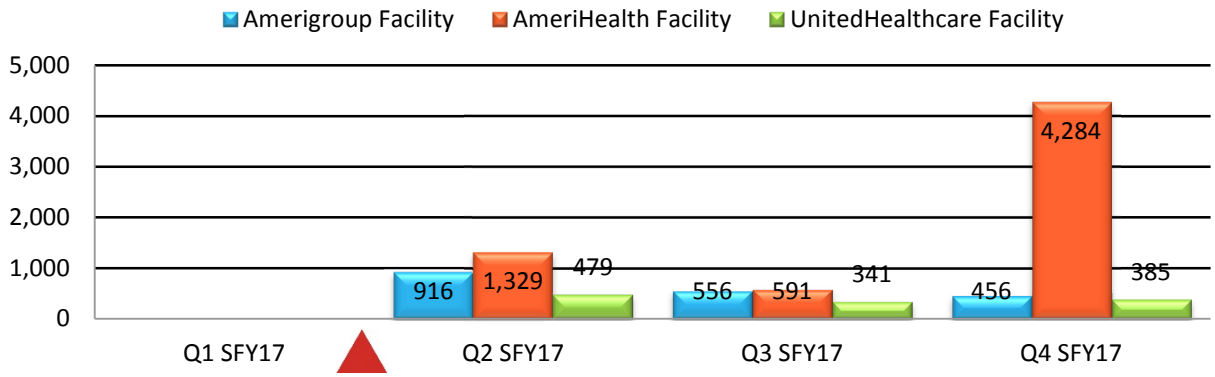
Adult: Number of Community-Based Case Manager Contacts for Members in a Community-Based Setting



▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.

Adult: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



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- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community-based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. Members in institutional settings must have a case manager. These managers are required to have face-to-face contact on a quarterly basis with members.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community-based case manager

function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

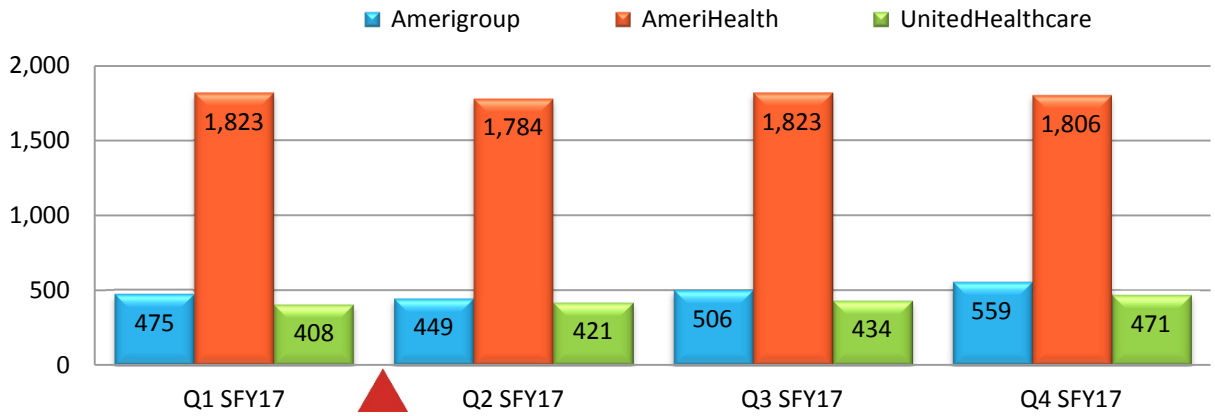
Community-Based Case Management Ratios			
The ratios below reflect combined adult and child populations for these waivers where applicable.			
Data Reported as of June 30, 2017	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Ratio of Member to Case Manager - Brain Injury	5.4	2.9	2.2
Ratio of Member to Case Manager - Health and Disability	12.9	2.6	5.9
Ratio of Member to Case Manager - HIV/AIDS	1.3	1.1	1.1
Ratio of Member to Case Manager - Intellectual Disability	24.0	16.4	11.1
Ratio of Member to Case Manager - Physical Disability	7.5	1.9	3.2

For this reporting period all plans are within appropriate case management ratios where defined. Iowa Medicaid requires that member to case manager ratios for the Intellectual Disability and Brain Injury Waivers is no more than 45 members to one case manager. The other Home- and Community-Based Waivers do not have member to case manager ratio requirements but the department requires the MCOs to closely monitor the ratios and ensure that all case management functions are met.

Child Special Needs Population Reporting

Children included in this report are under the age of 18 as determined at the end of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. This population report reflects home and community based members as well as facility based members. These members may also be reflected in the Behavioral Health Population.

Child: Members Served in Community-Based Settings



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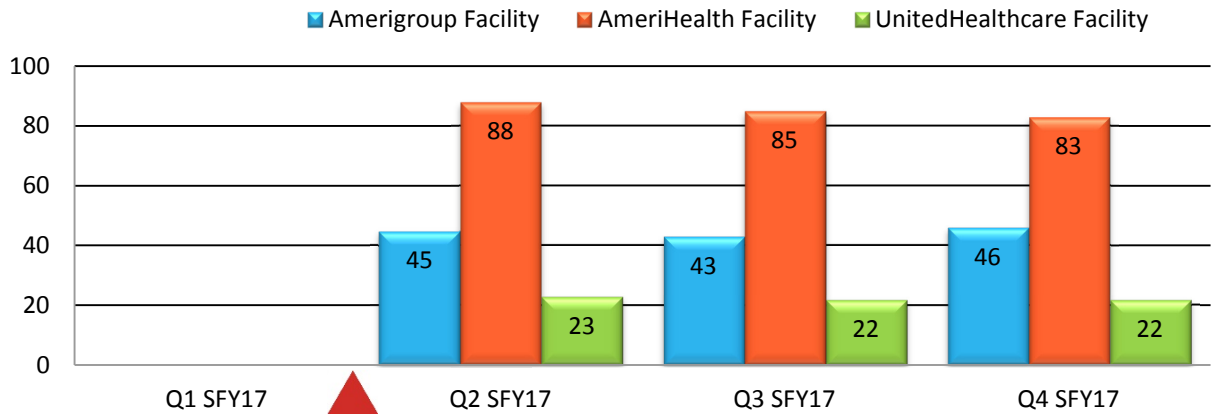
Child: Members Served in a Facility



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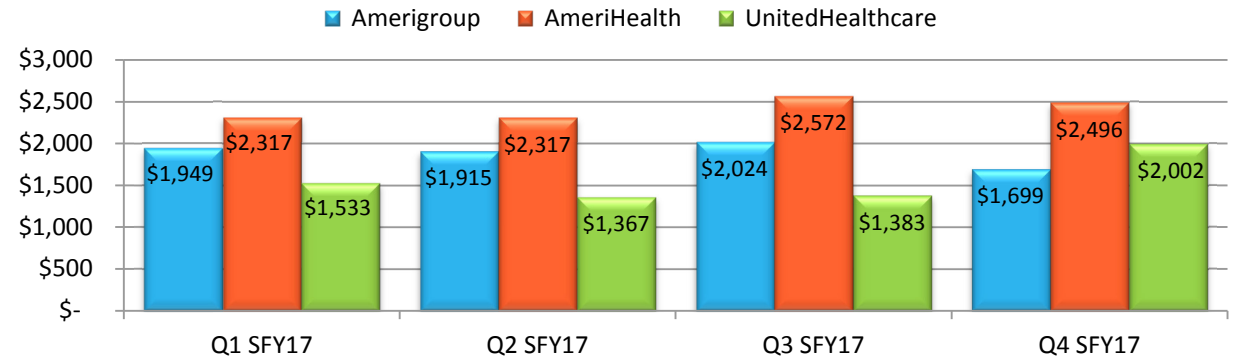
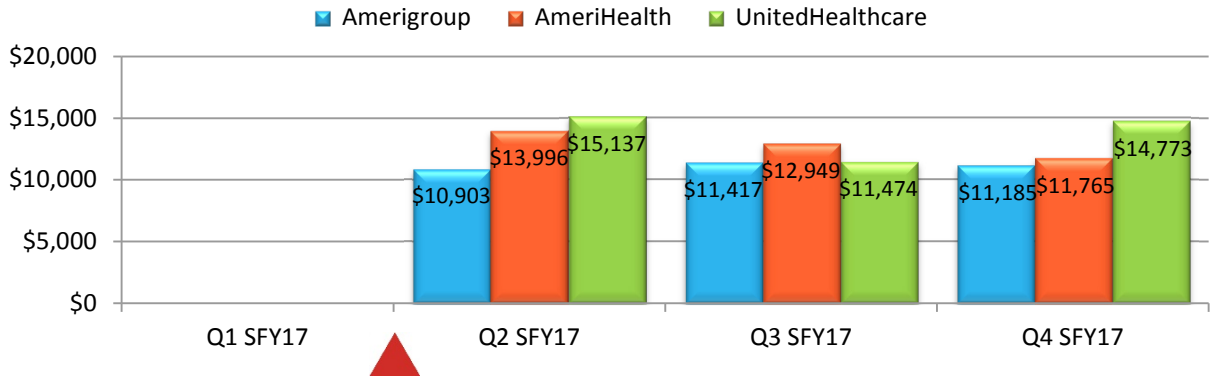
Special Needs Children in Community: Average Aggregate Cost per Member per Month



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

Special Needs Children in Facility Setting: Average Aggregate Cost per Member per Month



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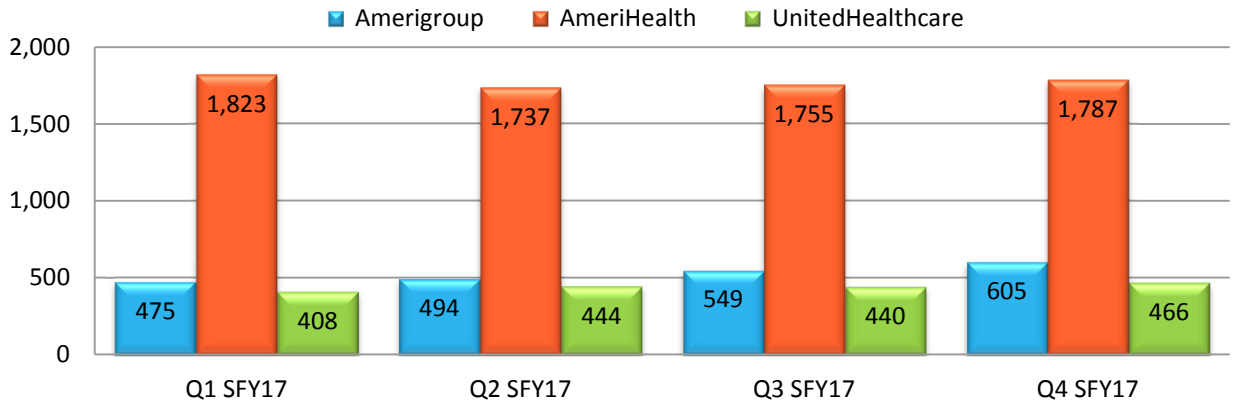
Child: Members Assigned a Community-Based Case Manager



While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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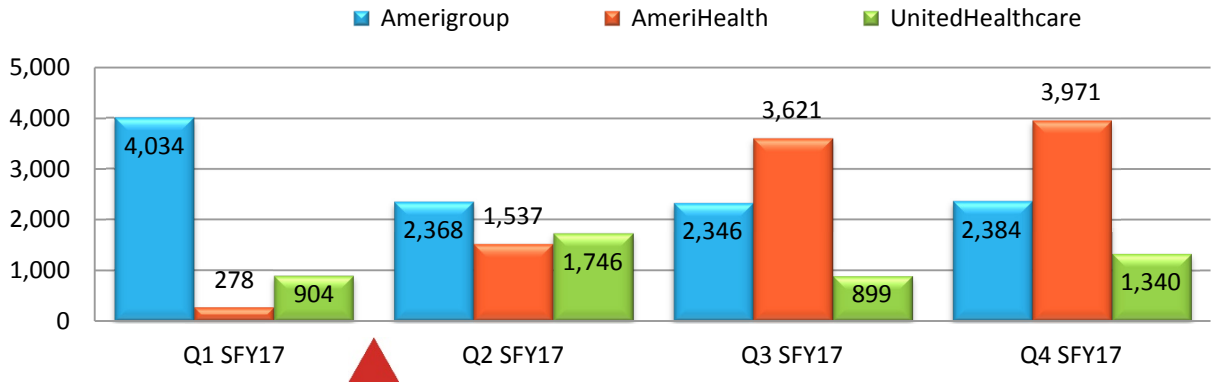

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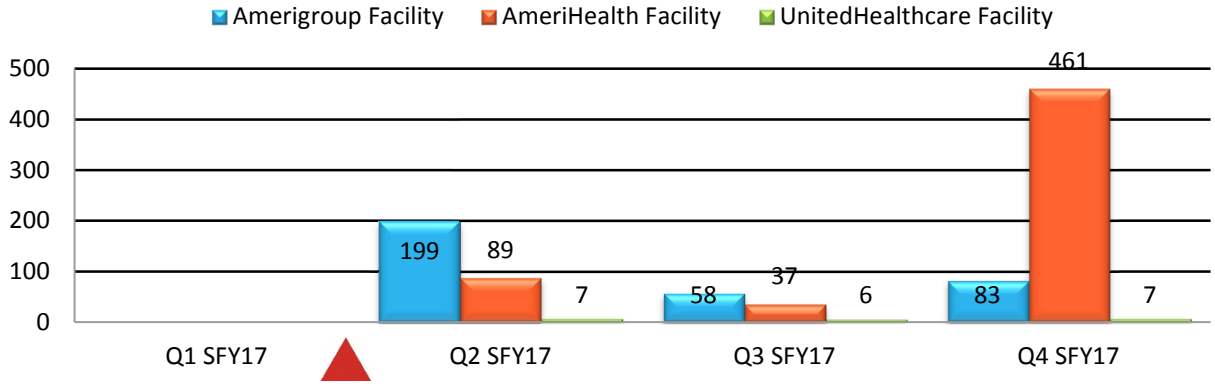
- Q2 SFY17 shows contacts split out for community-based members.

Child: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community-based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. Members in institutional settings must have a case manager. These community-based case managers are required to have face-to-face contact on a quarterly basis with members. This data element does not have a direct benchmark to compare to historical fee-for-service data.

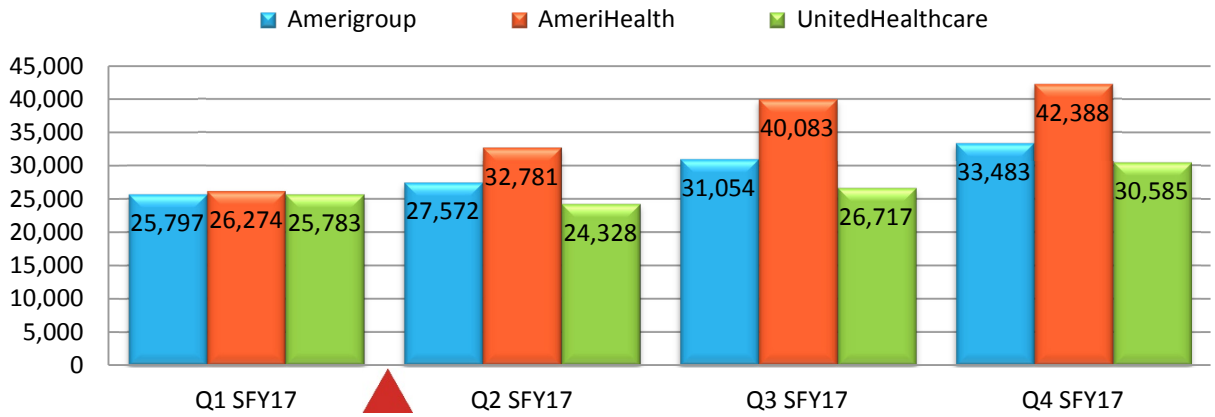
The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community-based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Adult Behavioral Health Population Reporting

Adults included in this report are members age 18 and older as determined at the end of the quarter who have serious and persistent mental illness or a serious emotional disturbance. These members may also be reflected in the Special Needs Population and the Elderly Population report.

