Iowa Medicaid Enterprise

Managed Care Organization Report: SFY 2017, Quarter 1

(July-September)

Performance Data

Published November 30, 2016

Iowa Department of Human Services

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 1 of State Fiscal Year (SFY) 2017 and includes the information for the Iowa Medicaid Managed Care Organizations (MCO):

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

Notes about the reported data:

- This quarterly report is focused on key descriptors and measures that provide information about the managed care implementation and operations.
- While this report does contain operational data that can be an indicator of positive member outcomes, standardized health outcome measures will not be reported with validity until after the first year of implementation. This will include measures associated with HEDIS®[1] CAHPS[2], and measures associated with the 3M Treo Value Index Score tool developed for the State Innovation Model (SIM) grant that the state has with the Centers for Medicare and Medicaid Services (CMS).
- The reports are largely based on managed care claims data. Because of this, the data will not be complete until a full 180 days has passed since the period reported. However,

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

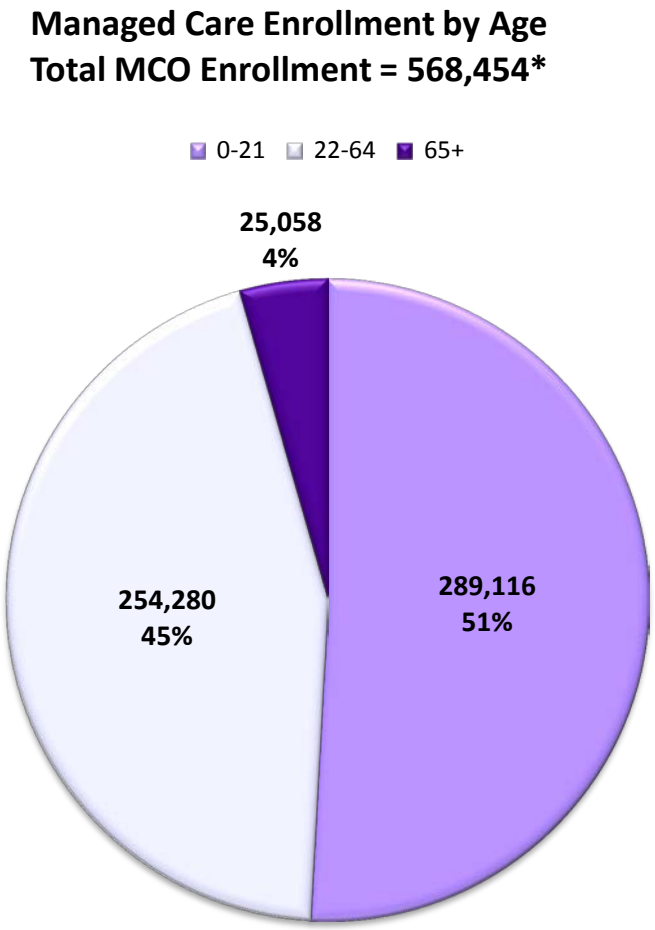
based on our knowledge of claims data this accounts for less than 15% of the total claim volume for that reporting period.

- Several data elements in the 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.

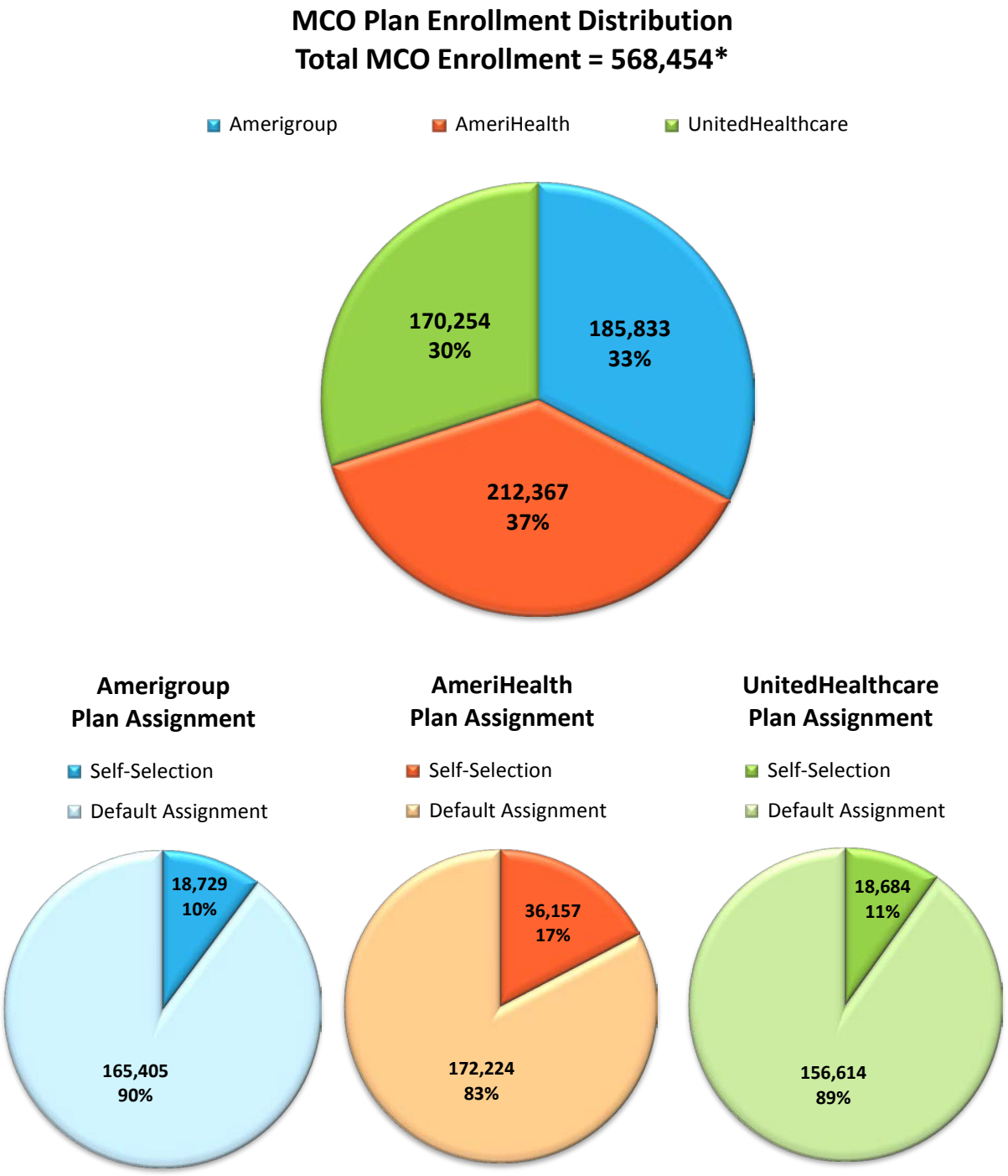
More information on the move to managed care is available at http://dhs.iowa.gov/ime/about/initiatives/MedicaidModernization

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

PLAN ENROLLMENT BY AGE



*September 2016 enrollment data as of October 10, 2016 – 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.



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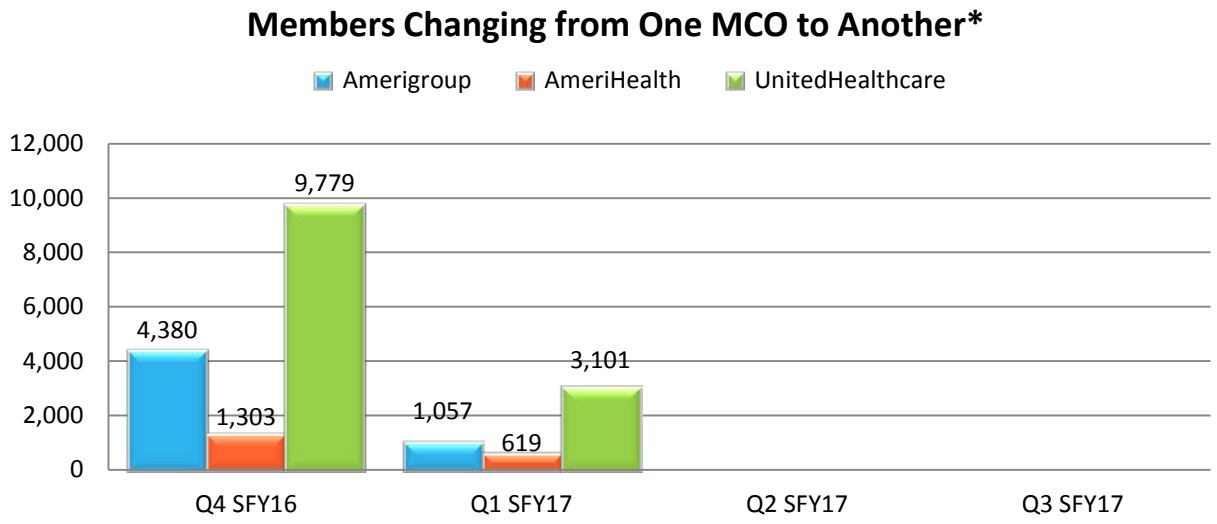
From the time tentative assignments were made in the fall of 2015 until the end of the first quarter, about 145,153 members, including ***hawk-i*** members, self-selected an MCO.



*Q1 SFY17 enrollment data as of October 10, 2016 – data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Disenrollment data refers to members who have chosen to change their enrollment with one MCO to an alternate 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.

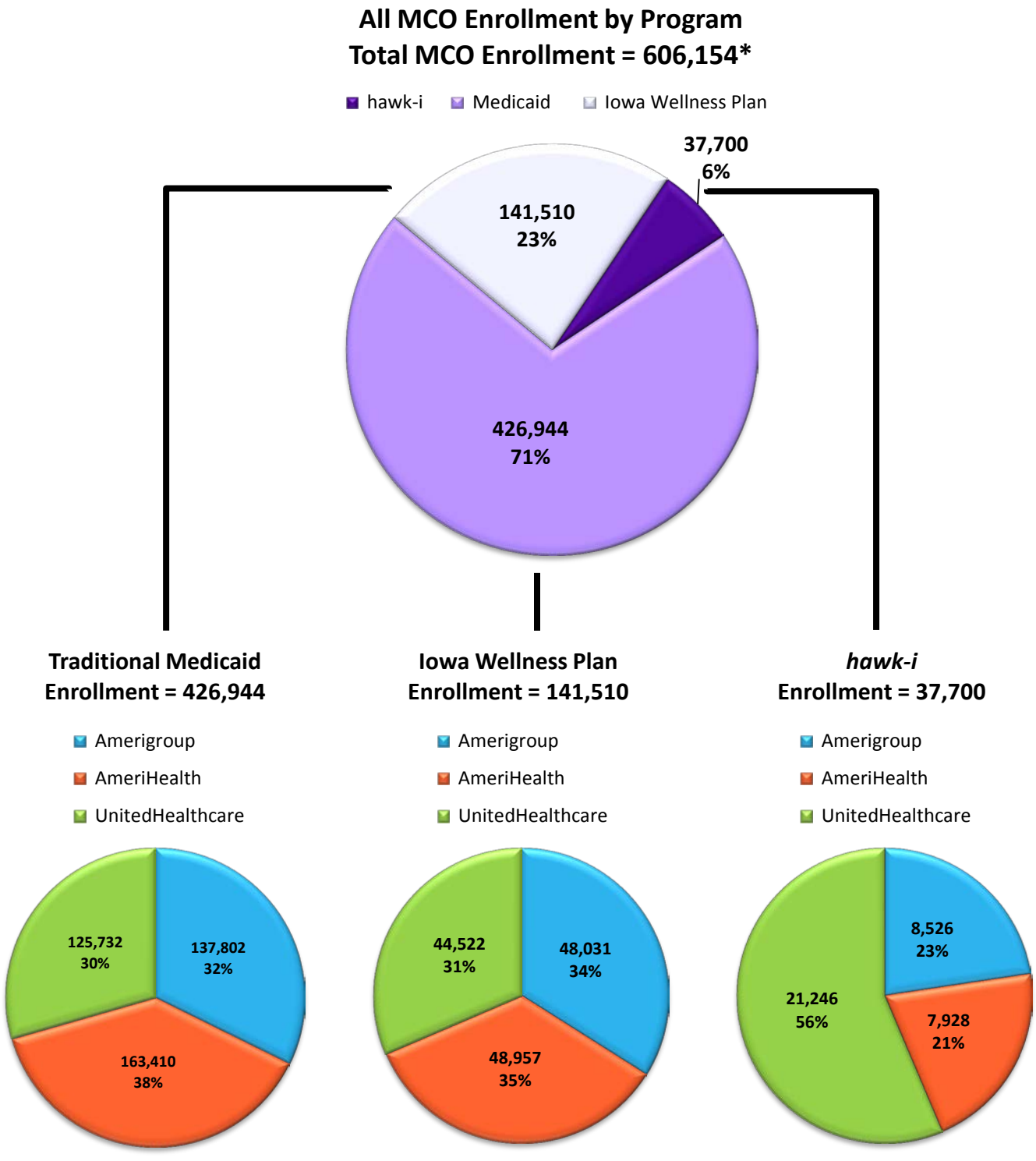
Reasons for "Good Cause" Disenrollment for Q1 SFY17

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	3849
Continuity of care	257
Other	25
Member needed related services to be performed at the same time that were not available in MCO's provider network unnecessary risk	4
MCO did not, because of moral or religious objections, cover the service the member seeks	3

PLAN ENROLLMENT BY PROGRAM



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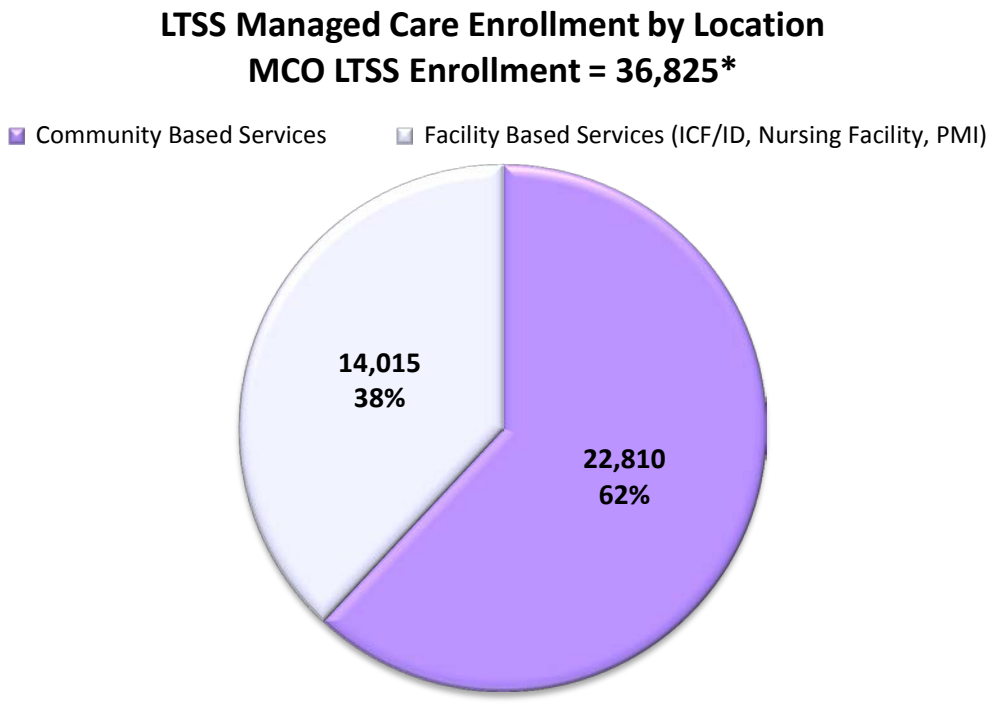
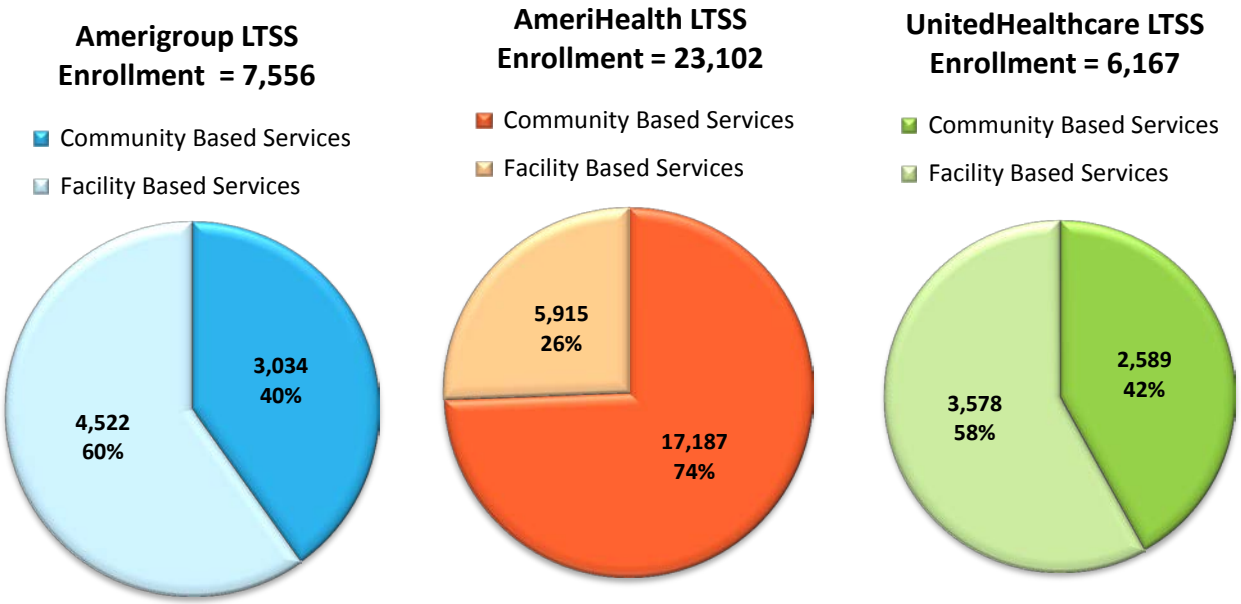
LONG TERM SERVICES AND SUPPORTS

ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT



Total MCO LTSS Enrollment by Plan



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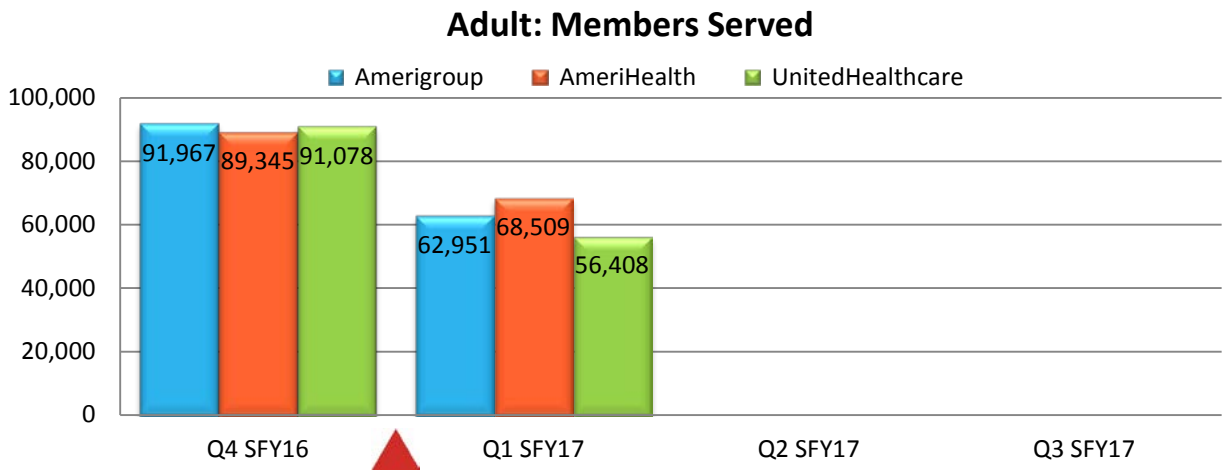
Adult General Population Reporting

