



Department of
HUMAN SERVICES

*Iowa Medicaid Managed Care
Quality Assurance System*

2018

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INTRODUCTION

GOALS

The overarching goal of the quality plan and managed care is to improve the health of Iowa Medicaid members. Over half a million Iowans receive health benefits from Iowa Medicaid, and it is our duty to ensure that the healthcare provided is meeting the needs of members. The triple aim goal is to improve outcomes, improve patient experience, and ensure that Medicaid programs are financially sustainable.

In alignment with the triple aim, each MCO will participate in value based purchasing (VBP) activities that effectively move the healthcare system from volume to value and increase cross sector engagement in population health improvement. The focus of these activities will be on value outcomes that connect each payer to communities and health systems to work together to produce healthier people and a system that is affordable and sustainable. Specifically, the department's managed care program aims to accomplish the following.

- Promote appropriate utilization of services within acceptable standards of medical practice.
- Ensure access to cost-effective healthcare through contract compliance by:
 - Timely review of managed care network adequacy reports
 - Incentivizing high performance in national Children's Access to Care and Adult Access to Care measures through financial incentives
- Comply with State and Federal regulatory requirements through the development and monitoring of quality improvement policies and procedures by:
 - Annually reviewing and providing feedback on managed care quality strategies
 - Quarterly reviewing managed care organization quality meeting minutes
- Healthcare costs are reduced while quality is improved by the end of 2019 by:
 - Increasing provider participation and covered lives in accountable care organizations (ACOs) to 50%
 - Decreasing Total Cost of Care (TCOC) 15% below trend
 - Reducing the rate of potentially preventable readmissions and potentially preventable ED visits both by 20%
 - Increase the utilization of a health risk screening tool that collects standardized social determinant of health data and measures patient confidence that ties those results to value-based purchasing agreements.
- Provide care coordination to members based on health risk assessment (HRA) by:
 - Quarterly monitoring of 70% initial HRA completion within 90 days of enrollment
- Ensure that transitions of care do not have adverse effects by:
 - Maintaining historical utilization file transfers between the Agency and MCOs include the information needed to effectively transfer members
 - Monitoring community rebalancing to ensure that members choosing to live in the community remain in the community
- Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist managed care plans with implementation of improvement strategies through:
 - Chartering a collaborative quality management committee that meets at least quarterly
 - Regularly monitoring health outcomes measure performance

- Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic care by focusing on specific populations. The income maintenance worker collects race and ethnicity as reported by the individual on a voluntary basis during the eligibility process.
- Promote the use and interoperability of Health Information Technology between providers, managed care organizations and Medicaid.

HISTORY

The Iowa Medicaid Enterprise (IME) is the division of the Iowa Department of Human Services (DHS) that administers the Medicaid program. Iowa's first managed care program began in 1990 when Iowa implemented a pilot Primary Care Case Management (PCCM) program called MediPASS in seven counties. The PCCM program was implemented to decrease costs, decrease inappropriate emergency department use, increase office visits, and improve quality of health.

In 1995, the Iowa Medicaid Program implemented a 1915(b) waiver for a behavioral health managed care carve-out. This became a three party contract when the Iowa Department of Public Health (IDPH) joined the managed care effort for the administration of substance abuse treatment services using block grant funding. This program is commonly referred to as the Iowa Plan. The Iowa Plan enrolled almost all of the Iowa Medicaid population and excluded only those who were residents in the State owned resource centers, those who had limited benefit packages, and those who had a spend-down requirement.

In 2012, Meridian Health Plan began providing healthcare services to members in select counties. The plan provided ambulatory health services, and was an alternative to the PCCM program for members in managed care benefit groups (like MediPass). During its operations, Meridian Health Plan served over 46,000 Iowans.

In 2014, Iowa Wellness Plan (Iowa's Medicaid Expansion program) members began receiving managed dental services through Delta Dental of Iowa. An innovative approach to care management, the plan provided a tiered benefit package that expanded benefits for members receiving preventive care.

In 2015, the Iowa Wellness Plan began a PCCM model similar to the MediPass program that provided incentive payments to providers based on the Value Index Score (VIS) used to determine quality standards of the composite score of key domains.

The VIS examines the overall value of care provided to a provider's member population. The Value Index Domains are: member experience, primary and secondary prevention, tertiary prevention, population health status, continuity of care, chronic and follow-up care, and efficiency. The VIS is still being used by managed care organizations today to assess Iowa's health systems.

In 2016, nearly all Iowa Medicaid members, including members receiving long-term services and supports (LTSS), were transitioned to the Iowa Health Link program, and began receiving benefits through one of three contracted managed care organizations (MCOs). MCOs operating

in Iowa are Amerigroup of Iowa and UnitedHealthcare Plan of the River Valley. Today the Iowa Health Link program has more than 600,000 members in all 99 counties.

