Iowa Medicaid Managed Care Quality Assurance System

2021

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INTRODUCTION

OVERVIEW

The Iowa Department of Human Services (DHS) contracts with Managed Care Organizations (MCOs) to provide comprehensive health care services including physical health, behavioral health (mental health and substance use disorders), and long-term services and supports (LTSS) to Iowans enrolled in Medicaid.

Iowa's Managed Care Quality Assurance Plan is Iowa Medicaid's guidance document to oversee Iowa's Medicaid managed care programs and to explore possibilities of utilizing clinical outcome-based research in the development of a set of measures to complement existing systems.

The Iowa Managed Care contracts are procured through a competitive bidding process. Contractually the MCOs are held responsible for addressing quality of care related problems at both the programmatic and individual provider level. The contracts contain requirements that are based on quality initiatives and measurements, are specifically designed to support the goals listed in the quality plan.

Performance monitoring and data analysis are critical components in assessing how well the MCOs are maintaining and improving the quality of care delivered to members. Multiple oversight tools are deployed in this effort. The Department develops and publishes a Medicaid Managed Care Performance Report quarterly, as well as annually. The MCO Performance Reports are posted to the DHS website: https://dhs.iowa.gov/ime/about/performance-data

HISTORY

The Iowa Medicaid Enterprise (IME) is the division of DHS that administers the Medicaid program. In 2016, nearly all Iowa Medicaid members, including members receiving LTSS, were transitioned to the IA Health Link program, and began receiving benefits through contracted MCOs. The state maintains a small Fee-for-Service (FFS) population that accounts for 6%.

- Health Insurance Premium Payment Program (HIPP)
- Medicare Savings Program (MSP)
- Qualified Medicare Beneficiary (QMB)
- Specified Low-Income Medicare Beneficiary (SLMB)
- Three Day Emergency
- Medically Needed (Spenddown Program)
- Presumptive Eligible (PE)
- Program of All-Inclusive Care for the Elderly (PACE)
- American Indian or Alaska Native Program

The MCOs in Iowa are Amerigroup, Iowa and Iowa Total Care. The number of people served and the number we project to service in State Fiscal Year (SFY) 2021 is 792,000 unduplicated members. Iowa served nearly 723,000 unduplicated members in SFY 2020. Today, the IA Health Link program has more than 738,000 members in all 99 counties. This includes

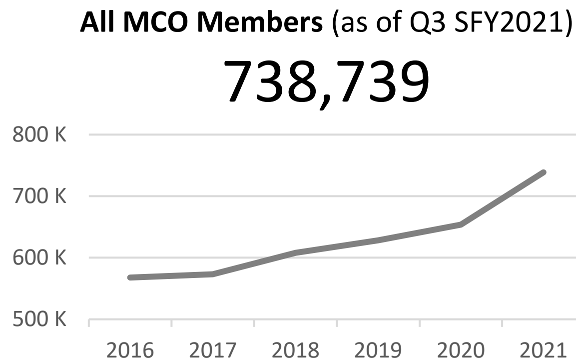
members that have not been disenrolled during the continuous eligibility required due to the COVID-19 Public Health Emergency.

Populations served by Managed Care

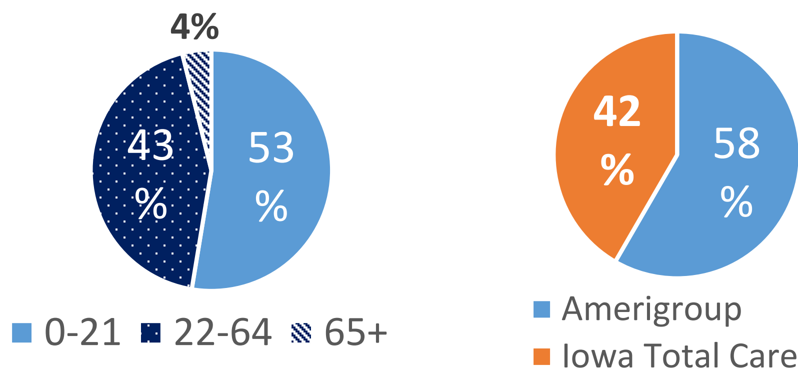
- Children's Health Insurance Program (CHIP)
- Healthy and Well Kids in Iowa (Hawki)
- Iowa Health and Wellness (IHAWP)
- IA Health Link

For the most up to date demographics: https://dhs.iowa.gov/dashboard_health

Managed Care Enrollment by Managed Care Organization (MCO) for SFY2021



MCO Enrollment Summary
SFY 2016 to SFY 2021 (30.1% Increase)



MCO Enrollment (by Age)	MCO Enrollment (by Market Share)

Since the beginning of COVID-19 which started the last month of **Q3 SFY20** (Jan-Mar 2020) enrollment has increased by **84,810** members or **12.97**% as of Q3 SFY2021.

See MCO Quarterly Reporting for more information:
https://dhs.iowa.gov/ime/about/performance-data/MC-quarterly-reports

GOALS

The triple aim goal is to improve outcomes and patient experience, while ensuring that Medicaid programs are financially sustainable.

In alignment with the triple aim, each MCO participates in improvement activities that effectively move the healthcare system from volume to value and increase cross sector engagement in population health improvement. These activities focus on value outcomes that connect each payer to communities and health systems to work together to improve the health of our members and create a system that is affordable and sustainable. The Quality Committee reviews the quarterly and annual managed care performance reports to identify trends across reports and make recommendations for potential improvements.

<u>Behavioral Health</u>

- Promote behavioral health by measuring Follow-up after Hospitalization/Follow-up after Emergency Department visit (FUH/FUM) for pediatric and adult populations. LTSS population including Health Home will be stratified.
- The state's External Quality Review contractor, Health Services Advisory Group (HSAG) will identify common behavioral health conditions, use of community services, follow-up care, and medication adherence. Once a baseline has been established, trends and recommendations for improvements will be identified.
  - Measure
  - Analyze
  - Suggest improvements

- Promote mental health through the Integrated Health Home Program.
- Assess the potential for a Substance Use Disorder (SUD) Health Home Program
- University of Iowa pre-print measures FUH/FUM for adult and children

<u>Access to Care</u>

- Increasing covered lives in value based purchasing arrangements at a minimum of 40%
- Improve network adequacy
- Improve timeliness of postpartum care
- Increase access to primary care and specialty care

<u>Program Administration</u>

- Meet performance measures thresholds for timely claims reprocessing and encounter data
- Integrate the MCO quality plan with the quarterly MCO review process

<u>Decrease Cost of Care</u>

- Reducing the rate of potentially preventable readmissions and non-emergent Emergency Department (ED) visits

Improving Coordinated Care

- 70% of Health Risk Assessments (HRAs) will be completed within 90 days of enrollment and annually thereafter
- Improve the postpartum visit rate, postpartum follow-up and care coordination, and glucose screening for gestational diabetes
- 100% timely completion of level of care and needs based eligibility assessments
- 100% timely completion of the initial and annual service plan review and updates

Continuity of Care

- Ensuring the accuracy and completeness of member information needed to efficiently and effectively transition members between plans and/or providers
- Monitoring long-term care facility documentation to ensure that members choosing to live in the community are able to successfully transition to the community as well as remain in the community (Minimum Data Set section Q, Intermediate Care Facility- Intellectual Disability discharge plans)
- Monitoring transition and discharge planning for LTSS members

Health Equity

- Identify health disparities or inequities and target those areas for improvements
- Monitor the implementation and progress of the Health Equity Plans

Voice of the Customer

- Annually review the Consumer Assessment of Healthcare Providers and Systems (CAHPS) results and make recommendations for improvement
- Quarterly review the Home and Community-Based Services (HCBS) Iowa Participant Experience Survey (IPES) results and make recommendations for improvement
- Quarterly review the appeals and grievance reports and make recommendations for improvement

STATE STANDARDS: WHOLE PERSON HEALTH CARE

MCOs must ensure their members have access to Medicaid covered services through their provider network. They are required to develop and maintain a network of providers to meet the needs of their members. MCOs must also maintain access to network providers based on federal and state requirements. If an in-network provider is not available, the MCO is still required to locate a willing provider in order to ensure members have access to medically necessary and appropriate services. These standards focus on supporting member's choice of a provider, ensure the health and welfare of the member and focus on community integration, and other considerations that are in the best interest of the member that need LTSS services.

438.68 Network adequacy standards: The Agency contracts with MCOs to deliver Medicaid services and develops and enforces network adequacy standards.

