Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2017, Quarter 2
(October - December)
Performance Data

Published March 10, 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 2 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,

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[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.

DEMOGRAPHICS

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

- The Medical Loss Ratio information is reflected as directly reported by the MCOs.
- Several data elements in the Q4 SFY16 report (the first 3 months of roll out) were under review at the time of the report and the methodology of data reporting was clarified and updated. However, as noted in the text of the report we did not revise Q4 SFY16 data.
- 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

DEMOGRAPHICS

Managed Care Enrollment by Age
Total MCO Enrollment = 567,943*
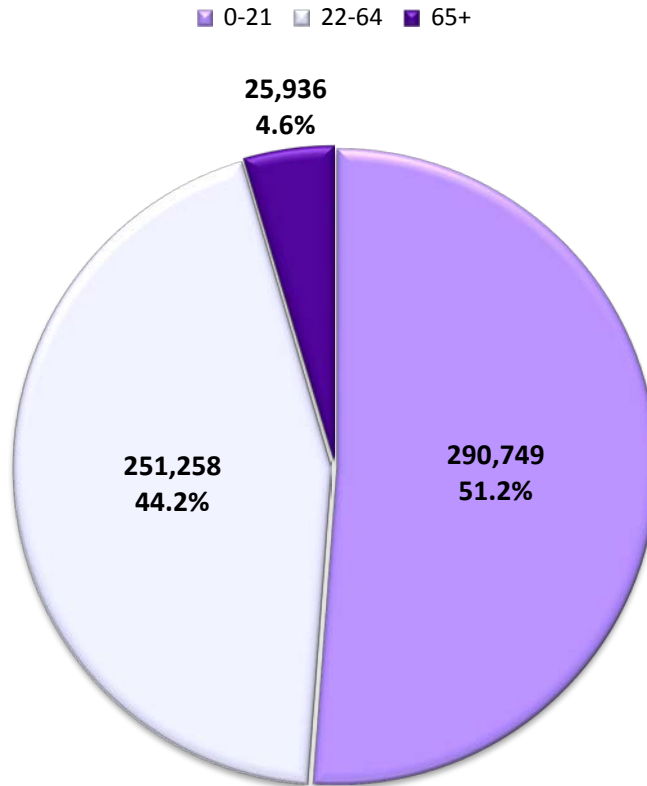
■ 0-21   ☐ 22-64   ■ 65+

25,936
4.6%

251,258
44.2%

290,749
51.2%

*December 2016 enrollment data as of January 31, 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. 49,988 members remain in the Fee-for-Service (FFS) program.

DEMOGRAPHICS

MCO Plan Enrollment Distribution
Total MCO Enrollment = 567,943*

■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare
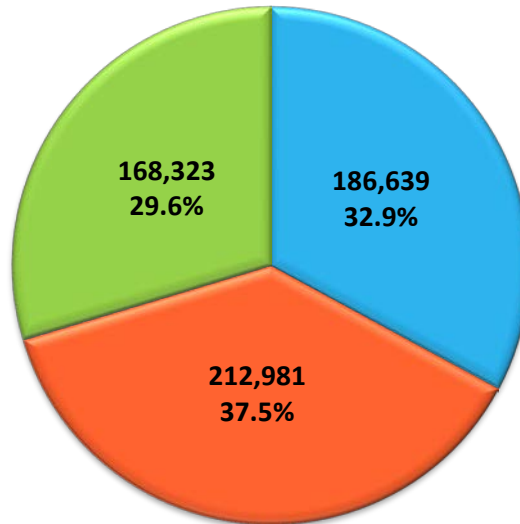
Amerigroup Plan Assignment	AmeriHealth Plan Assignment	UnitedHealthcare Plan Assignment
■ Self-Selection ☐ Default Assignment	■ Self-Selection ☐ Default Assignment	■ Self-Selection ☐ Default Assignment
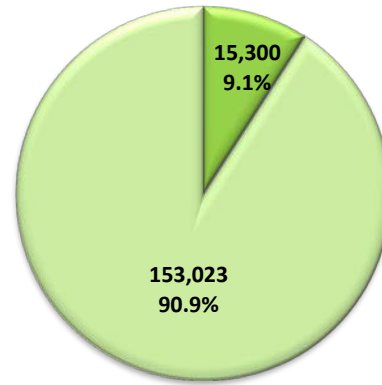
*December 2016 enrollment data as of January 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes. This does not include *hawk-i* enrollees. 49,988 members remain in the Fee-for-Service (FFS) program.
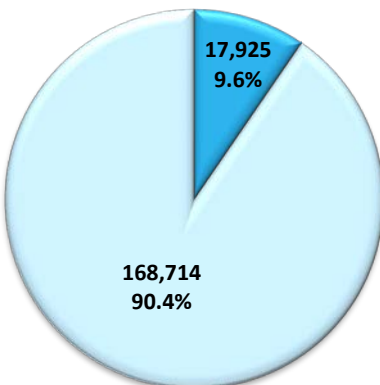
From the time tentative assignments were made in the fall of 2015 until the end of this quarter, about 173,959 members including *hawk-i* self-selected an MCO.

DEMOGRAPHICS

All MCO Enrollment by Program
Total MCO Enrollment = 605,708*

■ hawk-i   ■ Medicaid   ■ Iowa Wellness Plan

139,895
23.1%

37,765
6.2%

428,048
70.7%

Traditional Medicaid
Enrollment = 428,048

■ Amerigroup
■ AmeriHealth
■ UnitedHealthcare

124,739
29.1%

138,650
32.4%

164,659
38.5%
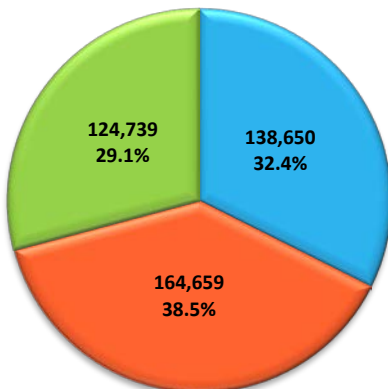
Iowa Wellness Plan
Enrollment = 139,895

■ Amerigroup
■ AmeriHealth
■ UnitedHealthcare

43,584
31.2%

47,989
34.3%

48,322
34.5%
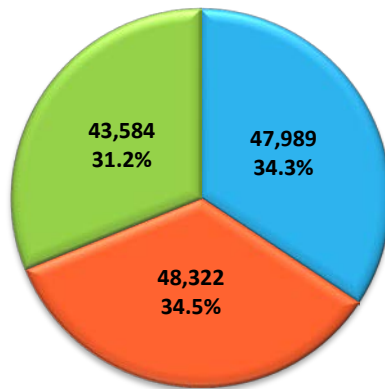
hawk-i
Enrollment = 37,765

■ Amerigroup
■ AmeriHealth
■ UnitedHealthcare
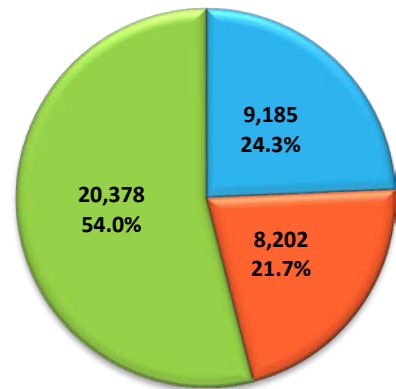
9,185
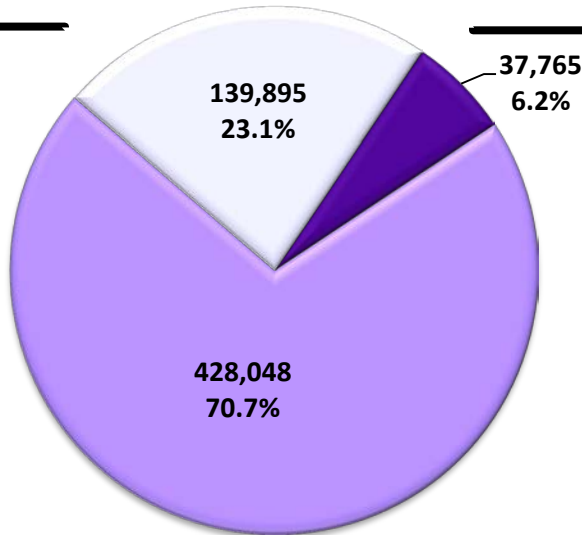24.3%

20,378
54.0%

8,202
21.7%

*December 2016 enrollment data as of January 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

DEMOGRAPHICS

Members Changing from One MCO to Another*

Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare
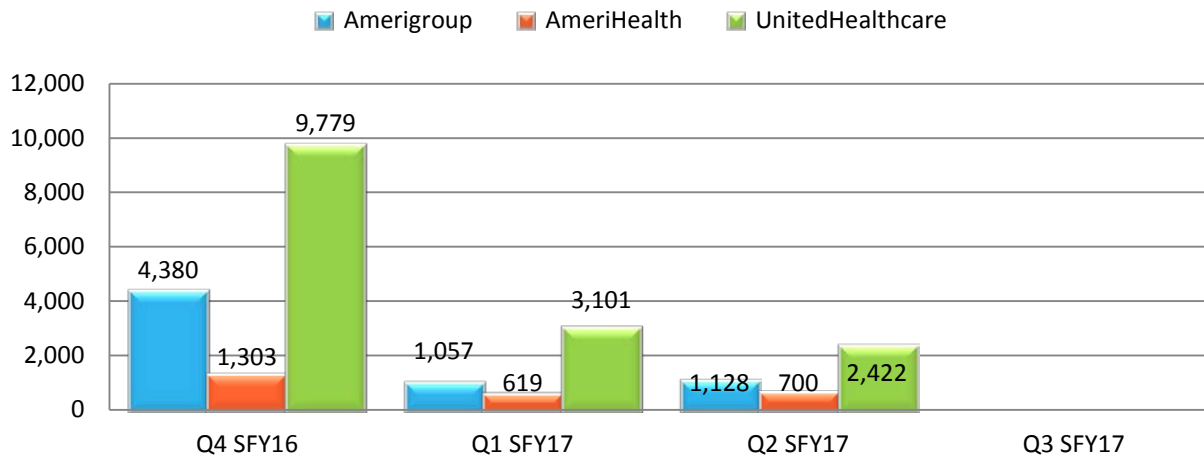
*Q2 SFY17 enrollment data as of January 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

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 Q2 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	2548
Lack of access to services covered under the contract	121
Lack of access to providers experienced in dealing with the member's health care needs	78
Continuity of care	52
Quality of care	36

LTSS Managed Care Enrollment by Location
MCO LTSS Enrollment = 37,219*

▪ Community Based Services   ▫ Facility Based Services (ICF/ID, Nursing Facility, PMI)

13,858
37.2%

23,361
62.8%
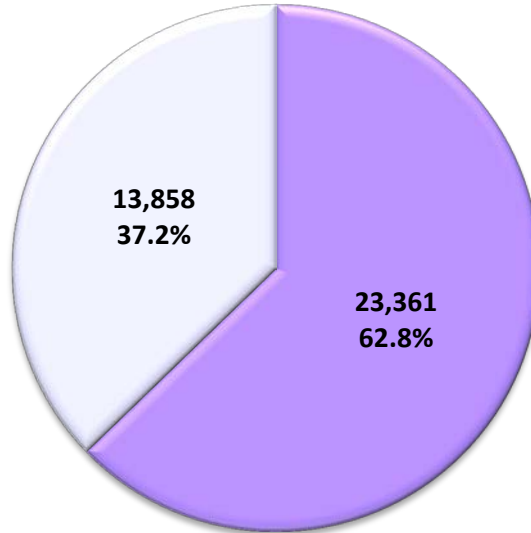
Total MCO LTSS Enrollment by Plan

Amerigroup LTSS
Enrollment = 7,633

▪ Community Based Services

▫ Facility Based Services

3,214
42.1%

4,419
57.9%
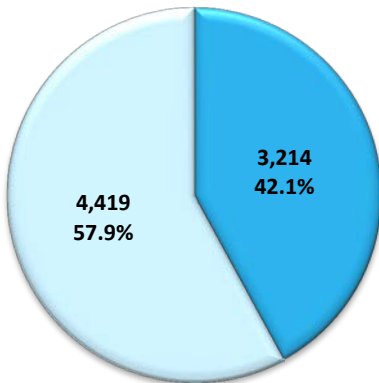
AmeriHealth LTSS
Enrollment = 23,310

▪ Community Based Services

▫ Facility Based Services

5,912
25.4%

17,398
74.6%
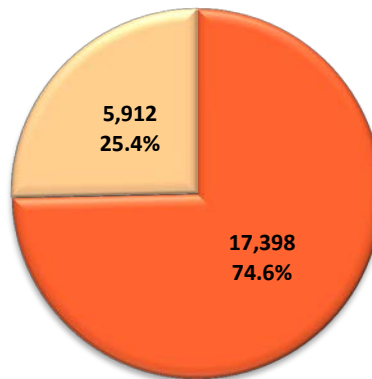
UnitedHealthcare LTSS
Enrollment = 6,276

▪ Community Based Services
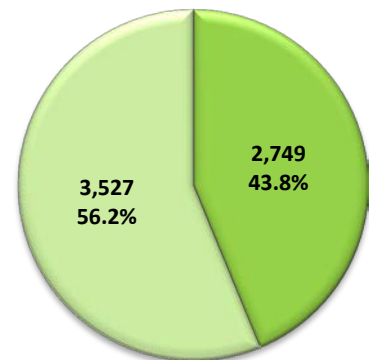
▫ Facility Based Services

2,749
43.8%

3,527
56.2%

*December 2016 enrollment data as of January 31, 2017 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

LONG TERM SERVICES AND SUPPORTS

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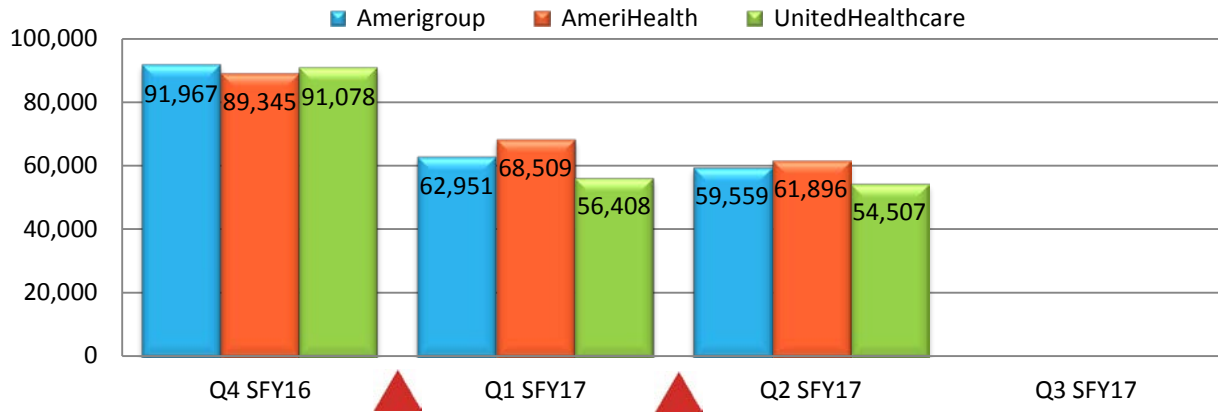
Adult: Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

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 a 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.

