Calendar Year 2019 External Quality Review Technical Report

April 2020

HSAG HEALTH SERVICES ADVISORY GROUP

Table of Contents

1. Executive Summary

Overview of the 2019 External Quality Review

According to the 42nd Code of Federal Regulations (CFR) §438.350, states with capitated Medicaid managed care delivery systems and that contract with managed care entities (MCEs) are required to arrange for the provision of annual external quality review (EQR) for each Medicaid managed care contractor. The external quality review organization (EQRO) must annually provide an assessment of each MCE's performance related to the quality, timeliness, and access to care and services provided by each MCE and produce the results in an annual EQR technical report (42 CFR §438.364). To meet this requirement, Iowa Department of Human Services (DHS) has contracted with Health Services Advisory Group, Inc. (HSAG), to perform EQR of the Iowa MCEs and produce this EQR technical report.

The Iowa Medicaid Enterprise (IME) is the division of DHS that administers the Iowa Medicaid program. On April 1, 2016, IME transitioned most Iowa Medicaid members to a managed care program called IA Health Link. This program is currently administered by two managed care organizations (MCOs) which provide members with comprehensive healthcare services, including physical health, behavioral health, and long-term services and supports (LTSS). While the program is currently administered by two MCOs, DHS held contracts with three MCOs during the review period for this annual report.[1-1] The three MCOs that delivered managed care and services in Iowa during CY 2019 are displayed in Table 1-1 below.

Table 1-1—IA Health Link MCOs

MCO Name	MCO Short Name
Amerigroup Iowa, Inc.	Amerigroup (AGP)
UnitedHealthcare Plan of the River Valley, Inc.	UnitedHealthcare (UHC)
Iowa Total Care, Inc.	Iowa Total Care (ITC)

Beginning July 1, 2017, most adult Medicaid members, ages 19 and older, were enrolled in the Dental Wellness Plan (DWP). Dental benefits through the DWP are administered by two prepaid ambulatory health plans (PAHPs). In addition to the DWP, dental benefits were offered through the Healthy and Well Kids in Iowa (Hawki) program,[1-2] the State's Children's Health Insurance Program (CHIP). The two PAHPs that delivered managed dental care and services in Iowa during CY 2019 are displayed in Table 1-2 below.

[1-1] UnitedHealthcare exited the IA Health Link program effective July 1, 2019, and Iowa Total Care entered the IA Health Link program effective July 1, 2019.

[1-2] Dental benefits offered through the Hawki program are administered by Delta Dental of Iowa (DDIA) only.

Table 1-2—Dental Wellness Plan PAHPs

PAHP Name	MCO Short Name
Delta Dental of Iowa	Delta Dental (DDIA)
Managed Care of North American Dental	MCNA Dental (MCNA)

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from CY 2019 to assess the performance of Medicaid MCOs and PAHPs in providing quality, timely, and accessible healthcare services to Iowa Medicaid members. For each MCO and PAHP reviewed, HSAG provides a summary of its overall findings, conclusions, and recommendations based on the plan's performance (refer to Sections 4 through 10 of this report). The overall findings and conclusions for all MCOs and PAHPs were also compared and analyzed to develop overarching conclusions and recommendations for the Medicaid managed care program. In addition to recommendations for the IA Health Link program, this section also contains a summary of the overall key findings for each MCO and PAHP.

IA Health Link Recommendations for Program Improvement

This annual comprehensive assessment revealed that predominant areas of the program had opportunities for improvement when overall program performance was evaluated through the compliance review, performance measure validation (PMV), Healthcare Effectiveness Data and Information Set (HEDIS®)[1-3] performance measures, performance improvement projects (PIPs), network adequacy, encounter data validation (EDV), and calculation of potentially preventable events (PPEs) activities. To improve statewide performance in the quality and timeliness of, and access to care, HSAG makes the following recommendations to DHS in the performance areas of Case Management, Access to Care, and Member Information and Communication.

Case Management

- As MCOs follow a different risk stratification methodology, to ensure consistency in case management services, DHS should consider developing a statewide standardized methodology. This methodology could also define the intensity and frequency of follow-up care required for each risk stratification level.
- DHS should enhance oversight of non-LTSS case management care plans. This process could include a review of care plan documentation and focus on the lower-scoring requirements identified during the MCO non-LTSS case management file reviews; and specifically, the care plan development requirements.

[1-3] HEDIS® is a registered trademark of the National Committee for Quality Assurance (NCQA).

- As MCOs interpreted the specifications for the case management performance measures for the waiver population differently, DHS could consider creating a collaborative workgroup inclusive of DHS and MCO participants to define a standard methodology for accounting for authorized services. As the MCOs continue to calculate the case management measures, further refinement of the measures could be completed through this workgroup. Once the methodology for all measures is standardized, DHS could consider developing minimum performance standards (MPSs) to monitor MCO performance of waiver case management standards.