The Agency develops a quantitative network adequacy standard for the following provider types:

- Primary care, adult and pediatric
- OB/GYN
- Behavioral health (mental health and substance use disorder), adult and pediatric.
- Specialist adult, and pediatric.
- Hospital
- Pharmacy

- LTSS. The Agency identifies in MCO contracts, which covered LTSS must develop a quantitative network adequacy standard for LTSS provider types
  - Time and distance standards for LTSS provider types in which a member must travel to the provider to receive services
  - Network adequacy standards other than time and distance standards for LTSS provider types that travel to the member to deliver services
- Network adequacy standards are outlined in the MCO contract and includes the following elements:
  - The anticipated Medicaid enrollment.
  - The expected utilization of services.
  - The characteristics and health care needs of specific Medicaid populations covered in the MCO contract.
  - The numbers and types (in terms of training, experience, and specialization) of network providers required to furnish the contracted Medicaid services.
  - The numbers of network providers who are not accepting new Medicaid members.
  - The geographic location of network providers and Medicaid members, considering distance, travel time, the means of transportation ordinarily used by Medicaid members.
  - The ability of network providers to communicate with limited English proficient members in their preferred language.
  - The ability of network providers to ensure physical access, reasonable accommodations, culturally competent communications, and accessible equipment for Medicaid members with physical or mental disabilities.
  - The availability of triage lines or screening systems, as well as the use of telemedicine, e-visits, and/or other evolving and innovative technological solutions.
- The Agency publishes these standards and is available at no cost to members with disabilities in alternate formats or through the provision of auxiliary aids and services.

IME standards expect MCOs provide available, accessible, and adequate numbers of institutional facilities, service locations, service sites, professional allied, and paramedical personnel for the provision of covered services, including all emergency services, on a twenty-four (24) -hour-a-day, seven (7)-day-a" week basis. IME's standards for access to care are outlined in the MCO's contracts Exhibit B: https://dhs.iowa.gov/MED-16-009_Bidders-Library.

The MCOs must demonstrate access within the contractual requirements or additional network adequacy standards developed by IME. The Managed Care Network Geographic Access reporting looks at MCO provider networks in order to assess member access and network capacity. This quarterly report is posted on the Department's website: https://dhs.iowa.gov/ime/about/performance-data-geoaccess

Access to care is reviewed during the external quality review (EQR) compliance process. The Annual EQR Report can be found on the Department's website: https://dhs.iowa.gov/ime/about/performance-data/annualreports

Below are the areas of compliance for the EQR review process and standards the MCOs must follow:

- 438.206 Availability of services The Agency ensures that all services covered under the State plan are available and accessible to members of MCOs in a timely manner.

- The Agency also ensures through its contracts, that each MCO consistent with the scope of its contracted services, meets the following requirements:

    - Maintains and monitors a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to all services covered under the contract for all members, including those with limited English proficiency or physical or mental disabilities.
    - Provides female members with direct access to a women's health specialist within the provider network for covered care necessary to provide women's routine and preventive health care services. This is in addition to the member's designated source of primary care if that source is not a women's health specialist.
    - Provides for a second opinion from a network provider, or arranges for the member to obtain one outside the network, at no cost to the member.
    - If the provider network is unable to provide necessary services, covered under the contract, to a particular member, the MCO must adequately and timely cover these services out of network for member, for as long as the MCO's provider network is unable to provide them.
    - Requires out-of-network providers to coordinate with the MCO for payment and ensures the cost to the member is no greater than it would be if the services were furnished within the network.
    - Demonstrates that providers are credentialed as required by § 438.214.
    - Demonstrates that the network includes sufficient family planning providers to ensure timely access to covered services.
- Furnishing of services. The Agency ensures that each contract with a MCO complies with the following requirements:
    - The MCO must require timely access
        - Of network providers to meet Agency standards for timely access to care and services, taking into account the urgency of the need for services.
        - By ensuring that the network providers offer hours of operation that are no less than the hours of operation offered to commercial

members or comparable to Medicaid FFS, if the provider serves only Medicaid members.
    - By ensuring providers make services included in the contract available 24 hours a day, 7 days a week, when medically necessary.
    - By establishing mechanisms to ensure compliance by network providers.
    - By monitoring network providers regularly to determine compliance.
    - By taking corrective action if there is a failure to comply by a network provider
- Provides cultural considerations through MCO participation in the Agency's efforts to promote the delivery of services in a culturally competent manner to all members, including those with limited English proficiency and diverse cultural and ethnic backgrounds, disabilities, and regardless of sex.

- Accessibility considerations by the MCO ensuring that network providers provide physical access, reasonable accommodations, and accessible equipment for Medicaid member with physical or mental disabilities.

  - § 438.208 - Coordination and continuity of care The Agency ensures through its contracts that each MCO complies with the requirements in this section. .
  - 438. 208(a)2 Provides additional services for persons with special healthcare needs, including:
    - Identification
    - Assessment
    - Treatment plans
    - Direct access to specialists

  - 438. 208(b) Each MCO must implement procedures to deliver care to and coordinate services for all MCO members. These procedures must meet State requirements and must do the following:
    - Ensure that each member has an ongoing source of care appropriate to their needs and a person or entity formally designated as primarily responsible for coordinating the services accessed by the member. The member must be provided information on how to contact their designated person or entity
    - Coordinate the services the MCO furnishes to the member
      - Between settings of care, including appropriate discharge planning for short term and long-term hospital and institutional stays
      - With the services the member receives from any other MCO
      - With the services the member receives in FFS Medicaid
      - With the services the member receives from community and social support providers
    - Provide that the MCO makes a best effort to conduct an initial screening of each member's needs, within 90 days of the effective

date of enrollment for all new members, including subsequent attempts if the initial attempt to contact the member is unsuccessful
- Share with the State or other MCOs serving the member the results of any identification and assessment of that member's needs to prevent duplication of those activities
- Ensure that each provider furnishing services to member maintains and shares, as appropriate, a member health record in accordance with professional standards
- Ensure that in the process of coordinating care, each member's privacy is protected in accordance with the privacy requirements in 45 CFR parts 160 and 164 subparts A and E, to the extent that they are applicable.

- 438. 208(c) Additional services for members with special health care needs or who need LTSS
  - Identification of members who are eligible for HCBS or Habilitation State Plan Amendment Services.
  - Assessment: The MCOs must implement mechanisms to comprehensively assess each Medicaid member identified by the State as needing LTSS or having special health care needs to identify any ongoing special conditions of the enrollee that require a course of treatment or regular care monitoring. The assessment mechanisms must use appropriate providers or individuals meeting LTSS service coordination requirements of the State as appropriate.
  - Treatment plans: MCOs, must produce a treatment or service plan meeting the following criteria members who require LTSS or with special health care needs, must produce a treatment or service plan that are determined through assessment to need a course of treatment or regular care monitoring. The treatment or service plan must be:
    - Developed by an individual meeting LTSS service coordination requirements with members participation, and in consultation with any providers caring for the member
    - Developed by a person trained in person-centered planning using a person-centered process and plan.
    - Approved by the MCO in a timely manner
    - In accordance with applicable State quality assurance and utilization review standards
    - Reviewed and revised upon reassessment of functional need, at least every 12 months, or when the member's circumstances or needs change significantly, or at the request of the member.
  - Direct access to specialists for members with special health care needs determined through an assessment to determine a course of treatment or regular care monitoring, each MCO must have a mechanism in place to allow members to directly access a specialist (for example, through a standing referral or an approved

number of visits) as appropriate for the member's condition and identified needs.

- § 438.310 Coverage and authorization of services
    - Identifies, defines, and specifies the amount, duration, and scope of each service that the plan is required to offer.
    - Specifies what constitutes "medically necessary services".
    - Has in place and follows written policies and procedures for authorization of services.
    - Ensures that any decision to deny a service is made by an appropriate healthcare professional.

ADVISORY AND OVERSIGHT COMMITTEES

The state promotes appropriate utilization of services within acceptable standards of medical practice through advisory committees. A link to the Advisory Committees can be found on the Department's website: https://dhs.iowa.gov/ime/about/advisory_groups

The **Stakeholder Advisory Board** provides input on issues such as service delivery, quality of care, member rights and responsibilities, resolution of grievances and appeals, operational issues, program monitoring and evaluation, member and provider education, and priority issues identified by members. At least 51% of each MCO Stakeholder Advisory Board is comprised of members and/or their representatives. Provider membership includes representatives of different services areas, such as nursing facility providers, behavioral health providers, primary care, and others. MCOs have plans in place to encourage participation, and have minutes available to IME upon request. Any issues that are identified by the Stakeholder Advisory Board are incorporated in MCO planning, operations, and quality work plans.

In addition to stakeholder recommendations, the MCOs each have a **Quality Management/ Quality Improvement (QM/QI) Committee**. This is a group of medical, behavioral health, public health, and long-term care staff and network providers that meets periodically (usually quarterly) to analyze and evaluate the result of QM/QI activities, recommend policy, ensure provider involvement, institute needed action, and ensure appropriate follow-up occurs. MCOs report the committee's activities on a quarterly basis using templates prescribed by the IME.

