



Department of
HUMAN SERVICES

*Iowa Medicaid Dental Pre-Ambulatory
Health Plan*

Quality Assurance System

2019

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INTRODUCTION

GOALS

The predominant goal of the dental prepaid ambulatory health plan (PAHP) quality plan and the State's managed care initiative is to improve the health of all Iowa Medicaid members. Over half a million Iowans receive health benefits from Iowa Medicaid, and it is Iowa Medicaid Enterprise's 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.

Each dental PAHP will work towards 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 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, through the use of a dental managed care program, the State aims to accomplish the following:

- Promote appropriate utilization of services within acceptable dental standards.
- Ensure access to cost-effective dental care through contract compliance by:
 - Timely review of PAHP network adequacy reports
 - Incentivizing access to preventative dental services
- 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 PAHP quality strategies
 - Quarterly reviewing PAHP quality meeting minutes
- Dental costs are reduced while quality is improved by the end of 2019 by:
 - Encouraging member engagement in dental care through completion of oral health risk assessment (HRA) and a tiered benefit structure that expands benefits for members receiving preventative services
- Provide care coordination to members based on oral health risk assessment (HRA) by:
 - Monitoring of HRA completion for members continuously enrolled for 6 months
- Ensure that transitions of care do not have adverse effects by:
 - Maintaining historical utilization file transfers between the Agency and PAHPs, including the information needed to effectively transfer members
- Promote quality standards in PAHP programs by monitoring processes for improvement opportunities and assist PAHPs with implementation of improvement strategies through:
 - 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 dental 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, PAHPs, and Medicaid.

HISTORY OF MANAGED CARE IN IOWA MEDICAID

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 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 January 2014, the State implemented the Iowa Wellness Plan, which was amended in May 2014 to provide an innovative dental benefit structure to members through the Dental Wellness Plan (DWP). At that time, 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 two 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 500,000 members in all 99 counties.

In July 2017, the DWP structure was amended to implement an integrated dental program for all Medicaid enrollees aged 19 and over. The redesigned DWP incorporated an incentive structure to improve oral health by encouraging utilization of preventive dental services and compliance with treatment plans. Today, the DWP has more than 300,000 members who receive services from the two dental PAHPs in Iowa, Delta Dental of Iowa and MCNA Dental. Additionally, Delta Dental also provides services for another 52,000 children through the Healthy and Well Kids in Iowa (hawk-i) program.

OVERVIEW

This document, in accordance with 42 CFR 438.340, sets forth Iowa's quality strategy for assessing and improving the quality of dental care and services furnished by the PAHPs. It sets forth the following:

1. network adequacy and availability of services standards for the contracted PAHPs;
2. examples of evidence-based clinical practice guidelines the State requires;
3. the State's goals and objectives for continuous quality improvement;
4. a description of the quality metrics and performance targets to be used in measuring the performance and improvement of the contracted PAHPs;
5. arrangements for annual, external independent reviews of the quality outcomes and timeliness of, and access to, the services covered through the dental PAHP contracts;
6. a description of the State's transition of care policy;
7. the State's plan to identify, evaluate, and reduce, to the extent practicable, health disparities based on age, race, ethnicity, sex, primary language, and disability status
8. mechanisms implemented by the State to identify persons who need long-term services and supports or persons with special health care needs;
9. the State's external quality review (EQR) activities required under § 438.360(c); and,
10. the State's definition of a "significant change" for the purposes of determining when revisions will be made to the quality strategy.

This document summarizes the existing strategies that have been or are being implemented to oversee Iowa's Medicaid dental PAHPs and to explore possibilities of utilizing clinical outcome-based research in the development of a set of measures to complement existing systems.

Contractually, the PAHPs 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 strategy.

STATE STANDARDS

COMMITTEES

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.

In addition to interagency cooperation, input to the quality strategy is reviewed periodically by significant entities. One of these is the legislatively mandated Medicaid Clinical Advisory Committee (Medicaid CAC). 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 its PAHP contracts. Periodically the PAHPs run access software to ensure providers are within contract 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 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 PAHP 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 and specialty services, to the extent covered under the contract.
 - 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 dental care.
 - Coordinates services that the member receives.
 - Shares identification and assessment information to prevent duplication of services.
 - Protects member privacy in the process of coordinating care.
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 a professional with appropriate expertise.