Adult: Members Served in Community-Based Settings

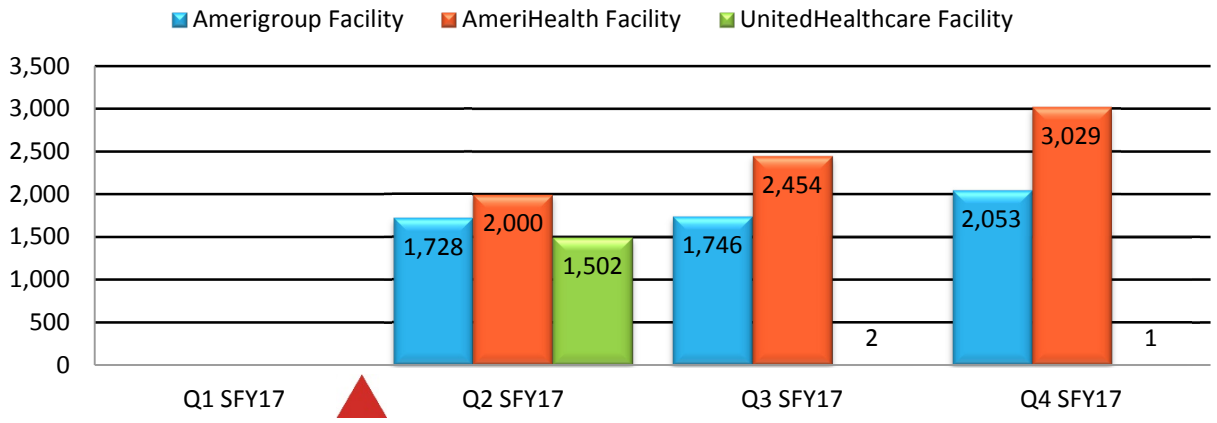


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for the increase.
- Q4 SFY16 and Q1 SFY17 include members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for community-based members.

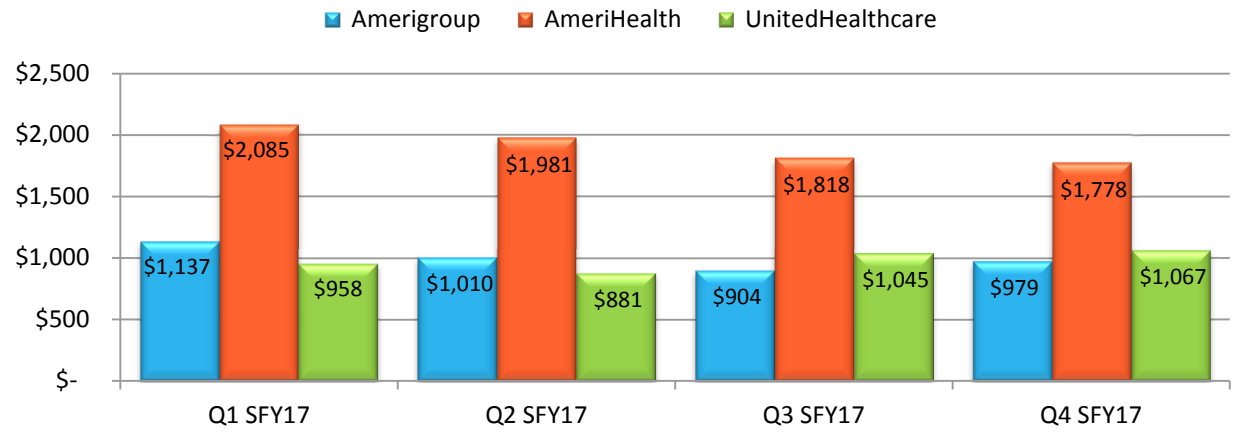
Adult: Members Served in a Facility



▲ Differences between quarters:

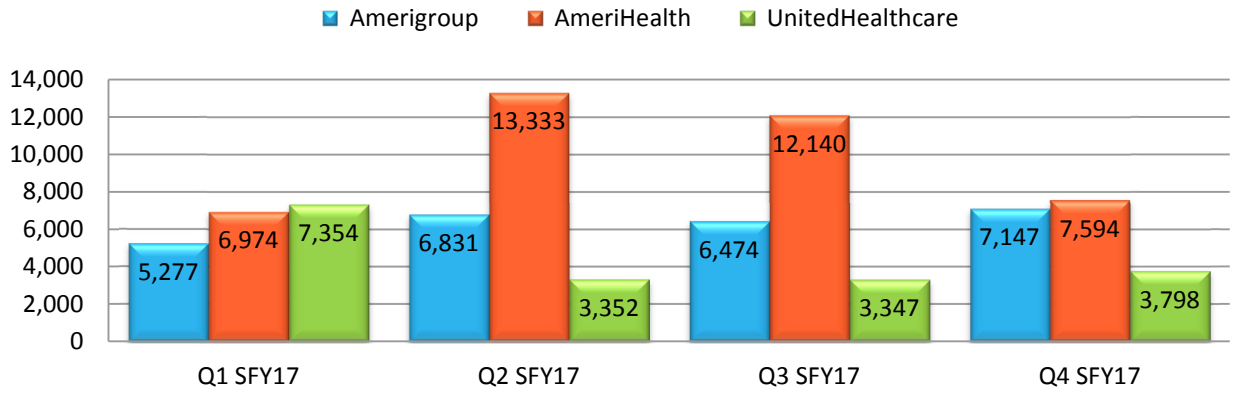
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 is split out for members in a facility.

Adult: Average Aggregate Cost per Member per Month



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

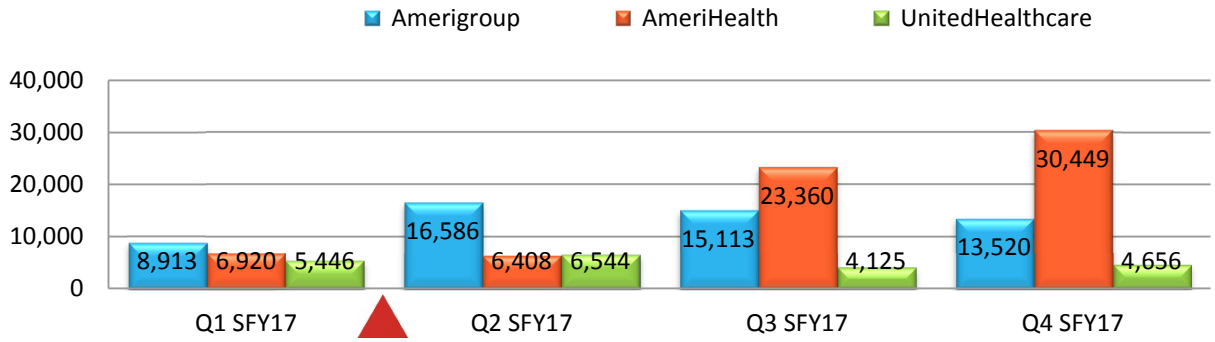
Adult: Members Assigned to a Community-Based Case Manager or Integrated Health Home Care Coordinator



Members who have an Integrated Health Home Care Coordinator have behavior health care needs and will benefit from more intensive behavioral health care management. Some of these members may have an Integrated Health Home Care Coordinator and Community-Based Case Manager due to participation in a Home- and Community-Based Waiver program, so there may be duplication in counts. Both entities are required to ensure that the member's needs are coordinated across health systems to improve the member's overall health status and quality of life.

This data element does not have a direct benchmark to compare to historical fee-for-service data.

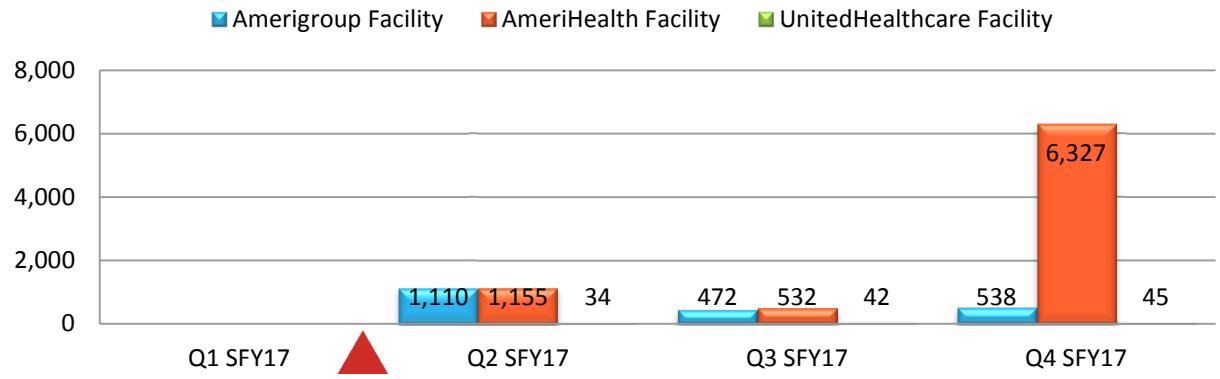
Adult: Number of Community-Based Case Manager and Integrated Health Home Care Coordinator Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows a contacts split out for community-based members.

Adult: Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for contacts occurring in a facility.

A small percentage of the members in this population receive Habilitation services and must have Integrated Health Home care coordinators conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. A member not receiving Habilitation services is not required to have as frequent contact.

An increase in Integrated Health Home care coordinator contacts is expected with the increase in identified behavioral health members. Number of Integrated Health Home care coordinator for Members represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the Integrated Health Home and community based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Integrated Health Home Care Coordinator Ratios

The department collects member to integrated health home care coordinator ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of October 31, 2016*	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Integrated Health Home Care Coordinator – Behavioral Health	50	50	50

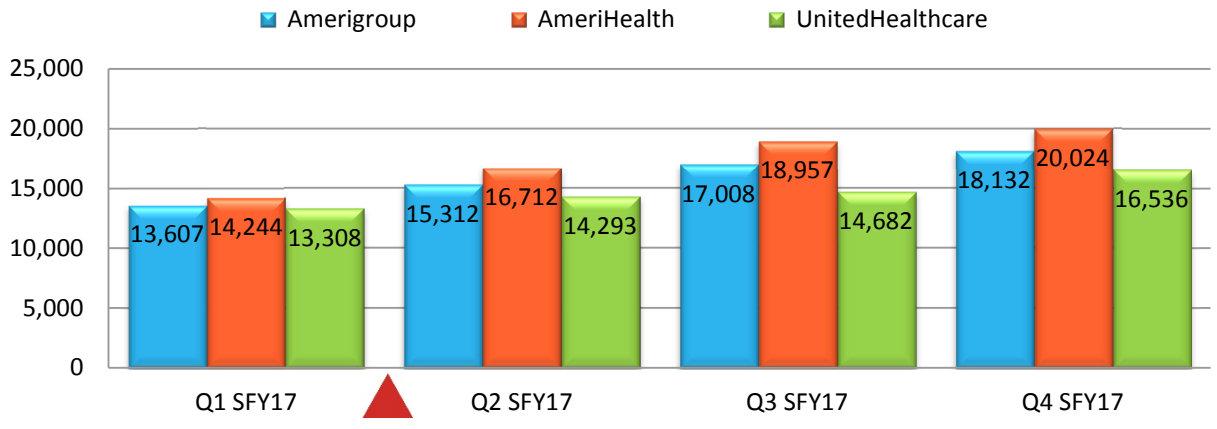
The behavioral health population does not have member to case manager or care coordinator ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

*MCOs leverage the same Integrated Health Homes. These ratios are based on a study conducted by UnitedHealthcare in Q1 SFY17.

Child Behavioral Health Population Reporting

Children included in this report are members under the age of 18 as determined at the end of the quarter who have serious and persistent mental illness or a serious emotional disturbance. These members may also be reflected in the Special Population report. These members may receive children's mental health waiver services.

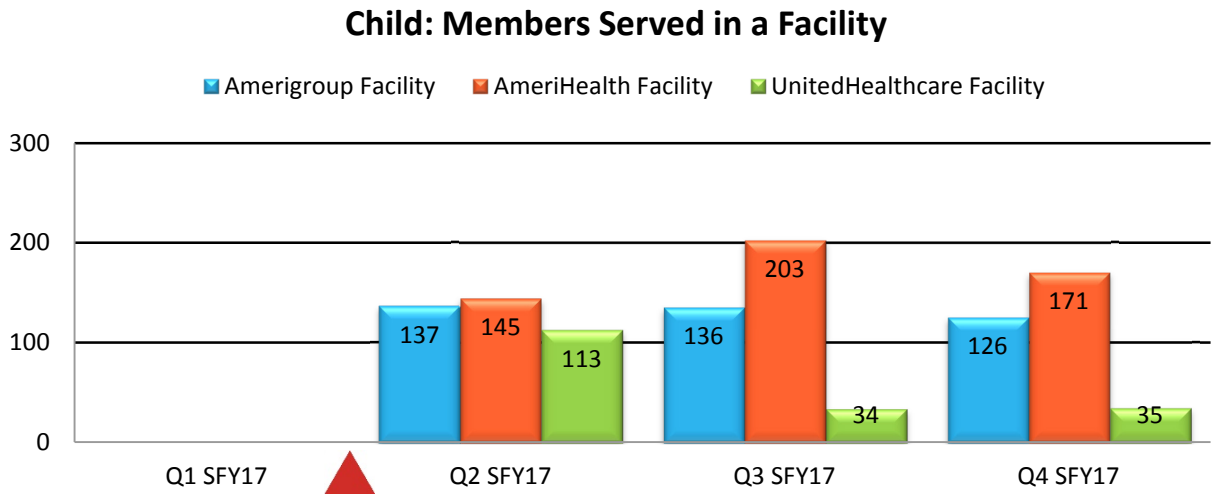
Child: Members Served in Community-Based Settings



Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:

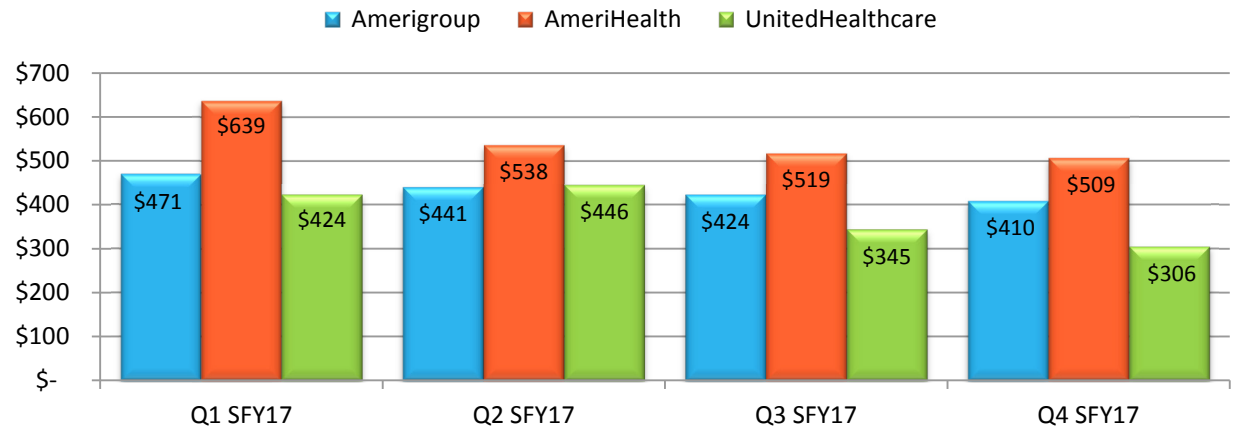
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for the increase.
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.



