Iowa Medicaid Enterprise

Managed Care Organization Report on

First Quarter Performance Data

Published August 26, 2016

Iowa Department
of Human Services

CONTENTS

EXECUTIVE SUMMARY

Performance monitoring and data analysis are critical components in assessing how well the managed care organizations (MCOs) are meeting contract requirements and maintaining and improving the quality of care delivered to members.

The Iowa Health Link Program and House File 2460 establish performance metrics and instills a level of transparency into this program in ways that the fee-for-service Medicaid Program did not. The quarterly data reports compile information on major contract compliance areas and member enrollment. The Iowa Department of Human Services (DHS or department) examines the data from a compliance perspective and conducts further analysis if any issues are identified. While there are specific performance standards in the contract for a limited set of items, not all data reported is directly linked to a contractual requirement. The department uses the data reported by the MCOs both to monitor contract compliance but also to indicate variances in the system that require further investigation and analysis. This report includes data from the first quarter of the managed care contracts (displayed as Q4 SFY16) and includes the months of April, May and June of 2016. This is the first comprehensive compilation of this set of data for the purpose of program management and may not be directly comparable to data in the Iowa Medicaid fee-for-service program.

In 2016, the Iowa Legislature passed House File 2460 which included mandated reports for oversight of the managed care organizations. The legislature grouped these reports into three main categories:

- Consumer Protection;
- Outcome Achievement; and,
- Program Integrity.

The department grouped the reports 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, and,
- Health care outcomes for Medicaid members.

Over time, the data experience will grow and produce trend information that will allow us to examine if the MCOs are accomplishing health outcomes and promoting quality in the health care delivery system, in addition to meeting contract requirements. Annual reports will include additional review. Other reporting, such as HEDIS®[1], CAHPS[2], and diagnostic related grouping

[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.

will also be available over time. Additionally, reports that are included in the Value Index Score, such as potentially preventable admissions, will be available at a later time.

Data collection and validation improves over time. For this reason, the ability to draw reasonable conclusions from data will increase over time as the data definitions are further refined and data is fully validated.

Where applicable, this publication includes caveats and supplemental information that should be considered when consuming the data. This includes information as to when the data was gathered, how the data might change over time, and whether there were extenuating circumstances to the reporting of the data or performance of the MCOs.

The MCOs participating in the IA Health Link program include:

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

The Iowa Medicaid Enterprise (IME) maintains all eligibility and enrollment functions for all Medicaid members. About 35,000 to 45,000 members remain in the fee-for-service program at any given time, due to initial Medicaid enrollment or enrollment in programs that are time limited or linked to premium payment programs. The categories of members not included in managed care include:

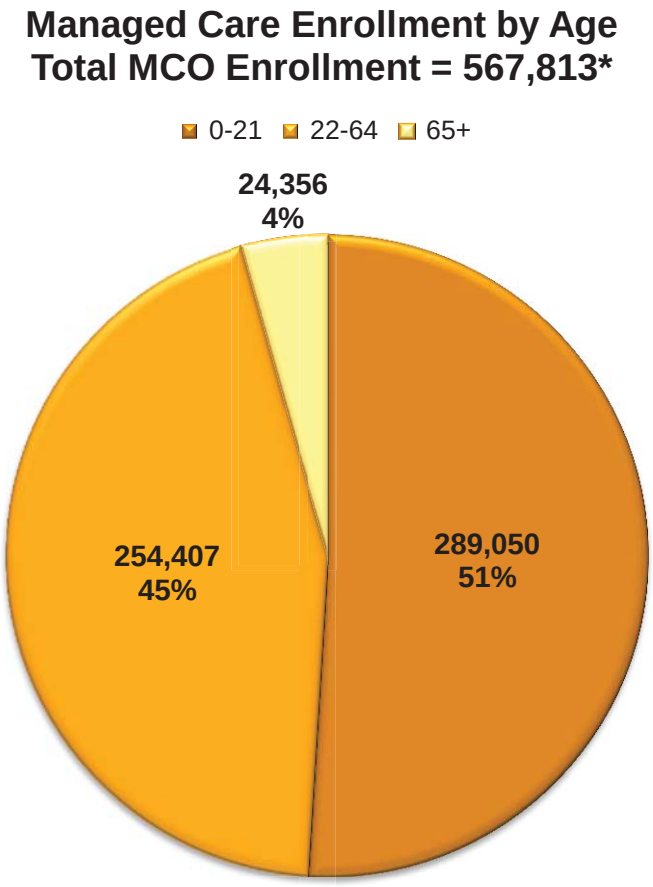
- Individuals enrolled in the Program for All-inclusive Care for the Elderly;
- Individuals with limited Medicaid eligibility and enrolled in Medicare Advantage Plans where the state is paying their premium;
- Individuals enrolled in the Health Insurance Premium Program;
- Individuals receiving three day emergency services; and
- Native Americans/Alaskan Natives (these individuals can opt-in).

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

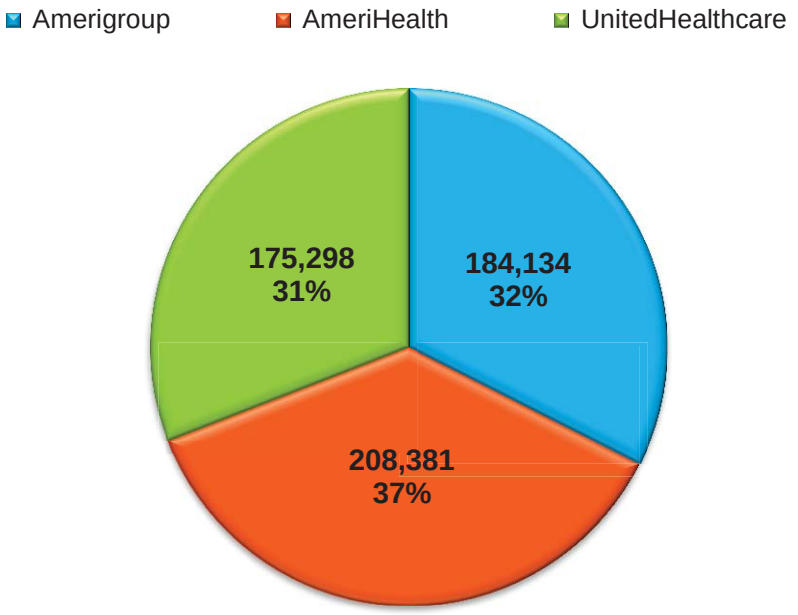
[2] The Consumer Assessment of Healthcare Providers and Systems (CAHPS) is a standardized, nationally-accepted survey that assesses health plan member satisfaction.

PLAN ENROLLMENT BY AGE

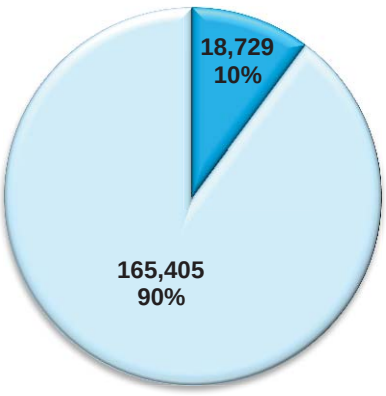


*June 2016 enrollment data as of August 10, 2016. 35,000 to 45,000 members remain in the Fee-for-Service (FFS) program. Does not include hawk-i enrollees.

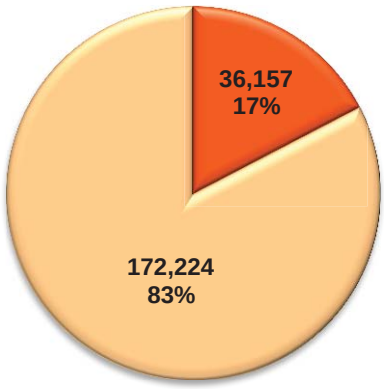
MCO Plan Enrollment Distribution
Total MCO Enrollment = 567,813*



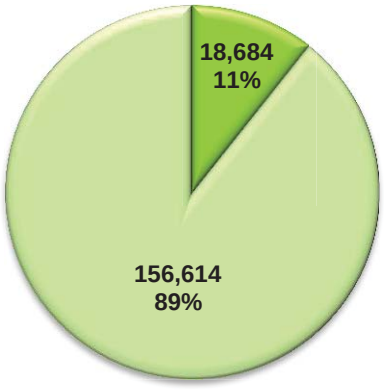
Amerigroup Plan Assignment



AmeriHealth Plan Assignment



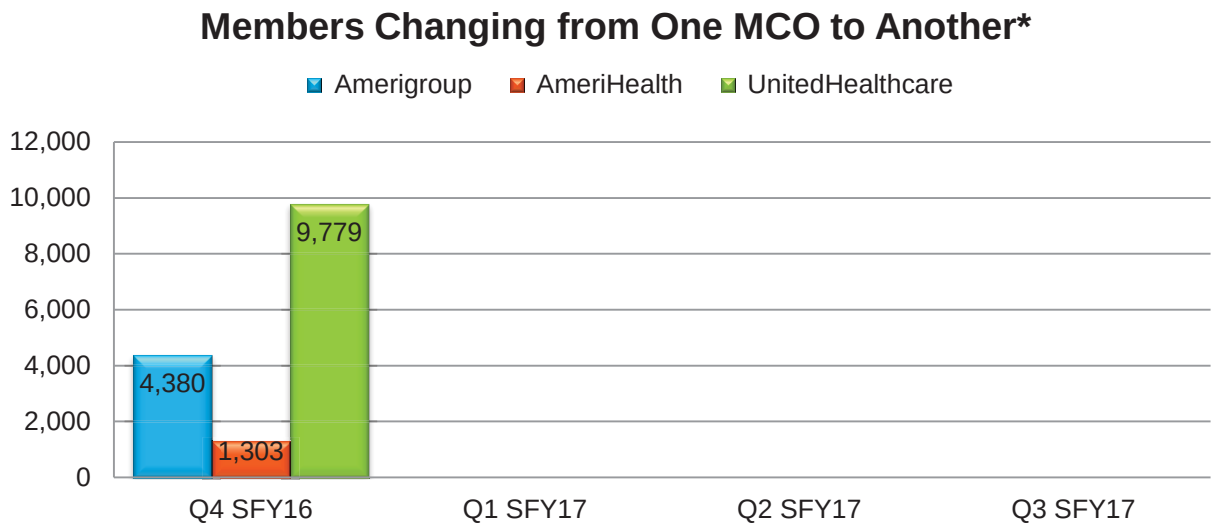
UnitedHealthcare Plan Assignment



*June 2016 enrollment data as of August 10, 2016. 35,000 to 45,000 members remain in the Fee-for-Service (FFS) program. Does not include hawk-i enrollees.

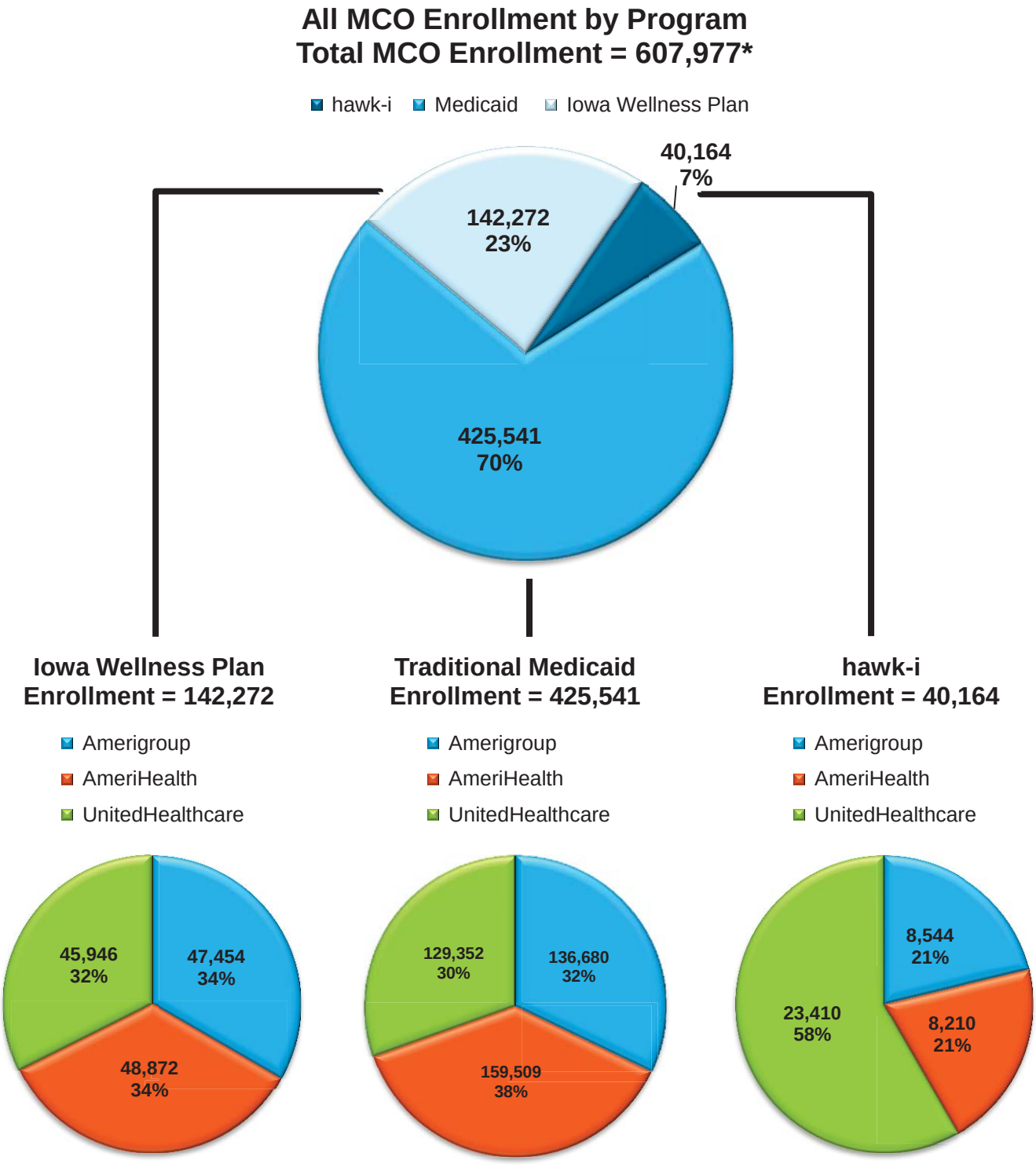
From the time tentative assignments were made in the fall of 2015 until the end of the first quarter, about 100,000 members including ***hawk-i*** self-selected an MCO.

PLAN DISENROLLMENT BY MCO



*Q4 SFY16 enrollment data as of August 10, 2016. 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.

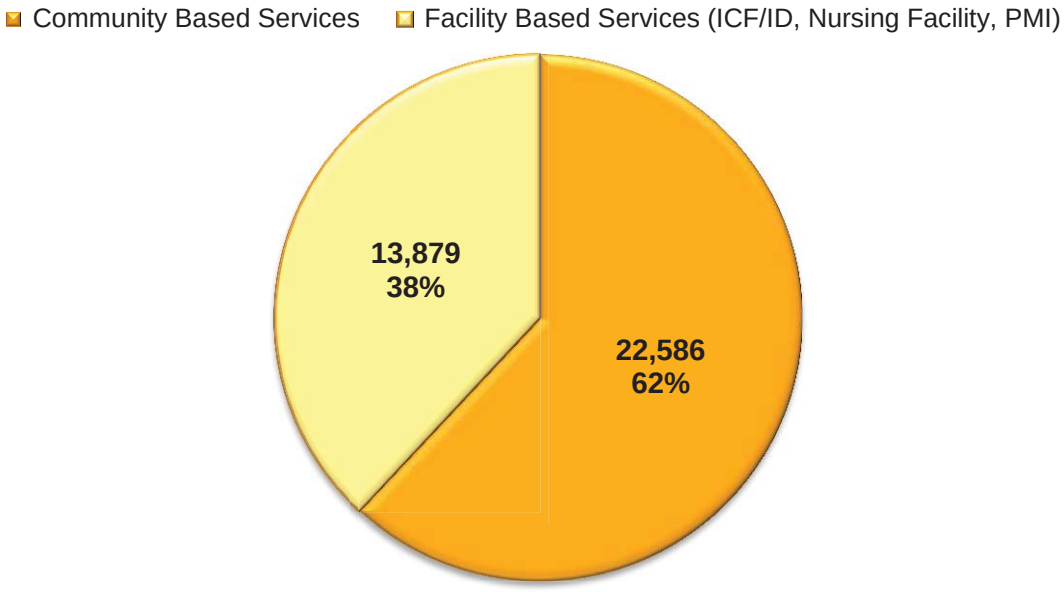
PLAN ENROLLMENT BY PROGRAM



*June 2016 enrollment data as of August 10, 2016. June 2016 hawk-i enrollment data as of July 11, 2016.