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

Adult: Members Assigned a Health Care Coordinator
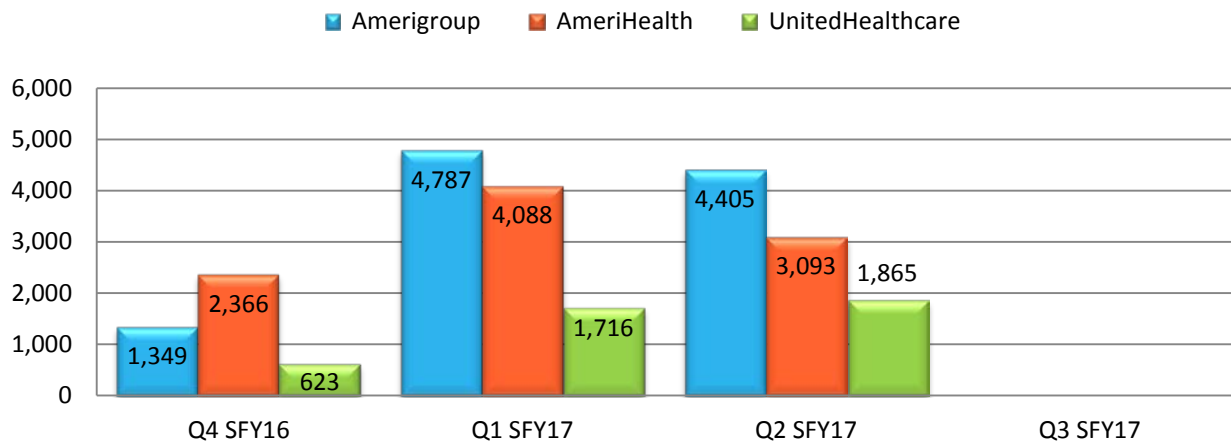
■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	1,349	4,787	4,405	
AmeriHealth	2,366	4,088	3,093	
UnitedHealthcare	623	1,716	1,865	

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

Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

	Amerigroup	AmeriHealth	UnitedHealthcare
Q4 SFY16	41% / 41,297	29% / 27,115	33% / 23,372
Q1 SFY17	36% / 19,014	53% / 22,212	85% / 1,230
Q2 SFY17	33% / 1,777	35% / 2,485	96% / 560
Q3 SFY17			

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. 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 who 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

■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare

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

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
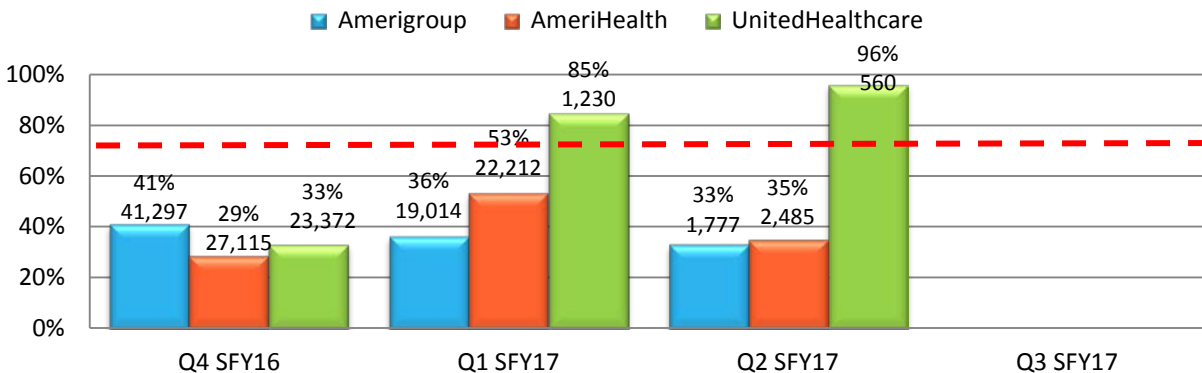
GENERAL POPULATION REPORTING

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 a 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.

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

Child: Members Assigned a Health Care Coordinator
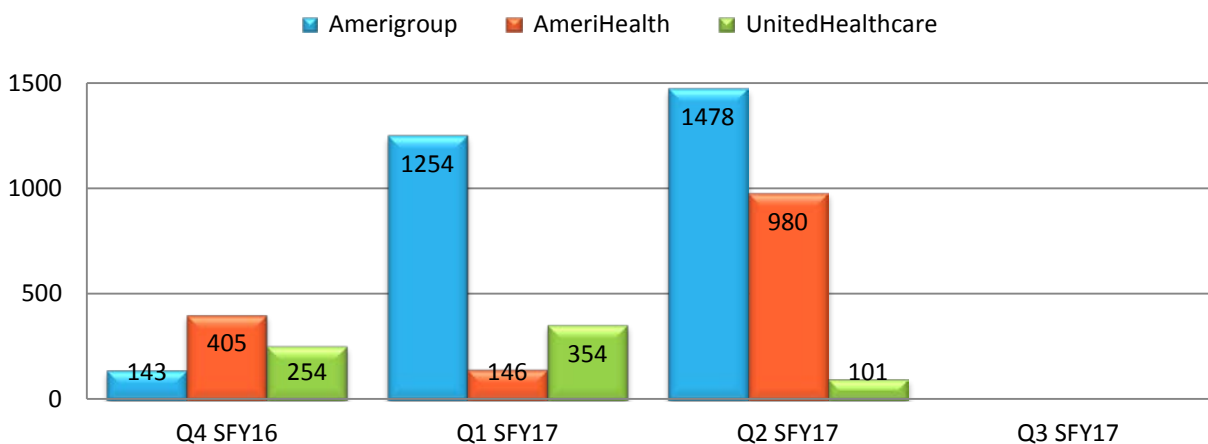
Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. This is a new and more comprehensive health care coordination 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 managed care organizations due to the scope of care coordination services reported.

Child: 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. 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 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.

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:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- 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

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

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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.

Special Needs Adults 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 a 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.

▲ Differences between quarters:

- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

Special Needs Adults in Facility Settings: Average Aggregate Cost per Member per Month
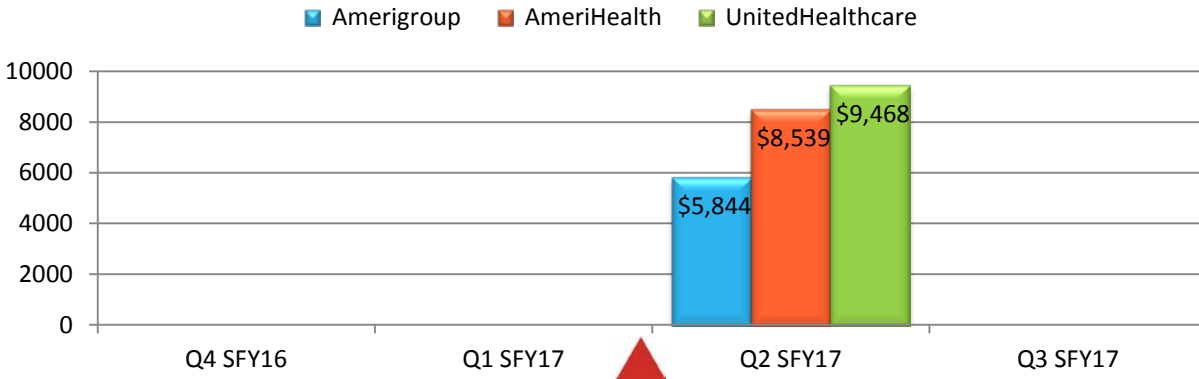
Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

Q2 SFY17 values: $5,844 (Amerigroup), $8,539 (AmeriHealth), $9,468 (UnitedHealthcare)

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 a 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 (8-12%) of claims may not be included in this measure.

Adult: Members Assigned a Community-Based Case Manager
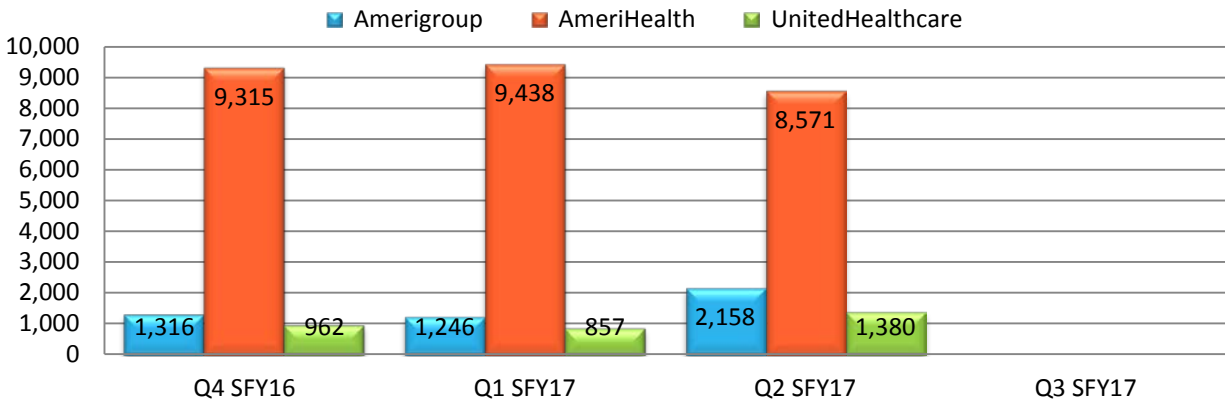
Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17
Amerigroup	1,316	1,246	2,158
AmeriHealth	9,315	9,438	8,571
UnitedHealthcare	962	857	1,380

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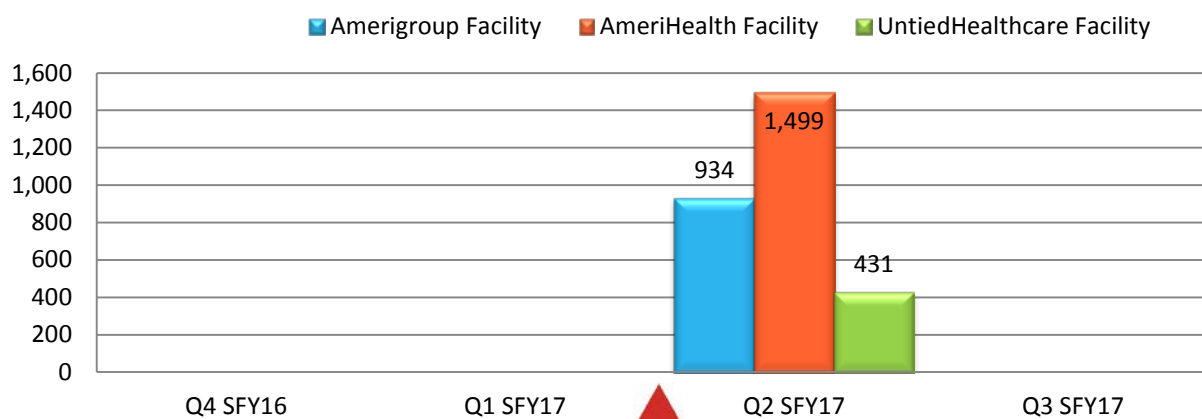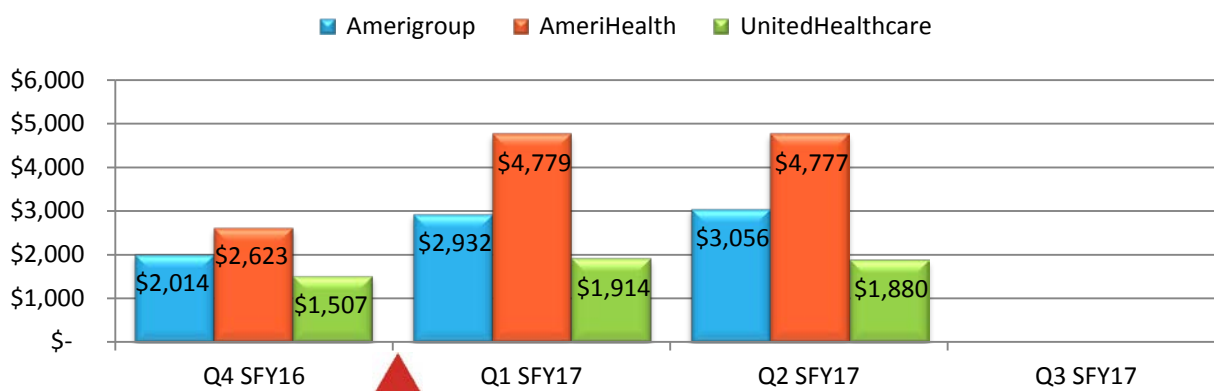trategy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

Adult: Number of Community-Based Case Manager Contacts for Members in a Community-Based Setting
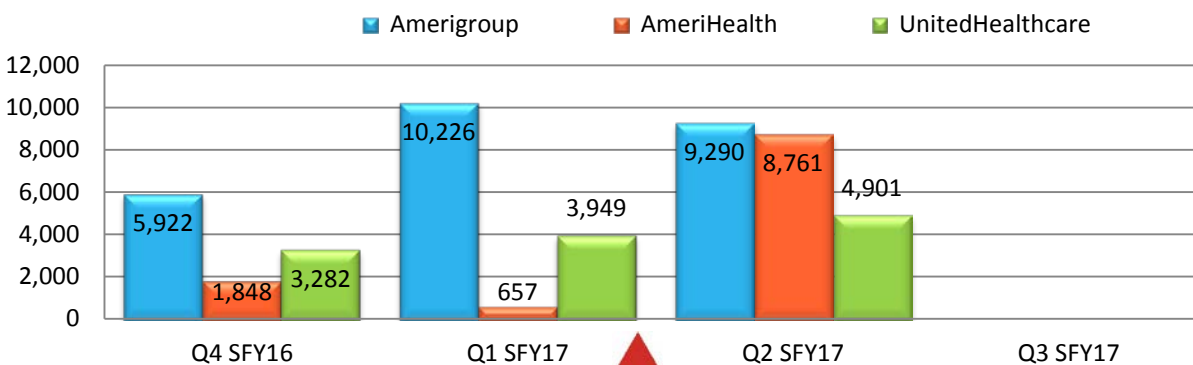
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.

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

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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.

Community-Based Case Management Ratios

The ratios below reflect combined adult and child populations for these waivers where applicable.

Data Reported as of January 30, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager - Brain Injury	4.0	2.9	2.0
Ratio of Member to Case Manager - Health and Disability	13.9	2.7	4.7
Ratio of Member to Case Manager - HIV/AIDS	1.1	1.1	1.1
Ratio of Member to Case Manager - Intellectual Disability	21.3	15.7	7.8
Ratio of Member to Case Manager - Physical Disability	7.7	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.

Child: Members Served in Community-Based Settings

■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	490	475	449	
AmeriHealth	1,804	1,823	1,784	
UnitedHealthcare	467	408	421	

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

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q4 SFY16 and Q1 SFY17 include 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.

Child: Members Served in a Facility

Legend: ■ Amerigroup Facility ■ AmeriHealth Facility ■ UnitedHealthcare Facility

Chart (Q4 SFY16, Q1 SFY17, Q2 SFY17, Q3 SFY17):
- Q2 SFY17: Amerigroup Facility = 45, AmeriHealth Facility = 88, UnitedHealthcare Facility = 23
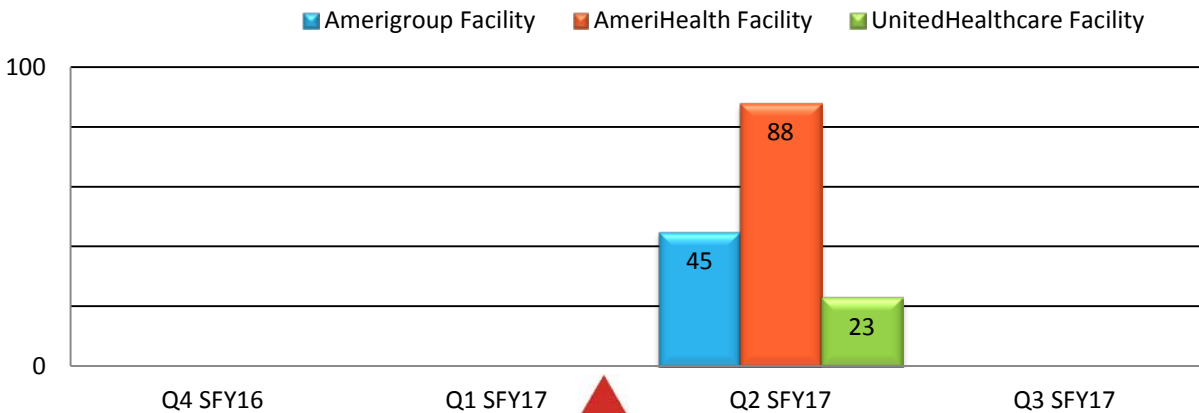
Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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 facility based members.