▲ Differences between quarters:

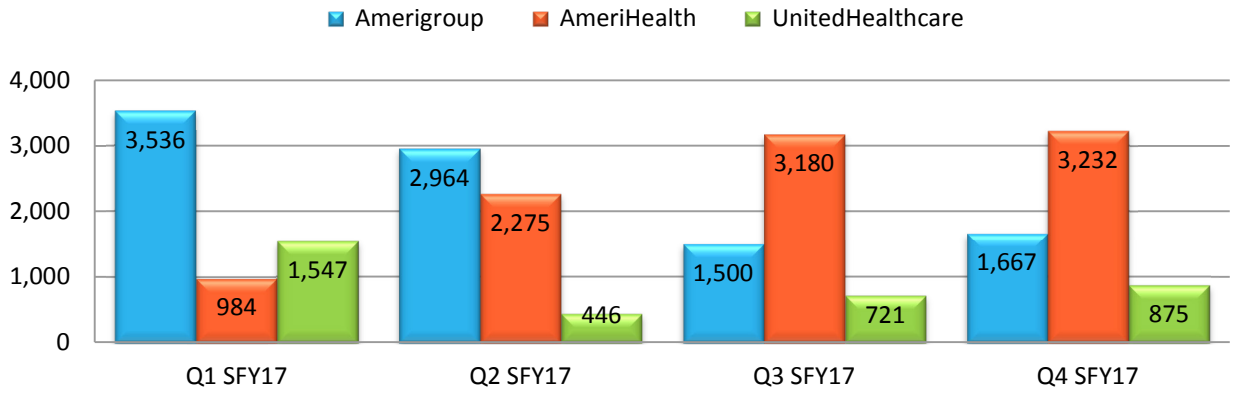
- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

Child: Average Aggregate Cost per Member per Month



The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.

Child: Members Assigned to a Community-Based Case Manager or Integrated Health Home Care Coordinator

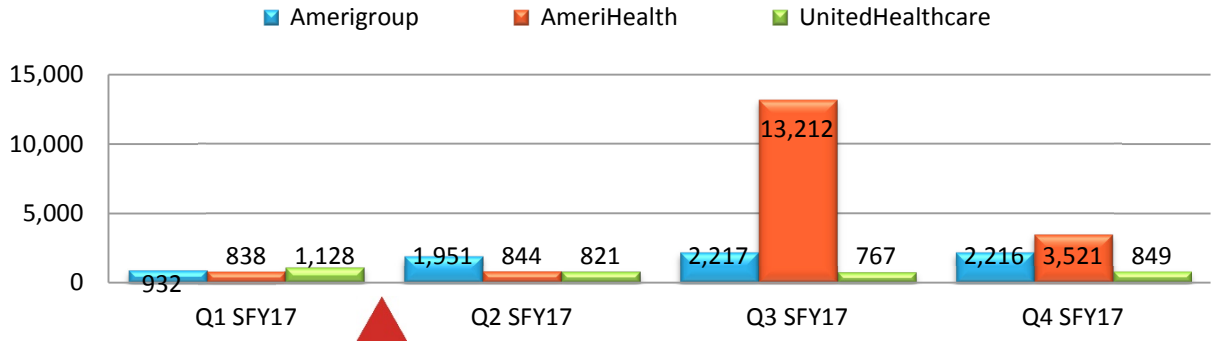


While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

Members who have an Integrated Health Home Care Coordinator have behavior health care needs and will benefit from more intensive behavioral health care management. Some of these members may have an Integrated Health Home Care Coordinator and Community-Based Case Manager due to participation in a Home- and Community-

Based Waiver program, so there may be duplication in counts. Both entities are required to ensure that the member's needs are coordinated across health systems to improve the member's overall health status and quality of life. This data element does not have a direct benchmark to compare to historical fee-for-service data.

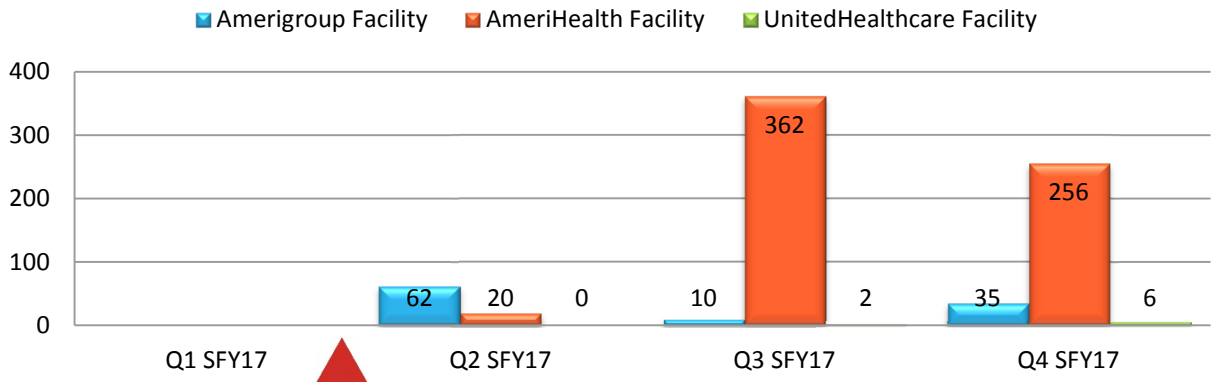
Child: Number of Community-Based Case Manager and Integrated Health Home Care Coordinator Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows a contacts split out for members in community-based settings.

Child: Number of Community-Based Case Manager Contacts for Members in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows a contacts split out for members in a facility.

A small percentage of the members in this population receive Children's Mental Health wavier services and must have Integrated Health Home care coordinators conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be more frequent. A member not receiving Children's Mental Health wavier services is not required to have as frequent contact.

An increase in Integrated Health Home care coordinator contacts is expected with the increase in identified behavioral health members. Number of Integrated Health Home care coordinator for Members represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the Integrated Health Home and community based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Integrated Health Home Care Coordinator Ratios

The department collects member to integrated health home care coordinator ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

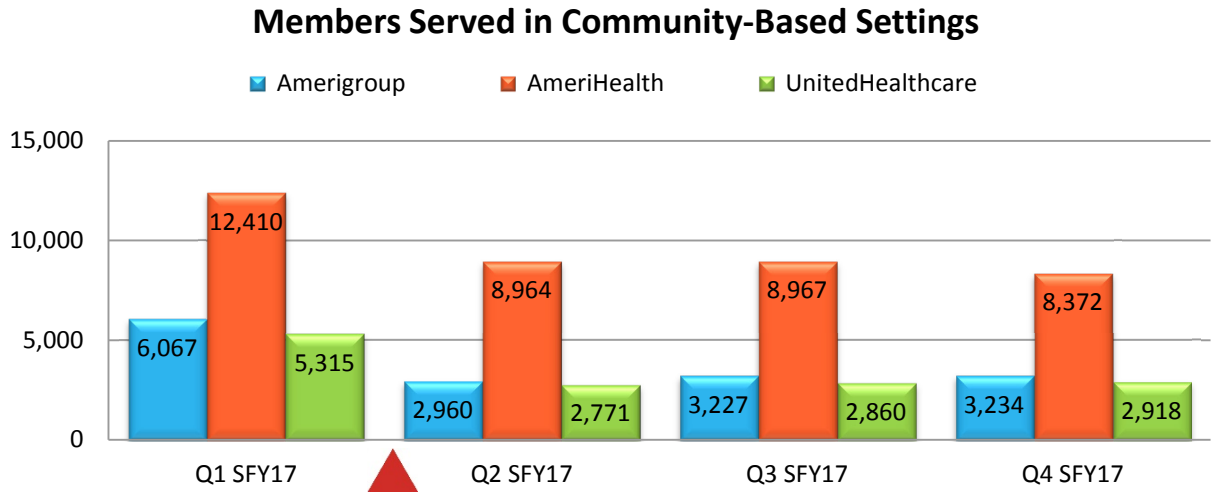
Data Reported as of October 31, 2016*	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Integrated Health Home Care Coordinator – Behavioral Health	50	50	50

The behavioral health population does not have member to case manager or care coordinator ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

*MCOs leverage the same Integrated Health Homes. These ratios are based on a study conducted by UnitedHealthcare in Q1 SFY17.

Elderly Population Reporting

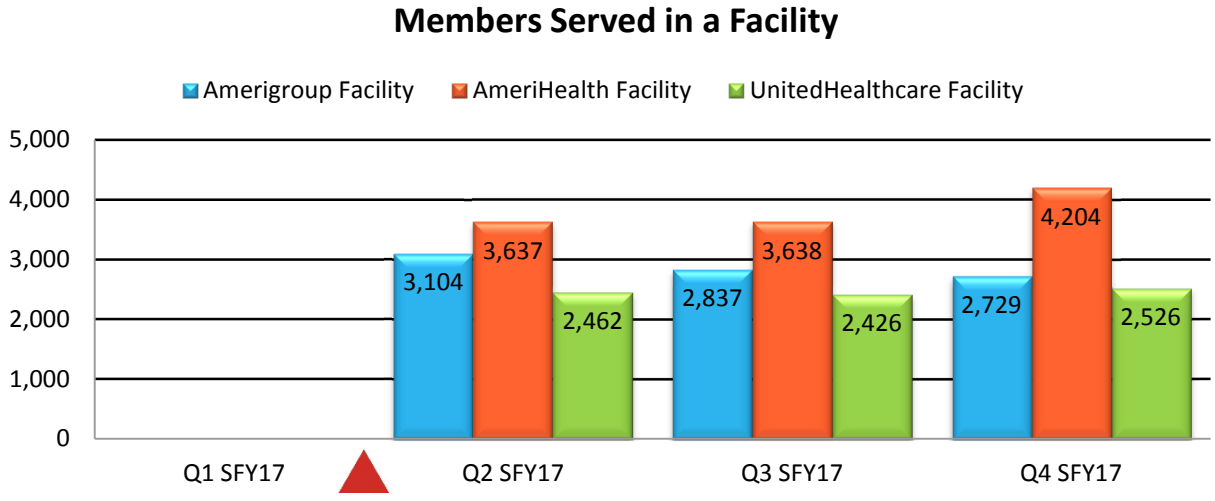
Elderly members included in this report are age 65 or older as determined at the end of the quarter. This population report reflects community based members as well as facility based members. These members may also be reflected in the Behavioral Health Population.



Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

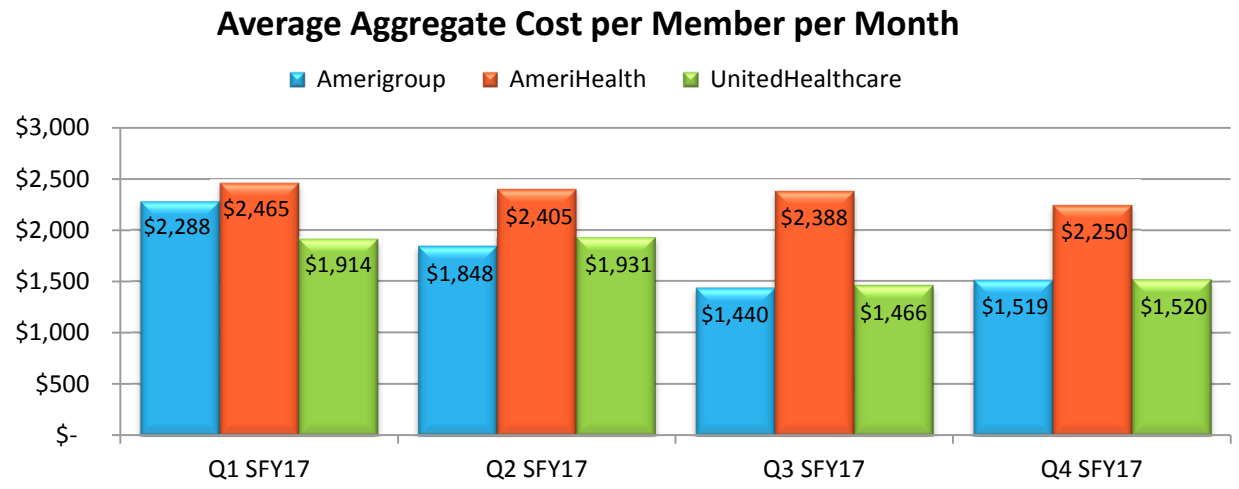
▲ Differences between quarters:

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in community-based settings.

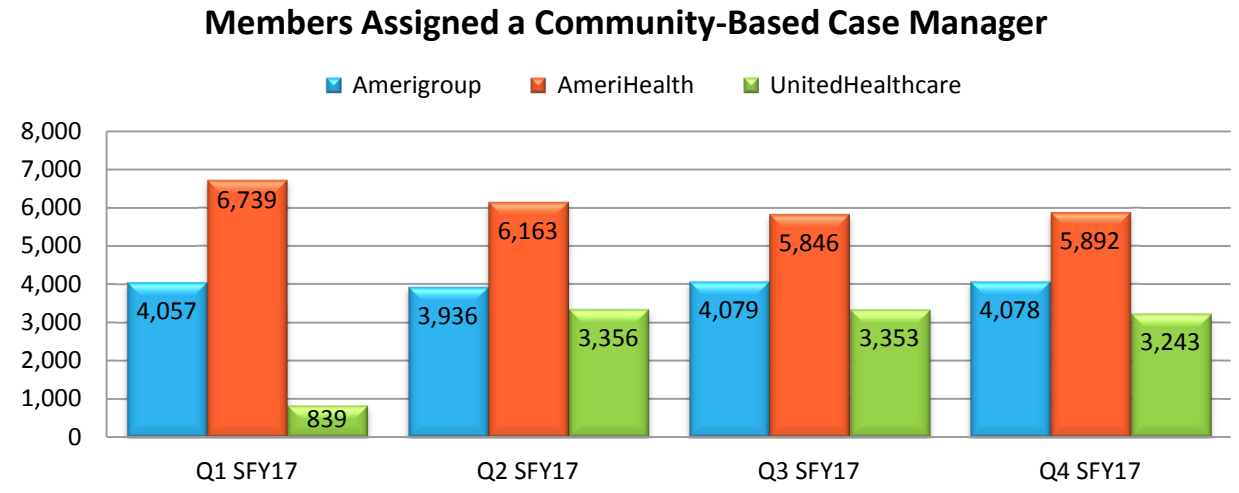


▲ Differences between quarters:

- Q1 SFY17 includes members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 represents numbers of members based on setting of care on the last day of the quarter, split out for members in a facility.



