# Iowa High Quality Health Care Initiative MED-16-009 – Contracting Requirements

**2.16 Response to State Inquiries & Requests for Information - Contracts at** http://dhs.iowa.gov/MED-16-009_Bidders-Library

The Agency may, at any time during the term of the Contract, request financial or other information from the Contractor. Contractor responses shall fully disclose all financial or other information requested. Information may be designated as confidential but may not be withheld from the Agency as proprietary. Information designated as confidential may not be disclosed by the Agency without the prior written consent of the Contractor except as required by law. If the Contractor believes the requested information is confidential and may not be disclosed to third parties, the Contractor shall provide a detailed legal analysis to the Agency, setting forth the specific reasons why the information is confidential and describing the specific harm or injury that would result from disclosure.

The Agency may directly receive inquiries and complaints from external entities, including but not limited to, providers, enrollees, legislators or other constituents which require Contractor research, response and resolution. The Contractor shall comply with requests for response to all such inquiries and complaints. Responses shall be provided in the timeframe specified by the Agency when the inquiry or complaint is forwarded to the Contractor for resolution.

**Performance Targets and Reporting Requirements**

**14.1 General**

Performance monitoring and data analysis are critical components in assessing how well the Contractor is maintaining and improving the quality of care delivered to members. The Agency will use various performance targets, industry standards, national benchmarks and program-specific standards in monitoring the Contractor's performance and outcomes. The Agency reserves the right to publish Contractor performance. Additionally, once sufficient baseline data is available, the Agency intends to utilize performance outcomes as a factor for auto-assignments and enrollment materials developed to facilitate member choice of contractor enrollment. Failure to meet performance targets shall subject the Contractor to the corrective actions as outlined in Exhibit E. Refer to Exhibit F for information on the pay-for-performance program.

**14.1.1 Reporting Requirements**

The Contractor shall comply with all reporting requirements and shall submit the requested data completely and accurately within the requested timeframes and in the format identified by the Agency. The Agency reserves the right to require the Contractor to work with and submit data to third-party data warehouses or analytic vendors. The Contractor shall have policies, procedures and mechanisms in place to ensure that the financial and non-financial performance data submitted to the Agency is accurate. In accordance with 42 C.F.R. § 438.604 and 42 C.F.R. § 438.606, Contractor shall certify enrollment information, encounter data, and other information submitted to

| the Agency for purposes of developing managed care rates. All such certified data shall be certified by the Contractor’s Chief Executive Officer, Chief Financial Officer or an individual who has delegated authority to sign for, and who reports directly to one of these employees. The certification shall attest, based on best knowledge, information and belief the accuracy, completeness and truthfulness of the data and documents submitted to the Agency. This certification shall be submitted concurrently with the certified data. |
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| **14.1.2 Audit Rights and Remedies** |
| The Agency reserves the right to audit the Contractor’s self-reported data at any time. The Agency may require corrective action or other remedies as specified in Exhibit E for Contractor non-compliance with these and other subsequent reporting requirements and performance standards. |
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| **14.1.3 Meeting with the Agency** |
| The Agency may schedule meetings or conference calls with the Contractor upon receiving the performance data. When the Agency identifies potential performance issues, the Contractor shall formally respond in writing to these issues within the timeframe required by the Agency. If the Contractor fails to provide a formal, written response to the feedback or fails to respond within the timeframe established by the Agency, the Agency may consider the Contractor noncompliant in its performance reporting and may implement corrective actions. |
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| **14.1.4 Implementation Reporting** |
| The Agency reserves the right to require more frequent reporting at the beginning of the Contract to: (i) monitor program implementation; (ii) permit adequate oversight and correction of problems as necessary; and (iii) ensure satisfactory levels of member and provider services. |
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| **14.1.5 Other Reporting and Changes** |
| The Agency may change the frequency of reports and may require additional reports and performance targets at any time. In these situations, the Agency will provide at least thirty (30) calendar days’ notice to the Contractor before changing reporting requirements. The Agency may request ad hoc reports at any time. The Reporting Manual, which shall be provided following the Contract award date, will detail reporting requirements and the full list of required reports. |
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| **14.2 Financial Reports and Performance Targets** |
| Financial reports assist the Agency in monitoring the Contractor’s financial trends to assess its stability and its ability to offer health care services to its members. The financial reports include but are not limited to the reports described in Section 14.2.1 through Section 14.2.7 |

