Iowa Department of Human Services

Calendar Year 2016 External Quality Review Technical Report

July 2017

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Purpose of Report

According to the 42nd Code of Federal Regulations (CFR) §438.350, states with capitated Medicaid managed care delivery systems and that contract with managed care organizations (MCOs) are required to arrange for the provision of annual external quality review (EQR) for each Medicaid managed care contractor. The external quality review organization (EQRO) must annually provide an assessment of each MCO's performance related to the quality, timeliness, and access to care and services provided by each MCO and produce the results in an annual EQR technical report (42 CFR §438.364). To meet this requirement, Iowa Department of Health Services (IDHS) has contracted with Health Services Advisory Group, Inc. (HSAG), to perform EQR of the Iowa MCOs and produce this EQR technical report. This is the first year HSAG has produced the report of results for the State of Iowa.

The Iowa Medicaid Enterprise (IME) is the division of the IDHS that administers the Iowa Medicaid program. On April 1, 2016, the IDHS transitioned most Iowa Medicaid members to a managed care program called IA Health Link. This program is administered by three MCOs which provide members with comprehensive healthcare services, including physical health, behavioral health, and long-term services and supports (LTSS).

The three MCOs that deliver managed care and services in Iowa are displayed in Table 1-1 below.

Table 1-1—IA Health Link MCOs

MCO Name	MCO Short Name
Amerigroup Iowa, Inc.	Amerigroup
AmeriHealth Caritas Iowa, Inc.	AmeriHealth
UnitedHealthcare Community Plan of the River Valley Inc.	UnitedHealthcare

Scope of EQR Activities

At the request of IDHS, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities were:

- **Mandatory EQR Activities**—Validation of Performance Improvement Projects, Review of Compliance with Managed Care Requirements, and Validation of Performance Measures[1-1]
- **Optional EQR Activity**—Encounter Data Validation

[1-1] The third mandatory activity, Validation of Performance Measures, will be conducted next year. Since the MCOs had not been operational long enough to provide sufficient data for validation, performance measure results are not included in this initial EQR annual report.

The purpose of these activities, in general, is to provide valid and reliable data and information about each MCO's performance. For this year's assessment, HSAG used findings from the EQR activities it conducted, described above, to derive conclusions and make recommendations about the quality and timeliness of, and access to, care and services provided by each MCO. More detailed information about each of the activities is contained in Section 3 of this report—External Quality Review Activities. Sections 4, 5, and 6 detail the MCO-specific findings, strengths, and recommendations for the activities conducted.

Overall Findings, Conclusions, and Recommendations

This section provides a high-level summary of activity findings and conclusions about MCO performance with respect to quality, timeliness, and access.

Although HSAG initiated three EQR activities in 2016, only two activities—Review of Compliance with Managed Care Standards and Encounter Data Validation—were completed within the time period and had results available for inclusion in this report.

Review of Compliance With Managed Care Requirements—HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews by organizing the State requirements for access to care, structure and operations, and quality measurement and improvement into the 13 categories listed in Table 1-2. These 13 categories, referred to as standards, align with the federal Medicaid managed care regulations and incorporate the domains of quality, access, and timeliness.

Table 1-2—Compliance Review Standard

Standard #	Standard Name
I	Availability of Services
II	Assurance of Adequate Capacity and Services
III	Coordination and Continuity of Care
IV	Coverage and Authorization of Services
V	Provider Selection
VI	Member Information
VII	Confidentiality of Health Information
VIII	Enrollment and Disenrollment
IX	Grievance System
X	Sub-contractual Relationships and Delegation
XI	Practice Guidelines
XII	Quality Assessment and Performance Improvement (QAPI)
XIII	Health Information Systems

Encounter Data Validation (EDV)—The 2016 EDV activity evaluated the extent to which IDHS and the MCOs had appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. Although potentially affecting all domains, the 2016 EDV activity primarily evaluated each of the MCO's information systems and processes, which relates more to the quality domain.

Amerigroup

For the compliance review activity, Amerigroup demonstrated moderate results, with an overall score of 80.6 percent. Of the 211 applicable elements, Amerigroup received a *Met* score for 170 elements and a *Not Met* score for 41 elements.

Although the overall compliance score was moderate at 80.6 percent, there were five standards for which Amerigroup achieved 100 percent compliance: Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality of Health Information, Enrollment and Disenrollment, and Health Information Systems. These findings suggest that Amerigroup had developed the necessary policies and procedures (P&Ps) and plans to operationalize the required elements of its contract and demonstrate its compliance in these standard areas. Interviews with Amerigroup's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

Amerigroup scored less than 80 percent in three of the 13 standards.The areas most in need of improvement include Coordination and Continuity of Care, Grievance System, and Practice Guidelines.

Based on contractual requirements and data submission requirements, such as companion guides and IDHS-specific edits, Amerigroup has P&Ps in place to document and guide its encounter data process. HSAG had only two recommendations for Amerigroup for this activity which are included in Section 4 of this report.

AmeriHealth

Overall, AmeriHealth demonstrated moderate results on the compliance review activity, with an overall compliance score of 82.9 percent for all elements reviewed. Of the 211 applicable elements, AmeriHealth received a *Met* score for 175 elements and a *Not Met* score for 36 elements.

AmeriHealth achieved 100 percent compliance in four standards: Assurance of Adequate Capacity and Services, Provider Selection, Enrollment and Disenrollment, and Health Information Systems. These findings suggest that AmeriHealth had developed the necessary P&Ps and plans to operationalize the required elements of its contract and demonstrate compliance in these four standard areas. Interviews with AmeriHealth's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

AmeriHealth scored less than 80 percent in two of the 13 standards, Grievance System and Practice Guidelines, indicating the areas in most need of improvement.

Based on contractual requirements and data submission requirements, such as companion guides and IDHS-specific edits, AmeriHealth has P&Ps in place to document and guide its encounter data process. HSAG had only one recommendation for AmeriHealth as a result of the Encounter Data Validation activity, which is included in Section 5 of this report.

UnitedHealthcare

Overall, UnitedHealthcare demonstrated moderate results on the compliance review activity, with an overall compliance score of 81.0 percent. Of the 211 applicable elements, UnitedHealthcare received a *Met* score for 171 elements and a *Not Met* score for 40 elements.

Of the 13 standard areas reviewed, UnitedHealthcare achieved 100 percent compliance in two standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Confidentiality of Health Information and Health Information Systems. These findings suggest that UnitedHealthcare developed the necessary P&Ps and plans to operationalize the required elements of its contract and demonstrate compliance in these two standard areas. Interviews with UnitedHealthcare's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

UnitedHealthcare scored below 80 percent in five of the 13 standards, indicating the areas in most need of improvement. The standards with the lowest scores include Availability of Services, Coverage and Authorization of Services, Member Information, Enrollment and Disenrollment, and Grievance System.

Based on contractual requirements and data submission requirements, such as companion guides and IDHS-specific edits, UnitedHealthcare has P&Ps in place to document and guide its encounter data process. HSAG had two recommendations for UnitedHealthcare as a result of the Encounter Data Validation activity, which is included in Section 6 of this report.

Recommendations for Improvement

Based on these findings and conclusions, HSAG provided recommendations for improvement to each MCO. Detailed information about MCO-specific findings, conclusions, and recommendations can be found in Sections 4–6 of this report.

2. The Iowa Medicaid and *hawk-i* Programs

Iowa Medicaid Managed Care Service Delivery Overview

The Iowa Medicaid Enterprise (IME) is the division of the Iowa Department of Human Services (IDHS) that administers the Iowa Medicaid program. In April 2016, the IDHS transitioned most Medicaid members to the IA Health Link managed care program. The State of Iowa made this change to bring healthcare delivery under one system, which allows for Medicaid enrolled family members to receive care from the same health plan. This plan creates one system of care to help deliver efficient, coordinated, and improved healthcare, and creates responsibility in healthcare coordination.

The program provides health coverage through three contracted MCOs that provide members with comprehensive healthcare services, including physical health, behavioral health, and long-term services and supports (LTSS).

Managed Care Organizations

The IDHS held contracts with three MCOs (Amerigroup, AmeriHealth, and UnitedHealthcare) during the review period for this annual report. All three MCOs provide for the delivery of healthcare services to enrolled IA Health Link members.

Amerigroup Iowa, Inc. is a wholly owned subsidiary of Anthem, Inc. Amerigroup operates in the states of Washington, Nevada, Iowa, Kansas, Texas, Louisiana, Tennessee, Georgia, Florida, Maryland, and New Jersey.[2-1] Amerigroup began operations in Iowa in April 2016 and currently serves 188,790 Iowa Medicaid members statewide.[2-2] In addition to providing physical and behavioral health IA Health Link covered services to members, the MCO also provides a range of value-added services including, but not limited to, dental hygiene kits, home-delivered meals, post-discharge stabilization kits, extra personal attendant support, and wellness/prevention programs.[2-3]

AmeriHealth Caritas Iowa is part of the AmeriHealth Caritas Family of Companies, and operates in the states of Iowa, Louisiana, Pennsylvania, California, Arizona, South Dakota, Missouri, Minnesota, Kentucky, Michigan, Illinois, Florida, South Carolina, North Carolina, Rhode Island, New Jersey, New York, and the District of Columbia.[2-4] AmeriHealth began operations in Iowa in April 2016 and

---

[2-1] Amerigroup Corporation. The States We Serve. Available at: https://www.amerigroup.com/the-states-we-serve.html. Accessed on: May 30, 2017.

[2-2] Iowa Medicaid Enterprise. *Managed Care Report March 2017 Performance Data published on May 12, 2017*. Available at: https://dhs.iowa.gov/sites/default/files/MCO_MthlyPerfData_March2017.pdf. Accessed on: May 22, 2017.

[2-3] Amerigroup, An Anthem Company. IA Health Link: Extra Benefits. Available at: https://www.myamerigroup.com/ia/your-plan/iowa-medicaid.html. Accessed on: Dec 16, 2016.