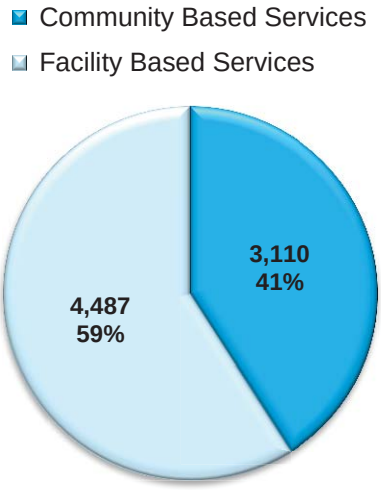
ALL MCO LONG TERM SERVICES AND SUPPORTS (LTSS) ENROLLMENT

LTSS Managed Care Enrollment by Location
MCO LTSS Enrollment = 36,465*

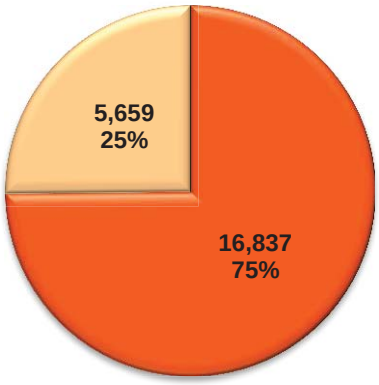


Total MCO LTSS Enrollment by Plan

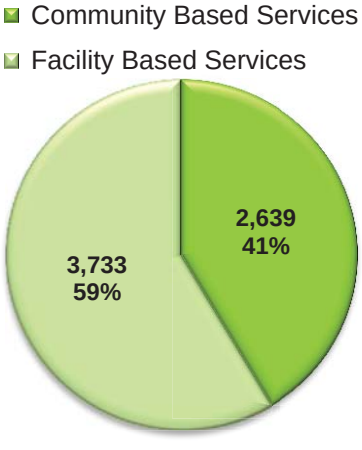
Amerigroup LTSS Enrollment = 7,597



AmeriHealth LTSS Enrollment = 22,496



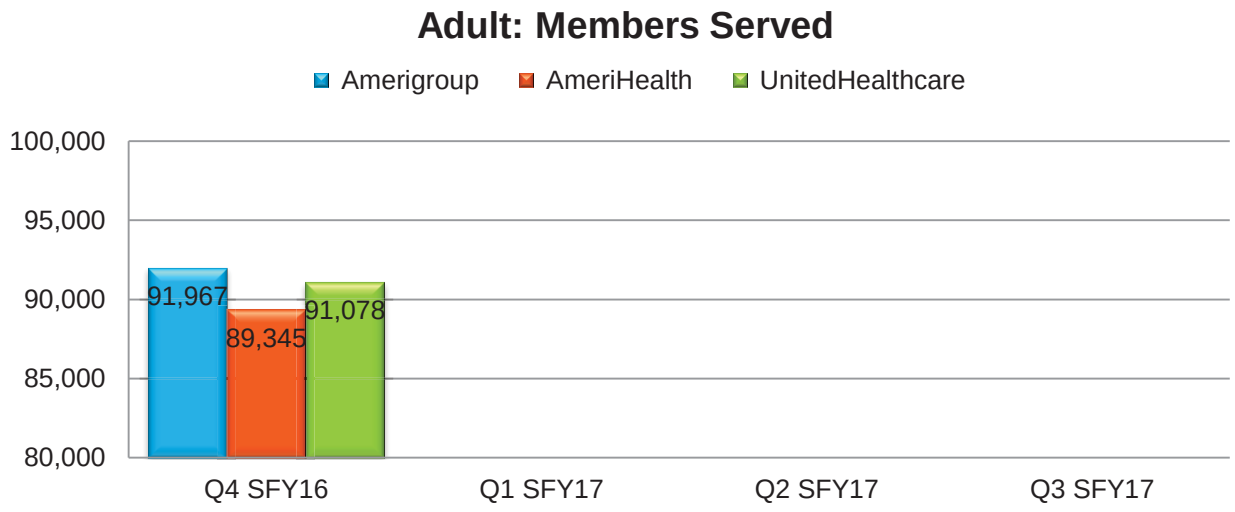
UnitedHealthcare LTSS Enrollment = 6,372



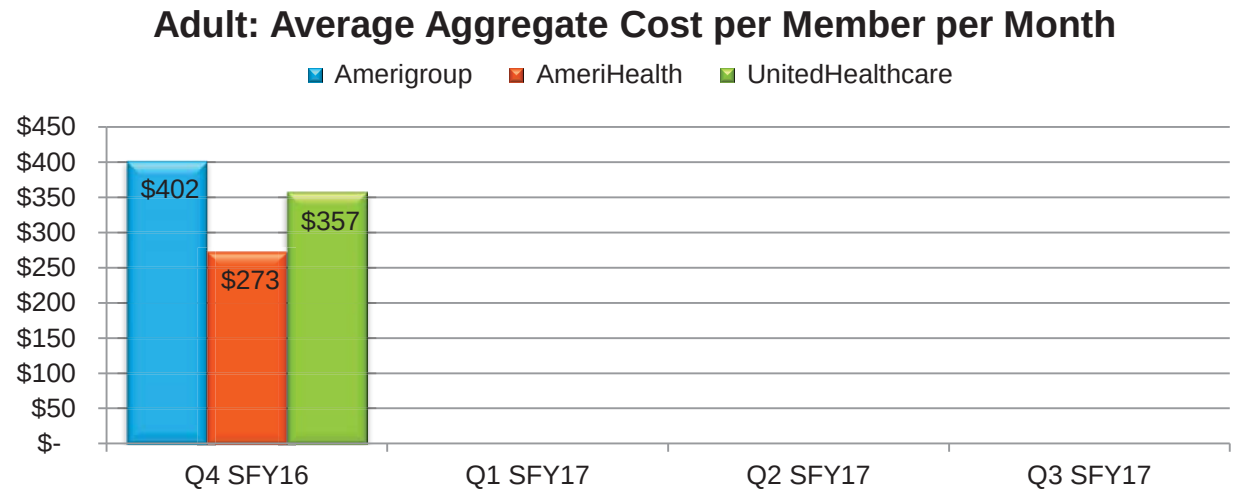
*June 2016 enrollment data as of August 10, 2016.

Adult General Population Reporting

Adults included in this report are members between the ages of 19 and 64 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.

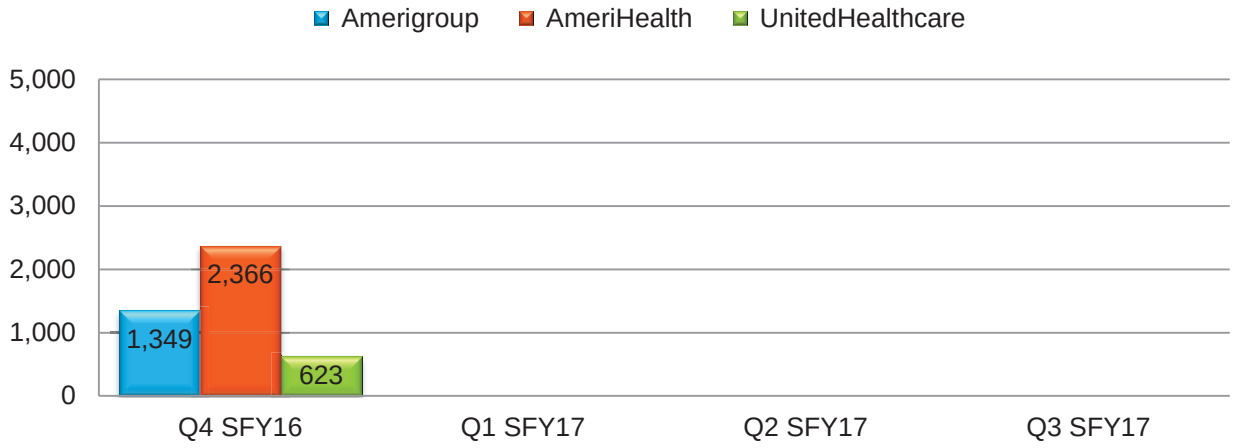


Adult: Members Served represents unduplicated members across the quarter and not a point in time enrollment.



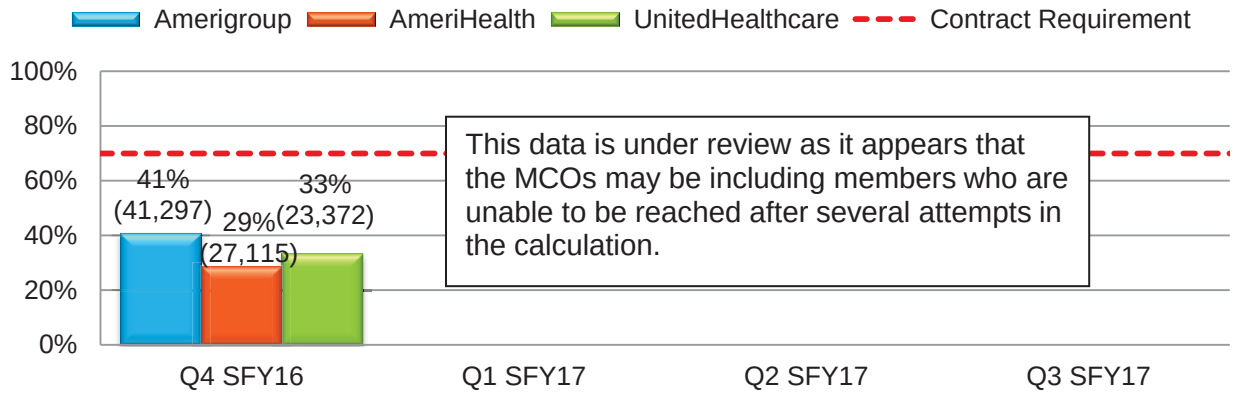
The aggregate average cost includes both health care and pharmacy services. The data is based on claims paid.

Adult: Members Assigned a Health Care Coordinator



Members who have a health care coordinator have special health care needs, and will benefit from more intensive health care management. The special health care needs include members with chronic conditions such as diabetes, COPD, and asthma. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service. This data element does not have a direct benchmark to compare to historical fee-for-service data.

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

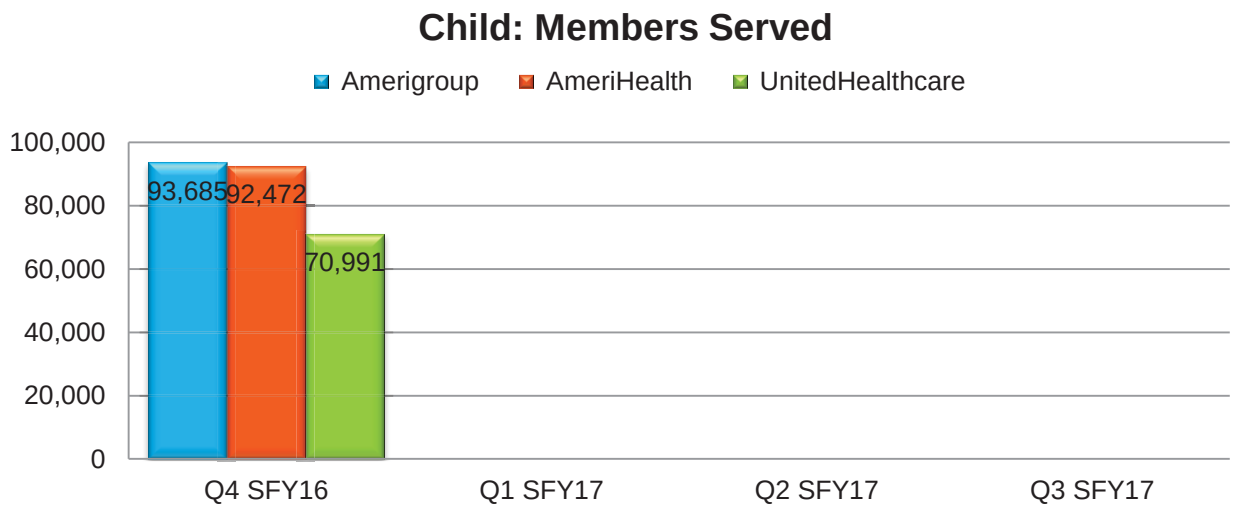


At least seventy percent (70%) of the MCO's new members, who have been assigned to the Contractor for a continuous period of at least ninety (90) days.

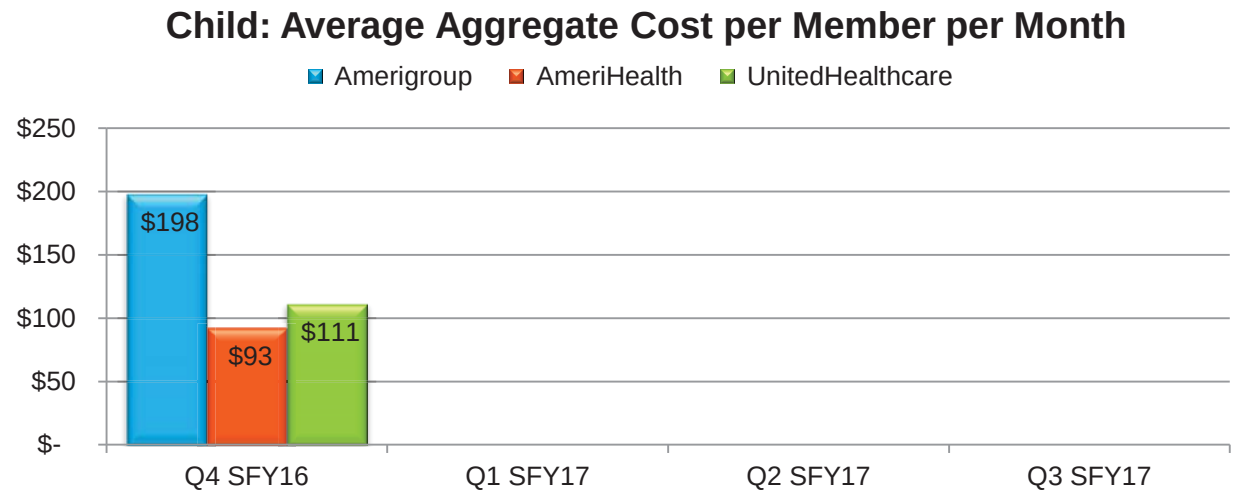
Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed. This data element 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 19 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.

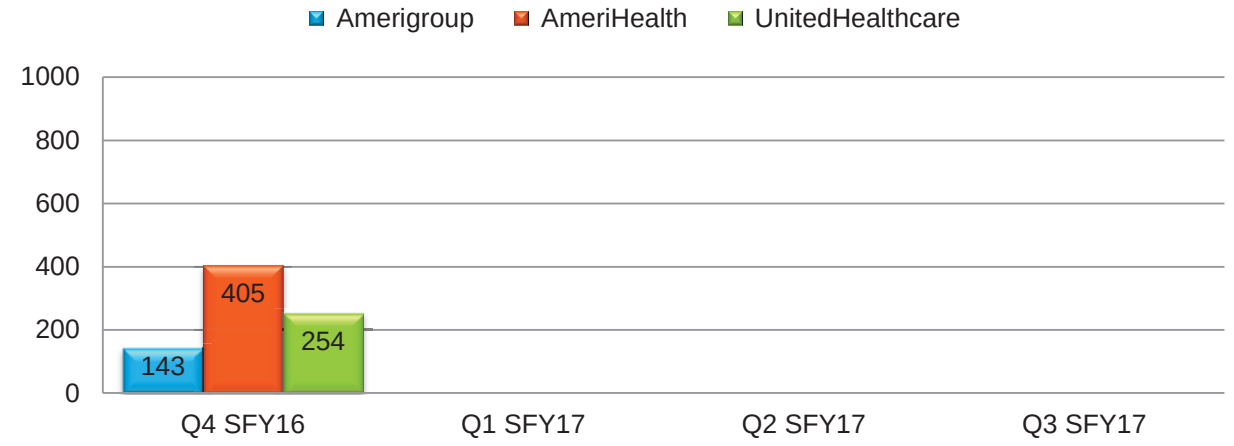


Child: Members Served represents unduplicated members across the quarter and not a point in time enrollment.



The aggregate average cost includes both health care and pharmacy services. The data is based on claims paid.

Child: Members Assigned a Health Care Coordinator



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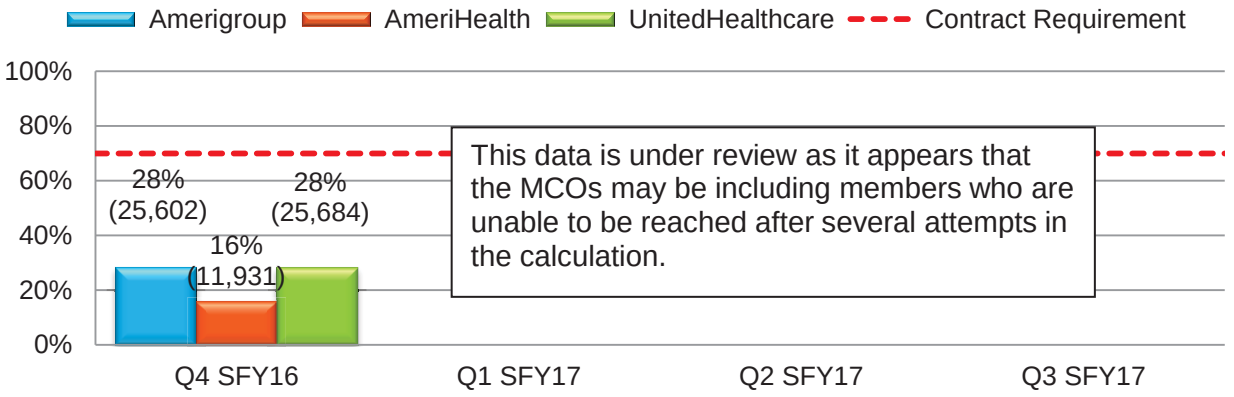
Child: Percentage (and Number) of Members Receiving Initial Health Risk Assessments Completed Timely

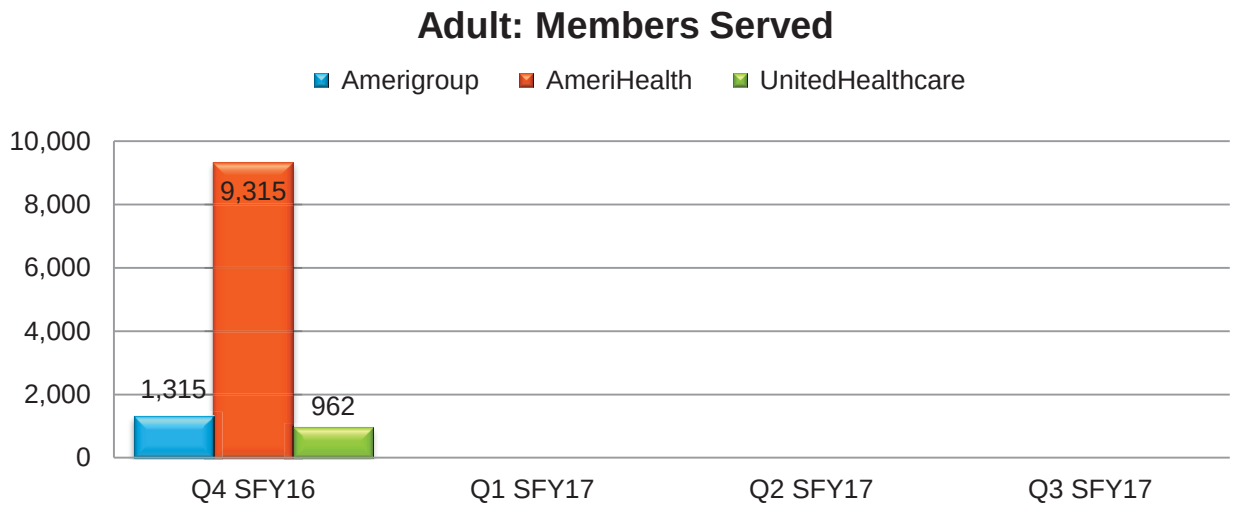


At least seventy percent (70%) of the MCO's new members, who have been assigned to the Contractor for a continuous period of at least ninety (90) days.