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

Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

Chart (Q4 SFY16, Q1 SFY17, Q2 SFY17, Q3 SFY17):
- Q4 SFY16: Amerigroup = $1,547, AmeriHealth = $1,065, UnitedHealthcare = $1,499
- Q1 SFY17: Amerigroup = $1,949, AmeriHealth = $2,317, UnitedHealthcare = $1,533
- Q2 SFY17: Amerigroup = $1,915, AmeriHealth = $2,317, UnitedHealthcare = $1,367

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 a 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.

▲ Differences between quarters:

- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average aggregate cost per member if the member does not utilize services during that time.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

Special Needs Children in Facility Setting: Average Aggregate Cost per Member per Month
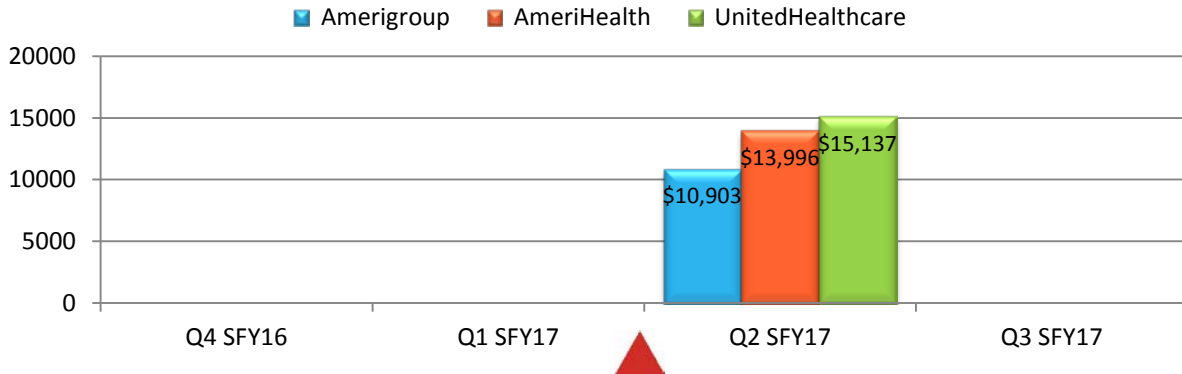
This data element is new as of Q2 SFY17. The aggregate average cost includes health care and pharmacy services for members in facility settings. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that 8-12% of claims may not be included in this measure.

Child: Members Assigned a Community-Based Case Manager
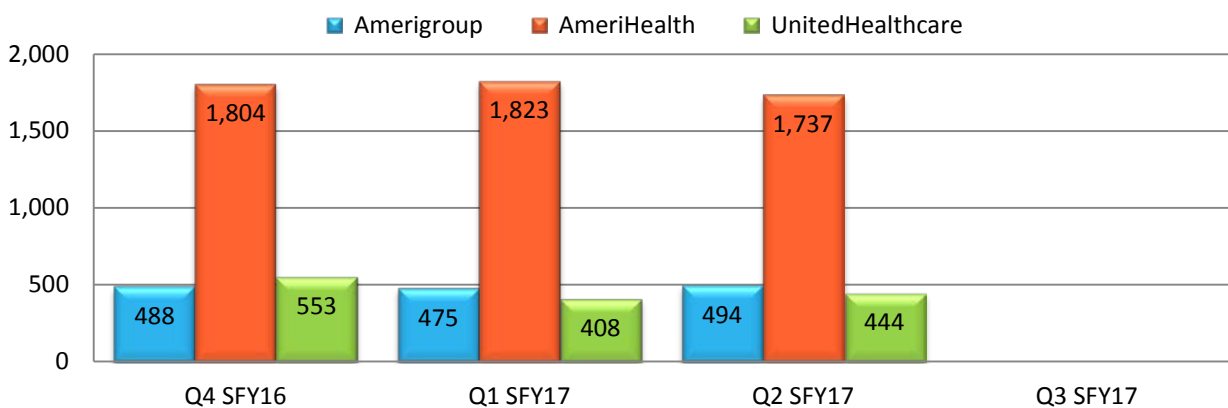
While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

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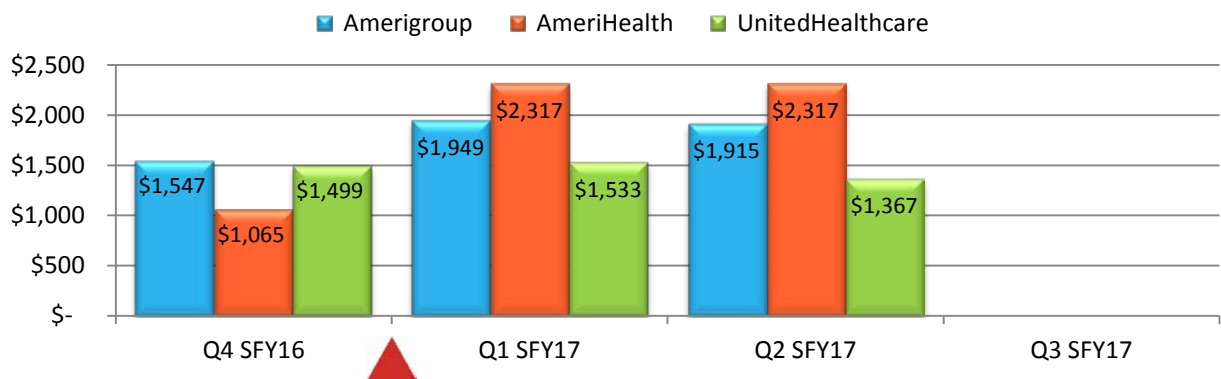egy than was available in fee-for-service. Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

Child: Number of Community-Based Case Manager Contacts for Members in Community-Based Settings
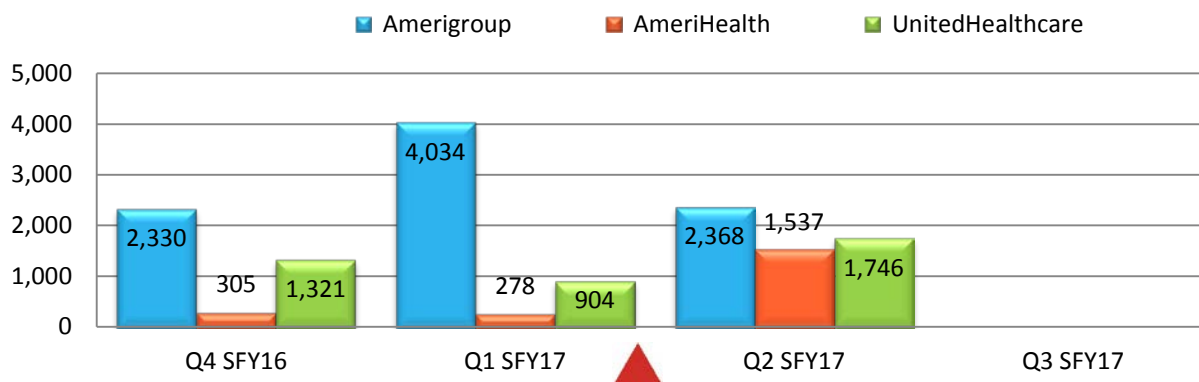
🔺 Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for community-based members.

Child: Number of Community-Based Case Manager Contacts for Members in a Facility
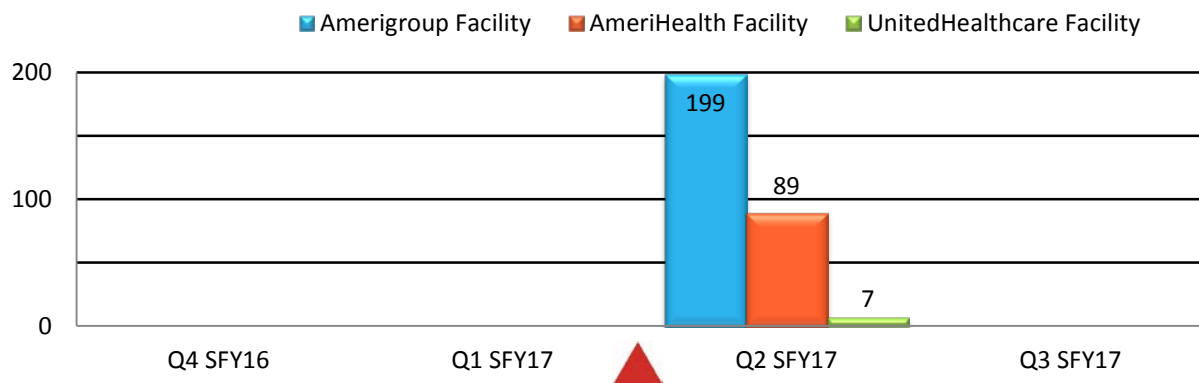
🔺 Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows contacts split out for members in a facility.

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.

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

Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

Quarter	Amerigroup	AmeriHealth	UnitedHealthcare
Q4 SFY16	9,920	10,771	4,064
Q1 SFY17	25,797	26,274	25,783
Q2 SFY17	27,572	32,781	25,803
Q3 SFY17			

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

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- 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

■ Amerigroup Facility ■ AmeriHealth Facility ■ UnitedHealthcare Facility

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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.

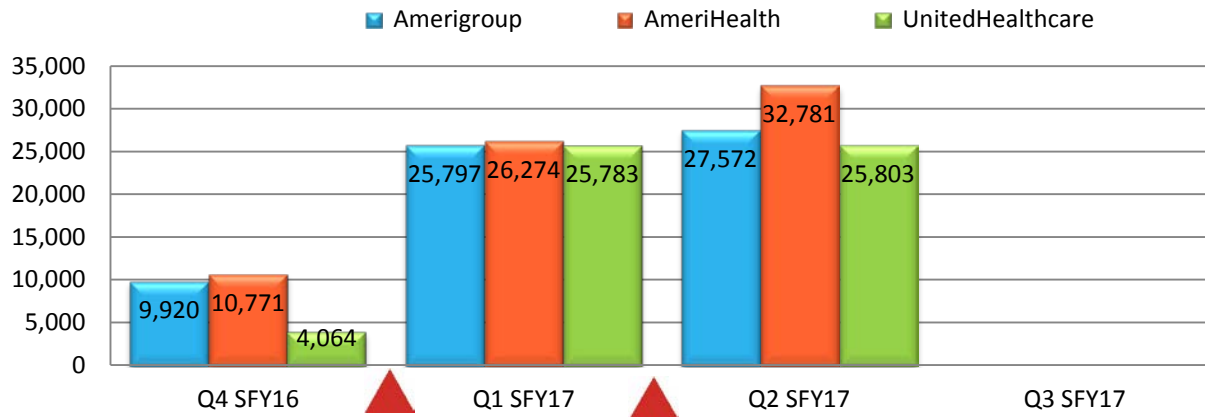## Adult: Average Aggregate Cost per Member per Month

■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

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 a 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.

▲ Differences between quarters:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.

- 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 some variance.

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

Legend: ■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	1,596	5,277	6,831	
AmeriHealth	1,070	6,974	13,333	
UnitedHealthcare	610	7,354	3,352	

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
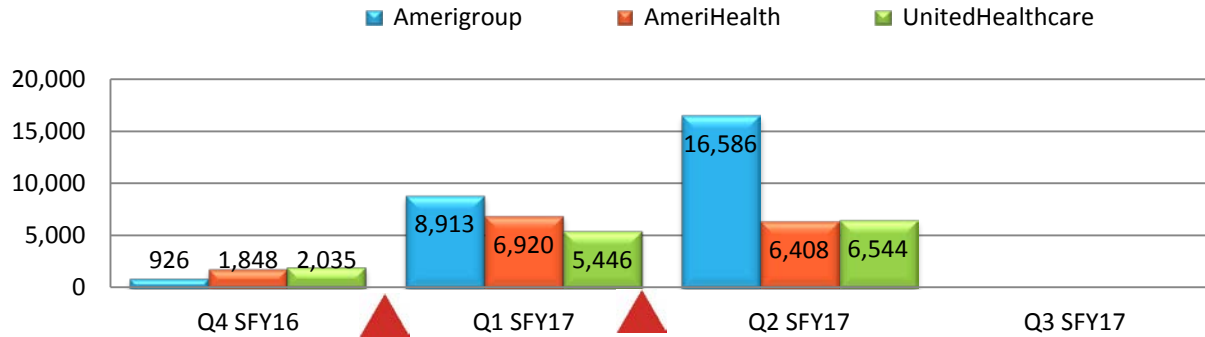
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total.
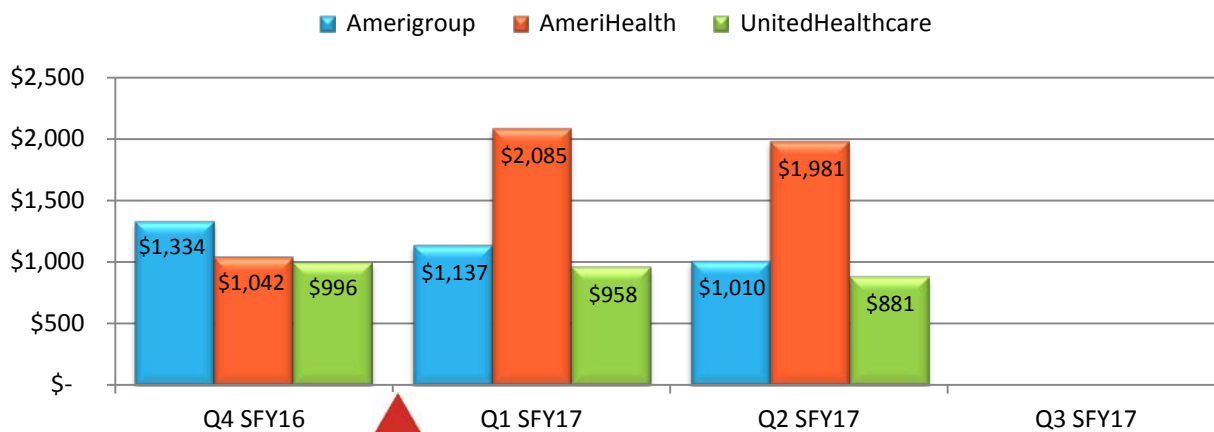- Q2 SFY17 shows a contacts split out for community-based members.

Adult: Number of Community-Based Case Manager and Integrated Health Home Care Coordinator Contacts for Members in a Facility
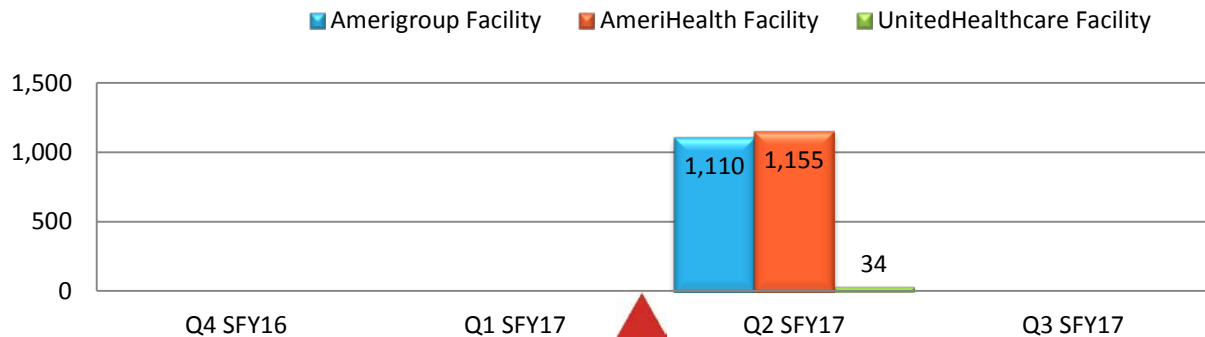
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows a contacts split out for members in a facility.