[2-4] AmeriHealth Caritas. Service Areas: A Growing National Footprint. Available at: http://www.amerihealthcaritas.com/corporate/companies-map.aspx. Accessed on: May 30, 2017.

currently serves 214,664 Iowa Medicaid members statewide.[2-5] In addition to providing physical and behavioral health IA Health Link covered services to members, the MCO also provides a range of value-added services, including, but not limited to, healthy incentives reward care; high school diploma equivalency; and wellness/prevention programs such as weight management and gym memberships.[2-6]

UnitedHealthcare Plan of the River Valley, Inc., is part of UnitedHealthcare Community & State, a subsidiary of UnitedHealth Group which operates in the states of Arizona, Delaware, District of Columbia, Florida, Georgia, Hawaii, Iowa, Kansas, Louisiana, Maryland, Massachusetts, Michigan, Mississippi, Nebraska, Nevada, New Jersey, New Mexico, New York, Ohio, Pennsylvania, Rhode Island, Tennessee, Texas, Washington, and Wisconsin.[2-7] UnitedHealthcare began operations in Iowa in April 2016 and currently serves 169,547 Iowa Medicaid members statewide.[2-8] In addition to providing physical and behavioral health IA Health Link covered services to members, the MCO also provides a range of value-added services including, but not limited to, a community awards program, school and sports physicals, and wellness/prevention programs.[2-9]

As of March 2017, 573,001 members were enrolled in the three MCOs. The table below outlines the total MCO enrollment distribution.

[2-5] Iowa Medicaid Enterprise. *Managed Care Report December 2016 Performance Data published on May 12, 2017*. Available at: https://dhs.iowa.gov/sites/default/files/MCO_MthlyPerfData_March2017.pdf. Accessed on: May 22, 2017.

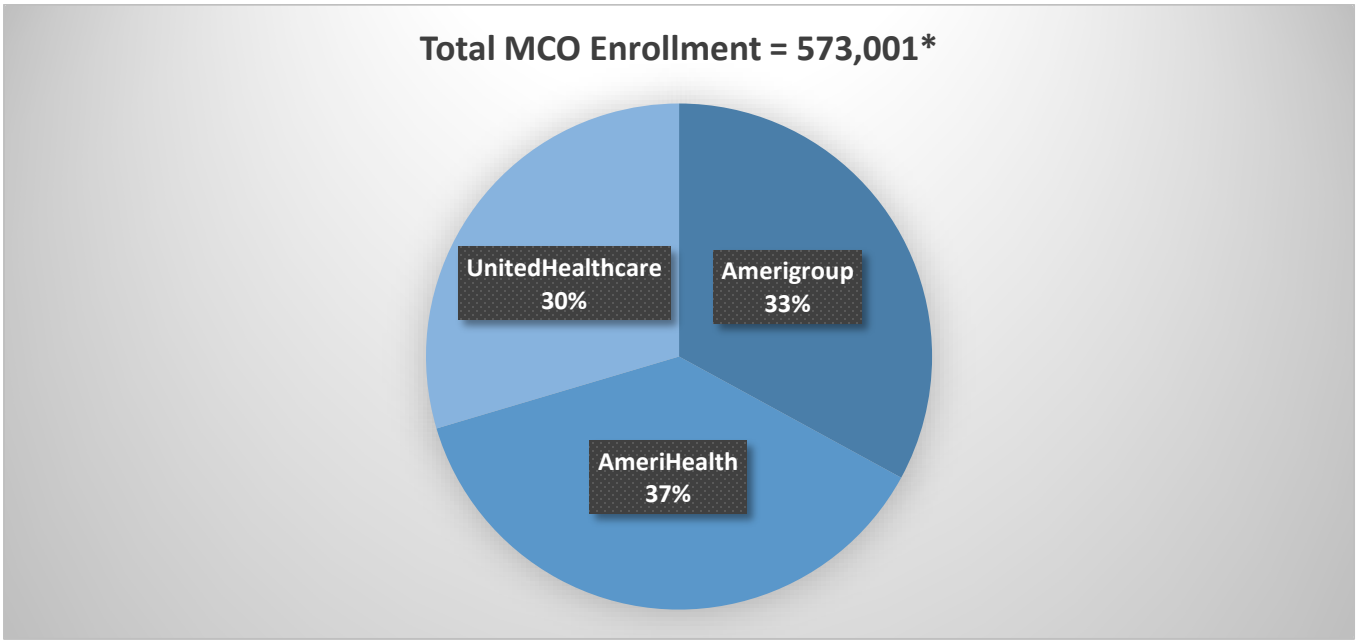
[2-6] AmeriHealth Caritas Iowa. Member Handbook. Available at: http://www.amerihealthcaritasia.com/pdf/member/eng/member-handbook.pdf. Accessed on: Dec 16, 2016.

[2-7] UnitedHealthcare Community & State. Fourth Quarter 2015 Company Information. Available at: https://www.uhccommunityandstate.com/content/dam/community-state/PDFs/CS_Corporate_Fact_Sheet.pdf. Accessed on May 12, 2017.

[2-8] Iowa Medicaid Enterprise. *Managed Care Report December 2016 Performance Data published on February 20, 2017*. Available at: https://dhs.iowa.gov/sites/default/files/MCO_MthlyPerfData_March2017.pdf. Accessed on: May 22, 2017.

[2-9] UnitedHealthcare Community Plan. Member Handbook. Available at: http://www.uhccommunityplan.com/content/dam/communityplan/plandocuments/handbook/en/IA-Handbook-EN.pdf. Accessed on: Dec 21, 2016.

Table 2-1—Total MCO Enrollment Per Health Plan



* Totals do not include *hawk-i* members (44,966).

State Quality Initiatives Driving Improvement

Iowa has several ongoing activities regarding quality initiatives. These initiatives are discussed below.

Health Homes (Integrated Health Homes and Chronic Condition Health Homes)—The IME has been actively collaborating with the three MCOs regarding oversight of the Integrated Health Homes and Chronic Condition Health Homes in Iowa. The IME and MCOs meet frequently to jointly develop and implement the processes (e.g., on-site reviews and desk reviews) that are being used to monitor the quality of service being provided in these homes and to provide support and education.

I-Smile Program—The I-Smile program has been working to improve the dental support system for children and families in Iowa. The use of a team approach and I-Smile coordinators has helped to identify children who have not previously had access to dental services and connect them to the resources necessary to improve their dental health.

State Innovation Model (SIM)—Iowa's State Innovation Model (SIM) Test is a four-year, $43.1 million federal grant to support health system transformation consistent with the Triple Aim. The essence of the grant is to build a statewide, aligned quality measurement process to shift healthcare payment from the predominantly volume-based models in place today to ones that increasingly aim at buying value (population health outcomes). This initiative requires commitment, leadership, and intensive collaboration among various payers and providers across the State and includes technical support for the delivery system. The State anticipates that the project will continue beyond the period

funded by the grant itself as value-based purchasing evolves and healthcare financing approaches change at the federal level.

Health Information Technology (HIT) and Electronic Health Record (EHR)—Iowa's Health Information Technology (HIT) and Electronic Health Record (EHR) Incentive program aims to play an important role in building a critical health information technology infrastructure designed to improve care, advance coordination, and reduce costs across the State's healthcare platforms. Advancing this technology is viewed as key to realizing the payment and delivery system reform goals of the SIM grant project described above. As of November 2016, Iowa had approved about 4,000 payments to eligible professionals and hospitals with over $130 million in incentive payments supporting the purchase, meaningful use, and interoperability of healthcare technology throughout the State.

3. External Quality Review Activities

In accordance with 42 CFR §438.356, IDHS contracted with HSAG as the EQRO for the State of Iowa to conduct the mandatory and certain optional EQR activities as set forth in 42 CFR §438.358. Because the IA Health Link program was implemented in April 2016, there were limitations to the amount of data available to complete all activities in the first year. Results from first-year activities are included in this report. Subsequent annual reports will contain additional mandatory and optional activity results.

CMS has chosen the domains of quality, access, and timeliness as keys to evaluating MCO performance. For each of our activities HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  > Quality, as it pertains to external quality review, means the degree to which an MCO [managed care organization], PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] entity (described in §438.310(c)(2)) increases the likelihood of desired health outcomes of its enrollees through:
  >
  > (1) Its structural and operational characteristics.
  >
  > (2) The provision of services that are consistent with current professional, evidenced-based-knowledge.
  >
  > (3) Interventions for performance improvement.[3-1]

- **Access—**CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  > Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[3-2]

- **Timeliness—**Federal managed care regulations at 42 CFR §438.206 require the State to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to enrollees and that require timely response by the managed care entity—e.g., processing member grievances and appeals and providing timely follow-up care. In addition, NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of

[3-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 81, No. 88, Friday May 6, 2016/Rules and Regulations

[3-2] Ibid.

a situation."[3-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

The following subsections describe the EQR activities that were performed or initiated during the review period. These activities provided findings for use in HSAG's evaluation of each MCO's performance. For each activity, this section describes the objectives, technical methods of data collection and analysis, and a brief description of the data obtained during the activity. The findings and conclusions drawn from the data obtained from each activity can be found in the individual result sections for each MCO (Sections 4 through 6) and in the comparative analysis presented in Section 7 of this report.

Mandatory Activities

Compliance Monitoring

Activity Objectives

According to federal requirements, the State must conduct or arrange for an independent review to determine each Medicaid managed care plan's compliance with standards set forth in the Code of Federal Regulations (CFR) Part 438 subpart D and the requirements described in 42 CFR §438.330. IDHS contracts with HSAG to conduct an annual compliance review. The review covered the period of April 1, 2016–October 31, 2016, and marked the first year of HSAG's compliance reviews in Iowa.

The primary objective of HSAG's review was to provide meaningful information to IDHS and the MCOs regarding compliance with State and federal requirements.

The IDHS and the MCOs will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Technical Methods of Data Collection and Analysis

HSAG conducted the on-site compliance reviews in November 2016, and provided detailed, final reports to the IDHS and MCOs in June 2017.

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between IDHS and the MCOs as they related to the scope of the review. HSAG followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for*

[3-3] National Committee for Quality Assurance: 2016 Standards and Guidelines for the Accreditation of Health Plans.

External Quality Review (EQR), Version 2.0, September 2012.[3-4] HSAG documented its findings in the data collection (compliance review) tool, which now serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring each MCO's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Pre-on-site activities also included generating a list of eight sample cases plus an oversample of three cases for grievances and appeals and case management for the on-site MCO audit. Information obtained from the file review was incorporated into the findings reported in the compliance review tool.

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review.

Description of Data Obtained

HSAG obtained information from a wide range of written documents produced by the MCO, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers/subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Member records included in the file review.

HSAG obtained additional information for the compliance review through interviews with each MCO's key staff members.