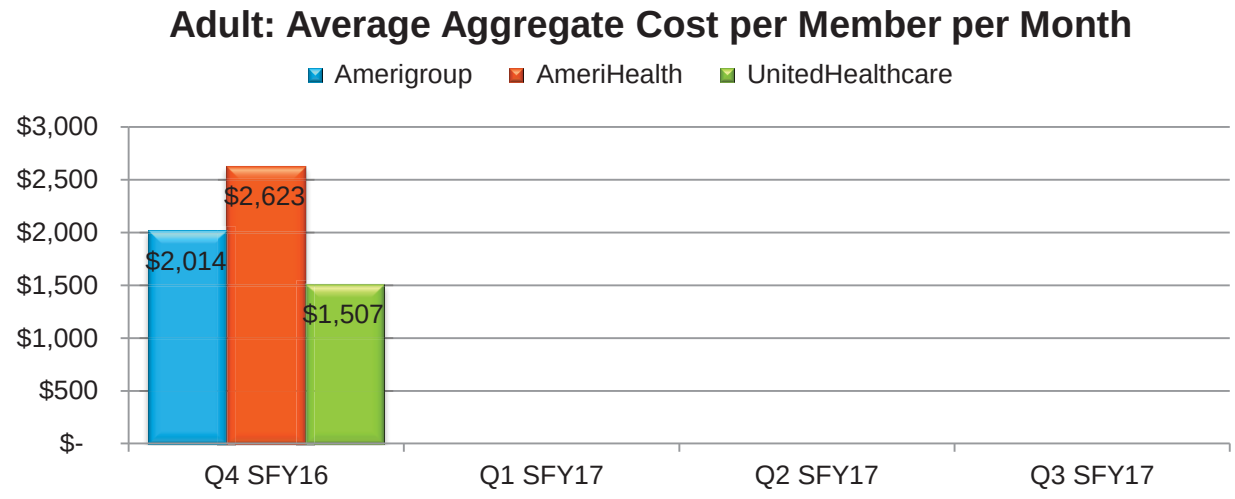
Health risk assessments were not required for all Medicaid members in fee-for-service prior to managed care implementation. Health risk assessments were considered a Healthy Behavior for members in the Iowa Health and Wellness Plan which would assist in premium reduction if completed. This data element 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 19 and 64 who have an intellectual disability, a brain injury, a physical or health disability, or HIV. They may receive waiver or institutional services.

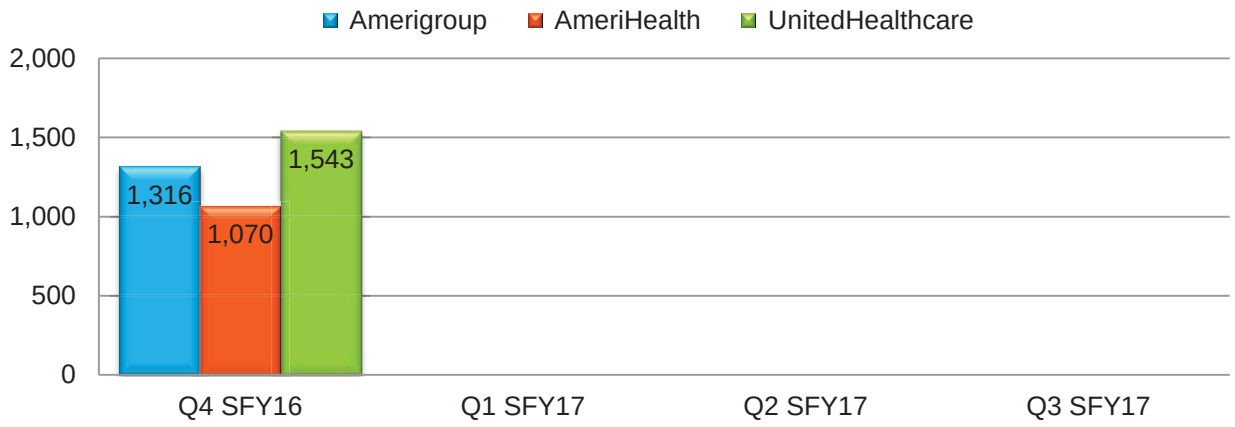


Adult: Members Served represents unduplicated members across the quarter and not a point in time enrollment.



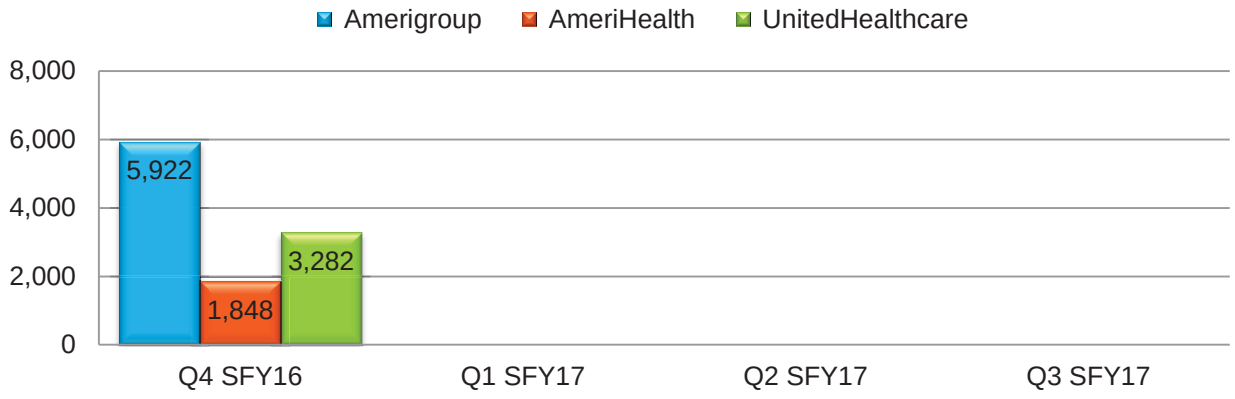
The aggregate average cost includes both health care, pharmacy services, waiver services and institutional services. The data is based on claims paid.

Adult: Members Assigned a Health Care Coordinator



Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs population includes 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. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Adult: Number of Community Based Case Manager Contacts for Members



Members who receive Home and Community Based Case Management 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.

Community-Based Case Management Ratios

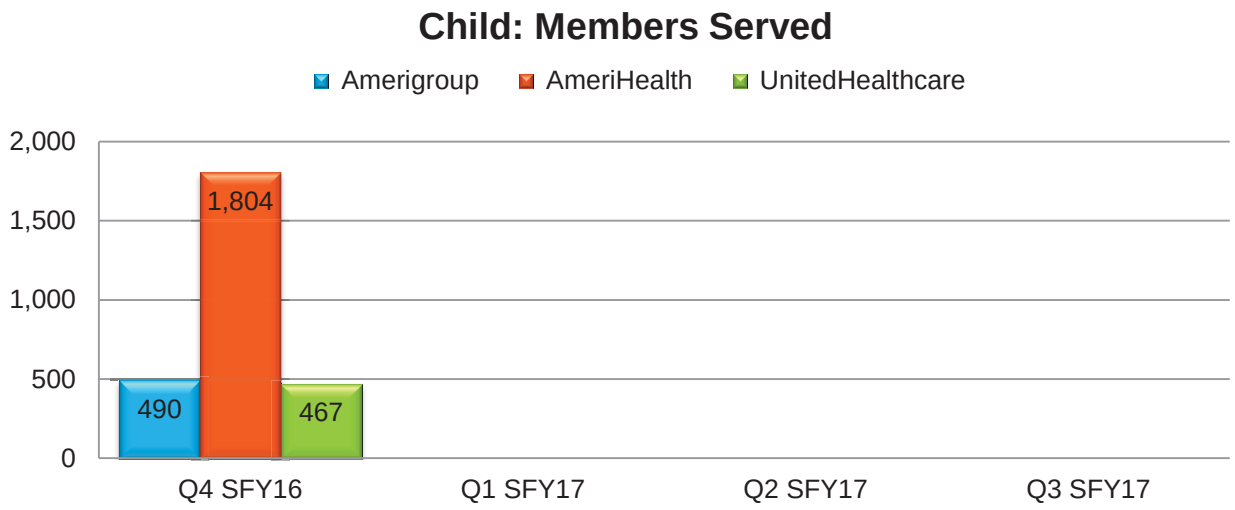
The ratios below reflect combined adult and child populations for these waivers where applicable.

Data Reported as of July 31, 2016	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager - Brain Injury	2.2	2.7	1.6
Ratio of Member to Case Manager - Health and Disability	5.5	3.0	3.4
Ratio of Member to Case Manager - HIV/AIDS	1.0	1.0	1.1
Ratio of Member to Case Manager - Intellectual Disability	11.3	16.3	5.9
Ratio of Member to Case Manager - Physical Disability	3.2	2.4	2.3

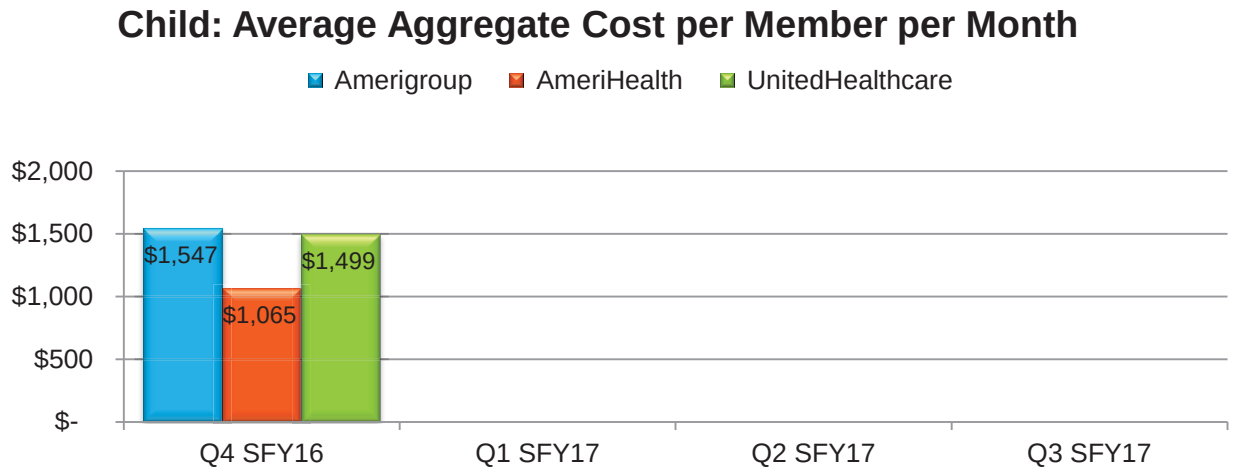
For this reporting period all plans are within appropriate case management ratios where defined. Iowa Medicaid requires that member to case manager ratios for the Intellectual Disability and Brain Injury Waivers is no more than 45 members to one case manager. The other Home and Community Based Waivers do not have member to case manager ratio requirements but the department requires the managed care organizations 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 19 who have an intellectual disability, a brain injury, a physical or health disability, or HIV. They may receive waiver or institutional services.

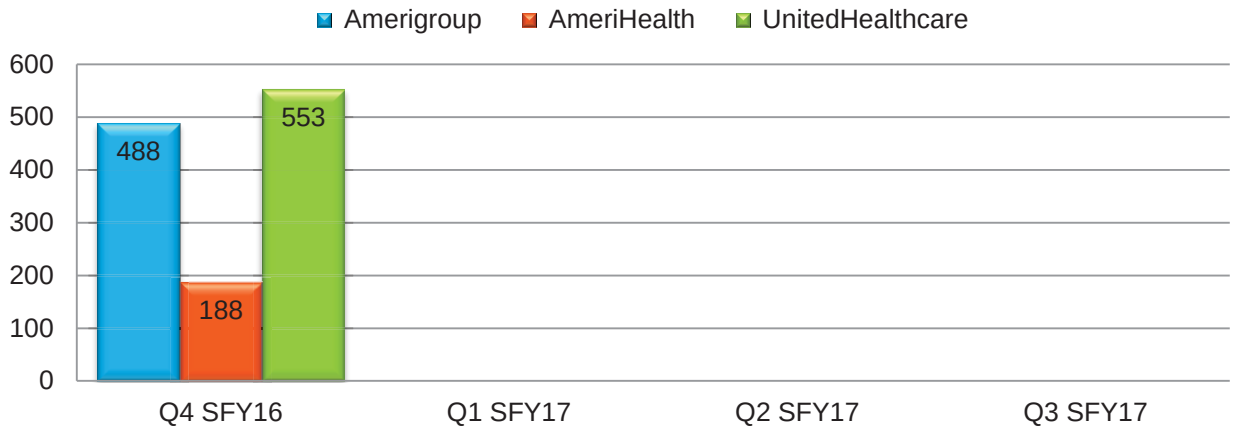


Child: Members Served represents unduplicated members across the quarter and not a point in time enrollment.



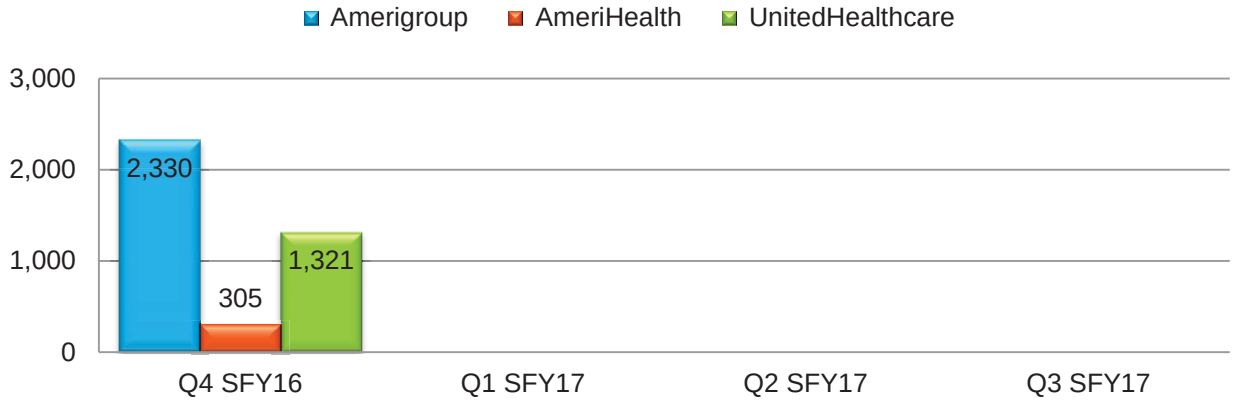
The aggregate average cost includes health care services, pharmacy services, waiver services and institutional services. The data is based on claims paid.

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

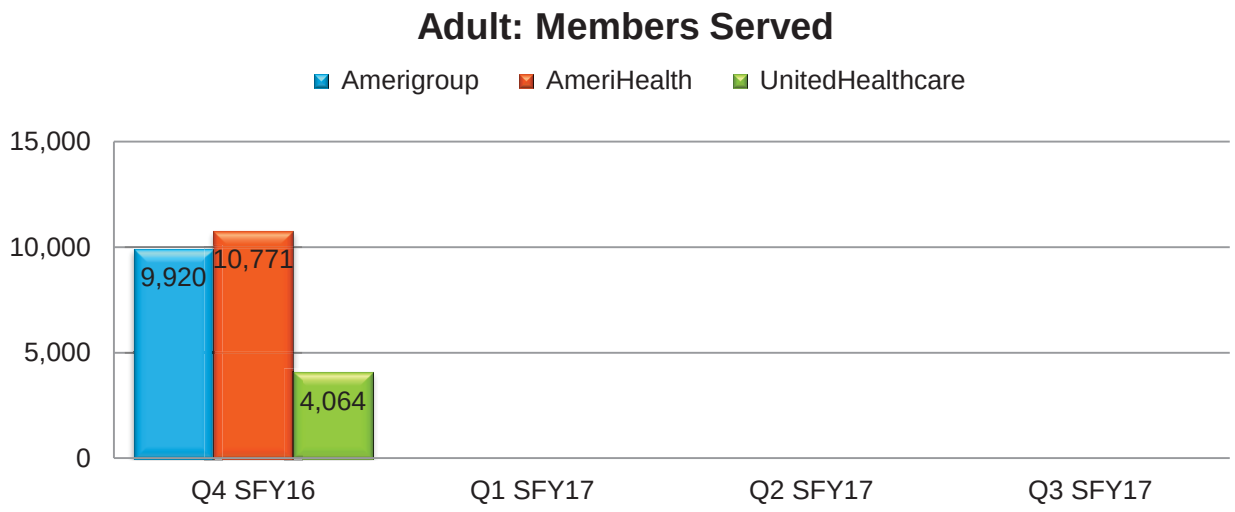
Child: Number of Community Based Case Manager Contacts for Members



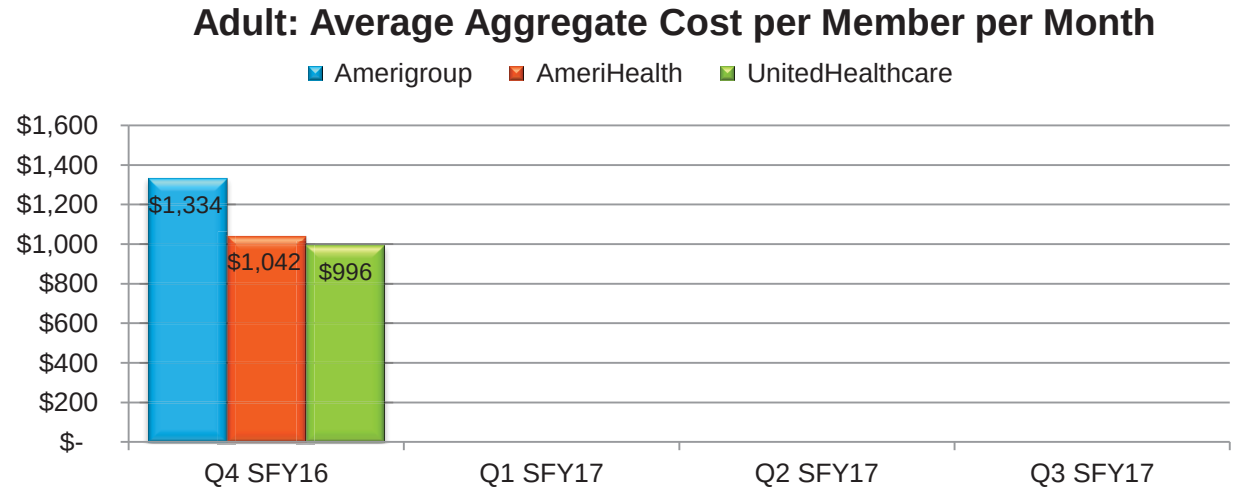
Members who receive Home and Community Based Case Management Waiver services must have a community based case manager who is required to conduct a face-to-face contact quarterly and either a face-to-face or phone contact monthly. Depending on the needs of the individual, the number of contacts may be 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.

Adult Behavioral Health Population Reporting

Adults included in this report are members age 19 and older 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.