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| **14.2.1 Third Party Liability Collections** |
| The Contractor shall report all third party liability collections to the Agency in the timeframe and format determined by the Agency. |
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| **14.2.2 Iowa Insurance Division Reporting** |
| The Contractor shall comply with all reporting requirements at Iowa Admin. Code r. 191-40.14(514B) and copy the Agency on all required filings with the Iowa Insurance Division. |
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| **14.2.3 Annual Independent Audit** |
| The Contractor shall complete an annual independent audit as described in Section 2.3.5. |
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| **14.2.4 Physician Incentive Plan Disclosure** |
| The Contractor shall submit information on physician incentive plans, in the manner prescribed by the Agency, with sufficient detail to permit the Agency to determine compliance with 42 C.F.R. § 422.208 and 42 C.F.R. § 422.210. |
| **14.2.5 Insurance Premium Notice** |
| The Contractor shall submit certificates of insurance for required insurance no less than thirty (30) calendar days after the policy renewal effective date. |
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| **14.2.6 Reinsurance** |
| The Contractor shall provide to the Agency all contracts of reinsurance or a summary of the plan of self-insurance which meet the requirements as set forth in Section 2.3.2. As applicable, the Contractor shall report to the Agency, in the manner dictated by the Agency, all health care claims costs paid by the Contractor's commercial reinsurer due to meeting the reinsurance attachment point. |
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| **14.2.7 Medical Loss Ratio** |
| The Contractor shall maintain, at minimum, a medical loss ratio of eighty-eight percent (88%). |
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| **14.3 Member Services Reports and Performance Targets** |
| Member services reports identify the methods the Contractor uses to communicate to members about health care and program services and monitor member satisfaction. Examples of member services reports to be submitted by the Contractor, in accordance with the terms of the Reporting Manual, include but are not limited to the reports described in Sections 14.3.1 through Section 14.3.10. |
| **14.3.1 Completion of Initial Health Risk Screening** |
| As described in Section 9.1.1, the Contractor shall complete an initial health risk screening no later than ninety (90) calendar days after |

| member enrollment with the Contractor. Each quarter, at least seventy percent (70%) of the Contractor's new members, who have been assigned to the Contractor for a continuous period of at least ninety (90) days, shall complete an initial health risk screening within ninety (90) days. For any member who does not obtain an initial health risk screening, the Contractor shall document at least three (3) attempts to conduct the screening. |
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| **14.3.2 Completion of Comprehensive Health Risk Assessment** |
| As described in Section 9.1.2, the Contractor shall complete a comprehensive health risk assessment, in the timeframe mutually determined by the Agency. |
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| **14.3.3 Care Plan Development** |
| One hundred percent (100%) of members identified by the Contractor through the comprehensive health risk assessment as having a potential special healthcare care need shall have a care plan developed. One hundred percent (100%) of care plans shall be updated, at minimum, annually. |
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| **14.3.4 Member Helpline Performance Report** |
| The Contractor shall demonstrate the following: maintain a service level of eighty percent (80%) for incoming calls that is calculated with this equation: SL= ((T-(A+B)/T)*100) where T= all calls that enter queue, A=calls that are answered after 30 seconds, B=calls that are abandoned after 30 seconds. |
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| **14.3.5 Member Enrollment and Disenrollment** |
| The Contractor shall report: (i) total member enrollment count for the reporting period; (ii) the total member disenrollment count for the reporting period; and (iii) break out the disenrollment data to show disenrollment occurring during the member's initial ninety (90) day enrollment period and disenrollment occurring after such enrollment period for cause. |
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| **14.3.6 Member Grievances Report** |
| The Contractor shall resolve one hundred percent (100%) of grievances within thirty (30) calendar days of receipt, or within three (3) business days of receipt for expedited grievances. The Contractor shall maintain and report to the Agency a member grievance log, which shall include the current status of all grievances. |
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| **14.3.7 Member Hearing and Appeals Report** |
| The Contractor shall resolve one hundred percent (100%) of appeals within forty-five (45) calendar days of receipt, or within three (3) business days of receipt for expedited appeals. Further, one hundred percent (100%) of appeals shall be acknowledged within three (3) |