[3-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 8, 2017.

Validation of Performance Improvement Projects

Activity Objectives

IDHS requires its contracted MCOs to conduct performance improvement projects (PIPs) as set forth in CFR 42 §438.350. The projects aim to improve the quality of care and service in a targeted clinical or nonclinical topic area and to report the results annually. IDHS contracted with HSAG as the EQRO for the Iowa Medicaid Managed Care Program to conduct the annual validation of PIPs. During 2016, HSAG provided technical assistance to IDHS and training to the MCOs to ensure successful initiation and implementation of the PIPs that will be assessed and validated in future years.

Technical Methods of Data Collection and Analysis

The MCOs are required to conduct two PIPs. In September 2016, HSAG worked with IDHS to determine relevant and feasible PIP topics that have the potential to affect member health, functional status, or satisfaction, and that had data available to be collected. IDHS determined the following two state-mandated topics to be initiated by the MCOs: *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*.

Although data were not collected in 2016, the activities implemented were necessary steps to prepare for the annual PIP validation that will take place for the first time in calendar year (CY) 2017. HSAG will use CMS' publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 as a guide to validate each PIP.[3-5] Results of this validation will be included in next year's EQR technical report, along with findings and outcomes of the MCOs' implementation of the PIPs.

HSAG worked with IDHS to develop a plan for training the MCOs on the PIP process and study design. During October 2016, HSAG held two webinars for each MCO to discuss the study design (Steps I through VI) and the requirements for each step for each PIP topic. As the MCOs work to complete each step of the Design stage for each PIP topic, they may seek ongoing, individual technical assistance from HSAG as needed. The following table outlines the planned progression for the *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life* PIPs.

[3-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 8, 2017.

Table 3-1—Timeline for PIP Progression

Stage	Timeline
1. Study Design	Submitted and Validated: Calendar Year (CY) 2017
2. Implementation	Validation of Baseline Data: CY 2018
3. Outcomes—Assessing for Real Improvement	Validation of Remeasurement 1 Data: CY 2019
4. Outcomes—Assessing for Sustained Improvement	Validation of Remeasurement 2 Data: CY 2020

Description of Data Obtained

Due to the short time period that the Iowa managed care program has been operational, PIP data were not yet available.

Validation of Performance Measures

Because the IA Health Link program was implemented in April 2016, there was not sufficient data to allow for the completion of performance measure validation in CY 2016. CY 2017 will provide the first full year of data for validation and reporting in the 2018 EQR technical report.

Optional Activities

Validation of Encounter Data

Activity Objective

During CY 2016, IDHS contracted with HSAG to conduct an encounter data validation (EDV) study. Because this was the first year the MCOs submitted encounter data to IDHS, IDHS and HSAG chose to conduct an information systems (IS) review with all three MCOs, consistent with the *CMS EQR Protocol 4: Validation of Encounter Data Reported by the MCO*.[3-6] The goal of the EDV study was to examine the extent to which IDHS and the MCOs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data.

[3-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO.* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: June 8, 2017.

Technical Methods of Data Collection and Analysis

To ensure the collection of critical information, HSAG employed a three-stage review process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. A detailed description of the EDV activity, methods, and results are contained in the *Calendar Year 2016 Encounter Data Process Evaluation Report* submitted by HSAG to IDHS in December 2016.[3-7] Please note that the study findings are based on the self-reported information collected from IDHS' and the MCOs' questionnaire responses, and HSAG did not validate the responses for accuracy.

Description of Data Obtained

For the first stage of the review, HSAG obtained information by reviewing a wide range of documents produced by IDHS and the MCOs. Documents included data dictionaries, process flow charts, data system diagrams, encounter system edits, and IDHS' current encounter data submission requirements, among others. The information from this review helped develop a targeted questionnaire to address specific topics of interest for IDHS.

During stage two of the project, HSAG, in collaboration with IDHS, developed a questionnaire customized to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. Questionnaires were distributed to both IDHS and the MCOs and analyzed by HSAG upon completion.

In stage three, HSAG obtained additional information via email from key MCO information technology personnel.

[3-7] Health Services Advisory Group. Iowa Department of Human Services: *Calendar Year 2016 Encounter Data Process Evaluation Report*; December 2016.

4. Plan-Specific Summary—Amerigroup Iowa, Inc.

This section presents HSAG's findings and conclusions from the EQR activities conducted for Amerigroup. It also provides a discussion of strengths, weaknesses, and recommendations for improvement.

Review of Compliance With Standards

Findings

Table 4-1 presents a summary of Amerigroup's performance results. Detailed findings can be found in the report, *Calendar Year 2016 External Quality Review of Compliance With Standards for Amerigroup Iowa, Inc*. As this marks the first year of Amerigroup's operation in the State of Iowa, there are no open corrective actions from a prior year's compliance review.

Table 4-1—Amerigroup Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Availability of Services	**31**	**31**	**25**	**6**	**0**	**80.6%**
II	Assurance of Adequate Capacity and Services	**8**	**5**	**5**	**0**	**3**	**100.0%**
III	Coordination and Continuity of Care	**54**	**54**	**42**	**12**	**0**	**77.8%**
IV	Coverage and Authorization of Services	**27**	**25**	**20**	**5**	**2**	**80.0%**
V	Provider Selection	**9**	**8**	**8**	**0**	**1**	**100.0%**
VI	Member Information	**25**	**25**	**24**	**1**	**0**	**96.0%**
VII	Confidentiality of Health Information	**5**	**5**	**5**	**0**	**0**	**100.0%**
VIII	Enrollment and Disenrollment	**4**	**4**	**4**	**0**	**0**	**100.0%**
IX	Grievance System	**29**	**29**	**17**	**12**	**0**	**58.6%**
X	Sub-contractual Relationships and Delegation	**6**	**5**	**4**	**1**	**1**	**80.0%**
XI	Practice Guidelines	**5**	**5**	**3**	**2**	**0**	**60.0%**
XII	Quality Assessment and Performance Improvement (QAPI)	**11**	**11**	**9**	**2**	**0**	**81.8%**
XIII	Health Information Systems	**4**	**4**	**4**	**0**	**0**	**100.0%**
	Total Compliance Score	**218**	**211**	**170**	**41**	**7**	**80.6%**

* **Total # of Elements:** The total number of elements in each standard.

** **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

*** **Total Compliance Score:** Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Of the 211 applicable elements, Amerigroup received a *Met* score for 170 elements and a *Not Met* score for 41 elements. This represented an overall compliance score of 80.6 percent for all elements reviewed.

MCO Strengths and Weakness

Of the 13 standard areas reviewed, Amerigroup achieved 100 percent compliance in five standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Assurance of Adequate Capacity and Services, Provider Selection, Confidentiality of Health Information, Enrollment and Disenrollment, and Health Information Systems. These findings suggest that Amerigroup developed the necessary policies and procedures (P&Ps) and plans to operationalize the required elements of its contract and demonstrate compliance in these five standard areas. Interviews with Amerigroup's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

Amerigroup scored in the 80 to 99 percent range on five standards: Availability of Services, Coverage and Authorization of Services, Member Information, Sub-contractual Relationships and Delegation, and Quality Assessment and Performance Improvement (QAPI). These are areas of moderate performance indicating a need for improvement.

Amerigroup scored less than 80 percent in three of the 13 standards, indicating the areas in most need of improvement. The standards with the lowest scores include Coordination and Continuity of Care, Grievance System, and Practice Guidelines.

Recommendations for Improvement

Based on the findings of the desk and on-site reviews, Amerigroup received recommendations for improvement for the following standards: Availability of Services,, Coordination and Continuity of Care, Coverage and Authorization of Services, Member Information, Grievance System, Sub-contractural Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement (QAPI). The recommendations for improvement by standard are included below.

Availability of Services

HSAG's specific recommendations for Amerigroup are to:

- Document and implement a process to ensure access standards meet the usual and customary standards for the community regarding areas of the State where provider availability is insufficient to meet IDHS-established standards.
- Develop a process that addresses how Medicaid membership is considered in developing and maintaining its network.
- Demonstrate how it ensures physical access to provider offices for members with disabilities and how that information is shared with members.

- Demonstrate that member wait times meet IDHS requirements.
- Demonstrate that appointment wait times meet IDHS requirements.

Coordination and Continuity of Care

HSAG's specific recommendations for Amerigroup are to:

- Ensure initial health screenings are completed for members when there is a reasonable belief they are pregnant.
- Develop processes to ensure members are offered assistance in arranging an initial primary care provider (PCP) appointment during the initial health risk screening (HRA).
- Conduct a comprehensive HRA when a member is determined through the initial risk screening to have a special healthcare need or there is a need for follow-up on an identified problem area.
- Track and monitor comprehensive HRA timelines that adhere to IDHS-approved timelines.
- Ensure members have a care plan developed by the member's PCP with member participation, and in consultation with any specialists caring for the member.
- Implement a care planning development process that includes a commmunication plan with members and providers.
- Provide the care plan to the member's PCP (if applicable) and allow the member the opportunity to review the care plan as requested.
- Track and report on level of care reassessment data and meet the IDHS-required time frames.
- Review and update its policies to ensure consistent policy language is used throughout.
- Ensure each in-person visit by a community based case manager (CBCM) to a member includes observations and documentation of all IDHS-required elements.
- Review its case management and assessment processes to ensure that identified member needs are addressed and documented in the case file.

Coverage and Authorization of Services

HSAG's specific recommendations for Amerigroup are to:

- Develop a process to ensure requests for home health services required upon discharge from an inpatient setting are considered as expedited requests.
- Comply with 42 CFR §438.210(d) requirements for both standard and expedited authorization decision extensions.
- Ensure notices of action (NOAs) are given within the time frames described in 42 CFR §438.404(c), including those related to the reduction, suspension, or termination of a previously authorized Medicaid-covered service.
- Ensure notice is given to members on the date of the action when the action is a denial of payment.

- Ensure that it takes financial responsibility for poststabilization services as required under 42 CFR §438.114(e) and 42 CFR §422.113(c).

Member Information

HSAG's specific recommendation for Amerigroup is to:

- Ensure that member information informs the member that charges for poststabilization services are limited to an amount that is no greater than what the organization would charge the member if he or she had obtained the services through the organization.