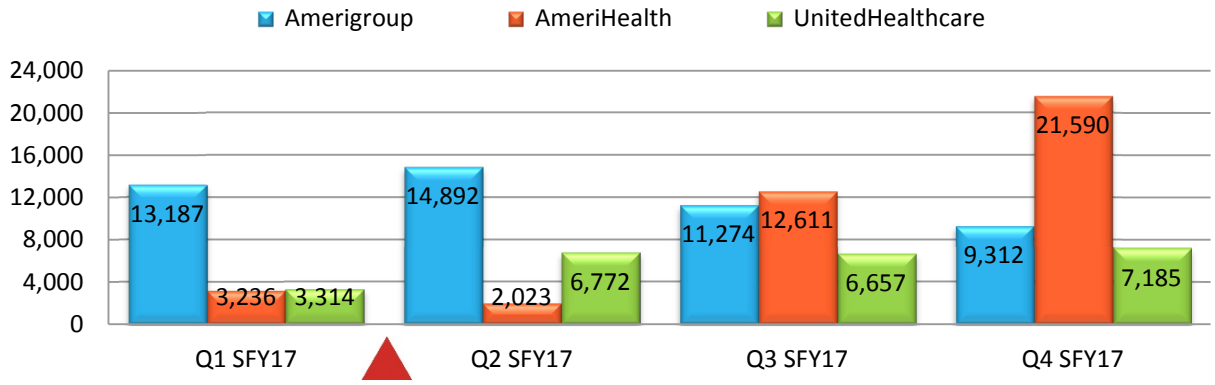
The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to twelve percent (8-12%) of claims may not be included in this measure.



Members who have a community-based case manager have special needs and will benefit from intensive case management. This is a new and more comprehensive case

management strategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

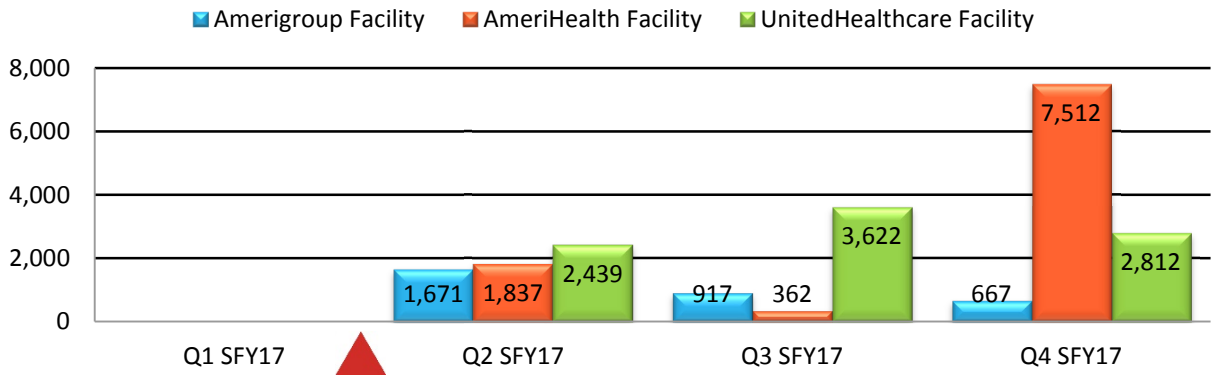
Number of Community-Based Case Manager Contacts for Members in Community-Based Settings



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.

Number of Community-Based Case Manager Contacts for Members Occurring in a Facility



▲ Differences between quarters:

- Q1 SFY17 represents contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

Members who receive Home- and Community-Based Waiver services must have a community based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs

of the individual, the number of contacts may be more frequent. Members in institutional settings must have a case manager. These managers are required to have face-to-face contact on a quarterly basis with members.

The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

AmeriHealth Caritas Iowa is committed to assuring that data in the reports most accurately reflects actual member contacts. AmeriHealth Caritas Iowa made system changes that facilitated the capture of additional contact activity that it was unable to capture in prior reports. The data in the report further appears disproportionate due to the volume of members in the population served by AmeriHealth Caritas Iowa.

Community-Based Case Management Ratios

The department collects member to community-based case manager ratios to ensure that adequate case management services are available to members in Long Term Services and Supports (LTSS). Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of July 30, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	18.7	12.5	10.1

The Elderly population does not have member to case manager ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark to compare to historical fee-for-service data.

MCO Member Grievances and Appeals

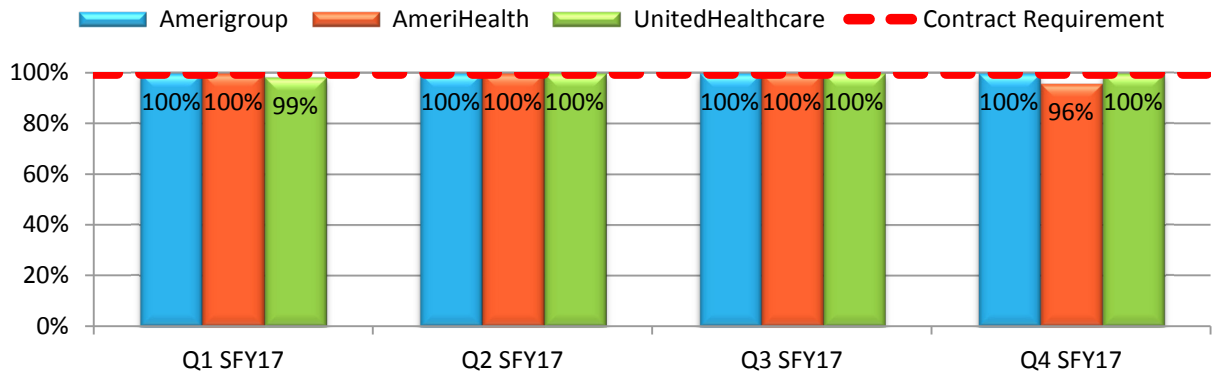
Grievance and appeal data demonstrates the level to which the member is receiving timely and adequate levels of service. If a member does not agree with the level in which services are authorized, they may pursue an appeal through the managed care organization.

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.

100% of Grievances Resolved within 30 Calendar Days of Receipt



This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. 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 SFY17	224	133	87
Grievances Received in Q2 SFY17	201	110	96
Grievances Received in Q3 SFY17	223	115	117

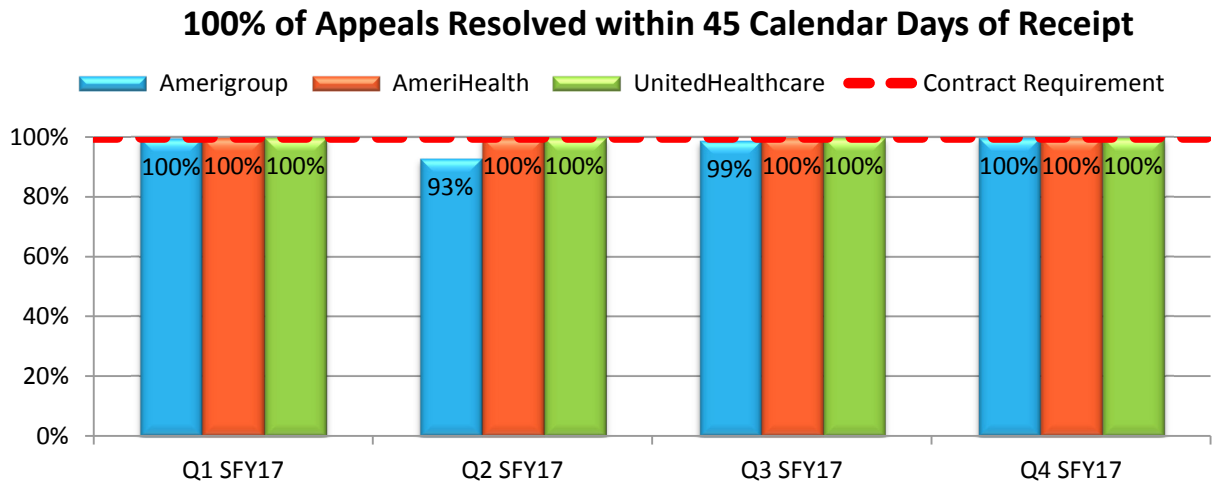
Grievances Received in Q4 SFY17	219	440	80

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 Q4 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	56	Provider Issue - Member Received Bill	273	Ambulance/Transportation – Dispute regarding non-ambulance methods of transportation	48
2	Provider Balance Billed	43	Provider Issue - Dissatisfied with Treatment or Service	31	Provider Issue- Balance Billing	21
3	Provider Attitude/ Rudeness	22	Administrative/MCO - Plan Policies and Procedures	19	Quality of Care	3
4	Treatment Dissatisfaction	10	Administrative/MCO - Issue with Service from Care Manager	12	Administration - Service Concerns	2
5	Provider Refusal to Treat	8	Transportation – No Pick-Up	12	Enrollee Access/Availability – Provider Locale Inconvenient	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 the contractual timeframes. If a member is not satisfied with the appeal decision, they may file an appeal with the state.

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Appeals Received in Q1 SFY17	370	216	117
Appeals Received in Q2 SFY17	473	230	76
Appeals Received in Q3 SFY17	425	413	108
Appeals Received in Q4 SFY17	361	455	143

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 Q4 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Appeals	Count	Appeals	Count	Appeals	Count
1	Pharmacy - Non Injectable	114	Skilled Care/Nursing	131	Pharmacy - Authorization	86
2	Pharmacy - Injectable	35	Pharmacy	81	Pharmacy – Covered Services	33
3	Skilled Nursing	27	Prior Authorization	40	Medical – Utilization Review Dispute	32
4	Radiology	22	Home Health Aide	40	Medical – Authorization for Durable Medical Equipment	14
5	Therapy - PT	21	DME (Durable Medical Equipment)	40	Pharmacy - Dispute of Excluded Medication	8

State Fair Hearing Summary for Members in Managed Care CY 2017

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Level of Care	13	1	2
Medical Service Denial/Reduction	17	45	17
Pharmacy Denial/Reduction	10	0	3
Durable Medical Equipment Denial/Reduction	8	9	7

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.

Critical Incidents

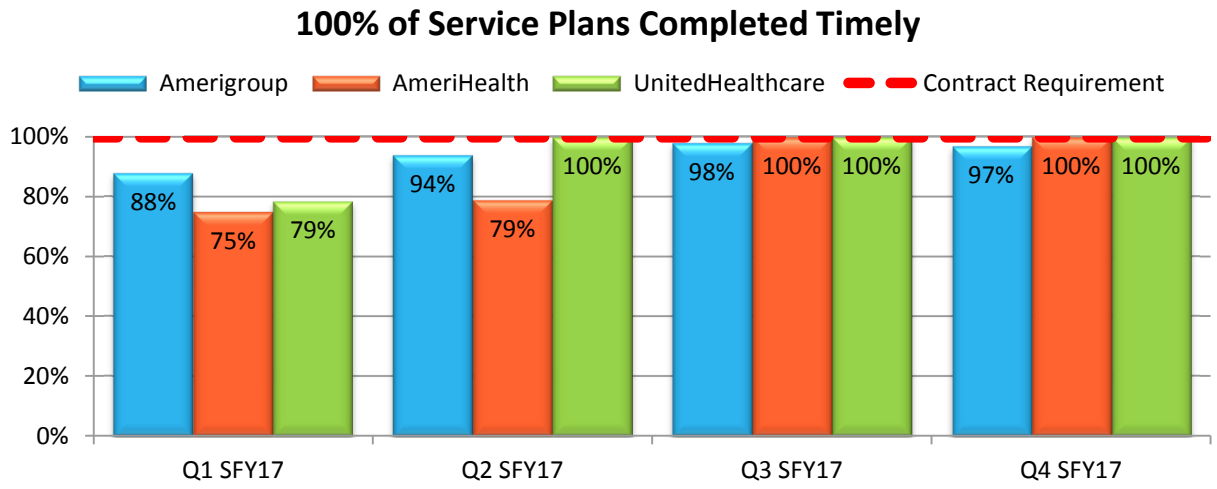
Home- and Community-Based Services (HCBS) Waiver and Habilitation providers and case managers/care coordinators are required to report critical incidents to the MCOs. These critical incidents are to be reported if the reporting entity witnesses the incident or is made aware of the incident. Critical 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.

Data Reported	Amerigroup	AmeriHealth	UnitedHealthcare
HCBS and Habilitation Members as of June 2017	3,574	17,309	3,056
Special Needs Population			
# of Critical Incidents Received in Q4 SFY17	127	1,126	93
# Critical Incidents Received and Resolved in Q4 SFY17	127	1,126	93
% Critical Incidents Resolved in Q4 SFY17	100%	100%	100%
Behavioral Health Population			
# of Critical Incidents Received in Q4 SFY17	629	1,855	312
# Critical Incidents Received and Resolved in Q4 SFY17	629	1,855	312
% Critical Incidents Resolved in Q4 SFY17	100%	100%	100%
Elderly Population			
# of Critical Incidents Received in Q4 SFY17	27	289	29
# Critical Incidents Received and Resolved in Q4 SFY17	25	289	29
% Critical Incidents Resolved in Q4 SFY17	93%	100%	100%

Service Plans

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

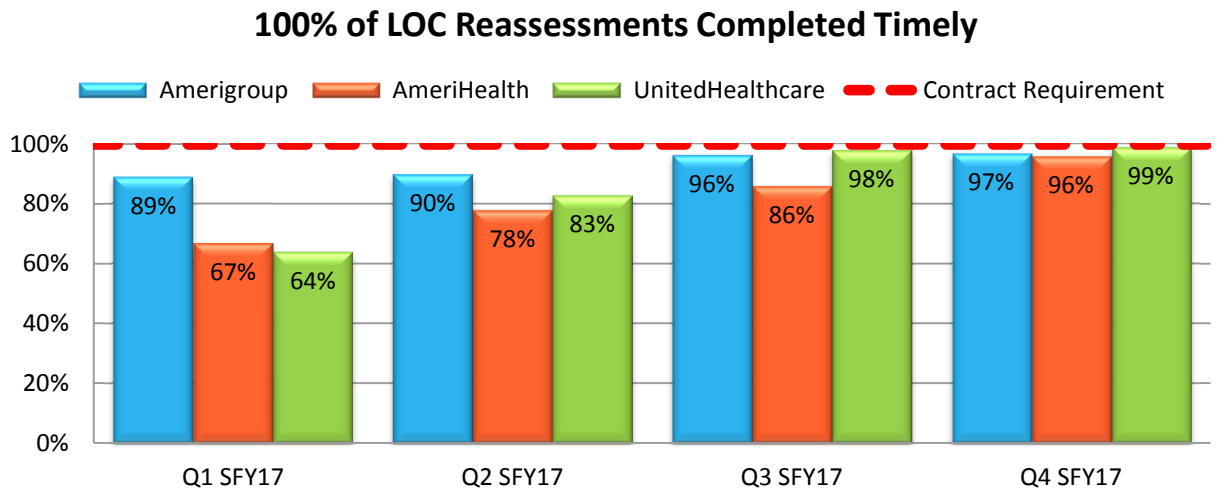


Members will continue to receive the same level of services regardless of whether service plan has been updated timely.