business days. The Contractor shall maintain and report to the Agency a member appeal log, which shall include the current status of all appeals.

**14.3.8 Summary of Consumer Assessment of Healthcare Providers and Systems (CAHPS) Survey**

The Contractor shall annually provide to the Agency the survey results from its independent CAHPS survey.

**14.3.9 Member Website Utilization Report**

The Contractor shall have the capability to track and report to the Agency member website utilization data, including EOB and quality information hits.

**14.3.10 Member PCP Assignment Report**

The Contractor shall report: (i) total member enrollment count for those members under a Value Based Purchasing arrangement for the reporting period; (ii) the total member disenrollment count for those members disenrolled from a Value Based Purchasing arrangement for the reporting period; and (iii) a separate, detail report showing each member assignment to their PCP, including, but not limited to the individual PCP (name, NPI), physical location, affiliated organizational NPI(s), organizational name and organizational tax ID. This report will be in the format and frequency determined by the Department.

**14.4 Provider Network Reports and Performance Targets**

Provider network reports assist the Agency in monitoring the Contractor's provider services, network composition and geo-access ratios in order to assess member access, network capacity and provider relations. The Contractor shall identify current enrollment, gaps in network services and the corrective actions that the Contractor is taking to resolve any potential problems relating to network access and capacity. The provider network reports and performance targets include but are not limited to the reports described in Section 14.4.1 through Section 14.4.5.

**14.4.1 Network Geographic Access Reports for Providers**

The Contractor shall demonstrate access within the requirements set forth in Exhibit B or additional network adequacy standards developed by the Agency. The Agency reserves the right to request more frequent Network Geographic Access Assessment reporting at the beginning of the Contract, until the Contractor demonstrates that the network access standards have been met.

**14.4.2 Twenty four (24) Hour Availability Audit**

One hundred percent (100%) of Contractor's network primary care providers shall be available to member's twenty-four (24) hours-a-day, seven (7) days-a-week, and the Contractor shall implement corrective actions for network providers identified through the audit as failing

to meet this standard.

**14.4.3 Provider Credentialing Report**

The Provider Credentialing Report details the timeliness and effectiveness of the Contractor provider credentialing processes. Credentialing of all providers applying for network provider status shall be completed as follows: (i) ninety percent (90%) within thirty (30) calendar days; and (ii) one hundred percent (100%) within forty-five (45) calendar days. The start time begins when the Contractor has received all necessary credentialing materials from the provider. Completion time ends when written communication is mailed or faxed to the provider notifying them of the Contractor's decision.

**14.4.4 Subcontractor Compliance Summary Report**

The Contractor shall conduct quarterly formal reviews of all subcontractors and provide summary reports to the Agency, in the prescribed format, of all key findings and any applicable corrective action plans implemented.

**14.4.5 Provider Helpline Performance Report**

The Contractor shall demonstrate the following: maintain a service level of eighty percent (80%) for incoming calls that is calculated with this equation: SL= ((T-(A+B)/T)*100) where T= all calls that enter queue, A=calls that are answered after 30 seconds, B=calls that are abandoned after 30 seconds.