IME collaborates with other agencies of state government to inform and focus quality improvement activities, such as the Department of Public Health (IDPH) or the Department of Education, both of which operate programs designed for early identification and assessment of disease processes and immunization patterns. IME ensures these efforts are appropriately prioritized, aligned and coordinated with our MCOs. A good example is the **Maternal Health Task Force**, which meets quarterly. Through the task force, DHS in cooperation with IDPH reviews and evaluates high-risk births of medical assistance recipients and evaluates services to reduce risk by creating actionable objectives based on data; the goal is to improve parity in access and outcomes in the maternal population in the state of Iowa with a focus on the Medicaid population.

In addition to Interdepartmental cooperation, input to the quality plan is also periodically reviewed by Medicaid **Clinical Advisory Committee (CAC)**. The purpose of the CAC is to increase the efficiency, quality and effectiveness of the Medicaid healthcare system. The CAC provides a process for physician/provider intervention to promote quality care, member safety, cost effectiveness and positive physician/provider relations through discussion about Medicaid benefits and healthcare services. This committee meets quarterly with managed care being a standard agenda item. Acting under the direction of the Medicaid Medical Director, the CAC provides guidance to IME regarding clinical policies of the managed care program, suggests areas of oversight, reviews, and informs various quality programs.

The purpose of the **Medical Assistance Advisory Council (MAAC)** is to "Advise the Director about health and medical care services under the medical assistance program." The Council is mandated by federal law and further established in Iowa Code. While the CAC is focused on clinical aspects of service delivery and policy, the MAAC oversees the Medicaid program more broadly, including LTSS, payment issues, network adequacy and more.
https://dhs.iowa.gov/ime/about/advisory_groups/clinical-advisory-group

The **IME Quality Committee** works to oversee the quality plan and implements strategies to ensure that the triple aim is met. These strategies include:

- The development of Pay for Performance measures for the MCOs and other programs as needed.
- Support policy in deciding measures to assess effectiveness of programs.
- Complete a formal review of the quality strategy.
- Review and approve or deny any updates or changes to the quality strategy as needed.
- Conduct a formal evaluation of the effectiveness of the quality strategy over those previous three years.
- Move the quality strategy through the update and approval process.

The **Council on Human Services** advises on matters within the jurisdiction of all of DHS. The Council on Human Services provides recommendations to the Governor. The Council meets monthly.

The **Healthy and Well Kids in Iowa (Hawki) Board** provides direction to the Department on the development, implementation, and ongoing administration of the Hawki program that covers children through CHIP funding. The Hawki Board meets six times a year.

The **Pharmaceutical and Therapeutics (P&T) Committee** is charged by law with developing and providing ongoing review of the Preferred Drug List (PDL). The PDL is a list of drugs approved by the Department to be prescribed for Medicaid members. Medicaid may not cover drugs not on the PDL. http://www.iowamedicaidpdl.com/pt_committee_info

The Centers for Medicare and Medicaid Services (CMS) also requires state Medicaid programs to have a **Drug Utilization Review (DUR)** commission consisting of prospective DUR, retrospective DUR, and an educational program. https://dhs.iowa.gov/node/3519
https://iadur.org/

Children's Behavioral Health System State Board

The Children's Behavioral Health System State Board (Children's Board) is the single point of responsibility in the implementation and management of a Children's Mental Health System (Children's System) that is committed to improving children's well-being, building healthy and resilient children, providing for educational growth, and coordinating medical and mental health care for those in need.

Mental Health Planning and Advisory Council

The Iowa Mental Health Planning and Advisory Council (MHPC) is a state advisory body authorized by federal law (42 U.S.C. Section 300x) and required as a condition for the receipt of federal Community Mental Health Services Block Grant funding. The objective of block grant funding is to support the State in providing comprehensive, community-based mental health services to adults with serious mental illnesses and to children with serious emotional disturbances and to monitor progress in implementing a comprehensive, community-based mental health system.

Iowa Mental Health and Disability Services Commission

The Iowa Mental Health and Disability Services (MHDS) Commission is the state policy-making body for the provision of services to persons with mental illness, intellectual disabilities or other developmental disabilities, or brain injury.

QUALITY ASSESSMENT & PERFORMANCE MEASUREMENT 438.330

The relationship between the MCOs and the Department is established through annual contracts, beginning with procurement though a competitive bidding process. The contract is the mechanism by which MCOs are held responsible for addressing quality of care at both the programmatic and individual provider level. They contain several requirements that are based on quality initiatives and measurements.

The IME annually evaluates the IA Health Link program through an external quality review and evaluation of national performance measures. Plans also receive financial withhold for high performance, which is referred to as "pay for performance." Pay for performance is made when plans meet performance standards in key areas described in contract Exhibit F in the plan's contract. https://dhs.iowa.gov/MED-16-009_Bidders-Library

The Agency requires through its contracts that each MCO establish and implement an ongoing comprehensive quality assessment and performance improvement program for the services it furnishes to its members and requires that it include the following elements.

- Performance improvement projects
- Collect and submit performance measurement data
- Includes mechanisms to detect both underutilization and overutilization of services
- Mechanisms to assess the quality and appropriateness of care furnished to enrollees with special health care needs
- LTSS
    - Mechanisms to assess the quality and appropriateness of care furnished to enrollees using long-term services and supports, including assessment of care

between care settings and a comparison of services and supports received with those set forth in the enrollee's treatment/service plan
- Participate in efforts to prevent, detect, and remediate critical incidents that are based on the requirements on the Agency for home and community-based waiver programs.

The Agency reviews annually, the quality assessment and performance improvement of each MCO.

PERFORMANCE MEASURMENT

438.350 EXTERNAL QUALITY REVIEW

An external quality review (EQR) of the MCOs is conducted annually related to quality outcomes, timeliness, and access to the services covered under each contract. The external quality review organization (EQRO), HSAG, reviews measures that include but are not limited to:

- Availability of services
- Credentialing and re-credentialing of providers
- Confidentiality and security
- Medical records content/retention
- Member education/prevention programs
- Coverage and authorization of services
- Cultural competency
- Enrollment/disenrollment timeliness
- Grievances and appeals
- Coordination and continuation of care
- Contract evaluation
- Encounter data
- Quality assurance plan

With a focus on the above measures, HSAG is responsible for the following:

- Validation of Performance Improvement Projects
- Validation of Performance Measures
- Review of compliance with access, structural and operations standards
- Network adequacy and capacity standards
- Encounter Data Validation
- Technical Report
- Review of Potentially Preventable Events

NATIONAL PERFORMANCE MEASURES In compliance with state and federal regulations, the MCOs submit quality improvement data to the IME on a monthly, quarterly, and annual basis. This includes data on the status and results of quality improvement projects.

HEDIS and CAHPS measures will be obtained and reported by for each MCO on an ongoing basis to assess the healthcare outcomes identified.

Review of National Performance Measures:

Health Effectiveness Data and Information Set (HEDIS) measures

> HEDIS is a comprehensive set of standardized performance measures designed to provide purchasers and consumers with the information they need for reliable comparison of health plan performance. HEDIS Measures relate to many significant public health issues, such as cancer, heart disease, smoking, asthma, and diabetes.

CAHPS

> The MCOs conduct CAHPS, which is a national instrument for measuring such issues as perceived access, perceived quality of services, perceived difficulty accessing primary care, and perceived difficulty accessing specialist care.

Member input is obtained through an annual member satisfaction survey. The MCOs shall conduct CAHPS, which is a national instrument for measuring such issues as perceived access, perceived quality of services, perceived difficulty accessing primary care, and perceived difficulty accessing specialist care. Our approach is that of comparison of Managed Care programs.

National Committee for Quality Assurance (NCQA) publishes annual Health Insurance Plan Ratings that are related on a scale of 0-5 with 0 being the lowest moving up to 5 in .5 increments. This measures health care quality, patient satisfaction, and accreditation standards scores.

Also listed in the EQR Technical Reports are HEDIS scores for the calendar year for each MCO that was eligible to submit them. These scores are validated and compared to scores from the previous year, noting the changes in percentage when appropriate. In the Technical Report, HSAG then assigned star ratings to each measure using the following scale:

5 stars – At or above the 90th percentile
4 stars – At or above the 75th percentile but below the 90th percentile
3 stars – At or above the 50th percentile but below the 75th percentile
2 stars – At or above the 25th percentile but below the 50th percentile
1 star – Below the 25th percentile

In addition to this rating system, HSAG is also in process of developing an MCO scorecard, using HEDIS and CAHPS measures to calculate and evaluate categories of measures such as:

- Doctors’ Communication and Patient Engagement
- Access to Preventive Care
- Women’s Health
- Living With Illness

- Behavioral Health
- Medication Management

The evaluation and results of for all of the PIPs listed above, as well as for all other EQR activities completed in each calendar year, can be found in the EQR Technical Reports, which are currently posted on the Department's website: https://dhs.iowa.gov/ime/about/performance-data/annualreports

PAY FOR PERFORMANCE MEASURES

Plans are eligible to earn withhold payments for meeting pay for performance standards on certain measures identified in Exhibit F of their contract. Full contracts are published on the Department's website at: https://dhs.iowa.gov/MED-16-009_Bidders-Library.