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.

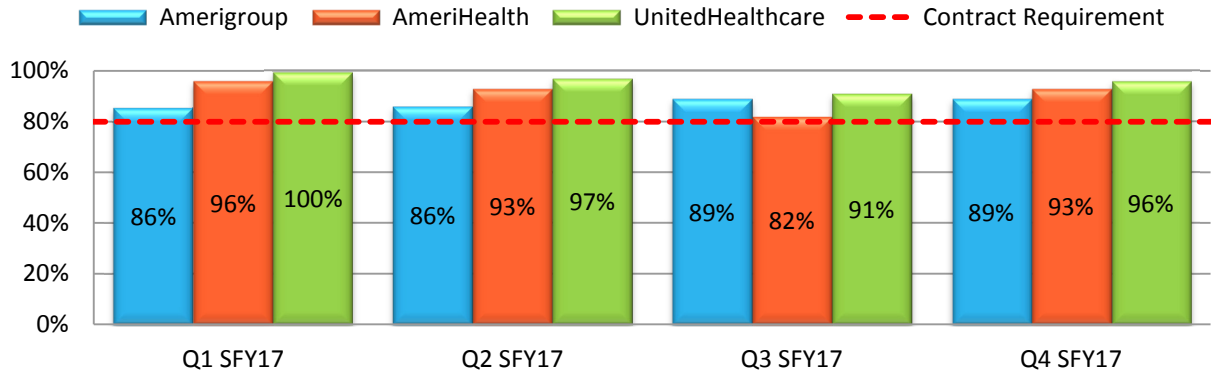


Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

The department will be closely monitoring 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.

Member Helpline

Service Level: 80% of Member Helpline Calls are Answered Timely, Not Abandoned



This performance target measures the timeliness of answering the helpline calls. 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.

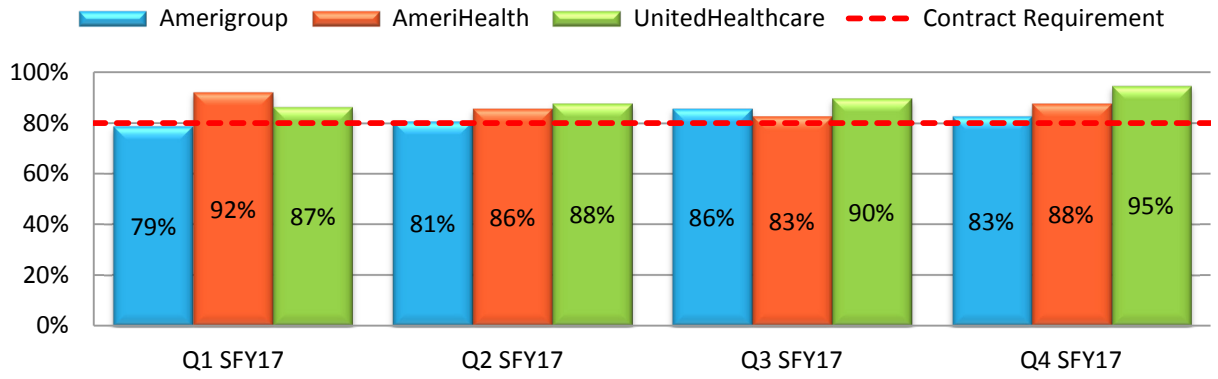
Top Five Reasons for Members Contacting Helplines for Q4 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
April 2017						
1.	Transportation Question	8,291	Plan Policy/Procedure Education	6,305	Benefits	3,208
2.	Benefit Inquiry	1,698	Member Demographic Changes	5,301	PCP Inquiry	2,789
3.	Enrollment Inquiry	1,190	Member Request for ID Card	2,831	Eligibility Inquiry	2,620
4.	Provider-Find/Change/Verify PCP	1,056	Benefit Inquiry	1,850	COB Information	924
5.	Pharmacy Inquiry	889	Member Eligibility	1,827	Claims Inquiry	902
May 2017						
1.	Transportation Question	9,373	Plan Policy/Procedure Education	6,931	Benefits	3,904
2.	Benefit Inquiry	1,739	Member Demographic Changes	5,507	PCP Inquiry	3,195
3.	Enrollment Inquiry	1,421	Member Request	3,125	Eligibility Inquiry	3,152

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			for ID Card			
4.	Pharmacy Inquiry	1,031	Member Eligibility	2,357	COB Information	1,262
5.	Provider-Find/Change/Verify PCP	978	PCP Change	1,984	Claims Inquiry	964
June 2017						
1.	Transportation Question	8,577	Plan Policy/Procedure Education	6,729	PCP Inquiry	4,232
2.	Benefit Inquiry	1,732	Member Demographic Changes	5,547	Benefits	4,081
3.	Enrollment Inquiry	1,341	Member Request for ID Card	2,836	Eligibility Inquiry	3,699
4.	Pharmacy Inquiry	1,147	Member Eligibility	2,032	COB Information	1,766
5.	Provider-Find/Change/Verify PCP	1,015	PCP Change	1,750	General Inquiry	926

Provider Helpline

Service Level: 80% of Provider Helpline Calls are Answered Timely, Not Abandoned



This performance target measures the timeliness of answering the helpline calls. 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.

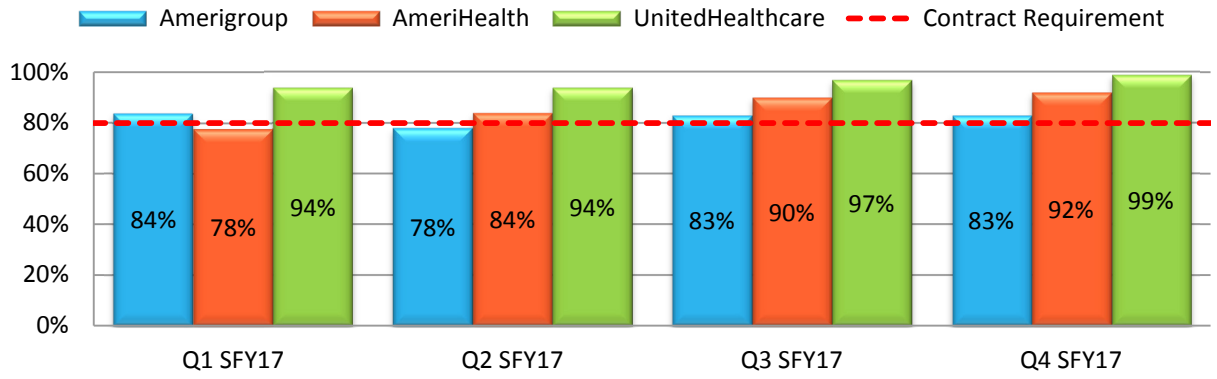
Top Five Reasons for Providers Contacting Helplines for Q4 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
April 2017						
1.	Claim Status Inquiry	3,290	Claim Status	12,953	Claims Inquiry	18,074
2.	Claim Rejected	1,942	Provider Requests-	7,807	Benefits	6,132

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			Check Remittance Advice			
3.	Pharmacy Department Call Inquiry	1,763	Plan Policy/Procedure Education	5,689	COB Information	2,191
4.	Benefits Inquiry	1,291	Eligibility/Enrollment-Member Eligibility	2,244	Membership Record	1,029
5.	Claims Inquiry	1,175	Claim Issues	1,802	Authorization Related	829
May 2017						
1.	Claim Status Inquiry	3,451	Claim Status	14,913	Claims Inquiry	14,437
2.	Claim Rejected	1,957	Provider Requests-Check Remittance Advice	8,614	Benefits	4,847
3.	Pharmacy Department Call Inquiry	1,927	Plan Policy/Procedure Education	7,604	COB Information	1,683
4.	Claim Denial Inquiry	1,218	Eligibility/Enrollment-Member Eligibility	2,674	Authorization Related	775
5.	Claims Inquiry	1,211	Claim Issues	2,429	Membership Record	743
June 2017						
1.	Claims Status Inquiry	3,565	Claim Status	15,302	Claims Inquiry	12,520
2.	Claim Rejected	1,918	Provider Requests – Check Remittance Advice	8,266	Benefits	4,129
3.	Pharmacy Department Call Inquiry	1,905	Plan Policy/Procedure Education	6,982	COB Information	1,367
4.	Claims Inquiry	1,381	Eligibility/ Enrollment – Member Eligibility	2,479	Authorization Related	760
5.	Claim Denial Inquiry	1,119	Claims Issues	2,077	Membership Record	722

Pharmacy Services Helpline

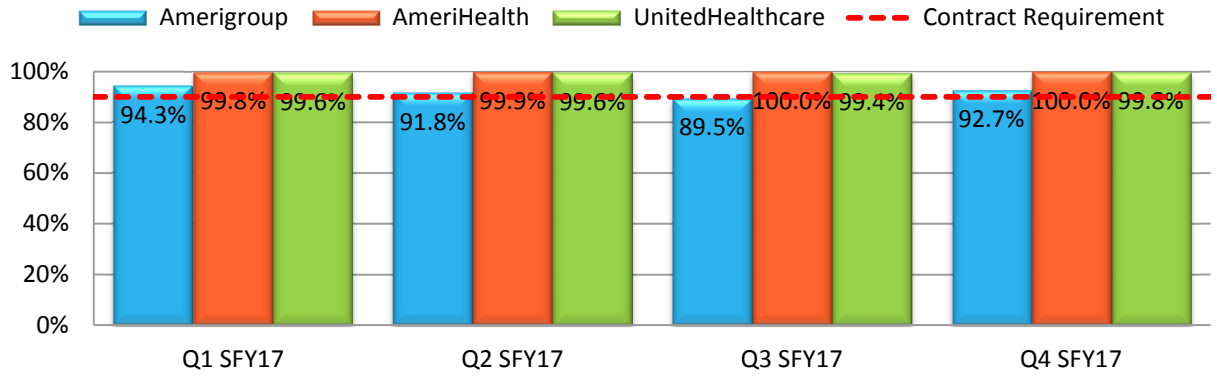
Service Level: 80% of Pharmacy Provider Helpline Calls are Answered Timely, Not Abandoned



Medical Claims Payment

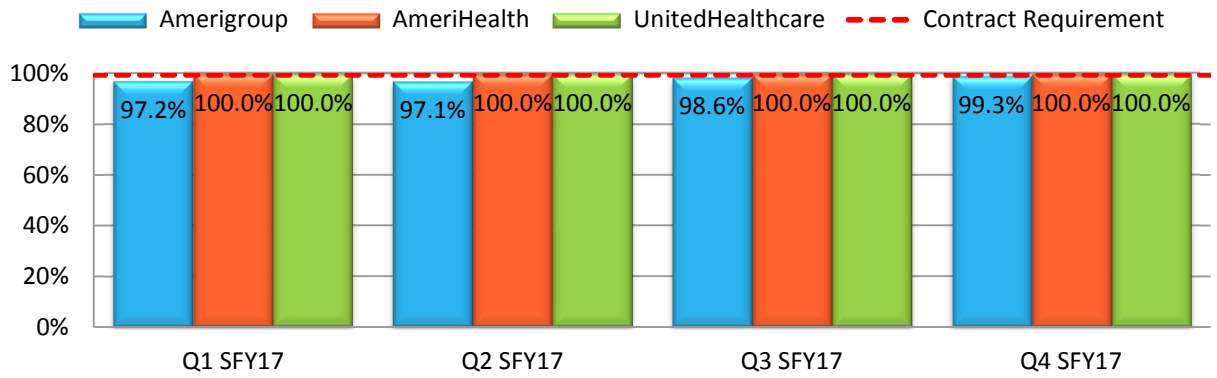
Medical claims processing data is for the entire quarter. Does not include pharmacy claims.

90% of Clean Medical Claims Must be Paid or Denied Within 14 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.

99.5% of Clean Medical Claims Must be Paid or Denied Within 21 Days



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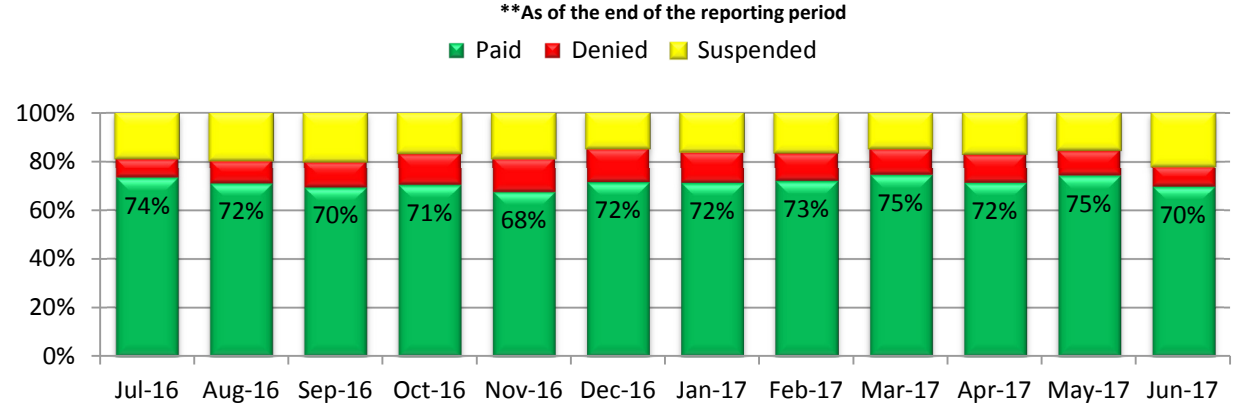
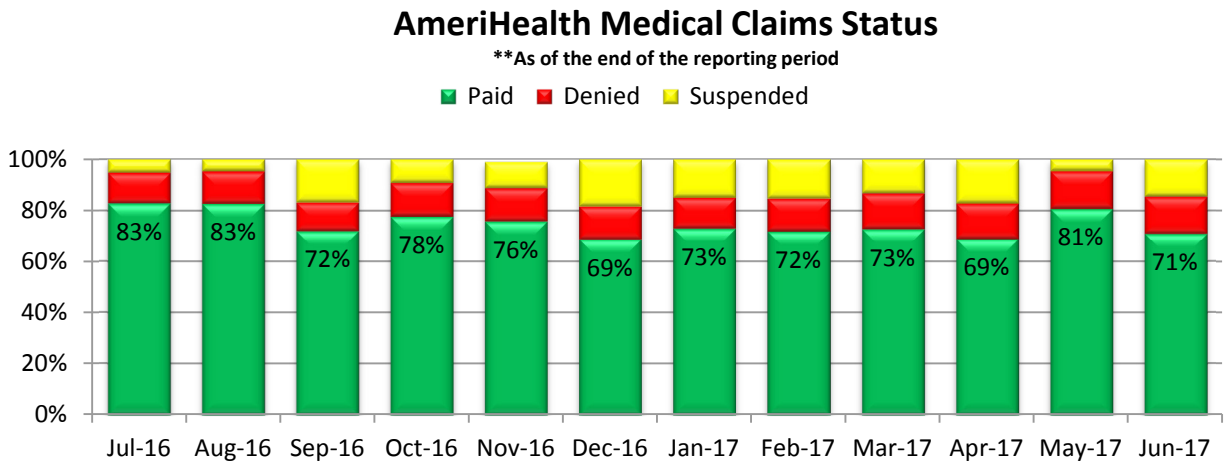
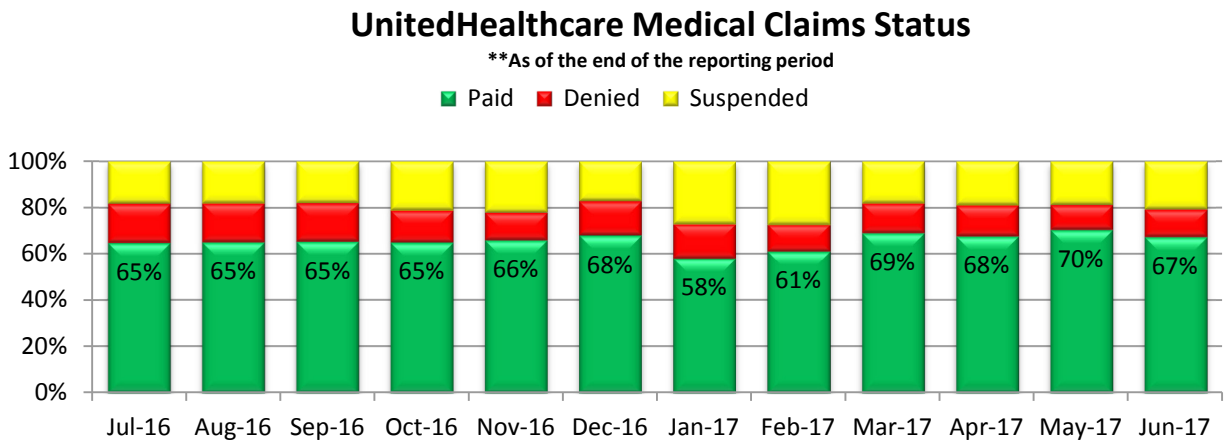
Amerigroup Medical Claims Status