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



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

- 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.
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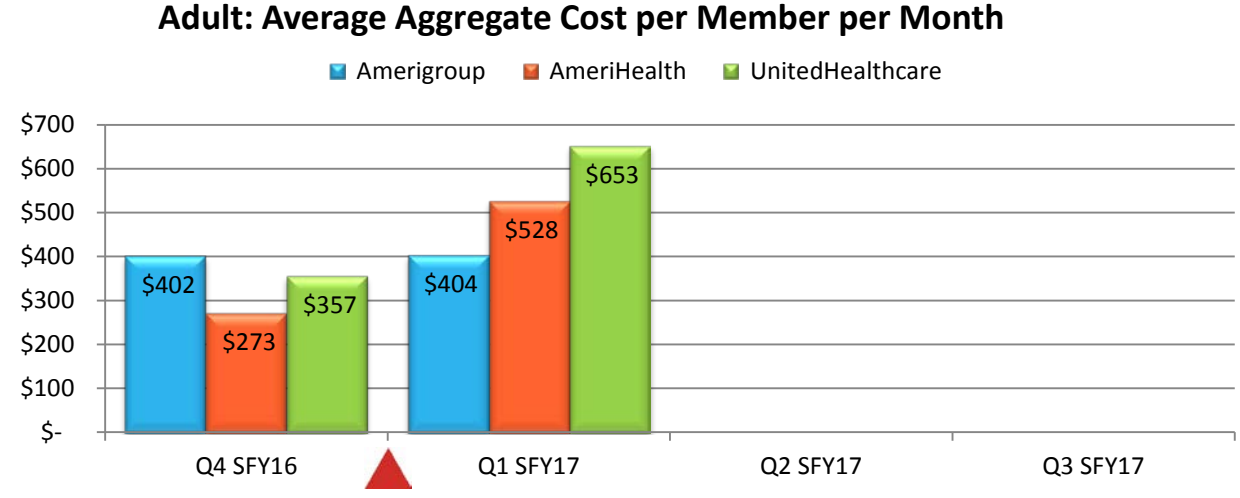

The aggregate average cost includes health care and pharmacy services. The data is based on claims paid during this reporting period and does not account for a claims that have not yet been submitted. After reviewing the percentage of claims that may be outstanding, it has been concluded that eight to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

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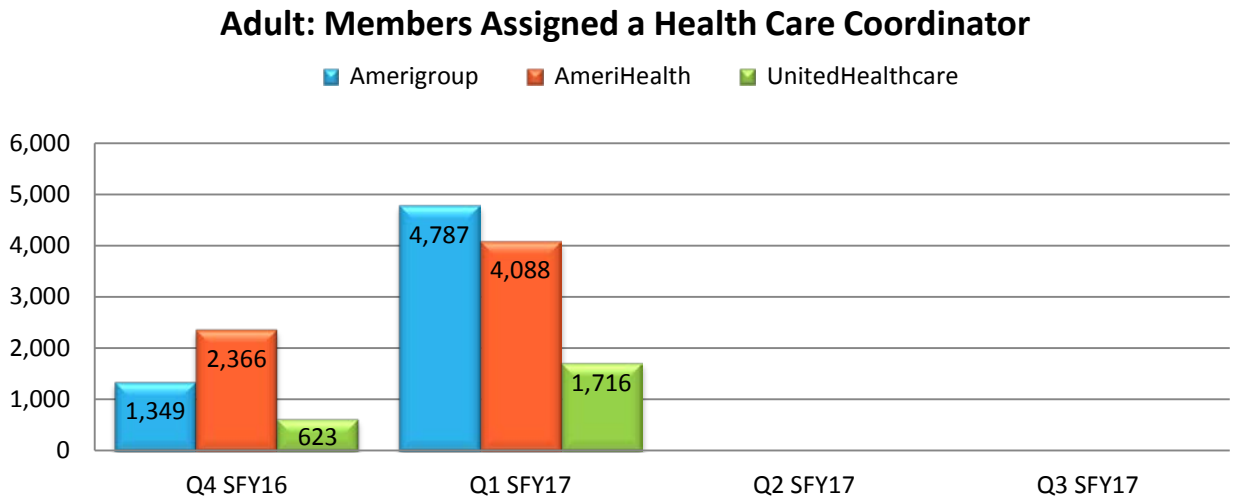
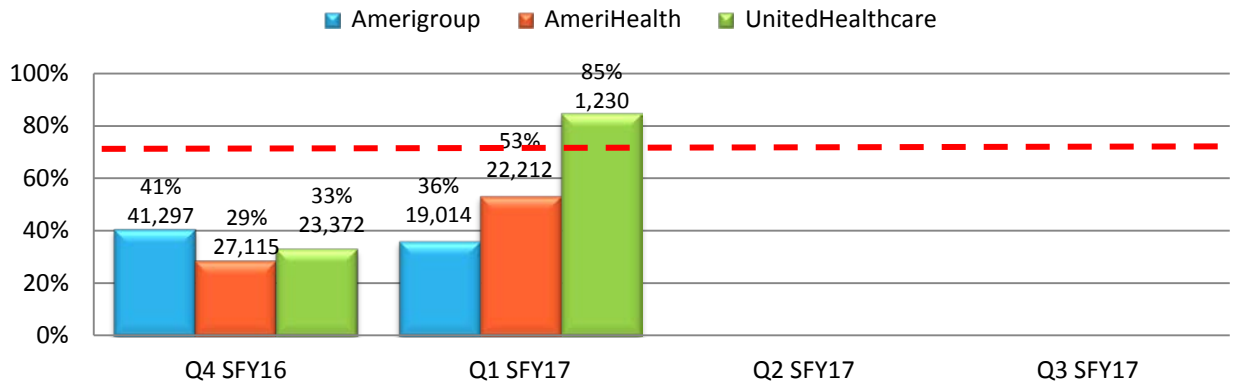


Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. This is a new and more comprehensive health care coordination 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. For example, the numbers reported for AmeriHealth and UnitedHealthcare are representative of members assigned to a care coordinator in the field, while Amerigroup reported telephonic care coordination as well.

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



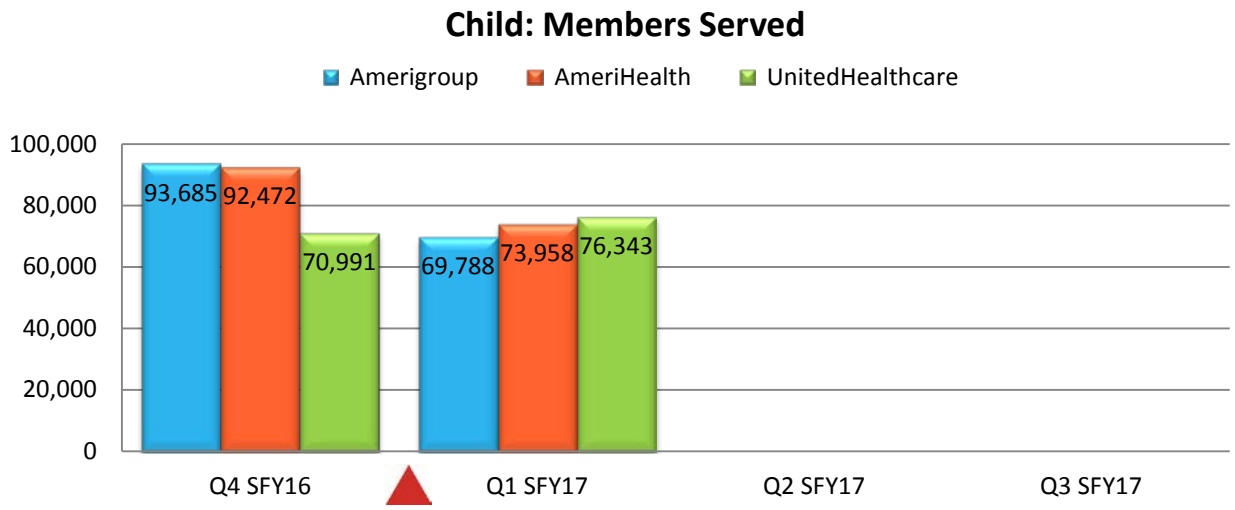
At least seventy percent (70%) of the MCO's new members, who have been assigned to the MCO for a continuous period of at least ninety (90) days and the MCO has been able to reach within three attempts. The department has issued remedies for this performance metric and continues to monitor the MCO work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



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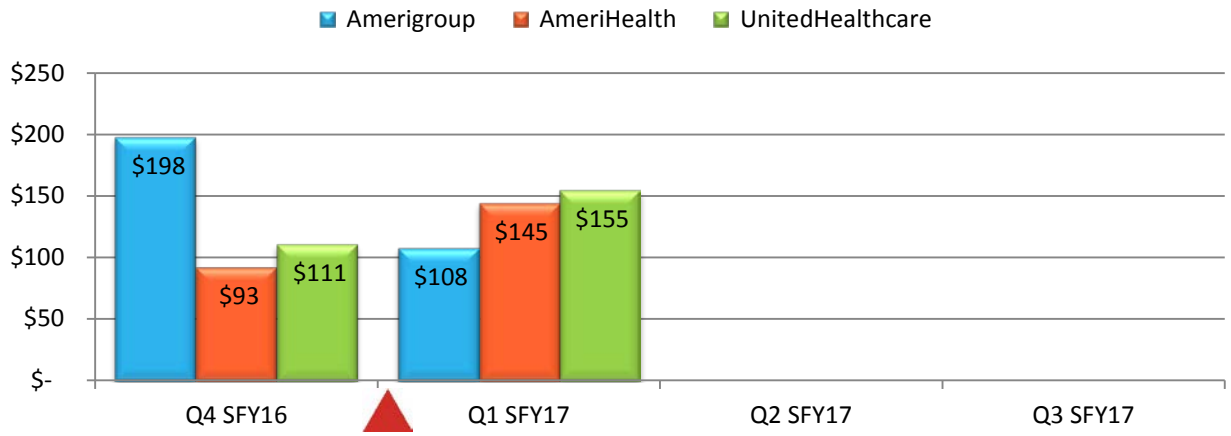

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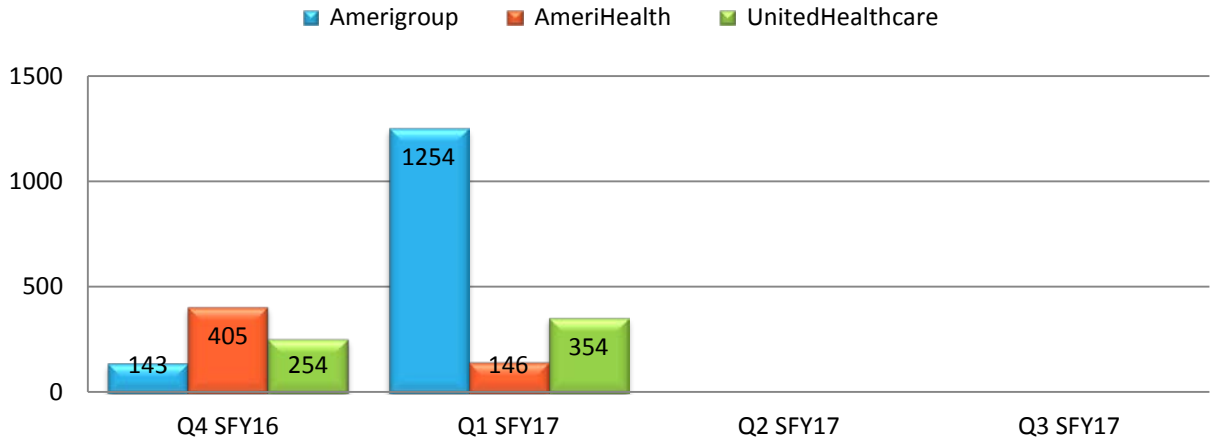

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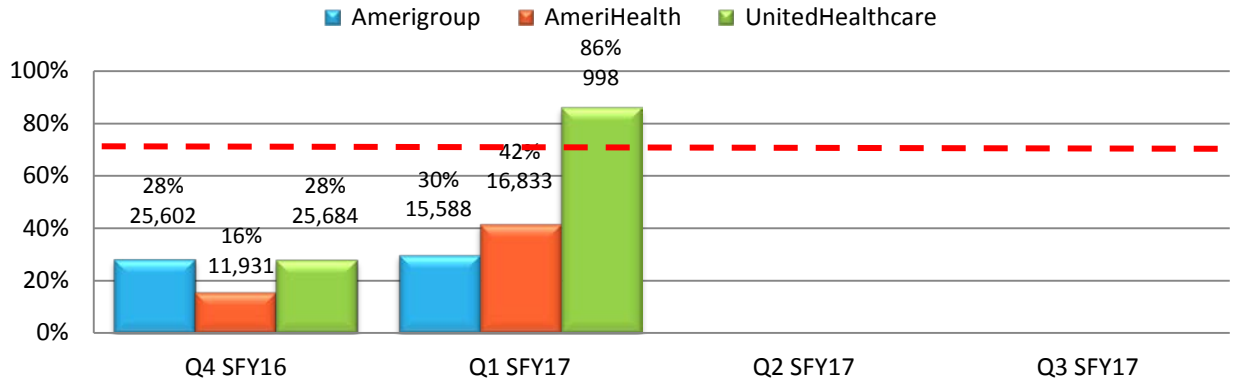

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Adult Special Needs Population Reporting

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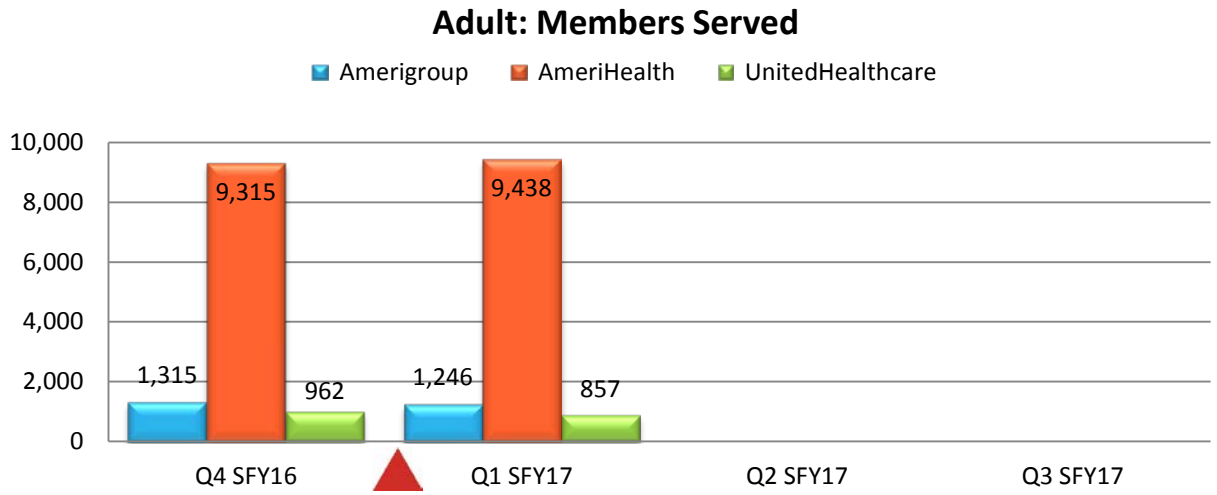

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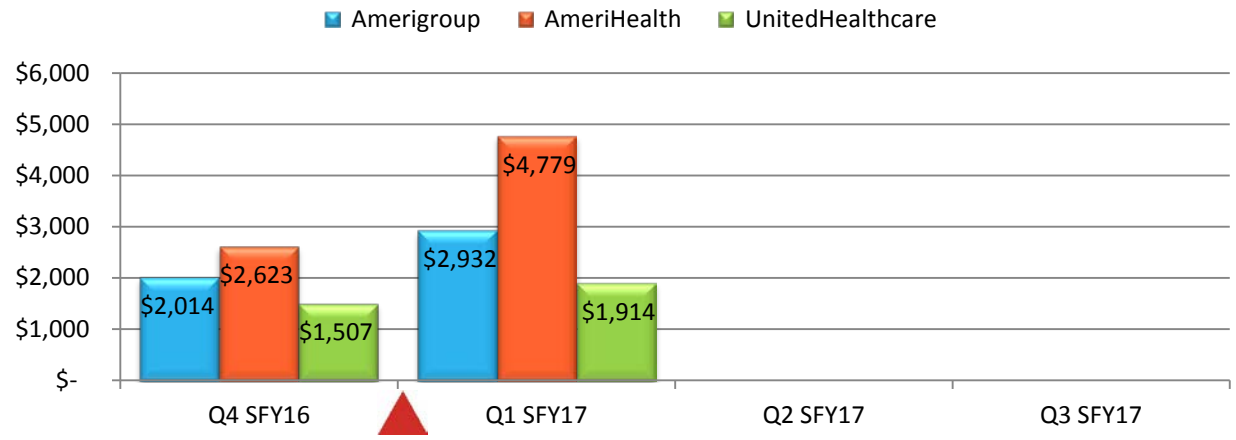

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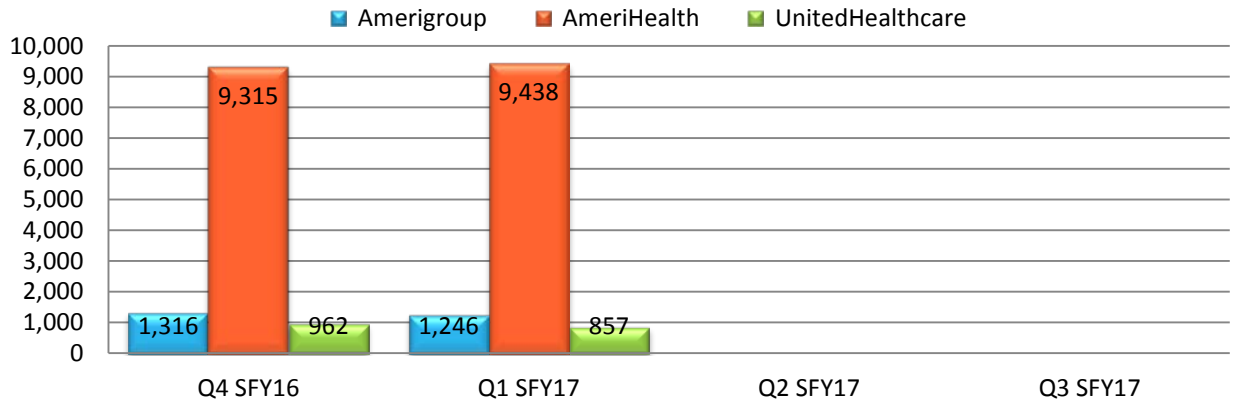
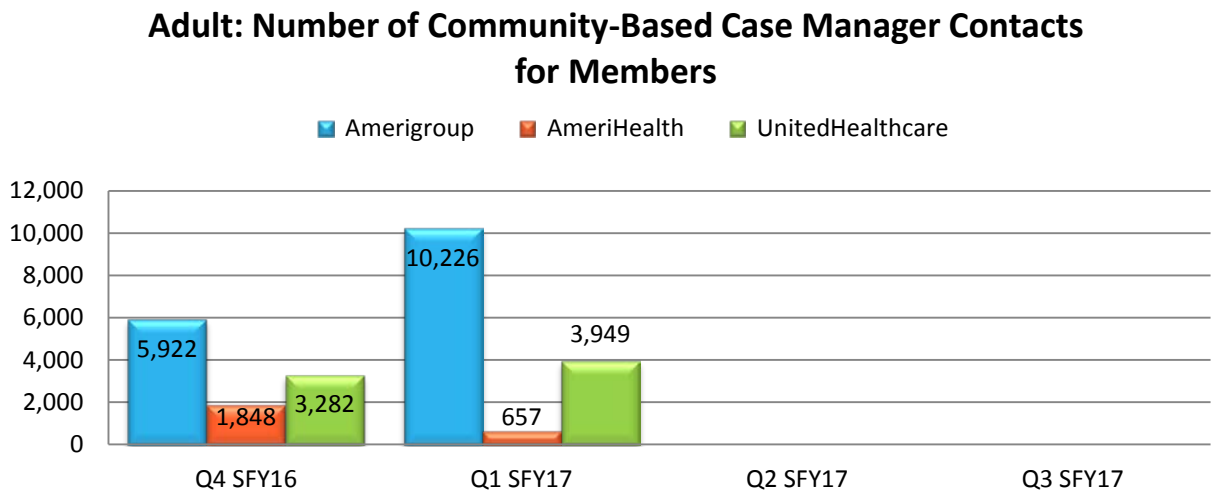
Adult: Members Assigned a Community Based Case Manager



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

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



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.