Over the last several years, pay for performance measures identified in the MCO contracts have fallen into a number of different categories:

Year 1	Year 2	Year 3	Year 4/Year 1	Year 5/Year2
SFY17	SFY18	SFY19	SFY20	SFY21
Jul 2016 – Jun 2017	Jul 2017 – Jun 2018	Jul 2018 –Jun 2019	Jul 2019 – Jun 2020	Jul 2020 – Jun 2021
Prior Authorization Processing	Value Based Purchasing - Provider Incentives	Encounter Data Reconciliation	Encounter Data Reconciliation	Encounter Data Reconciliation
Timely Claims Reprocessing	Children's Access to Care - HEDIS (CAP)	Timely Claims Reprocessing	Timely Claims Reprocessing	Timely Claims Reprocessing
Completion of Initial Health Screening	Adult Access to Care - HEDIS (AAP)	Interdisciplinary Team Planning - Questions	Provider Network	*Follow-up After Hospitalization for Mental Illness (ages 6+) <CMS Core Set Measures>

Provider Credentialing	Provider Network - PCP and BHP	IPES - Questions 401 - Part of Service Planning	Provider Credentialing	*Follow-up After Emergency Department Visit for Mental Health <CMS Core Set Measures>
Provider Network	Provider Network - HCBS	LTSS - Increase Participation in Employment Activities	Prior Authorizations	*LTSS: Balancing Toward Community-Based Services
	Appeals - Timely within 25 days	Reduce rate of Emergency Department (ED) Use	Health Screenings	**Social Determinants of Health (SDOH)

*Measures impacted by COVID-19 and percentages updated to 0%
**Measure added mid-year to replace COVID-19 impacted metrics

PERFORMANCE IMPROVEMENT PROJECTS

The Agency requires each MCO to report the status of each project conducted annually.

Performance Improvement Projects have been conducted over the last several years as part of the EQR process.

In Calendar Year (CY) 2017, DHS determined that the first two state-mandated Performance Improvement Project (PIP) topics to be initiated by the MCOs would be:

- Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10. Specific interventions implemented by the MCOs to address the Member Satisfaction PIP included:
    - Conducting post-call survey audits of customer service representatives and providing coaching, feedback, and additional training as needed.
    - Providing medical education training and credits to improve communication skills, build patient trust, and expand knowledge of the CAHPS survey.
    - Development of a New Member Quick Reference Guide— A one-page quick-start guide for new members. Member education presentations on this guide were offered at town hall meetings.

- Improving Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life. Specific interventions implemented by the MCOs to address the Well Child Visits PIP included:
    - Conducting telephonic outreach to members who have not had their well-child exam to assist them in scheduling an appointment.
    - Sponsoring clinic days at provider offices to promote preventive well-child visits.
    - Implementing an incentive program to encourage well-child exams

In CY2020, DHS determined that the MCOs should initiate PIPs on two new topics:

- Timeliness of Postpartum Care
- CAHPS Measure – Customer Service at Child's Health Plan Gave Information or Help Needed

The MCOs are currently working on designing the specific interventions they will implement to improve this measure.

MEMBER SATISFACTION

ENROLLMENT/ ASSIGNMENT/ DISENROLLMENT

Iowa uses a default enrollment program for MCO assignment. Upon approval, members are given the choice of which MCO they would like to be assigned. If a member fails to make a choice, the member is assigned to a default MCO. Members may change their MCO selection at any time during the first 90 days of their initial enrollment or during the 60 days following their renewed enrollment in the program. Following the 90 days of enrollment, a member may request to disenroll if good cause exists. Examples of "good cause" include availability of network providers, their chosen provider switches networks, member needs related services, or other reasons related to lack of services. In addition, a change may occur if a new MCO becomes available.

In accordance with the managed care contracts, to request disenrollment for cause, the member must file an oral or written request to address the issue through the MCO's grievance system. This allows the MCO the opportunity to attempt to resolve the concern. The MCO follows the timelines of an expedited grievance. If the member remains dissatisfied with the outcome, the MCO must direct the member (as well as member representative) to the Enrollment Broker to request disenrollment. The MCO then provides a copy of the member's grievance record to the Enrollment Broker to allow the Enrollment Broker to render a recommendation for the Department review regarding approval or denial of the disenrollment request.

Outside of these circumstances, however, the member is required to remain with the final MCO. This period is referred to as the extended participation program (EPP).

Per managed care contracts, the MCO shall not disenroll an enrollee or encourage a member to disenroll because of:

- Member health care needs
- A change in health care status

- The enrollee's utilization of:
    - Medical services
    - Diminished capacity
    - Uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees).

In instances where the exception is true, the MCO shall provide evidence to the State that continued enrollment of an enrollee seriously impairs the MCO's ability to furnish services to either this particular enrollee or other enrollees. The MCO shall have methods by which the State is assured that disenrollment is not requested for any other reason. State-initiated disenrollment may occur based on changes in circumstances including:

- Ineligibility for Medicaid
- Shift to an eligibility category not covered by the contract
- Change of place of residence to another state
- The Department has determined that participation in HIPP is more cost-effective than enrollment in the contract
- Death

Members may request disenrollment from an MCO according to the following guidelines:

- For "good cause", at any time.
- Without cause, at the following times:
    - During the 90 days following the date of the member's initial enrollment with the MCO or the date the State sends the member notice of the enrollment, whichever is later. At least once every 12 months thereafter.
    - Upon automatic reenrollment of a member who is disenrolled solely because he or she loses Medicaid eligibility for a period of 2 months or less, if the temporary loss of Medicaid eligibility has caused the member to miss the annual disenrollment opportunity.

A member who is terminated from an MCO solely because they have lost Medicaid eligibility for a period of two months or less is automatically be re-enrolled into the same MCO upon regaining eligibility.

GRIEVANCE AND APPEALS REPORTING

MCOs provide IME with quarterly grievance and appeals reports that provide information on timely resolution of standard and expedited grievances and appeals and the top 10 reasons for grievances and appeals. IME reviews these reports to ensure member issues are addressed timely and to investigate systemic issues apparent in grievance and appeals reasons. IAC 441--88.8(5)

ENROLLED RECIPIENTS SUMMARY

This report allows verification of the algorithm for enrollment and categorizes the disenrollments and enrollments for the reporting period as follows:

- Total Enrollment in Managed Care
- Enrollments as ‘Default’
- Enrollments as ‘Self-Selection’
- Disenrollment Reasons for Good Cause

TELEPHONE STATISTICS

The Telephone Statistics Report demonstrates the call volume and effectiveness of the MCO call centers. The system records the volume of calls received, wait time to speak with a representative, and dropped calls as compared to contractual service levels. The report is reviewed quarterly to look for specific increases and is addressed by IME staff.

MEMBER SATISFACTION SURVEYS

The MCOs are responsible to conduct the IPES with a statistically valid random sample of the HCBS Waiver and HCBS Habilitation populations on a quarterly basis. The IPES report is an important measure of the member’s satisfaction and experience receiving HCBS Waiver or Habilitation services. The IPES report is reviewed quarterly and used to provide training and technical assistance intended to improve or enhance the overall HCBS experience for members.

The MCOs provide to the Department the survey results from the annual independent CAHPS. The CAHPS program is a multi-year initiative of the Department for Healthcare Research and Quality (AHRQ). Its purpose is to support investigator-led research to better understand patient experience with health care and develop scientifically valid and feasible strategies and tools to:

- Assess patient experience.
- Report survey results.
- Help organizations use the results to improve the quality of care

The quality committee analyzes the findings of the CAHPS to identify required performance improvement activities, make the findings available to stakeholders and have the EQRO validate the findings.

MCOs may conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The quality committee analyzes the findings of the survey to identify required performance improvement activities, make the findings available to stakeholders and have the EQRO validate the findings.

Iowa's MCOs are contractually required to conduct initial health risk screenings for new members, within 90 days of enrollment for the purpose of assessing need for any special health care or care coordination services. During the initial health risk screening process, members are offered assistance in arranging a visit with their PCP (as applicable) for a baseline medical assessment and other preventive services, including an assessment or screening of the member’s potential risk, if any, for specific diseases or conditions. Information collected assesses the member’s physical, behavioral, social, functional and psychological status and needs and determines the need for care coordination, behavioral health services, or any other health or community services. The tool shall also comply with NCQA standard for health risk

screenings and contain standardized questions provided by the Department that tie to social determinants of health, including a health confidence indication.