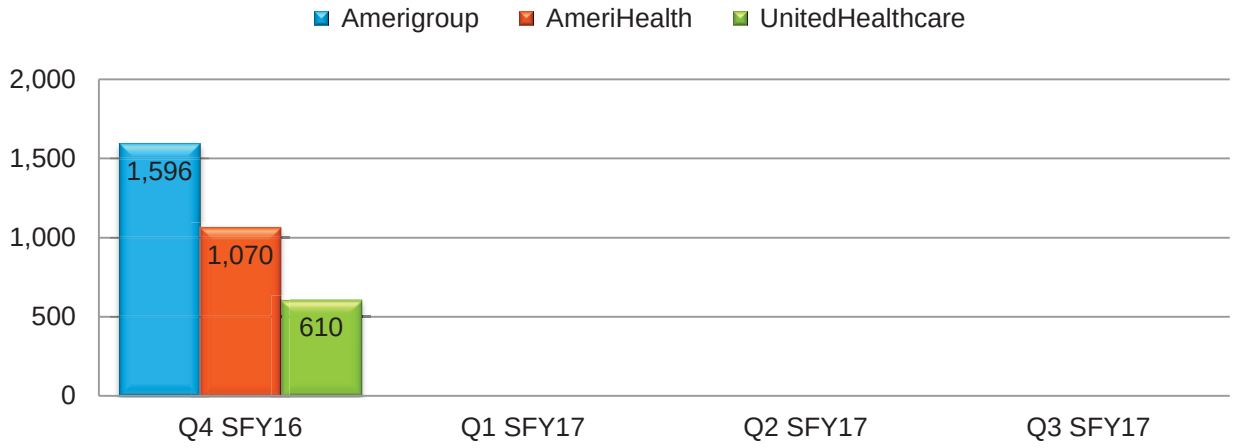


Adult: Members Served represents unduplicated members across the quarter and not a point in time enrollment.



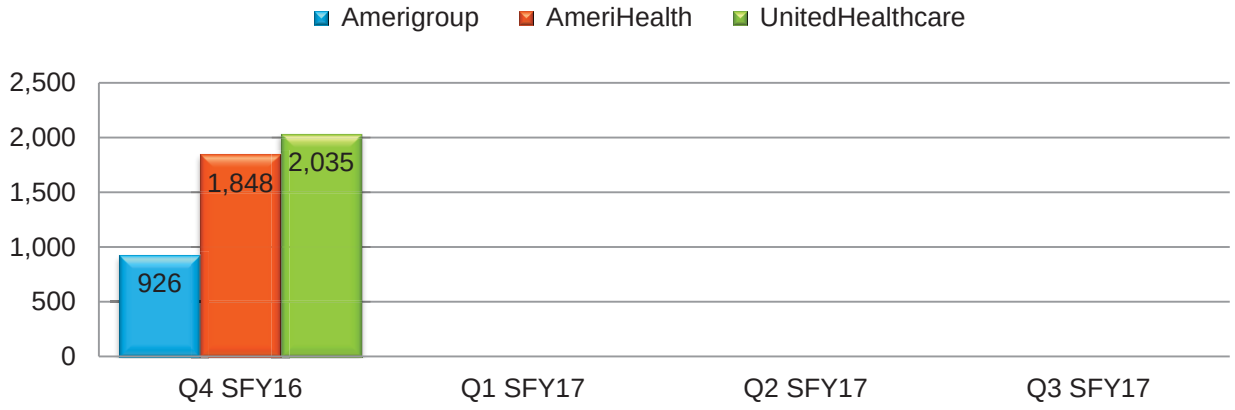
The aggregate average cost includes health care, pharmacy services, habilitation, and behavioral health services (including inpatient and outpatient). The data is based on claims paid.

Adult: Members Assigned a Health Care Coordinator



Members who have a health care coordinator have special health care needs and will benefit from more intensive health care management. The special health care needs population includes members with chronic conditions such as diabetes, COPD, and asthma. Members may also be assigned a care coordinator through Integrated Health Home enrollment. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Adult: Number of Care Coordinator Contacts for Members



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

Community Based Case Management Ratios

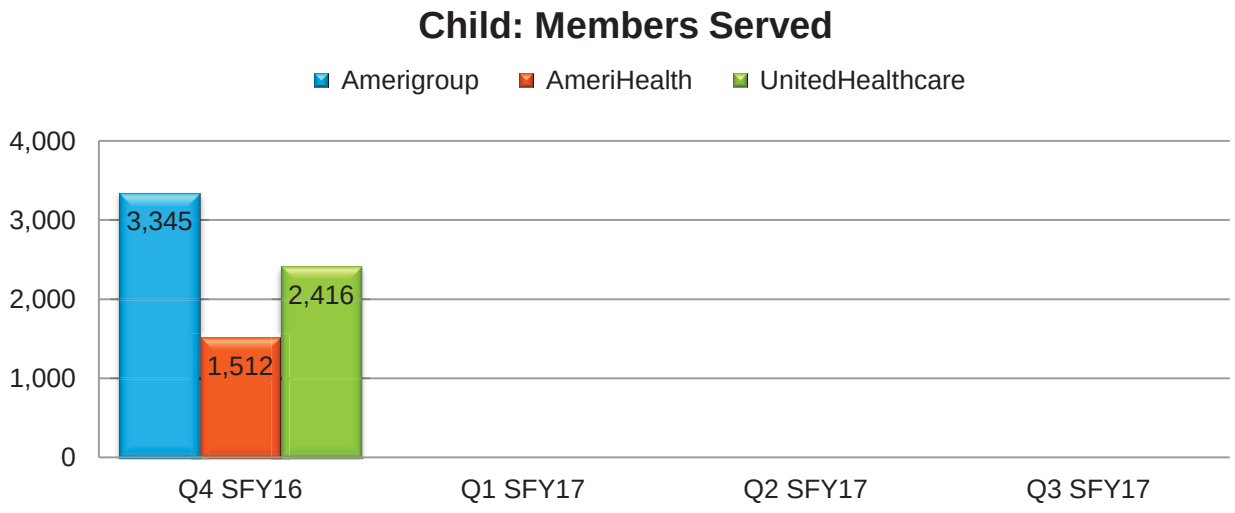
The department collects member to community based case manager ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of July 31, 2016	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Behavioral Health	11.9	NR	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.

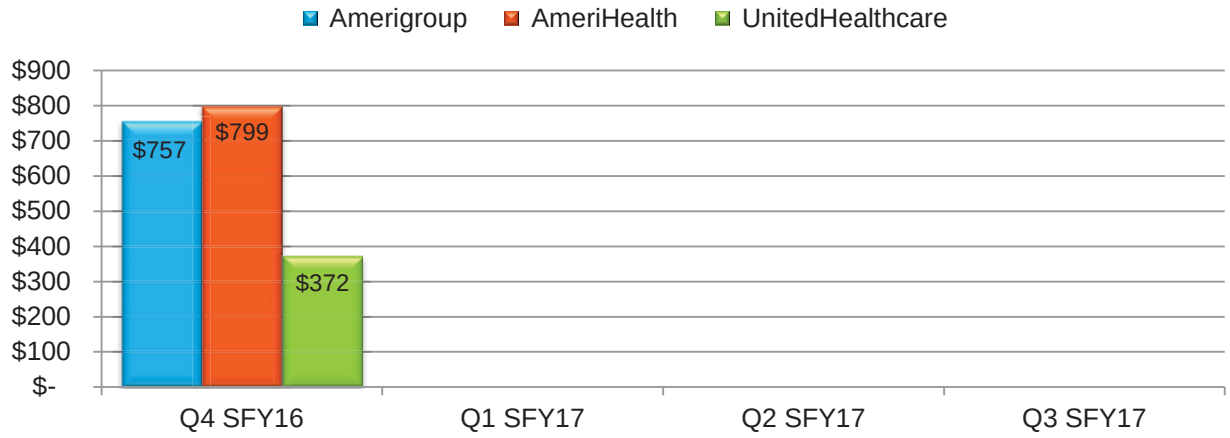
Child Behavioral Health Population Reporting

Children included in this report are members under the age of 19 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.



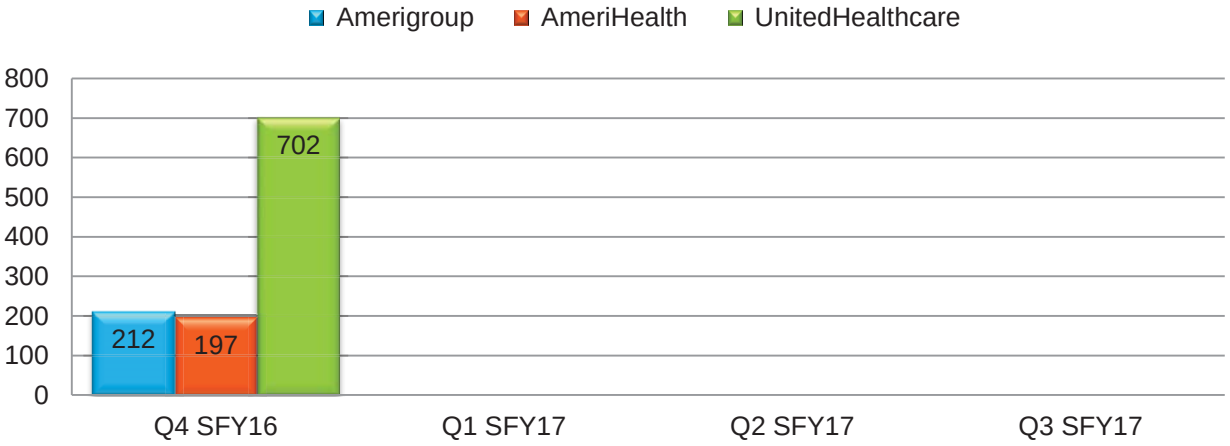
Child: Members Served represents unduplicated members across the quarter and not a point in time enrollment.

Child: Average Aggregate Cost per Member per Month



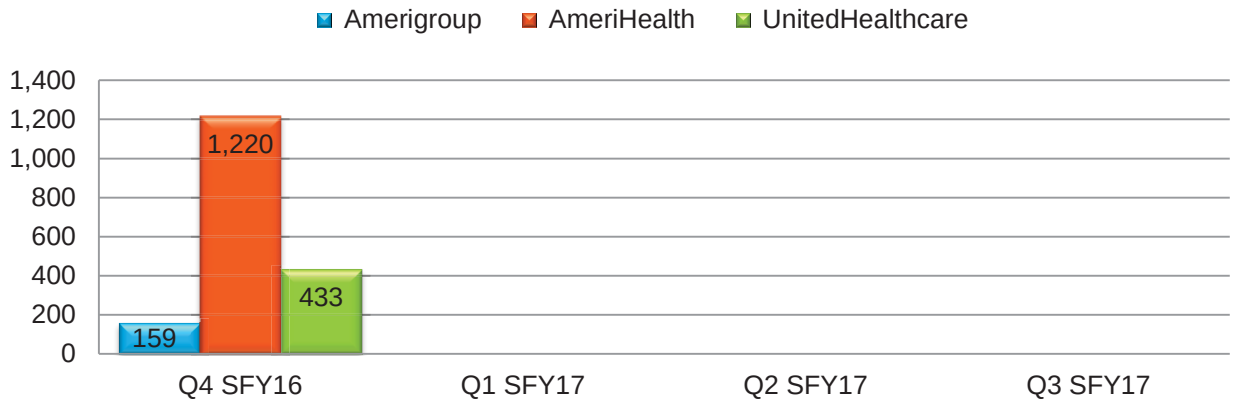
The aggregate average cost includes health care, pharmacy services, children mental health waiver, BHIS, and behavioral health services (including inpatient and outpatient). The data is based on claims paid.

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 population include members with chronic conditions such as diabetes, COPD, and asthma. Members may also be assigned a care coordinator through Integrated Health Home enrollment. This is a new and more comprehensive health care coordination strategy than was available in fee-for-service. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Child: Number of Care Coordinator Contacts for Members



A small percentage of the members in this population receive Children's Mental Health Waiver 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 Waiver services is not required to have as frequent contact. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Community-Based Case Management Ratios

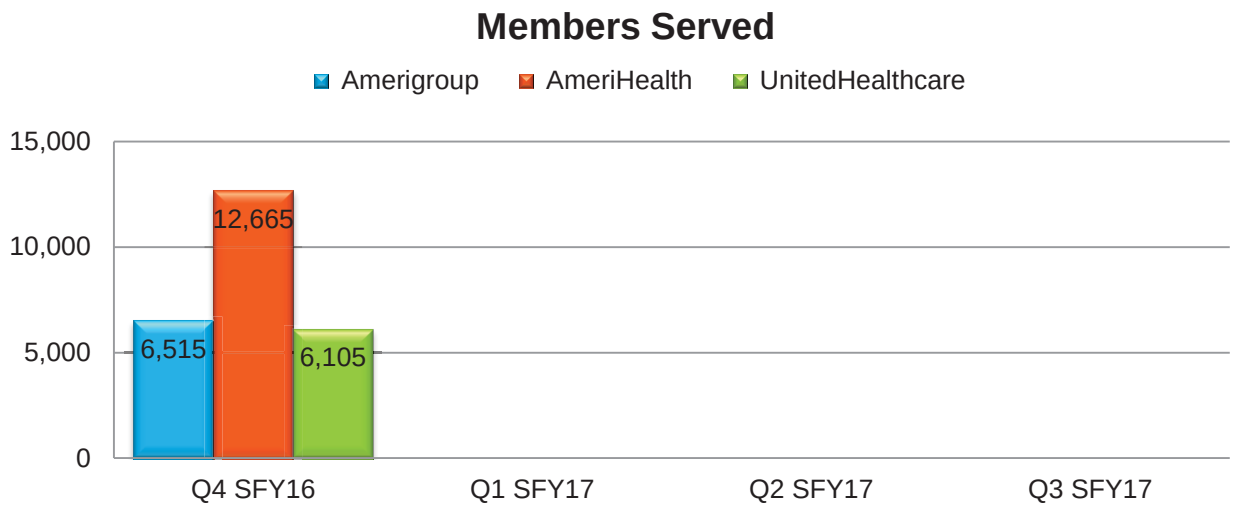
The department collects member to community based case manager ratios to ensure adequate case management and care coordination services. Adequate case management ratios are important to ensure that members receive sufficient time and resources to coordinate services and work toward goals.

Data Reported as of July 31, 2016	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Behavioral Health	2.6	NR	50

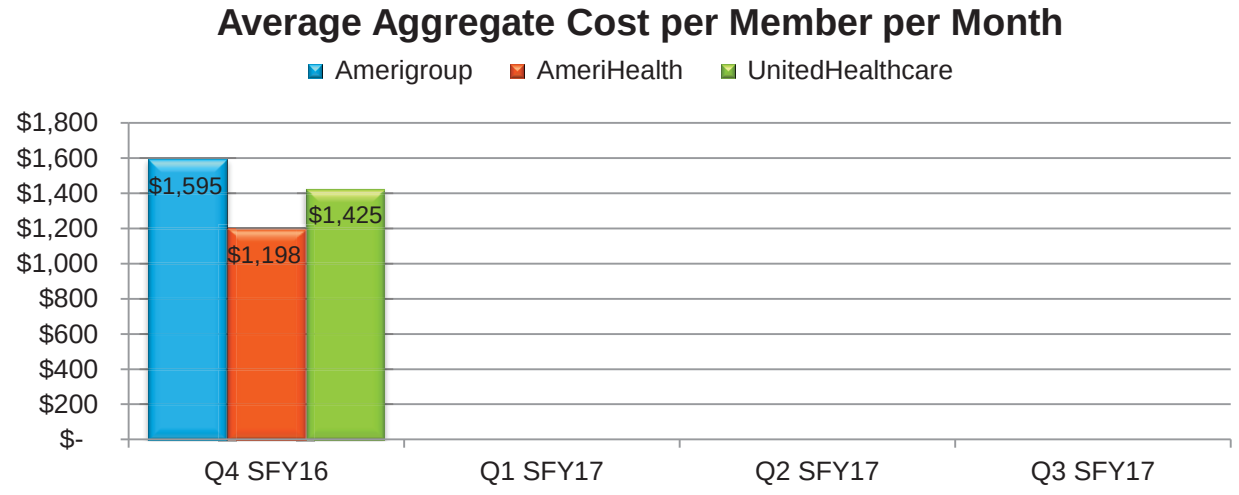
The behavioral health population does not have member to case manager or care coordinator ratio requirements but the department requires the managed care organizations to closely monitor the ratios and ensure that all case management functions are met. This data element does not have a direct benchmark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

Elderly Population Reporting

Elderly members included in this report are age 65 or older. These members may receive elderly waiver services or institutional services.

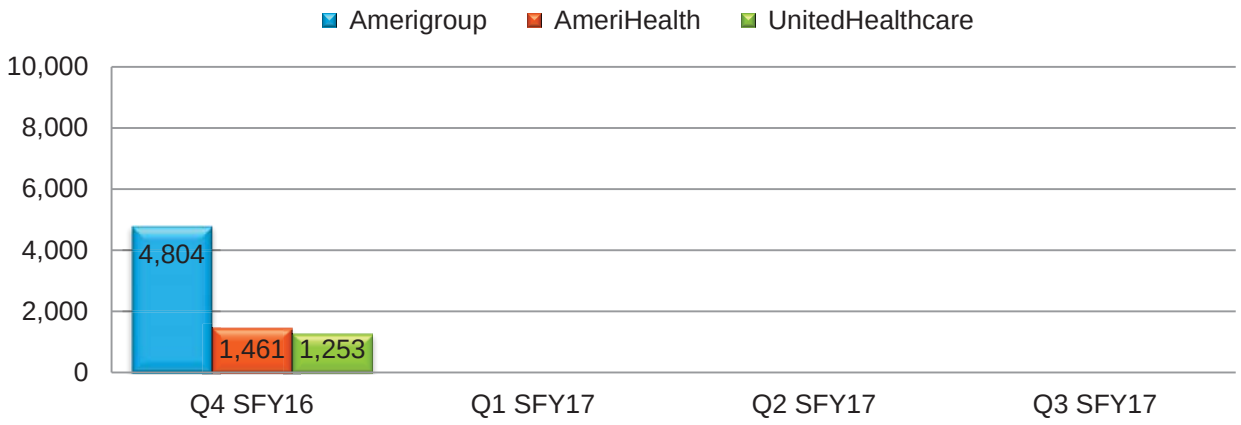


Members Served represents unduplicated members across the quarter and not a point in time enrollment.



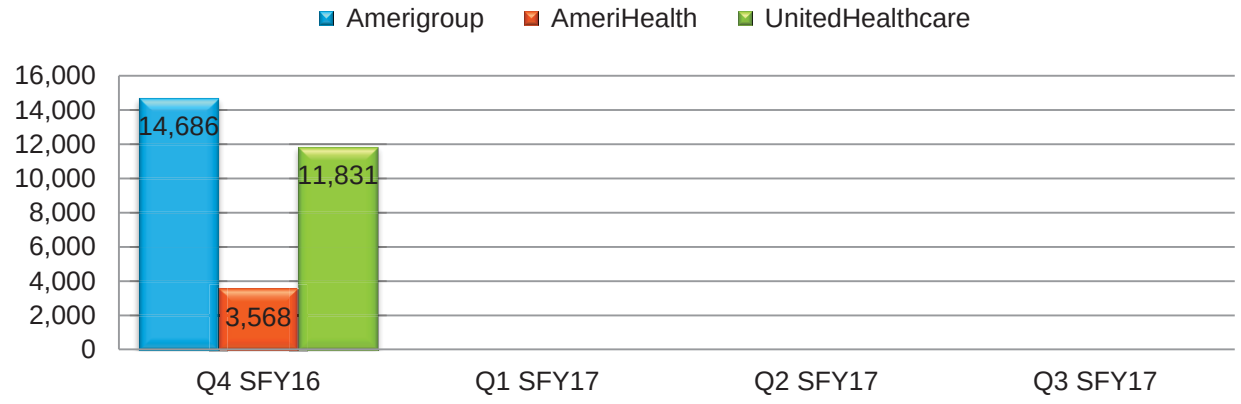
The aggregate average cost includes both health care, pharmacy services, waiver services and institutional services. The data is based on claims paid.