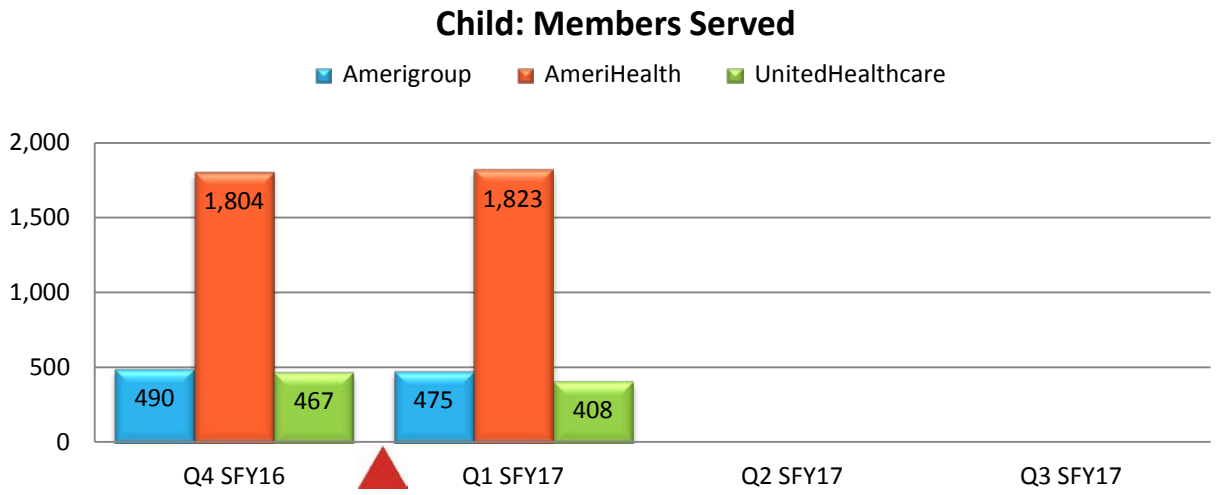
The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the community-based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report 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 October 31, 2016	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Ratio of Member to Case Manager - Brain Injury	2.1	2.7	2.0
Ratio of Member to Case Manager - Health and Disability	6.0	2.8	3.0
Ratio of Member to Case Manager - HIV/AIDS	1.0	1.0	1.0
Ratio of Member to Case Manager - Intellectual Disability	10.9	15.5	6.0
Ratio of Member to Case Manager - Physical Disability	3.8	2.1	2.0

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 beginning of the quarter who have an intellectual disability, a brain injury, a physical or health disability, or HIV. At this time only home- and community-based members are included in this Population Reporting. In the future the report will include facility-based members as well.



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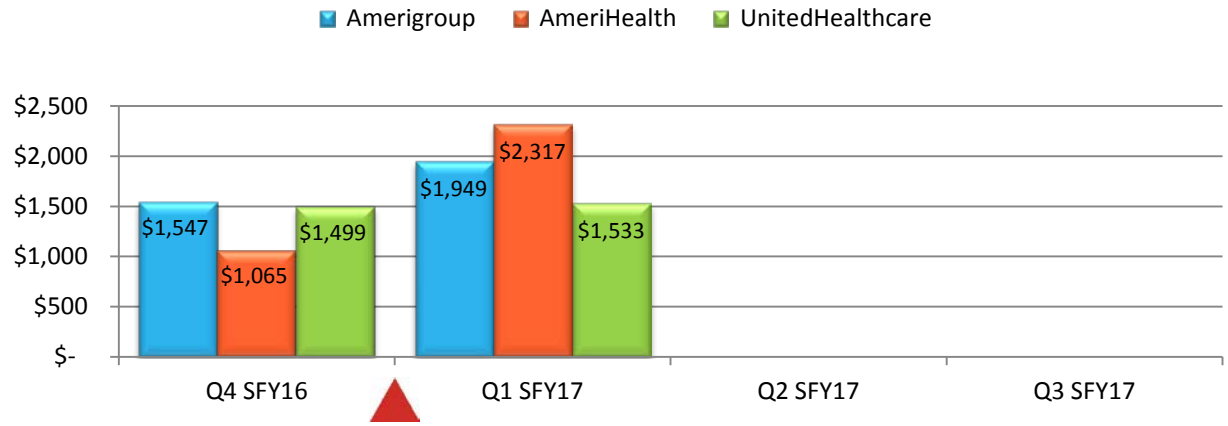

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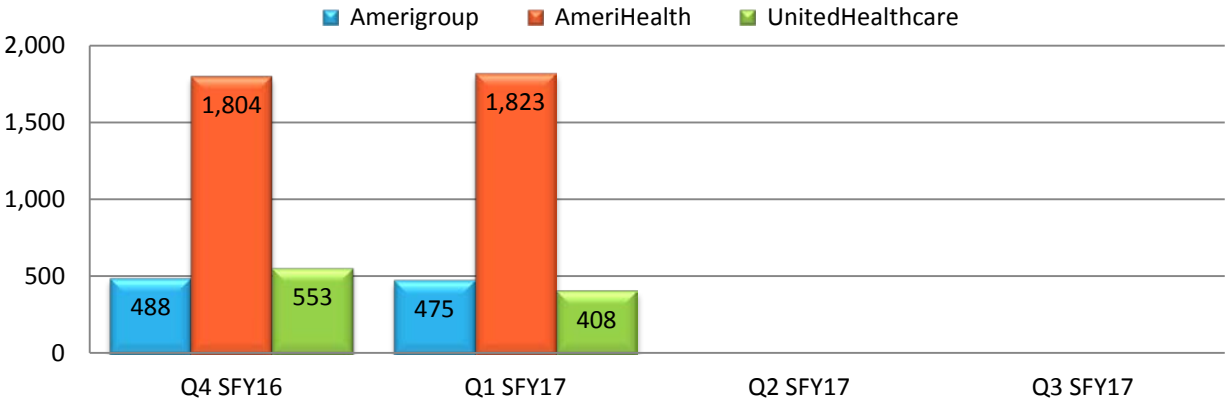

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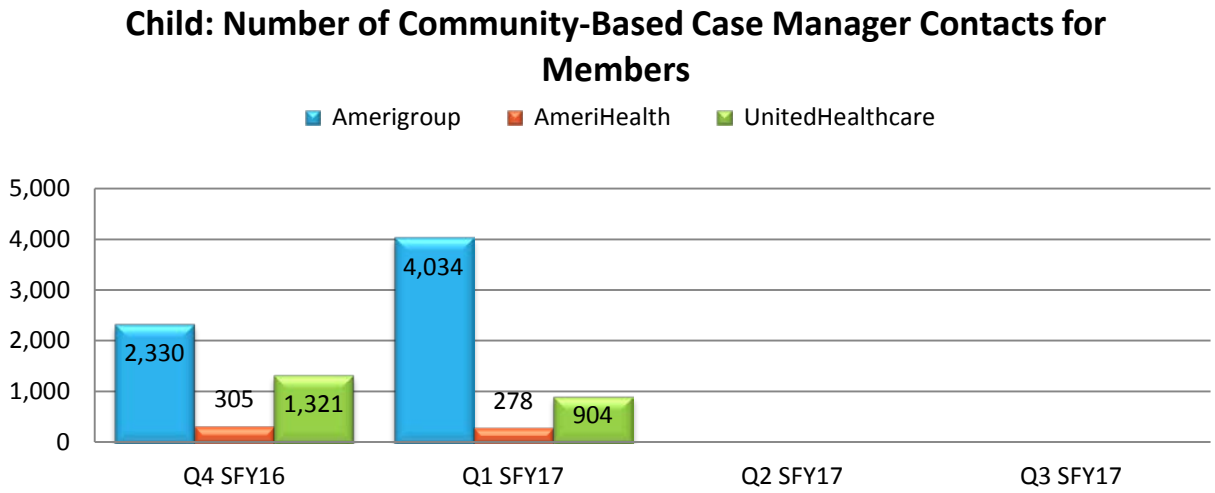

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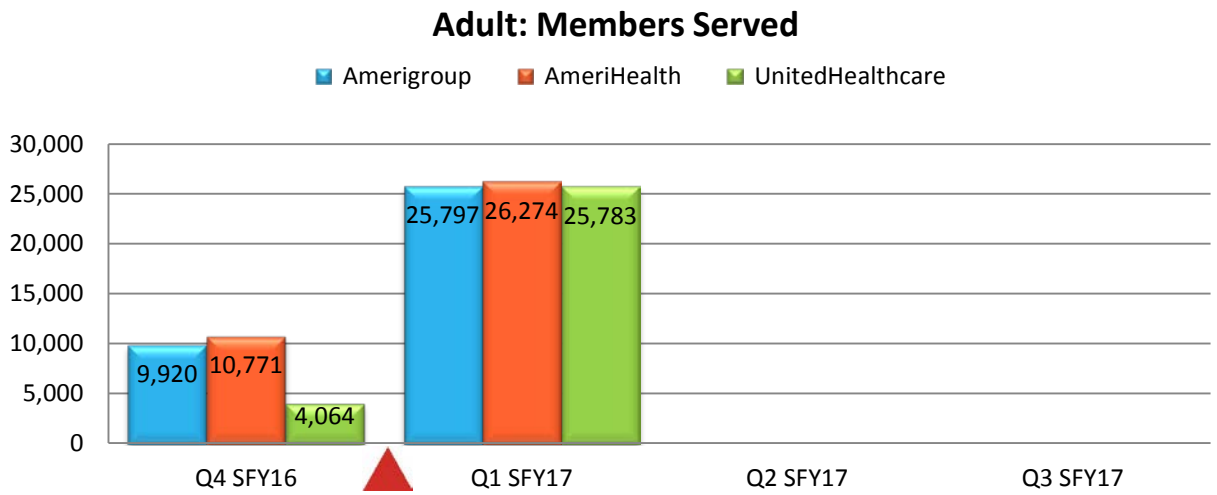
Adult Behavioral Health Population Reporting

Adults included in this report are members age 18 and older as determined at the beginning 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.



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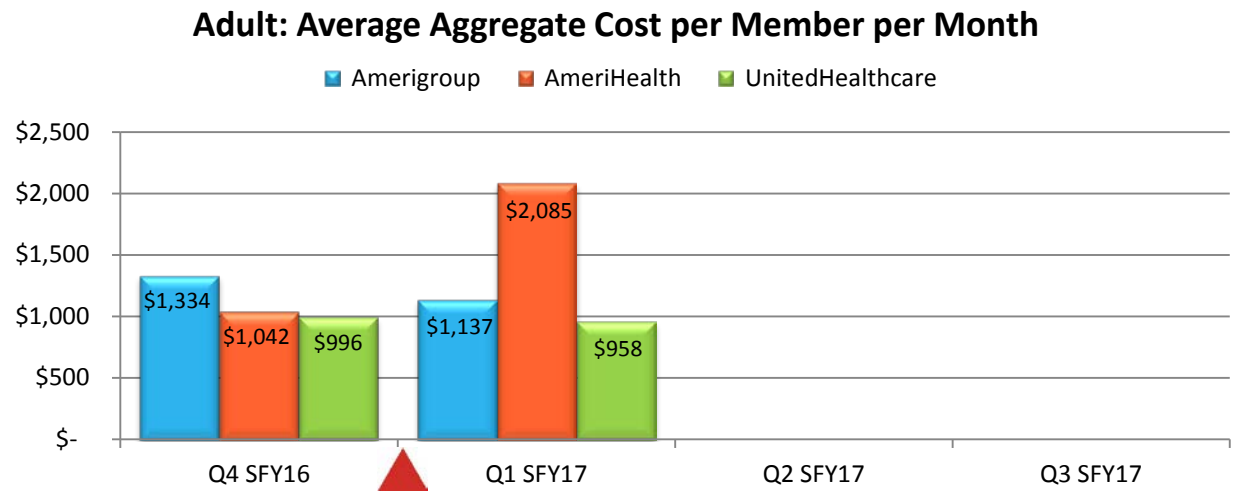

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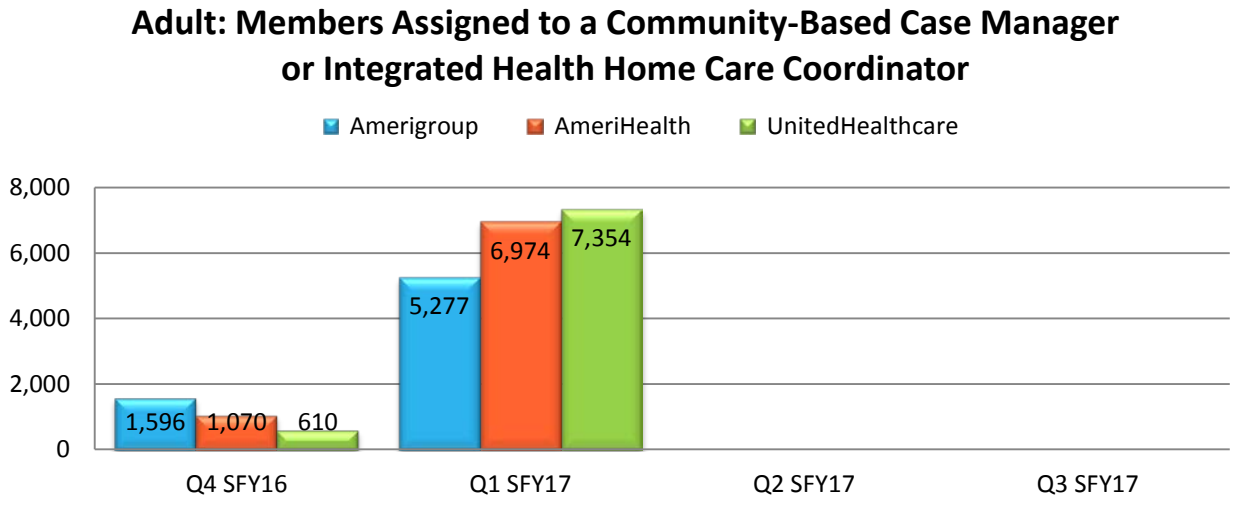
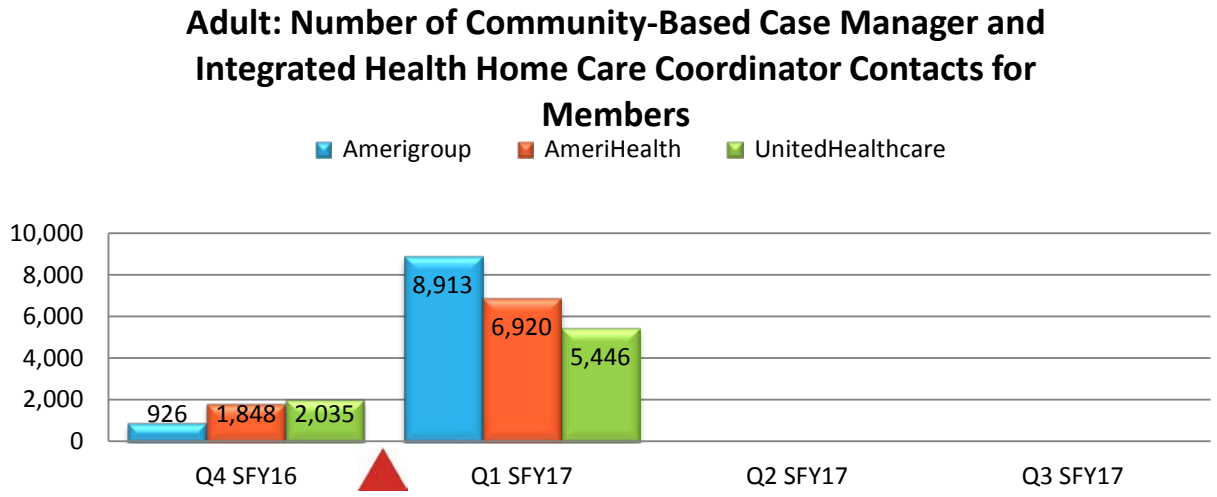
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for some variance.



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 Community-Based Case Manager due to participation in a Home- and Community-Based Waiver program. 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.



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.

- The increase in number of the Integrated Health Home and community based case manager contacts for members between Q4 SFY16 and Q1 SFY17 is likely due to a standardization regarding how to classify behavioral health diagnoses for reporting purposes. 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.