IMPROVEMENTS

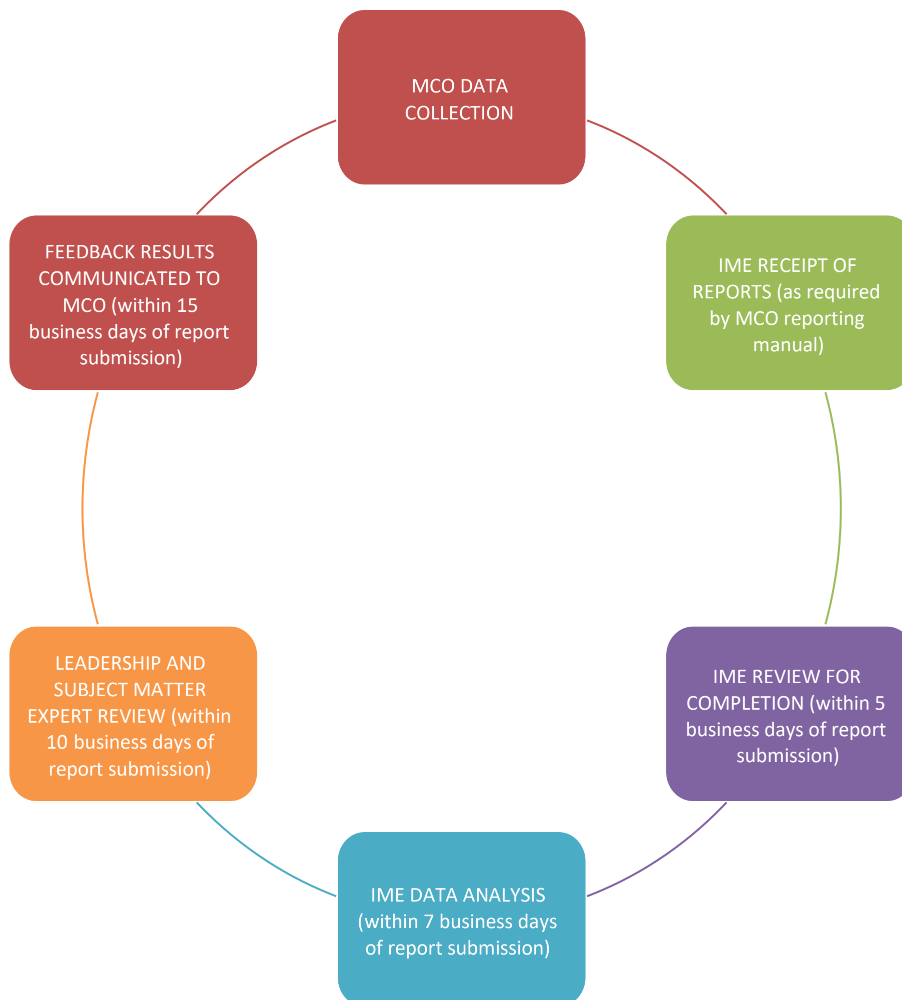
MCOs represent a critical lever in improving the health of low-income and vulnerable populations. Improvements are be based on best practices. The Department leverages and manages Value-Based Purchasing contracts that tie payments to health outcomes. For more information, refer to Pay for Performance under Evaluation. Continuous quality improvement related to health outcomes of the population is stated in each MCO's contract and is required by federal managed care regulation 42 CFR 438.240, which describes measurement and intervention in clinical and non-clinical care areas designed to achieve significant and sustained improvement. For more information, refer to External Quality Review under Evaluation.

CONTRACT COMPLIANCE

The state has clearly described MCO performance standards within each MCO's contract. These are terms that were deliberately considered and articulated to ensure accountability and reward excellence. The IME requires timely and accurate reporting on all state standards and follows a standardized process for reviewing reports and providing feedback to MCOs. This process along with feedback letters and templates ensures that quality issues are addressed and resolved quickly.

Upon receipt of reports, IME Managed Care Bureau staff review all reports for completion within 5 days of report submission. After confirming all required elements have been reported, the IME trend and analyzes data. When data analysis is complete, the original MCO report and analysis summary are forwarded to subject matter experts (SMEs) and IME leadership. SMEs and IME leadership provide feedback, which is communicated through MCO account managers, who serve as the IME's liaisons to the MCOs.

MONITORING CYCLE



REPORTING TRANSPARENCY

IME is committed to providing quarterly and annual reports that accurately demonstrate managed care program performance. Reports focus on contractual performance guarantees that include management of specific populations, consumer supports, and program operations.

After evaluation, the format of the quarterly performance report (QPR) and annual performance report (APR) was updated for SFY2021. The new format allows for greater ease of comparison between different quarters of the state fiscal year, as well as between MCOs. Information currently found in the updated version includes:

- MCO Member Summary
- MCO Financial Summary
- Claims Summary (Non-Pharmacy)

- Claims Summary (Pharmacy)
- Prior Authorizations
- Grievances and Appeals
- MCO Care Quality and Outcomes
- MCO Children Summary
- Long Term Services - Care Quality and Outcomes
- Call Center Performance Metrics
- MCO Program Integrity
- MCO COVID-19 Summary

The updated format also condenses the report information into fewer pages, while at the same time adding information that was not previously included in the report. This newly added information includes:

- Lists and counts of the most frequently used HCBS services per quarter (identified by waiver)
- Enrollment, screening, and immunization totals for children in Medicaid per quarter
- COVID-19 related information, including totals regarding testing, service usage and telehealth

The change in report format can be observed through the quarterly and annual performance reports that are posted on the DHS website at: https://dhs.iowa.gov/ime/about/performance-data.

Below are state standards that are part of the MCO contracts and have been paraphrased. Full contracts are published on the DHS website at: https://dhs.iowa.gov/MED-16-009_Bidders-Library.

CONTRACT TERMS

EVIDENCE-BASED PRACTICES

MCO quality management and utilization management programs is based on valid and reliable clinical evidence or a consensus of providers in the particular field. Evidence-based programming supports member access to care and availability of services by ensuring that inappropriate procedural barriers to care are not in place. Examples of evidence-based approaches include:

- Scheduled reviews of national utilization management policies
- Reviews of appeals metrics to identify trends
- Evaluating quality and utilization management activities that have been implemented

COORDINATION AND CONTINUITY OF CARE

Care coordination is a key strategy in improving member health and reducing duplicative services. To facilitate the care coordination process, MCOs do the following:

Perform an initial health risk screening.

MCOs use a standardized tool to assess the member's physical, behavioral, social, functional and psychological status and needs. New members should receive an initial health risk screening within 90 days, and also be offered assistance with scheduling an initial visit with their PCP if needed. MCOs submit quarterly reports that include the number of members enrolled for at least 90, the number of initial risk assessments completed within 90 days, and the average number of days to complete the initial health risk assessment. This requirement supports the identification of persons who need LTSS or persons with special health care needs.

Place members in a care coordination program based on assessed level of risk.

Care coordination programs are subject to IME approval and evaluation for eligibility in programs must follow industry standards of predictive modeling, claims review, member and caregiver requests, and physician referrals. Care coordination programs must include catastrophic case management, disease management, programs targeting overuse or abuse of services, discharge planning, and transition planning. MCOs provide the IME with quarterly reports for members identified as having special healthcare needs. Reports include the number of members per care coordinator, the number of contacts made with member, follow-up after hospital discharge, and health home enrollment.

Perform a comprehensive health risk assessment for members identified as having a special health care need.

Members identified in the initial health risk screening as having a special health care need or requiring follow-up on problem areas receive a follow-up comprehensive health risk assessment with a health care professional. The comprehensive health risk assessment is completed using a standardized tool compliant with NCQA health risk screening standards and assesses the member's need for care coordination, behavioral health services, or any other health or community service. MCOs provide the IME with quarterly reports including the number of new members enrolled for at least 90 days, the number of comprehensive health risk assessments completed, and the average number of days to complete the comprehensive health risk assessment.

Develop a care plan.

All members found eligible for the care coordination program have care plans developed by the MCO they are assigned, and have care plans shared with the member's PCP to facilitate communication and coordinate care. The care plan establishes prioritized goals and actions, facilitate seamless transitions between care settings, create a communication plan with providers and members, and monitor whether the member is receiving the recommended care.

Plans must be person-centered, reflecting cultural considerations and making the process accessible and understandable for members with disabilities and/or limited English proficiency. MCOs must conduct on-going assessment of the effectiveness of care coordination programs and processes.

Care plans must also incorporate non-clinical interventions utilizing the outcome of the initial, follow-up, or yearly health risk assessment. The care plan must address the patient's health confidence level as well as any social determinants that present barriers to health improvement or maintenance. MCOs are required to submit several reporting metrics to capture care coordination needs. Quarterly self-reporting from MCOs allows the IME to monitor the quality of care and verify that some of our most vulnerable members are receiving services.

