Department of HUMAN SERVICES

Kim Reynolds, Governor | Adam Gregg, Lt. Governor | Jerry R. Foxhoven, Director

January 7, 2018

W. Charles Smithson
Secretary of Senate
State Capitol
LOCAL

Carmine Boal
Chief Clerk of the House
State Capitol
LOCAL

Dear Ms. Boal and Mr. Smithson:

Enclosed please find copies of reports to the General Assembly relative to Medical Assistance Advisory Council Executive Committee Finds and Recommendations Final Report.

This report was prepared pursuant to the directive contained in 2018 Senate File 2418.

Please feel free to contact me if you need additional information.

Sincerely,

Mikki Stier
Deputy Director

MS/em

Enclosure

cc: Kim Reynolds, Governor

Department of
HUMAN SERVICES

Medical Assistance Advisory Council (MAAC) Data Recommendations Report

December 2018

Contents

Background

Senate File 2418 appropriates general funds to state agencies, including the Department of Human Services (the Department) and the Iowa Medicaid program. Section 131 of the bill requires the Medical Assistance Advisory Council (MAAC) executive committee to review data currently being collected, reported and recommend to the General Assembly any changes to this data for future reporting. The text of Section 131 of SF 2418 follows:

> Sec. 131. MEDICAL ASSISTANCE ADVISORY COUNCIL —— REVIEW OF MEDICAID MANAGED CARE REPORT DATA. The executive committee of the medical assistance advisory council shall review the data collected and analyzed for inclusion in periodic reports to the general assembly, including but not limited to the information and data specified in 2016 Iowa Acts, chapter 1139, section 93, to determine which data points and information should be included and analyzed to more accurately identify trends and issues with, and promote the effective and efficient administration of, Medicaid managed care for all stakeholders. At a minimum, the areas of focus shall include consumer protection, provider network access and safeguards, outcome achievement, and program integrity. The executive committee shall report its findings and recommendations to the medical assistance advisory council for review and comment by October 1, 2018, and shall submit a final report of findings and recommendations to the Governor and the general assembly by December 31, 2018.

A subcommittee of the MAAC Executive Committee was selected and met several times to evaluate the current reports, and develop recommendations on the report for the full MAAC and its Executive Committee's consideration, according to the requirements of section 131.

More specifically, the subcommittee:

- Reviewed the requirements of SF 2418, and 2016 Iowa Acts, chapter 1139, section 93.
- Evaluated legislatively required reporting by conducting a thorough review of the existing managed care quarterly reports.
- Discussed standards available and under development nationally for managed care reporting.
- Developed high-level recommendations for future reporting.
- Identified high priority categories of reporting as well as suggesting more specific measures to be included in future reporting for the IA Health Link program.

The Executive Committee established a few high level goals which guided its discussions and recommendations, as follows:

- **Focus on health outcomes** – while a high level of interest exists to ensure that administrative processes are in place and operating effectively for the program, the overriding concern for the MAAC should be an emphasis on

health improvement for Medicaid beneficiaries under the managed care arrangement.

- **Accessible data** – while it may be tempting to expand on the number of measures included in reports, growth in the number of measures can also create more confusion just simply in adding to the number of measures available. The subcommittee was guided by ensuring that whatever reporting is available is accessible, understandable, and meaningful to all audiences including Medicaid enrollees and the general public. This means that the committee was open to the possibility of recommending the elimination of less meaningful measures to allow more emphasis on fewer and higher quality measures to promote better understanding on the reader's part.

High Level Recommendations

Process indicators versus health outcomes – The Iowa Medicaid program should create a reasonable mix of data points reported which focus on both administrative process indicators (payment timeliness, pre-authorization counts, for example) and health outcomes indicators (Percentage of Live Births that Weighed Less than 2,500 Grams, Beneficiaries who Quit Smoking, percentage MLTSS plan members 18 years of age and older who have documentation of a comprehensive LTSS, for example).

Report brevity and focus – The subcommittee discussed the large number and variety of reports that the Department has made publicly available. While the sheer number and length of reports suggest a high level of transparency in communicating with the public and stakeholders on program performance, the subcommittee also felt that the volume of information can be overwhelming for the public to make good sense of the program. Policymakers and the public would be better served through a refinement of reporting that helps identify issues of key interest and organizing this information in a way that promotes better accessibility of information by the public.

Interactive report tools – Rather than print lengthy and static reports, use of technology could assist the public and policymakers in a better understanding of program performance information. An easily accessible website-based query tool could allow more effective access to information, as needed, on issues of particular interest. Iowa Medicaid should consider this option as part of system updates, including modernization and modularity of the Medicaid Management Information System (MMIS). Iowa Medicaid should publicize this tool once created to ensure that policymakers, stakeholders and the public are aware of its availability. The accomplishment of this recommendation will certainly be dependent upon resource availability and time to implement changes.