OVERVIEW

This document is an attempt to summarize the existing strategies that have been or are being implemented 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 were procured through a competitive bidding process. Contractually the managed care organizations are held responsible for addressing quality of care related problems at both the programmatic and individual provider level. The contracts contain several requirements that are based on quality initiatives and measurements, and were specifically designed to support the goals listed in the quality plan.

STATE STANDARDS

ADVISORY COMMITTEES

The state aims to promote appropriate utilization of services within acceptable standards of medical practice. Chief among these efforts are the required committees. The first of these required committees is the quarterly-held Stakeholder Advisory Board facilitated by each of the MCOs. 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 the Stakeholder Advisory Board is comprised of members and/or their representatives. Provider membership includes representatives of different services covered, such as nursing facility providers, behavioral health providers, primary care, and other service providers. MCOs have plans in place to encourage participation, and will 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, MCOs will 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 decisions, 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.

Periodically, IME seeks input from several sources to determine the focus of quality improvement activities. This input can come from other governmental agencies such as the Department of Public Health or the Department of Education, both of which operate programs designed for early identification and assessment of disease processes. Indeed, the

immunization patterns of all Iowa children are monitored through a working relationship between these two agencies. It is, therefore, important that efforts aimed at treatment or supplying necessary medical intervention are coordinated with payers of services.

In addition to interagency cooperation, input to the quality plan is reviewed periodically by significant entities. One of these is the legislatively mandated Medicaid Clinical Advisory Committee (Medicaid CAC). Medical managed care at one time had a separate committee of practitioners that met expressly for the purpose of providing advice to IME on medical managed care issues. However, because the same membership was being used for both committees, CMS agreed that the Medicaid CAC could perform both FFS and managed care oversight duties effectively.

This committee meets quarterly with managed care being a standard agenda item. It is at that meeting that state staff reviews issues that have arisen since the last meeting. It is, however, incumbent upon the medical director to act as the representative of the committee as a whole if there is an immediate need for a decision. This can be important, for example, when considering practitioners who have left their practices without appropriate direction to enrolled members.

The Medicaid CAC provides advice to IME regarding all policies of the managed care program, Medicaid in general, and specifically to review oversight of the policy and quality programs in place or otherwise to be developed.

ACCESS

IME's standards for access to care are outlined in the Amerigroup and United Healthcare contracts. Periodically the managed care organizations run access software to ensure providers are within contract Exhibit B time and distance standards. Access is also reviewed during the external quality review (EQR) compliance process. The standards include the plans ensure the following:

1. Availability of Services
 - Maintains and monitors a network of appropriate providers. Provides female members with direct access to a women's health specialist.
 - Provides for a second opinion from a qualified healthcare professional.
 - Provides necessary services that are not available in the network.
 - Requires out of network providers to coordinate with the MCO with respect to payment.
 - Demonstrates that providers are credentialed.
 - Requires timely access.
 - Provides cultural considerations.

2. Assurances of adequate capacity and service
 - Offers an appropriate range of preventative, primary care, and specialty services.
 - Maintains a network of providers that is sufficient in number, mix, and geographic distribution.

3. Coordination and continuity of care
 - Ensures that each member has an ongoing source of primary care.
 - Coordinates all services that the member receives.
 - Shares identification and assessment information to prevent duplication of services for individuals with special healthcare needs.
 - Protects member privacy in the process of coordinating care.
 - Provides additional services for persons with special healthcare needs, including:
 - Identification,
 - Assessment,
 - Treatment plans, and
 - Direct access to specialists.

4. 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.

ANNUAL EVALUATION

The IME annually evaluates the Iowa Health Link program through an external quality review and evaluation of national performance measures. Plans receive financial incentives 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.

National performance measures include:

- Health Effectiveness Data and Information Set (HEDIS) measures
- Consumer Assessment of Healthcare Providers and Systems (CAHPS) composite and rating measures

EXTERNAL QUALITY REVIEW (EQR)

An 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), Health Services Advisory Group (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:

1. Validation of Performance Improvement Projects
2. Validation of Performance Measures
3. Review of compliance with access, structural and operations standards
4. Network adequacy and capacity standards
5. Technical Report

Performance Improvement Projects will be initiated as part of the EQR during the first 12 months of managed care implementation to monitor and improve MCO performance in several areas. The Iowa Department of Human Services determined the two state-mandated Performant Improvement Project 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* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*.

The Agency has assessed EQR activities in comparison to accreditation activities. Although there are similar domains addressed by the EQR and accreditation processes (including but not limited to scorecard development and network adequacy), there is not duplication of activities.

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.

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

Member input is obtained through an annual member satisfaction survey. The MCOs shall conduct the Consumer Assessment of Healthcare Providers and Systems (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. The results of CAHPS are shared at the Medical Assistance Advisory Council (MAAC). The MAAC is a council established to advise the Medicaid Director about the health and medical care services under the Medical Assistance Program. The council is mandated by Federal law and further established in Iowa Code. The council meets quarterly and makes recommendations to the Director regarding the budget, policy, and administration of the Medical Assistance Program.