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.	1. CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.	1. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement.
2. CARC-177 Patient has not met the required eligibility requirements.	2. CARC-197 Precertification/ authorization/ notification absent. -RARC-M62 Missing/ incomplete/ invalid treatment authorization	2. CARC-18 Exact duplicate claim/ service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
	code.	
3. CARC-29 The time limit for filing has expired.	3. CARC-29 The time limit for filing has expired.	3. CARC-252 An attachment/other documentation is required to adjudicate this claim/ service. -RARC-MA04 Secondary payment cannot be considered without the identity of or payment information from the primary payer. The information was either not reported or was illegible.
4. CARC-197 Precertification/ authorization/ notification absent	4. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.	4. CARC-B13 Previously paid. Payment for this claim/ service may have been provided in a previous payment.
5. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/ legislated fee arrangement -RARC N-381 Consult our contractual agreement for restrictions/ billing/ payment information related to these charges.	5. CARC-22 This care may be covered by another payer per coordination of benefits. -RARC-N4 Missing/ Incomplete/ Invalid prior Insurance Carrier(s) EOB.	5. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.
6. CARC-252 An attachment/ other documentation is required to adjudicate this claim/ service. At least one Remark Code must be provided. -RARC N-479 Missing Explanation of Benefits.	6. CARC-8 The procedure code is inconsistent with the provider type (taxonomy). RARC-N95 This provider type/ provider specialty may not bill this service.	6. CARC-29 The time limit for filing has expired.
7. CARC-256- Service not payable per managed care contract.	7. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. RARC-M15 Separately	7. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. -RARC-M15 Separately

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
	billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	billed services/ tests have been bundled as they are considered components of the same.
8. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. -RARC-MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	8. CARC-236 This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier provided on the same day according to the National Correct Coding Initiative or workers compensation state regulation/ fee schedule requirements. RARC-N657This should be billed with the appropriate code for these services.	8. CARC-256 Service not payable per managed care contract.
9. CARC-97 The benefit for this service is included in the payment/allowance for another service/procedure that has already been adjudicated. RARC-N432 Alert: Adjustment based on Recovery Audit.	9. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC-N253 Missing/incomplete/invalid attending provider primary identifier.	9. CARC-16 Claim/ service lacks information or has submission/ billing error(s) which is needed for adjudication. RARC-N258 Missing/ incomplete/ invalid billing provider/ supplier address.
10. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been adjudicated. RARC-N19 Procedure code incidental to primary procedure.	10. CARC-109 Claims/ service not covered by this payer/ contractor. RARC-N193 Alert: Specific federal/ state/ local program may cover this service through another payer.	10. CARC-251 The attachment/ other documentation that was received was incomplete or deficient. RARC-M127 Missing patient medical record for this service.

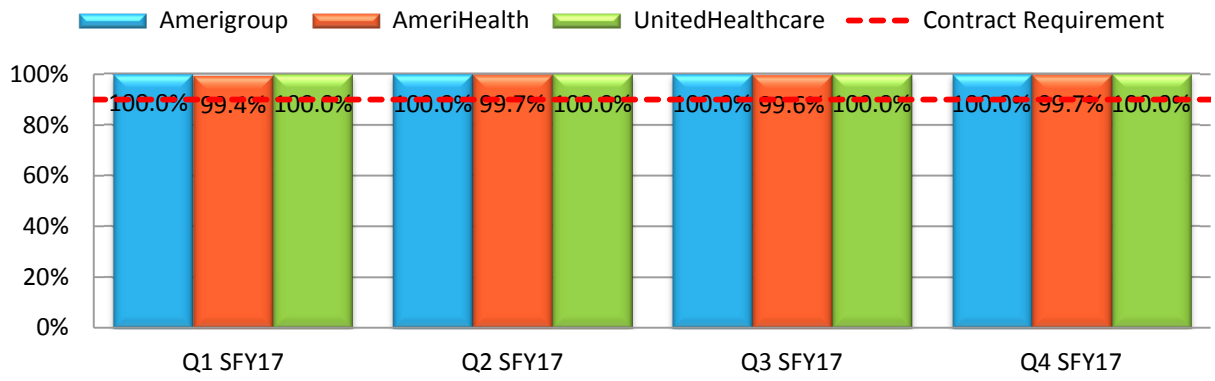
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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/

Pharmacy Claims Payment

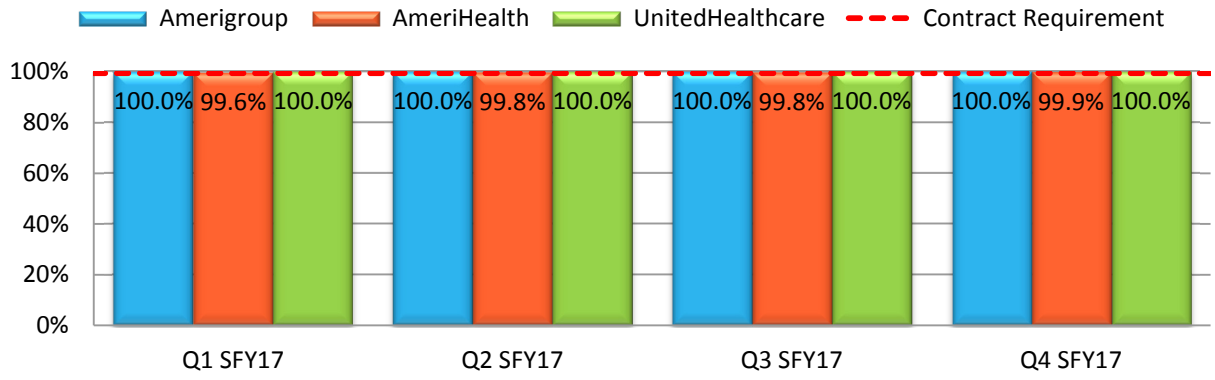
Pharmacy claims processing data is for the entire quarter.

90% of Clean Pharmacy Claims Must be Paid or Denied Within 14 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.

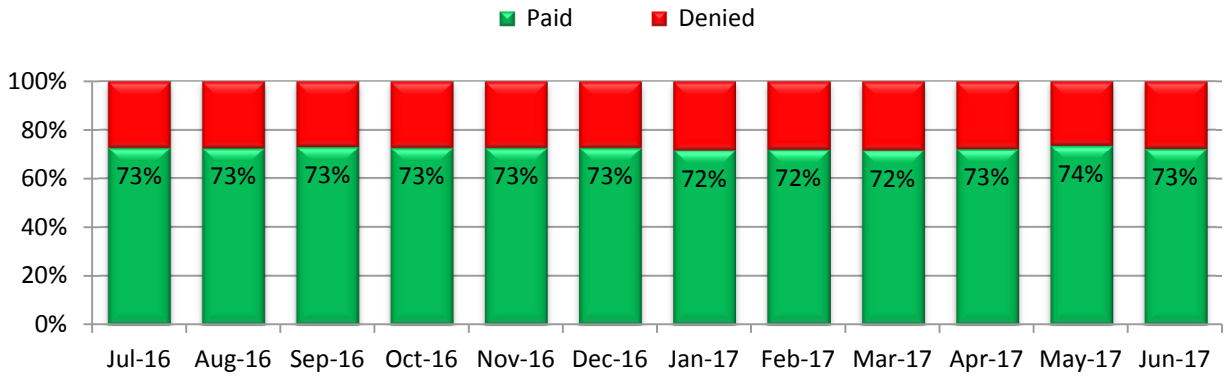
99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days



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.

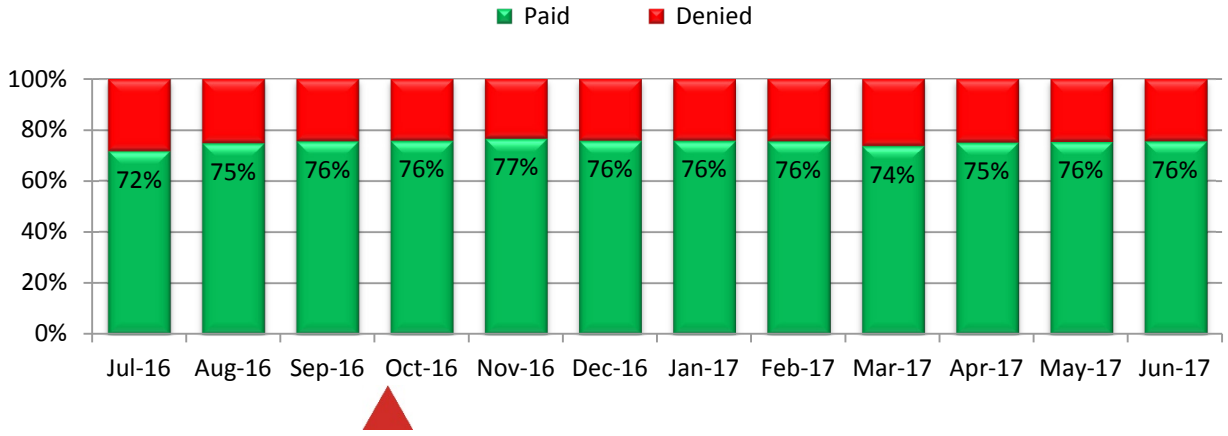
Amerigroup Pharmacy Claims Status

**As of the end of the reporting period



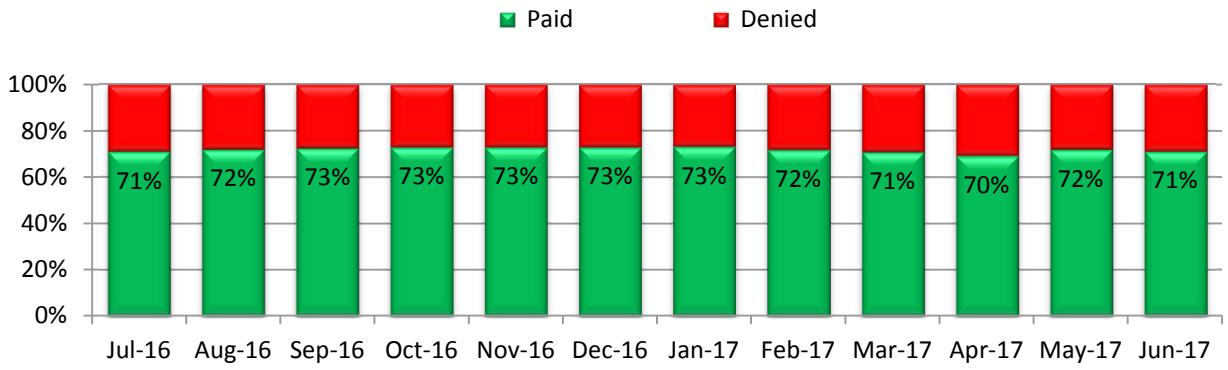
AmeriHealth Pharmacy Claims Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period



Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
1. Refill Too Soon	1. Refill Too Soon	1. Refill Too Soon
2. Submit Bill To Other Processor Or Primary Payer	2. Product/Service Not Covered-Plan/Benefit Exclusion	2. Product Service Not Covered
3. Product Not On Formulary	3. Patient Is Not Covered	3. Filled After Coverage Termed
4. Prior Authorization Required	4. Prior Authorization Required	4. Prior Authorization Required
5. Days Supply Exceeds Plan Limitation	5. Submit Bill to Other Processor or Primary Payer	5. Plan Limitations Exceeded
6. Plan Limitations Exceeded	6. Plan Limitations Exceeded	6. Submit Bill To Other Processor
7. Product/Service Not Covered – Plan/Benefit Exclusion	7. Duplicate Paid/ Captured Claim	7. Missing Invalid Days Supply
8. DUR Reject Error	8. Non-Matched Product/ Service ID number	8. DUR Reject Error
9. This Medicaid Patient Is Medicare Eligible	9. DUR Reject Error	9. Missing Invalid Group Number
10. Scheduled Downtime	10. Provider Ineligible to Perform Service	10. Non-Matched Pharmacy

Utilization of Health Care Services Reported			
Q4 SFY17 Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$15,607,206	$10,033,488	$8,654,667
Inpatient Medical Claims Reimbursed	$43,716,265	$24,021,602	$32,606,922
Inpatient Behavioral Health Claims Reimbursed	$14,069,916	$26,623,158	$2,651,483
Outpatient Claims Reimbursed	$55,084,213	$38,469,580	$38,508,022

This type of data will undergo ongoing validation for increased accuracy.

This data is reflective of point in time and will change to reflect reprocessing associated with rate adjustments as well as recoveries related to program integrity and third party liability coverage.

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.

Q4 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Family Planning and Resources	4,121	2,539	1,165	7,825
Healthy Incentives	3,255	8,243	1,713	13,211
Health and Wellness	88	5,716	116	5,920
Additional Benefits	1,040	1,929	339	3,308
Tobacco Cessation	244	707	481	1,432

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/Comm480.pdf
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Network Adequacy and Historical Utilization

The IME and the Centers for Medicare and Medicaid Services (CMS) developed a network adequacy tool that is based on Medicaid members' historical utilization of services. **Historical utilization**, as seen in the table below, is 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.

Data below comes from the June 2017 Monthly MCO Performance Report.