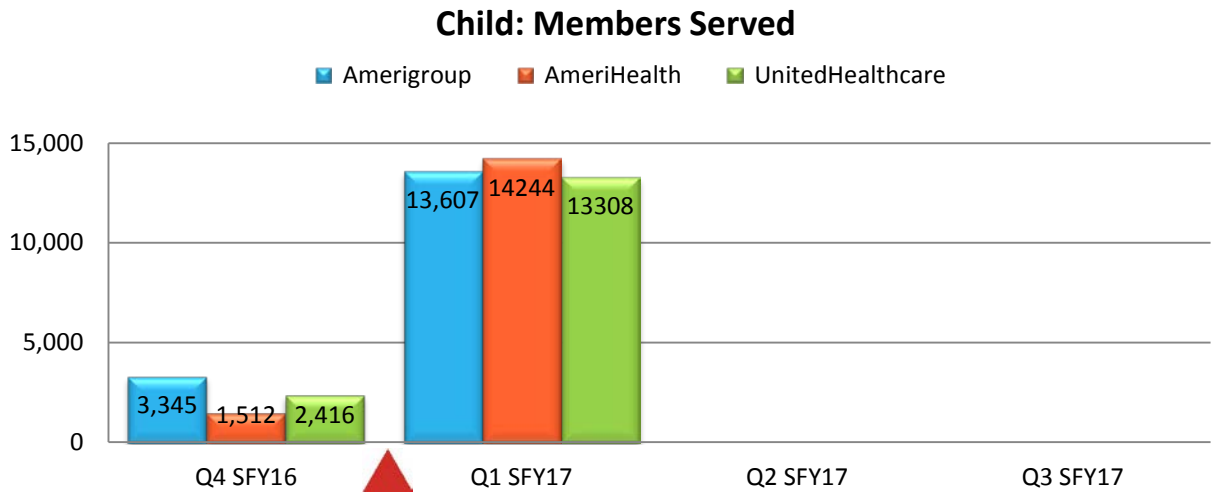
The department continues to monitor this measure to ensure that actions are being taken to meet the minimum contacts required for the Integrated Health Home and community-based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not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

Integrated Health Home Ratios			
The department collects member to community-based case manager 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 Case Manager – 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.

Child Behavioral Health Population Reporting

Children included in this report are members under the age of 18 as determined at the beginning 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.

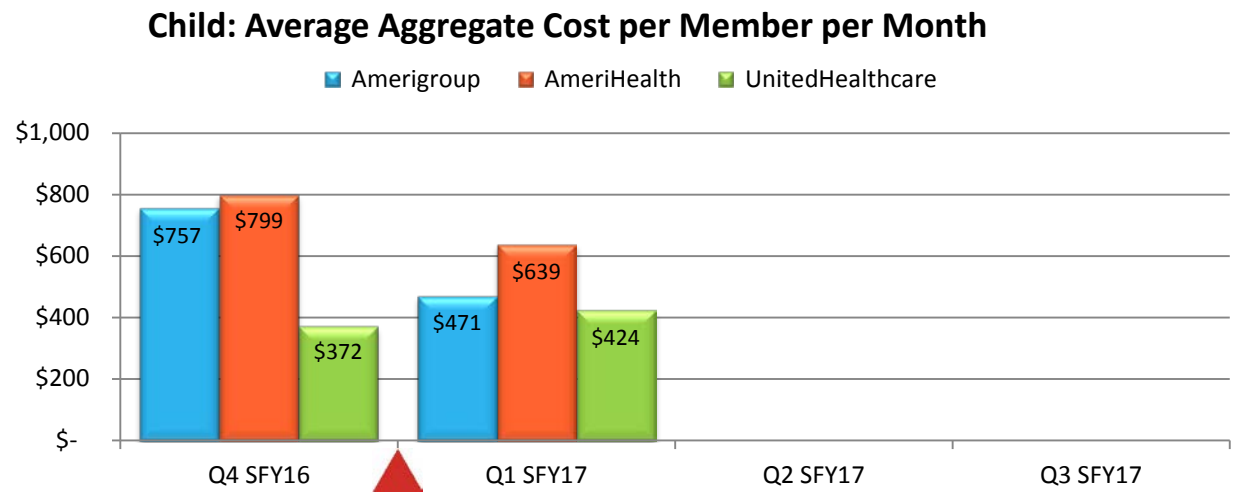


Members Served represents unduplicated and continuously enrolled members across the quarter and not a point in time enrollment.

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.

▲ Differences between quarters:

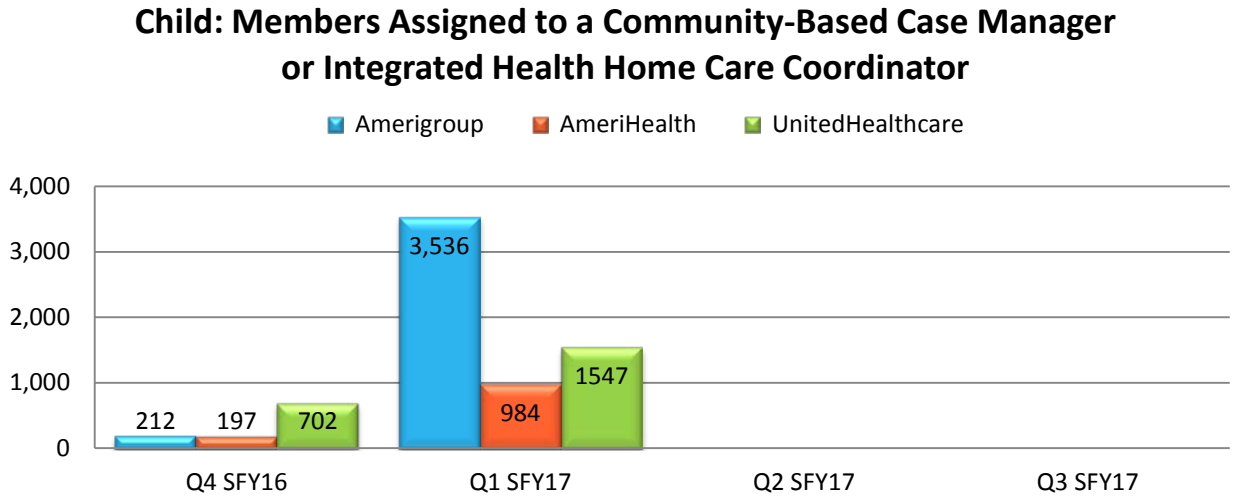
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter. The department also standardized how to identify these members for reporting which accounts for the increase.



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.

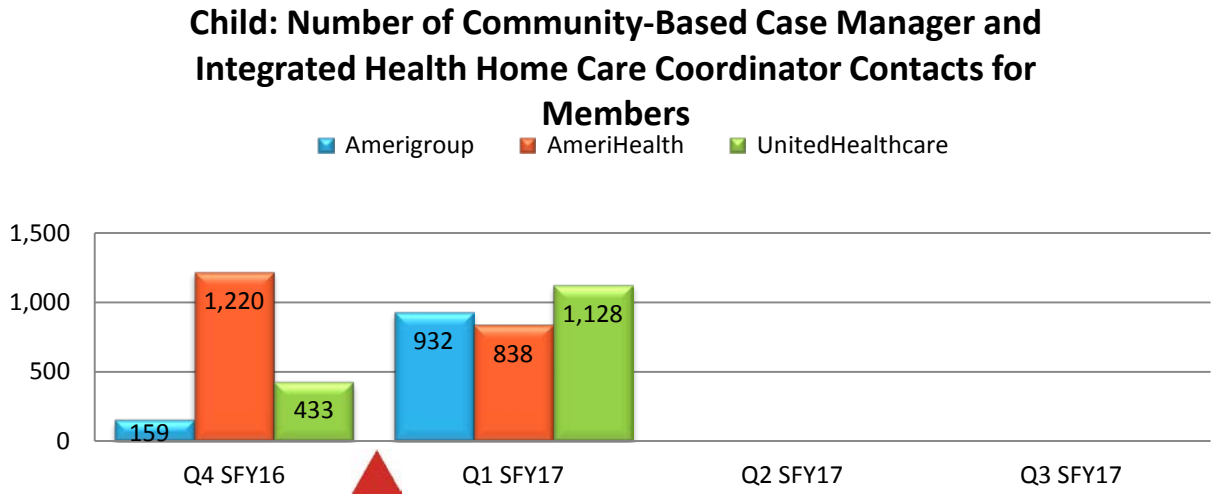
▲ Differences between quarters:

- 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.



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 Community-Based Case Manager due to participation in a Home- and Community-Based Waiver program. 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.



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.

▲ The increase in number of the Integrated Health Home and community based case manager contacts for members between Q4 SFY16 and Q1 SFY17 is likely due to a standardization regarding how to classify behavioral health diagnoses for reporting purposes. 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

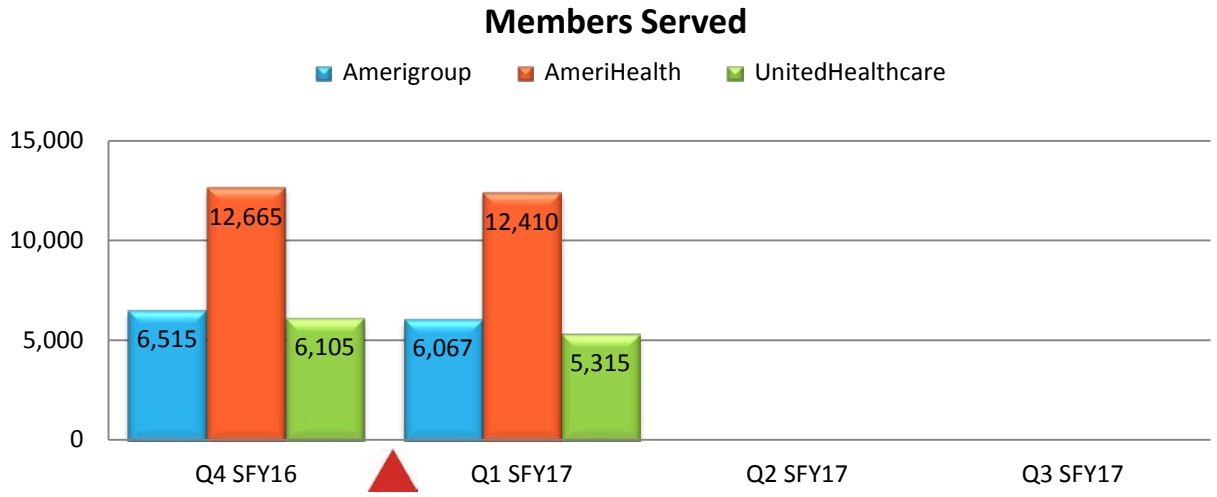
community-based case manager function. At this time, the department believes that adequate contacts are being made but that systems are not set up to capture and report this information.

IHH Care Coordinator Ratios			
The department collects member to community-based case manager 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 IHH 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.

Elderly Population Reporting

Elderly members included in this report are age 65 or older as determined at the beginning of the quarter. These members may receive elderly waiver services or institutional services. This population report reflects home and community based members only at this time but in the future will include facility based members as well.

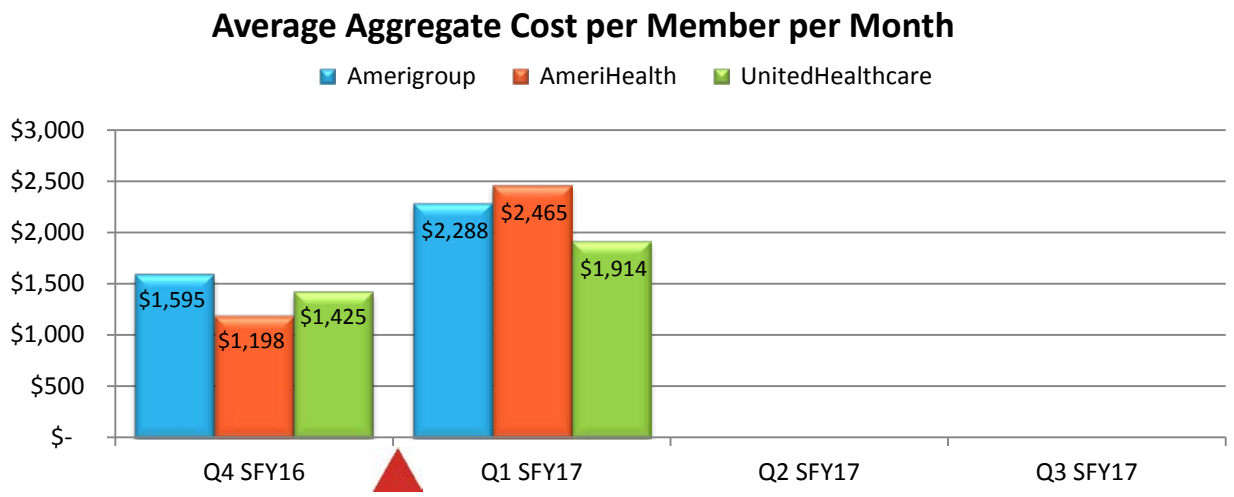


While the department intended to differentiate between members served by community- and facility-based settings for this population, it was not possible for this report due to the complexities of considerations, including how members shift between settings during the quarter.

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

▲ Differences between quarters:

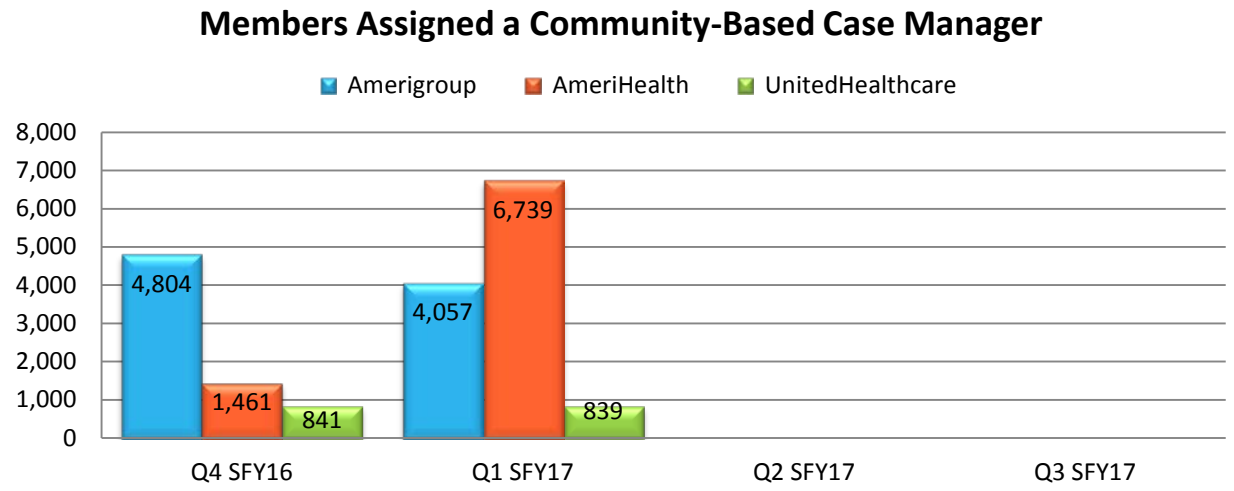
- Q4 SFY16 represented numbers of unduplicated members enrolled anytime during the quarter which could show members that have only been enrolled for a short time with the MCO.
- Q1 SFY17 represents numbers of members unduplicated and continuously enrolled which reduces the count of members for the quarter.



The 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.

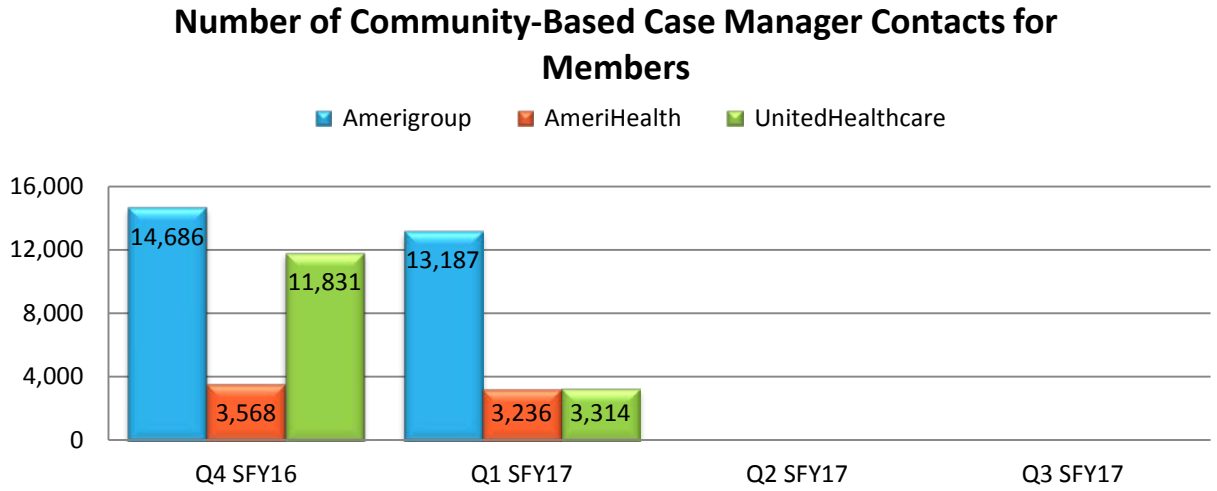
▲ Differences between quarters:

- 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.



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

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



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 October 31, 2016	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	9.3	17.8	6.0

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.

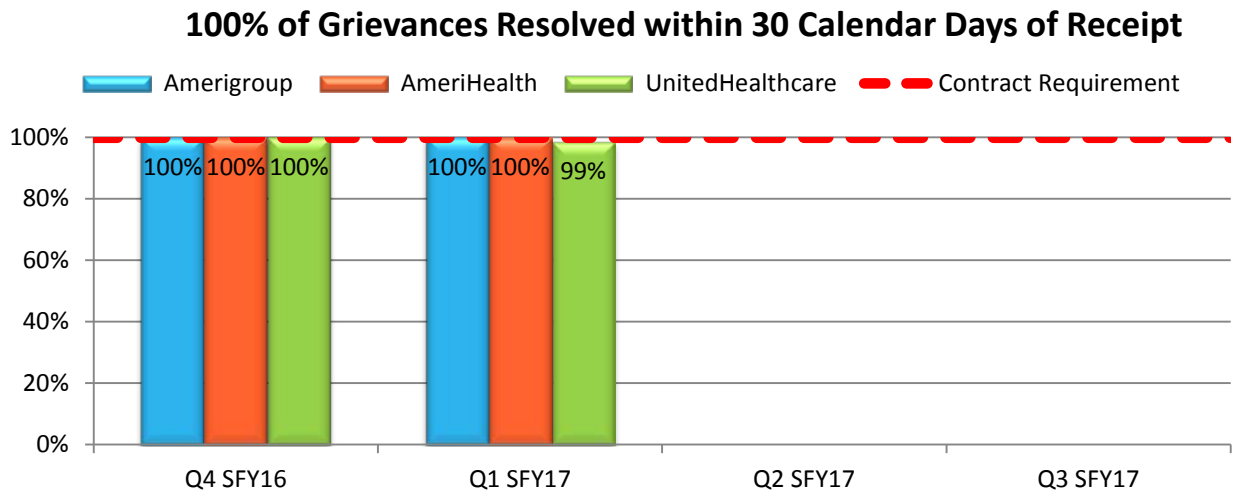
MCO Member Grievances and Appeals

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.