MEMBER SATISFACTION

ENROLLMENT/ ASSIGNMENT

Iowa uses a default enrollment program in mandatory counties whereby a potential member is provided a choice. The failure of the member to make that choice results in the member being assigned to a default MCO. The member may change that selection (or any prior selection) at any time within the first 90 days of the initial enrollment and the first 90 days of enrollment at least every twelve months. An enrollment period does not exceed twelve months. A member may disenroll following the initial 90 days of any period of enrollment if the member requests disenrollment for good cause. Examples of “good cause” include availability of network providers, member needs related services, or other reasons related to lack of services. In addition a change may occur if a new MCO becomes available or if a provider within a network were to leave and that provider’s members wish to change options.

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 Contractor’s grievance system. This allows the Contractor the opportunity to attempt to resolve the concern. The Contractor follows the timelines of an expedited grievance. If the member remains dissatisfied with the outcome, the Contractor must direct the member (as well as his or her representative) to the Enrollment Broker to request disenrollment. The Contractor 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 Agency 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). This action is consistent with Iowa Administrative Code found at 441 IAC 88.

On a monthly basis, the department monitors and reports the number of current members in each program and the number who accepted the default enrollment and the number who actually made a choice. This is an important report because the default enrollment algorithm requires that members receive the default selection based on a prior enrollment history with the

program. Any serious deviation from this might indicate a problem with the default selection algorithm which would be corrected immediately to assure continuity of care.

Per managed care contracts, the Contractor (or, the MCO) shall not disenroll an enrollee or encourage a member to disenroll because of his or her health care needs or a change in health care status or because of the enrollee's utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception is true, the Contractor shall provide evidence to the State that continued enrollment of an enrollee seriously impairs the Contractor's ability to furnish services to either this particular enrollee or other enrollees. The Contractor 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: (i) ineligibility for Medicaid; (ii) shift to an eligibility category not covered by the Contract; (iii) change of place of residence to another state; (iv) the Agency has determined that participation in the Health Insurance Premium Payment Program (HIPP) is more cost-effective than enrollment in the Contract; and (v) death.

The MCO will not discriminate against members eligible to be covered under contracts on the basis of health status or need for services. They may not terminate enrollment of a member because of adverse changes in the member's health.

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

GRIEVANCE REPORTING

MCOs provide the IME with quarterly grievance reports that provide information on timely resolution of standard and expedited grievances and the top ten reasons for grievances. The IME reviews these reports to ensure member issues are addressed timely and to investigate systemic issues apparent in grievance reasons.

ENROLLED RECIPIENTS SUMMARY

This report 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

This report allows verification of the algorithm for enrollment.

TELEPHONE STATISTICS

This report demonstrates the call volume and effectiveness of the MCO Member Services 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. This member satisfaction tool is reviewed monthly to look for specific increases and is addressed by IME staff.

MEMBER/ PROVIDER RATIOS

This shows the current number and type of providers in each county. The IME monitors these counts to assure that each mandatory county maintains an appropriate mix of provider availability both by practice type, restrictions and geography within the county. This document shows the average number of providers participating and the average number of members enrolled. A high average of members per provider may indicate the need for provider recruitment in that county.

INTERVENTIONS AND IMPROVEMENTS

IMPROVEMENTS

Medicaid Managed Care Organizations represent a critical lever in improving the health of low-income and vulnerable populations. Amerigroup, and United Healthcare will continuously work to improve the health outcomes of Medicaid members. Improvements should be based on best practices including: participation in local and state Community Health Needs Assessments, support for utilization of social determinants screening tools for comprehensive care, implementation of data sharing between physical and behavioral health, and leveraging and managing Value-Based Purchasing contracts that tie payments to health outcomes.

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. Together with the Health Services Advisory Group (HSAG), the IME will identify several improvement interventions to be implemented within the MCOs. Performance improvement measures required by the state will not be the only measures MCOs must improve, and will not be replaced by MCO-selected measures. MCOs will also create their own performance improvement projects, reporting those results and subsequent program modifications to IME regularly.

Performance improvement projects that MCOs begin must be sustainable over time and have favorable effects on health outcomes and enrollee satisfaction. MCOs will accomplish this by creating work plans that clearly explain what they are improving, why it matters, the processes they will use in each phase of the project, and how they will measure success. Those work

plans will be shared with IME who will provide guidance for modifications that are necessary to improve member outcomes, efficient delivery of services, and increase quality of services that are delivered.

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 analyzes data for logic and compares MCO information with IME information. 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 managed care organizations.