Reporting Frequency and Formats – While interactive reporting tools may be effective in the distribution of some metrics, others may be best reported at less frequent intervals and lend themselves to more static (paper-based) reports. The Department should give consideration to those measures which are more accurately or productively

reported on an annual basis, for example, and consider publishing those in a static report. Similarly, for measures that change more frequently, or for which quarterly reporting may be more valuable, the interactive tools may be a more effective way of reporting these metrics.

Rolling periods – While more frequent quarterly reporting is valuable, some health care measures require more data to ensure reliable and valid information is available. In other cases, claims-based reporting may require a claims run-out period to ensure that a statistically significant amount of activity in the quarter is available for analysis. For measures requiring multiple reporting periods to ensure reliability and validity, the Department should consider establishing a set of rolling quarters. In this way, more valid data will be made available on a quarterly basis, but reporting will rely on the most recent four quarters of data, for example, to keep the information current and relevant.

Trends – Data can help illuminate issues when it is a performance that is being compared to similar factors. For example, presenting information as trends over time would be very valuable in ascertaining performance improvement or degradation.

Comparability of data between plans – Efforts to ensure the comparability of data between the Iowa Medicaid managed care plans is paramount to providing accurate information. In some cases, where one plan measures a process or outcome differently from another plan, the Department should take action to ensure that the data is collected and reported in a way to ensure that "apples to apples" comparisons are being made.

Comparability of data across state programs – Independent organizations such as the National Council on Quality Assurance (NCQA) and the National Quality Forum (NQF) promote patient protections and healthcare quality through the administration of evidence-based standards and measures. They have worked to establish such standards and measure definitions for health care performance across the country. This standardization of measures ensures that national resources have been invested to ensure that measures do, in fact, reflect the performance of the health system. Standard measures also ensure that health care providers have a single standard against which to report. Different ways of measuring the same metric cause confusion among health care providers, introduce inefficiencies in collecting and reporting data, and create confusions for information consumers because measures that sound similar are not measuring the same activity.

Elimination of measures from current reports - Where performance is high and has been consistent following the implementation of managed care, consideration should be given to eliminating these in the public reports indicators. These indicators may certainly have administrative importance and be retained for performance monitoring, but in order to economize on space, and communicate on those indicators which are meaningful and changing, the Department should be provided some flexibility, with the concurrence of the MAAC for example, to make these report adjustments. The following indicators in the existing reports are recommended for elimination:

- Secret shopper data in the current quarterly report is more useful than all member response timeliness because data is not changing
- Payment timeliness data in the quarterly reports may reflect payments made but could be partial, incomplete or inaccurate. Measures in the current quarterly report do not reflect these nuances. To better inform quality improvement efforts, perhaps adjustments to these metrics could be made to refocus the data on the particularly services for which payments are timely – hospitalizations, pharmaceuticals, etc.
- Timely submission of files as reported in the quarterly reports are not very useful. The focus could instead be placed on actual health care utilization data.
- Subcommittee to identify additional metric candidates for elimination (and justification as to why elimination is recommended) which reflect consistently high performance, several quarters of no material change, or meet other criteria for elimination.

MAAC Managed Care Organizations (MCOs) Report Modification Recommendations

(If not mentioned in the following table, the committee's recommendation is that the existing measure be retained in the Department's reporting requirements. References to "eliminate" measurements from the report, below, indicate that these measures will not be present in report format, but will continue to be available from Iowa Medicaid online in an accessible format and upon request or in other periodic reporting.)

Measure (Page Number)	Eliminate/Modify	Rationale
MCO Enrollment Data (5,6,8)	Modify	Break Out Data By Specific Program/Waiver Populations
Care Coordination Reporting – Population-Specific Supporting Data (9-10)	Available on request	Demographic Data of Limited Value, Outcomes Data More Useful
Health Risk Assessments (9)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Chronic Health Homes – Population-Specific Supporting Data (11)	Available on request	Demographic Data of Limited Value, Outcomes Data More Useful
Non-LTSS Care Plans – Members with Care Plans Updated Timely (12)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Non-LTSS Care Plans – Population-Specific Supporting Data (12)	Available on request	Demographic Data of Limited Value, Outcomes & Member Participation Data More Useful
Integrated Health Homes – Population-Specific Supporting Data (13)	Available on request	Demographic Data of Limited Value, Outcomes Data More Useful
LTSS/HCBS Care Coordination – Members Assigned a Case Manager	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Member Participation Data More Useful
HCBS Service Plans Completed Timely (17)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Member Grievance & Appeals – Percentage Resolved within 30 Days (22)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Percentage of Appeals Resolved within 30 Days (24)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Member Helpline – Percentage of Calls Answered Timely (26)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Provider Helpline – Percentage of Calls Answered Timely (29)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Pharmacy Services Helpline – Percentage of Calls Answered	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of