**14.5 Quality Management Reports & Performance Targets**

Quality management reports document the methods and processes the Contractor uses to identify program and clinical improvements that enhance the appropriate access, level of care, quality and utilization of program services by its members and providers. These reports assist the Agency in monitoring the Contractor's quality management and improvement activities. The quality management reports include but are not limited to the reports described in Section 14.5.1 through Section 14.5.5.

**14.5.1 Quality Management and Improvement Program Work Plan**

In the Work Plan required by 2.13, the Contractor shall develop a work plan for the Quality Management and Improvement Program to identify the goals the Contractor has set to address its strategy for improving the delivery of health care benefits and services to its members (QMIP Plan). In the QMIP Plan, the Contractor shall identify the steps to be taken and include a timeline with target dates. The plan shall be submitted prospectively for each year, with quarterly updates and a final evaluation of the prior year. As a part of this work plan, the Contractor shall include its proposal to align with the SIM project, including specific detail for the value based purchasing requirements described in section 6.1.2. The Contractor shall incorporated use of the Value Index Score (VIS) in the QMIP plan.

| **14.5.2 Quality Management Committee Meeting Minutes** |
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| The Contractor shall report Quality Management Committee meeting minutes, document the actions of the Contractor's Quality Management Committee, and shall be provided in the reporting cycle following the meeting. |
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| **14.5.3 Care Coordination Report** |
| The Contractor shall submit the Care Coordination Report to summarize all members engaged in care coordination programs developed by the Contractor, in accordance with Section 9, including summary information on active participation, number of contacts, disenrollment and outcomes. |
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| **14.5.4 HEDIS Report** |
| The Contractor shall conduct an annual HEDIS audit survey and submit the compliance auditor's final audit report along with the same audited data provided to NCQA. The Agency will establish baseline performance targets for all HEDIS measures. |
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| **14.5.5 Quarterly Health Outcomes and Clinical Reports** |
| The Agency intends to establish quarterly clinical reports and baseline rates to monitor healthcare services utilization and quality outcomes. Priority areas for monitoring which the Contractor shall report on include, but are not limited to: |
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| **14.5.5.1 Behavioral Health.** (i) Follow-up after inpatient hospitalization for mental illness; (ii) readmission rates for psychiatric hospitalizations; (iii) anti-depression medication management; (iv) follow-up care for children prescribed attention deficit hyperactivity disorder (ADHD) medication; (v) diabetes screening for people with schizophrenia or bipolar disorder who are using antipsychotic medication; (vi) adherence to antipsychotic medications; (vii) number and percentage of members receiving mental health services; and (viii) number and percent of members receiving substance use disorder services; (ix) report that identifies foster children by a common identifier, their age, diagnosis, prescribed medications; and (x) a report that identifies foster children by a common identifier who are on two (2) or more prescribed psychotropic medications, psychotropic prescriptions, and diagnoses to support prescribing pattern. |
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| **14.5.5.2 Children's Health.** (i) EPSDT screening rate; (ii) well-child visits; (iii) adolescent well-care visits; (iv) childhood immunization status; (v) adolescent immunization status; (vi) developmental screening for children age 0-3; and (vii) report that identifies foster children that receive EPSDT screenings. |
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| **14.5.5.3 Prenatal and Birth Outcomes.** (i) Number of infants born between thirty-four (34) and thirty-six (36) weeks gestation; (ii) percentage of deliveries that received recommended prenatal and postpartum visit; (iii) cesarean rate; and (iv) frequency of ongoing prenatal care. |