Monitoring activities include:

- Ongoing Data Analysis
- Geographic mapping of provider networks
- External Quality Review (EQR)
- Network adequacy assurance submitted by MCOs
- On-site Monitoring Reviews
- Member and Provider Helpline monitoring
- Member and Provider Issue Log and Confirmation of Resolution
- Policy and Procedure Analysis
- Review of Reporting Provided to the State (timeliness, completeness, and plan for implementation of results)

MONITORING CYCLE



REPORTING TRANSPARENCY

The IME is committed to providing monthly and quarterly 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. Monthly and quarterly performance reports are posted to the Iowa Department of Human Services 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 Iowa Department of Human Services Bidder's Library at: https://dhs.iowa.gov/MED-16-009_Bidders-Library.

CONTRACT TERMS

EVIDENCE-BASED PRACTICES

MCO quality management and utilization management programs must be 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, and evaluating quality and utilization management activities that have been implemented.

AVAILABILITY

MCOs must require providers to meet IME standards for timely access to care and services, taking into account the urgency of the need for services. Network providers must offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service, if the provider serves only Medicaid enrollees. Provider services included in contracts must be available 24 hours a day, 7 days a week, when medically necessary. MCOs must have mechanisms to ensure compliance by providers, and monitor providers regularly to determine compliance.

ASSURANCE OF ADEQUATE CAPACITY AND SERVICES

In general, the MCOs will provide available, accessible, and adequate numbers of institutional facilities, service locations, and 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.

NETWORK CAPACITY AND ACCESS STANDARDS	
PROVIDER TYPE	STANDARD
PRIMARY CARE PHYSICIAN	<u>DISTANCE</u> : 30 MINUTES OR 30 MILES FROM PERSONAL RESIDENCE OF MEMBER <u>APPOINTMENT TIMES</u> : WITHIN 4-6 WEEKS FROM DATE OF REQUEST FOR ROUTINE APPOINTMENTS, WITHIN 48 HOURS FOR PERSISTENT SYMPTOMS
SPECIALTY CARE ACCESS	MUST HAVE PROVIDER AGREEMENTS WITH PROVIDERS IN THE FOLLOWING SPECIALTIES: <ul style="list-style-type: none"> - Cardiology - Dermatology - Endocrinology

	<ul style="list-style-type: none"> - Gastroenterology - General surgery - Neonatology - Nephrology - Neurology - Neurosurgery - Obstetrics and gynecology - Occupational therapy - Oncology/hematology - Ophthalmology - Orthopedics - Otolaryngology - Pathology - Physical therapy - Pulmonology - Psychiatry - Radiology - Reconstructive surgery - Rheumatology - Speech therapy - Urology - Pediatric specialties <p><u>DISTANCE:</u> 60 MINUTES OR 60 MILES FROM PERSONAL RESIDENCE OF MEMBER FOR 75% OF NON-DUAL MEMBERS 90 MINUTES OR 90 MILES FROM PERSONAL RESIDENCE FOR ALL NON-DUAL MEMBERS</p> <p><u>APPOINTMENT TIMES:</u> WITHIN 30 DAYS FOR ROUTINE CARE AND WITHIN 1 DAY FOR URGENT CARE</p>
HOSPITAL AND EMERGENCY SERVICES	<p><u>HOSPITAL:</u> 30 MINUTES OR 30 MILES EXCEPT IN RURAL AREAS WHERE ACCESS TIMES MAY BE GREATER*</p> <p><u>EMERGENCY CARE:</u> IMMEDIATE AT THE NEAREST FACILITY AVAILABLE REGARDLESS OF IF THE FACILITY OR PROVIDER IS UNDER CONTRACT WITH THE MCO</p>
LONG-TERM CARE SERVICES	<p><u>INSTITUTIONAL PROVIDERS:</u> ALL LICENSED AND MEDICAID CERTIFIED NURSING FACILITIES AND ICF/IDs WILL BE OFFERED INCLUSION IN MCO NETWORKS FOR 2 YEARS. AFTER THAT PERIOD, MCOs CAN EVALUATE ENROLLMENT BASED ON QUALITY AND PERFORMANCE OUTCOMES FOR COORDINATION OF CARE AS APPROVED BY THE STATE.</p> <p><u>HCBS STANDARDS:</u> ALL CERTIFIED, ACCREDITED, OR APPROVED HCBS PROVIDERS WILL BE OFFERED INCLUSION IN MCO NETWORKS FOR 2 YEARS. MCOs MUST CONTRACT WITH AT LEAST 2 PROVIDERS PER COUNTY FOR EACH COVERED HCBS BENEFIT IN THE WAIVER*</p> <p><u>DISTANCE:</u> TRANSPORT TIME WITHIN 30 MINUTES OR 30 MILES IN URBAN AREAS TRANSPORT TIME WITHIN 60 MINUTES OR 60 MILES IN RURAL AREAS EXCEPT WHERE COMMUNITY STANDARD AND DOCUMENTATION APPLIES</p>
OUTPATIENT	<p><u>DISTANCE:</u> 30 MINUTES OR 30 MILES FROM PERSONAL</p>