Reassess

MCOs must have processes in place for reviewing and updating care plans on an as-needed basis, but no less often than annually. This included developing methods to identify members who need to move to a more assistive level of care immediately. Members or providers can also request reassessment at any time. MCOs provide IME with a quarterly report of care plan updates. The report includes the number of member care plans up for renewal, the number of care plans updated prior to the renewal date, the number of care plans updated after the renewal date, and the number of plans updated because of a change in need.

438.62(b) TRANSITION OF CARE POLICIES

The Agency has a transition of care policy to ensure continued access to services during a transition from FFS to a MCO entity or transition from one MCO entity to another when a member, in the absence of continued services, would suffer serious detriment to their health or be at risk of hospitalization or institutionalization.

The State makes its transition of care policy publicly available and provide instructions to members in the member handbook and can be accessed on our website. The member handbook describes how the member can access continued services upon transition.

MCOs must implement mechanisms to ensure continuity of care of members transitioning in and out of enrollment. This includes the following transitions:

- The member has access to services consistent with the access they previously had, and is permitted to retain their current provider for a period of time if that provider is not in the MCO network.
- The member is referred to appropriate providers of services that are in the network.
- The Agency, in the case of FFS, or the MCO that was previously serving the member, fully and timely complies with requests for historical utilization data from the new MCO entity.

- The member's new provider(s) are able to obtain copies of the member's medical records, as appropriate.
- Any other necessary procedures to ensure continued access to services to prevent serious detriment to the member's health or reduce the risk of hospitalization or institutionalization.
- A process for the electronic exchange of, at a minimum, the data classes and elements included in the content standard adopted at 45 CFR 170.213. Such information received by the MCO must be incorporated into the MCO's records about the current member. With the approval and at the direction of a current or former member or the member's personal representative, the MCO must:
    - Receive all such data for a current member from any other payer that has provided coverage to the member within the preceding 5 years;
    - At any time the member is currently enrolled in the MCO and up to 5 years after disenrollment, send all such data to any other payer that currently covers the member or a payer the member or the member's personal representative specifically requests receive the data; and
    - Send data received from another MCO under this paragraph in the electronic form and format it was received

- A member is able to change MCOs for the following:
    - Initial program implementation
    - Initial enrollment with the MCO
    - Transitions between MCOs during the first 90 days of enrollment
    - Transition for cause

MCO transition of care includes the following requirements:

- Transfer prior authorization and clinical data to the receiving MCO.
- The initial contract year provisions for access to out of network providers
- Provisions for members receiving
    - LTSS
    - Pregnancy continuity of care
    - Dual diagnosis continuity of care

ADDRESSING HEALTH DISPARITIES

The Department collects member race and ethnicity, as well as coverage group, age, and gender. This information is passed to MCOs through monthly and daily enrollment files. These data fields support MCO quality assurance activities and contractual requirements that MCOs are culturally competent and deliver culturally appropriate services.

Another area of MCO operations that supports reduction of health disparities is the collection and management of initial health risk assessment data, which includes Social Determinates of Health (SDOH).

Future Pay for Performance includes a Health Equity Plan that addresses health disparities as well as a Potentially Preventable Events project, which plans to break out utilization measures by subpopulations.

COVERAGE AND AUTHORIZATION OF SERVICES

MCOs have developed and must maintain a utilization management program. Mechanisms must be in place to ensure that required services are not arbitrarily denied or reduced in amount, duration, or scope solely because of the diagnosis, type of illness or condition. The IME ensures quality of coverage and service authorization by ensuring appropriate MCO staffing, reviewing MCO policies and procedures, evaluating work plans, and analyzing utilization reports.

The Utilization Management program must involve senior physicians and behavioral health practitioners. MCO staff and subcontractors cannot receive compensation that provides incentives for denying, limiting or discontinuing medically necessary services.

Utilization policies and procedures must be objective and based on medical, behavioral health and/or long-term care evidence, to the extent possible, be based on individual needs, be applied based on an assessment of the local delivery system, involve appropriate practitioners in developing, adopting and reviewing them, and be annually reviewed and up-dated as appropriate.

To ensure that utilization management is occurring appropriately, the Department monitors quarterly and annually on the following reports:

- The number of claims denials
- The number of member grievances received
- Timeliness of member grievance resolution
- The number of member appeals received
- Timeliness of member appeal resolution
- The number of prior authorizations submitted
- The number of prior authorizations approved
- Timeliness of prior authorization processing
- The most frequent reasons for prior authorization denial and modification

In addition to the information received from MCOs, the Department also receives reports from the Ombudsman addressing any MCO performance issues from the member perspective.

STRUCTURE AND OPERATIONS STANDARDS

PROVIDER SELECTION (refer to Enrollment/Assignment/Disenrollment)

ENROLLEE INFORMATION (refer to Enrollment/Assignment/Disenrollment)

CONFIDENTIALITY

The MCO shall develop, implement, and adhere to written policies and procedures, subject to Department review and approval, pertaining to maintaining the confidentiality of all medical records and other pertinent information, including, but not limited to, health and enrollment information. In compliance with 42 C.F.R. § 438.224, for medical records and any other health and enrollment information that identifies a particular Member, the MCO only uses and discloses such individually identifiable health information in accordance with the privacy requirements in 45 C.F.R. parts 160 and 164, subparts A and E), to the extent that these requirements are applicable. The MCO complies with all other applicable State and Federal privacy and confidentiality requirements. The MCO protects and maintains the confidentiality of mental health information by implementing policies for staff and through contract terms with network providers which allow release of mental health information only as allowed by Iowa Code §228. Further, the MCO protects and maintains the confidentiality of substance use disorder information, allowing the release of substance use disorder information only in compliance with policies set forth in 42 C.F.R. Part 2 and other applicable State and Federal law and regulations. The MCO shall notify IME of a HIPAA-related breach in accordance with the terms of Section 1.5 of the Contract's Special Terms. The MCO shall notify the Department within one (3) business days upon discovery of a non-HIPAA-related breach.

GRIEVANCE AND APPEALS SYSTEM

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO. Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required periods.
- For a resident of a rural area with only one MCO, the denial of services outside the network

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

- Member is unhappy with the quality of your care
- Doctor who the member wants to see is not in the MCO's network
- Member is not able to receive culturally competent care

- Member got a bill from a provider for a service that should be covered by the MCO
- Rights and dignity
- Member is commended changes in policies and services
- Any other access to care issues

The MCOs must have internal grievance and appeal procedures for members in accordance with law. The MCOs inform members of their grievance, appeal, and State fair hearing rights in the member enrollment materials. Member eligibility and eligibility-related grievances and appeals (including but not limited to long-term care eligibility and enrollment), including termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities are directed to the Department.

Members may file grievances either orally or in writing. The MCO’s policies and procedures governing grievances include provisions that allow for and assist members with the filing, notice and resolution timeframes. The written notice of the resolution includes the results of the resolution and the date it was completed. The MCOs must acknowledge receipt of each grievance within three (3) business days. The MCO must ensure that qualified health professionals involved in review or decision making were not involved in previous levels of review or decision making related to the issue filed as a grievance. The MCO shall make a decision on grievances and provide written notice of the disposition of grievance within thirty (30) calendar days of receipt of the grievance or as expeditiously as the member’s health condition requires. This timeframe may be extended up to fourteen (14) calendar days. The MCOs must maintain and report the member grievance log, which includes the status of all grievances.

Members may file appeals either orally or in writing. The MCO’s policies and procedures governing appeals include provisions that allow for and assist members with the filing, notice and resolution timeframes. The MCOs must have internal appeals procedures for members in accordance with law. Following receipt of a notification of an adverse benefit determination by the MCO, a member has 60 calendar days from the date on the adverse benefit determination notice in which to file a request for an appeal to the managed care plan. The member may request an appeal either orally or in writing. Further, unless the member requests an expedited resolution, an oral appeal must be followed by a written, signed appeal. The MCO shall direct the member to the Department Appeal and Request for Hearing form as an option for submitting a request for an appeal. The member must exhaust the first level of appeal with the MCO before requesting a state fair hearing.

SUB-CONTRACTUAL RELATIONSHIPS AND DELEGATION

The MCO is responsible for any functions and responsibilities that are delegated to a subcontractor, and is required to certify and warrant all subcontractor work. The MCO shall also ensure all written subcontracts meet the requirements of 42 C.F.R. § 434.6 and shall incorporate by reference the applicable terms and conditions of the Contract. The MCO shall notify the state in writing of all subcontracts relating to deliverables to be provided under the Contract prior to the time the subcontract(s) become effective. The Department shall have the right to request the removal of a subcontractor for good cause. Subcontractors shall be bound to the same contractual terms and conditions as the MCO.