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| **14.5.5.4 Chronic Condition Management.** These reports shall include measures that report on the effectiveness of services for members with chronic conditions, including but not limited to: (i) diabetes; (ii) cardiovascular conditions; (iii) HIV/AIDS; (iv) COPD; (v) asthma; (vi) chronic kidney disease; and (vii) other chronic conditions prevalent among enrolled program membership identified by the Contractor or the Agency. |
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| **14.5.5.5 Hospitalization and ER.** (i) potentially preventable admissions; (ii) hospital readmission rates; (iii) potentially preventable ER visits; and (iv) emergency room diversion. |
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| **14.5.5.6 Adult Preventive Care.** (i) cervical cancer screening; (ii) breast cancer screening; (iii) colorectal cancer screening; and (iv) adult access to preventive/ambulatory health services. |
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| **14.6 LTSS Reports and Performance Targets** |
| LTSS reports document the Contractor's quality and management outcomes for individuals residing in an institutional setting or receiving HCBS. These reports document the Contractor's effectiveness in implementing institutional diversion strategies and promoting the provision of HCBS include but are not limited to the reports described in this section. |
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| **14.6.1 Nursing Facilities Admission Rates** The Nursing Facilities Admission Rates Report shall document the nursing facility, ICF/ID, and PMIC admission rate. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the number of nursing facility, ICF/ID, and PMIC days used by eligible members. |
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| **14.6.2 Nursing Facility Days of Care** The Nursing Facility Days of Care report shall document the number of nursing facility, ICF/ID, and PMIC days used by members. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the number of nursing facility, ICF/ID, and PMIC days used by eligible members. |
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| **14.6.3 Return to Community** The Return to Community report shall document the percentage of members who return to the community following nursing facility, ICF/ID, and PMIC admission. The Agency will establish a baseline rate and the Contractor shall demonstrate an increase in the number of members returning to the community. |
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| **14.6.4 ICF/ID and PMIC Report** The ICF/ID and PMIC report shall document measures for ICF/ID and PMIC services to be determined by the Agency. |
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| **14.6.5 Fall Risk Management** The Fall Risk Management report shall document the percentage of members in long-term care who are at risk for falling who are seen by a practitioner and receive fall risk intervention. |
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| **14.6.6 Hospital Admission after Nursing Facility Discharge** The Hospital Admission after Nursing Facility Discharge Report shall document the percentage of members discharged from a nursing facility who had a hospital admission within thirty (30) days. The Agency will establish a baseline rate and the Contractor shall demonstrate a decrease in the admission rate. |
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| **14.6.7 Self-Direction** The Self-Direction report shall document the number of members who are self-directing eligible HCBS as described in Section 4.4.8. The Agency will establish a baseline rate and the Contractor shall demonstrate an increase in self-directed services. |
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| **14.6.8 Timeliness of Level of Care** The Timeliness of Level of Care Report shall document the Contractor's timely completion of level of care reassessments. One hundred percent (100%) of reassessments shall be completed within twelve (12) months of the previous assessment. The Agency also reserves the right to audit the application of level of care criteria to ensure the accurate and appropriate application of criteria. |
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| **14.6.9 Timeliness of Needs Assessment and Reassessments** The Timeliness of Needs Assessment and Reassessments report shall document the Contractor's timely completion of needs assessments and reassessments for 1915(c) HCBS waiver enrollees. One hundred percent (100%) of needs assessment shall be completed within the timeframe mutually agreed upon between the Contractor and the Agency in the course of Contract negotiations. |
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| **14.6.10 Care Plan and Case Notes Audit** The Agency reserves the right to conduct an audit, or to utilize a subcontractor to conduct an audit, of 1915(c) HCBS waiver care plans and case notes to determine Contractor compliance with: (i) timely completion; (ii) care plan addressing the member's assessed health and safety risks, and personal goals; (iii) member signature on the care plan; (iv) all providers are listed on the care plan; (v) all funding sources are listed on the care plan; (vi) plan for supports available to the member in the event of an emergency are documented; (vii) provision of services as delineated in the care plan; (viii) discussion of advanced directives with members; (ix) percentage of new members starting ongoing services within the required timeframe; (x) member and/or guardian participation in care plan development; and (xi) number and percentage of in-person visits that were on time, late or missed. |
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| **14.6.11 Critical Incident Reporting** This report shall document, at minimum, the number, percent and frequency of critical incidents and the number and percent reported within the required timeframes. The Agency will monitor critical incident reports submitted by the Contractor to identify potential performance improvement activities. |