Grievance System

HSAG's specific recommendations for Amerigroup are to:

- Implement a process that ensures written consent is received from a member in instances when an authorized representative or a provider files an appeal on the member's behalf.
- Ensure that all grievance decision letters include the results of the resolution and the date it was completed.
- Revise its policy to indicate that, for decisions on grievances involving clinical issues or regarding the denial of an expedited resolution of an appeal, the medical director involved in the review will hold the same or similar specialty as the treating practitioner and have experience treating the member's health problem.
- Allow for the member, member's authorized representative, or the legal representative of a deceased member's estate to file an appeal and to be parties to the appeal.
- Ensure that appeal acknowledgement letters reflect resolution time frames as specified in policy, or revise the policy to reflect Amerigroup's actual practice.
- Follow its policy and resolve all preservice appeals within 30 calendar days, or revise the policy to reflect actual practice.
- Clearly indicate that the expedited review process resolves appeals when the MCO determines, or the provider indicates in making the request on the member's behalf or supporting the member's request, that taking the time for a standard resolution could seriously jeopardize the member's life or health or ability to attain, maintain, or regain maximum function.
- Provide education to members regarding the procedures the member must follow when there is a need for an expedited appeal.
- Include the citation of the Iowa Code and/or Iowa Administrative Code on the disposition notice.
- Revise its disposition letters to reflect accurate information, including that appeal decisions are made by the MCO, not the State of Iowa.
- Update its member appeals policy to include the appropriate federal citations.
- Demonstrate that it has a documented process for reporting appeals, grievances, and the status and resolution of grievance and appeals information to IDHS.

Sub-Contractual Relationships and Delegation

HSAG's specific recommendation for Amerigroup is to:

- Conduct quarterly reviews for all delegated functions as required by IDHS, including delegated credentialing functions.

Practice Guidelines

HSAG's specific recommendations for Amerigroup are to:

- Document the process used to identify and implement practice guidelines that consider the needs of members.
- Implement mechanisms to ensure decisions for utilization management, member education, and coverage of services decisions are consistent with the practice guidelines.

Quality Assessment and Performance Improvement

HSAG's specific recommendations for Amerigroup are to:

- Implement processes to assess over- and underutilization of services.
- Develop and implement mechanisms to demonstrate how the MCO assesses the quality and appropriateness of care furnished to members with special healthcare needs.

Performance Improvement Projects

In 2016 Amerigroup initiated the two state-mandated PIPs, *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*. The validation findings and any results of its PIP processes will be included in the 2017 EQR technical report.

Validation of Encounter Data

Findings

Amerigroup responded to the questionnaire developed for the EDV study, and HSAG worked with Amerigroup on follow-up items. This section summarizes the findings from the Amerigroup questionnaire responses.

Encounter Data Sources and Systems

For professional (including laboratory) services and facility services, Amerigroup receives claims directly from providers or a clearinghouse/trading partner such as TransUnion. Amerigroup uses the Facets system to adjudicate claims. Amerigroup provides pharmacy, transportation, and vision services through subcontractors, as shown in Table 4-2. Vendor files are loaded into a designated database other than Facets. Medical claims, claims from vendors, and other relevant data (e.g., provider data) are collected into Encounter Data Manager (EDM) to create and manage encounter data submissions to IDHS.

Table 4-2—Format and Submission Frequency for Pharmacy, Transportation, and Vision Encounters

	Pharmacy	Transportation	Vision
Vendor	Express Scripts	LogistiCare	Superior Vision
Format	Proprietary	837P	837P
Frequency	Weekly	Monthly	Monthly

For home and community-based services (HCBS) and long-term care (LTC) services, Amerigroup responded with "NA" for the data submission frequency.

Amerigroup submits both paid and denied encounters to IDHS. When Amerigroup recognizes further claims adjustments after the original encounters have been submitted to IDHS, Amerigroup submits them according to the 837/National Council for Prescription Drug Programs (NCPDP) guidelines.

Amerigroup and its subcontractors collect and maintain the MCO's provider data. The MCO verifies whether the provider information on the claims/encounters matches Amerigroup's provider data. Amerigroup also compares its provider data with the Iowa Medicaid Enterprise (IME) provider data file. If the billing provider's national provider identifier (NPI) or atypical provider identifier (API) is not included in the IME provider data, the encounter is scrubbed until the claim is fixed or the provider is registered with Iowa. Amerigroup may update the provider's address if there are any Health Insurance Portability and Accountability Act (HIPAA) issues in the incoming claims (i.e., Amerigroup first uses the provider address from the inbound claim. If that address causes issues, Amerigroup will reference the address from the provider file).

Data Exchange P&Ps

Based on contractual requirements and data submission requirements such as companion guides and IDHS-specific edits, Amerigroup has P&Ps in place to document and guide its encounter data process. For example, Amerigroup performs additional data quality checks based on IDHS-specific requirements. Any errors detected are corrected before the encounter is released for submission to IDHS. Any items that cannot be corrected are stored in the database, with specific error codes for further analysis. Once a record is corrected, it is recycled into the next file submission or is submitted as a one-time correction file. Amerigroup also generates a Scrub/Pend Report to track all records that did not pass Amerigroup's validations, and Amerigroup's encounter team reviews and makes corrections. Amerigroup's vendor

files must pass HIPAA validation before they are stored in the data warehouse for encounter submission. Amerigroup also monitors and tracks the vendors' submission totals monthly, and any variance greater than 15 percent from month to month is researched to ensure all records are being received from the vendors. If a response file indicates errors regarding a vendor's file, Amerigroup will work with the vendor to correct the errors.

Management of Encounter Data: Collection, Storage, and Processing

Table 4-3 shows Amerigroup's pricing methodology for inpatient and outpatient encounters. The distribution for this methodology was not available when HSAG conducted the questionnaire. However, Amerigroup stated that all paid amounts for inpatient and outpatient claims are captured from the claims processing system and reported on the encounter file based on the State's companion guide regardless of payment arrangement.

Table 4-3—Pricing Methodology for Amerigroup

Outpatient	Inpatient
• Ambulatory Payment Classification (APC) • Reasonable Cost (Percentage of Charges) • Fee Schedule • End Stage Renal Disease Prospective Payment System (PPS)	• Medicare Severity-Diagnosis Related Group (MS-DRG) • Reasonable Cost (Percentage of Charges) • Per Diem • Fee Schedule

Amerigroup tracks other insurance coverage using three data sources:

- Third Party Liability (TPL) Proprietary File and/or 834 Eligibility File from IDHS
- Providers or members (e.g., information in claims submitted by providers)
- The MCO's recovery vendor for other insurance coverage

Amerigroup considers TPL data before finalizing its claims adjudication. For example, if a claim is eligible for coordination of benefits (COB), but the required explanation of benefits (EOB) is not attached to the claim, Amerigroup notifies the provider that the claim must be resubmitted. If the required EOB information is attached to the claim, Amerigroup suspends the claim for additional analyst review. In addition, Amerigroup conducts post-payment reviews and works directly with providers and carriers to recoup payments when the TPL data are not present at the time of the initial claims payment.

For Medicare crossover claims, Amerigroup receives the claims from CMS' Coordination of Benefits Agreement (COBA) vendor daily and ultimately processes them through its data systems, similar to other third party claims. When Amerigroup is not responsible for the payment from a service due to a primary carrier, it reports both the primary carrier's payment information and a zero-paid amount for itself in the submitted encounters.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness and accuracy of the encounter data providers submit, Amerigroup performs the following audits, in addition to the edits at the point of claims submission, HIPAA compliance checks, and IDHS-specific edits:

- Amerigroup audits a random sample of 50 Iowa claims per week (200 per month). The sample consists of claims from providers, including vision, nonemergency medical transportation, nursing facility claims, and home and community-based waiver claims. This audit process consists of a thorough, end-to-end review (from receipt to final claim disposition) to assure that Amerigroup is in alignment with all federal, State, and internal requirements, as well as any specifics in the provider contracts. This audit process requires that Amerigroup reviews source documentation, including provider contracts, State websites, fee schedules, and process instructions.
- To further assess claims accuracy, Amerigroup performs additional audits. If errors are found, Amerigroup does not close the audit until the auditor validates the updated claim. Amerigroup also works to determine the root cause of errors so it can prevent future instances. These additional audits are:
  - Daily prepayment audits of all high-dollar claims.
  - Weekly audits on five claims from each claims analyst.
  - Targeted audits on specific claim types or surrounding processes to measure performance and remediate claims issues.

For timeliness metrics, Amerigroup denies claims not submitted within 180 days of the service date. For the vendors' encounter data, Amerigroup monitors accuracy and completeness through a reconciliation with the vendors' financial data. Amerigroup also monitors the timeliness of encounter data submitted by its vendors on a set frequency. If a vendor's file is not received in a timely manner, Amerigroup works with the vendor to resolve the issue as soon as possible.

Amerigroup has processes in place to track the encounters sent to IDHS and then stores and processes the 999 response files, 277 response files, and proprietary error reports received from IDHS so it can monitor the rejections/errors and process corrections and resubmissions, if necessary.[4-1] While any high-volume rejections (e.g., greater than 1 percent of a response file) are processed for immediate resolution, lower rejection percentages are grouped and processed over time.

MCO Strengths and Weaknesses

Amerigroup has P&Ps in place to document and guide its encounter data process. The MCO stated that all paid amounts for inpatient and outpatient claims were captured from its claims processing system and reported on the encounter file based on the State's companion guide regardless of payment

[4-1] While Amerigroup loads the 277 response files and the proprietary error reports into its system, it does not load the 999 files into its encounter system but does review the 999 files for accuracy.

arrangement. Amerigroup monitors the completeness and accuracy of the encounter data submitted by its vendors and providers. HSAG had two recommendations for improvement for Amerigroup as a result of the Encounter Data Validation activity.

Recommendations for Improvement

Based on its review, HSAG recommends the following for Amerigroup to strengthen its encounter data quality:

- For HCBS and LTC encounters, Amerigroup responded with "NA" for the data submission frequency. Amerigroup should ensure that it is submitting HCBS and LTC encounters to IDHS.
- Amerigroup produces a weekly aging summary report and assumes that a large volume of missing remit statuses for a period of time typically indicates a rejected file. Therefore, when encountering this scenario, Amerigroup queries the system to check for the specific file, compliance checks the file, and then resubmits it. While this is effective to ensure complete data submissions, Amerigroup should work with IDHS to ensure that Amerigroup's assumption is correct or develop a communication process to avoid duplicated submissions.