Timely (31)		Limited Value
Medical Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (32)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Medical Claims Status (33)	Modify	Data Insufficient to Provide Value; Additional Data on Suspended & Denied Claims of Greater Value
Provider Adjustments Reprocessed within 30 Days (36)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Pharmacy Claims Payment – Clean Claims Paid/Denied within 30 Days/45 days (37)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Value-Added Services (39)	Modify	Data Insufficient to Provide Value; Additional Information on Specific Services of Greater Value
Provider Access Network (40)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Members with Coverage in Time & Distance Standards (41)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value
Prior Auths (Medical) – Percentage Completed Within 14 Days/ 72 Hours (42)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Prior Auth (Medical) Status (43)	Modify	Data Insufficient to Provide Value; Additional Data on Modified & Denied Prior Auths of Greater Value
Prior Auths (Pharmacy) – Percentage Completed Within 24 Hours (44)	Available on request	Threshold Consistently Met – DHS Continue to Monitor, But Reporting of Limited Value; Alternative Data Metrics of Greater Value
Prior Auth (Pharmacy) Status (45)	Modify	Data Insufficient to Provide Value; Additional Data on Denied Prior Auths of Greater Value
VBP Enrollment (46)	Modify	Data Insufficient to Provide Value; Additional Information on Specific Arrangements of Greater Value.
MCO Reported Reserves (51)	Available on request	DHS Continue to Monitor, But Reporting of Limited Value

Meaningful and sufficient data in report – Some metrics in the current report lack a level of meaningfulness and sufficiency to be important and informative. For example, confusion exists over value-added services in the report. Categories are too broad to be meaningful, and the enrollment counts, as a result, don't provide meaningful and useful information on service use. Similarly, information in the report reflecting the use of value-based purchasing also lacks a level of meaningfulness to provide useful insights into the utilization of value-based purchasing to advance quality improvement in the program.

Periodic review – the Executive Committee recommends that it conduct periodic reviews of data to be reported to ensure that measures that are being reported continue to be valuable and that additional measures are incorporated as needs arise.

Specific Measure Recommendations

The Executive Committee recommends the following as it relates to specific measures:

The Department identifies existing, nationally endorsed key performance measures in the following categories of health outcomes:

- Overall acute care
- Long Term Supports and Services
- Behavioral Health
- Substance Use Disorder
- Long Term Care

Healthcare Effectiveness Data and Information Set (HEDIS) - Iowa's Medicaid program requires each MCO to be accredited by the NCQA. Becoming accredited means that MCOs are capable of reporting on a standard list of measures called the Healthcare Effectiveness Data and Information Set (HEDIS). HEDIS is a widely used set of performance measures in the managed care industry, developed and maintained by the NCQA. These measures are revised and updated each year, and the 2019 set of measures is available online. Link: https://www.medicaid.gov/medicaid/quality-of-care/downloads/performance-measurement/2019-adult-core-set.pdf. Iowa Medicaid's use of these measures for reporting will ensure reliance on a national standard of measures that will simplify reporting by MCOs and their provider partners and ensure comparability from state to state in gauging the performance of Iowa's plans.

Beyond HEDIS data, additional information should be incorporated in reports, as follows:

- Long-Term Services and Supports (LTSS) Comprehensive Assessment and Update –Considerations should be given to adding metrics to the report which capture additional information on the LTSS available to Iowans. These additional metrics might include data regarding the completion of comprehensive assessments of plan development, which break out data points by waiver/population and/or age should be included in this analysis. Another metric to consider would be care plan updates' timeliness also broken out by population and age.

- Data which would allow the analysis of actual costs of care for certain populations.

LTSS Reassessment/Care Plan Update after Inpatient Discharge—Consideration should be given to adding metrics to the report which capture additional information which is outcome-based rather than process-oriented. Recommendations include:

- Members feel that they are a part of service planning.
- Members feel safe where they live.
- Percent of members who are involved in employment activities.
- Rate of member falls.
- Medication adherence for individuals with behavioral health diagnosis

Other Recommendations

- While quarterly reports can be made available through a database of information which provides appropriate patient level protections for confidentiality as dictated by Health Insurance Portability and Accountability Act (HIPAA), a standard annual report for the program should continue to be provided.

- Similarly, if the recommendation to post data on the website and make the information accessible, a more frequent hard copy report may be unnecessary to publish.

- Consider including statistics in the current enrollment information that reflect behavioral health and LTSS along with traditional Medicaid enrollment

- Consider including B-3 report-type data.

- Consideration should be given to include health outcomes specific data to individuals receiving health home program benefits.

- In the current report sections which recap the “Top 5 Reasons”, including data that would reflect trends over time would be particularly beneficial to show how the processes in the program are changing over time.

- Fair Hearing data in the current quarterly report should include trends to better show change over time.

- Prior Authorization denials in the current report do not provide enough information to be valuable. Reasons for denials also need to be addressed and integrated into MCO, health care provider, and program quality improvement efforts.

- Regarding value-added services, meaningful comparisons of these services by MCO are difficult because all these services are not required. Instead, perhaps more granular reporting of the 40 value added services and their connection to “base” benefits, and utilization that supports health improvement might yield more interesting insights.