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| **14.6.12 Out of State Placements** This report shall include information regarding the members receiving out of state placements and providers for adults and children. |
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| **14.6.13 Oral Health** The Contractor shall ensure coordination of preventative oral health for the LTSS populations, including members residing in a facility. |
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| **14.7 Quality of Life Reports and Performance Targets** |
| The Agency intends to develop reports, baseline data and performance targets surrounding quality of life outcomes for members. Potential areas for measurement include but are not limited to: (i) increased life expectancy; (ii) number and percentage of members who gain and maintain competitive employment; (iii) number and percentage of members engaged in volunteer work; (iv) satisfaction; and (v) reduction in homelessness. The Agency may require the Contractor to conduct a member survey to measure key experience and quality of life indicators using best practices for reaching populations with special healthcare needs. The Agency will analyze the findings of the survey to identify required performance improvement activities, shall make the findings available to stakeholders and shall have the EQRO validate the findings. |
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| **14.8 Utilization of Reports and Performance Targets** |
| Utilization reports assist the Agency in monitoring the Contractor's utilization trends to assess its stability and continued ability to offer health care services to its members. The Contractor shall submit these reports to the Agency. The utilization reports and performance targets include but are not limited to the reports described in this section. |
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| **14.8.1 Program Integrity Plan** The Program Integrity Plan shall be updated annually and submitted to the Agency for review. Quarterly high-level progress reports shall be submitted to the Agency outlining key activities, findings and progress toward meeting goals and objectives. Quarterly recoupment totals shall also be provided. All plan updates shall be approved by the Agency. |
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| **14.8.2 Prior Authorization Report** One hundred percent (100%) of standard authorization decisions shall be rendered within seven (7) calendar days of the request for service, or three (3) business days for expedited authorization decisions. For pharmacy prior authorization one hundred percent (100%) of authorization decisions shall be rendered within twenty-four (24) hours of the request for service. On a quarterly basis, the Contractor shall submit a summary report of approvals, pending requests and denials from the end of the previous reporting period. |
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| **14.8.3 Pharmacy Rebate Reporting** In accordance with Section 3.2.6, the Contractor shall submit reports to facilitate pharmacy rebate |

| collection in the manner and timeframe required by the Agency. |
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| **14.8.4 Pharmacy Reporting** The Contractor shall provide additional reporting specific to the pharmacy program, including, but not limited to: Pharmacy help desk performance; Prior authorization performance; Prior Authorization request turnaround time; Number of claims submitted as a 72-hour emergency supply; Denials (name of drug, number of requests, number of denials); Pharmacy network access; Grievance and appeals and Medication therapy management initiatives. |
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| **14.9 Claims Reports and Performance Targets** |
| The Claims Reports assist the Agency in monitoring the Contractor's claims processing activities to ensure appropriate member access to services and payments to providers. The Contractor shall submit claims processing and adjudication data. The Contractor shall also identify specific cases and trends to prevent and respond to any potential problems relating to timely and appropriate claims processing. The Contractor shall meet the performance targets described below & submit the data and reports described in Section 14.9.1 and Section 14.9.2. |
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| **14.9.1 Adjudicated Claims Summary, Claims Aging Summary, and Claims Lag Report** The Contractor shall pay or deny ninety percent (90%) of clean claims within fourteen (14) calendar days of receipt, ninety-nine point five percent (99.5%) of clean claims within twenty-one (21) calendar days of receipt and one hundred percent (100%) of claims within ninety (90) calendar days of receipt. |
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| **14.9.2 Claims Denials Reasons** The Contractor shall report to the Agency the top ten (10) most common reasons for claim denial. |
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| **14.10 CMS Reporting** |
| The Contractor shall be required to submit data necessary to support and report on federal waiver requirements and as requested by CMS in the manner and timeframe required by the Agency and CMS. This includes, but is not limited to, data related to the Iowa Health and Wellness Plan, HCBS waiver programs and members, the hawk-i program, and the SIM grant. |
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| **14.11 Reserved** |