5. Plan-Specific Summary—AmeriHealth Caritas Iowa, Inc.

This section presents HSAG's findings and conclusions from the EQR activities conducted for AmeriHealth. It also provides a discussion of strengths, weaknesses, and recommendations for improvement.

Review of Compliance With Standards

Findings

Table 4-1 presents a summary of AmeriHealth's performance results. Detailed findings can be found in the report, *Calendar Year 2016 External Quality Review of Compliance With Standards for AmeriHealth Caritas Iowa, Inc*. As this marks the first year of AmeriHealth's operation in the State of Iowa, there are no open corrective actions from a prior year's compliance review.

Table 5-1—AmeriHealth Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Availability of Services	**31**	**31**	**26**	**5**	**0**	**83.9%**
II	Assurance of Adequate Capacity and Services	**8**	**5**	**5**	**0**	**3**	**100.0%**
III	Coordination and Continuity of Care	**54**	**54**	**46**	**8**	**0**	**85.2%**
IV	Coverage and Authorization of Services	**27**	**25**	**23**	**2**	**2**	**92.0%**
V	Provider Selection	**9**	**8**	**8**	**0**	**1**	**100.0%**
VI	Member Information	**25**	**25**	**22**	**3**	**0**	**88.0%**
VII	Confidentiality of Health Information	**5**	**5**	**4**	**1**	**0**	**80.0%**
VIII	Enrollment and Disenrollment	**4**	**4**	**4**	**0**	**0**	**100.0%**
IX	Grievance System	**29**	**29**	**20**	**9**	**0**	**69.0%**
X	Sub-contractual Relationships and Delegation	**6**	**5**	**4**	**1**	**1**	**80.0%**
XI	Practice Guidelines	**5**	**5**	**0**	**5**	**0**	**0.0%**
XII	Quality Assessment and Performance Improvement (QAPI)	**11**	**11**	**9**	**2**	**0**	**81.8%**
XIII	Health Information Systems	**4**	**4**	**4**	**0**	**0**	**100.0%**
	Total Compliance Score	**218**	**211**	**175**	**36**	**7**	**82.9%**

* **Total # of Elements:** The total number of elements in each standard.

** **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

*** **Total Compliance Score:** Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Of the 211 applicable elementsAmeriHealth received a *Met* score for 175 elements and a *Not Met* score for 36 elements. This represented an overall compliance score of 82.9 percent for all elements reviewed.

MCO Strengths and Weakness

Of the 13 standard areas reviewed, AmeriHealth achieved 100 percent compliance in four standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Assurance of Adequate Capacity and Services, Provider Selection, Enrollment and Disenrollment, and Health Information Systems. These findings suggest that AmeriHealth developed the necessary policies and procedures (P&Ps) and plans to operationalize the required elements of its contract and demonstrate compliance in these four standard areas. Interviews with AmeriHealth's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

AmeriHealth scored in the 80 to 99 percent range on seven standards: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Member Information, Confidentiality of Health Information, Sub-contractual Relationships and Delegation, and Quality Assessment and Performance Improvement (QAPI), indicating areas of moderate performance and a need for improvement.

AmeriHealth scored less than 80 percent in two of the 13 standards, indicating these areas in most need of improvement: Grievance System and Practice Guidelines.

Recommendations for Improvement

Based on the findings of the desk and on-site reviews, AmeriHealth received recommendations for improvement in the following standards: Availability of Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Member Information, Confidentiality of Health Information, Grievance System, Sub-contractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement (QAPI).

Availability of Services

HSAG's specific recommendations for AmeriHealth are to:

- Develop a process to determine the impact that providers not accepting new patients has on availability and accessibility of care.
- Provide for a second opinion from a contracted qualified healthcare professional or arrange for a member to obtain a second opinion from a non-contracted provider at no cost to the member.
- Implement a process to ensure member wait times do not exceed IDHS requirements.
- Demonstrate that appointment wait times meet IDHS requirements.

Coordination and Continuity of Care

HSAG's specific recommendations for AmeriHealth are to:

- Ensure initial health risk screenings are completed for members when there is a reasonable belief that they are pregnant.
- Implement a process to track completion of comprehensive assessments that meet IDHS requirements.
- Ensure members have a care plan developed by the member's PCP with member participation, and in consultation with any specialists caring for the member.
- Demonstrate that it tracks and monitors care plan development time frames.
- Provide the care plan to the member's PCP (if applicable) and allow the member the opportunity to review the care plan as requested.
- Track and monitor compliance with time frames and/or peformance standards for long-term services and supports to ensure compliance with requirements and to identify process improvement opportunities.
- Implement mechanisms to ensure needs assessments/level of care (LOC) assessments are completed in an appropriate and timely manner.
- Ensure each in-person visit by a community based case manager (CBCM) to a member includes observations and documentation of all IDHS-required elements.

Coverage and Authorization of Services

HSAG's specific recommendations for AmeriHealth are to:

- Ensure that services are sufficient in amount, duration, or scope to reasonably be expected to achieve the purpose for which they were furnished.
- Document that the MCO does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

Member Information

HSAG's specific recommendations for AmeriHealth are to:

- Ensure that member information addresses notifying a member of the termination of a provider from which the member was receiving services other than the PCP.
- Ensure that member enrollment information includes the rules that govern representation at the State fair hearing.
- Include in member information regarding the grievance, appeal, and State Fair Hearing procedures the availability of assistance with filing a grievance or an appeal, or requesting a State fair hearing.

Confidentiality of Health Information

HSAG's specific recommendation for AmeriHealth is to:

- Ensure policies regarding a breach of unsecured protected health information (PHI) incorporate the plain language requirement as required by 45 CFR §164.404 (c)(2) for breach notifications.

Grievance System

HSAG's specific recommendations for AmeriHealth are to:

- Revise its policy language to clearly indicate that member eligibility and eligibility-related grievances are to be directed to IDHS.
- Provide members with any reasonable assistance in filing an appeal, a grievance, or a State fair hearing request, which includes completing forms and taking other procedural steps, and providing interpreter services.
- Acknowledge the receipt of each grievance within three business days and document this in the case file.
- Ensure that all grievances are resolved within the required time frames.
- Ensure that all grievance decision letters include the results of the resolution and the date it was completed.
- Ensure written member consent is obtained when a provider submits an appeal on a member's behalf.
- Ensure documentation includes consistent time frames.
- Demonstrate how it provides general and targeted information to members and providers regarding instances when an expedited appeal was appropriate, including the procedures demonstrating the need for an expedited appeal.
- Ensure appeal notification letters are written in a professional, clear, and consistent format and language, and include the Iowa Code citation and/or Iowa Administrative Code sections supporting the action.

Sub-contractual Relationships and Delegation

HSAG's specific recommendation for AmeriHealth is to:

- Monitor the subcontractor's perfomance on an ongoing basis, conduct quarterly reviews, and subject the contractor to a formal review according to a periodic schedule established by the State.

Practice Guidelines

HSAG's specific recommendations for AmeriHealth are to:

- Adopt clinical practice guidelines (CPGs) that are based on valid and reliable clinical evidence or a consensus of healthcare professionals in a particular field.
- Adopt CPGs that consider the needs of its members and in consultation with contracted healthcare professionals.
- Develop a process to disseminate practice guidelines to all affected providers and to members and potential members upon request.
- Demonstrate how it ensures decisions made for utilization management, member education, and coverage of services are consistent with the practice guidelines.

Quality Assessment and Performance Improvement (QAPI)

HSAG's specific recommendations for AmeriHealth are to:

- Develop a performance improvement project (PIP) process which includes the planning, initiation, and implementation of activities for increasing or sustaining improvement.
- Conduct monitoring activities which assess over- and underutilization of services, and take action when areas of concern were identified.

Performance Improvement Projects

In 2016 AmeriHealth initiated the two state-mandated PIPs, *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*. The validation findings and any results of its PIP processes will be included in the 2017 EQR technical report.

Validation of Encounter Data

Findings

AmeriHealth responded to the questionnaire developed for the EDV study, and HSAG worked with AmeriHealth on a few follow-up items. This section summarizes the findings from the AmeriHealth questionnaire responses.

Encounter Data Sources and Systems

For professional (including laboratory services) and facility services, AmeriHealth uses Emdeon to process electronic medical claims and SourceHOV for paper claims, and it uses the Facets system to adjudicate claims. AmeriHealth provides pharmacy, transportation, and vision services through subcontractors, as shown in Table 5-2. Files from vendors are loaded into a designated database other than Facets. Medical claims, claims from vendors, and other relevant data (e.g., provider data) are all

collected into Encounter Data Manager (EDM) to create and manage encounter data submissions to IDHS.

Table 5-2—Format and Submission Frequency for Pharmacy, Transportation, and Vision Encounters

	Pharmacy	Transportation	Vision
Vendor	PerformRx	Access2Care	Avesis
Format	National Council for Prescription Drug Programs (NCPDP) D.0	837P	Proprietary
Frequency	Weekly	Weekly	Monthly

AmeriHealth submits both paid and denied encounters to IDHS. AmeriHealth also submits adjusted encounters to IDHS after the original encounters have been submitted. When a correction pertains to member or provider information, AmeriHealth sends a void record for a previously submitted encounter and, once accepted by IDHS, the MCO sends a new initial encounter representing the corrected claim information. For all other corrections, AmeriHealth submits a replacement encounter for previously submitted encounters.

AmeriHealth and its subcontractors collect and maintain the MCO's provider data. The MCO verifies whether the provider information on the claims/encounters matches AmeriHealth's provider data. AmeriHealth also compares its provider data with the IME provider data file, and its analysts then categorize differences by key fields and review them for further action including, but not limited to, following up with vendors and escalating to IDHS.

Data Exchange P&Ps

Based on contractual requirements and data submission requirements such as companion guides and IDHS-specific edits, AmeriHealth has P&Ps in place to document and guide its encounter data process. For example, AmeriHealth developed a file named "AmeriHealth Caritas Encounters Policies and Procedures Document–Encounter Data Manager (EDM)" to document the contractual requirements and P&Ps for Iowa's encounter data process.

Management of Encounter Data: Collection, Storage, and Processing

Table 5-3 shows AmeriHealth's pricing methodology for inpatient and outpatient encounters. More than 75 percent of AmeriHealth's inpatient and outpatient encounters were priced using the "Other Pricing" methodology.