<p>BEHAVIORAL HEALTH PROVIDERS</p>	<p>RESIDENCE OF MEMBER* <u>APPOINTMENT TIMES:</u> EMERGENCY: WITHIN 15 MINUTES OF PRESENTATION MOBILE CRISIS: WITHIN 1 HOUR OF PRESENTATION OR REQUEST URGENT: URGENT NON-EMERGENCY NEEDS SHALL BE SEEN BY APPROPRIATE PROVIDER WITHIN 1 HOUR OF PRESENTATION OR WITHIN 24 HOURS OF TELEPHONE CONTACT PERSISTENT SYMPTOMS: WITHIN 48 HOURS OF REPORTING SYMPTOMS ROUTINE: WITHIN 3 WEEKS OF REQUEST FOR APPOINTMENT SUBSTANCE USE DISORDER & PREGNANCY: PREGNANT WOMEN IN NEED OF ROUTINE SUBSTANCE USE DISORDER SERVICES MUST BE ADMITTED WITHIN 48 HOURS OF SEEKING TREATMENT INTRAVENOUS DRUG USE: INTRAVENOUS DRUG USERS MUST BE ADMITTED WITHIN 14 DAYS OF REQUEST FOR ADMISSION, OR WITHIN 120 DAYS OF REQUEST IF NO PROGRAM HAS THE CAPACITY TO ADMIT THE INDIVIDUAL ON THE DATE OF THE REQUEST AND INTERIM SERVICES ARE MADE AVAILABLE WITHIN 48 HOURS OF REQUEST</p>
<p>OPTOMETRY</p>	<p><u>DISTANCE:</u> 30 MINUTES OR 30 MILES* <u>APPOINTMENT TIMES:</u> WITHIN 3 WEEKS FOR REGULAR APPOINTMENTS FOR REGULAR APPOINTMENTS AND WITHIN 48 HOURS FOR URGENT CARE</p>
<p>LAB AND X-RAY</p>	<p><u>DISTANCE:</u> 30 MINUTES OR 30 MILES* <u>APPOINTMENT TIMES:</u> WITHIN 3 WEEKS FOR REGULAR APPOINTMENTS AND WITHIN 48 HOURS FOR URGENT CARE</p>
<p>PHARMACY</p>	<p><u>DISTANCE:</u> AT LEAST 2 PHARMACY PROVIDERS WITHIN 30 MINUTES OR 30 MILES WITHIN A MEMBER'S RESIDENCE IN EACH COUNTY, EXCLUDING SPECIALTY PHARMACY PROGRAMS</p>

* If a county does not have enough providers licensed, certified, or available, the access standard will be based on the community standard and will be justified and documented to the state.

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 will do the following:

- 1) Perform an initial health risk screening.

MCOs will 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 will 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 long-term services and supports or persons with special health care needs.

- 2) 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 chronic condition health home enrollment.

- 3) 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 will 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.

Follow-up risk assessments for members who are identified as having a special health care need should be conducted on a yearly basis. The use of the Assess My Health tool is highly suggested as the data can be collected and aggregated electronically and is patient-reported. If the Assess My Health tool is not selected for the annual health risk screening, the selected tool must incorporate state-identified questions related to social determinants, health literacy, and social connection. The selected tool must also incorporate the Health Confidence question as it appears in Assess My Health. See the Health Information Technology (HIT) section for more information about data collection, analysis, implementation, and reporting.

- 4) Develop a care plan.

All members found eligible for the care coordination program will 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 will establish 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 reports on care plan completion with elements including:

- i. The number of care plans completed
- ii. The number of care plans completed by waiver
- iii. The number audited
- iv. The number of care plans addressing needs identified in the HRA
- v. The number of care plans addressing member goals
- vi. The number of care plans with all providers listed
- vii. The number of care plans with all funding sources and natural supports listed
- viii. The number of plans identifying emergency supports
- ix. The number of care plans with documentation of members receiving all services identified in the care plan

Quarterly self-reporting from MCOs allows the IME to monitor the quality of care and verify that services are being received by some of our most vulnerable members.

5) 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 will provide IME with a quarterly report of care plan updates. The report will include 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.

TRANSITION OF CARE POLICIES

MCOs must implement mechanisms to ensure continuity of care of members transitioning in and out of enrollment. This includes the following transitions: 1) initial program implementation, 2) initial enrollment with the MCO, 3) transitions between MCOs during the first 90 days of enrollment, and 4) transition for cause as described in managed care contract section 7.4.

MCO transition of care requirements can be found in managed care contract section 3.3 which includes requirements to transfer prior authorization and clinical data to the receiving MCO,

initial contract year provisions for access to out of network providers, provisions for members receiving long term services and supports, pregnancy continuity of care, and dual diagnosis continuity of care.

ADDRESSING HEALTH DISPARITIES

The Agency collects member race and ethnicity, as well as aid category, 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, and required support of the State Innovation Model (SIM). In addition to value-based purchasing, the SIM works with MCOs to align Social Determinant data collection to address health disparities.