EVALUATION

The IME evaluates its PAHP programs 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 Section 3.1:

Performance Measure	Required Contractual Standard	Withhold Payment Obligation	
		Perf. Level	Percentage of Withhold Payable
Access to Dental Services	Within each Contract year, at least 25 percent of enrollees who have had continuous enrollment with the Contractor for at least six months shall have received at least one dental service.	30% or above	50%
		29%	40%
		28%	30%
		27%	20%
		26%	10%
		25% or below	0%
Access to Preventative Dental Services	Of the enrollees who have had continuous enrollment with the Contractor for at least six months and have received at least one dental service, at least 65 percent of those enrollees have a preventive exam within each Contract year.	70% or above	30%
		69%	25%
		68%	20%
		67%	15%
		66%	10%
		65% or below	0%
Continued Preventive Utilization	Twenty-five percent of enrollees who are eligible to receive a follow up preventive exam will return within six to twelve months of their initial exam within each Contract year.	30% or above	20%
		29%	15%
		28%	12%
		27%	10%
		26%	5%
		25% or below	0%

EXTERNAL QUALITY REVIEW (EQR)

An EQR of the PAHPs 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. Validation of encounter data
6. Technical Report

Performance Improvement Projects will be initiated as part of the EQR to monitor and improve PAHP performance. The Iowa Department of Human Services determined the two state-mandated Performance Improvement Project topics to be initiated by the PAHP's would be:

- Annual Dental Visit: All members 19 years of age and older will receive at least one dental visits during the measurement year.

In addition, Delta Dental of Iowa will have a second study indicator for the *hawk-I* population:

- Preventive Dental Visit: All children 1-18 years of age will have at least one preventive dental visit during the measurement year.

PERFORMANCE MEASURES

In compliance with state and federal regulations, PAHPs 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.

Member input is obtained through an annual member satisfaction survey. The approach is that of comparison of the PAHPs. The results of the survey 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 currently uses a default enrollment program 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 PAHP. 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 available services. By July 1, 2019 Iowa will be implement a passive assignment process. This removes the interim assignment in Medicaid FFS at the beginning a member's enrollment. Instead, enrollment will be directly to PHAP assignment. Members will still have the opportunity to change assignment within the first 90 days.

In accordance with the PAHP contracts, to request disenrollment for cause, the member must file an oral or written request to address the issue through the PAHP's grievance system. This allows the PAHP the opportunity to attempt to resolve the concern. The PAHP follows the grievance timeline. If the member remains dissatisfied with the outcome, the PAHP must direct the member (as well as his or her representative) to the Enrollment Broker to request disenrollment. The Enrollment Broker may request a copy of the member's grievance record 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 PAHP, consistent with Iowa Administrative Code.

Although not published, IME monitors 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 step will no longer be needed once IME implements passive assignment.

The PAHPs 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 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 PAHP's ability to furnish services to either this particular enrollee or other enrollees). In instances where the exception is true, the PAHP shall provide evidence to the State that continued enrollment of an enrollee seriously impairs the

PAHP's ability to furnish services to either this particular enrollee or other enrollees. The PAHP 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; or (iv) death.

Each PAHP 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 a PAHP solely because they have lost Medicaid eligibility for a period of two (2) months or less will automatically be re-enrolled into the same PAHP upon regaining eligibility.

GRIEVANCE REPORTING

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

TELEPHONE STATISTICS

This report demonstrates the PAHPs ability to answer calls timely to ease member's access to information about their healthcare. The system records the volume of calls received, wait time to speak with a representative, and dropped calls as compared to contractual service levels. These stats are 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. Geo Access maps have been posted the IME website and can be found here: <https://dhs.iowa.gov/ime/about/performance-data-GeoAccess>

INTERVENTIONS AND IMPROVEMENTS

IMPROVEMENTS

PAHPs represent a critical lever in improving the health of low-income and vulnerable populations. Delta Dental and MCNA will continuously work to improve the health outcomes of Medicaid members. Improvements should focus on restoring basic functionality for the enrollees; improving the oral health of enrollees over time; habilitating enrollees through education, care facilitation and community support; ensuring adequate, quality access to dental providers across the state; and establishing a meaningful and sustainable adult dental program for Iowa. 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, 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 PAHP's contract. Together with the external quality review organization (EQRO), the IME will identify several improvement interventions to be implemented within the PAHPs. Performance improvement measures required by the state will not be the only measures PAHPs must improve, and will not be replaced by PAHP-selected measures.

Performance improvement projects that PAHPs begin must be sustainable over time and have favorable effects on health outcomes and enrollee satisfaction. PAHPs 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. The 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