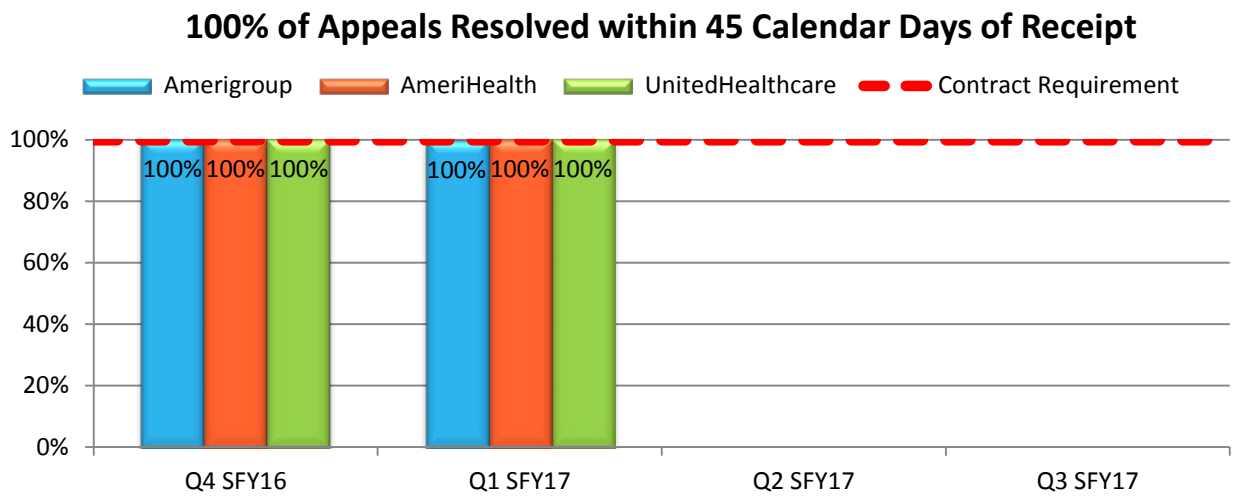
This measure represents grievances resolved within the contractual timeframes and does not measure the member's satisfaction with that resolution. If a member is not resolved with a MCO resolution to their grievance, the member may contact the Iowa Medicaid Enrollment Broker to disenroll if "good cause" 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	40
Grievances Received in Q1 SFY17	224	133	79

Top Five Reasons for Grievances for Q1 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Grievances	Count	Grievances	Count	Grievances	Count
1	Transportation - Delay	79	Provider Issue - Excessive Waiting	17	Transportation - Billing	34
2	Voluntary Disenrollment Request	52	Transportation – No Pick Up	15	Provider Issue- Balance Billing	25
3	Provider Issue- Balance Billing	15	Provider Issue – Not Happy with Service	12	Transportation - Ambulance	4
4	MCO Staff - Attitude/Rudeness	12	Benefits	10	Provider Issue – Not Happy with Service	3
5	Provider Issue – Attitude/Rudeness	11	Did Not Receive ID Card	9	Provider Issue - Excessive Waiting	2

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



This measure represents appeals resolved within the contractual timeframes. If a member is not satisfied with the appeal decision, they may file an appeal with the state.

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Appeals Received in Q4 SFY16	14	52	50
Appeals Received in Q1 SFY17	370	216	100

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

Top Five Reasons for Appeals for Q1 SFY17

	Amerigroup		AmeriHealth		UnitedHealthcare	
#	Appeals	Count	Appeals	Count	Appeals	Count
1	Pharmacy - Non Injectable	138	Pharmacy	143	Pharmacy - Authorization	88
2	Behavioral Health – Authorization for Inpatient	55	Level of Care	20	Medical – Utilization Review Dispute	33
3	Pharmacy - Injectable	36	Medical – Authorization for Durable Medical Equipment	18	Pharmacy – Covered Services	30
4	Medical – Authorization for Radiology	29	Medical – Authorization for Radiology	8	Level of Care	10
5	Medical – Authorization for Inpatient	22	Medical - Authorization	6	Medical – Authorization for Durable Medical Equipment	8

State Fair Hearing Summary for Members in Managed Care Year to Date

Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Level of Care	0	0	0
Medical Service Denial/Reduction	31	30	48
Pharmacy Denial/Reduction	85	10	16
Durable Medical Equipment Denial/Reduction	4	2	5

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 due to resolution of the issue prior to hearing.

Critical Incidents

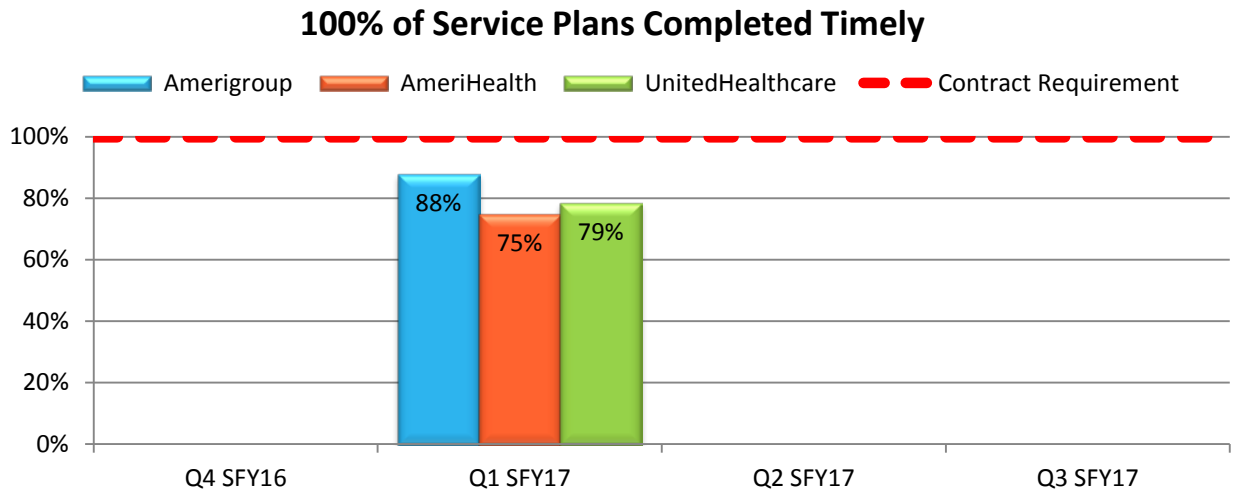
Home- and Community-Based Services (HCBS) Waiver and Habilitation providers and case managers/care coordinators are required to report critical incidents to the MCOs. These critical incidents are to be reported if the reporting entity witnesses the incident or is made aware of the incident. Critical 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 September 2016	3,034	17,187	2,589
Special Needs Population			
# of Critical Incidents Received for Q1 SFY17	53	1,245	78
# Critical Incidents Received and Resolved for Q1 SFY17	53	1,236	78
% Critical Incidents Resolved for Q1 SFY17	100%	99.3%	100%
Behavioral Health Population			
# of Critical Incidents Received for Q1 SFY17	675	1,687	252
# Critical Incidents Received and Resolved for Q1 SFY17	675	1,679	252
% Critical Incidents Resolved for Q1 SFY17	100%	99.5%	100%
Elderly Population			
# of Critical Incidents Received for Q1 SFY17	84	339	23
# Critical Incidents Received and Resolved for Q1 SFY17	84	335	23
% Critical Incidents Resolved for Q1 SFY17	100%	98.8%	100%

Service Plans

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



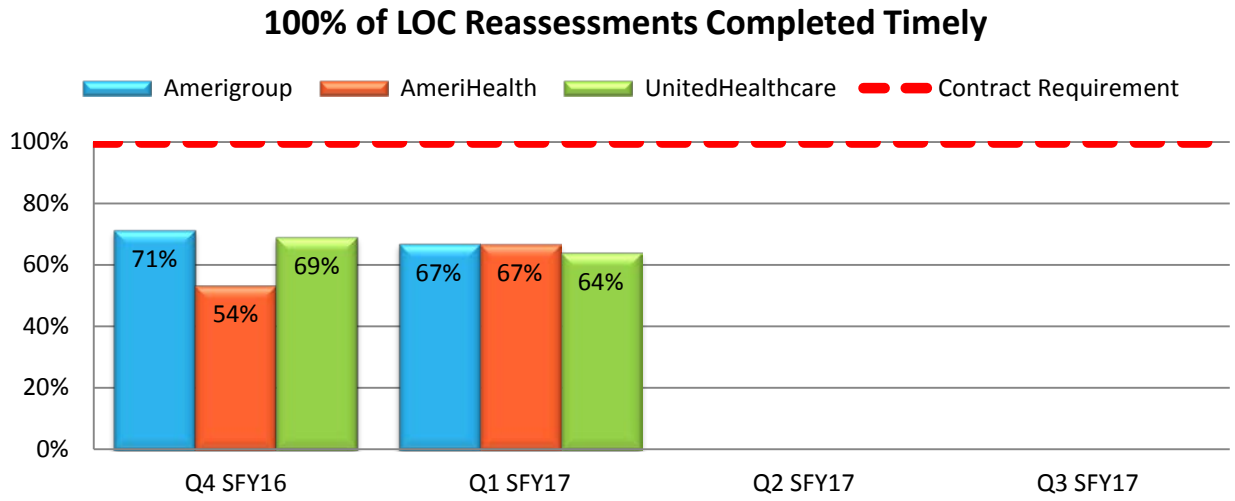
There is no data for Q4 SFY16 due to no service plans being due during that period.

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.

Level of Care

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

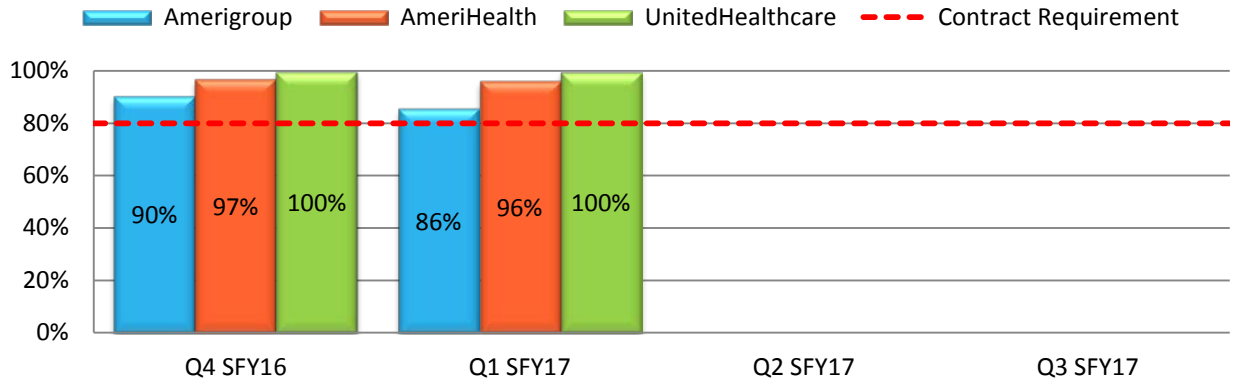


Members will continue to receive the same level of services regardless of whether level of care has been reassessed timely. LOC reassessment timeliness does not have an impact on a member's eligibility for services.

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

Member Helpline

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



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

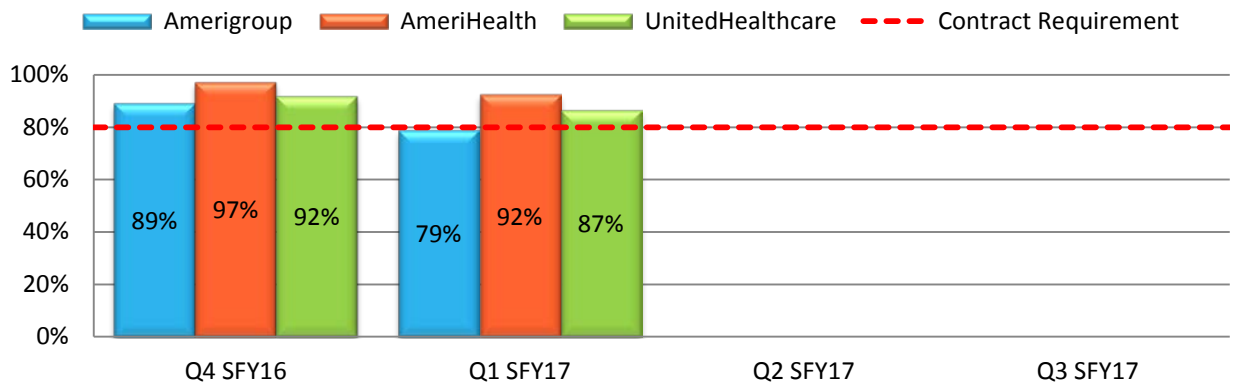
Top Five Reasons for Members Contacting Helplines for Q1 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2016						
1.	Transportation Question	6,906	Member Changes	10,534	Benefits	5,297
2.	Provider-Find/Change/Verify PCP	1,527	Member Inquiries	10,421	PCP Inquiry	3,444
3.	Benefit Inquiry	1,398	Transportation Questions	9,077	Eligibility Inquiry	3,274
4.	Order ID Card	624	Member Request	7,754	ID Cards	1,374
5.	Pharmacy Inquiry	566	Other Programs & Services	3,986	COB Information	1,144
August 2016						
1.	Transportation Question	8,395	Transportation Questions	11,028	Benefits	6,016
2.	Provider-Find/Change/Verify PCP	1,912	Member Changes	8,875	Eligibility Inquiry	3,904
3.	Benefit Inquiry	1,649	Member Inquiries	8,358	PCP Inquiry	3,783
4.	Order ID Card	850	Member Request	7,067	ID Cards	1,669

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
5.	Claim/Billing Issue	584	Other Programs & Services	4,224	COB Information	1,251
September 2016						
1.	Transportation Question	7,779	Transportation Questions	9,757	Benefits	4,769
2.	Provider-Find/Change/Verify PCP	1,490	Member Inquiries	7,213	Eligibility Inquiry	3,652
3.	Benefit Inquiry	1,374	Member Changes	7,020	PCP Inquiry	3,109
4.	Order ID Card	705	Member Request	5,290	ID Cards	1,482
5.	Pharmacy Inquiry	587	Other Programs & Services	3,819	COB Information	1,269

Provider Helpline

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



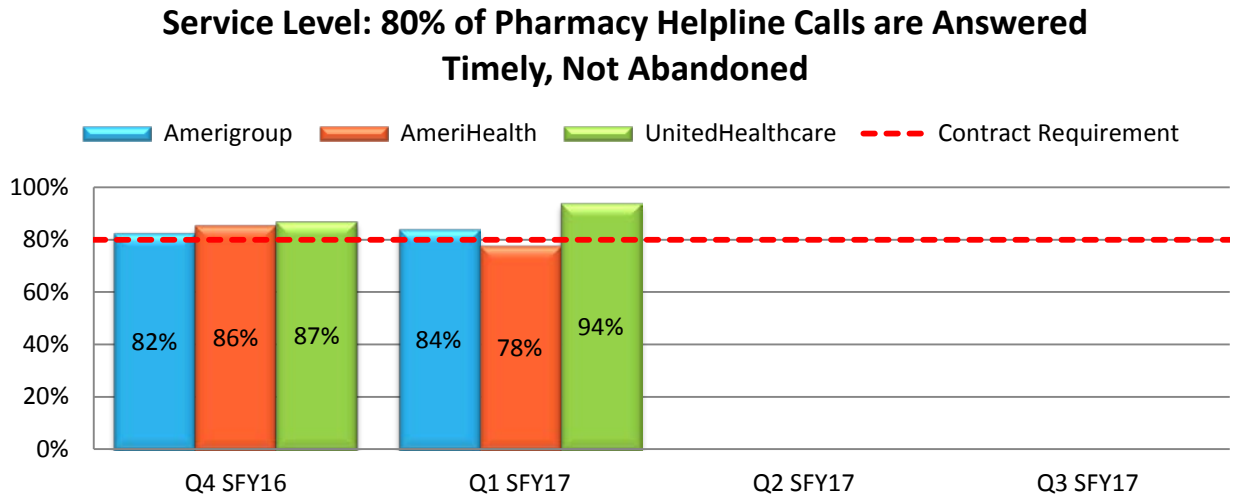
This performance target measures the timeliness of answering the helpline calls. Each MCO conducts internal quality assurance programs for their helplines. Additionally, the department conducts secret shopper calls to measure adequacy, consistency, and soft skills associated with the MCO helplines.

Top Five Reasons for Providers Contacting Helplines for Q1 SFY17

#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
July 2016						
1.	Claim Status Inquiry	1,843	Provider Inquiries	8,988	Claims Inquiry	11,308
2.	Auth-Status	1,533	Provider Requests	7,507	Benefits	6,057
3.	Pharmacy Department Call Inquiry	1,378	Claims	7,070	COB Information	1,146

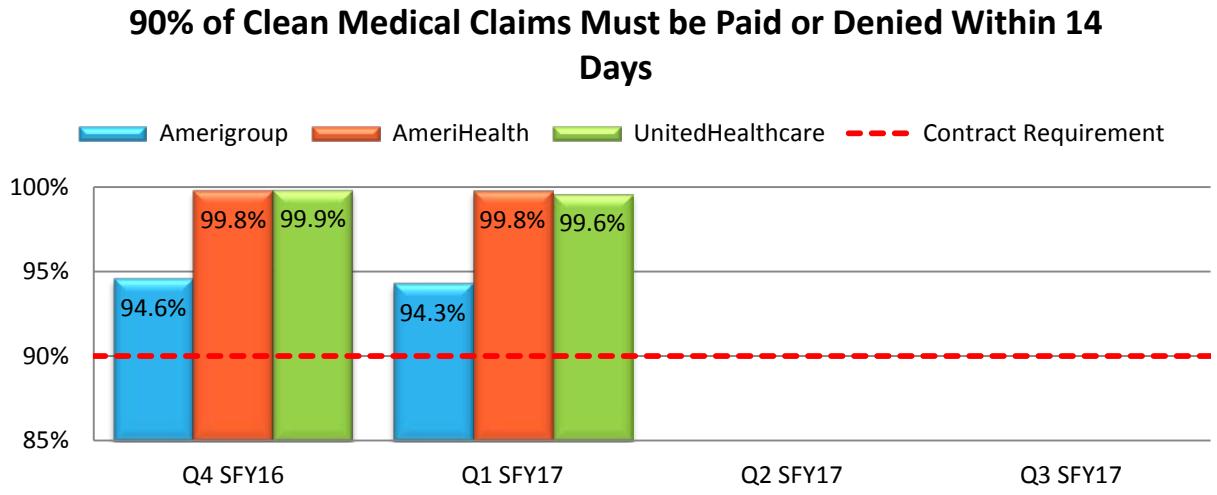
#	Amerigroup	Count	AmeriHealth	Count	UnitedHealthcare	Count
4.	Benefits Inquiry	1,181	Eligibility/Enrollment	3,388	Membership Record	686
5.	Auth-New	969	Other Programs & Services	2,791	Authorization Related	449
August 2016						
1.	Claim Status Inquiry	2,561	Claims	9,058	Claims Inquiry	10,849
2.	Auth-Status	1,832	Provider Inquiries	8,944	Benefits	5,107
3.	Pharmacy Department Call Inquiry	1,799	Provider Requests	7,231	COB Information	1,264
4.	Benefits Inquiry	1,232	Other Programs & Services	3,124	Membership Record	632
5.	Claims Inquiry	1,210	Eligibility/Enrollment	3,809	Authorization Related	371
September 2016						
1.	Claim Status Inquiry	2,565	Claims	9,220	Claims Inquiry	10,498
2.	Auth-Status	1,698	Provider Inquiries	8,046	Benefits	5,217
3.	Pharmacy Department Call Inquiry	1,270	Provider Requests	7,868	COB Information	1,490
4.	Claims Inquiry	1,079	Other Programs & Services	3,546	Membership Record	461
5.	Benefits Inquiry	1,063	Eligibility/Enrollment	2,528	Authorization Related	338