	Amerigroup			AmeriHealth			UnitedHealthcare		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	85.8%	90.6%	93.4%	96.0%	99.0%	99.0%	99.5%	99.9%	99.6%
Cardiology	88.1%	95.4%	89.0%	100.0%	100.0%	80.0%	99.8%	99.8%	99.2%
Endocrinology	91.5%	63.2%	100.0%	95.0%	98.0%	100.0%	99.7%	99.8%	97.9%
Gastroenterology	88.5%	93.6%	81.1%	100.0%	96.0%	98.0%	99.5%	100.0%	99.2%
Neurology	92.5%	94.2%	99.0%	97.0%	100.0%	99.0%	98.9%	99.9%	95.5%
Oncology	76.9%	84.0%	98.0%	99.0%	100.0%	100.0%	100.0%	99.9%	99.8%
Orthopedics	71.8%	85.7%	94.3%	100.0%	100.0%	97.0%	99.9%	99.9%	99.3%
Pulmonology	79.8%	97.1%	91.2%	100.0%	100.0%	100.0%	99.8%	99.4%	97.9%
Rheumatology	100.0%	100.0%	95.0%	100.0%	97.0%	100.0%	99.8%	100.0%	100.0%
Urology	80.2%	99.0%	78.0%	98.0%	99.0%	100.0%	100.0%	99.8%	99.5%
Provider Type - Pediatric	East	Central	West	East	Central	West	East	Central	West
Primary Care	88.9%	97.3%	98.0%	95.0%	98.0%	98.0%	99.9%	100.0%	99.7%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	96.8%	98.4%	95.0%	100.0%	100.0%	99.0%	99.1%	99.2%	99.2%
Pharmacies	99.8%	99.6%	99.9%	98.0%	98.0%	97.0%	100.0%	100.0%	99.9%
ICF/ID	99.6%	100.0%	100.0%	99.0%	98.0%	97.0%	100.0%	100.0%	100.0%
ICF/SNF	94.8%	91.6%	93.2%	95.0%	97.0%	96.0%	99.5%	97.9%	99.8%

	Amerigroup			AmeriHealth			UnitedHealthcare		
Provider Type - Waiver	East	Central	West	East	Central	West	East	Central	West
AIDS/HIV Level 1: Adult Day Care	No Util	No Util	No Util	No Util	No Util	No Util	100.0%	100.0%	100.0%
AIDS/HIV Level 2: CDAC, Home Health Aide	No Util	100.0%	100.0%	100.0%	100.0%	No Util	100.0%	100.0%	100.0%
AIDS/HIV Level 4: Home Delivered Meals	100.0%	100.0%	No Util	100.0%	No Util	100.0%	100.0%	100.0%	100.0%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	93.1%	100.0%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%	100.0%
BI Level 2: CDAC	96.6%	97.0%	95.9%	100.0%	97.0%	100.0%	100.0%	100.0%	100.0%
BI Level 3: Supported Community Living	96.7%	95.8%	99.2%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
Elderly Level 1: Adult Day Care	91.2%	100.0%	100.0%	86.0%	100.0%	No Util	100.0%	100.0%	100.0%
Elderly Level 2: CDAC, Home Health Aide	91.7%	95.0%	95.5%	100.0%	92.0%	100.0%	100.0%	100.0%	100.0%
Elderly Level 4: Home Delivered Meals	92.4%	92.7%	95.1%	100.0%	96.0%	99.0%	100.0%	100.0%	100.0%
HD Level 1: Adult Day Care	100.0%	100.0%	No Util	100.0%	100.0%	No Util	100.0%	100.0%	100.0%
HD Level 2: CDAC, Counseling, Home Health Aide	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
HD Level 4: Home Delivered Meals	91.1%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	92.4%	93.8%	100.0%	98.0%	99.0%	100.0%	100.0%	100.0%	100.0%
ID Level 2: CDAC, Home Health Aide	88.5%	95.2%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%
ID Level 3: Supported Community Living	96.3%	92.3%	99.3%	99.0%	98.0%	98.0%	100.0%	100.0%	100.0%
PD Level 2: CDAC,	96.2%	100.0%	98.3%	100.0%	98.0%	100.0%	100.0%	100.0%	100.0%
Provider Type - Behavioral	East	Central	West	East	Central	West	East	Central	West
Behavioral Health - Inpatient	99.9%	100.0%	94.7%	100.0%	98.0%	100.0%	100.0%	97.6%	84.0%
Behavioral Health - Outpatient	95.1%	89.7%	88.4%	93.0%	98.0%	98.0%	99.5%	99.6%	99.8%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	89.5%	96.0%	100.0%	100.0%	99.0%	100.0%	100.0%	100.0%	100.0%
Habilitation Level 3: Home Based Habilitation	97.5%	100.0%	94.6%	100.0%	99.0%	91.0%	100.0%	99.9%	94.7%
Children's Mental Health Level 1: Respite	100.0%	92.8%	69.5%	100.0%	100.0%	100.0%	100.0%	100.0%	100.0%

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:

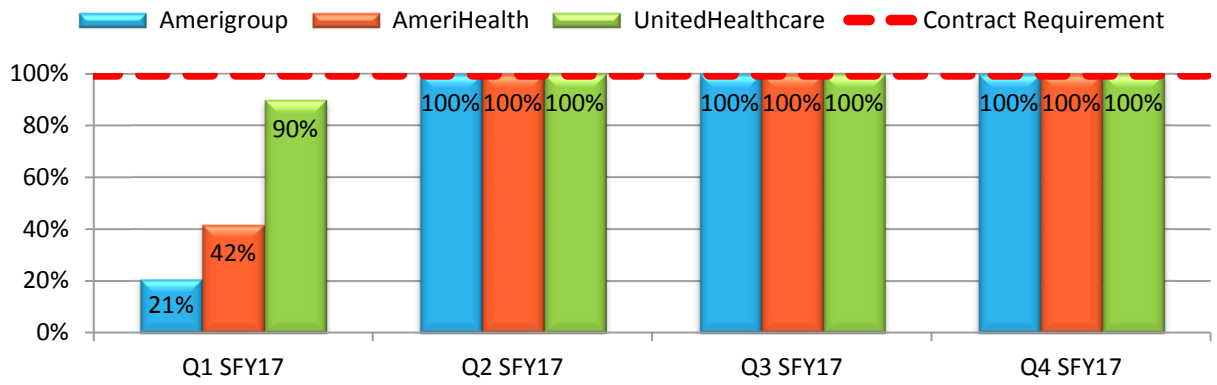
- Amerigroup:
  - https://dhs.iowa.gov/sites/default/files/AmerigroupIA_GeoAccess_SFY17_Qtr4.pdf
- AmeriHealth Caritas:
  - https://dhs.iowa.gov/sites/default/files/AmeriHealthCaritasIowa__GeoAccess_SFY17_Qtr4.pdf
- UnitedHealthcare:
  - https://dhs.iowa.gov/sites/default/files/UHC__GeoAccess_SFY17_Qtr4.pdf

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%

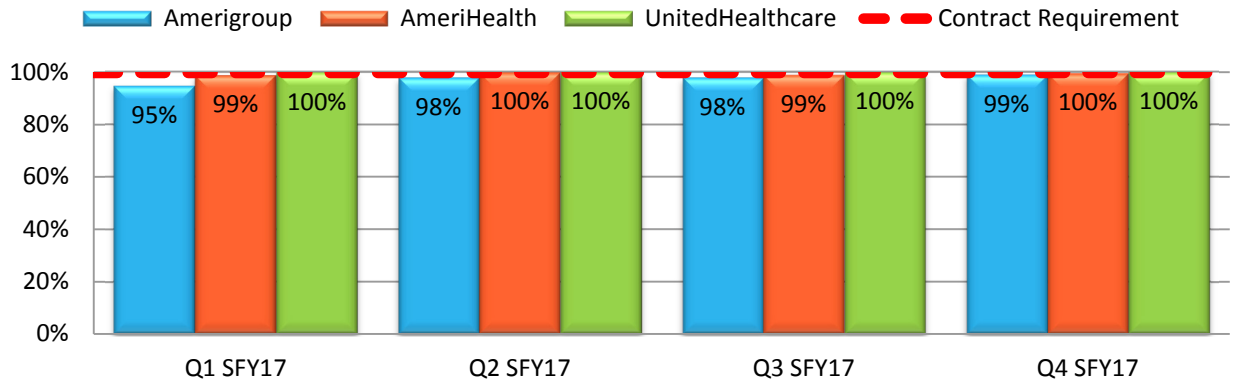
100% of Counties Have ≥ 2 HCBS Providers Per County Per 1915c Program



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

Prior Authorization - Medical

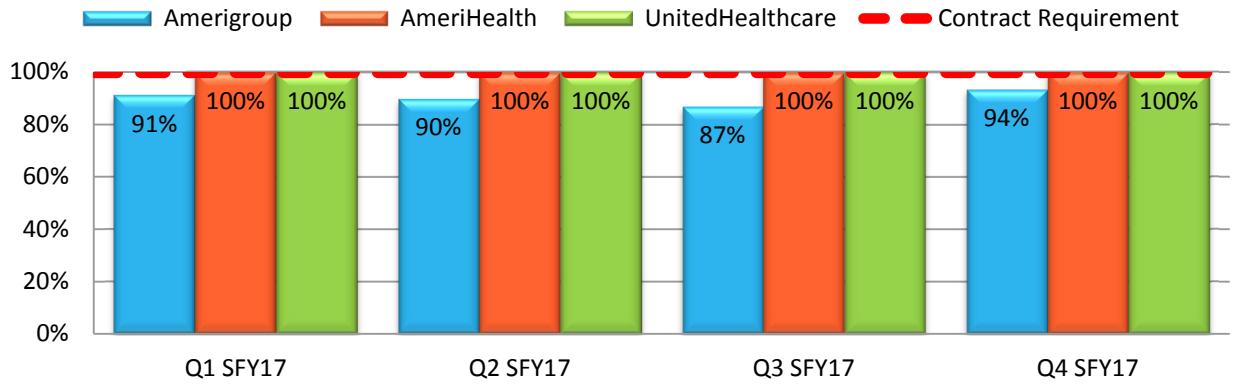
100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request



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.

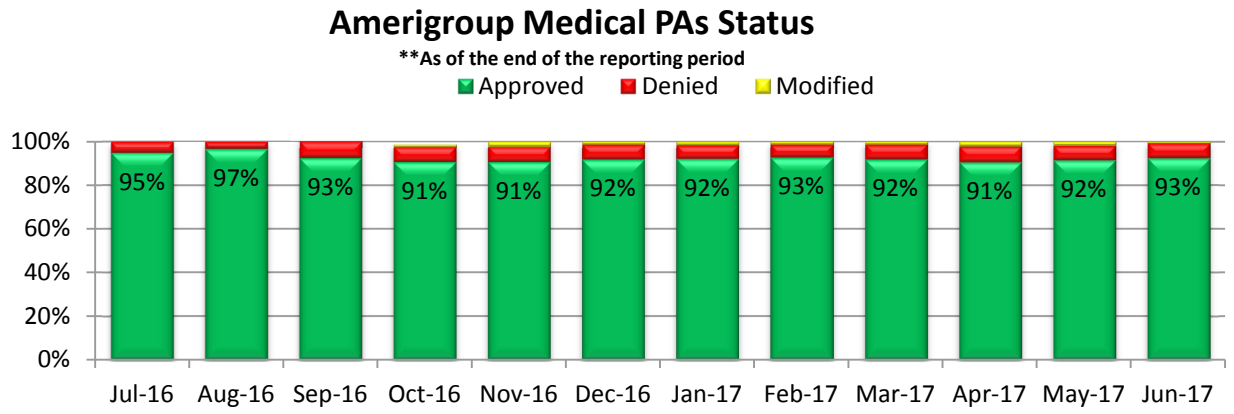
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

100% of PAs for Expedited Services Must be Authorized Within 3 Business Days of Request

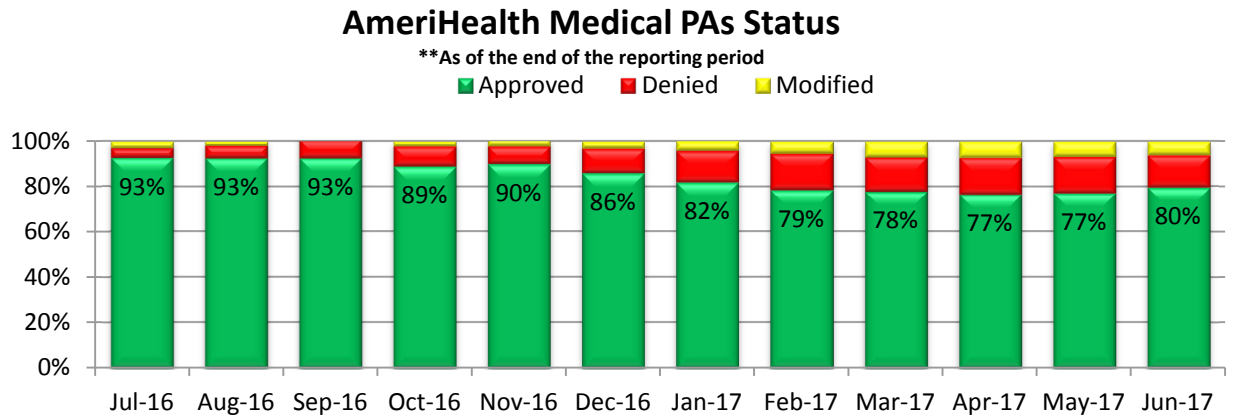


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

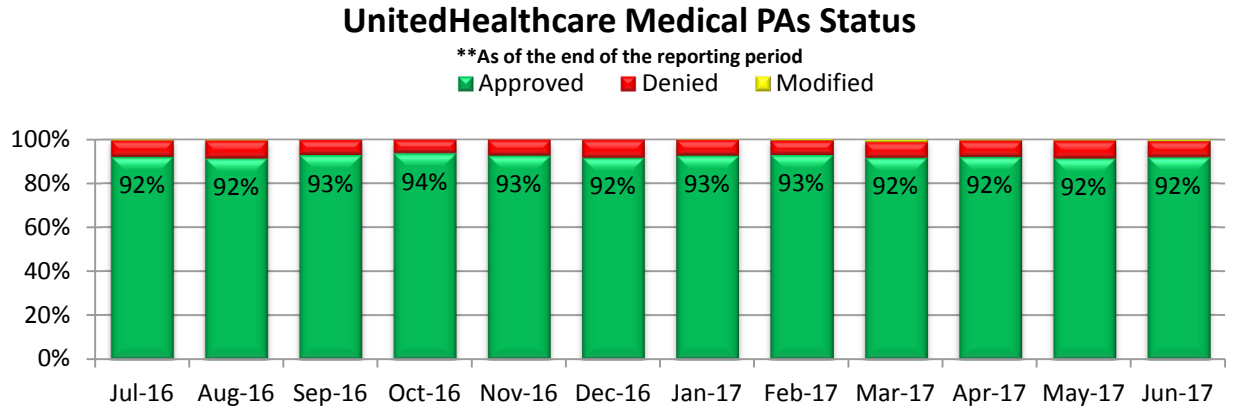
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract.



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.