Access to Care

- While the State's contract with the MCOs requires some time and distance standards (primary care, specialty care, behavioral health, and pharmacy) to be calculated using members' personal residences, other time and distance standards (emergency care, optometry, and lab and x-ray) do not specifically require the use of members' personal residences. DHS could provide clarity to the MCOs as to whether the intent is to always use members' personal residences for all time and distance standards or whether using member ZIP Codes from some standards is acceptable.
- To ensure members receive timely access to medically necessary care and services, DHS could mandate specific outreach requirements to ensure service authorization decisions are made with all available documentation; for example, requiring the MCOs and PAHPs to make at least two attempts to obtain missing clinical documentation. DHS could also consider requiring MCOs and PAHPs to keep the prior authorization (PA) request open for a certain number of days prior to allowing the PA to be denied due to a missing clinical documentation.
- When compared to national Medicaid benchmarks, the overall CY 2018 emergency department (ED) utilization rate ranked between the 50th and 75th percentiles, indicating utilization rates that are on the high end of the normal range. DHS should investigate further into whether this inappropriate ED utilization is due to members being unable to access primary care effectively or due to member conditions being ineffectively treated or managed in a primary care setting. DHS could require MCOs to conduct an internal review of their data. To ensure members are receiving access to the appropriate level of service, and based on the MCOs results, MCO-specific or statewide interventions could be implemented to promote appropriate use of EDs.
- To improve the accuracy of provider information, members' ability to successfully schedule an appointment, and the timeliness of available appointments relative to members' needs, DHS should monitor appointment availability to assess changes in the member experience based on the changes to the provider networks (i.e., UnitedHealthcare exiting the IA Health Link program and Iowa Total Care entering the IA Health Link program) by conducting follow-up telephone surveys. Monitoring activities may also include validation of the MCOs' network adequacy efforts, in alignment with federal regulations relating to the mandatory EQR-related activity described in the Centers for Medicare & Medicaid Services (CMS) rule §438.358(b)(1)(iv) which is further detailed in Section 8.
- DHS should consider reviewing the appointment availability standards and determine if prenatal-specific standards are appropriate for its member population. Compliance with appointment availability for specialist providers (i.e., 30 days) may not be clinically appropriate for a member seeking care in the second or third trimester of a pregnancy.

- DHS should consider expanding the current appointment availability surveys to assess provider data accuracy. In addition to evaluating the timeliness of appointments, the survey could verify providers' demographic information, including physician name, telephone number, and address. These responses could then be compared to DHS' provider data or the MCOs' electronic provider directories. Quantifying discrepancies between the electronic provider data and the providers' self-reported feedback would provide a foundation from which DHS could aid the MCOs in improving data quality, and subsequently, the accuracy of provider information available to Medicaid members.
- DHS should consider a review of underlying issues to determine the differences between MCNA and DDIA members' service utilization. Since MCNA members had significantly lower service utilization, HSAG recommends conducting either a secret shopper survey of dental providers to assess appointment availability or a provider directory audit to review the online provider information available to members. DHS should consider adding these future network adequacy studies to assess if the difference in utilization rates could be related to either the members' ability to contact the provider (i.e., is the contact information available and accurate?) or the members' ability to obtain an appointment when they call the provider.
- DHS should encourage MCNA to review its provider directory and identify providers who have not delivered services to any members in the past year to determine if the provider should remain contracted with the PAHP and why the provider has not delivered any services to Medicaid members.
- DHS should continue to collaborate with the PAHPs to identify and contract with additional providers in those areas with exceptionally long drive times and distances, as available. The provider categories of highest concern include endodontics, periodontics, and prosthodontics.
- DHS should consider implementing pay-for-performance measures that focus on increasing rates for lower-scoring HEDIS measures pertaining to preventive care; and specifically in the Women's Health domain.

Member Information and Communication

- In adherence to 42 CFR §438.10(c)(4)(i-ii) and to ensure consistency of member information and communication materials, DHS should:
  - Ensure state-developed managed care terminology for all terms required under federal regulations. The state-developed terminology should be used across MCOs and PAHPs.
  - Create and mandate the use of state-developed letter templates (e.g., notices of adverse benefit determination [NABDs], grievance resolution letters, appeal resolution letters, notice of the denial of an expedited service authorization, notice of the denial of an expedited appeal resolution, notice of a service authorization extension, notice of an appeal resolution extension). The state-developed letter templates should be used across MCOs and PAHPs.
- DHS should provide clarity or guidance to the MCOs surrounding requirements pertaining to member communication; and specifically, documentation of and the use of a member's preferred mode of communication, expectations for communicating with members via a secure portal, and what written member materials must be automatically provided in Spanish (when known) versus

providing these materials only upon request. While the recommendation is based on one MCO's activity findings, other MCOs may also benefit from this guidance.

Managed Care Organizations (MCOs)

For each MCO reviewed, HSAG provides the following summary of its overall key findings and conclusions based on each entity's performance. Sections 4 through 10 detail activity- and MCO-specific findings, strengths, and recommendations for the activities conducted.