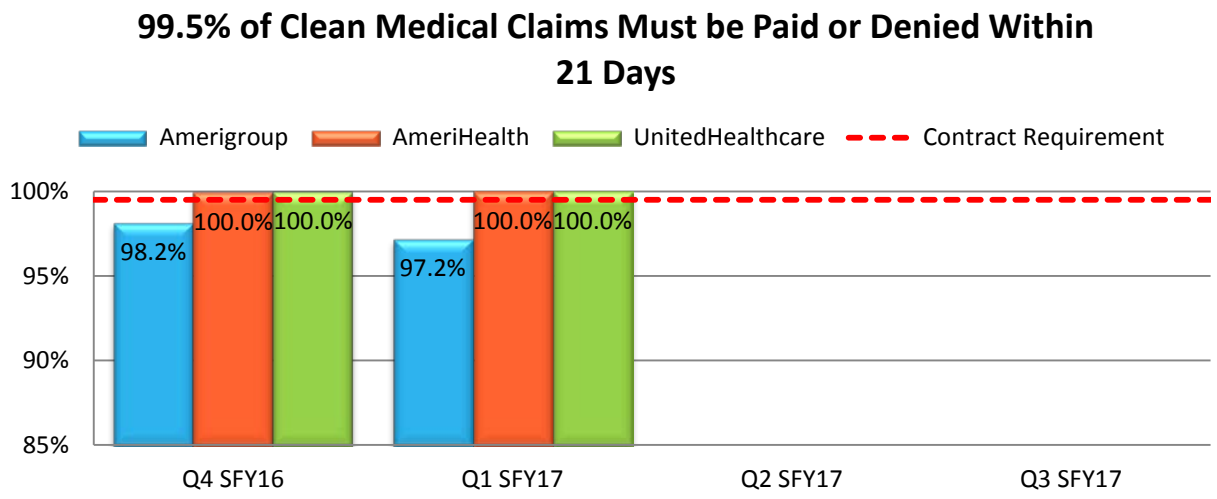
Pharmacy Services Helpline



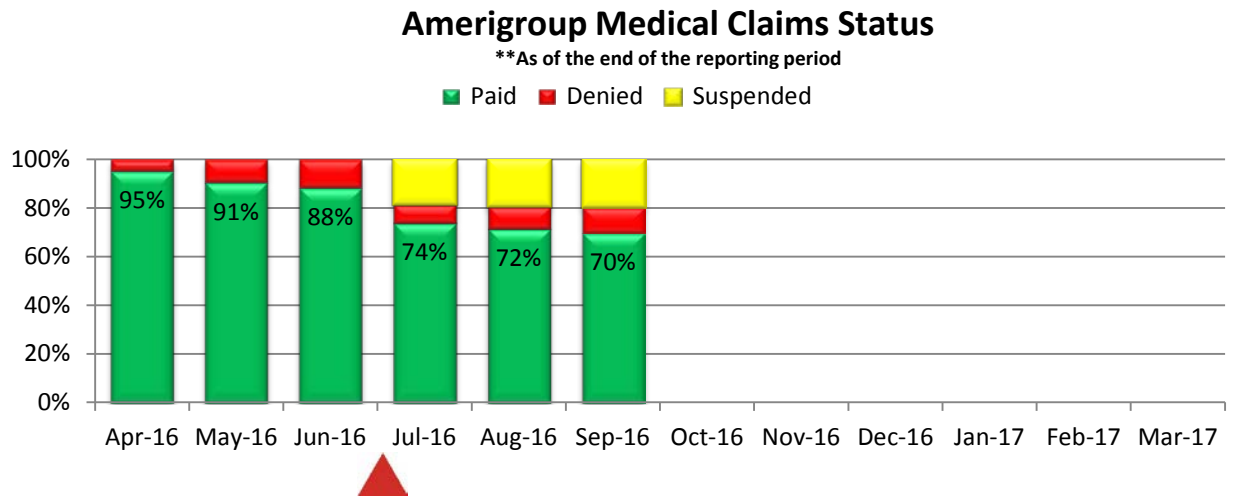
Medical Claims Payment

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

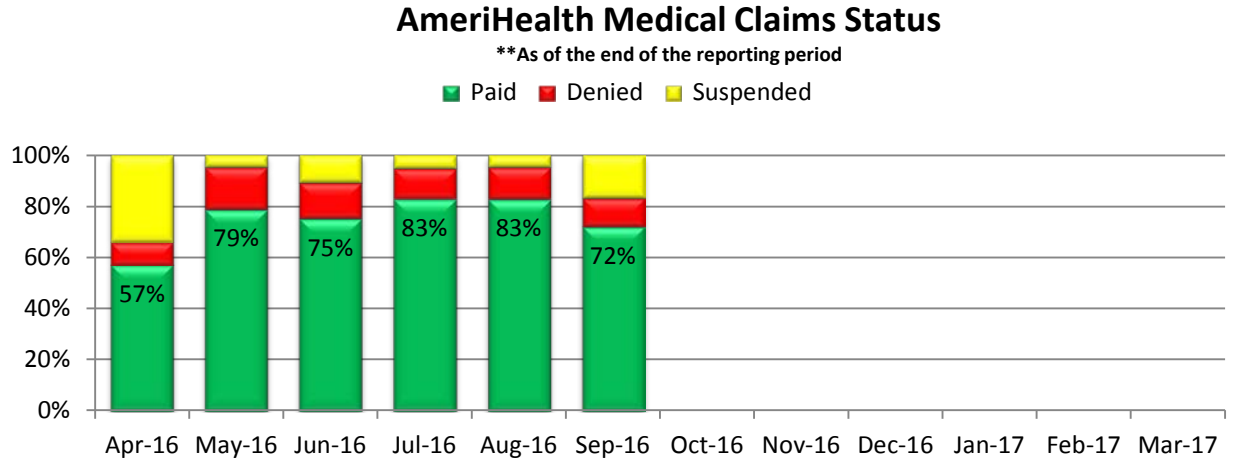


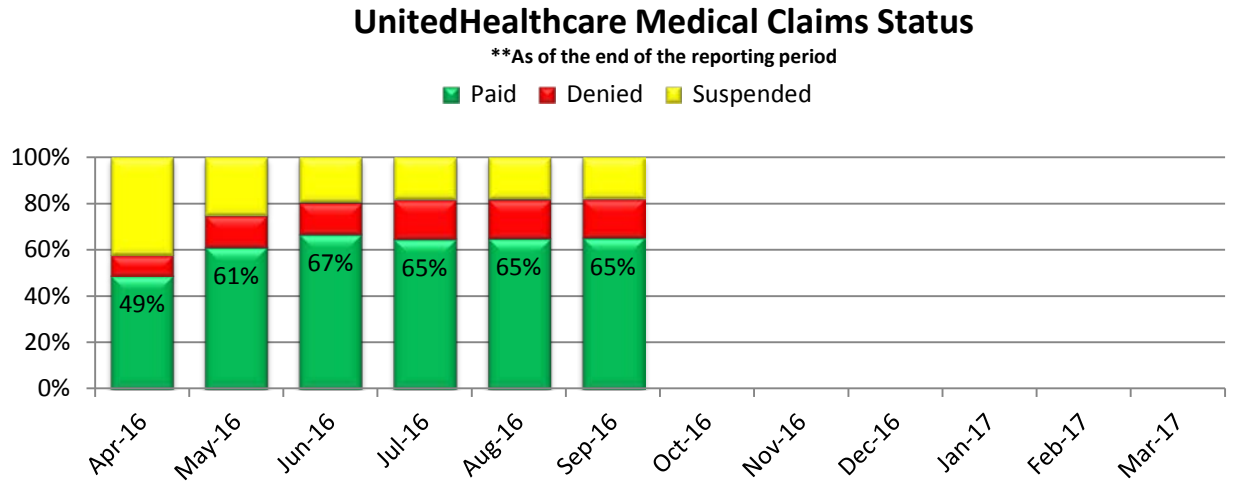


The department is closely monitoring this measure to ensure that corrective actions are taken to remedy performance for adjudicating claims within 21 days.



▲ Amerigroup did not correctly report suspended claims in April, May, and June of 2016.





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-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.
2. CARC-197 Precertification/ authorization/notification absent.	2. 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.	2. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement.
3. CARC-177 Patient has not met the required eligibility requirements.	3. CARC-22 This care may be covered by another payer per coordination of benefits. -RARC-N4 Missing/ Incomplete/ Invalid prior Insurance Carrier(s) EOB.	3. CARC-18 Exact duplicate claim/ service. -RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.
4. CARC-252 An attachment/ other documentation is required to adjudicate this claim/service. -RARC-N479: Missing Explanation of Benefits.	4. CARC-27 Expenses incurred after coverage terminated. -RARC-N30 Patient ineligible for this service.	4. 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.
5. CARC-45 Charge exceeds fee schedule/ maximum allowable or contracted/legislated fee arrangement. -RARC-N381 Alert: Consult our contractual agreement for restrictions/billing/payment information related to these charges.	5. 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.	5. CARC-96 Non-covered charge(s). -RARC-N448 This drug/ service/ supply is not included in the fee schedule or contracted/ legislated fee arrangement.

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
6. CARC-256 Service not payable per managed care contract	6. CARC-197 Precertification/authorization/ notification absent. -RARC-M62 Missing/ incomplete/invalid treatment authorization code.	6. 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.
7. CARC-16 Claim/ service lacks information or has submission/billing error(s) which is needed for adjudication. -RARC-MA130 Your claim contains incomplete and/ or invalid information, and no appeal rights are afforded because the claim is unprocessable.	7. CARC-A1 Claim/Service denied. -RARC-N142 The original claim was denied. Resubmit a new claim, not a replacement claim.	7. CARC-13 The date of death precedes the date of service.
8. CARC-242 Services not provided by network/ primary care providers.	8. CARC-16 Claim/ service lacks information or has submission/ billing error(s) which is needed for adjudication. -RARC-N329 Missing/incomplete/invalid patient birth date.	8. CARC-26 Expenses incurred prior to coverage. -RARC-N30 Patient ineligible for this service.
9. CARC-204 Service not payable per managed care contract -RARC-N130 Consult plan benefit documents/ guidelines for information about restrictions for this service.	9. CARC-96 Non-covered charge(s). -RARC-N381 Alert: Consult our contractual agreement for restrictions/ billing/payment information related to these charges.	9. CARC-197 Precertification/ authorization/ notification absent.
10. CARC-97 The benefit for this service is included in the payment/ allowance for another service/ procedure that has already been	10. CARC-16 Claim/ service lacks information or has submission/billing error(s) which is needed for adjudication. -RARC-N253	10. CARC-96 Non-covered charge(s). -RARC-N425 Statutorily excluded service(s).

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	**AmeriHealth**	**UnitedHealthcare**
adjudicated. -RARC-N19 Procedure code incidental to primary procedure.	Missing/incomplete/invalid attending provider primary identifier.	

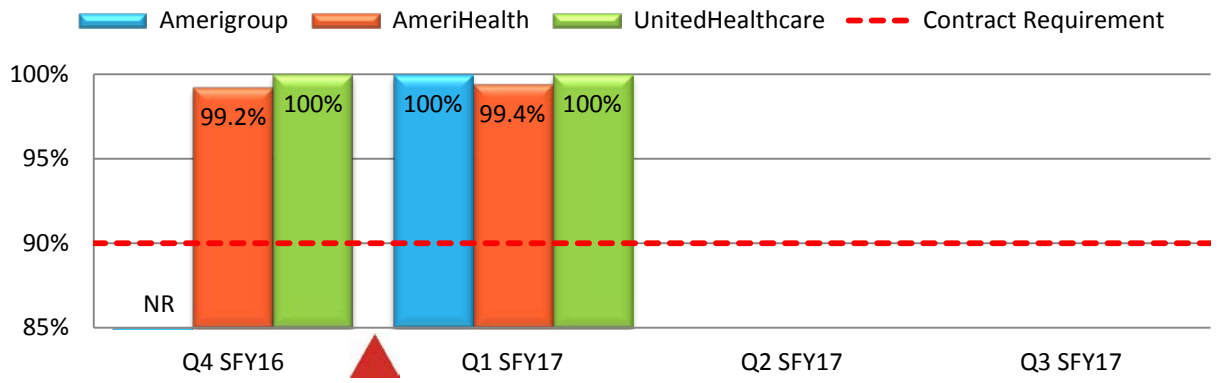
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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

Pharmacy Claims Payment

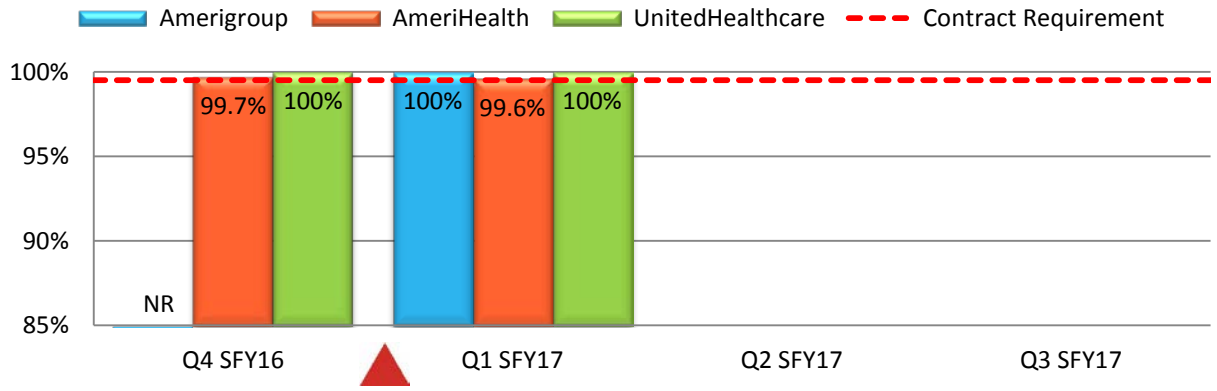
Pharmacy claims processing data is for the entire quarter.

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

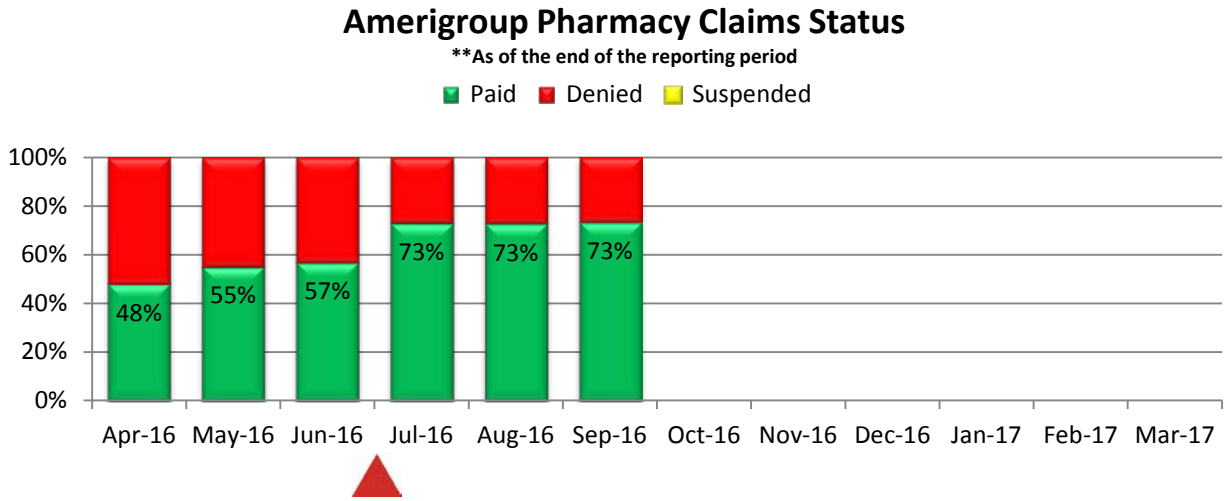


▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.

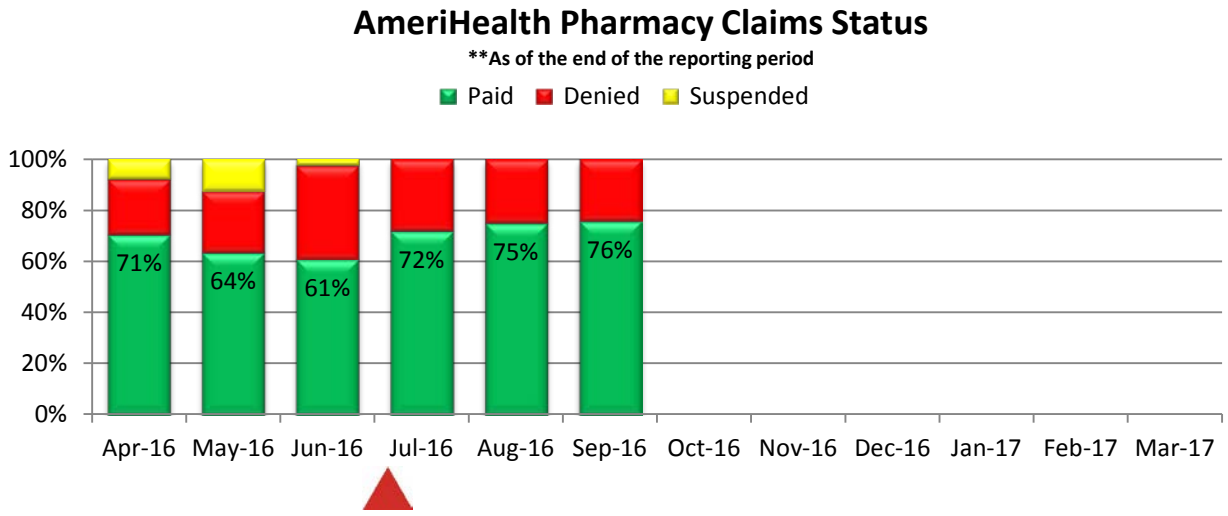
99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days



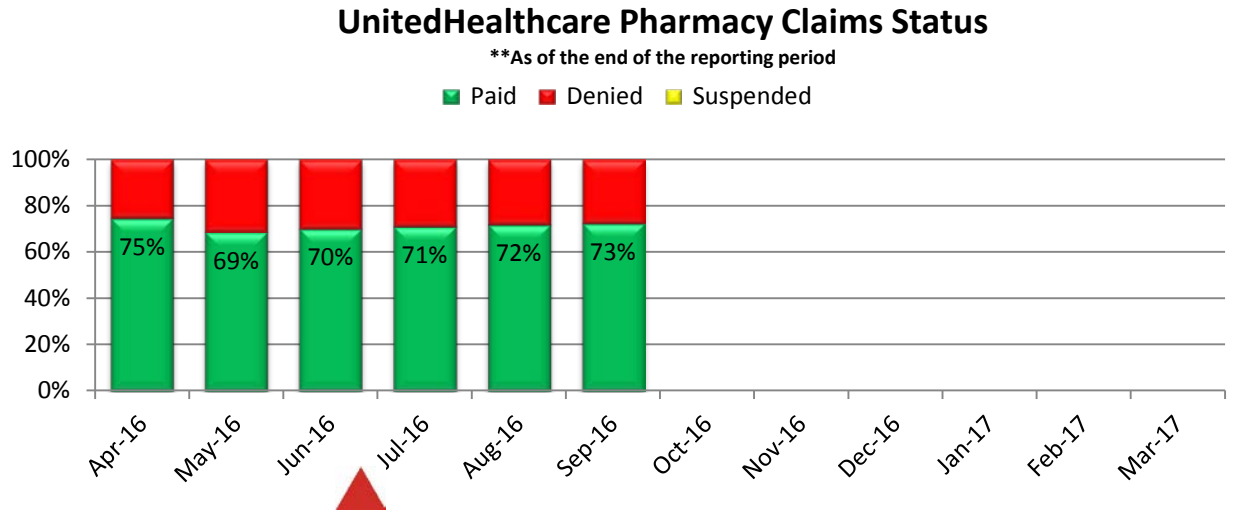
▲ AmeriHealth did not correctly report this for Q4 SFY16 but corrected the issue for Q1 SFY17.