A small percentage of the members in this population receive 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.

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:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- 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 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: Members Served in a Facility

■ Amerigroup Facility ■ AmeriHealth Facility ■ UnitedHealthcare Facility

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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

■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

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 a 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.

▲ Differences between quarters:

- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- 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 variance.

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

Amerigroup ■ AmeriHealth ■ UnitedHealthcare ■

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

■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare
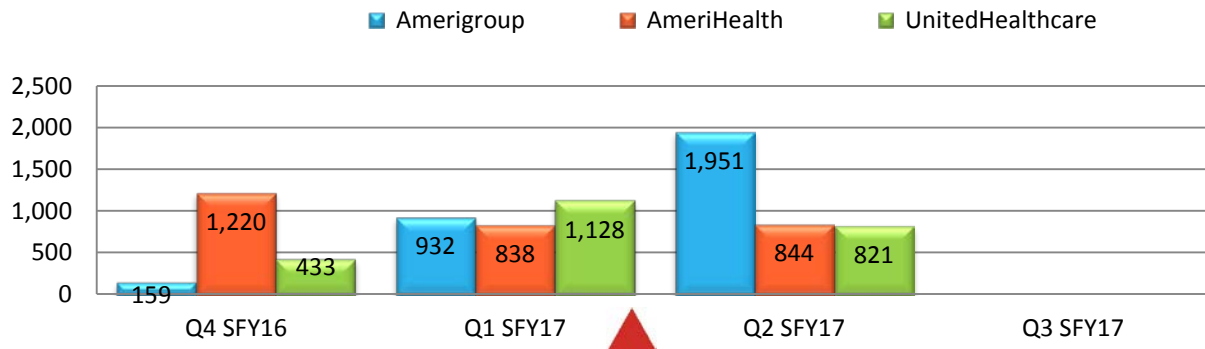
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows a contacts split out for members in community-based settings.

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

■ Amerigroup Facility   ■ AmeriHealth Facility   ■ UnitedHealthcare Facility
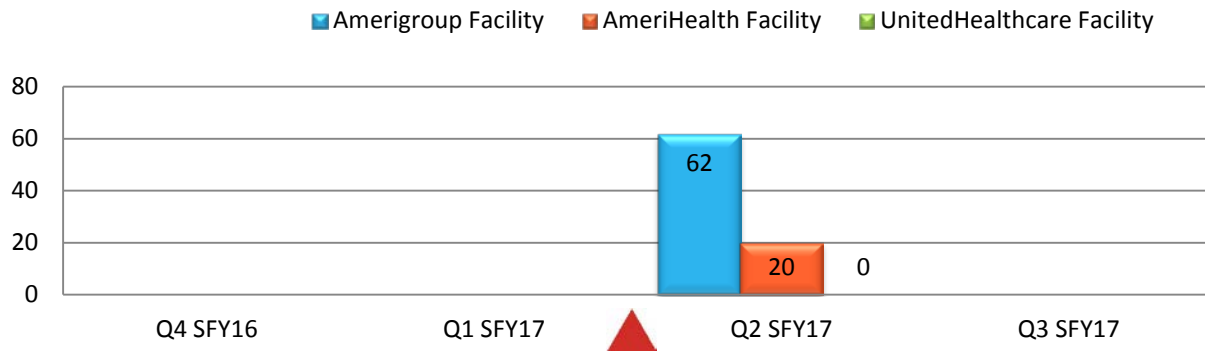
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total, which is shown on the previous chart.
- Q2 SFY17 shows a contacts split out for members in a facility.

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.

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.

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:
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.
- Q4 SFY16 and Q1 SFY17 include 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.

Members Served in a Facility

■ Amerigroup Facility   ■ AmeriHealth Facility   ■ UnitedHealthcare Facility

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 include 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.

Average Aggregate Cost per Member per Month
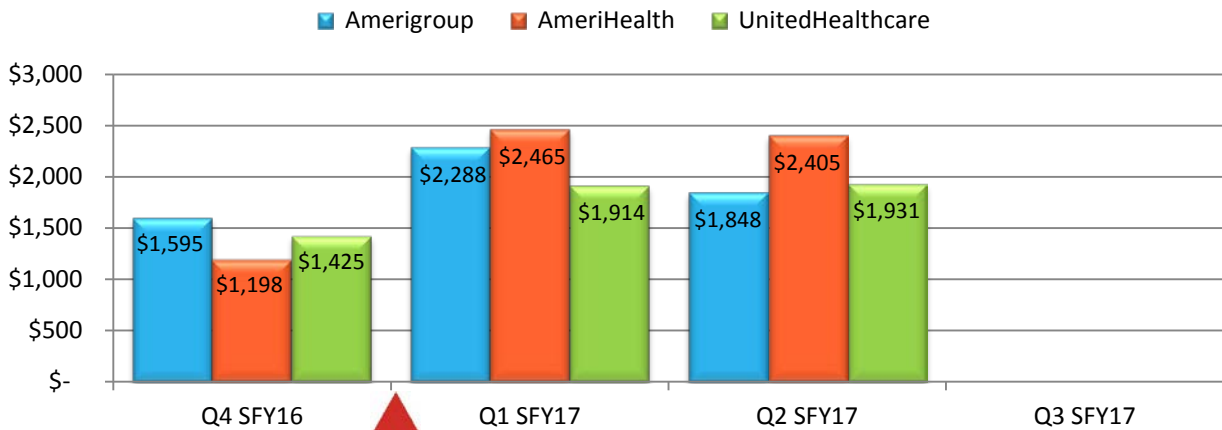
■ Amerigroup   ■ AmeriHealth   ■ UnitedHealthcare

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 a 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.

▲ Differences between quarters:
- Q4 SFY17 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO. This can create an artificially low average

aggregate cost per member if the member does not utilize services during that time.

- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.

Members Assigned a Community-Based Case Manager
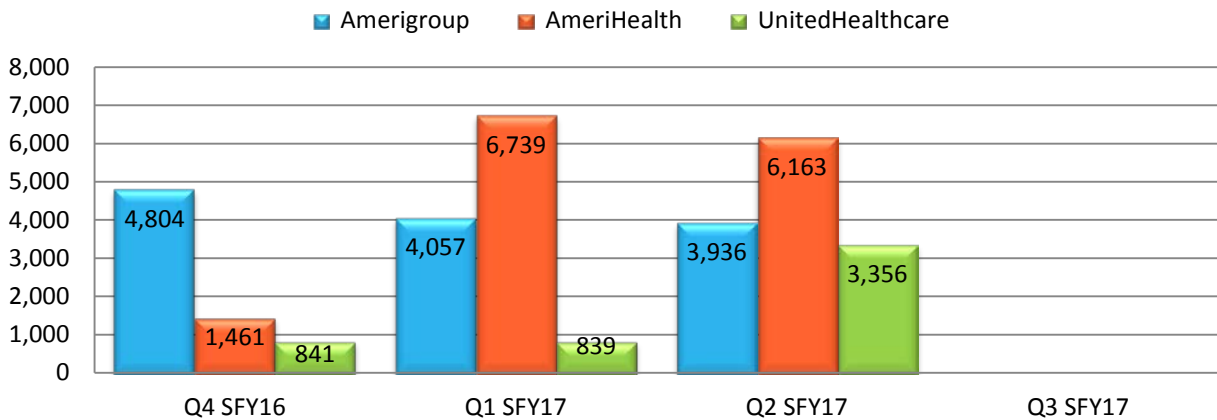
Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	4,804	4,057	3,936	
AmeriHealth	1,461	6,739	6,163	
UnitedHealthcare	841	839	3,356	

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.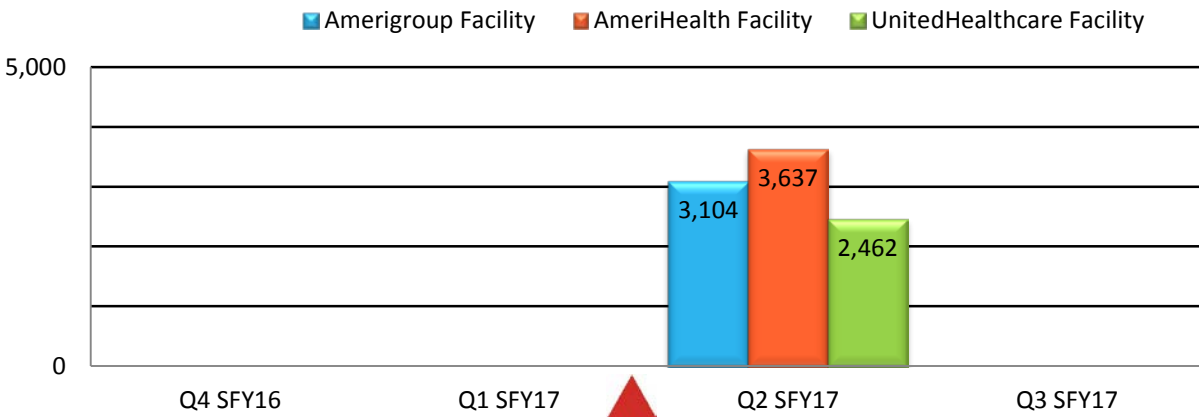 Members Assigned a Community-Based Case Manager represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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

Legend: ■ Amerigroup ■ AmeriHealth ■ UnitedHealthcare

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	14,686	13,187	14,892	
AmeriHealth	3,568	3,236	2,023	
UnitedHealthcare	11,831	3,314	6,772	
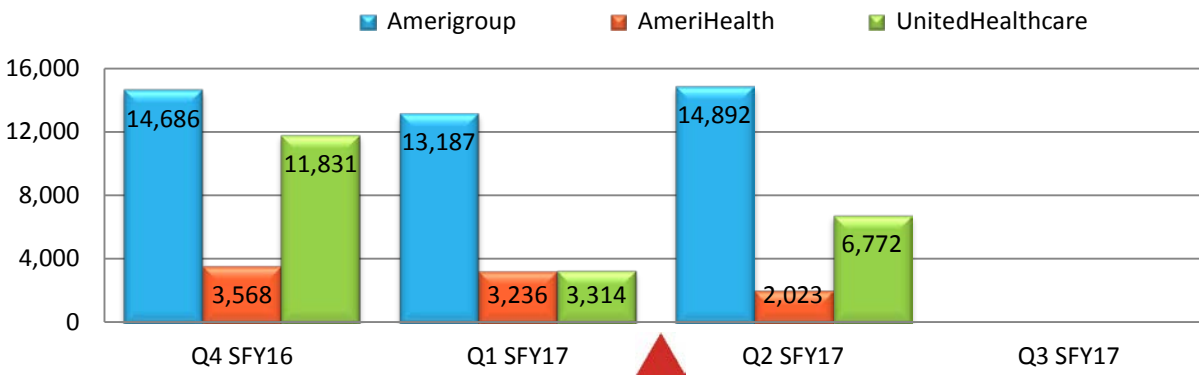
▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent contacts for members served in the community and in a facility as part of a combined total.
- Q2 SFY17 shows contacts split out for members in community-based settings.

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

▲ Differences between quarters:
- Q4 SFY16 and Q1 SFY17 represent 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.

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 January 30, 2017	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	17.0	17.3	8.0

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
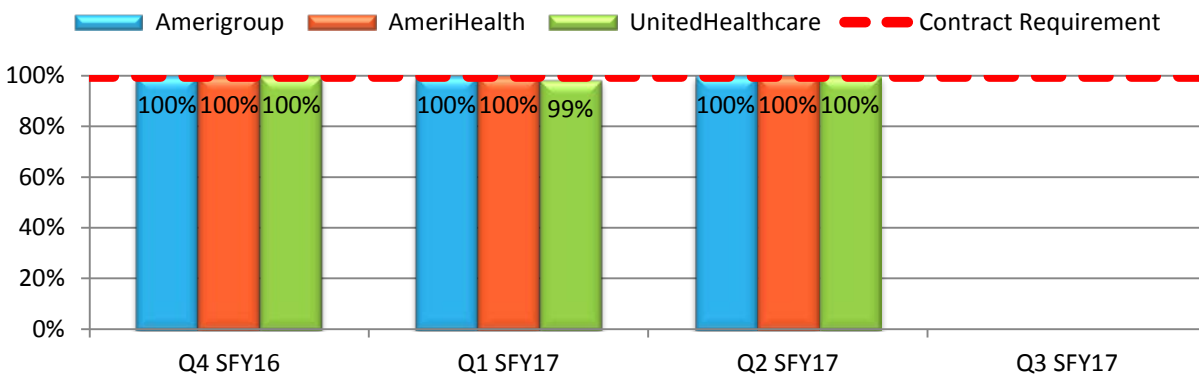
This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. If a member is not satisfied with the MCO's resolution to their grievance, the member may contact the Iowa Medicaid Enrollment Broker to disenroll if "good 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 Q4 SFY16	145	42	48
Grievances Received in Q1 SFY17	224	133	79
Grievances Received in Q2 SFY17	201	149	100

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

Top Five Reasons for Grievances for Q2 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	66	Transportation - No Pick-Up	26	Transportation	69
2	Voluntary Disenrollment Request	34	Provider Issue - Dissatisfied with Treatment or Service	18	Provider Issue- Balance Billing	21
3	Provider Issue- Balance Billing	27	Transportation - Driver Rude	13	Claim Processing - Auto- Adjudication Error at Original Processing	3
4	Effective dates of coverage	15	Transportation - Excessive Waiting	13	Quality of Care	2
5	Provider Issue – Attitude/Rudeness	11	Transportation - Staff (not Aide/not Driver) Rude	12	Provider Issue - Cleanliness of Provider Facility	1

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

100% of Appeals Resolved within 45 Calendar Days of Receipt
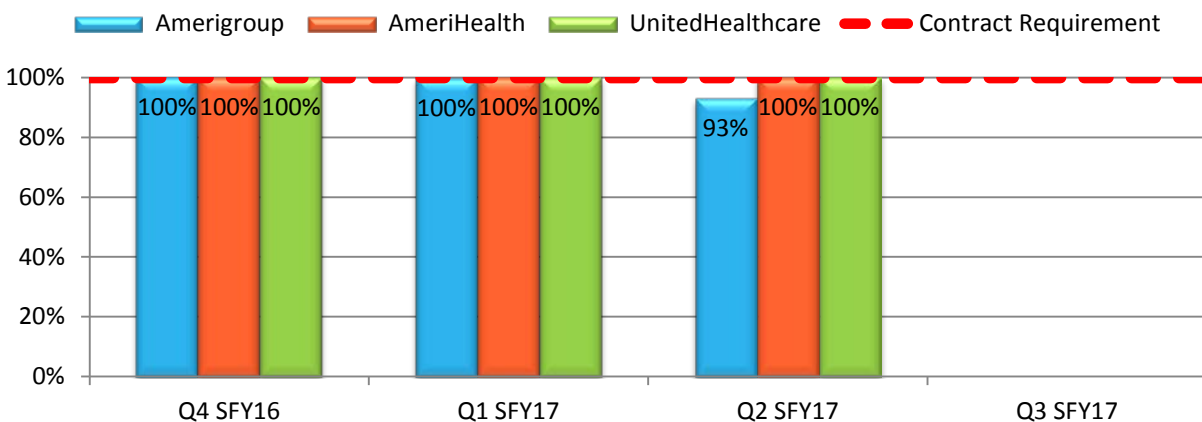
This measure represents appeals resolved within the contractual timeframes. If a member is not satisfied with the appeal decision, they may file an appeal with the state.