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 IME monitors monthly and quarterly reports on the following:

- i. The number of claims denials
- ii. The number of member grievances received
- iii. Timeliness of member grievance resolution
- iv. The number of member appeals received
- v. Timeliness of member appeal resolution

- vi. The number of prior authorizations submitted
- vii. The number of prior authorizations approved
- viii. Timeliness of prior authorization processing
- ix. The most frequent reasons for prior authorization denial and modification

In addition to the information received from MCOs, the IME will also be receiving reports from the Ombudsman addressing any MCO performance issues from the member perspective.

STRUCTURE AND OPERATIONS STANDARDS

PROVIDER SELECTION

The MCO shall maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. The MCO is required to:

- 1) Adequately serve the expected enrollment
- 2) Offer an appropriate range of services and access to preventative and primary care services for the population expected to be enrolled
- 3) Maintain a sufficient number, mix, and geographic distribution of providers
- 4) Meet and require its providers to meet Agency standards for timely access to care and services
- 5) Ensure that the network providers offer hours of operation that are no less than the hours of operation offered to commercial enrollees or comparable to Medicaid fee-for-service
- 6) Makes services included in the contract available 24 hours a day, 7 days a week, when medically necessary
- 7) Establish mechanisms to ensure compliance by providers
- 8) Monitor providers regularly to determine compliance

The MCO must have at least 40% of its total assigned population in a value based purchasing (VBP) arrangement with a healthcare delivery system by calendar year 2018. The VBP arrangement must recognize population health outcome improvement as measured through the 3M Value Index Score (VIS) combined with a decrease in total cost of care for the population in the VBP arrangement.

The MCO's credentialing and re-credentialing process for all contracted providers must meet the guidelines and standards of the accrediting entity through which the MCO attains accreditation and in compliance with 441 Iowa Administrative Code Chapter 88 as well as all State and Federal rules and regulations. The MCO will implement processes to streamline provider credentialing requirements while ensuring the integrity of the credentialing process.

ENROLLEE INFORMATION

Enrollees who are known to be eligible for enrollment with the MCO as of the start date of operations (“Current Enrollees”) will be assigned by the IME to an MCO in accordance with the auto-assignment process. Following auto-assignment of Current Enrollees, the Agency will notify the member that they have ninety (90) days to choose another MCO if they wish. Applicants have the opportunity to select an MCO at the time of application, based on the plan information provided to them at the time of application. New enrollees who do not select an MCO at the time of application are auto-assigned to one in accordance with the auto-assignment process.

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

- 1) For cause, at any time.
- 2) Without cause, at the following times:
 - i. 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.
 - ii. At least once every 12 months thereafter.
 - iii. 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.
 - iv. When the State imposes the intermediate sanction specified in 42 C.F.R. § 438.702(a)(3).

The MCO may not disenroll an enrollee or encourage a member to disenroll because of his or her health care needs or a change in health care status or because of the enrollee’s utilization of medical services, diminished capacity, or uncooperative or disruptive behavior resulting from his or her special needs (except when his or her continued enrollment seriously impairs the Contractor’s ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception is true, the MCO must 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 will have methods by which the State is assured that disenrollment is not requested for any other reason.

CONFIDENTIALITY

The MCO shall develop, implement, and adhere to written policies and procedures, subject to IME 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 accordance with 42 C.F.R. § 438.224, the MCO will ensure that member medical records, as well as any other health and enrollment information that contains individually identifiable health information, is used and disclosed in accordance with the privacy requirements set forth in the

Health Insurance Portability and Accountability Act (HIPAA). The MCO will also comply with all other applicable State and Federal privacy and confidentiality requirements. The MCO will protect and maintain 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 will protect and maintain 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 the 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 IME within one (1) Business Day upon discovery of a non-HIPAA-related breach.

GRIEVANCE SYSTEM

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 Agency.

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.

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 Agency 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 subcontractor activities on an ongoing basis, and conduct formal reviews of such activities at least quarterly. The Agency reserves the right to audit subcontractor data. The MCO shall provide to the Agency the findings of all subcontractor performance monitoring and reviews upon request and shall notify the Agency 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 will be held accountable for any functions and responsibilities that it delegates.