The MCO must oversee sub activities on an ongoing basis, and conduct formal reviews of such activities at least quarterly. The Department reserves the right to audit subcontractor data. The MCO shall provide to the Department the findings of all subcontractor performance monitoring and reviews upon request and shall notify the Department any time a contractor is placed on corrective action. The MCO must submit an annual report on its subcontractors' compliance, corrective actions and outcomes of the contracted health plan's monitoring activities. The MCO is held accountable for any functions and responsibilities that it delegates.

FINANCIAL INTERVENTIONS

Performance monitoring and data analysis are critical components in assessing how well the MCO is maintaining and improving the quality of care delivered to members. The Department uses various performance targets, industry standards, national benchmarks and program" specific standards in monitoring the MCO's performance and outcomes. The Department publishes MCO performance. Failure to meet performance targets shall subject the MCO to the corrective actions as outlined in Exhibit E, Refer to Exhibit F for information on the pay-for-performance program. https://dhs.iowa.gov/MED-16-009_Bidders-Library

§ 438.700 Basis for imposition of sanctions.

The Agency may establish intermediate sanctions that it may impose if it makes any of the following determinations. The Agency may base its determinations on findings from onsite surveys, enrollee or other complaints, financial status, or any other source.

The Agency determines that an MCO acts or fails to act as follows:

- Fails substantially to provide medically necessary services that the MCO is required to provide, under law or under its contract with the Agency, to a member covered under the contract.
- Imposes on members premiums or charges that are in excess of the premiums or charges permitted under the Medicaid program.
- Acts to discriminate among members on the basis of their health status or need for health care services. This includes termination of enrollment or refusal to reenroll a beneficiary, except as permitted under the Medicaid program, or any practice that would reasonably be expected to discourage enrollment by beneficiaries whose medical condition or history indicates probable need for substantial future medical services.
- Misrepresents or falsifies information that it furnishes to CMS or to the Agency.
- Misrepresents or falsifies information that it furnishes to a member, potential member, or health care provider.
- Fails to comply with the requirements for physician incentive plans.

The Agency determines that an MCO has distributed directly or indirectly through any agent or independent contractor, marketing materials that have not been approved by the Agency or that contain false or materially misleading information.

REVISION PROCESS FOR QUALITY STRATEGY

The Medicaid Quality Strategy undergoes a formal review by the IME Quality Committee no less than once every three years. The IME Quality Committee also reviews and approves or denies

any updates or changes to the Quality Strategy as needed. As part of the IME Quality Committee's formal review of the Medicaid Quality Strategy once every three years, the Quality Committee also conducts a formal evaluation of the effectiveness of the Quality Strategy over those previous three years. The results of the Quality Committee's formal review and evaluation is documented and posted on the IME website once CMS review is completed. The IME Quality Committee's formal review and evaluation also includes review of all recommendations identified in the External Quality Review Technical Report for the previous year.

"Significant change" to the Iowa Medicaid Quality Strategy is defined as any change that is made which requires the addition or removal of entire processes or measures from the document.

The initial draft of the Medicaid Quality Strategy is also be made available to all members of the MAAC within 30 days of its completion. All committee feedback is taken into consideration in the development of the next Quality Strategy.

Due to members of American Indian descent having the choice to participate in Medicaid managed care through an MCO, PIHP, or PAHP, Iowa's Tribal Consultation policy is followed in regards to the Medicaid Quality Strategy.

Once the initial draft of the Medicaid Quality Strategy has been through the MAAC committee and Tribal Consultation reviews, a copy is submitted to CMS for comment and approval before finalization. This process is completed every time a significant change is made to the Medicaid Quality Strategy.

QUALITY STRATEGY REVIEW 2021

The Quality Committee as defined in this strategy, reviewed the 2018 Quality Strategy and made updates as identified through a review process that included referencing updated CFR, changes in MCOs, updates to measures, and quality improvement activities. The Quality Committee also incorporated CMS feedback into our 2021 Quality Strategy.

GLOSSARY

Abandonment Rate: Percentage of unanswered calls abandoned by the caller after 30 seconds of the call entering the queue. (E.g., caller hangs up before speaking to anyone after waiting more than 30 seconds in a queue.)

Administrative Loss Ratio (**ALR**): See Financial Ratios

Adult Day Care: An organized program of supportive care in a group environment. The care is provided to members who need a degree of supervision and assistance on a regular or intermittent basis in a day care setting.

All Cause Readmissions: This measure looks at the rate of provider visits within 30 days of discharge from an acute care hospital per 1,000 discharges among beneficiaries assigned.

AIDS/HIV Waiver: A HCBS waiver that offers services for those who have been diagnosed with AIDS or HIV.

Appeal: An appeal is a request for a review of an adverse benefit determination. A member or a member's authorized representative may request an appeal following a decision made by an MCO. Actions that a member may choose to appeal:

- Denial of or limits on a service.
- Reduction or termination of a service that had been authorized.
- Denial in whole or in part of payment for a service.
- Failure to provide services in a timely manner.
- Failure of the MCO to act within required periods.
- For a resident of a rural area with only one MCO, the denial of services outside the network

Members may file an appeal directly with the MCO. If the member is not happy with the outcome of the appeal, they may file an appeal with DHS or they may ask to ask for a state fair hearing.

Brain Injury (**BI**) **Waiver**: A HCBS waiver that offers services for those who have been diagnosed with a brain injury due to an accident or an illness.

Capitation Expenditures: Medicaid payments the Department makes on a monthly basis to the MCOs for member health coverage. MCOs are paid a set amount for each enrolled person assigned to that MCO, regardless of whether services are used that month. Capitated rate payments vary depending on the member's eligibility.

- **Adjustments**: Monetary only payments/adjustments that can occur within the paid month for same month or prior months
    - Example - Recoup and repay when rate changes occur
- **Current**: Payments that occur within the paid month for same month
- **Retro**: Payments for months prior to the current month for member months not previously paid for

- Member months are counted if the request is to provide member months within a specific date range for more than one month
- Data is not pulled by paid date, but by eligibility month

Care Coordinator: A person who helps manage the health of members with chronic health conditions.

Case Manager: See Community Based Case Management (CBCM)

Centers for Medicare and Medicaid Service (**CMS**): A federal Department that administers the Medicare program and works in partnership with state governments to administer Medicaid standards.

Children's Mental Health (**CMH**) **Waiver**: A HCBS waiver that offers services for children up to age 18, who have been diagnosed with a serious emotional disturbance.

Children's Health Insurance Program (**CHIP**): A federal program administered by state governments to provide health care coverage for children and families whose income is too high to qualify for Medicaid, but too low to afford individual or work-provided health care.

Claims: What providers submit to the MCOs or the Department in order to receive payment for services rendered.

- **Paid**: Claim is received and the provider is reimbursed for the service rendered.
- **Denied**: Claim is received and services are not covered benefits, are duplicate, or have other substantial issues that prevent payment.
- **Provider Adjustment Requests and Errors Reprocessed**: Claims where the provider may request a reopening to fix clerical errors or billing errors; or claims identified by the MCOs as erroneously paid or denied which are corrected
- **Suspended**: Pending internal review for medical necessity and/or may need additional information to be submitted for processing
- **Run Out**: Additional time for providers to submit claims for services rendered.

Clean Claims: The claim is on the appropriate form, identifies the service provider that provided service sufficiently to verify, if necessary, affiliation status, patient status and includes any identifying numbers and service codes necessary for processing.

Community: A natural setting where people live, learn, work, and socialize.

Community Based Case Management (**CBCM**): Helps LTSS members manage complex health care needs. It includes planning, facilitating and advocating to meet the member's needs. It promotes high quality care and cost effective outcomes. CBCMs make sure that the member's care plan is carried out. They make updates to the care plan as needed.

Consumer Directed Attendant Care (**CDAC**): Helps people do things that they normally would for themselves if they were able. CDAC services may include unskilled tasks such as bathing, grocery shopping, household chores or skilled tasks such as medication management, tube feeding, recording vital signs. CDAC providers are available through a Department or from an individual such as a family member, friend, or neighbor that meets eligibility requirements.

Denied Claims: See Claims

Department of Human Services (**DHS**): The state's health and social services Department.

Disenrollment: Refers to members who have chosen to change their enrollment with one MCO to an alternate MCO.

Dual: Members who have both Medicare and Medicaid benefits.

Durable Medical Equipment (**DME**): Reusable medical equipment for use in the home. It is rented or owned by the member and ordered by a provider.

Elderly Waiver: A HCBS waiver that offers services for elderly persons. An applicant must be at least 65 years of age.

Financial Ratio: The Affordable Care Act requires insurance companies to spend at least 80% or 85% of premium dollars on medical care. In Iowa, the Medical Loss Ratio (MLR) for MCOs is contractually set at 88%.