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



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



▲ 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. Prior Authorization Required
3. Submit Bill To Other Processor Or Primary Payer	3. Patient Is Not Covered	3. Refill Too Soon
4. Days' Supply Exceeds Plan Limitation	4. Prior Authorization Required	4. Prod/Service Not Covered
5. Prior Authorization Required	5. Plan Limitations Exceeded	5. Filled After Coverage Terminated
6. Product/Service Not Covered	6. Submit Bill To Other Processor Or Primary Payer	6. Plan Limitations Exceeded
7. Plan Limitations Exceeded	7. DUR Reject Error	7. Submit Bill To Other Processor
8. DUR Reject Error	8. Duplicate Paid/Captured Claim	8. Prescriber Is Not Covered
9. Product Not Covered Non-Participating Manufacturer	9. Non-Matched Product/Service Id Number	9. M/I Days Supply
10. Non-Matched Pharmacy Number	10. M/I Date Of Birth	10. Non-Matched Pharmacy Number

Utilization of Health Care Services Reported			
Data	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Emergency Department Claims Reimbursed	$13,319,409	$21,186,429	$10,607,158
Inpatient Medical Claims Reimbursed	$36,040,867	$23,626,949	$30,875,681
Inpatient Behavioral Health Claims Reimbursed	$13,303,815	$23,625,159	$2,545,170
Outpatient Claims Reimbursed	$36,874,601	$35,264,221	$38,025,560

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

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

Utilization of Value Added Services Reported
Count of Members

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

Q1 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare	Total
Family Planning and Resources	491	1,275	742	2,508
Healthy Incentives	8,524	15,113	813	24,450
Health and Wellness	368	1,112	92	1,572
Additional Benefits	4,137	6,665	229	11,031
Tobacco Cessation	113	682	450	1,245

This is a new reporting requirement for Q1 SFY17, so data is not available for publication for Q4 SFY16. Additional 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.

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 September 2016 Monthly MCO Performance Report.

	AmeriHealth			Amerigroup			UnitedHealthcare		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	94.0%	98.0%	98.0%	85.78%	90.56%	93.44%	98.9%	99.6%	97.6%
Cardiology	100%	100%	98.0%	88.11%	95.41%	88.86%	99.1%	99.1%	93.8%
Endocrinology	94.0%	98.0%	100%	91.45%	63.17%	100%	98.9%	87.7%	79.5%
Gastroenterology	100%	96.0%	92.0%	88.50%	93.56%	81.05%	98.8%	99.4%	97.6%
Neurology	91.0%	100%	94.0%	95.46%	94.23%	99.01%	98.8%	99.7%	98.4%
Oncology	91.0%	97.0%	100%	76.93%	83.95%	98.03%	98.7%	99.9%	99.6%
Orthopedics	92.0%	95.0%	95.0%	72.61%	86.85%	93.04%	99.1%	80.8%	91.4%
Pulmonology	100%	100%	99.0%	79.80%	97.07%	91.16%	98.8%	100%	95.7%
Rheumatology	100%	100%	100%	100%	100%	94.74%	97.4%	100%	98.5%
Urology	98.0%	99.0%	100%	80.46%	98.96%	77.97%	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%	88.92%	97.29%	98.04%	98.9%	99.3%	97.2%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	99.0%	100%	99.0%	96.82%	98.40%	93.56%	99.0%	98.4%	93.0%
Pharmacies	98.0%	98.0%	97.0%	99.79%	99.58%	99.85%	100%	99.5%	100%
ICF/ID	100%	100%	100%	99.55%	100%	100%	100%	100%	100%
ICF/SNF	96.0%	95.0%	95.0%	93.04%	91.55%	93.22%	99.7%	99.2%	100%

	AmeriHealth			Amerigroup			UnitedHealthcare		
Provider Type - Waiver	East	Central	West	East	Central	West	East	Central	West
AIDS/HIV Level 1: Adult Day Care	No Util	No Util	No Util	No Util	No Util	No Util	100%	100%	100%
AIDS/HIV Level 2: CDAC, Home Health Aide	100%	100%	No Util	No Util	100%	100%	100%	100%	100%
AIDS/HIV Level 4: Home Delivered Meals	100%	100%	100%	100%	100%	No Util	100%	100%	100%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	100%	100%	100%	93.13%	100%	100%	100%	100%	100%
BI Level 2: CDAC	100%	100%	100%	96.64%	96.99%	95.86%	100%	100%	100%
BI Level 3: Supported Community Living	100%	100%	100%	96.72%	95.75%	99.21%	100%	100%	100%
Elderly Level 1: Adult Day Care	100%	100%	No Util	91.18%	100%	100%	100%	100%	100%
Elderly Level 2: CDAC, Home Health Aide	99.0%	93.0%	100%	91.73%	94.99%	95.49%	100%	100%	100%
Elderly Level 4: Home Delivered Meals	100%	96.0%	99.0%	92.38%	92.69%	95.11%	100%	100%	100%
HD Level 1: Adult Day Care	100%	100%	No Util	100%	100%	No Util	100%	100%	100%
HD Level 2: CDAC, Counseling, Home Health Aide	100%	100%	100%	96.39%	100%	100%	100%	100%	100%
HD Level 4: Home Delivered Meals	100%	100%	100%	91.11%	100%	98.98%	100%	100%	100%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	100%	100%	100%	93.28%	93.81%	100%	99.8%	100%	100%
ID Level 2: CDAC, Home Health Aide	100%	100%	100%	88.49%	95.18%	100%	100%	100%	100%
ID Level 3: Supported Community Living	100%	100%	99.0%	96.79%	92.30%	99.28%	99.9%	100%	100%
PD Level 2: CDAC,	100%	99.0%	100%	96.21%	100%	98.30%	100%	100%	100%
Provider Type - Behavioral	East	Central	West	East	Central	West	East	Central	West
Behavioral Health - Inpatient	100%	98.0%	100%	99.94%	100%	94.69%	97.4%	94.9%	41.7%
Behavioral Health - Outpatient	97.0%	98.0%	98.0%	95.12%	89.70%	88.35%	99.4%	98.9%	99.7%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	100%	100%	100%	96.59%	95.97%	100%	80.4%	97.3%	100%
Habilitation Level 3: Home Based Habilitation	100%	100%	90.0%	98.53%	99.98%	94.62%	99.8%	99.2%	94.2%
Children's Mental Health Level 1: Respite	100%	100%	100%	100%	92.77%	69.53%	100%	100%	100%

Provider Network Access

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

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

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

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

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

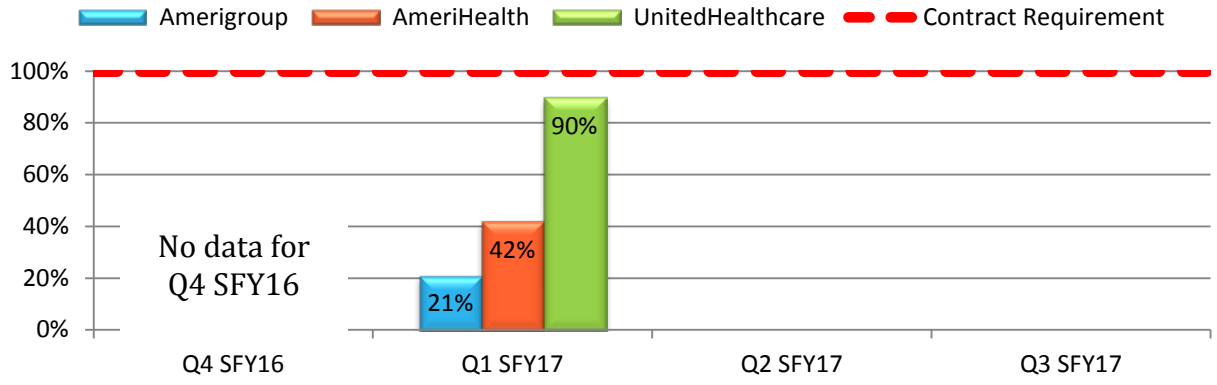
- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/Amerigroup_GeoAccess_Adequacy%2020160921.pdf.
- AmeriHealth Caritas:
    - https://dhs.iowa.gov/sites/default/files/AmeriHealth%20Caritas%20Iowa_Report%201_Maps_2016_09_26.pdf
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/UHC_Report1_Maps_20160926.pdf

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**	**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**
Primary Care - Adult	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Primary Care – Child	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Hospital	100%	N/A	N/A	100%	N/A	N/A	99%	N/A	N/A
ICF/SNF	50%	100%	N/A	100%	100%	N/A	100%	100%	N/A
ICF/ID	100%	100%	N/A	99%	100%	N/A	99%	100%	N/A
Behavioral Health – Inpatient	N/A	98%	100%	N/A	96%	100%	N/A	97%	100%
Behavioral Health – Outpatient	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
General Optometry	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A
Lab and X-ray Services	100%	N/A	N/A	98%	N/A	N/A	99%	N/A	N/A
Pharmacy	100%	N/A	N/A	100%	N/A	N/A	100%	N/A	N/A

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

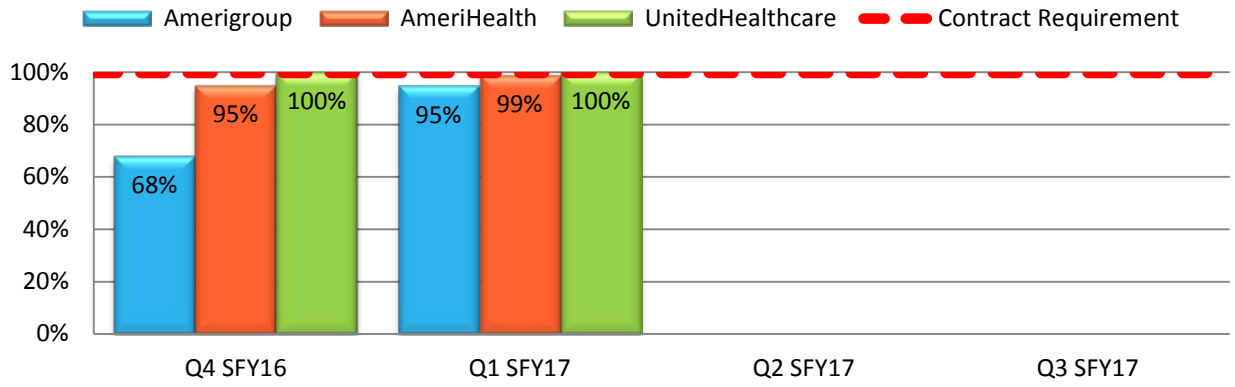


Amerigroup and AmeriHealth do not yet have approved exception requests for the network standards in Exhibit B of the contract for HCBS services. Once those have been submitted to demonstrate acceptable justifications for an exception, it is anticipated that these percentages will increase.

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

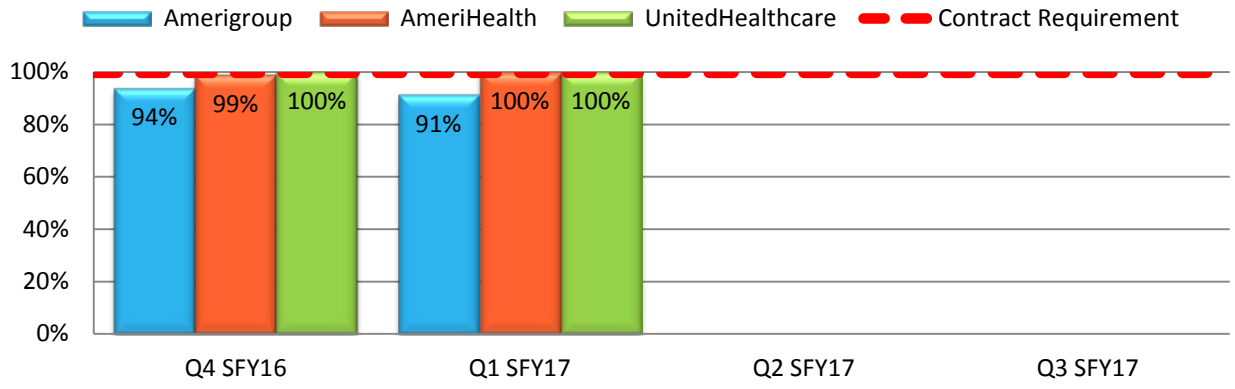
100% of Regular Prior Authorizations (PAs) Must be Completed Within 7 Calendar Days of Request



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

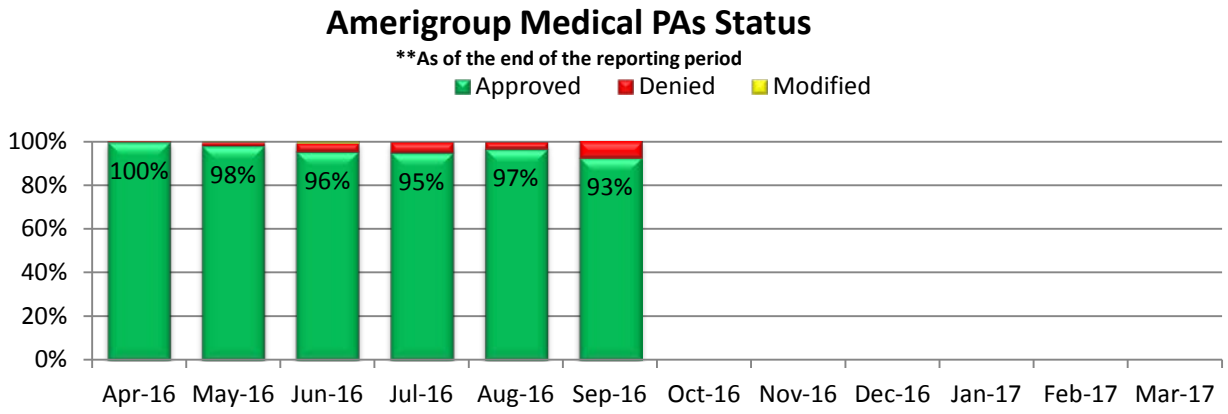
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a PA request is not approved or denied within seven days, the authorization is considered approved.

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

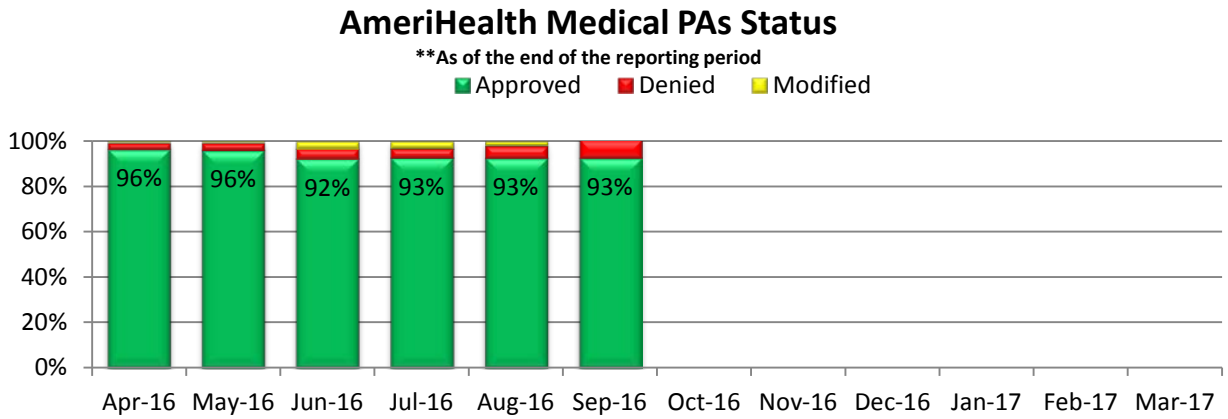


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

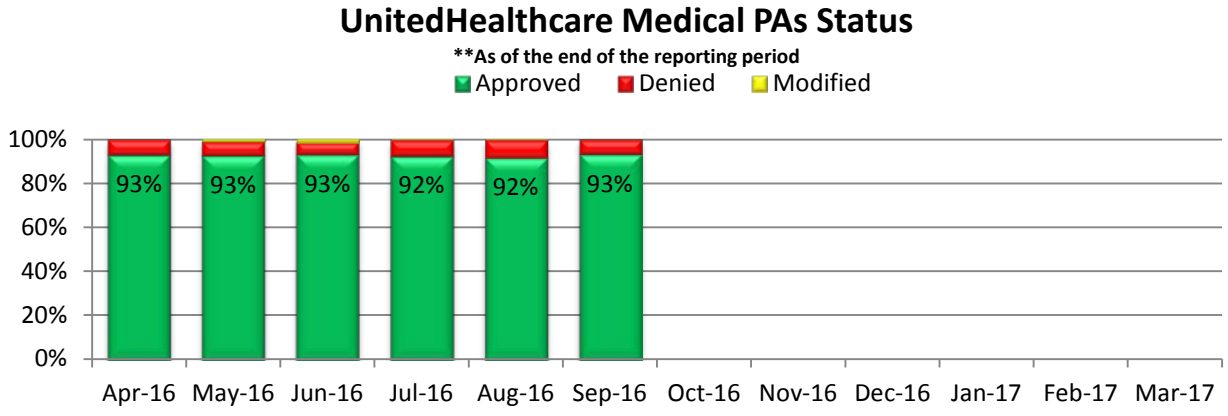
The department continues to monitor corrective action to ensure that these performance targets are met as defined in the contract. If a prior authorization request is not approved or denied within seven days, the authorization is considered approved.