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

Number of Community Based Case Manager Contacts for Members



Members who receive Home and Community Case Based Management 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. This data element does not have a direct benchmark to compare to historical fee-for-service data.

Community Based Case Management Ratios

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

Data Reported as of July 31, 2016	Amerigroup	AmeriHealth	UnitedHealthcare
Ratio of Member to Case Manager – Elderly	9.9	17.5	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.

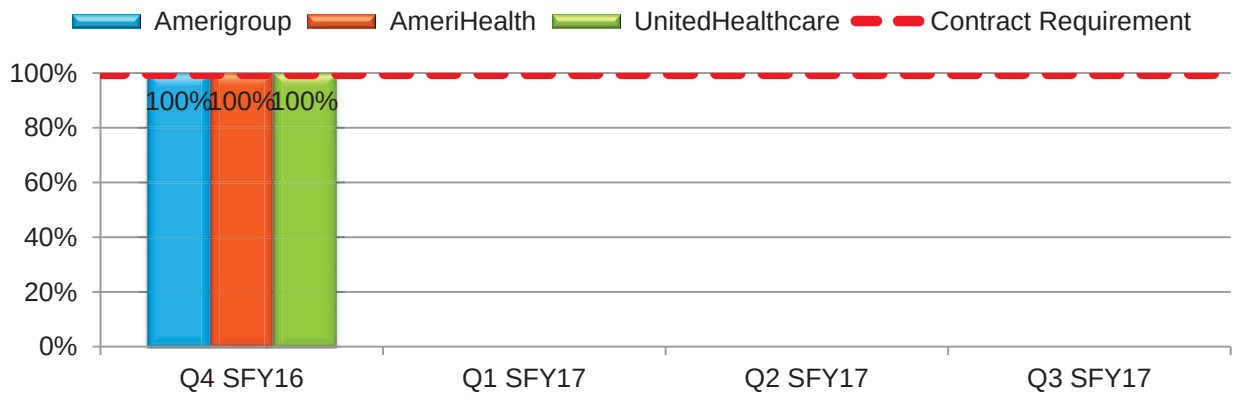
MCO Member Grievances and Appeals

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.

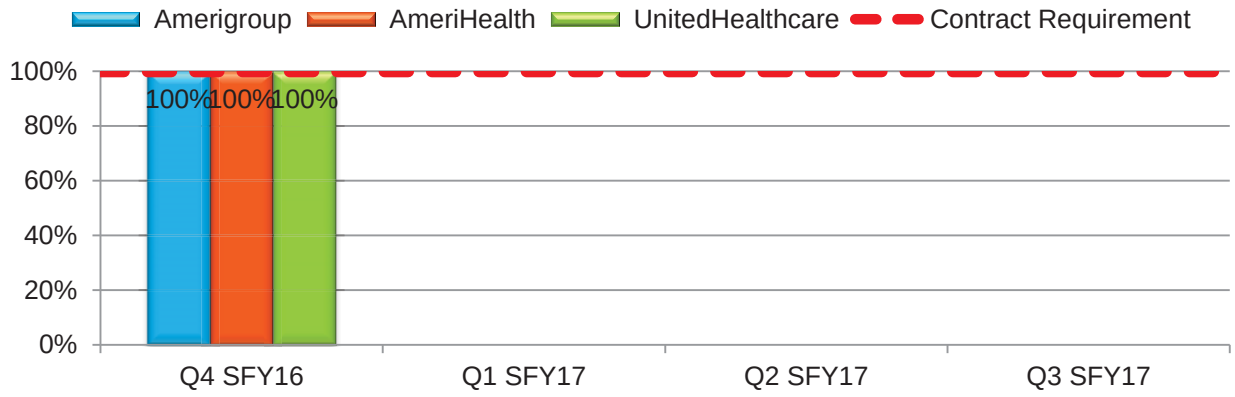
100% of Grievances Resolved within 30 Calendar Days of Receipt



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 Required to be Resolved in Q4 SFY16	145	42	39

100% of Appeals Resolved within 45 Calendar Days of Receipt



Supporting Data			
	Amerigroup	AmeriHealth	UnitedHealthcare
Appeals Received in Q4 SFY16 Required to be Resolved in Q4 SFY16	14	52	49

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.

Critical Incidents

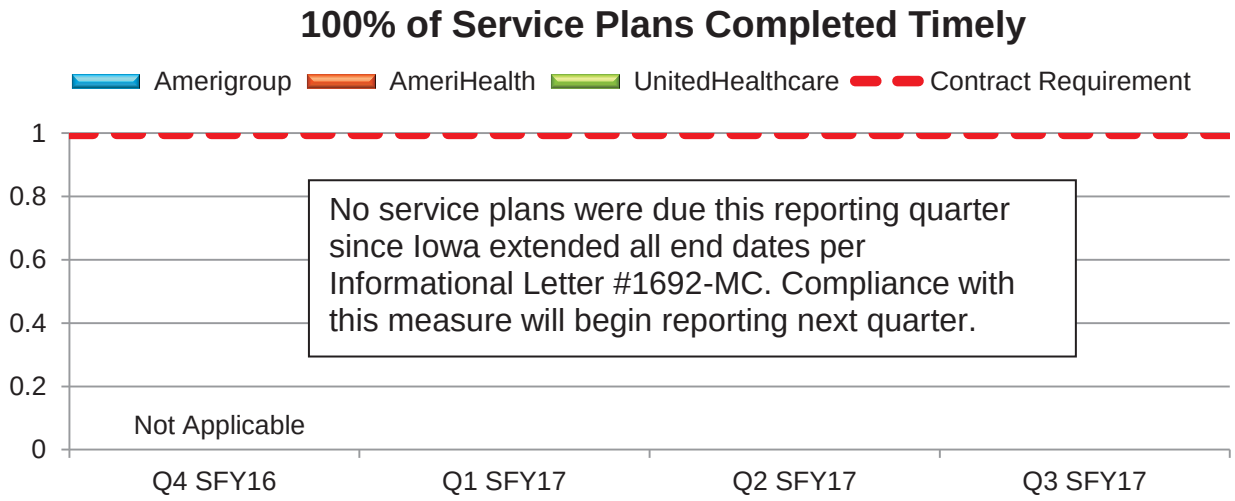
Home and Community Based Waiver and habilitation providers and case managers/care coordinators are required to report critical incidents to the MCOs. These critical incidents are to be reported if the reporting entity witnesses the incident or is made aware of the incident. Critical incidents are events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

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

Data Reported	Amerigroup	AmeriHealth	UnitedHealthcare
HCBS and Habilitation Members as of June 2016	3,110	16,837	2,639
Special Needs Population			
Total Number of Critical Incidents for Q4 SFY16	85	1,093	105
# Members Involved (unduplicated)	36	774	84
Behavioral Health Population			
Total Number of Critical Incidents for Q4 SFY16	232	868	252
# Members Involved (unduplicated)	153	476	180
Elderly Population			
Total Number of Critical Incidents for Q4 SFY16	38	193	38
# Members Involved (unduplicated)	38	184	36