Table 5-3—Pricing Methodology for AmeriHealth

Outpatient	Inpatient
• HCP Code 10—Other Pricing (94.1%) • HCP Code 01—Priced as Billed at 100% (5.9%)	• HCP Code 10—Other Pricing (77.6%) • HCP Code 01—Priced as Billed at 100% (22.4%)

AmeriHealth tracks other insurance coverage using four data sources:

- Third Party Liability (TPL) Proprietary File and/or 834 Eligibility File from IDHS.
- Providers or members (e.g., information in claims submitted by providers).
- The MCO's recovery vendor for other insurance coverage.
- The MCO's internal department (e.g., medical management).

AmeriHealth considers TPL data before finalizing its claims adjudication. For example, if TPL data on the EOB do not match the TPL information documented in AmeriHealth's system, a TPL investigation is submitted to the TPL unit. In addition, AmeriHealth contracts with a recovery vendor to identify claims for which TPL data are identified after the initial claims processing. However, AmeriHealth's vendor limits recoveries to those claims for which members have commercial-only TPL coverage.

For Medicare crossover claims, AmeriHealth receives the claims from CMS's Coordination of Benefits Agreement (COBA) vendor daily and ultimately processes the claims through its data systems, similar to other third-party claims. If AmeriHealth is not responsible for the payment from a service due to a primary carrier, it reports both the primary carrier's payment information and a zero-paid amount for itself in the submitted encounters.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness and accuracy of the encounter data providers submit, AmeriHealth performs the following checks in addition to the edits at the point of claims submission, Health Insurance Portability and Accountability Act (HIPAA) compliance checks, and IDHS-specific edits:

- AmeriHealth monitors claims to ensure all services provided are documented on the claim regardless of whether the provider is reimbursed for a specific service. For capitated providers, AmeriHealth monitors the monthly encounter submission rates for providers along with the percentage change from the prior reporting period. If a provider's encounter submission rate falls below a threshold based on historical submission rates, the provider network account executive reviews the cause of the lower rate with the provider and requests corrections, if warranted.
- AmeriHealth's claims processing edits verify the accuracy of key fields such as provider identifiers (IDs), member IDs, diagnosis codes, procedure codes, and national drug codes.

For timeliness metrics, AmeriHealth supports the submission of timely and accurate claims and encounters by informing providers of the billing requirements and instructions for paper and electronic claims submission through provider orientations, ongoing trainings, and the provider handbook.

AmeriHealth monitors its vendors' encounter data for accuracy and completeness through a reconciliation with the vendor's financial data. AmeriHealth also monitors the timeliness of encounter data submitted by its vendors on a set frequency. If a vendor's file is not received in a timely manner, AmeriHealth works with the vendor to resolve the issue as soon as possible.

AmeriHealth has processes in place to track the encounters sent to IDHS and then stores and processes the 999 response files, 277 response files, and proprietary errors reports received from IDHS so that AmeriHealth can monitor the rejections/errors and process the corrections and resubmissions, if necessary.

MCO Strengths and Weaknesses

AmeriHealth has P&Ps in place to document and guide its encounter data process. The MCO also has processes to collect, store, and process encounter data. AmeriHealth monitors the completeness and accuracy of the encounter data submitted by its vendors and providers. HSAG had only one recommendation for AmeriHealth as a result of the Encounter Data Validation activity.

Recommendations for Improvement

Based on its review, HSAG recommends the following for AmeriHealth to strengthen its encounter data quality:

- More than 75 percent of AmeriHealth's inpatient and outpatient encounters were priced under "HCP Code 10—Other Pricing." AmeriHealth should work with IDHS to evaluate whether having a large unspecified group meets IDHS' expectations.

6. Plan-Specific Summary—UnitedHealthcare Community Plan, Inc.

This section presents HSAG's findings and conclusions from the EQR activities conducted for UnitedHealthcare. It also provides a discussion of strengths, weaknesses, and recommendations for improvement.

Review of Compliance With Standards

Findings

Table 4-1 presents a summary of UnitedHealthcare's performance results. Detailed findings can be found in the report, *Calendar Year 2016 External Quality Review of Compliance With Standards for UnitedHealthcare Plan of the River Valley, Inc*. As this marks the first year of UnitedHealthcare's operation in the State of Iowa, there are no open corrective actions from a prior year's compliance review.

Table 6-1—UnitedHealthcare Standards and Compliance Scores

Standard #	Standard Name	# of Elements*	# of Applicable Elements**	# *Met*	# *Not Met*	# *Not Applicable*	Total Compliance Score***
I	Availability of Services	**31**	**31**	**24**	**7**	**0**	**77.4%**
II	Assurance of Adequate Capacity and Services	**8**	**5**	**4**	**1**	**3**	**80.0%**
III	Coordination and Continuity of Care	**54**	**54**	**50**	**4**	**0**	**92.6%**
IV	Coverage and Authorization of Services	**27**	**25**	**19**	**6**	**2**	**76.0%**
V	Provider Selection	**9**	**8**	**7**	**1**	**1**	**87.5%**
VI	Member Information	**25**	**25**	**19**	**6**	**0**	**76.0%**
VII	Confidentiality of Health Information	**5**	**5**	**5**	**0**	**0**	**100.0%**
VIII	Enrollment and Disenrollment	**4**	**4**	**3**	**1**	**0**	**75.0%**
IX	Grievance System	**29**	**29**	**18**	**11**	**0**	**62.1%**
X	Sub-contractual Relationships and Delegation	**6**	**5**	**4**	**1**	**1**	**80.0%**
XI	Practice Guidelines	**5**	**5**	**4**	**1**	**0**	**80.0%**
XII	Quality Assessment and Performance Improvement (QAPI)	**11**	**11**	**10**	**1**	**0**	**90.9%**
XIII	Health Information Systems	**4**	**4**	**4**	**0**	**0**	**100.0%**
	Total Compliance Score	**218**	**211**	**171**	**40**	**7**	**81.0%**

* **Total # of Elements:** The total number of elements in each standard.

** **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

*** **Total Compliance Score:** Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Of the 211 applicable elements, UnitedHealthcare received a *Met* score for 171 elements and a *Not Met* score for 40 elements. This represented an overall compliance score of 81.0 percent for all elements reviewed.

MCO Strengths and Weakness

Of the 13 standard areas reviewed, UnitedHealthcare achieved 100 percent compliance in two standards, demonstrating performance strengths and adherence to all requirements measured in the areas of Confidentiality of Health Information and Health Information Systems. These findings suggest that UnitedHealthcare developed the necessary policies and procedures (P&Ps) and plans to operationalize the required elements of its contract and demonstrate compliance in these two standard areas. Interviews with UnitedHealthcare's staff further demonstrated that staff members were knowledgeable about the requirements of the contract and the P&Ps the MCO employed to meet its contractual requirements.

UnitedHealthcare scored in the 80 to 99 percent range on six standards: Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Provider Selection, Sub-contractual Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement (QAPI). These are areas of moderate performance indicating a need for improvement.

UnitedHealthcare scored below 80 percent in five of the 13 standards, indicating the areas in most need of improvement. The standards with the lowest scores include Availability of Services, Coverage and Authorization of Services, Member Information, Enrollment and Disenrollment, and Grievance System.

Recommendations for Improvement

UnitedHealthcare received recommendations for improvement in the standard areas of Availability of Services, Assurance of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Selection, Member Information, Enrollment and Disenrollment, Grievance System, Sub-contractural Relationships and Delegation, Practice Guidelines, and Quality Assessment and Performance Improvement (QAPI).

Availability of Services

HSAG's specific recommendations for UnitedHealthcare are to:

- Develop a process to ensure access standards meet the usual and customary standards for the community during situations when provider availability is insufficient to meet IDHS-established standards.
- Implement a process which considers the providers' closed panel status when developing its network.
- Inform providers that member wait times must meet IDHS requirements.
- Inform providers of the maximum appointment wait times as specified in the IDHS contract.

- Develop a comprehensive, written cultural competency plan which describes and ensures that services are provided in a culturally competent manner to all members; addresses the special healthcare needs of members who are poor, homeless, or belong to a minority population; and includes the requirement of honoring members' beliefs.
- Document that it will care for members regardless of their health status, ancestry, gender identity, income status, or physical or mental disability.

Assurance of Adequate Capacity and Services

HSAG's specific recommendation for UnitedHealthcare is to:

- Ensure it has written documentation to support that it provides members with written notice of any significant change that may impact members' accessibility to services and benefits at least 30 days before the intended effective date of the change.

Coordination and Continuity of Care

HSAG's specific recommendations for UnitedHealthcare are to:

- Update its process to identify members eligible for care coordination, which includes ensuring timely outreach to members and/or ensuring the case file clearly documents the reason why the member was not enrolled in the program.
- Ensure members have a care plan developed by the member's PCP with member participation, and in consultation with any specialists caring for the member.
- Provide the care plan to the member's PCP (if applicable) and allow the member the opportunity to review the care plan as requested.
- Ensure each in-person visit by a community based case manager (CBCM) with a member includes observations and documentation of all IDHS-required elements.

Coverage and Authorization of Services

HSAG's specific recommendations for UnitedHealthcare are to:

- Include a documented definition of an "emergency medical condition" in its policy.
- Develop a process to ensure claims for emergency medical services would not be denied including cases in which the absence of immediate medical attention would not result in placing the health of the individual in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part or when the member was instructed to seek emergency medical services by a representative of the MCO.
- Document that it does not limit what constitutes an emergency medical condition on the basis of lists of diagnoses or symptoms.

- Implement a process which supports the MCO's requirement to pay for all emergency services which are medically necessary until the clinical emergency is stabilized.
- Implement State and federal requirements for providing notice to members for the reduction, suspension, or termination of a previously authorized Medicaid-covered service.
- Demonstrate that it is financially responsible for poststabilization care services obtained within or outside the network in accordance with provisions set forth in 42 CFR §422.113(c).
- Update documentation pertaining to poststabilization services to stipulate that the MCO limits charges to members to an amount no greater than what the MCO would charge the member if he or she had obtained the services through an MCO in-network provider.

Provider Selection

HSAG's specific recommendations for UnitedHealthcare are to:

- Implement mechanisms to ensure providers are credentialed within the required 45-day turnaround time.
- Implement mechanisms to ensure providers are accurately listed as network providers based on contractual status.