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

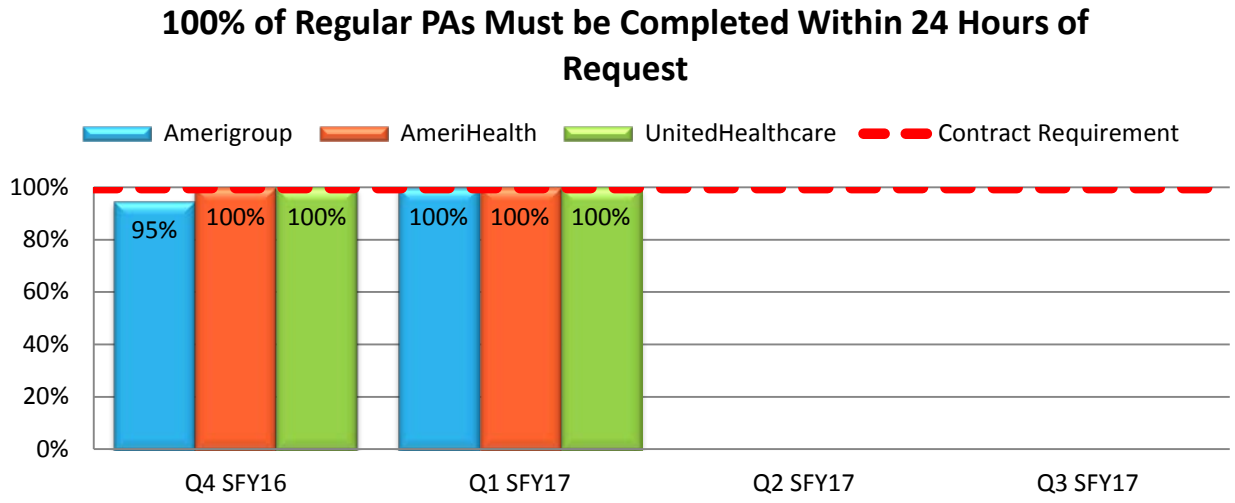


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



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

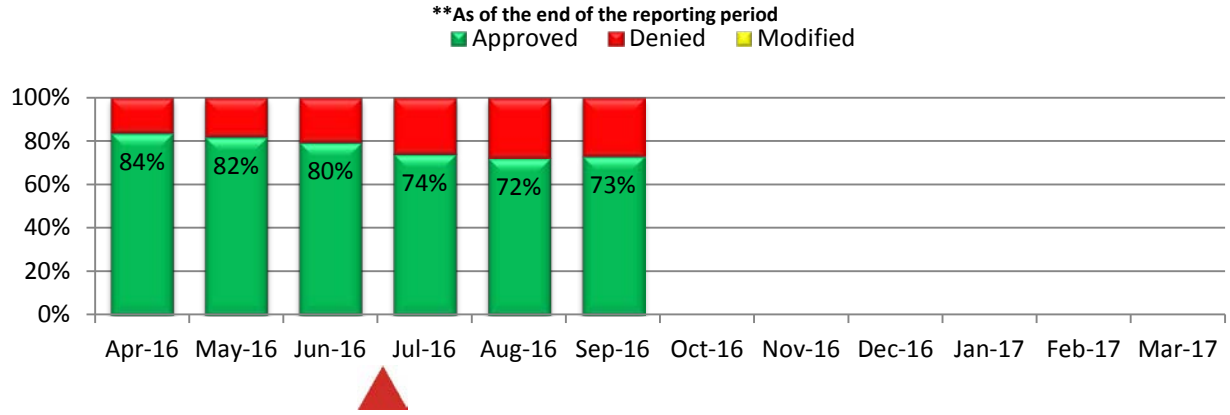
Prior Authorization - Pharmacy



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

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

Amerigroup Pharmacy PAs Submitted Status



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

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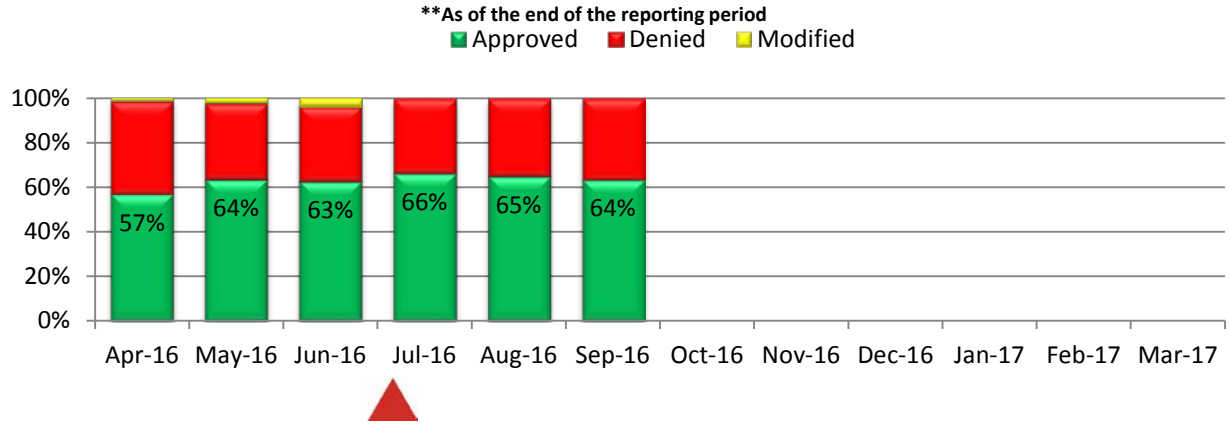
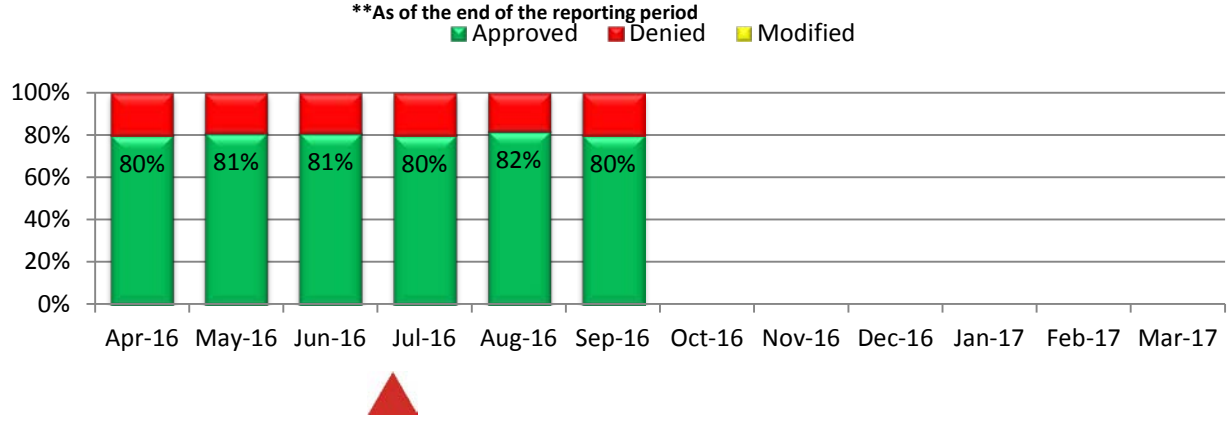
AmeriHealth Pharmacy PAs Submitted Status



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

UnitedHealthcare Pharmacy PAs Submitted Status



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

Encounter Data Reported

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

Performance Measure	Amerigroup			AmeriHealth			UnitedHealthcare		
Encounter Data Submitted Timely By 20th of the Month	July	August	Sept	July	August	Sept	July	August	Sept
	Y	N	Y	Y	Y	N	N	Y	N

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

Value-Based Purchasing Enrollment

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

Data as of September 2016	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement	17%	6%	2%

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

MLR/ALR/Underwriting

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

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

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

Q1 SFY17 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	109.92%	114.05%	111.88%
ALR	7.85%	6.65%	13.36%
Underwriting	-17.78%	-20.70%	-25.24%

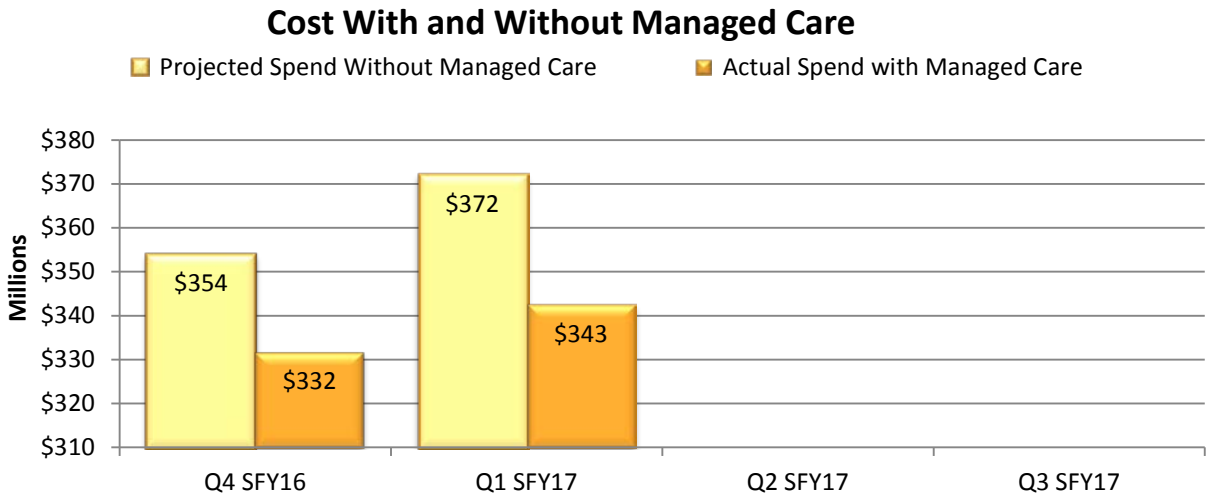
The department expects quarter-to-quarter fluctuations in financial metrics while the plans' experience in the Iowa Medicaid market matures. The financial ratios presented above are common financial metrics used to assess MCO financial performance. The financial ratios presented here are consistent with Q3 calendar year 2016 (Q1 SFY17) financial information submitted to the Iowa Insurance Division by each MCO.

The financial metrics presented here reflect financial performance for Q1 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.
In this Q1 SFY17 report:

- The MCOs are not including pre-contract administration, graduate medical education, and pass-through items.
- UnitedHealthcare is the only one of the three MCOs to include an assumed return of the capitation withhold. This reduced the MLR, slightly reduced the ALR, and increased the UR, all by less than 2%.
- For AmeriHealth Caritas and United Healthcare, risk adjustment and LTSS rebalancing was included in both the Q4 SFY16 and Q1 SFY17 reports. For Amerigroup, these two adjustments were introduced with the Q1 SFY17 report, which impacts the results of both quarters.

Program Cost Savings			
Data	**Projected State Spend Without Managed Care**	**Actual State Spend with Managed Care**	**Program Cost Savings (State)**
Program Cost Savings (State)	$372,185,691	$342,520,628	$29,665,063



Savings reported in this quarter (Q1 SFY17) 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.

Second quarter savings from managed care are being reported at $29.7 million. 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 following factors contribute to changes in savings estimates over time:

- Fluctuations in membership in total and across the rate cells as compared to earlier estimates; this includes fluctuation in waiver membership
- Timing differences relative to maternity case rates
- Timing of incentive pay outs
- Other factors outside of the current capitation rates that contribute to savings such as decreases in costs experienced prior to comprehensive managed care; this includes administrative costs paid to behavioral and voluntary managed care companies under the prior model

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	$77,422,067	$103,953,146	$74,723,413	$256,098,626
Physician Claims Paid	$33,127,436	$42,065,712	$34,513,843	$109,706,991
HCBS Claims Paid	$9,911,741	$157,864,042	$8,803,660	$176,579,443
DME Claims Paid	$3,388,730	$10,586,891	$3,164,056	$17,139,677
Pharmacy Claims Paid	$48,332,307	$53,397,131	$40,040,427	$141,769,865
Home Health Claims Paid	$7,463,075	$20,956,062	$7,324,435	$35,743,572
Hospice Claims Paid	$5,676,988	$3,026,813	$1,791,777	$10,495,578
Nursing Facility Claims Paid	$48,652,558	$42,662,746	$48,198,337	$139,513,641
ICF/ID Claims Paid	$28,090,758	$34,181,042	$10,509,258	$72,781,058
Behavioral Health Claims Paid	$24,690,345	$32,824,642	$15,784,143	$73,299,130
Speech Therapy Claims Paid	$26,654	$35,321	$418,768	$480,743
Occupational Therapy Claims Paid	$96,011	$49,012	$292,275	$437,298
Non-Emergency Transportation Claims Paid	$1,385,565	$1,405,419	$1,572,634	$4,363,618

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.

Total Capitation Payments Made to the Managed Care Organizations				
MCO	**Q4 SFY16**	**Q1 SFY17**	**Q2 SFY17**	**Q3 SFY17**
Amerigroup	$237,540,157	$238,096,189		
AmeriHealth	$408,575,970	$444,903,457		
UnitedHealthcare	$229,442,968	$209,092,263		

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

Third Party Liability Recovery for Q1 SFY17			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Amount of TPL Recovered	$2,861,668	$13,021,872	$6,947,462

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

Program Integrity

Program integrity (PI) encompasses a number of activities to ensure appropriate billing and payment. The main strategy for eliminating fraud, waste and abuse is to use state-of-the art technology to eliminate inappropriate claims before they are processed. This pre-edit process is done through sophisticated billing systems which have a series of edits that reject inaccurate or duplicate claims.

Increased program integrity activities will be reported over time as more claims experience is accumulated by the MCOs, medical record reviews are completed, and investigations are closed.

Fraud, Waste and Abuse

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

Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Investigations Opened During the Quarter	3	30	20
Overpayments Identified During the Quarter	381	0	1
Amount of Recovery for the Quarter	$26,548	$0	$3,897
Amount of Recovery Year to Date	$26,604	$0	$4,076
Cases Referred to the Medicaid Fraud Control Unit During the Quarter	0	8	1
Member Concerns Referred to IME	2	15	2

The MCOs have attended more than 25 meetings or on-site visits with regulators during this quarter. The plans have initiated 53 investigations in the second quarter and referred nine cases to Medicaid Fraud Control Unit (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		
	July	August	September*	July	August	September*	July	August	September*
Members (from IME)	192,267	193,793	194,359	218,303	220,207	220,295	193,881	193,556	191,500
Total Inpatient Admissions	2,201	2,220	2,219	1,416	1,438	1,301	2,106	1,857	1,720
Readmissions within 15 days of Discharge	285	268	280	84	79	57	150	131	106
Readmissions between 16 and 30 days of Discharge	140	171	196	58	50	44	12	73	50
Readmissions between 31 and 45 days of Discharge	62	93	132	31	30	25	5	35	29
Readmissions between 46 and 60 days of Discharge	14	25	13	29	26	26	0	11	33

*September member totals were calculated on October 10, 2016 – 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		
	July	August	September*	July	August	September*	July	August	September*
ED Visits for Non-Emergent Conditions – Adult	23.0	15.4	21.3	56.0	71.6	65.4	61.0	61.0	54.0
ED Visits for Non-Emergent Conditions – Child	17.9	13.6	19.4	26.4	29.7	29.4	30.0	28.0	22.0
Supporting Data									
Members (from IME)	192,267	193,793	194,359	218,303	220,207	220,295	193,881	193,556	191,500
Members Using ED More Than Once in 30 Days	327	193	328	2,973	3,696	2,571	2,640	2,644	1,934
Members Using ED More Than Once between 31 and 60 Days**	23	15	23	1,115	1,402	1,037	359	544	662

*September member totals were calculated on October 10, 2016 – 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		
	July	August	September	July	August	September	July	August	September
Members in Out-of-State PMIC	12	12	10	4	0	3	1	1	1
Members in Out-of-State Skilled Nursing Facility	8	17	17	17	20	29	9	8	7
Members Placed in an Out-of-State ICF/ID	3	3	3	7	20	2	0	0	0
Members in Out-of-State nursing facilities	0	0	0	25	0	0	0	0	0
Members in Out-of-State Other Institutions	12	12	10	4	0	3	1	1	1

*IME is working with each MCO to standardize reporting of Out-of-State Placement data.

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 – October 2016*							
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	32	1,220	715	7,774	2,057	12,064	775
Number of Individuals on Waiver Waitlist (DHS Function)	0	813	1,223	0	2,375	2,216	1,149
Waitlist Increase or (Decrease)	0	-182	-349	0	-246	-268	-243

*As reported in October 2016. October data represents September eligibility statistics.

Q1 SFY17 –Compliance Remedies	
MCO	**Rollup of Remedy Recommendations**
Amerigroup	• Corrective action to address timeliness, completeness, and accuracy of reporting. o Reports ▪ Elderly Population Report ▪ Special Needs Population Report ▪ General Population Report ▪ Correct Coding Report ▪ Waivers Report • Corrective action plan to address contractual standards not met: o Reports ▪ Risk Assessments ▪ Updated Care Plans ▪ Provider Credentialing ▪ Waivers – Care Plans • Liquated damages o Liquidated Damages have been assessed for five instances in which reports were not complete. $315*5 = $1,575 o Liquidated Damages have been assessed for 149 instances in which care plans were not completed timely. $315*149 = $46,935 o Liquidated Damages not available for one occurrence of updated care plans not timely. o Two performance standards are tied to pay-for-performance (Risk Assessment and Provider Credentialing) and liquidated damages are not assessed for performance standards not being met.

Q1 SFY17 –Compliance Remedies	
MCO	**Rollup of Remedy Recommendations**

AmeriHealth	• Corrective action to address timeliness, completeness, and accuracy of reporting
	  o Reports:
	  ▪ Waiver Report
	  ▪ Behavioral Health Report
	• Corrective action to address contractual standards not met
	  o Reports
	  ▪ Behavioral Health Report
	  ▪ 24 Hour Access Report
	  ▪ Risk Assessments Report (under Q4 SFY 2016 Corrective Action Plan)
	  ▪ Provider Credentialing Report (under Q4 SFY 2016 Corrective Action Plan)
	  ▪ Waivers Report (under Q4 SFY 2016 Corrective Action Plan)
	• Liquidated damages
	  o Liquidated Damages not available for one occurrence of C-2 Behavioral Health incomplete care plans.
	  o Liquidated Damages have been assessed for two instances of incomplete report. $315*2 = $630
	  o Liquidated Damages have been assessed for eight occurrences of care plans not completed (E-9 Care Plans). $315*8 = $2,520
	  o Liquidated Damages assessed at $284 per day beginning October 1, 2016 and continuing until corrective action plan (CAP) is met for Quarter 4 SFY 2016 CAP.
	  o Two performance standards are tied to pay-for-performance (Risk Assessment and Provider Credentialing) and liquidated damages are not assessed for performance standards not being met.

Q1 SFY17 –Compliance Remedies	
MCO	**Rollup of Remedy Recommendations**
UnitedHealthcare	• Corrective action to address timeliness, completeness, and accuracy of reporting. o Reports ▪ Special Needs Population Report ▪ General Population Report • Corrective action plan to address contractual standards not met: o Reports ▪ Grievances and Appeals Report ▪ Waivers Report • Liquated damages o Liquidated Damages have been assessed for two instances in which reports were not complete. $315*2 = $630 o Liquidated Damages have been assessed for five instances in which appeals were not resolved timely. $157*5 = $785 o Liquidated Damages have been assessed for 155 instances in which care plans were not completed timely. $315*155 = $48,825

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.