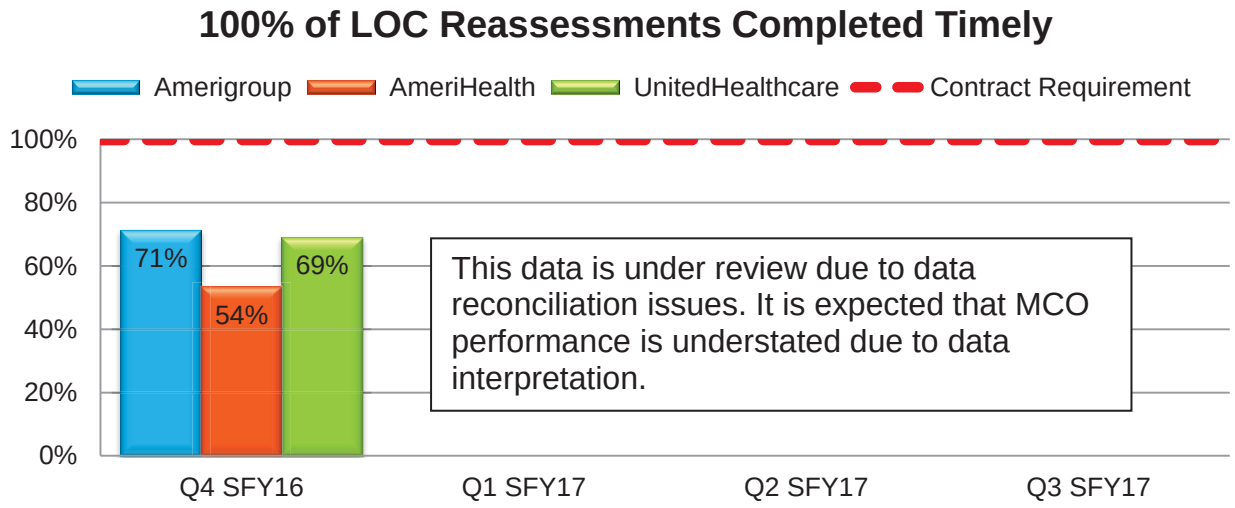
Service Plans

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



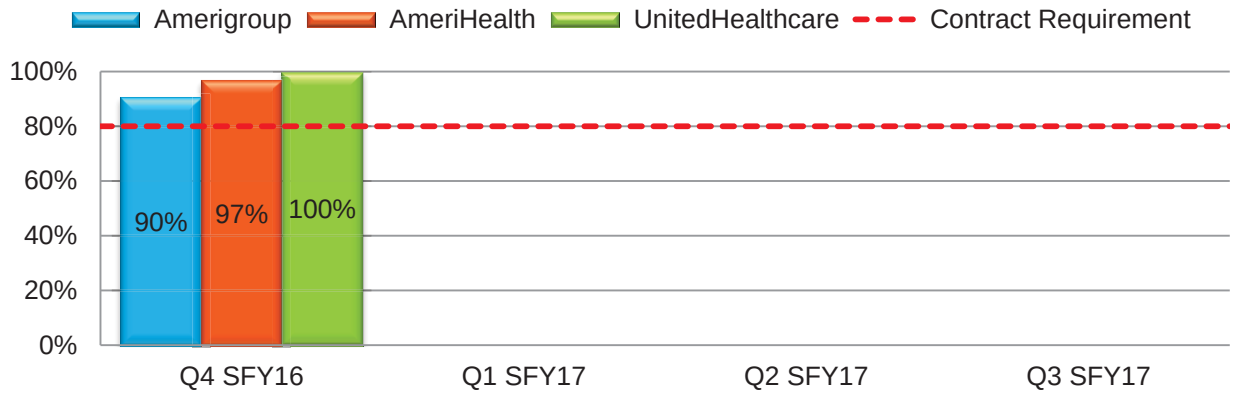
Level of Care

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



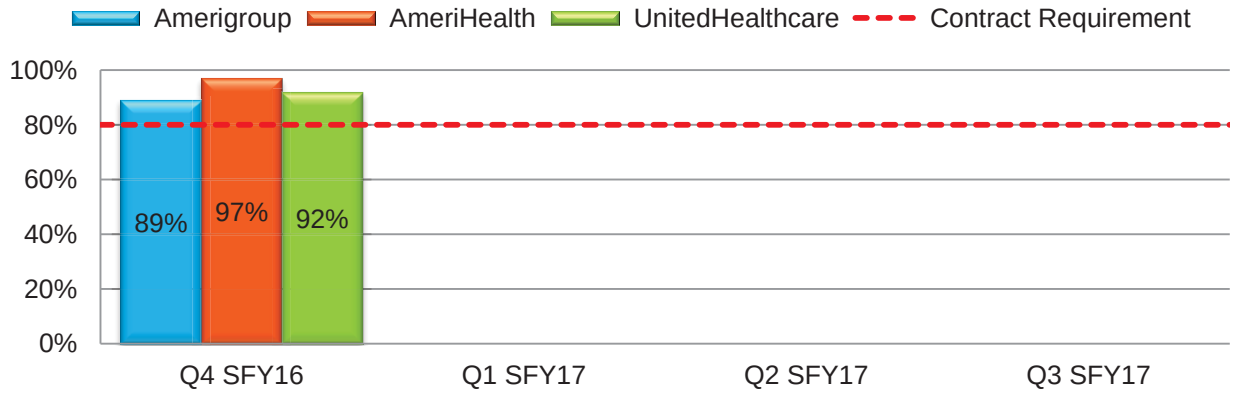
Member Helpline

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

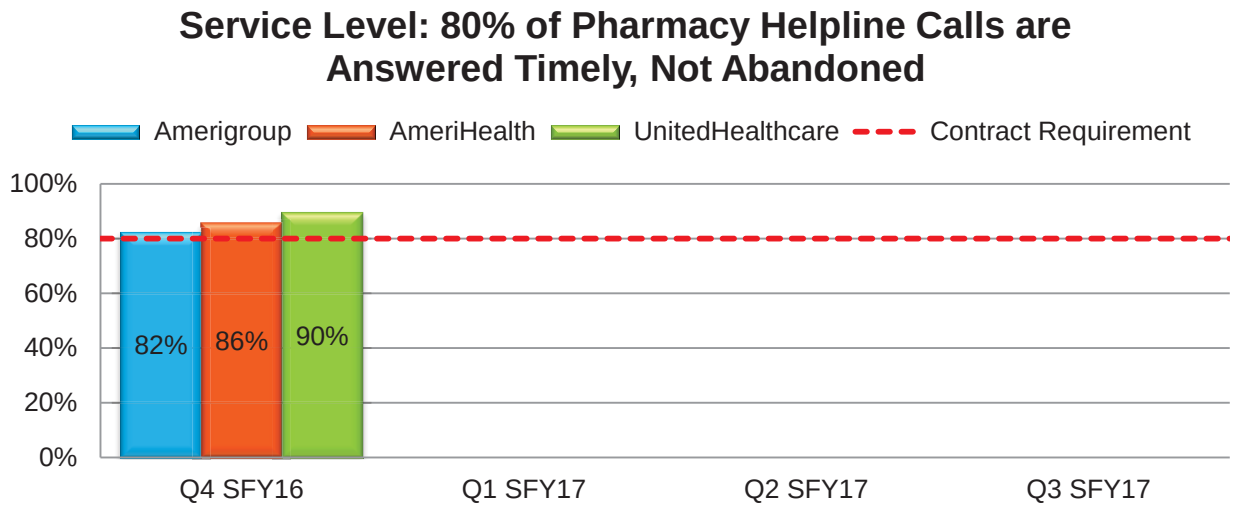


Provider Helpline

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



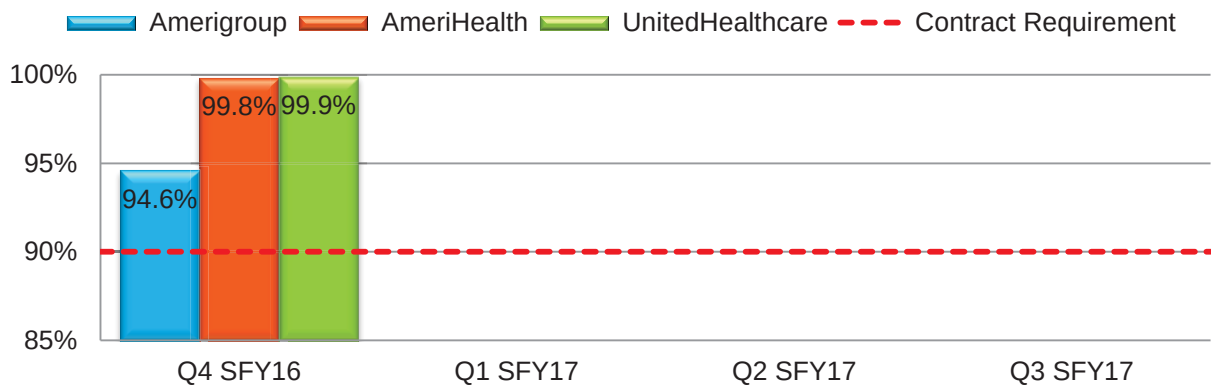
Pharmacy Services Helpline



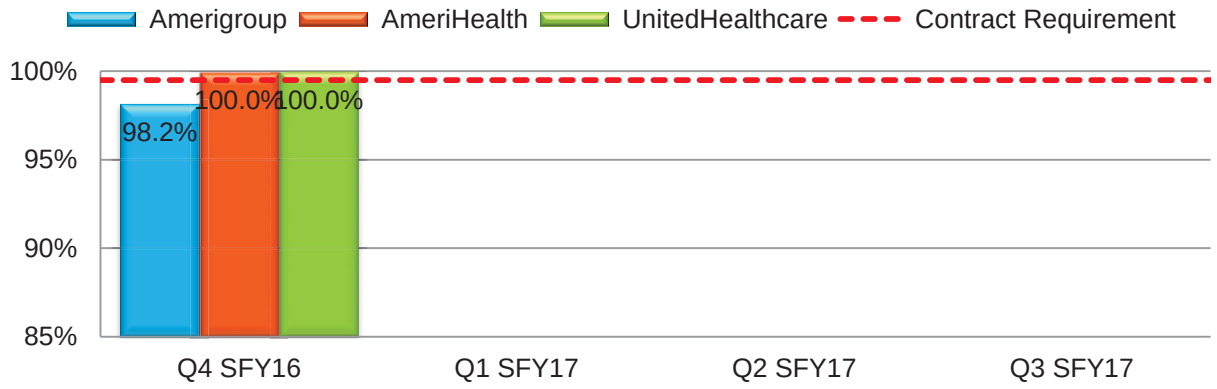
Medical Claims Payment

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

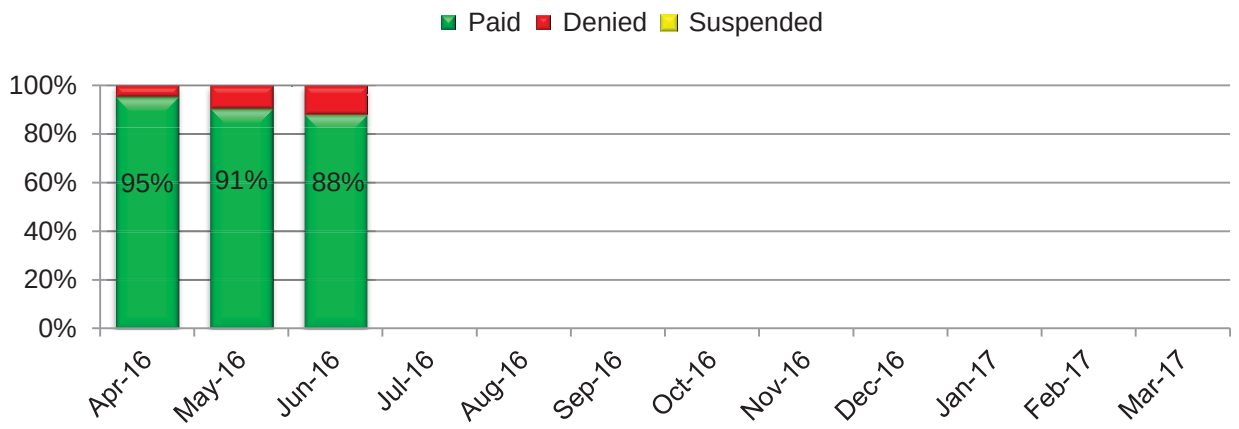


99.5% of Clean Medical Claims Must be Paid or Denied Within 21 Days



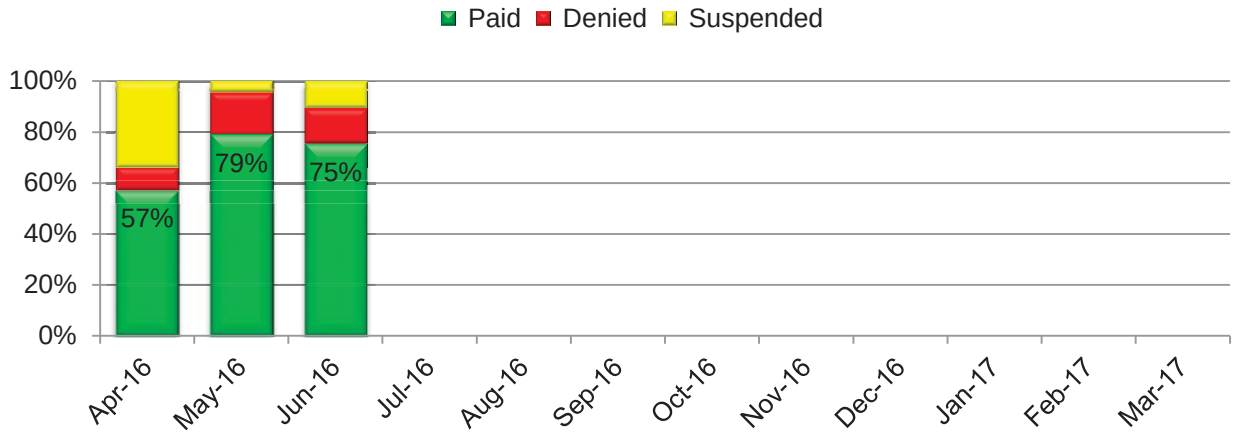
Amerigroup Medical Claims Status

**As of the end of the reporting period



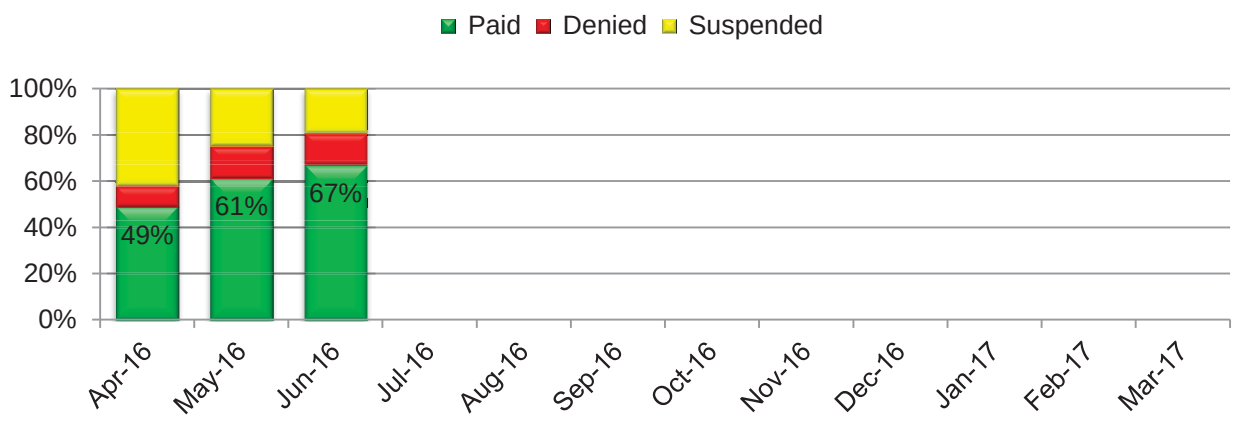
AmeriHealth Medical Claims Status

**As of the end of the reporting period



UnitedHealthcare Medical Claims Status

**As of the end of the reporting period



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-8 The procedure code is inconsistent with the provider type/specialty (taxonomy).	1. CARC-45 Charge exceeds fee schedule/maximum allowable or contracted/legislated fee arrangement.
2. 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.	2. CARC-236 This procedure or procedure/modifier combination is not compatible with another procedure or procedure/modifier combination provided on the same day according to the National Correct Coding Initiative or workers compensation state regulations/ fee schedule requirements. -RARC-N657 This should be billed with the appropriate code for these services.	2. 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.
3. CARC-177 Patient has not met the required eligibility requirements.	3. CARC-18 Exact duplicate claim/service (Use only with Group Code OA except where state workers' compensation regulations requires CO) -RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.	3. CARC-96 Non-covered charge(s). RARC-N448 This drug/service/supply is not included in the fee schedule or contracted/legislated fee arrangement.
4. CARC-252 An attachment/other documentation is required to adjudicate this claim/service. RARC-N479: Missing Explanation of Benefits.	4. CARC-22 This care may be covered by another payer per coordination of benefits. RARC-N4 Missing/Incomplete/Invalid prior Insurance Carrier(s) EOB.	4. CARC-18 Exact duplicate claim/service. RARC-N522 Duplicate of a claim processed, or to be processed, as a crossover claim.
5. 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.	5. CARC-95 Plan procedures not followed.	5. CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service.
6. CARC-97 The benefit for this service is included in the payment/allowance for another service/procedure	6. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for	6. CARC-97 The benefit for this service is included in the payment/allowance for another service/procedure

Top Ten Reasons for Medical Claims Denial as of End of Reporting Period		
CARC and RARC are defined below table		
Amerigroup	AmeriHealth	UnitedHealthcare
that has already been adjudicated. RARC-N19 Procedure code incidental to primary procedure.	adjudication. -RARC-N329 Missing/incomplete/invalid patient birth date.	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-MA120 Missing/incomplete/invalid CLIA certification number.	7. CARC-27 Expenses incurred after coverage terminated. RARC-N30 Patient ineligible for this service.	7. CARC-16 Claim/service lacks information or has submission/billing error(s) which is needed for adjudication. RARC-MA120 Missing/incomplete/invalid CLIA certification number.
8. CARC-242 Services not provided by network/primary care providers.	8. CARC-26 Expenses incurred prior to coverage. RARC-N30 Patient ineligible for this service.	8. CARC-26 Expenses incurred prior to coverage. RARC-N30 Patient ineligible for this service.
9. CARC-4 The procedure code is inconsistent with the modifier used or a required modifier is missing.	9. 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.	9. CARC-96 Non-covered charge(s). RARC-N425 Statutorily excluded service(s).
10. CARC-119 Benefit maximum for this time period or occurrence has been reached. RARC-N587 Policy benefits have been exhausted.	10. CARC-5 The procedure code/bill type is inconsistent with the place of service. RARC-M77 Missing/incomplete/invalid/inappropriate place of service.	10. CARC-197 Precertification/authorization/notification absent.

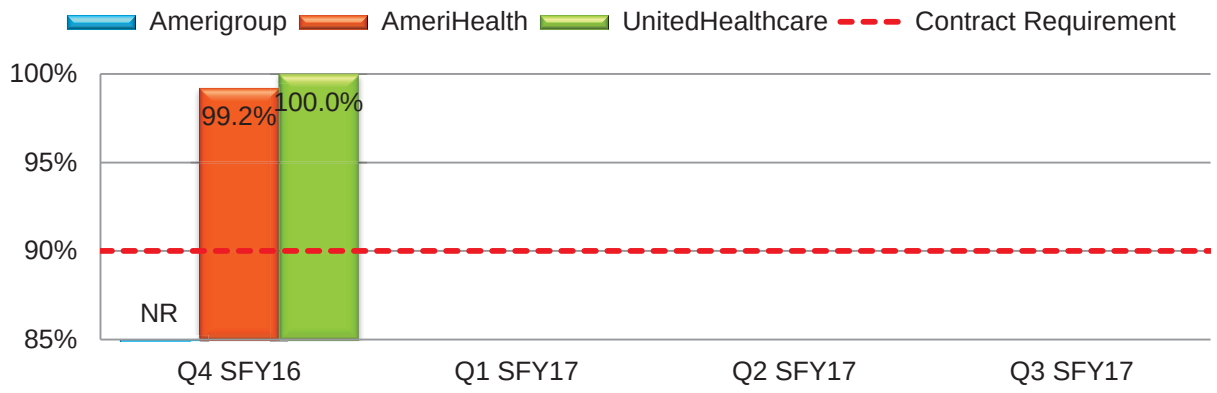
Claim Adjustment Reason Codes (CARC): A nationally-accepted, standardized set of denial and payment adjustment reasons used by all MCOs. http://www.wpc-edi.com/reference/codelists/healthcare/claim-adjustment-reason-codes/

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/

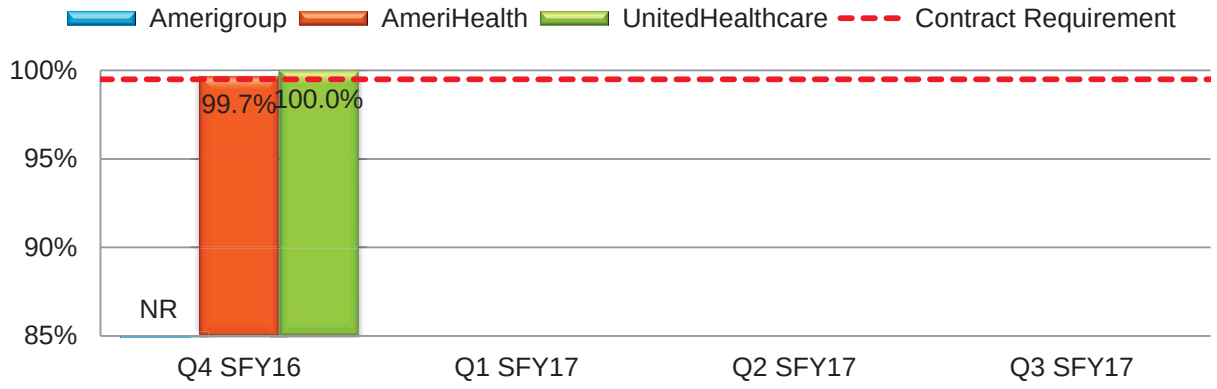
Pharmacy Claims Payment

Pharmacy claims processing data is for the entire quarter.

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

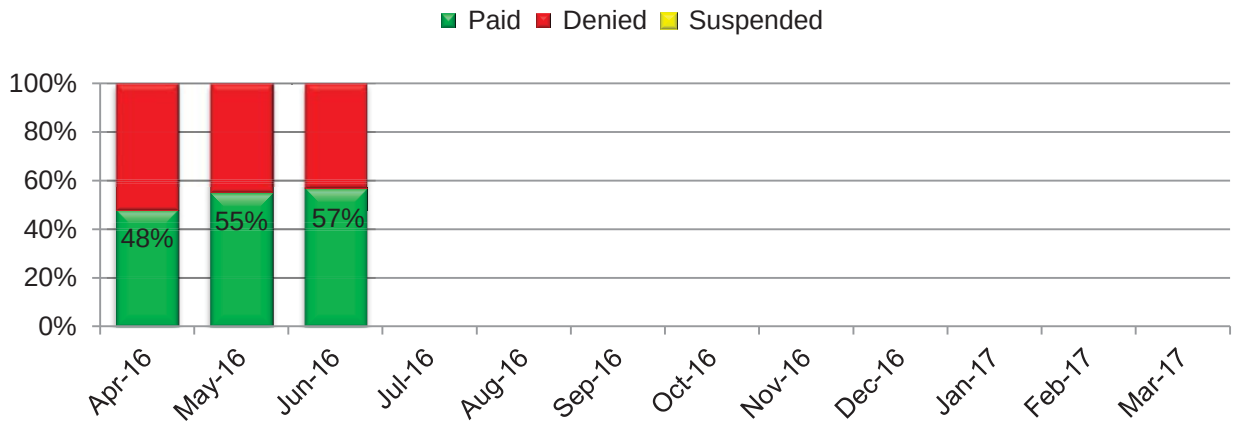


99.5% of Clean Pharmacy Claims Must be Paid or Denied Within 21 Days



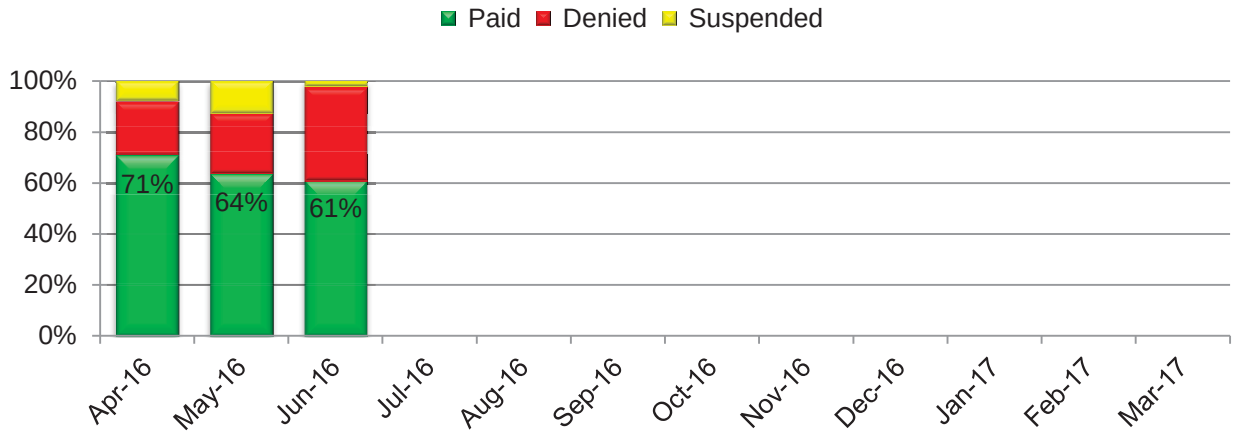
Amerigroup Pharmacy Claims Status

****As of the end of the reporting period**



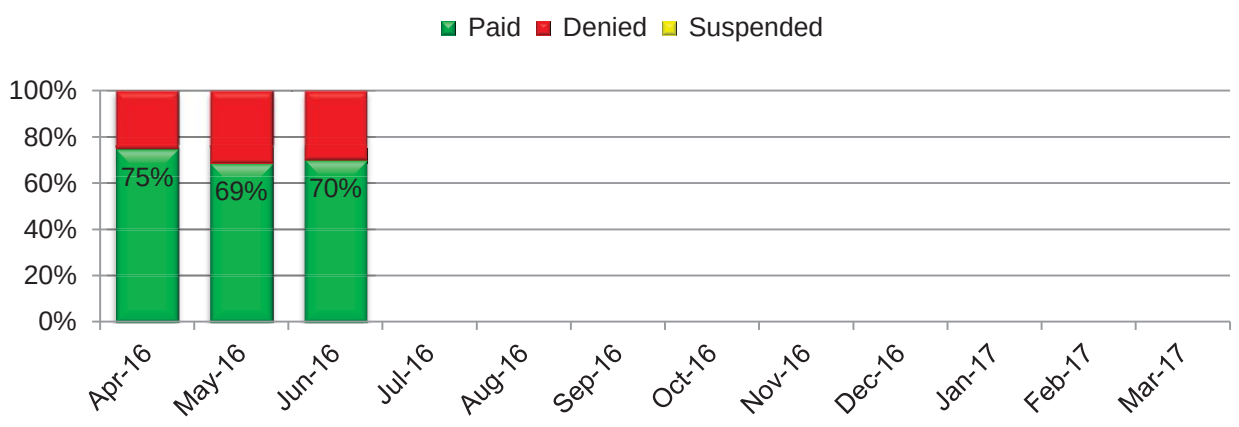
AmeriHealth Pharmacy Claims Status

****As of the end of the reporting period**



UnitedHealthcare Pharmacy Claims Status

****As of the end of the reporting period**



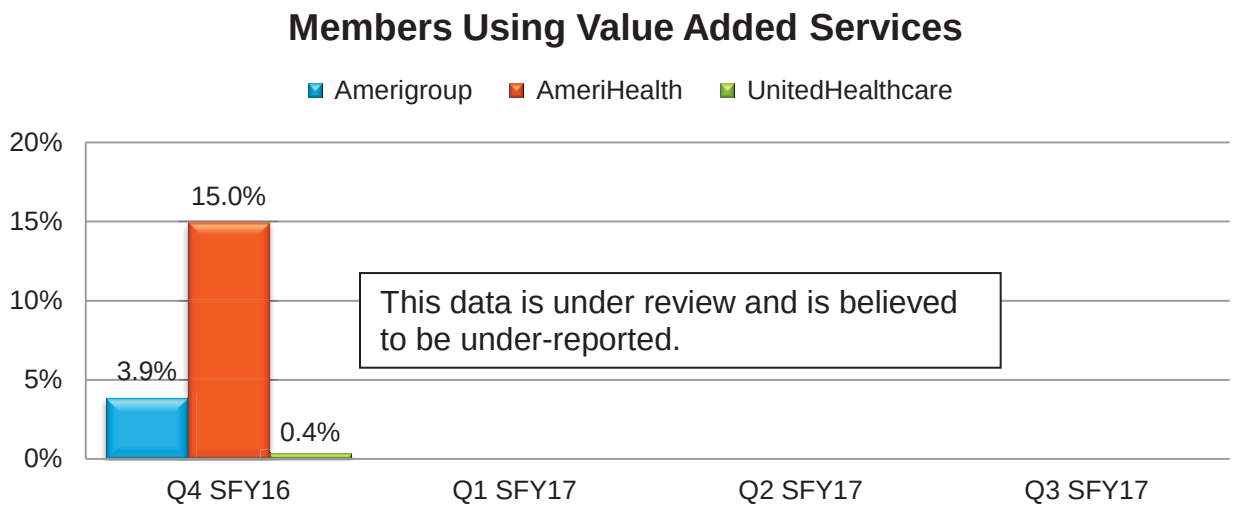
Top Ten Reasons for Pharmacy Claims Denial as of End of Reporting Period		
Amerigroup	AmeriHealth	UnitedHealthcare
1. Refill Too Soon	1. M/I Ingredient Cost Submitted	1. DUR Reject Error
2. Product Not On Formulary	2. Claim Has Not Been Paid	2. Refill Too Soon
3. Submit Bill To Other Processor Or Primary Payer	3. Product/Service Not Covered - Plan/Benefit Exclusion	3. Prior Authorization Required
4. Prior Authorization Required	4. Refill Too Soon	4. Prod/Service Not Covered
5. Plan Limitations Exceeded	5. Plan Limitation Exceeded	5. Filled After Coverage Trm
6. Days Supply Exceeds Plan Limitation	6. Claim Submitted Does Not Match Prior Authorization	6. Plan Limitations Exceeded
7. DUR Reject Error	7. Submit Bill To Other Processor Or Primary Payer	7. Sbmt bill to other procsr
8. Product/Service Not Covered - Plan/Benefit Exclusion	8. Prior Authorization Required	8. M/I Days Supply
9. Product Not Covered Non-Participating Manufacturer	9. Patient Is Not Covered	9. Non-Matched Pharmacy Nbr
10. Scheduled Downtime	10. DUR Reject Error	10. Patient is Not Covered

Utilization of Health Care Services Reported			
Data	Amerigroup	AmeriHealth	UnitedHealthcare
Emergency Department Claims Reimbursed	$20,350,842	$1,288,735	$6,951,341
Inpatient Medical Claims Reimbursed	$46,305,694	$12,715,587	$18,087,466
Inpatient Behavioral Health Claims Reimbursed	$4,677,901	$2,905,204	$1,912,945
Outpatient Claims Reimbursed	$50,153,705	$6,631,812	$22,652,592

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



Between the plans there are over 60 total value added services available as part of the managed care program. 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 June 2016 STC3 Network Adequacy Executive Summary.