Member Information

HSAG's specific recommendations for UnitedHealthcare are to:

- Make a good faith effort to provide written notice of a provider's disenrollment to members who receive care from the provider within 15 days of when the provider terminates from its network.
- Revise policy to include that if an LTSS provider closes, the MCO staff members participate as part of the facility in crisis transition team.
- Update policy to ensure marketing material will not imply that the MCO was the only opportunity for the member to obtain benefits under the program and that materials will not mislead or falsely describe covered or available services, membership, or availability of network providers, and qualifications or skills of network providers.
- Implement a process to ensure that its staff and affiliated providers take member rights into account when furnishing services to members.
- Include in written policies the right of a member to refuse treatment or to be furnished healthcare services in accordance with requirements for access and quality of services (42 CFR §438.206 through 42 CFR §438.210).
- Update policies to include all member rights including those specified in Title VI of the Civil Rights Act of 1964, the Age Discrimination Act of 1975 as implemented by regulations at 45 CFR part 91, the Rehabilitation Act of 1973, Titles II and III of the Americans with Disabilities Act, and other laws regarding privacy and confidentiality.

Enrollment and Disenrollment

HSAG's specific recommendation for UnitedHealthcare is to:

- Implement a process to assure the State that it does not request disenrollment for reasons other than those permitted under the contract and federal regulations.

Grievance System

HSAG's specific recommendations for UnitedHealthcare are to:

- Ensure that all grievances are resolved within required time frames.
- Develop a process for grievance extensions to show, to the satisfaction of IDHS upon request, that there is a need for additional information and how the delay was in the member's interest.
- Implement a process to complete a quality check of letters that will be sent to members in response to a grievance to ensure resolution notifications contained required content, including the resolution of the complaint, and that the notifications are easily understood or free from grammatical and spelling errors.
- Develop a process for appeals to inform the member of the limited time available for presenting evidence in the case of an expedited resolution.
- Ensure the member's written consent is obtained when a provider appeals on the member's behalf.
- Ensure written notification letters regarding appeal decisions include the member's right to request and receive benefits while a hearing is pending, and how to make the request.
- Ensure there are no delays in notification or mailing the appeal decision to the member and member representative.
- Implement a process to review and resolve each appeal as expeditiously as the member's health condition requires, and that the resolution time frame does not exceed 45 calendar days from receipt for a standard appeal and three business days for an expedited appeal unless the resolution time frame was extended.
- Follow time frames documented in its policy if the policy is more stringent than the State requirement.
- Implement a process to clearly explain that both standard and expedited appeal resolution time frames may be extended up to 14 calendar days, that members may request an extension, and that the MCO will send the member written notification for the reason for the delay.
- Demonstrate how it provides general and targeted information to members and providers regarding instances when an expedited appeal is appropriate and procedures for providing written certification of the need for an expedited appeal.
- Ensure appeal disposition letters included the citation of the Iowa Code and/or Iowa Administrative Code sections supporting the action in nonauthorization and care review letters that advise members of the right to appeal.

- Implement a process to make reasonable efforts to provide oral notice to the member for expedited appeal resolutions.
- Revise written appeal notices to clearly explain how the member can request continuation of benefits during the State fair hearing process.
- Demonstrate accurate reporting on grievances and appeals to IDHS that is based on the actual date of notification to the member of the resolution, not the date the letter was developed.

Sub-contractual Relationships and Delegation

HSAG's specific recommendation for UnitedHealthcare is to:

- Conduct formal quarterly reviews of all subcontractors and delegated entities, including a review of excluded status.

Practice Guidelines

HSAG's specific recommendation for UnitedHealthcare is to:

- Implement a process to ensure staff decisions for utilization management, member education, and coverage of service decisions are consistent with the adopted practice guidelines.

Quality Assessment and Performance Improvement (QAPI)

HSAG's specific recommendation for UnitedHealthcare is to:

- Assess the quality and appropriateness of care furnished to members with special healthcare needs.

Performance Improvement Projects

In 2016 UnitedHealthcare initiated the two state-mandated PIPs, *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*. The validation findings and any results of its PIP processes will be included in the 2017 EQR technical report.

Validation of Encounter Data

Findings

UnitedHealthcare responded to the questionnaire developed for the EDV study, and HSAG worked with the MCO on a few follow-up items. This section summarizes the findings from the UnitedHealthcare questionnaire responses.

Encounter Data Sources and Systems

For professional (including laboratory) services and facility services, UnitedHealthcare uses an in-house Facets system to adjudicate claims. As shown in Table 6-2, UnitedHealthcare provides pharmacy, transportation, and vision services through subcontractors. Files from vendors are loaded into a vendor database. Medical claims, claims from vendors, and other relevant data (e.g., provider data) are collected into the National Encounter Management Information System (NEMIS) to create and manage encounter data submissions to IDHS.

Table 6-2—Format and Submission Frequency for Pharmacy, Transportation, and Vision Encounters

	Pharmacy	Transportation	Vision
Vendor	OptumRx	MTM Transportation	Superior Vision
Format	Proprietary	Proprietary	Proprietary
Frequency	Weekly for denied encounters and twice a month for paid encounters	Monthly	Monthly

UnitedHealthcare submits both paid and denied encounters to IDHS. When UnitedHealthcare recognizes additional claims adjustments after the original encounters have been submitted to IDHS, UnitedHealthcare submits the adjustment as a replacement. UnitedHealthcare also includes the original claim ID that is being replaced in the submission file.

UnitedHealthcare and its subcontractors collect and maintain the MCO's provider data. For example, UnitedHealthcare has a proactive data quality program that solicits updates from providers, uses large data analytics to detect suspected stale or inaccurate data, and uses third-party authoritative sources to validate and make necessary changes to ensure accuracy of the provider records.

UnitedHealthcare verifies whether provider information on the claims/encounters matches its provider data. The MCO also compares its provider data with the IME provider data file, sending all providers without an exact match (i.e., by tax ID, national provider identifier [NPI], and provider type) to its network management area for review and correction, if necessary.

When submitting provider data to IDHS, UnitedHealthcare updates the county information on the file prior to sending to IDHS if the county information is missing for a provider. For other types of data concerns, UnitedHealthcare temporarily removes providers as necessary to ensure complete data accuracy on the file. These providers who have been temporarily removed due to incomplete or inaccurate data are subsequently sent to a specialized team within UnitedHealthcare networks to determine accuracy and remediate, as appropriate. In the case of vendor data quality issues, UnitedHealthcare identifies these providers to the vendors for data quality validation.

For atypical providers, UnitedHealthcare stores the seven-digit state Medicaid ID. IDHS requires that provider Medicaid IDs include leading text to match the length of an NPI; therefore, UnitedHealthcare

adds "X00" to the beginning of the ID number. For example, a provider Medicaid ID 1234567 would be represented as X001234567 in the encounter file.[6-1]

Data Exchange P&Ps

Based on contractual requirements and data submission requirements such as companion guides and IDHS-specific edits, UnitedHealthcare has P&Ps in place to document and guide its encounter data process. For example, it has operational procedures for the production mode to document:

- When medical and behavioral health files and files from vendors are loaded to the internal system.
- When a monthly file is submitted to IDHS.
- That both paid and denied encounters are submitted.
- That rejection rates should not exceed 1 percent.
- The time frames to correct encounter data submission errors.
- That the MCO is responsible for vendor encounter performance.
- That the MCO reviews monitoring reports to ensure encounters submitted to IDHS are accurate and complete, and meet timeliness requirements.

Management of Encounter Data: Collection, Storage, and Processing

Table 6-3 shows UnitedHealthcare's pricing methodology for inpatient and outpatient encounters.

Table 6-3—Pricing Methodology for UnitedHealthcare

Outpatient	Inpatient
• Ambulatory Payment Classification (APC) (85%) • Line by Line (14%) • Percent of Charge (1%)	• Diagnosis-Related Group (DRG) (64%) • Per Diem (36%)

UnitedHealthcare tracks other insurance coverage using a Third Party Liability (TPL) Proprietary File and/or an 834 Eligibility File from IDHS. UnitedHealthcare considers TPL data before finalizing its claim adjudication. For example, if a claim is eligible for coordination of benefits (COB) but the required explanation of benefits (EOB) is not attached to the claim, UnitedHealthcare notifies the provider that the claim must be resubmitted.

For Medicare crossover claims, UnitedHealthcare receives the claims from CMS' Coordination of Benefits Agreement (COBA) vendor daily and then ultimately processes them through its data systems, similar to other third-party claims. Before the COBA process became effective in July 2016, UnitedHealthcare received Medicare crossover claims from providers through Medicare EOB. The

[6-1] IDHS confirmed with HSAG on December 9, 2016, that UnitedHealthcare is following IME protocol.

secondary payment allowable was designed to match the Medicare amount for full member reimbursement of the primary allowed amount.

When UnitedHealthcare is not responsible for the payment from a service due to a primary carrier, it reports both the primary carrier's payment information and a zero-paid amount for itself in the submitted encounters.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness and accuracy of the encounter data providers submit, UnitedHealthcare developed a Financial Completeness Report and a Submission Stat Report in addition to applying edits at the point of claim submission, performing Health Insurance Portability and Accountability Act (HIPAA) compliance checks, and applying IDHS-specific edits. For timeliness metrics, UnitedHealthcare uses internal reporting to track the aging of inventory and claims as submitted by providers, based on the received date of the claim.

For the vendors' encounter data, UnitedHealthcare monitors their accuracy and completeness through a reconciliation with the vendors' financial data. UnitedHealthcare also monitors the timeliness of encounter data submitted by its vendors on set dates. If a vendor's file is not received in a timely manner, UnitedHealthcare works with the vendor to resolve the issue as soon as possible.

UnitedHealthcare has processes in place to track encounters sent to IDHS and subsequently stores and processes the 999 response files, 277 response files, and the proprietary error reports received from IDHS so that UnitedHealthcare can monitor the rejections/errors and process the corrections and resubmissions, if necessary.

UnitedHealthcare noted that the data in its encounter database are used strictly for preparing the encounter submissions to IDHS. The claims data are used for rate setting, Healthcare Effectiveness Data and Information Set (HEDIS®)[6-2] reporting, and contractual requirements. UnitedHealthcare also noted that it currently has no capitated provider agreements.