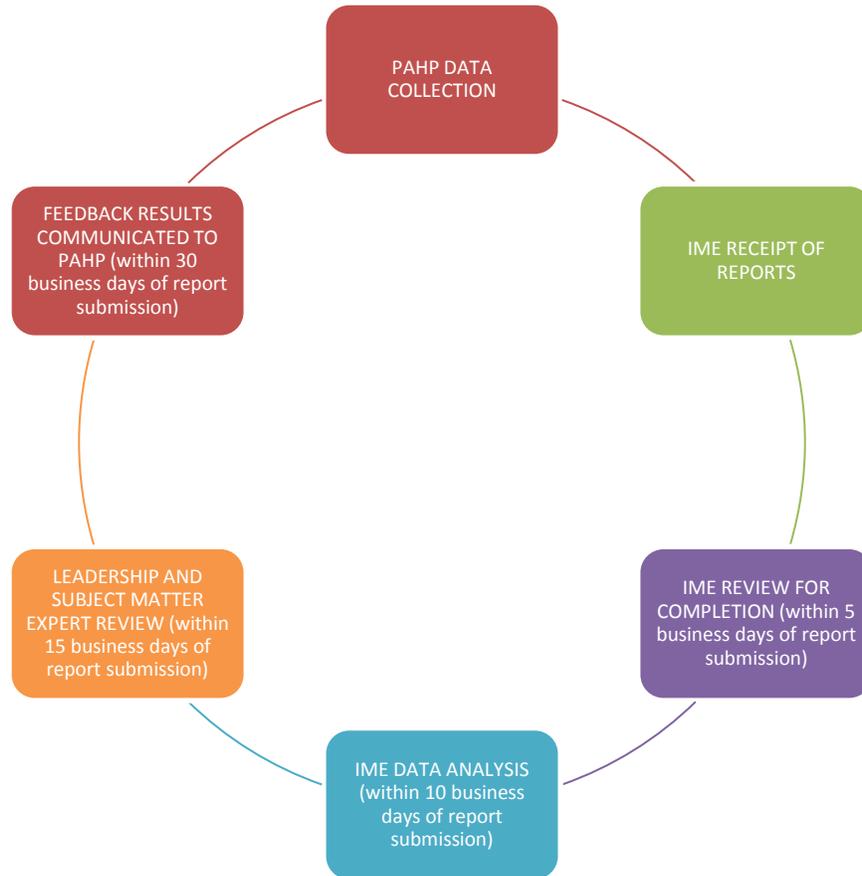
The state has clearly described performance standards within each contract. These are terms that were deliberately considered and articulated to ensure accountability and reward excellence. The IME requires timely and accurate reporting on all state standards and follows a standardized process for reviewing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

Upon receipt of reports, IME 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 PAHP information with IME information. When data analysis is complete, the original PAHP report and analysis summary are forwarded to subject matter experts (SMEs) and IME leadership. SMEs and IME leadership provide feedback which is communicated through the IME's liaisons to the PAHPs.

Monitoring activities include:

- Ongoing Data Analysis
- Geographic mapping of provider networks
- External Quality Review (EQR)
- Network adequacy assurance
- 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 PAHP performance. Reports focus on contractual performance guarantees that include management of specific populations, consumer supports, and program operations. Monthly and quarterly performance reports will soon be 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 contracts and have been paraphrased.

CONTRACT TERMS

EVIDENCE-BASED PRACTICES

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

PAHPs 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. PAHPs must have mechanisms to ensure compliance by providers, and monitor providers regularly to determine compliance.

ASSURANCE OF ADEQUATE CAPACITY AND SERVICES

In general, the PAHPs will provide available, accessible, and adequate numbers of providers for the provision of covered services, including any emergency services, on a twenty-four (24) -hour-a-day, seven (7)-day-a-week basis. Geo Access maps posted to the IME website can be found here:

<https://dhs.iowa.gov/ime/about/performance-data-GeoAccess>

NETWORK CAPACITY AND ACCESS STANDARDS	
PROVIDER TYPE	STANDARD
GENERAL DENTIST	<u>DISTANCE</u> : 60 miles or 60 minutes in rural areas; 30 miles or 30 minutes in urban areas
PEDIATRIC DENTIST (<i>hawk-i</i> program)	DISTANCE: 60 miles or 60 minutes in rural areas; 30 miles or 30 minutes in urban areas

* 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. PAHPs must implement State-approved procedures to deliver care and coordinate services. The procedures must ensure that all members have an ongoing source of care and a person or entity responsible for coordinating services accessed by the member and must also ensure coordination of the services the PAHP furnishes with services between settings or care, with services from other MCOs, PAHPs, fee-for-service Medicaid, and from community and social support providers. The PAHP should make a best effort to conduct an initial oral health risk screening within 90 days of the effective date of enrollment and share with the State or other MCOs or PAHPs serving the enrollee the results of any identification and assessment of that member's needs to prevent duplication of those activities.

TRANSITION OF CARE POLICIES

PAHPs 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 PAHP, 3) transitions between PAHPs during the first 90 days of enrollment, and 4) transition for cause.

ADDRESSING HEALTH DISPARITIES

The Agency collects member race and ethnicity, as well as aid category, age, and gender. This information is passed to PAHPs through enrollment files. These data fields support PAHP quality

assurance activities and contractual requirements that PAHPs are culturally competent and deliver culturally appropriate services.