	AmeriHealth			Amerigroup			United		
Provider Type - Adult	East	Central	West	East	Central	West	East	Central	West
Primary Care	93.0%	97.0%	96.0%	94.41%	96.35%	96.94%	84.6%	92.5%	76.0%
Cardiology	100.0%	100.0%	95.0%	97.29%	96.47%	97.08%	89.9%	93.5%	71.4%
Endocrinology	94.0%	100.0%	98.0%	89.74%	99.55%	99.47%	99.1%	93.5%	63.9%
Gastroenterology	90.0%	97.0%	86.0%	99.24%	93.56%	100.00%	82.8%	98.7%	97.0%
Neurology	91.0%	100.0%	89.0%	96.23%	94.57%	97.04%	75.4%	97.0%	94.4%
Oncology	93.0%	97.0%	94.0%	91.63%	94.33%	99.77%	99.1%	99.4%	88.1%
Orthopedics	77.0%	95.0%	93.0%	76.18%	97.32%	98.92%	88.7%	94.3%	88.4%
Pulmonology	100.0%	100.0%	95.0%	97.57%	97.17%	98.04%	82.5%	93.7%	78.9%
Rheumatology	100.0%	100.0%	97.0%	100.00%	85.16%	94.74%	2.7%	81.2%	3.4%
Urology	98.0%	99.0%	100.0%	98.93%	98.96%	99.35%	94.3%	94.4%	58.2%
Provider Type - Pediatric	East	Central	West	East	Central	West	East	Central	West
Primary Care	95.0%	97.0%	90.0%	92.23%	97.39%	97.72%	85.1%	93.7%	86.6%
Provider Type - Facilities and Pharmacy	East	Central	West	East	Central	West	East	Central	West
Hospitals	99.0%	100.0%	96.0%	99.49%	96.55%	97.91%	95.2%	90.1%	75.2%
Pharmacies	98.0%	98.0%	95.0%	99.79%	99.68%	99.85%	99.0%	99.1%	97.3%
ICF/ID	100.0%	100.0%	99.0%	98.80%	100.00%	92.90%	60.8%	93.3%	90.8%
ICF/SNF	98.0%	95.0%	98.0%	99.23%	93.95%	99.50%	92.2%	97.5%	94.6%

NETWORK ADEQUACY AND HISTORICAL UTILIZATION

	AmeriHealth			Amerigroup			United		
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	No Util	No Util	No Util
AIDS/HIV Level 2: CDAC, Home Health Aide	100.0%	100.0%	No Util	No Util	100.00%	100.0%	100.0%	100.0%	No Util
AIDS/HIV Level 4: Home Delivered Meals	100.0%	100.0%	No Util	100.00%	100.00%	No Util	100.0%	100.0%	100.0%
BI Level 1: Adult Day Care, Prevocational Services, Supported Employment	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	68.1%	100.0%	86.5%
BI Level 2: CDAC	100.0%	100.0%	96.0%	100.00%	100.00%	95.86%	100.0%	100.0%	100.0%
BI Level 3: Supported Community Living	100.0%	100.0%	100.0%	99.24%	100.00%	99.21%	92.1%	99.1%	97.2%
Elderly Level 1: Adult Day Care	100.0%	100.0%	No Util	100.00%	100.00%	100.00%	100.0%	100.0%	100.0%
Elderly Level 2: CDAC, Home Health Aide	99.0%	92.0%	99.0%	98.44%	96.71%	96.73%	91.7%	99.8%	99.8%
Elderly Level 4: Home Delivered Meals	99.0%	95.0%	99.0%	97.35%	91.82%	95.78%	98.8%	96.1%	94.0%
HD Level 1: Adult Day Care	100.0%	100.0%	No Util	100.00%	100.00%	No Util	No Util	100.0%	No Util
HD Level 2: CDAC, Counseling, Home Health Aide	100.0%	99.0%	98.0%	98.80%	100.00%	100.00%	100.0%	100.0%	100.0%
HD Level 4: Home Delivered Meals	100.0%	100.0%	100.0%	100.00%	100.00%	100.00%	95.1%	96.2%	100.0%
ID Level 1: Adult Day Care, Day Habilitation, Prevocational Services, Supported Employment	100.0%	100.0%	100.0%	99.88%	97.73%	100.00%	86.9%	95.0%	94.1%
ID Level 2: CDAC, Home Health Aide	100.0%	97.0%	98.0%	94.84%	100.00%	100.00%	100.0%	100.0%	100.0%
ID Level 3: Supported Community Living	100.0%	100.0%	99.0%	99.26%	98.71%	98.96%	89.6%	93.5%	92.6%
PD Level 2: CDAC,	100.0%	100.0%	100.0%	97.56%	98.75%	98.30%	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%	100.00%	100.00%	100.00%	96.4%	90.9%	73.9%
Behavioral Health - Outpatient	97.0%	97.0%	97.0%	98.37%	98.29%	98.03%	97.9%	97.0%	81.8%
Habilitation Level 1: Day Habilitation, Prevocational Services, Supported Employment	100.0%	100.0%	100.0%	100.00%	90.49%	100.00%	84.3%	98.7%	100.0%
Habilitation Level 3: Home Based Habilitation	100.0%	100.0%	90.0%	99.84%	96.60%	98.97%	89.8%	98.8%	97.4%
Children's Mental Health Level 1: Respite	100.0%	100.0%	100.0%	100.0%	98.76%	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.

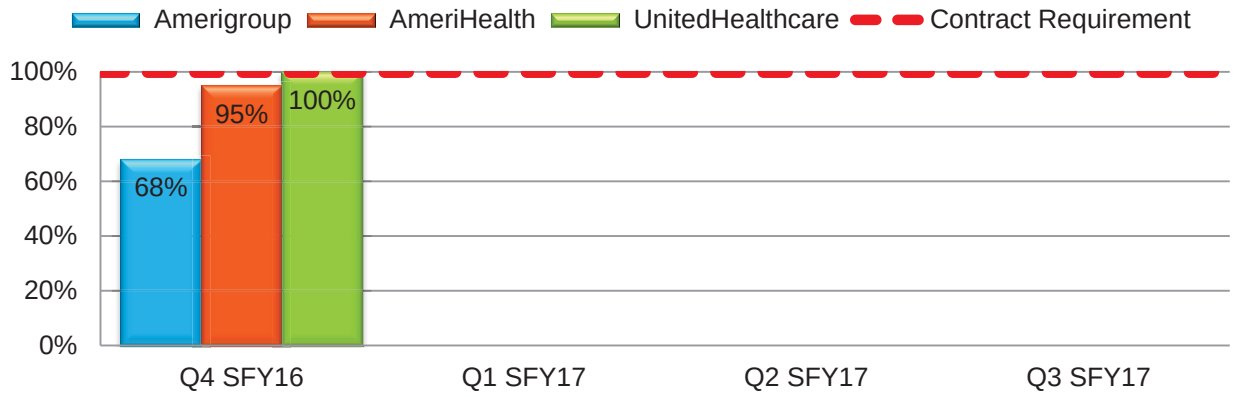
Links to time and distance reports for this reporting period can be found at:

- Amerigroup:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-AGP-070116.pdf
- AmeriHealth Caritas:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-ACIA-070616.pdf
- UnitedHealthcare:
    - https://dhs.iowa.gov/sites/default/files/GeoAccess-Standards-for-Exhibit-B-Worksheet-UHC-070516.pdf

GeoAccess maps reflect traditional time and distance standards. As of the date of this publication, the MCOs have not yet submitted exception requests to be reviewed and approved by the department. The department has initiated corrective action related to compliance with the time and distance standards reporting. Based on the Iowa Medicaid fee-for-service coverage, it is anticipated the MCOs will show comparable or better coverage than what was available prior to managed care implementation on April 1, 2016.

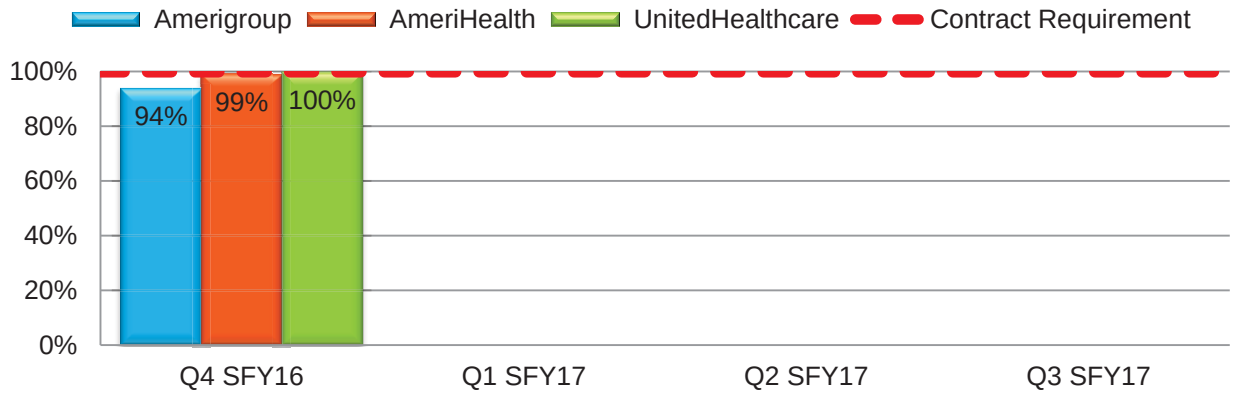
Prior Authorization - Medical

100% of Regular 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.

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



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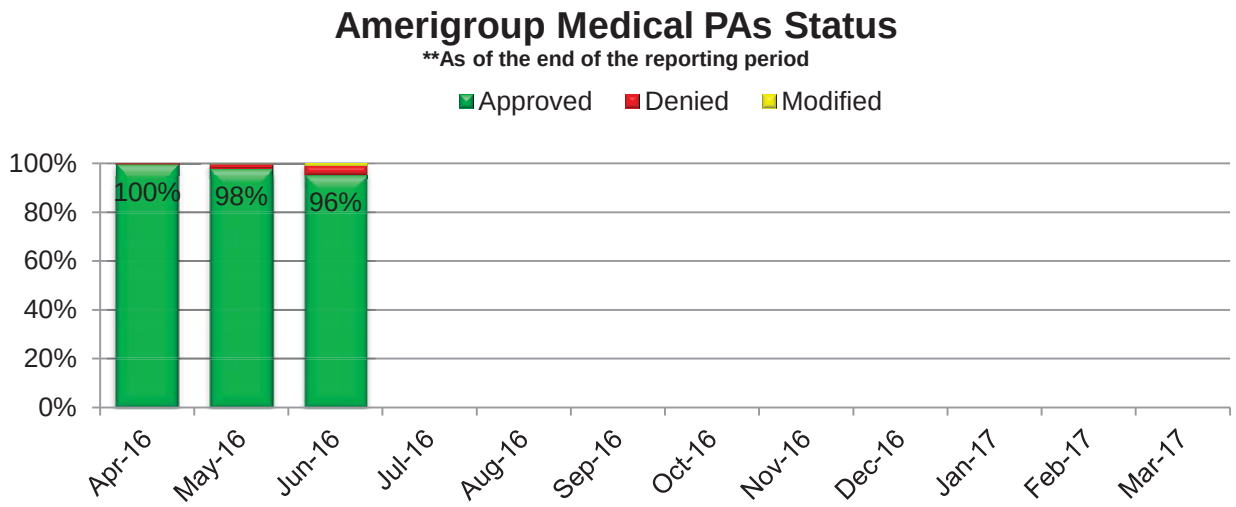

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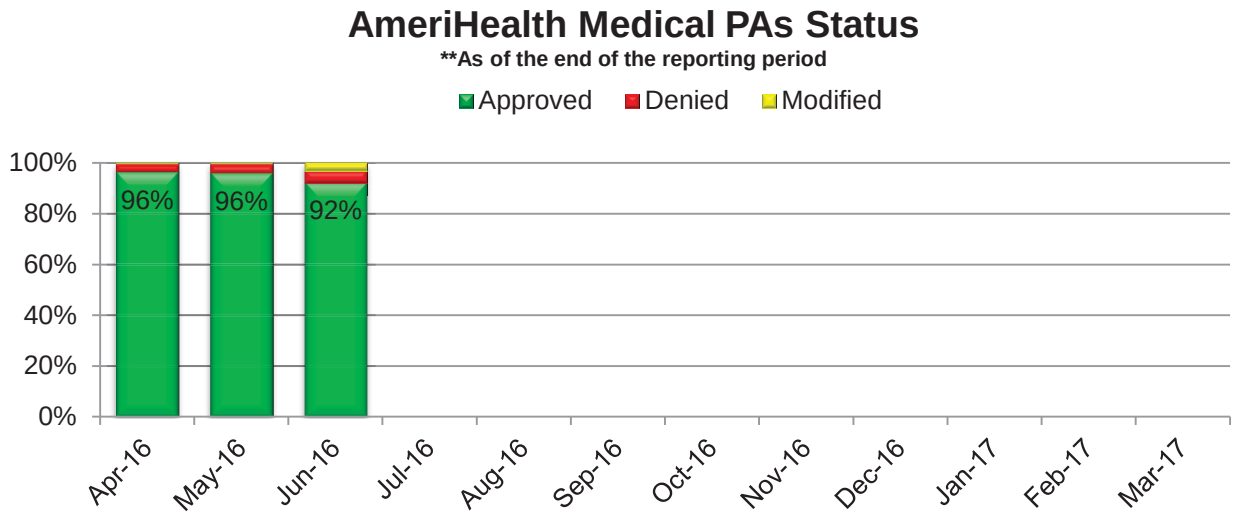
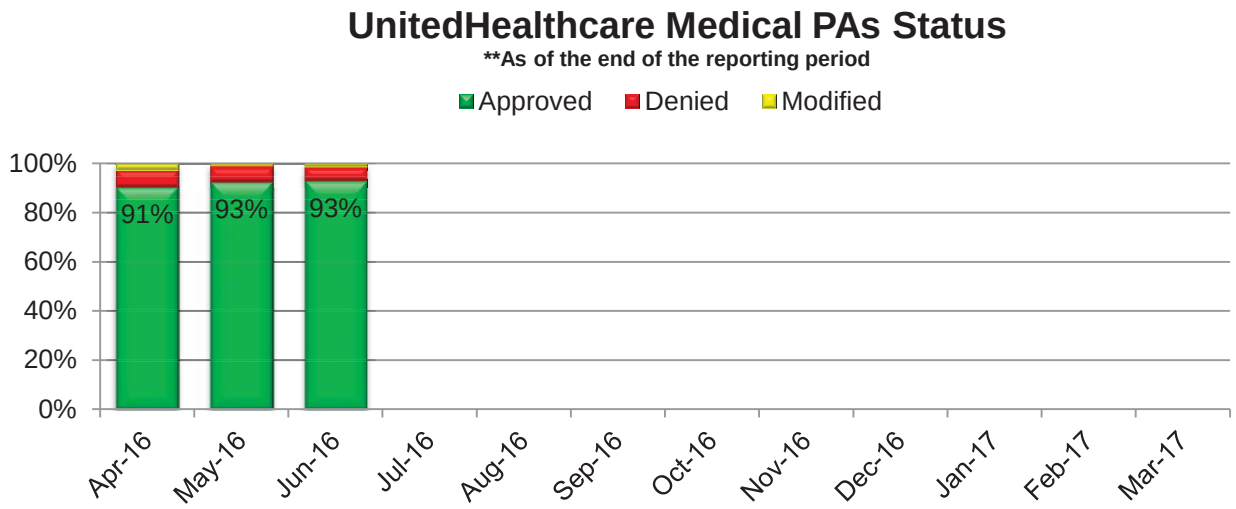
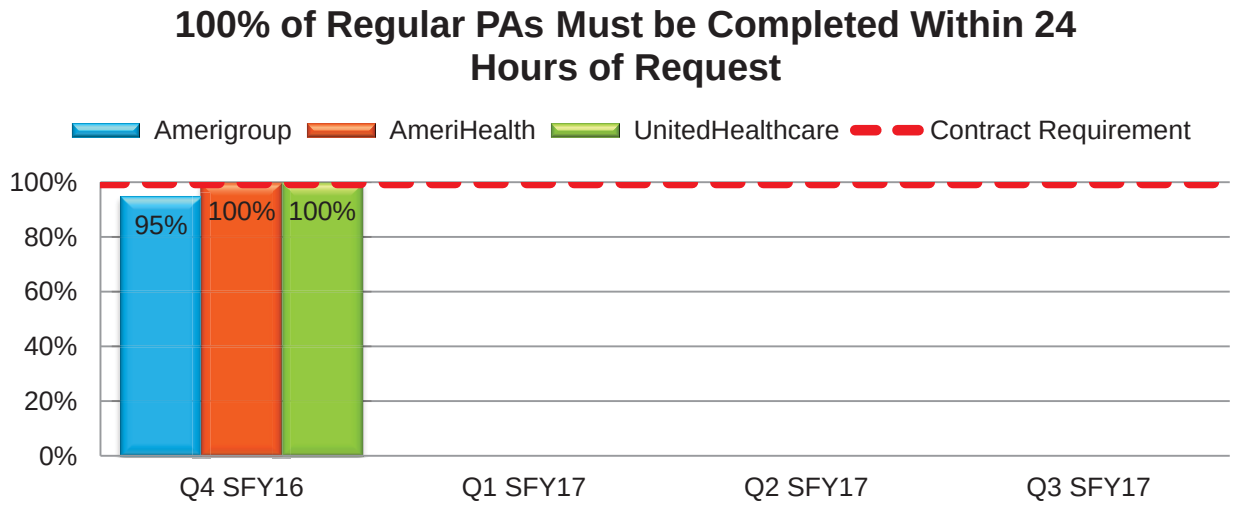


This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.