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Appeals Received in Q4 SFY16	14	52	50

CONSUMER PROTECTIONS AND SUPPORTS

Appeals Received in Q1 SFY17	370	216	100
Appeals Received in Q2 SFY17	473	230	115

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

Top Five Reasons for Appeals for Q2 SFY17

#	Amerigroup		AmeriHealth		UnitedHealthcare	
	Appeals	**Count**	**Appeals**	**Count**	**Appeals**	**Count**
1	Pharmacy - Non Injectable	94	Pharmacy	116	Pharmacy - Authorization	102
2	Behavioral Health – Authorization for Inpatient	61	Skilled Care/ Nursing	26	Medical – Utilization Review Dispute	36
3	Medical-Authorization for Inpatient	46	Medical – Authorization for Durable Medical Equipment	18	Pharmacy – Covered Services	34
4	Pharmacy-Injectable	35	Home Health Aide	14	Medical – Authorization for Durable Medical Equipment	10
5	Medical – Authorization for Radiology	20	Medical – Authorization for Radiology	14	Level of Care	6

State Fair Hearing Summary for Members in Managed Care CY 2016

Supporting Data			
	Amerigroup	**AmeriHealth**	**UnitedHealthcare**
Level of Care	14	1	12
Medical Service Denial/Reduction	35	50	39
Pharmacy Denial/Reduction	32	11	14
Durable Medical Equipment Denial/Reduction	1	4	3

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

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 December 2016	3,214	17,398	2,749
Special Needs Population			
# of Critical Incidents Received in Q2 SFY17	85	1,055	83
# Critical Incidents Received and Resolved in Q2 SFY17	85	1,033	83
% Critical Incidents Resolved in Q2 SFY17	100%	98%	100%
Behavioral Health Population			
# of Critical Incidents Received in Q2 SFY17	549	1,829	234
# Critical Incidents Received and Resolved in Q2 SFY17	549	1,795	234
% Critical Incidents Resolved in Q2 SFY17	100%	98%	100%
Elderly Population			
# of Critical Incidents Received in Q2 SFY17	50	347	27
# Critical Incidents Received and Resolved in Q2 SFY17	49	337	27
% Critical Incidents Resolved in Q2 SFY17	98%	97%	100%

CONSUMER PROTECTIONS AND SUPPORTS

Service Plans

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

100% of Service Plans Completed Timely

Legend: Amerigroup | AmeriHealth | UnitedHealthcare | Contract Requirement

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup		88%	94%	
AmeriHealth		75%	79%	
UnitedHealthcare		79%	100%	
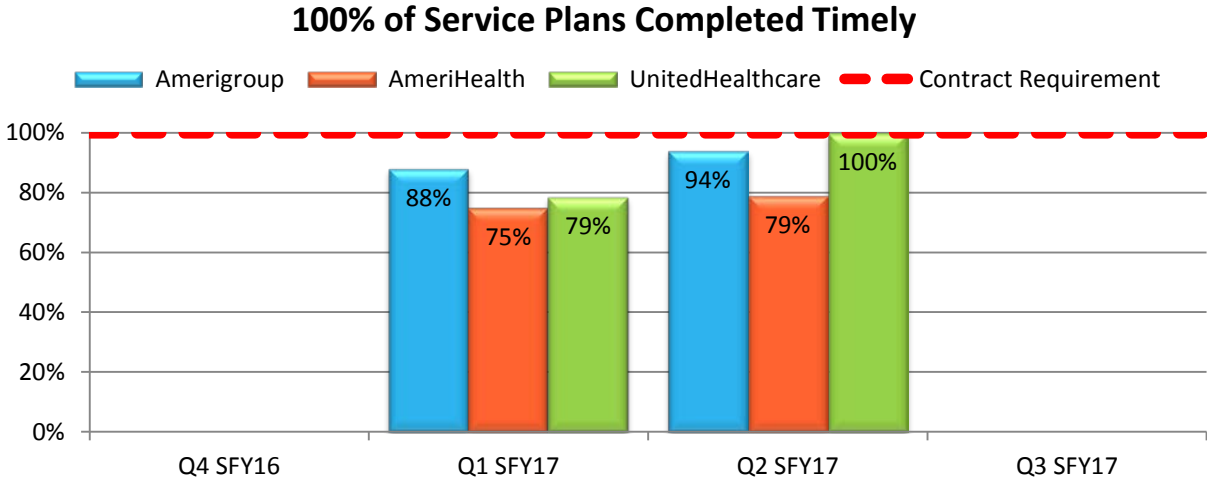
There is no data for Q4 SFY16 due to no service plans being due during that period.

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.

CONSUMER PROTECTIONS AND SUPPORTS

Level of Care

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

100% of LOC Reassessments Completed Timely

Legend: Amerigroup | AmeriHealth | UnitedHealthcare | Contract Requirement

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	71%	89%	90%	
AmeriHealth	54%	67%	78%	
UnitedHealthcare	69%	64%	83%	
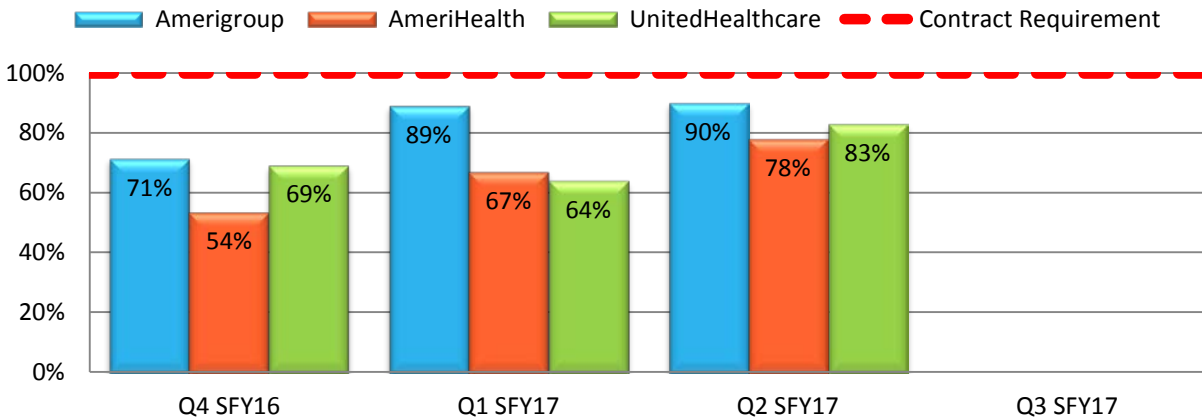
Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

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
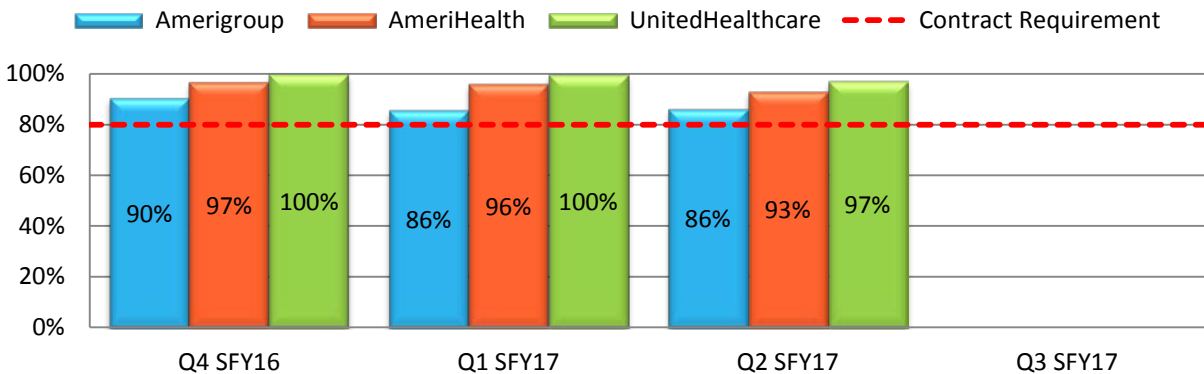
This performance target measures the timeliness of answering the helpline calls. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines. The CAHPs surveys conducted annually also measure member satisfaction with their health plan.

Top Five Reasons for Members Contacting Helplines for Q2 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
October 2016						
1.	Transportation Question	7,647	Transportation Questions	9,675	Benefits	4,357
2.	Benefit Inquiry	1,324	Member Inquiries	6,741	Eligibility Inquiry	2,730
3.	Provider-Find/Change/Verify PCP	1,233	Member Changes	6,337	PCP Inquiry	2,710
4.	Order ID Card	714	Member Request	4,683	ID Cards	1,071
5.	Claim/Billing Issue	516	Other Programs & Services	3,117	COB Information	967
November 2016						
1.	Transportation Question	7,366	Transportation Questions	9,183	Benefits	3,748
2.	Benefit Inquiry	1,309	Member Inquiries-Plan Policy/Procedure Education	5,151	Eligibility Inquiry	2,483
3.	Provider-Find/Change/Verify PCP	1,085	Member Changes-Demographic	5,003	PCP Inquiry	2,478

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
			Changes			
4.	Order ID Card	589	ID Card Request	4,016	ID Cards	1,425
5.	Pharmacy Inquiry	539	Member Changes-PCP Change	2,566	COB Information	867
December 2016						
1.	Transportation Question	7,525	ID Card Request	10,618	Benefits	3,815
2.	Benefit Inquiry	1,201	PCP Changes	9,986	Eligibility Inquiry	2,961
3.	Provider-Find/Change/Verify PCP	1,003	Member Changes	9,430	PCP Inquiry	2,335
4.	Enrollment Information	665	Transportation Question	9,053	COB Information	1,043
5.	Order ID Card	537	Plan Policy/ Procedure Education	8,359	General Inquiry	858

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.
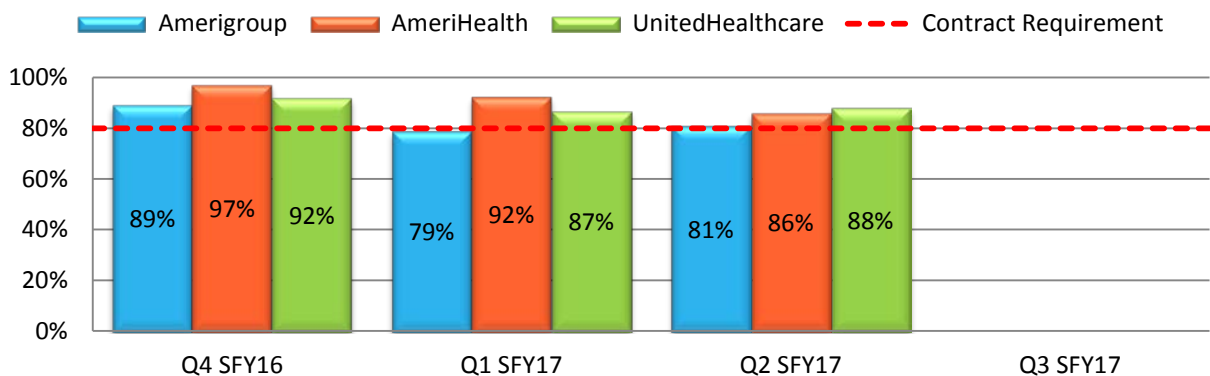
Top Five Reasons for Providers Contacting Helplines for Q2 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
October 2016						
1.	Claim Status Inquiry	2,876	Claims	9,401	Claims Inquiry	11,014
2.	Claim Rejected	1,985	Provider Requests	7,681	Benefits	5,355
3.	Auth-Status	1,633	Provider Inquiries	7,196	COB Information	1,380

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
4.	Pharmacy Department Call Inquiry	1,609	Other Programs & Services	3,395	Provider-Related	605
5.	Benefits Inquiry	1,068	Eligibility/Enrollment	3,050	Membership Record	581
November 2016						
1.	Claim Status Inquiry	2,954	Claims-Claim Status	8,917	Claims Inquiry	10,849
2.	Claim Rejected	2,054	Provider Requests-Check Remittance Advice	7,186	Benefits	4,218
3.	Pharmacy Department Call Inquiry	1,695	Provider Inquiries-Plan Policy/Procedure Education	5,515	Membership Record	1,371
4.	Auth-Status	1,584	Other Programs & Services-Transfer/Redirected Call	2,748	COB Information	629
5.	Claim Denial Inquiry	1,041	Eligibility/Enrollment-Member Eligibility	2,148	Authorization Related	396
December 2016						
1.	Claim Status Inquiry	3,281	Claims Status	9,828	Claims Inquiry	13,980
2.	Claim Rejected	1,928	Provider Check Remittance Advice	7,464	Benefits	4,947
3.	Pharmacy Department Call Inquiry	1,655	Plan Policy/Procedure Education	5,209	COB Information	1,567
4.	Authorization Status	1,612	Other Programs & Services	3,050	Membership Record	671
5.	Claims Inquiry	1,083	Member Eligibility/Enrollment	2,019	Authorization Related	529

Pharmacy Services Helpline

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

Legend: Amerigroup, AmeriHealth, UnitedHealthcare, Contract Requirement

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	82%	84%	78%	
AmeriHealth	86%	78%	84%	
UnitedHealthcare	87%	94%	94%	

MCO PROGRAM MANAGEMENT
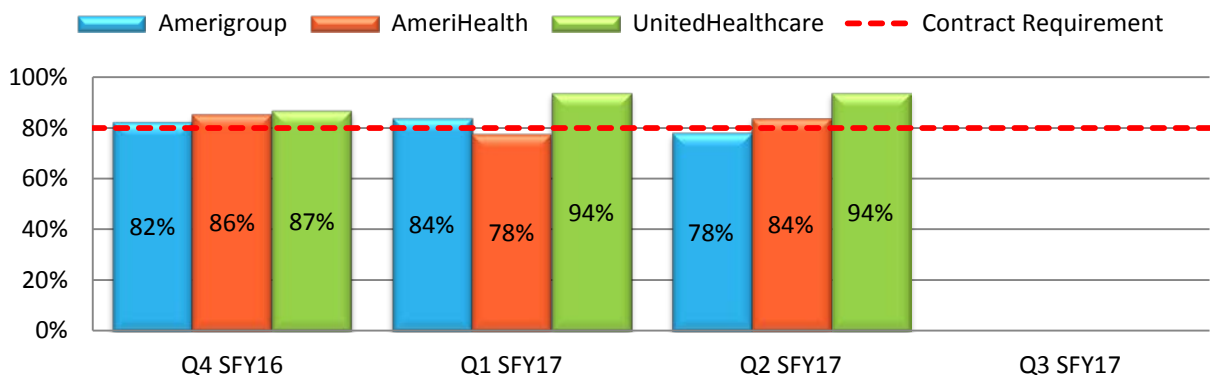
Medical Claims Payment

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
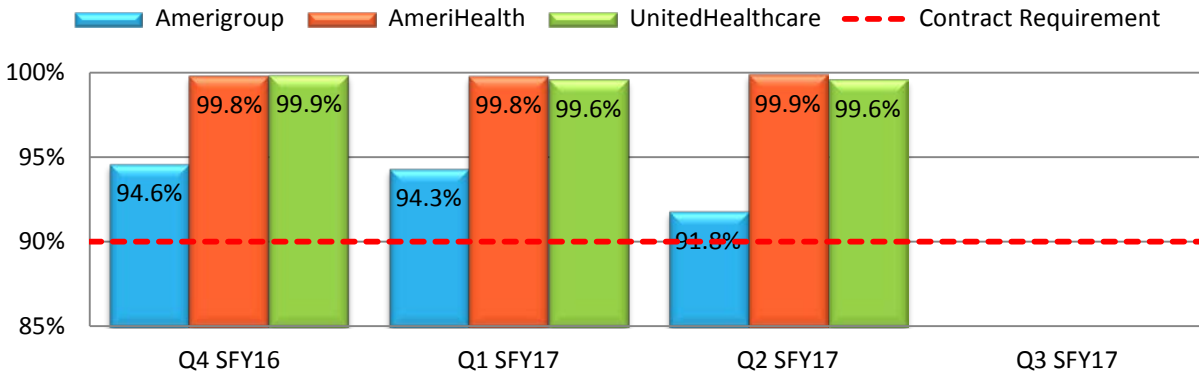
Legend: Amerigroup | AmeriHealth | UnitedHealthcare | - - - Contract Requirement