FINANCIAL INTERVENTIONS

METRICS WITH LIQUIDATED DAMAGES FOR NON-COMPLIANCE	
METRIC	STANDARD
HONORING OUTSTANDING PRIOR AUTHORIZATIONS(PAs)	CONTRACT- MUST HONOR 100% OUTSTANDING PAs FOR FIRST 90 DAYS OF COVERAGE DURING YEAR 1 AND MUST HONOR 100% OUTSTANDING PA'S FOR FIRST 30 DAYS COVERAGE AFTER YEAR 1
1915(C), 1915(I) HCBS WAIVER ASSESSMENT AND CARE PLAN DEVELOPMENT	CONTRACT- MUST COMPLETE COMPREHENSIVE ASSESSMENT, DEVELOP CARE PLAN, AUTHORIZE & INITIATE LTC SERVICES
COMMUNICATIONS	CONTRACT- MUST RECEIVE AGENCY APPROVAL FOR ANY MEMBER/ PROVIDER COMMUNICATIONS
MARKETING	CONTRACT- MUST RECEIVE AGENCY APPROVAL FOR ALL MARKETING
MEMBER SERVICES HELPLINE	CONTRACT- MUST MEET 80% SERVICE LEVEL FOR INCOMING CALLS SEE MEASURE 8.3.3 FOR FURTHER GUIDANCE
TIMELY PRIOR AUTHORIZATION PROCESSING	CONTRACT- MUST PROCESS WITHIN 14 CALENDAR DAYS OF REQUEST, OR 72 HOURS FOR EXPEDITED AUTHS, OR 24 HOURS FOR PHARMACY PAs
GRIEVANCE RESOLUTION	CONTRACT- MUST RESOLVE 100% WITHIN 30 CALENDAR DAYS OF RECEIPT OR 72 HOURS OF RECEIPT FOR EXPEDITED GRIEVANCES
APPEALS RESOLUTION	CONTRACT- MUST RESOLVE 100% WITHIN 30 CALENDAR DAYS OF RECEIPT, OR 72 HOURS OF RECEIPT FOR EXPEDITED APPEALS
REPORTING	CONTRACT- MUST SUBMIT REPORTS AS REQUIRED IN THE REPORTING MANUAL; REPORTS MUST BE COMPLETE, ACCURATE, AND SUBMITTED BY DEADLINE
PROVIDER ENROLLMENT FILE	CONTRACT- MUST SUBMIT PROVIDER ENROLLMENT FILE THAT MEETS AGENCY SPECIFICATIONS
TIMELY CLAIMS PROCESSING	CONTRACT- MUST PAY OR DENY 90% OF CLEAN CLAIMS WITHIN 30 CALENDAR DAYS, 95% OF CLEAN CLAIMS WITHIN 45 CALENDAR DAYS, AND 100% OF ALL CLAIMS WITHIN 90 DAYS
ENCOUNTER	CONTRACT- MUST COMPLY WITH ALL COMPONENTS

SUBMISSION	LISTED IN 13.5 INCLUDING FORMAT, SCHEDULE, ACCURACY, COMPLETENESS, AND RECORDS MAINTENANCE
PROVIDER CREDENTIALING	CONTRACT- MUST CREDENTIAL 85% OF PROVIDERS WITHIN 30 DAYS, 100% WITHIN 45 DAYS, SECTION 6.1.3
PROVIDER AGREEMENTS	CONTRACT- MUST MAINTAIN AGREEMENTS IN ACCORDANCE WITH SECTION 6.1.2
NETWORK ACCESS	CONTRACT- MUST MAINTAIN NETWORK ACCESS STANDARDS IN ACCORDANCE WITH SECTION 6 OR EXHIBIT B.
RESPONSE TO AGENCY INQUIRIES	CONTRACT- MUST PROVIDE TIMELY AND ACCURATE REPONSES TO AGENCY INQUIRIES WITHIN TIMEFRAMES SET FORTH BY AGENCY IN ACCORDANCE WITH 2.16
ONSITE STAFF ATTENDANCE REVIEW	CONTRACT- MUST HAVE SUBJECT APPROPRIATE STAFF ATTEND ONSITE MEETINGS AS REQUESTED BY AGENCY
READINESS REVIEW	CONTRACT- MUST PASS READINESS REVIEW AT LEAST 30 DAYS PRIOR TO SCHEDULED MEMBER ENROLLMENT
CORRECTIVE ACTION PLAN COMPLIANCE	CONTRACT- MUST PROVIDER TIMELY AND ACCEPTABLE CORRECTIVE ACTION PLAN OR COMPLY WITH CAP TIMELINE AGREED UPON WITH THE AGENCY