- **Administrative Loss Ratio** (**ALR**): The percent of capitated rate payments an MCO spends on administrative costs.
- **Medical Loss Ratio** (**MLR**): The percent of capitated rate payments an MCO spends on claims and expenses that improve health care quality of Medicaid members.
- **Underwriting Ratio** (**UR**): If total expenses exceed capitated rate payments, an underwriting loss occurs. If total capitated rate payments exceed total expenses, an underwriting profit occurs.

Grievance: Members have the right to file a grievance with their MCO. A grievance is an expression of dissatisfaction about any matter other than a decision. The member, the member's representative or provider who is acting on their behalf and has the member's written consent may file a grievance. The grievance must be filed within 30 calendar days from the date the matter occurred. Examples include but are not limited to:

- The member is unhappy with the quality of your care.
- The doctor who the member wants to see is not in the MCO's network.
- The member is not able to receive culturally competent care.
- The member got a bill from a provider for a service that should be covered by the MCO.
- Rights and dignity.
- The member is commended changes in policies and services.
- Any other access to care issues.

Habilitation (**Hab**) **Services**: A program that provides HCBS for Iowans with the functional impairments typically associated with chronic mental illnesses.

Health & **Disability** (**HD**) **Waiver**: A HCBS waiver that offers services for those persons who are blind or disabled. An applicant must be less than 65 years of age for this waiver.

Healthy and Well Kids in Iowa (**Hawki**): In Iowa, CHIP is offered through the Hawki program. Hawki offers health coverage, through a MCO, for uninsured children of working families. A family who qualifies for Hawki may have to pay a monthly premium.

Home Delivered Meals: Meals that are prepared outside of the member's home and delivered to the member.

Home Health Aide: Medical services that provide direct personal care. This may include assistance with oral medications, eating, bathing, dressing, personal hygiene, accompanying member to medical services, transporting member to and from school or medical appointments, and other necessary activities of daily living that is intended to prevent or postpone institutionalization.

Homemaker Services: Services provided when the member lives alone or when the person who usually performs these functions for the member needs assistance. Homemaker service is limited to essential shopping, limited house cleaning, and meal preparation.

Home and Community Based Services (**HCBS**): Types of person-centered care delivered in the home and community. A variety of health and human services can be provided. HCBS programs address the needs of people with functional limitations who need assistance with everyday activities, like getting dressed or bathing. HCBS are often designed to enable people to stay in their homes, rather than moving to a facility for care.

Inpatient Admissions: A member has formally been admitted to a hospital to receive care.

Intellectual Disability (**ID**) **Waiver**: A HCBS waiver that offers services for persons who have been diagnosed with an intellectual disability.

Intermediate Care Facilities for the Intellectually Disabled (**ICF/ID**): The ICF/IID benefit is an optional Medicaid benefit. The Social Security Act created this benefit to fund "institutions" (4 or more beds) for individuals with intellectual disabilities, and specifies that these institutions must provide "active treatment," as defined by the Secretary. Currently, all 50 States have at least one ICF/IID facility. This program serves over 100,000 individuals with intellectual disabilities and other related conditions. Most have other disabilities as well as intellectual disabilities. Many of the individuals are non-ambulatory, have seizure disorders, behavior problems, mental illness, visual or hearing impairments, or a combination of the above. All must qualify for Medicaid assistance financially.

Iowa Health and Wellness Plan (**IHAWP**): The Iowa Health and Wellness Plan covers Iowans, ages 19-64, with incomes up to and including 133 percent of the Federal Poverty Level (FPL). The plan provides a comprehensive benefit package and is part of Iowa's implementation of the Affordable Care Act or Medicaid expansion.

Iowa Insurance Division (**IID**): The state regulator, which supervises all insurance business, transacted in the state of Iowa.

Iowa Medicaid Enterprise (**IME**): The division of DHS that administers the Iowa Medicaid Program.

Iowa Participant Experience Survey (**IPES**): A survey tool developed for use with HCBS programs that asks members about the services they receive, and where the service is provided.

Level of Care (**LOC**): Members asking for HCBS waivers or facility care must meet Level of Care criteria. These must be consistent with people living in a care facility such as a nursing facility. Level of Care is determined by an assessment approved by DHS.

Long Term Services and Supports (**LTSS**): Medical and/or personal care and supportive services needed by individuals who have lost some capacity to perform activities of daily living, such as bathing, dressing, eating, transfers, and toileting, and/or activities that are essential to daily living, such as housework, preparing meals, taking medications, shopping, and managing money.

M-CHIP: Refers to Medicaid CHIP, or Medicaid expansion. M-CHIP provides coverage to children ages 6-18 whose family income is between 122 and 167 percent of the Federal Poverty Level (FPL), and infants whose family income is between 240 and 375 percent of the FPL.

Managed Care Organization (**MCO**): A health plan contracted with DHS to provide Iowa Medicaid members with comprehensive health care services, including physical health, behavioral health, and LTSS.

Medicaid: Provides medically necessary health care coverage for financially needy adults, children, parents with children, people with disabilities, elderly people and pregnant women. Also known as Title XIX under the Social Security Act.

Medicaid Expansion: See Iowa Health and Wellness Plan (IHAWP) and/or M-CHIP

Medicaid Fraud Control Unit (**MFCU**): A division within the Iowa Department of Inspections & Appeals whose primary goal is to prevent abuse of taxpayer resources through professional investigation of criminal activity. MFCU staffs experienced criminal investigators, auditors, and attorneys to achieve this goal.

Medical Loss Ratio (**MLR**): See Financial Ratios

Mental Health Institute (**MHI**): Provide short-term psychiatric treatment and care for severe symptoms of mental illness. Iowa has two MHIs located in **Cherokee** and **Independence**. The services at each MHI vary.

Nursing Facility (**NF**): Provide 24-hour care for individuals who need nursing or skilled nursing care.

Non-Emergent Use: Illnesses or injuries that are generally not life threatening and do not need immediate treatment at an Emergency Department.

Non-Emergency Medical Transportation (**NEMT**): Services are for members with full Medicaid benefits, who need travel reimbursement or a ride to get to their medical appointments.

Physical Disability (**PD**) **Waiver**: A HCBS waiver that offers services for persons who are physically disabled. An applicant must be at least 18 years of age, but less than 65 years of age.

Prior Authorization (**PA**): Some services or prescriptions require approval from the MCO for them to be covered. This must be done before the member gets that service or fills that prescription.

Primary Care Provider (**PCP**): A physician, a physician assistant or nurse practitioner, who directly provides or coordinates member health care services. A PCP is the main provider the member sees for checkups, health concerns, health screenings, and specialist referrals.

Program Integrity (**PI**): Program Integrity (PI) is charged with reducing fraud, waste and abuse in the Iowa Medicaid program.

Provider Adjustment Requests and Errors Reprocessed: See Claims

Provider Network Access: Each MCO has a network of providers across Iowa who their members may see for care. Members do not need to call their MCO before seeing one of these providers. Before getting services from providers, members should show their ID card to ensure they are in the MCO network. There may be times when a member needs to get services outside of the MCO network. If a needed and covered service is not available in-network, it may be covered out-of-network at no greater cost to the member than if provided in-network.

Psychiatric Medical Institute for Children (**PMIC**): Institutions, which provide more than 24-hours of continuous care involving long-term psychiatric services to three or more children in residence. The expected periods of stay for diagnosis and evaluation are fourteen days or more and for treatment, the expected period of stay is 90-days or more.

Run Out: See Claims

Service Level (**SL**): In relation to call centers, service level is defined as the percentage of calls answered within a predefined amount of time.

Service Plan: Plan of services for HCBS members. A member's service plan is based on the member's needs and goals. The member and their interdisciplinary team to meet HCBS Waiver criteria create it.

Skilled Nursing Care: See Nursing Facility

Suspended Claims: See Claims

Temporary Assistance for Needy Families (**TANF**) **Adult and Child**: A program to help needy families achieve self-sufficiency.

Third-Party Liability (**TPL**) **Recovered**: Third party payments include recoveries from health insurance coverage, settlements or court awards for casualty/tort (accident) claims, product liability claims (global settlements), medical malpractice, worker's compensation claims, etc. This means all other available TPL resources must meet their legal obligation to pay claims for the care of an individual eligible for Medicaid. By law, Medicaid is generally the payer of last resort, meaning that Medicaid only pays claims for covered items and services if there are no other liable payers.

Underwriting Ratio (**UR**): See Financial Ratios

Value Added Services (**VAS**): Optional benefits provided by the MCOs.

Value Based Purchasing (**VBP**) **Agreement**: An agreement that holds health care providers accountable for both the cost and quality of care they provide by providing payment to improved performance.

Waivers: See Home and Community Based Services (HCBS) or specific waivers listed above.

Waiver Service Plan: See Service Plan