MCO Strengths and Weaknesses

UnitedHealthcare has P&Ps in place to document and guide its encounter data process. The MCO also has processes to collect, store, and process encounter data. UnitedHealthcare monitors the completeness and accuracy of the encounter data submitted by its vendors and providers. HSAG had two recommendations for improvement for UnitedHealthcare as a result of the Encounter Data Validation activity.

[6-2] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

Recommendations for Improvement

Based on its review, HSAG recommends the following for UnitedHealthcare to strengthen its encounter data quality:

- IDHS requires pharmacy encounters to be submitted weekly. UnitedHealthcare receives denied pharmacy encounters from its subcontractor weekly and twice a month for paid encounters. UnitedHealthcare should work with IDHS to evaluate whether the MCO should receive paid encounters weekly from its subcontractor.
- UnitedHealthcare noted that IDHS requires providers' Medicaid IDs to match the length of an NPI (e.g., 10 digits) in the encounters; therefore, UnitedHealthcare adds "X00" to the beginning of the seven-digit state provider Medicaid IDs (e.g., provider Medicaid ID 1234567 will be represented as X001234567 on the encounter file). UnitedHealthcare should work with IDHS to evaluate whether the newly created 10-digit provider ID meets IDHS' expectations.[6-3]

[6-3] Through email communication with IDHS on December 9, 2016, IDHS confirmed that UnitedHealthcare is following IME protocol. Therefore, this recommendation has been addressed.

7. Comparative Analysis of the Iowa Medicaid and *hawk-i* Managed Care Organizations

Comparative Analysis of the MCOs

This section provides a comparison of the MCOs' performance on the 2016 Review of Compliance With Standards and Encounter Data Validation activities.

Review of Compliance

The following table provides information that can be used to compare the MCOs' performance on each of the 13 compliance standard areas selected for the review period.

Table 7-1—Standards and Compliance Scores: MCO Comparison

Standard #	Compliance Standard	Amerigroup	AmeriHealth	UnitedHealthcare
I	Availability of Services	**80.6%**	**83.9%**	**77.4%**
II	Assurance of Adequate Capacity and Services	**100.0%**	**100.0%**	**80.0%**
III	Coordination and Continuity of Care	**77.8%**	**85.2%**	**92.6%**
IV	Coverage and Authorization of Services	**80.0%**	**92.0%**	**76.0%**
V	Provider Selection	**100.0%**	**100.0%**	**87.5%**
VI	Member Information	**96.0%**	**88.0%**	**76.0%**
VII	Confidentiality of Health Information	**100.0%**	**80.0%**	**100.0%**
VIII	Enrollment and Disenrollment	**100.0%**	**100.0%**	**75.0%**
IX	Grievance System	**58.6%**	**69.0%**	**62.1%**
X	Sub-contractual Relationships and Delegation	**80.0%**	**80.0%**	**80.0%**
XI	Practice Guidelines	**60.0%**	**0.0%**	**80.0%**
XII	Quality Assessment and Performance Improvement (QAPI)	**81.8%**	**81.8%**	**90.9%**
XIII	Health Information Systems	**100.0%**	**100.0%**	**100.0%**
	Total Compliance Score	**80.6%**	**82.9%**	**81.0%**

The MCOs received similar overall compliance scores ranging between 80.6 and 82.9 percent, indicating that the MCOs had the P&Ps and operational structure in place to meet many of the federal and State requirements.

All three MCOs received a compliance score of 100 percent for the Health Information Systems standard, indicating a particular area of strength statewide. The MCOs had processes that supported business intelligence needs and allowed for the collection, integration, tracking, analysis, and reporting of data.

Overall, the lowest-scored area for all three MCOs was the Grievance System standard, with scores ranging from 58.6 to 69.0 percent. As displayed in the plan-specific results in Sections 4–6, this is an area that will require focus and attention by all three MCOs.

Recommendations to IDHS Regarding Compliance Review Findings

Although each of the MCOs will be working on different aspects of compliance, in order for IDHS to assist the MCOs to improve their overall compliance scores, HSAG suggests a focus on the corrective action plan (CAP) process during CY 2017, with monitoring of CAP implementation followed by reevaluation of MCO compliance.

For all elements that were found to be out of compliance, the MCOs will be required to submit a CAP that includes specific actions and interventions that the organization will implement to bring the element into compliance. The CAP must include the person responsible for overseeing the process as well as the timeline and targeted completion date. The CAP will be evaluated based on the following three criteria:

- The degree to which the planned activities/interventions meet the intent of the requirement
- The degree to which the planned interventions are anticipated to bring the organization into compliance with the requirement
- The appropriateness of the timeline for correcting the deficiency

Any CAPs that do not meet the above criteria will require resubmission by the MCO until approved by IDHS.

Review of Encounter Data Validation

The following summarizes and compares MCO performance on the IS review conducted for the CY 2016 EDV activity.

Based on contractual requirements and data submission requirements, such as companion guides and IDHS-specific edits, all MCOs have P&Ps in place to document and guide their encounter data processes. Currently, all MCOs submit professional encounters in the 837P format and institutional encounters in the 837I format to IDHS monthly, and they submit pharmacy encounters in the NCPDP D.0 format weekly. However, these data may originally come from MCOs' vendors in different formats.

For example, all MCOs provide pharmacy, transportation, and vision services through subcontractors in various formats. All MCOs submit paid, denied, and adjusted encounters to IDHS. While all MCOs are able to submit adjusted encounters to IDHS after the original encounters have been submitted, AmeriHealth's and UnitedHealthcare's processes to accomplish this differ slightly.

Each MCO and its subcontractors collect and maintain the respective MCO's provider data, and each MCO verifies whether the provider information on the claims/encounters matches the MCO's provider data. All MCOs compare their provider data with the IME provider data file and then select certain records for review and correction, where necessary. These activities are driven by the requirements that all MCOs' providers should be enrolled with IME Provider Services, and encounters submitted without a valid provider ID (e.g., NPI and tax ID) are rejected in the Medicaid Management Information System (MMIS).

For inpatient and outpatient encounters, there are large variations in pricing methodology among the three MCOs. For example, while more than 75 percent of AmeriHealth encounters are priced using "Other Pricing" methodology, Amerigroup and UnitedHealthcare generally do not use this methodology. All MCOs are tracking other insurance coverages for their members. However, the number of data sources that MCOs use varied from one source (UnitedHealthcare) to four sources (AmeriHealth). All MCOs consider the TPL data before finalizing their claims adjudication. Amerigroup and AmeriHealth also have a process to recoup payments when TPL data are identified after the initial claims processing. For Medicare crossover claims, all three MCOs receive the claims from CMS' COBA vendor daily and ultimately process them through their data systems, similar to other third-party claims. When MCOs are not responsible for the payment from a service due to a primary carrier, all three report both the primary carrier's payment information and a zero-paid amount for themselves in the submitted encounters.

To monitor the completeness and accuracy of the encounter data submitted by providers, all MCOs apply edits at the point of claim submission, perform HIPAA compliance checks, and apply IDHS-specific edits. All MCOs monitor the accuracy and completeness of encounter data submitted by their vendors through a reconciliation with their vendors' financial data. For timeliness metrics, all MCOs monitor encounter data on set dates or frequencies for data submissions. All MCOs have processes in place to track encounters sent to IDHS. The MCOs then process the 999 response files, 277 response files, and proprietary error reports received from IDHS so that the MCOs can monitor the rejections/errors and process the corrections and resubmissions, if necessary.

The 22 error codes used in MMIS are reasonable edits to include during the encounter implementation stage. As all MCOs move into production, additional edits should be added after they review the encounter data submitted. In addition, areas for improvement for the encounter monitoring metrics were identified in order to ensure MCOs' encounter data submissions are accurate and complete and meet timeliness requirements.

Recommendations to IDHS Regarding EDV Findings

Based on its review, HSAG recommends the following for IDHS to strengthen its encounter data quality:

- IDHS requires pharmacy encounters to be submitted weekly. UnitedHealthcare receives denied pharmacy encounters from its subcontractor weekly and twice a month for paid encounters. IDHS should evaluate whether UnitedHealthcare should receive paid encounters weekly from its subcontractor.
- IDHS should evaluate whether Amerigroup has submitted HCBS and LTC encounters to IDHS.
- UnitedHealthcare noted that IDHS requires provider Medicaid IDs to be the same length as an NPI (e.g., 10 digits) in the encounters. Therefore, UnitedHealthcare adds "X00" to the beginning of the seven-digit State provider Medicaid IDs (e.g., provider Medicaid ID 1234567 will be represented as X001234567 on the encounter file). IDHS may want to evaluate whether the newly created 10-digit provider ID meets IDHS' expectations and how other MCOs are handling this requirement for consistency.[7-1]
- More than 75 percent of inpatient and outpatient encounters from AmeriHealth were priced under "HCP Code 10—Other Pricing." IDHS should evaluate whether having a large unspecified group meets IDHS' expectations.
- Amerigroup produces a weekly aging summary report and assumes that a large count of missing remit statuses for a period of time typically indicates a rejected file. Therefore, when encountering this scenario, Amerigroup queries its system to check for the specific file, compliance check the file, and then resubmit. IDHS should work with Amerigroup to ensure the MCO's assumption is correct or develop a communication process to avoid duplicated submissions.
- IDHS should consider improving and expanding the edits in MMIS based on the recommendations listed in Table 2-5 of the *CY 2016 Encounter Data Process and Evaluation Report*[7-2] and future reviews of encounter data.
- MCOs noted the following challenges they are facing, and IDHS should take actions to alleviate these challenges:
  - MCOs would like to receive accurate response files from IDHS in a timely manner.
  - It is unclear what date and file range are covered by the proprietary error file.
  - There is uncertainty regarding what has been processed at IDHS.
- IDHS should develop encounter monitoring metrics to ensure the accuracy and completeness (i.e., detect missing encounters) of encounter data submitted by MCOs.
- IDHS should enhance monitoring metrics for encounter timeliness based on the lag days between dates of service and the dates when encounters are submitted to IDHS, or when they are available for the IDHS user community. This metric will help IDHS determine how long its staff members should wait for reporting purposes in order to have relatively complete data.

[7-1] Through email communication with IDHS on December 9, 2016, IDHS confirmed that UnitedHealthcare is following IME protocol. Therefore, this recommendation has been addressed.

[7-2] Health Services Advisory Group. Iowa Department of Human Services: *Calendar Year 2016 Encounter Data Process Evaluation Report*; December 2016: 2-10.