Q4 SFY16: Amerigroup 94.6%, AmeriHealth 99.8%, UnitedHealthcare 99.9%
Q1 SFY17: Amerigroup 94.3%, AmeriHealth 99.8%, UnitedHealthcare 99.6%
Q2 SFY17: Amerigroup 91.8%, AmeriHealth 99.9%, UnitedHealthcare 99.6%
Q3 SFY17: (no data)

Y-axis: 85% to 100%

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
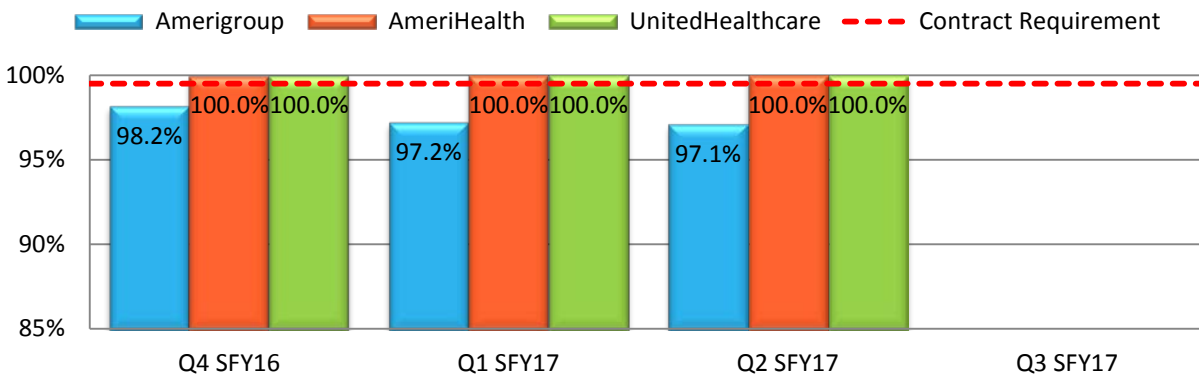
Legend: Amerigroup | AmeriHealth | UnitedHealthcare | - - - Contract Requirement

Q4 SFY16: Amerigroup 98.2%, AmeriHealth 100.0%, UnitedHealthcare 100.0%
Q1 SFY17: Amerigroup 97.2%, AmeriHealth 100.0%, UnitedHealthcare 100.0%
Q2 SFY17: Amerigroup 97.1%, AmeriHealth 100.0%, UnitedHealthcare 100.0%
Q3 SFY17: (no data)

Y-axis: 85% to 100%

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

MCO PROGRAM MANAGEMENT

MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.

Amerigroup Medical Claims Status
**As of the end of the reporting period

■ Paid ■ Denied □ Suspended
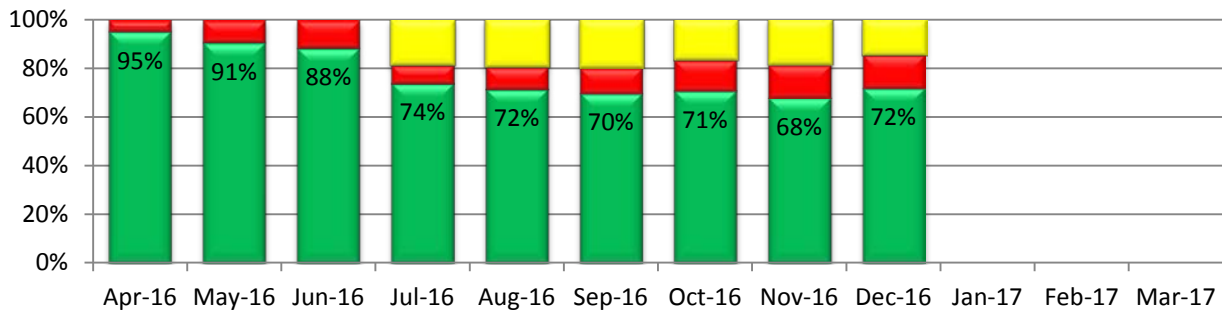
▲ Amerigroup did not correctly report suspended claims in April, May, and June of 2016.

AmeriHealth Medical Claims Status
**As of the end of the reporting period

■ Paid ■ Denied □ Suspended

UnitedHealthcare Medical Claims Status
**As of the end of the reporting period

■ Paid ■ Denied ■ Suspended

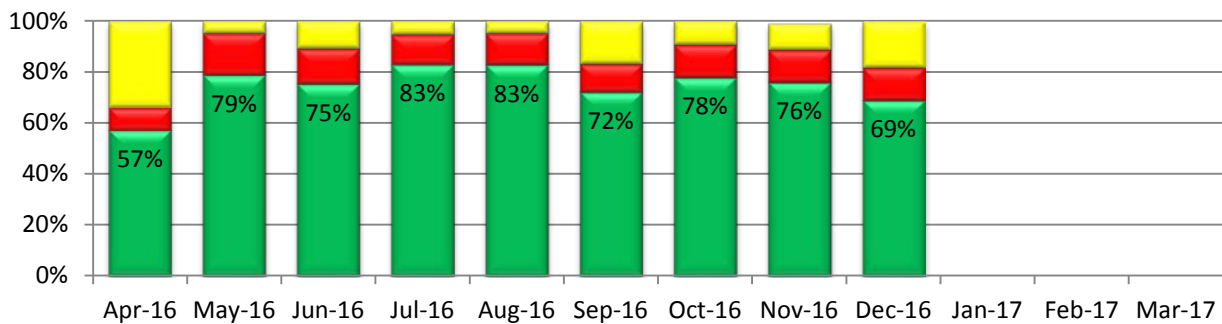|	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Paid	49%	61%	67%	65%	65%	65%	65%	66%	68%

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-197 Precertification/ authorization/notification absent.	2. CARC-197 Precertification/authorization/notification absent. -RARC-M62 Missing/incomplete/invalid treatment authorization code.	2. CARC-18 Exact duplicate claim/ service. -RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim
3. CARC-177 Patient has not met the required eligibility requirements.	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-29 The time limit for filing has expired.	4. CARC-97 The benefit for this service is included in the payment/allowance for another	4. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
	service/procedure that has already been adjudicated. -RARC-M15 Separately billed services/tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.	ineligible for this service.
5. CARC-252 An attachment/other documentation is required to adjudicate this claim/service. -RARC-N479 Missing Explanation of Benefits (Coordination of Benefits or Medicare Secondary Payer).	5. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.	5. CARC-29 The time limit for filing has expired.
6. CARC-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement -RARC N-31 Missing/incomplete/invalid prescribing provider identifier.	6. CARC-A1 Claim/Service denied. At least one Remark Code must be provided. -RARC-N142 The original claim was denied. Resubmit a new claim, not a replacement claim.	6. CARC-B13 Previously paid. Payment for this claim/service may have been provided in a previous payment.
7. CARC-256- Service not payable per managed care contract.	7. CARC-8 The procedure code is inconsistent with the provider type/specialty (taxonomy). -RARC-N95 This provider type/provider specialty may not bill this service.	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 billed services/ tests have been bundled as they are considered components of the same procedure. Separate payment is not allowed.
8. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed	8. CARC-22 This care may be covered by another payer per coordination of benefits.	8. CARC-96 Non-covered charge(s). -RARC-N448 This drug/ service/ supply is not

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
for adjudication. -RARC-MA130 Your claim contains incomplete and/or invalid information, and no appeal rights are afforded because the claim is unprocessable.	-RARC-N4 Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	included in the fee schedule or contracted/ legislated fee arrangement.
9. CARC-11 The diagnosis is inconsistent with the procedure. RARC-N657 This should be billed with the appropriate code for these services.	9. CARC-185 The rendering provider is not eligible to perform the service billed. -RARC-N95 This provider type/provider specialty may not bill this service.	9. CARC-96 Non-covered charge(s). -RARC-N425 Statutorily excluded service(s).
10. CARC-204 This service/equipment/drug is not covered under the patient's current benefit plan RARC-N130 Consult plan benefit documents/guidelines for information about restrictions for this service.	10. 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.	10. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication -RARC-N78 The necessary components of the child and teen checkup (EPSDT) were not completed.

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/

MCO PROGRAM MANAGEMENT

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
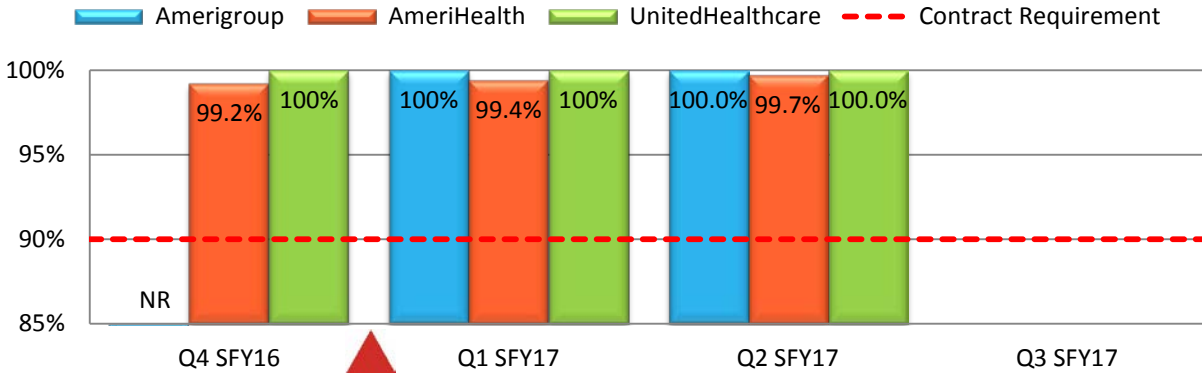
▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.

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

▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.

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 validat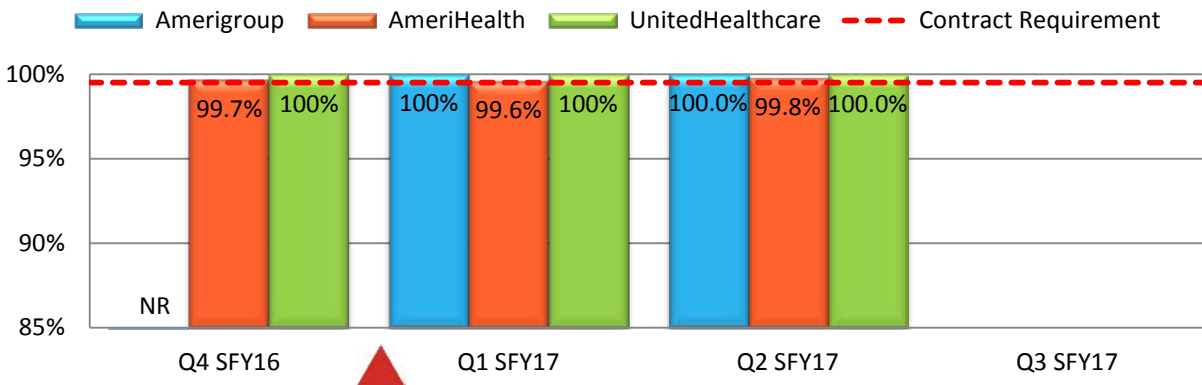ion projects with the MCOs, as well as investigation and follow up when the department is made aware of provider reimbursement concerns.

Amerigroup Pharmacy Claims Status
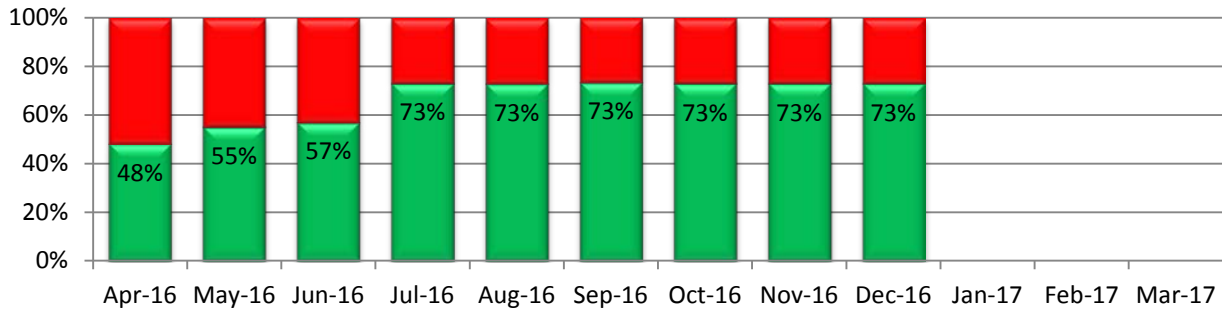
**As of the end of the reporting period

Paid ■ Denied ■ Suspended

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Paid	48%	55%	57%	73%	73%	73%	73%	73%	73%

▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.

AmeriHealth Pharmacy Claims Status

**As of the end of the reporting period

Paid ■ Denied ■ Suspended

	Apr-16	May-16	Jun-16	Jul-16	Aug-16	Sep-16	Oct-16	Nov-16	Dec-16
Paid	71%	64%	61%	72%	75%	76%	76%	77%	76%

▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.

UnitedHealthcare Pharmacy Claims Status

**As of the end of the reporting period

■ Paid ■ Denied □ Suspended

▲ All MCOs stopped reporting suspended claims for Pharmacy POS as their system is not meant to put these claims into suspense.

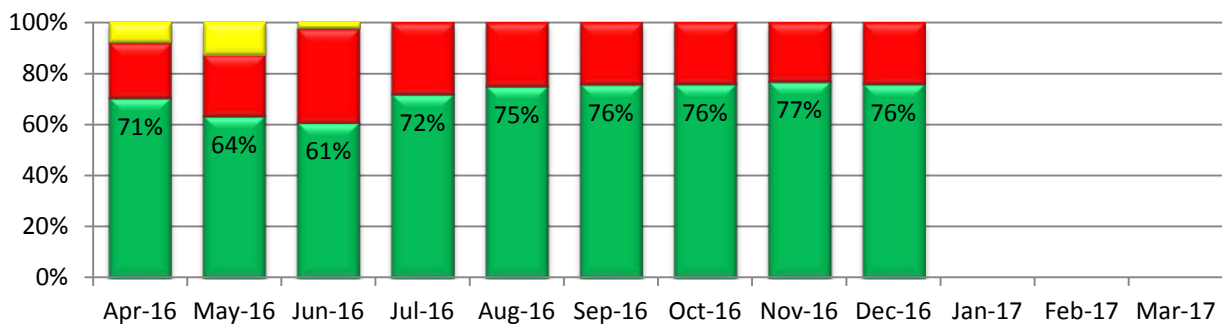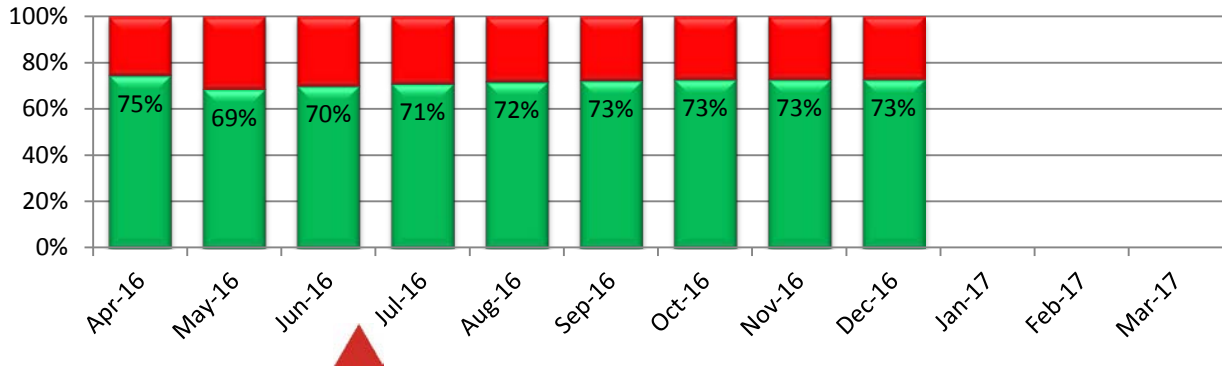| Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
1. Refill Too Soon	1. Refill Too Soon	1. DUR Reject Error
2. Product Not On Formulary	2. Product/Service Not Covered-Plan/Benefit Exclusion	2. Refill Too Soon
3. Submit Bill To Other Processor Or Primary Payer	3. Patient Is Not Covered	3. Prior Authorization Required
4. Prior Authorization Required	4. Prior Authorization Required	4. Prod/Service Not Covered
5. Days' Supply Exceeds Plan Limitation	5. Plan Limitations Exceeded	5. Filled After Coverage Terminated
6. Plan Limitations Exceeded	6. Submit Bill To Other Processor Or Primary Payer	6. Plan Limitations Exceeded
7. Product/Service Not Covered	7. Duplicate Paid/Captured Claim	7. Submit Bill To Other Processor
8. DUR Reject Error	8. DUR Reject Error	8. M/I Days Supply
9. Product Not Covered Non-Participating Manufacturer	9. Non-Matched Product/Service Id Number	9. Non-Matched Pharmacy Number
10. This Medicaid Patient Is Medicare Eligible	10. M/I Date Of Birth	10. Prescriber Is Not Covered

Utilization of Health Care Services Reported			
Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$11,731,009	$19,297,989	$11,097,856
Inpatient Medical Claims Reimbursed	$37,473,679	$21,390,422	$26,547,433
Inpatient Behavioral Health Claims Reimbursed	$14,177,194	$21,777,454	$2,879,682
Outpatient Claims Reimbursed	$36,493,221	$31,976,808	$37,258,734

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.