PAY FOR PERFORMANCE TIED TO MEDICAL CAPITATION PAYMENTS	
METRIC	STANDARD TO RECEIVE INCENTIVE PAYMENTS
VALUE BASED PURCHASING	1) REACH 25% OF DESIGNATED MEMBERSHIP COVERED BY VALUE BASED PURCHASING CONTRACTS BY JUNE 30, 2018, INCLUSIVE OF USE OF THE VIS AND TCOC OR MLR <i>TO RECEIVE 75% OF INCENTIVE</i> , 2) REACH 30% OF DESIGNATED MEMBERSHIP COVERED BY VALUE BASED PURCHASING CONTRACTS BY JUNE 30, 2018, INCLUSIVE OF THE VIS AND TCOC OR MLR <i>TO RECEIVE 100% OF INCENTIVE</i>
CHILDREN'S ACCESS TO CARE	1) REACH A TOTAL RATE OF 70 <i>TO RECEIVE 50% OF INCENTIVE</i> , 2) REACH A TOTAL RATE OF 80 <i>TO RECEIVE 75% OF INCENTIVE</i> , 3) REACH A TOTAL RATE OF 85 <i>TO RECEIVE 100% OF INCENTIVE</i>
ADULT ACCESS TO CARE	1) REACH A TOTAL RATE OF 65 <i>TO RECEIVE 50% OF INCENTIVE</i> , 2) REACH A TOTAL RATE OF 70 <i>TO RECEIVE 75% OF INCENTIVE</i> , 3) REACH A TOTAL RATE OF 85 <i>TO RECEIVE 100% OF INCENTIVE</i>
APPEALS	1) DECISIONS ON 90% OF STANDARD, NON-EXPEDITED APPEALS WITHIN 25 CALENDAR DAYS OF RECEIPT <i>TO RECEIVE 75% OF INCENTIVE</i> , 2) DECISIONS ON 95% OF STANDARD, NON-EXPEDITED APPEALS WITHIN 25 CALENDAR DAYS OF RECEIPT <i>TO RECEIVE 100% OF INCENTIVE</i> *APPEALS WITH AGENCY APPROVED EXTENSIONS WILL BE EXCLUDED FROM THESE CALCULATIONS
PROVIDER NETWORK	ALL OF THE FOLLOWING TO RECEIVE 100% OF INCENTIVE: PCPs WITHIN 20 MILES OR 20 MINUTES, BEHAVIORAL

	HEALTH PROVIDER WITHIN 20 MILES OF 20 MINUTES, * FOR AREAS OF THE STATE WHERE PROVIDER AVAILABILITY IS INSUFFICIENT TO MEET STANDARDS, ACCESS STANDARDS SHALL MEET USUAL AND CUSTOMARY STANDARDS FOR THE COMMUNITY WHICH ARE DOCUMENTED AND JUSTIFIED TO THE STATE
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PAY FOR PERFORMANCE TIED TO LTSS CAPITATION PAYMENTS	
METRIC	STANDARD TO RECEIVE INCENTIVE PAYMENTS
PROVIDER NETWORK	3 HCBS PROVIDERS PER COUNTY FOR EACH COVERED HCBS SERVICE * FOR AREAS OF THE STATE WHERE PROVIDER AVAILABILITY IS INSUFFICIENT TO MEET STANDARDS, ACCESS STANDARDS SHALL MEET USUAL AND CUSTOMARY STANDARDS FOR THE COMMUNITY WHICH ARE DOCUMENTED AND JUSTIFIED TO THE STATE

HEALTH INFORMATION TECHNOLOGY (HIT)

Amerigroup, and United Healthcare will have HIT that collects, analyzes, compiles, and reports data. Strong HIT systems that meet these standards are absolutely necessary for the IME to confirm quality of care. The IME will collect information on utilization, grievances, appeals, and disenrollments. IME will also request data obtained through the initial health screening as well as subsequent health screening using the Assess My Health tool, including data related to social determinants and health confidence. MCO data will be compared with IME data and reviewed for accuracy, completeness, logic, and consistency. If there are concerns about data integrity, the IME will investigate data collection processes and may issue corrective action. Each MCO should identify policies and procedures for collection, analysis, compilation, and reporting data as requested by IME as well as policies and procedures for utilizing the data to inform and modify practice to improve patient outcomes.

- To meet the goal of the triple aim information must be shared across the continuum of care, therefore, MCOs shall interface with the IHIN, promote the use of HIT, and agree to align with State led HIT initiatives as they develop.
- Promote Medicaid provider connections to the IHIN and also use of Direct secure messaging to communicate with the MCO when health information must be shared.
- Promote EHR adoption among providers.

REVISION PROCESS FOR QUALITY STRATEGY

“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 will also be made available to all members of the Medical Assistance Advisory Council (MAAC) within 30 days of its completion. All committee feedback will be 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 will be followed in regards to the Medicaid Quality Strategy.

The Medicaid Quality Strategy will undergo a formal review by the IME Quality Committee no less than once every three years. The IME Quality Committee will also review and approve or deny 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 will also conduct 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 will be documented and posted on the IME website within XX days of its completion. The IME Quality Committee's formal review and evaluation will also include review of all recommendations identified in the External Quality Review Technical Report for the previous year.

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

GLOSSARY

EHR. Electronic Health Record.

EQR. External Quality Review.

EQRO. External Quality Review Organization.

HCBS. Home and Community-Based Services.

HIT. Health Information Technology.

HSAG. Health Services Advisory Group.

IME. The Iowa Medicaid Enterprise.

MAAC. Medical Assistance Advisory Council.

MCO. Managed Care Organization.

MLR. Medical Loss Ratio.

PCP. Primary Care Provider.

Iowa Medicaid Enterprise Bureau of Managed Care
Quality Plan 2018

SME. Subject Matter Expert.

TCOC. Total Cost of Care.

VBP. Value Based Purchasing.

VIS. Value Index Score.