COVERAGE AND AUTHORIZATION OF SERVICES

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 PAHP staffing, reviewing policies and procedures, evaluating work plans, and analyzing utilization reports.

PAHP 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 evidence and, 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:

- 1) The number of claims denials
- 2) The number of member grievances received
- 3) Timeliness of member grievance resolution
- 4) The number of member appeals received
- 5) Timeliness of member appeal resolution
- 6) The number of prior authorizations submitted
- 7) The number of prior authorizations approved
- 8) Timeliness of prior authorization processing
- 9) The most frequent reasons for prior authorization denial and modification

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

STRUCTURE AND OPERATIONS STANDARDS

PROVIDER SELECTION

The PAHP shall maintain a network sufficient to offer members a choice of providers to the extent possible and appropriate. The PAHP 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 State 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 PAHP's credentialing and re-credentialing process for all contracted providers must meet the guidelines and standards of the accrediting entity through which the PAHP attains accreditation and in compliance with all State and Federal rules and regulations. The PAHP will implement processes to streamline provider credentialing requirements while ensuring the integrity of the credentialing process.

ENROLLEE INFORMATION

Iowa currently uses a default enrollment program 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 PAHP. 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. By July 1, 2019 Iowa will implement a passive assignment process. This removes the interim assignment in Medicaid FFS at the beginning of a member's enrollment. Instead, enrollment will be directly to PHAP assignment. Members will still have the opportunity to change assignment within the first 90 days.

Members may request disenrollment according to the following guidelines:

- 1) For cause, at any time.
- 2) Without cause, at the following times:
 - During the 90 days following the date of the member's initial enrollment with the PAHP 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.

The PAHP may not disenroll a member 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 PAHP's ability to furnish services to either the member or other members). In instances where the exception is true, the PAHP must provide evidence to the State that continued enrollment of a member seriously impairs the PAHP's ability to furnish services to either the member or other members. The PAHP will have methods by which the State is assured that disenrollment is not requested for any other reason.

CONFIDENTIALITY

The PAHP 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 CFR 438.224, the PAHP 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 PAHP will also comply with all other applicable State and Federal privacy

and confidentiality requirements. The PAHP 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 PAHP 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 CFR Part 2 and other applicable State and Federal law and regulations. The PAHP shall notify the IME of a HIPAA-related breach or non-HIPAA breach in accordance with the terms of the PAHP contract with the State.

GRIEVANCE SYSTEM

The PAHPs must have internal grievance and appeal procedures for members in accordance with State and Federal requirements. The PAHPs are required 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 termination of eligibility, effective dates of coverage, and the determination of premium, copayment, and patient liability responsibilities are directed to the State.

Members may file grievances either orally or in writing. The PAHP'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 PAHPs must acknowledge receipt of each grievance within three (3) business days. The PAHP 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 PAHP 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 PAHP is responsible for any functions and responsibilities that are delegated to a subcontractor, and is required to certify and warrant all subcontractor work. The PAHP shall also ensure all written subcontracts meet the requirements of 42 CFR 434.6 and shall incorporate by reference the applicable terms and conditions of the Contract. The PAHP 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 State 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 PAHP.

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

HEALTH INFORMATION TECHNOLOGY (HIT)

Delta Dental and MCNA will have HIT that collects, analyzes, compiles, and reports data. Strong HIT systems that meet these standards are 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 oral health screening as well as subsequent health screenings. PAHP 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 PAHP 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.

REVISION PROCESS FOR QUALITY STRATEGY

“Significant change” to the Iowa Medicaid PAHP 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 PAHP Quality Strategy will also be made available to all members of the Medical Assistance Advisory Council (MAAC) within 60 days of its completion. The Medical Care Advisory Committee will be given 30 days from the date received to provide their feedback/comments. All committee feedback will be taken into consideration in the development of the final PAHP Quality Strategy.

Iowa’s Tribal Consultation policy will be followed in regards to the Medicaid PAHP Quality Strategy.

The Medicaid PAHP 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 PAHP Quality Strategy as needed. As part of the IME Quality Committee’s formal review of the Medicaid PAHP Quality Strategy once every three years, the Quality Committee will also conduct a formal evaluation of the effectiveness of the PAHP 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 60 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 PAHP 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, as defined above, is made to the Medicaid Quality Strategy.

GLOSSARY

EQR. External Quality Review
EQRO. External Quality Review Organization
HIT. Health Information Technology
HSAG. Health Services Advisory Group
IME. The Iowa Medicaid Enterprise
MAAC. Medical Assistance Advisory Council
MCO. Managed Care Organization
PAHP. Prepaid Ambulatory Health Plan
SME. Subject Matter Expert
TCOC. Total Cost of Care
VBP. Value Based Purchasing