MCO PROGRAM MANAGEMENT

Utilization of Value Added Services Reported
Count of Members

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

Q1 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Family Planning and Resources	5,095	1,807	989	7,891
Healthy Incentives	4,771	6,658	1,173	12,602
Health and Wellness	1,259	1,286	71	2,616
Additional Benefits	38	1,850	233	2,121
Tobacco Cessation	114	666	468	1,248

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

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

MCO PROGRAM MANAGEMENT

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 December 2016 Monthly MCO Performance Report.

	AmeriHealth			Amerigroup			UnitedHealthcare		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	95.0%	98.0%	99.0%	85.8%	90.6%	93.4%	98.9%	99.6%	97.6%
Cardiology	100.0%	100.0%	98.0%	88.1%	95.4%	88.9%	99.1%	99.1%	93.8%
Endocrinology	95.0%	99.0%	100.0%	91.5%	63.2%	100.0%	98.9%	87.7%	79.5%
Gastroenterology	100.0%	96.0%	99.0%	88.5%	93.6%	81.1%	98.8%	99.4%	97.6%
Neurology	92.0%	100.0%	94.0%	92.5%	94.2%	99.0%	98.8%	99.7%	98.4%
Oncology	91.0%	100.0%	100.0%	76.9%	84.0%	98.0%	98.7%	99.9%	99.6%
Orthopedics	92.0%	95.0%	96.0%	71.8%	85.7%	94.3%	99.1%	98.1%	92.3%
Pulmonology	100.0%	100.0%	99.0%	79.8%	97.1%	91.2%	98.8%	100.0%	95.7%
Rheumatology	100.0%	100.0%	100.0%	100.0%	100.0%	94.7%	97.4%	100.0%	98.6%
Urology	97.0%	99.0%	100.0%	80.2%	99.0%	78.0%	99.3%	99.6%	97.0%
Provider Type - Pediatric	East	Central	West	East	Central	West	East	Central	West
Primary Care	94.0%	97.0%	99.0%	88.9%	97.3%	98.0%	98.9%	99.3%	97.2%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	100.0%	100.0%	99.0%	96.8%	98.4%	95.0%	98.4%	99.0%	93.1%
Pharmacies	98.0%	98.0%	97.0%	99.8%	99.6%	99.9%	100.0%	99.5%	100.0%
ICF/ID	100.0%	97.0%	97.0%	99.6%	100.0%	100.0%	100.0%	100.0%	100.0%
ICF/SNF	97.0%	96.0%	95.0%	94.8%	91.6%	93.2%	99.9%	99.3%	100.0%

Provider Type - Waiver	AmeriHealth			Amerigroup			UnitedHealthcare		
	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	100.0%	100.0%	No Util	No Util	100.0%	100.0%	100.0%	100.0%	100.0%
AIDS/HIV Level 4: Home Delivered Meals	100.0%	100.0%	100.0%	100.0%	100.0%	No Util	100.0%	100.0%	100.0%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	98.0%	100.0%	100.0%	93.1%	100.0%	100.0%	100.0%	100.0%	100.0%
BI Level 2: CDAC	100.0%	100.0%	100.0%	96.6%	97.0%	95.9%	100.0%	100.0%	100.0%
BI Level 3: Supported Community Living	100.0%	98.0%	100.0%	96.7%	95.8%	99.2%	100.0%	100.0%	100.0%
Elderly Level 1: Adult Day Care	86.0%	100.0%	No Util	91.2%	100.0%	100.0%	100.0%	100.0%	100.0%
Elderly Level 2: CDAC, Home Health Aide	99.0%	93.0%	100.0%	91.7%	95.0%	95.5%	100.0%	100.0%	100.0%
Elderly Level 4: Home Delivered Meals	99.0%	96.0%	87.0%	92.4%	92.7%	95.1%	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	100.0%	100.0%	100.0%	96.4%	100.0%	100.0%	100.0%	100.0%	100.0%
HD Level 4: Home Delivered Meals	100.0%	100.0%	94.0%	91.1%	100.0%	99.0%	100.0%	100.0%	100.0%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	100.0%	100.0%	99.0%	92.4%	93.8%	100.0%	99.8%	100.0%	100.0%
ID Level 2: CDAC, Home Health Aide	100.0%	100.0%	100.0%	88.5%	95.2%	100.0%	100.0%	100.0%	100.0%
ID Level 3: Supported Community Living	100.0%	99.0%	96.0%	96.3%	92.3%	99.3%	99.9%	100.0%	100.0%
PD Level 2: CDAC,	100.0%	99.0%	100.0%	96.2%	100.0%	98.3%	100.0%	100.0%	100.0%
Provider Type - Behavioral	East	Central	West	East	Central	West	East	Central	West
Behavioral Health - Inpatient	100.0%	98.0%	100.0%	99.9%	100.0%	94.7%	98.1%	93.7%	65.7%
Behavioral Health - Outpatient	97.0%	98.0%	96.0%	95.1%	89.7%	88.4%	99.5%	99.4%	99.8%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	100.0%	100.0%	100.0%	89.5%	96.0%	100.0%	100.0%	100.0%	100.0%
Habilitation Level 3: Home Based Habilitation	100.0%	100.0%	91.0%	97.5%	100.0%	94.6%	100.0%	99.7%	94.7%
Children's Mental Health Level 1: Respite	100.0%	100.0%	100.0%	100.0%	92.8%	69.5%	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:

  o https://dhs.iowa.gov/sites/default/files/AmerigroupIA_GeoAccess_SFY17_Qtr2.pdf

- AmeriHealth Caritas:

  o https://dhs.iowa.gov/sites/default/files/AmeriHealthCaritasIowa__GeoAccess_SFY17_Qtr2.pdf

- UnitedHealthcare:

  o https://dhs.iowa.gov/sites/default/files/UHC__GeoAccess_SFY17_Qtr2.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%	99%
Behavioral Health – Outpatient	100%	100%	100%
General Optometry	100%	100%	100%
Lab and X-ray Services	100%	98%	99%
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%		88%	99%	
Behavioral Health – Inpatient		98%	100%		100%	100%		98%	100%

100% of Counties Have ≥ 2 HCBS Providers Per County Per 1915c Program
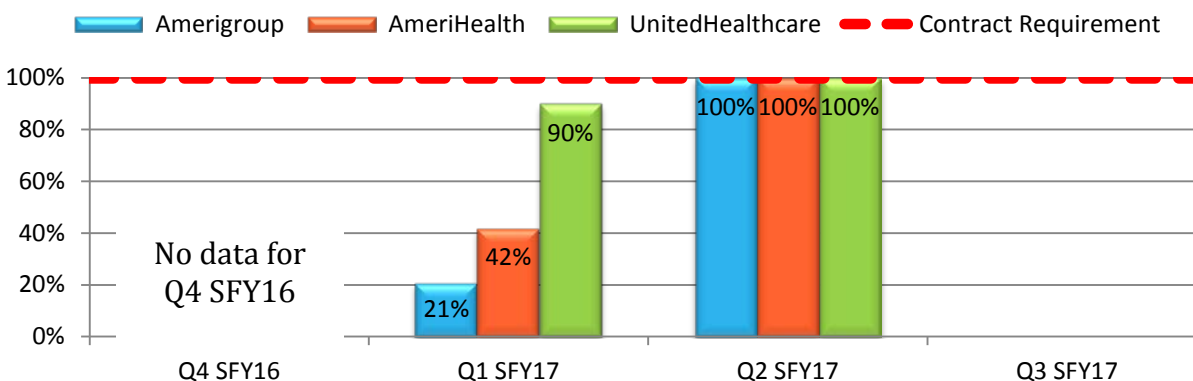
All MCOs have approved exception requests for the network standards in Exhibit B of the contract for HCBS services. Once those have been submitted to demonstrate acceptable justifications for an exception, it is anticipated that these percentages will increase.

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

Prior Authorization - Medical

100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request
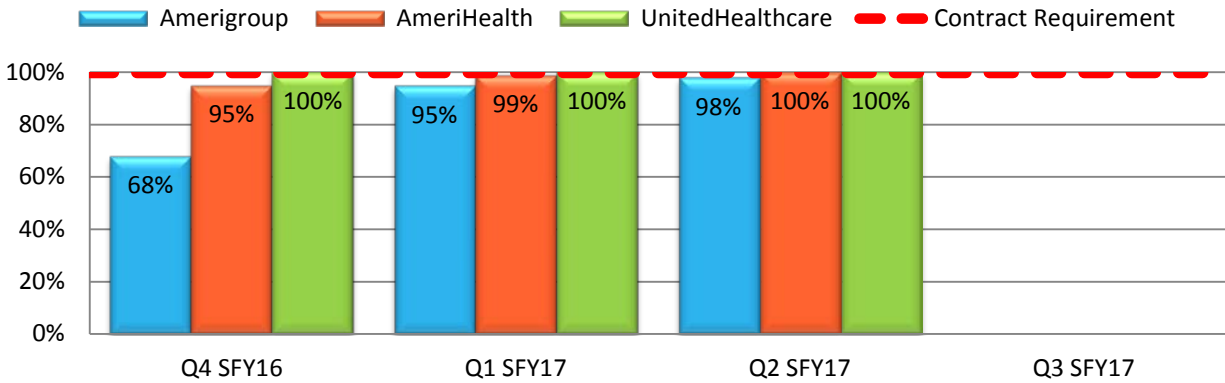
Legend: Amerigroup | AmeriHealth | UnitedHealthcare | Contract Requirement

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	68%	95%	98%	
AmeriHealth	95%	99%	100%	
UnitedHealthcare	100%	100%	100%	

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
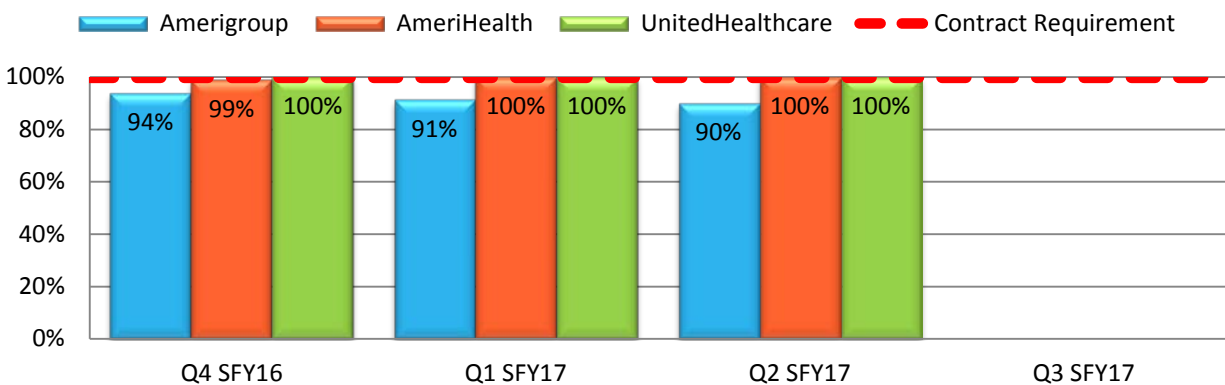
Legend: Amerigroup | AmeriHealth | UnitedHealthcare | Contract Requirement

	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	94%	91%	90%	
AmeriHealth	99%	100%	100%	
UnitedHealthcare	100%	100%	100%	

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.

Amerigroup Medical PAs Status

**As of the end of the reporting period

Legend: ■ Approved ■ Denied ■ Modified

Bar values (Approved): Apr-16 100%, May-16 98%, Jun-16 96%, Jul-16 95%, Aug-16 97%, Sep-16 93%, Oct-16 91.0%, Nov-16 91.0%, Dec-16 92.0%

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.

AmeriHealth Medical PAs Status

**As of the end of the reporting period

Legend: ■ Approved ■ Denied ■ Modified

Bar values (Approved): Apr-16 96%, May-16 96%, Jun-16 92%, Jul-16 93%, Aug-16 93%, Sep-16 93%, Oct-16 89%, Nov-16 90%, Dec-16 86%

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.