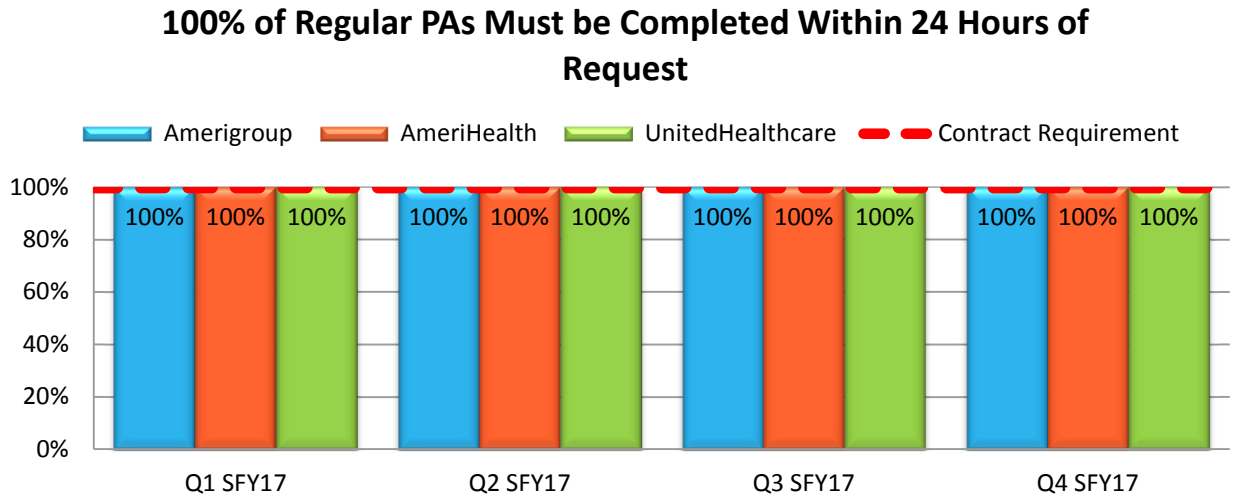


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



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.

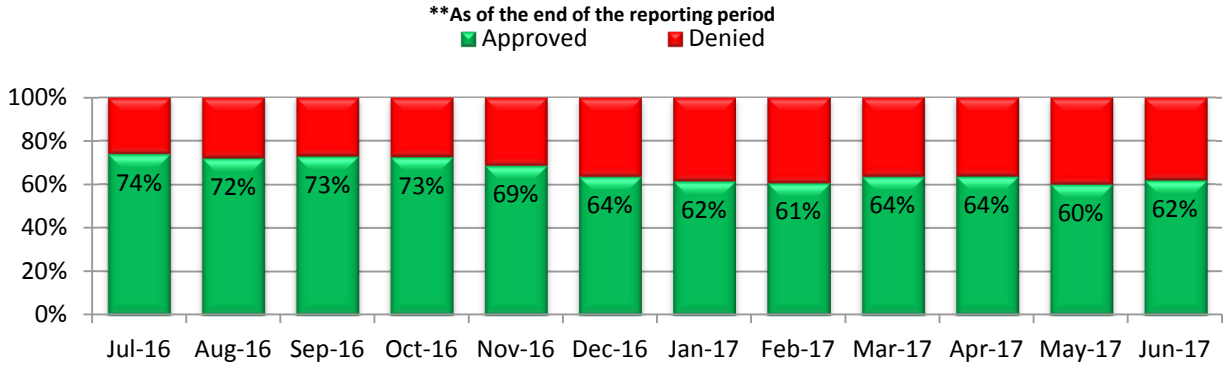
Prior Authorization - Pharmacy



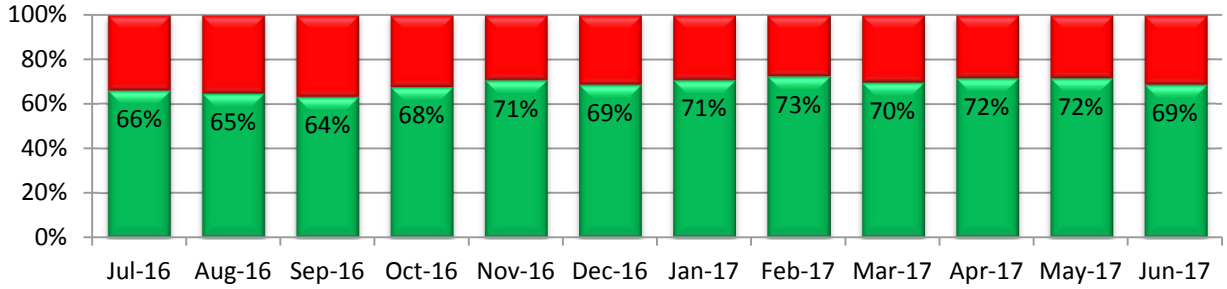
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service PA process and volume may differ.

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

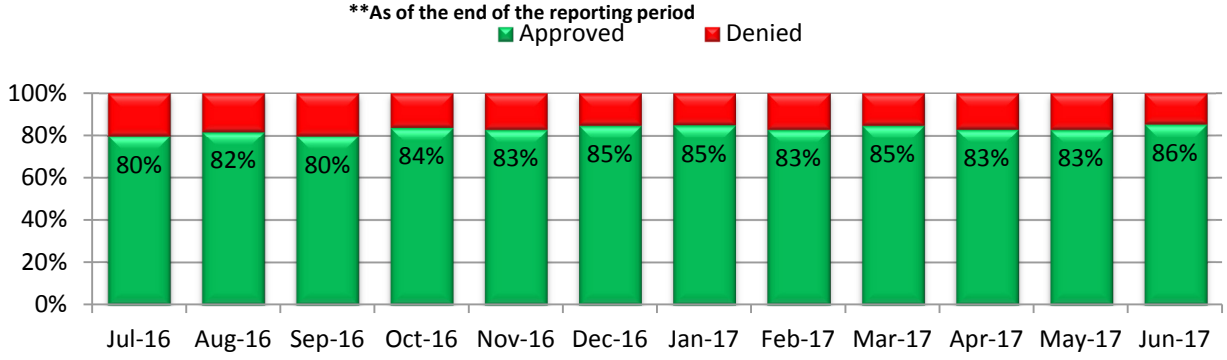
Amerigroup Pharmacy PAs Submitted Status



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 Timely By 20th of the Month	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
	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 June 2017	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement	16.2%	0%	28.7%

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.

Q4 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	101.6%	108.5%	102.6%
ALR	6.8%	8.4%	11.7%
Underwriting	-8.4%	-16.9%	-14.3%

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 combined Q4 calendar year 2016 (Q2 SFY17) and Q1 calendar year 2017 (Q3 SFY17) financial information submitted to the Iowa Insurance Division by each MCO.

The financial metrics presented here reflect financial performance for the contract period, i.e., the period beginning April 1, 2016. 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)**	$1,702,214,039	$1,583,553,786	$118,660,253

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 $118.7 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 2% 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 of total Medical claims payments before and after the managed care transition. 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.

Provider Type Reimbursement During Quarter by MCOs

Included in the data below are provider types with the highest amount of utilization. This data does not include an exhaustive list of all provider types or all reimbursements for each managed care organization.

Q4 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Hospital Claims Paid	$104,566,346	$99,491,089	$78,225,354	$282,282,789
Physician Claims Paid	$40,817,922	$48,777,058	$45,772,267	$135,367,247
HCBS Claims Paid	$22,208,133	$153,906,460	$9,116,591	$185,231,184
DME Claims Paid	$5,072,751	$10,771,592	$3,975,085	$19,819,428
Pharmacy Claims Paid	$51,917,635	$53,353,258	$42,080,144	$147,351,037
Home Health Claims Paid	$10,361,661	$18,151,023	$6,191,010	$34,703,694
Hospice Claims Paid	$6,791,548	$3,194,137	$1,725,656	$11,711,342
Nursing Facility Claims Paid	$67,237,103	$42,630,900	$44,375,817	$154,243,820
ICF/ID Claims Paid	$27,247,692	$35,782,943	$8,570,204	$71,600,840
Behavioral Health Claims Paid	$30,687,217	$34,446,604	$19,096,510	$84,230,331
Speech Therapy Claims Paid	$38,063	$12,001	$423,138	$473,201
Occupational Therapy Claims Paid	$2,044,204	$39,006	$322,343	$2,405,553
Non-Emergency Transportation Claims Paid	$2,475,100	$2,104,581	$1,712,523	$6,292,204

Population differences between plans are a factor in different levels of reimbursement by each plan for the provider types listed above.

This data is reflective of point in time and will change to reflect reprocessing associated with rate adjustments as well as recoveries related to program integrity and third party liability coverage.

Capitation Payments Made to the Managed Care Organizations				
MCO	**Q1 SFY17**	**Q2 SFY17**	**Q3 SFY17**	**Q4 SFY17**
Amerigroup	$238,096,189	$237,566,370	$250,682,589	$253,268,602
AmeriHealth	$444,903,457	$445,036,927	$457,263,121	$457,842,200
UnitedHealthcare	$209,092,263	$205,695,971	$222,018,555	$220,227,900

▲ Differences between quarters:

- Q1 SFY17, and Q2 SFY17 represent capitation payments for members in every program except for Hawk-i.
- Q3 SFY17 represents capitation payments for members in all programs managed by MCOs, including Hawk-i.
- The above totals are point-in-time representations made by DHS and may vary based on the date the data is pulled, as well as based on ongoing reconciliations.

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 Q4 SFY17			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Amount of TPL Recovered	$9,227,609	$26,270,230	$21,039,239

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	84	86	46
Overpayments Identified During the Quarter	22	0	2
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	10	42	7
Member Concerns Referred to IME	1	20	2

In prior reports, dollars recovered through Program Integrity efforts were reported on a quarterly basis. However, MCOs may not collect overpayment until review by the agency has been completed to assure law enforcement activities have been conducted. Given the review and approval process required by the state to collect dollars, recoveries may occur at a much later date. Due to the complexity of actual collection of dollars, recovery of overpayments will be reported on an annual basis. The MCOs have attended more than nine meetings or on-site visits with regulators during this quarter. The plans have initiated 216 investigations in the second quarter and referred 59 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	Amerigroup			AmeriHealth			UnitedHealthcare		
	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
Members (from IME)	200,461	200,695	200,086	225,252	225,234	224,600	191,644	191,807	191,434
Total Inpatient Admissions	1,323	1,360	1,314	1,464	1,607	1,369	736	761	768
Readmissions within 15 days of Discharge	72	81	85	190	190	156	96	118	100
Readmissions between 16 and 30 days of Discharge	28	38	38	88	87	59	42	44	44
Readmissions between 31 and 45 days of Discharge	25	14	13	60	72	61	18	30	33
Readmissions between 46 and 60 days of Discharge	2	1	2	80	57	47	28	16	17

*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 during this reporting period and does not account for a claims that have not yet been submitted.

Emergency Department									
Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
ED Visits for Non-Emergent Conditions – Adult	19.0	18.6	19.5	55.9	56.2	54.6	15	18	18
ED Visits for Non-Emergent Conditions – Child	19.3	16.8	15.8	31.2	29.1	25.5	10	10	10
Supporting Data									
Members (from IME)	200,461	200,695	200,086	225,252	225,234	224,600	191,644	191,807	191,434
Members Using ED More Than Once in 30 Days	475	466	473	2,955	2,988	2,872	509	557	641
Members Using ED More Than Once between 31 and 60 Days**	341	314	364	1,355	1,431	1,278	256	279	274

*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. ED Visits for Non-Emergent Conditions are reported per 1,000 member months.

The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted.

Out-of-State Placement*									
Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	Apr	May	Jun	Apr	May	Jun	Apr	May	Jun
Members in Out-of-State PMIC	10	13	11	9	8	9	0	0	0
Members in Out-of-State Skilled Nursing Facility	17	20	15	39	37	38	10	10	11
Members Placed in an Out-of-State ICF/ID	3	3	3	1	1	1	1	1	1
Members in Out-of-State nursing facilities	1	1	1	0	0	0	0	0	0
Members in Out-of-State Other Institutions	0	0	0	9	11	12	2	2	2

The data is based on claims paid during this reporting period and does not account for claims that have not yet been submitted.

APPENDIX

HCBS Waiver Waitlist –July 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	34	1,459	1,037	7,918	2,178	12,004	940
Number of Individuals on Waiver Waitlist (DHS Function)	0	953	1,067	0	2,770	2,760	1,214
Waitlist Increase or (Decrease)	0	+156	+232	0	+172	+378	-120

As reported in July 2017. July data represents June 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**
24 Hour Provider Access Report	1	1	-	2
Adult Preventative Care Report	1	-	-	1
Behavioral Health Population Report	-	-	-	-
Care Coordination Report	-	-	1	1
Correct Coding Initiative Report	-	-	-	-
Claims Processing Report	1	-	1	2
Elderly Population Report	-	-	-	-
Fall Risk Report	-	-	-	-
General Population Report	-	-	-	-
Geographic Access Report	-	-	-	-
Grievances and Appeals	-	1	-	1
Level of Care Assessment Report	1	1	1	3
Med PA – Regular Report	1	-	-	1
Pharmacy Helpline Report	1	-	-	1
Prenatal and Childbirth Outcomes Report	-	-	-	-
Program Integrity Report	1	-	1	2
Provider Credentialing Report	1	-	-	1
Provider Helpline Report	-	-	-	-
Provider Type Reimbursement	-	-	-	-
Risk Assessment Report	1	-	-	1
Special Needs Population Report	-	-	-	-
Staff Resources Monitoring Report	-	-	-	-
Third Party Liability	-	-	-	-
Value Based Purchasing Report	-	-	-	-
Waivers Report	1	-	1	2
Grand Total	**10**	**3**	**5**	**18**

Type of Noncompliance Identified by MCO During this Reporting Period				
Type of Noncompliance	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**	**Grand Total**
Did not meet performance standard	8	3	3	14
Incomplete/Untimely/Inaccurate	2	0	2	4
Grand Total	**10**	**3**	**5**	**18**

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

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.

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.

CBCM: Community based case management. Community based case managers are responsible for coordinating services and health outcomes for Medicaid LTSS members.

CDAC: Consumer Directed Attendant Care. In the Home and Community Based Services (HCBS) waiver program, there is an opportunity for people to have help in their own homes. CDAC services are designed to help people do things that they normally would for themselves if they were able such as bathing, grocery shopping, medication management, household chores.

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.

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.

DME: Durable Medical Equipment

ED: Emergency department

Fee-for-Service (FFS): Some Iowa Medicaid members are served through a Fee-for-Service (FFS) system where their health care providers are paid separately for each service (like an office visit, test, or procedure). Members who are not transitioning to the IA Health Link managed care program will remain in Medicaid FFS.

HCBS: Home- and Community-Based Services, waiver services

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: An individual on staff or subcontracted with a managed care organization that manages the health of members with chronic health conditions.

Health Risk Assessment (HRA): A questionnaire to gather health information about the member which is used to evaluate health risks and quality of life.

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: A program that provides in-home medical services by Medicare-certified home health agencies.

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: A team of professionals working together to provide whole-person, patient centered, coordinated care for adults with a serious mental illness (SMI) and children with a serious emotional disturbance (SED).

LOC: Level of Care.

LTSS: Long Term Services and Supports

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

MCO: Managed Care Organization

NF: Nursing Facility

PA: Prior Authorization. A PA is a requirement that the provider obtain approval from the health plan to prescribe medication or service. PA ensures that services and medication delivered through the program are medically necessary.

PCP: Primary Care Provider

PDL: Preferred Drug List

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.

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.