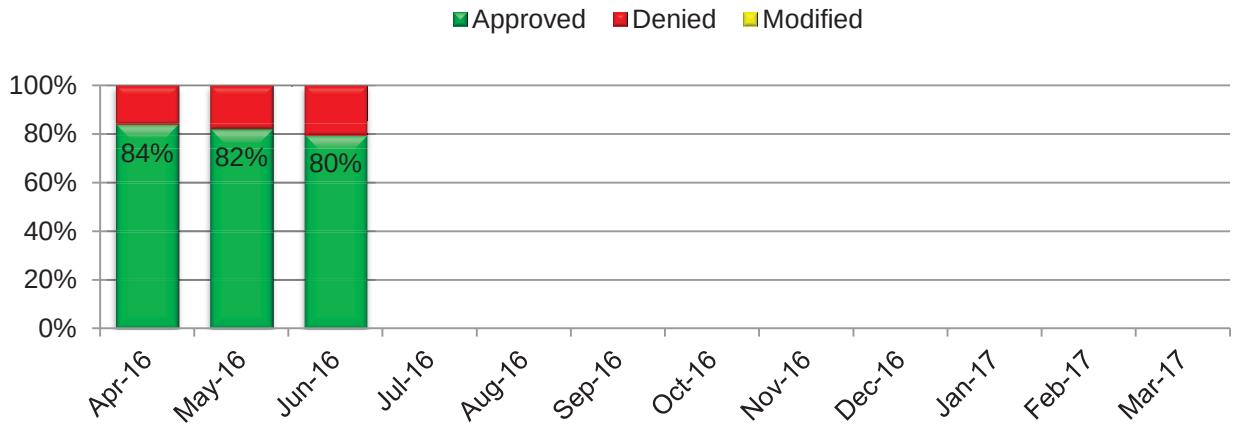
This data element does not have a direct benchmark to compare to historical fee-for-service data as the managed care and fee-for-service prior authorization process and volume may differ.

Prior Authorization - Pharmacy



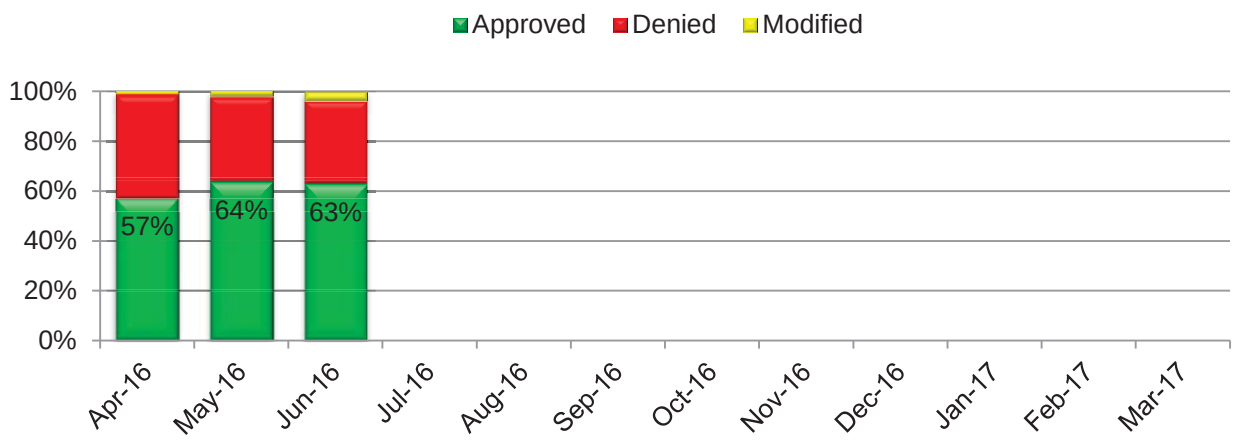
Amerigroup Pharmacy PAs Submitted Status

**As of the end of the reporting period



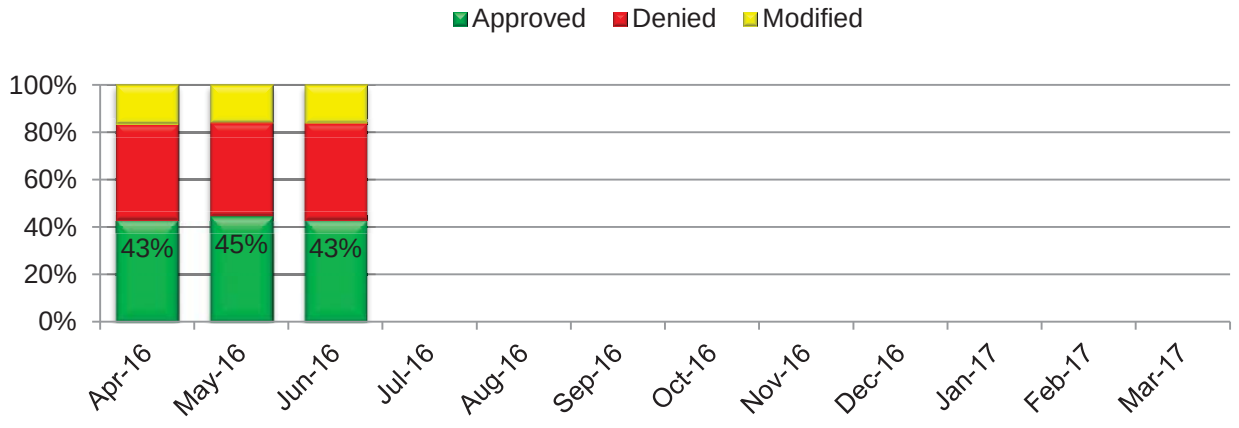
AmeriHealth Pharmacy PAs Submitted Status

**As of the end of the reporting period



UnitedHealthcare Pharmacy PAs Submitted Status

**As of the end of the reporting period

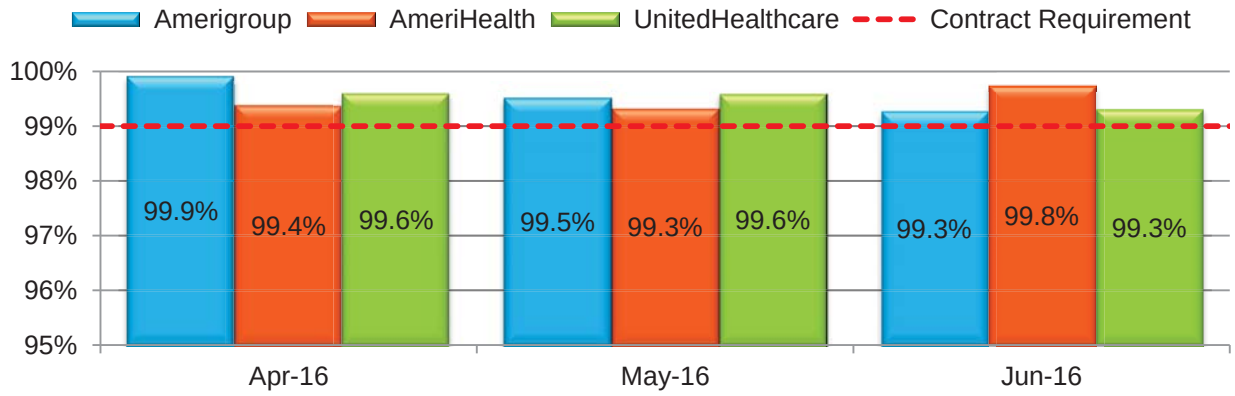


Encounter Data Reported

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	April	May	June	April	May	June	April	May	June
	Y	Y	Y	Y	Y	Y	Y	Y	Y

99% Encounter Data Meeting DHS IT System Acceptance Standards



Value Based Purchasing Enrollment

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

Data as of June 2016	Amerigroup	AmeriHealth	UnitedHealthcare
% of Members Covered by a Value Based Purchasing Agreement	0.0%	3.4%	0.0%

Amerigroup does not yet have department approved value based purchasing contracts.

MLR/ALR/Underwriting

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

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

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

Q4 SFY16 Data	Amerigroup	AmeriHealth	UnitedHealthcare
MLR	123.30%	102.45%	104.38%
ALR	12.33%	6.27%	12.70%
Underwriting	-35.63%	-8.72%	-17.08%

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 Q2 calendar year 2016 (Q4 SFY16) financial information submitted to the Iowa Insurance Division by each MCO.

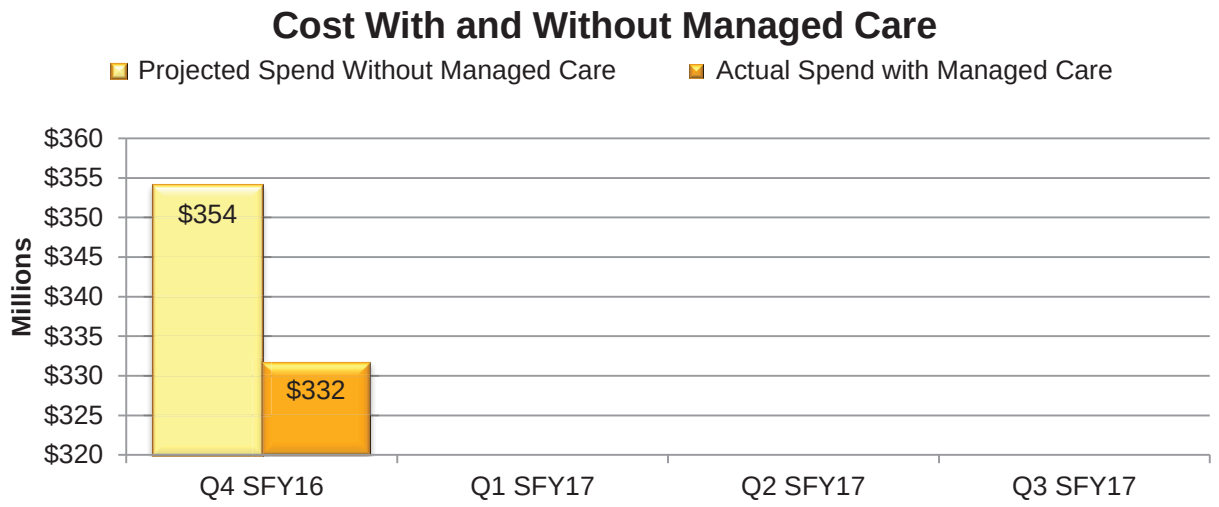
The financial metrics presented here reflect financial performance for the contract period, i.e., the period beginning April 1, 2016. Premium deficiency reserves and/or changes in premium deficiency reserves are excluded from the calculations. The department believes this approach most accurately reflects financial performance for service delivery under the contract.

It is important to note that accounting and reporting differences among MCOs may result in variance among plans beyond the variance in medical expenses per member. Examples of items that may contribute to variance include:

- Treatment of capitation rate performance withhold (2%)
- Methodology and assumptions related to recognition of claims incurred but not reported
- Treatment of graduate medical education and other pass through payments
- Treatment of anticipated risk adjustment
- Inclusion or exclusion of pre-contract administrative expense
- Various other accounting policies and assumptions

In the next quarterly report, the department will work with the MCOs to standardize reporting of financial metrics and minimize controllable variances. This will enhance benchmarking of performance across the plans.

Program Cost Savings (To Date)			
Data	**Projected State Spend Without Managed Care**	**Actual State Spend with Managed Care**	**Program Cost Savings (State)**
Program Cost Savings (State)	$354,021,175	$331,757,270	$22,263,905



Savings achieved are unique to this quarter. The state expects to meet the savings amount ($110M) projected by the Medicaid Forecast Group, passed by the legislature, and signed by the governor.

Savings reported in this quarter (Q4 SFY16) 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.

First quarter savings from managed care are being reported at $22.3 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	$58,821,540	$23,483,915	$47,165,099	$129,470,554
Physician Claims Paid	$80,388,610	$20,577,749	$3,219,047	$104,185,406
HCBS Claims Paid	$57,150,836	$63,991,468	$6,607,076	$127,749,380
DME Claims Paid	$31,822,459	$2,144,113	$1,757,751	$35,724,323
Pharmacy Claims Paid	$31,675,007	$50,701,666	$41,586,516	$123,963,189
Home Health Claims Paid	$24,907,269	$5,638,926	$2,758,004	$33,304,199
Hospice Claims Paid	$19,604,714	$1,171,549	$155,942	$20,932,205
Nursing Facility Claims Paid	$43,383,537	$22,388,394	$24,727,481	$90,499,412
ICF/ID Claims Paid	$8,764,795	$14,345,835	$14,555,366	$37,665,996
Behavioral Health Claims Paid	$65,142,064	$19,537,194	$3,542,021	$88,221,279
Speech Therapy Claims Paid				
Occupational Therapy Claims Paid				
Non-Emergency Transportation Claims Paid	$1,298,516	$1,200,597	$755,553	$3,254,666

This data is under review due to data reconciliation issues.

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

The department continues validation processes to consider accuracy and consistency in claims reporting. As an example, the MCOs do not all define speech therapy and occupational therapy the same way in their systems as these services may be covered across more provider types than classified in Medicaid fee-for-service.

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

Capitation Payments Made to the Managed Care Organizations for Q4 SFY16			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Capitation Payments Paid by DHS	$237,540,157	$408,575,970	$229,442,968

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			
Data reported	**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
Amount of TPL Recovered	$6,746,400	$13,842,202	$7,651,869

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.

Program Integrity Activities

Data reported	Amerigroup	AmeriHealth	UnitedHealthcare
Claims Systems with Pre-Edits Established April 1	✓	✓	✓
Implemented PI processes that complement FFS processes	✓	✓	✓
Participated in bi-weekly PI meetings with IME, Medicaid Fraud Control Unit (MFCU) and Attorneys General	✓	✓	✓

The MCOs have attended more than 25 meetings or on-site visits with regulators. The plans have initiated 27 investigations in the first quarter and referred five 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.

Hospital Admissions

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

Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	April	**May**	**June**	**April**	**May**	**June**	**April**	**May**	**June**
Members (from IME)	186,363	190,991	192,678	201,935	209,917	216,591	211,352	203,756	198,708
Total Inpatient Admissions	1,302	1,639	2,262	507	5,454	11,722	2,096	1,800	1,680
Readmissions within 15 days of Discharge	89	227	288	15	80	259	106	104	88
Readmissions within 30 days of Discharge	95	324	441	15	89	345	115	158	127
Readmissions within 45 days of Discharge	95	388	537	15	92	381	120	183	147
Readmissions within 60 days of Discharge	95	396	552	15	92	397	120	193	177

Readmissions may include duplicate members (e.g., a member readmitted within 15 days is also included as a member readmitted within 30, 45 and 60 days).

Emergency Department

Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	April	May	June	April	May	June	April	May	June
ED Visits for Non-Emergent Conditions – Adult	14.1	14.3	21.8	17.2	52.2	133.1	58.0	59.0	49.0
ED Visits for Non-Emergent Conditions – Child	14.7	13.8	18.1	12.0	30.5	77.8	29.0	28.0	21.0
Supporting Data									
Members (from IME)	186,363	190,991	192,678	201,935	209,917	216,591	211,352	203,756	198,708
Members Using ED More Than Once in 30 Days	178	168	302	182	2,046	5,464	2,030	1,092	795
Members Using ED More Than Once in 60 Days*	178	178	312	182	2,077	6,703	2,402	1,483	1,173

*Members Using ED More Than Once in 30 Days are also included in counts for Members Using ED More Than Once in 60 Days.

Out-of-State Placement*

Data	Amerigroup			AmeriHealth			UnitedHealthcare		
	April	May	June	April	May	June	April	May	June
Members in Out-of-State PMIC	15	19	20	0	0	0	2	2	2
Members in Out-of-State Skilled Nursing Facility	11	20	17	0	0	0	3	7	7
Members Placed in an Out-of-State ICF/ID	4	3	0	67	66	66	1	1	1
Members in Out-of-State nursing facilities	0	0	0	0	0	0	2	0	0
Members in Out-of-State Other Institutions	0	0	0	0	0	0	0	1	1

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

Health Care Outcomes

APPENDIX

HCBS Waiver Waitlist – June 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	31	1,219	630	7,729	1,968	12,041	681
Number of Individuals on Waiver Waitlist (DHS Function)	0	1,275	1,223	0	2,781	2,484	1,297
Waitlist Increase or (Decrease)	0	-175	-579	0	147	57	-421

*As reported in July. July data represents June eligibility statistics.

Q4 SFY16 - Quarterly	
MCO	**Rollup of Remedy Recommendations**

Amerigroup	• Corrective action to address timeliness, completeness, and accuracy of reporting.
	  ○ Reports:
	  ▪ Special Needs Population Report
	  ▪ Correct Coding Initiative Report
	  ▪ 24 Hour Access Report
	  ▪ Prenatal and Childbirth Outcomes Report
	• Corrective action plan to address contractual standards not met.
	  ○ Reports:
	  ▪ Initial Health Risk Assessment Report
	  ▪ Provider Credentialing Report
	• Liquidated damages = $1,260
	  ○ Liquidated Damages have been assessed for four instances in which reports were not complete. $315 * 4 = $1,260
	  ○ Liquidated Damages have not been assessed for two performance standards not met (Initial Risk Assessment and Provider Credentialing) as they are tied to pay-for-performance measures.

AmeriHealth	• Corrective action to address timeliness, completeness, and accuracy of reporting.
	  ○ Reports:
	  ▪ Correct Coding Initiative Report
	  ▪ Waivers Report
	• Corrective action plan to address contractual standards not met.
	  ○ Reports:
	  ▪ Initial Health Risk Assessment Report
	  ▪ Provider Credentialing Report
	• Liquidated damages = $630
	  ○ Liquidated Damages have been assessed for two instances in which reports were not complete. $315 * 2 = $630
	  ○ Liquidated Damages have not been assessed for two performance standards not met (Initial Risk Assessment and Provider Credentialing) as they are tied to pay-for-performance measures.

Q4 SFY16 - Quarterly	
MCO	**Rollup of Remedy Recommendations**

UnitedHealthcare	• Corrective action to address timeliness, completeness, and accuracy of reporting.
	  ○ Reports:
	  ▪ General Population Report
	  ▪ Special Needs Population Report
	  ▪ Behavioral Health Population Report
	  ▪ Elderly Population Report
	  ▪ Care Coordination Report
	  ▪ Children's Health Outcomes Report
	  ▪ Correct Coding Initiative Report
	  ▪ Waivers Report
	• Corrective action plan to address contractual standards not met.
	  ○ Reports:
	  ▪ Initial Health Risk Assessment Report
	• Liquidated damages = $2,520
	  ○ Liquidated Damages have been assessed for eight instances in which reports were not complete or timely. $315 * 8 = $2,520
	  ○ Liquidated Damages have not been assessed for one performance standards not met (Initial Risk Assessment) as it is tied to pay-for-performance measures.

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.