UnitedHealthcare Medical PAs Status

**As of the end of the reporting period

Legend: ■ Approved ■ Denied ■ Modified

Bar values (Approved): Apr-16 93%, May-16 93%, Jun-16 93%, Jul-16 92%, Aug-16 92%, Sep-16 93%, Oct-16 94%, Nov-16 93%, Dec-16 92%
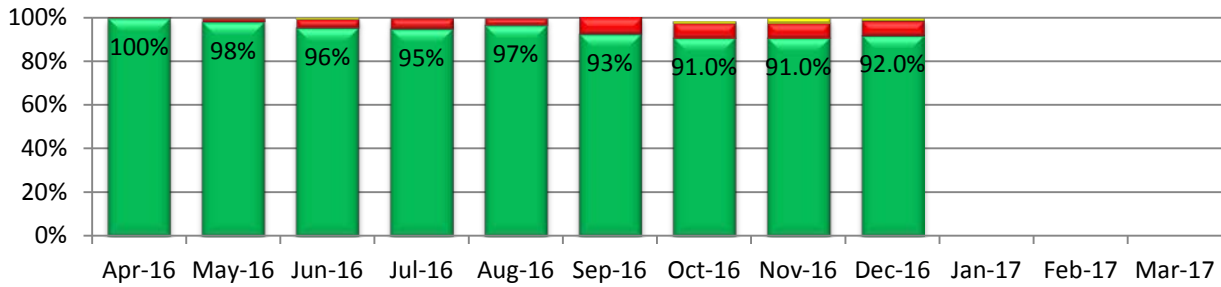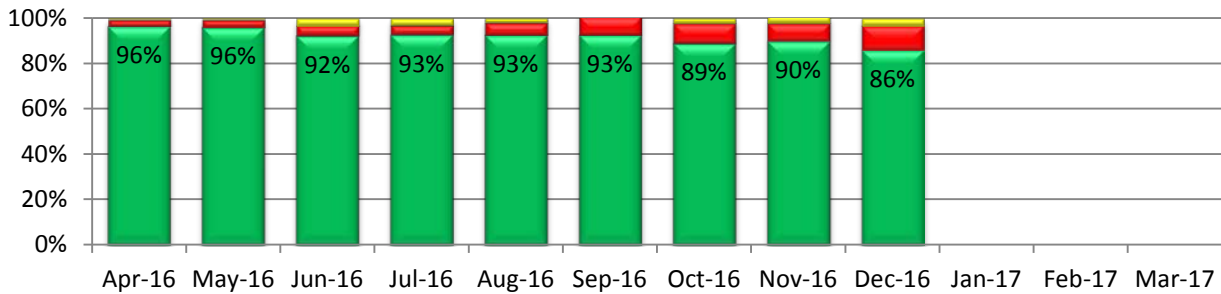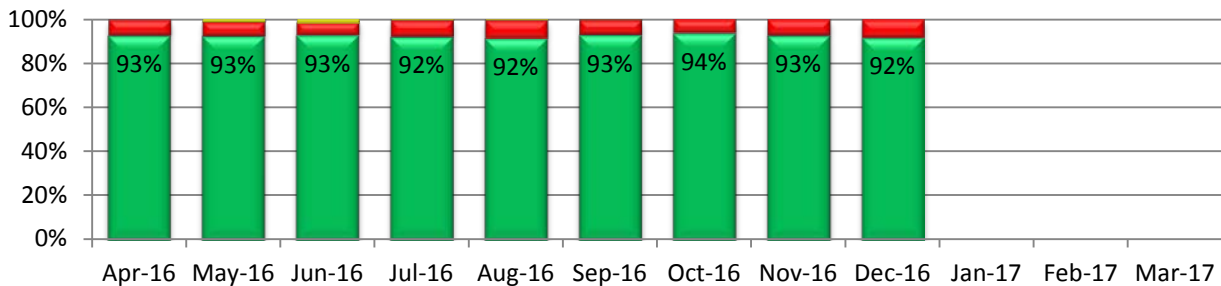
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

MCO FINANCIALS

Prior Authorization - Pharmacy

100% of Regular PAs Must be Completed Within 24 Hours of Request

Legend: Amerigroup | AmeriHealth | UnitedHealthcare | Contract Requirement

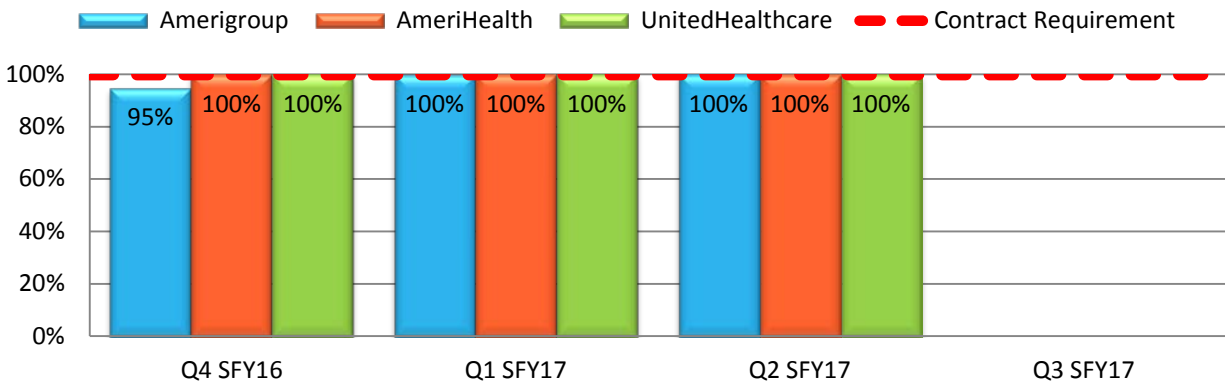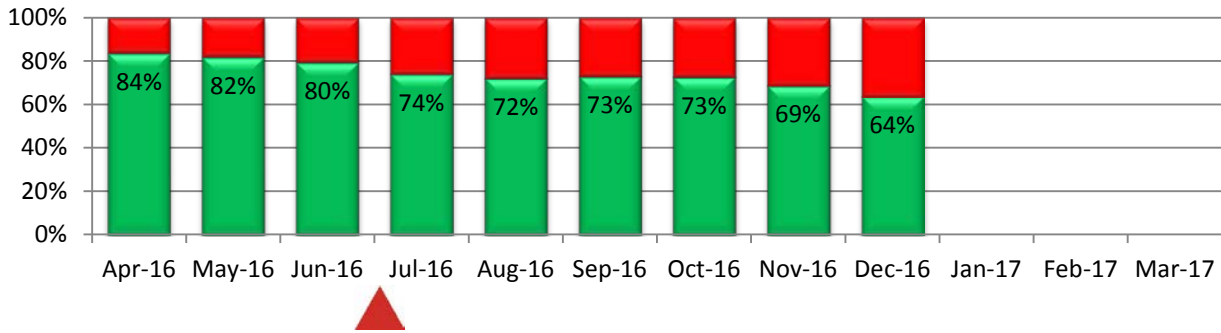|	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	95%	100%	100%	
AmeriHealth	100%	100%	100%	
UnitedHealthcare	100%	100%	100%	

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.

MCO FINANCIALS

Amerigroup Pharmacy PAs Submitted Status

■ Approved ■ Denied ■ Modified

Apr-16: 84%, May-16: 82%, Jun-16: 80%, Jul-16: 74%, Aug-16: 72%, Sep-16: 73%, Oct-16: 73%, Nov-16: 69%, Dec-16: 64%

▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.

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AmeriHealth Pharmacy PAs Submitted Status

**As of the end of the reporting period

■ Approved ■ Denied ■ Modified

Apr-16: 57%, May-16: 64%, Jun-16: 63%, Jul-16: 66%, Aug-16: 65%, Sep-16: 64%, Oct-16: 68%, Nov-16: 71%, Dec-16: 69%
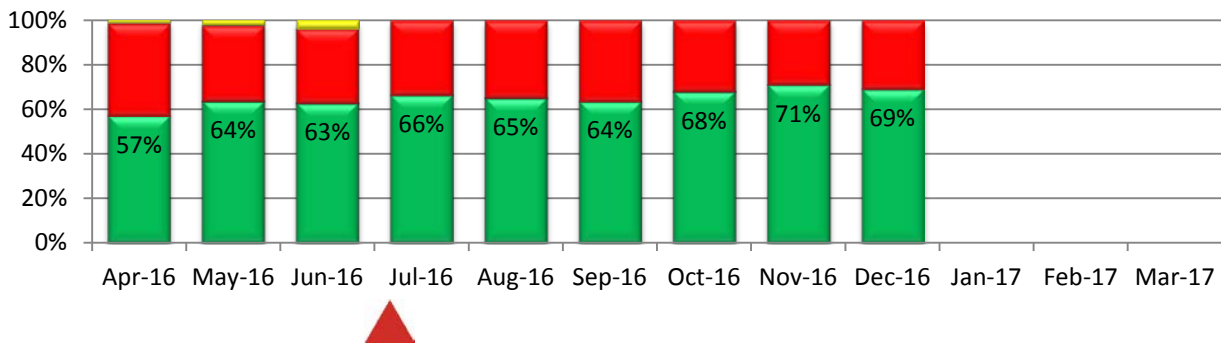
▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.

UnitedHealthcare Pharmacy PAs Submitted Status

**As of the end of the reporting period

■ Approved ■ Denied ■ Modified

Apr-16: 80%, May-16: 81%, Jun-16: 81%, Jul-16: 80%, Aug-16: 82%, Sep-16: 80%, Oct-16: 84%, Nov-16: 83%, Dec-16: 85%

▲ All MCOs stopped reporting modified PAs for Pharmacy as ultimately these should be considered approved or denied.

MCO FINANCIALS

Encounter Data Reporting

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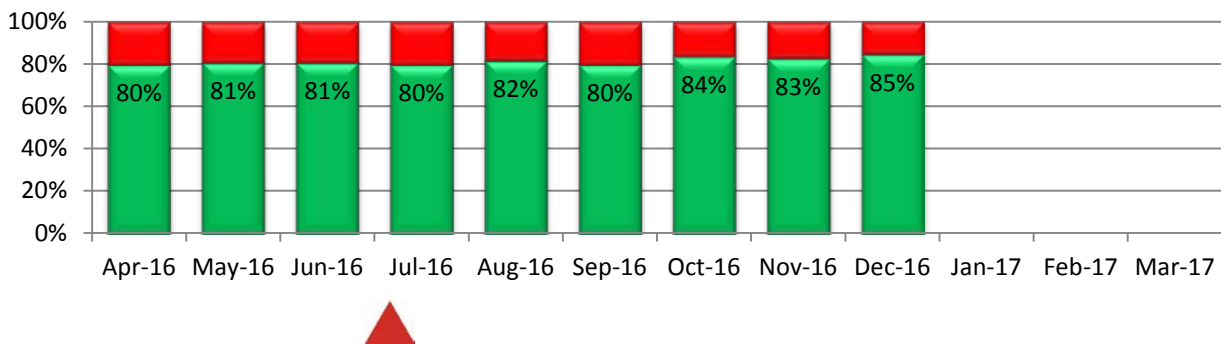s of validating all encounter data to ensure adequate development of capitation rates and overall program and data integrity.

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

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

Value Based Purchasing Enrollment

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

Data as of December 2016	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement	16%	0%	5%

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

MCO FINANCIALS

MLR/ALR/Underwriting			

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

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

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

Q2 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	116.0%	110.4%	99.7%
ALR	11.6%	6.8%	11.9%
Underwriting	-27.6%	-16.6%	-11.6%

The department expects quarter-to-quarter fluctuations in financial metrics while the plans' experience in the Iowa Medicaid market matures. The financial ratios presented above are common financial metrics used to assess MCO financial performance. **The financial ratios presented here were reported by the MCOs and are consistent with Q4 calendar year 2016 (Q2 SFY17) financial information submitted to the Iowa Insurance Division by each MCO.**

The financial metrics presented here reflect financial performance for Q2 SFY17. 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.

MCO FINANCIALS

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.

MCO FINANCIALS

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.

Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Hospital Claims Paid	$74,554,986	$94,663,279	$72,402,420	$241,620,685
Physician Claims Paid	$37,237,024.85	$44,675,374.96	$48,749,520	$130,661,920
HCBS Claims Paid	$12,351,692	$159,212,776	$8,272,430	$179,836,898
DME Claims Paid	$3,803,197	$9,889,505	$3,806,965	$17,499,666
Pharmacy Claims Paid	$519,900	$54,688,658	$43,980,508	$99,189,066
Home Health Claims Paid	$5,295,183	$18,543,013	$6,620,051	$30,458,247
Hospice Claims Paid	$4,944,468	$3,289,832	$1,655,394	$9,889,695
Nursing Facility Claims Paid	$44,637,766	$40,053,415	$41,539,898	$126,231,079
ICF/ID Claims Paid	$17,424,529	$27,938,018	$8,165,061	$53,527,608
Behavioral Health Claims Paid	$33,273,413	$34,499,805	$16,128,689	$83,901,907
Speech Therapy Claims Paid	$135,699	$42,270	$386,351	$564,320
Occupational Therapy Claims Paid	$1,658,060	$37,565	$257,447	$1,953,072
Non-Emergency Transportation Claims Paid	$1,807,288	$1,736,359	$1,914,848	$5,458,495

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.

MCO FINANCIALS

Capitation Payments Made to the Managed Care Organizations

MCO	Q4 SFY16	Q1 SFY17	Q2 SFY17	Q3 SFY17
Amerigroup	$237,540,157	$238,096,189	$237,566,370	
AmeriHealth	$408,575,970	$444,903,457	$445,036,927	
UnitedHealthcare	$229,442,968	$209,092,263	$205,695,971	

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 Q2 SFY17

Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Amount of TPL Recovered	$6,148,299	$15,797,282	$13,421,413

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.

MCO FINANCIALS

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	34	49	56
Overpayments Identified During the Quarter	21	16	0
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	2	4	5
Member Concerns Referred to IME	0	27	1

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 93 investigations in the second quarter and referred 11 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**		
	Oct	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**	**Oct**	**Nov**	**Dec**
Members (from IME)	186,789	186,993	186,639	213,382	213,452	212,981	169,977	169,205	168,323
Total Inpatient Admissions	1,234	1,210	1,324	1,609	1,474	1,868	1,644	1,719	973
Readmissions within 15 days of Discharge	79	69	84	112	127	212	79	70	129
Readmissions between 16 and 30 days of Discharge	36	31	64	61	60	98	43	45	53
Readmissions between 31 and 45 days of Discharge	11	18	41	47	45	67	31	25	29
Readmissions between 46 and 60 days of Discharge	3	6	4	41	54	60	13	25	24

*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**		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
ED Visits for Non-Emergent Conditions – Adult	21.7	18.4	17.3	57.1	54.7	58.5	16	15	17
ED Visits for Non-Emergent Conditions – Child	19.4	18.1	18.6	28.2	29.3	33.1	8	8	12
Supporting Data									
Members (from IME)	186,789	186,993	186,639	213,382	213,452	212,981	169,977	169,205	168,323
Members Using ED More Than Once in 30 Days	577	499	483	3,100	2,858	2,594	526	489	527
Members Using ED More Than Once between 31 and 60 Days**	341	325	323	1,433	1,266	1,177	236	244	264

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

The data is based on claims paid 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		
	Oct	Nov	Dec	Oct	Nov	Dec	Oct	Nov	Dec
Members in Out-of-State PMIC	12	9	9	12	11	10	1	1	1
Members in Out-of-State Skilled Nursing Facility	17	16	16	32	37	38	9	10	11
Members Placed in an Out-of-State ICF/ID	3	3	3	2	3	4	0	0	1
Members in Out-of-State nursing facilities	0	1	1	0	0	0	0	0	0
Members in Out-of-State Other Institutions	0	0	0	10	10	10	1	2	2

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

APPENDIX

HCBS Waiver Waitlist – January 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	33	1,311	882	7,927	2,157	11,867	867
Number of Individuals on Waiver Waitlist (DHS Function)	0	710	652	0	2,344	2,131	1,067
Waitlist Increase or (Decrease)	0	-103	-571	0	-31	-85	-82

As reported in January 2017. January data represents December eligibility statistics.

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	-	-	-	-
Adult Preventative Care Report	-	-	-	-
Behavioral Health Population Report	1	1	-	2
Care Coordination Report	-	-	-	-
Correct Coding Initiative Report	-	-	-	-
Claims Processing Report	1	1	1	3
Elderly Population Report	-	1	-	1
Fall Risk Report	-	-	-	-
General Population Report	-	-	-	-
Geographic Access Report	-	-	-	-
Grievances and Appeals	1	-	1	2
Level of Care Assessment Report	1	1	1	3
Med PA – Regular Report	1	1	-	2
Pharmacy Helpline Report	-	1	-	1
Prenatal and Childbirth Outcomes Report	-	-	-	-
Program Integrity Report	1	-	1	2
Provider Credentialing Report	1	-	-	1
Provider Helpline Report	1	-	-	1
Provider Type Reimbursement	1	-	-	1
Risk Assessment Report	1	1	-	2
Special Needs Population Report	-	1	1	2
Staff Resources Monitoring Report	1	-	-	1
Third Party Liability	1	-	-	1
Value Based Purchasing Report	-	-	-	-
Waivers Report	1	2	-	3
Grand Total	13	10	5	28

Type of Noncompliance Identified by MCO During this Reporting Period				
Type of Noncompliance	Amerigroup	AmeriHealth	UnitedHealthcare	Grand Total
Did not meet performance standard	8	7	3	18
Incomplete/Untimely	5	3	2	10
Grand Total	**13**	**10**	**5**	**28**

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 ensure 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.