Amerigroup

Compliance Monitoring Review—HSAG conducted a review of four of the State's 13 compliance review standards. Amerigroup received a total compliance score of 83 percent. Amerigroup achieved full compliance in the Practice Guidelines standard, indicating strong performance in this area.

Amerigroup scored 81 percent, 82 percent, and 80 percent, respectively, in the Coordination and Continuity of Care, Coverage and Authorization of Services, and Confidentiality of Health Information standards, indicating that additional focus is needed in these areas.

Performance Measures—HSAG validated a set of six state-defined performance measures calculated and reported by the MCOs for the July 1, 2017–June 30, 2018 (state fiscal year [SFY] 2018) measurement period. Amerigroup received a rating of *Report* for the following four performance measures: *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by the Member*, and *Member Choice of HCBS [Home and Community-Based]Settings.*

Amerigroup received a rating of *Not Reported* for the following two performance measures: *Receipt of Authorized Services (Informational Only)* and *Receipt of Authorized One-Time Services (Informational Only)*. HSAG identified several measure calculation steps and structural limitations of the data that potentially affected the production of performance measure rates and comparability with other MCOs' reported rates.

Amerigroup also submitted HEDIS Interactive Data Submission System (IDSS) files for HEDIS 2019 (CY 2018). HSAG compared the performance measure results to the National Committee for Quality Assurance's (NCQA's) Quality Compass®[1-4] national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019. For HEDIS 2019, 43 of 68 (63.2 percent) of Amerigroup's measure rates were above the 50th percentile, with 23 (33.8 percent) measure rates above the 75th percentile. Of note, Amerigroup demonstrated positive performance related to access to care for adults and children, outcomes for members with diabetes, ensuring members receive appropriate follow-up services after episodes related to mental illness or alcohol and other drugs (AOD) abuse and dependence, care for children and adolescents, and managing opioid and cardiovascular medications.

[1-4] Quality Compass® is a registered trademark of the NCQA.

Conversely, Amerigroup demonstrated opportunities for improvement in several areas, particularly related to preventive care for children, medication management, appropriately monitoring adults on antipsychotics, and managing members with behavioral health conditions through appropriate follow-up care or pharmacotherapy. Amerigroup should work with providers to ensure that children and adults with behavioral health conditions receive appropriate medications and receive appropriate monitoring to identify any adverse effects (e.g., type 2 diabetes, concerning changes in mood).

Performance Improvement Projects—HSAG validated two PIPs for Amerigroup for the 2019 validation cycle: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction*. Both PIPs received an overall validation score of 85 percent for all applicable evaluation elements. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received an overall *Partially Met* validation status, and the *Member Satisfaction* PIP received an overall *Not Met* validation status.

Amerigroup demonstrated a statistically significant improvement over the baseline for the study indicator for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP topic. While the *Member Satisfaction* PIP demonstrated improvement, that improvement was not statistically significant. Amerigroup did not meet the plan-specific goals for either PIP topic.

Network Adequacy—HSAG conducted the statewide secret shopper telephone survey of obstetrics/gynecology (OB/GYN) providers enrolled with Amerigroup. Survey results indicated a relatively high rate of data accuracy, with over 90 percent of contacted provider locations accepting Amerigroup and almost 90 percent of participating providers confirming their provider type (i.e., OB/GYN provider) and acceptance of new patients.

While HSAG callers were able to contact 254 of the 336 provider locations in the survey sample, they were only able to obtain appointment dates for new Medicaid patients at 91 provider locations. Among those calls that garnered an appointment, 98.1 percent and 82.1 percent of the first and second trimester calls, respectively, were in compliance with the 30-day contract standard.

CY 2018 Encounter Data Validation—HSAG conducted a comparative analysis between DHS' electronic encounter data and the data extracted from Amerigroup's data system. HSAG evaluated the encounter data record omission rate, record surplus rate, element omission rate, element surplus rate, element accuracy rate, and all-element accuracy rate for professional encounters, institutional encounters, and pharmacy encounters with dates of service between January 1, 2017, and December 31, 2017.

- No issues were noted with regard to the record omission and surplus rates for professional encounters, or for pharmacy encounters. Additionally, while no issues were noted with regard to the record omissions for institutional encounters, the record surplus rate was relatively high.
- No issues were noted with regard to data element accuracy rates associated with the evaluated data elements for professional encounters; however, findings were noted for the element omission rate for one data element (Referring Provider NPI [National Provider Identifier]) and the element surplus rate for one data element (Rendering Provider NPI).

- No issues were noted with regard to the data element surplus rates associated with the evaluated data elements for institutional encounters; however, findings were noted for the element omission rates for three data elements (Admission Date, Primary Diagnosis Code, and Secondary Diagnosis Code) and the element accuracy rate for two elements (Admission Date and Header Paid Amount).
- No issues were noted with regard to the data element omission, data element surplus, and data element absent associated with data elements that were evaluated for the pharmacy encounters; however, findings were noted for the element accuracy rate for two data elements (Header Paid Amount and Dispensing Fee).

While the comparative analysis results indicated relatively complete and accurate data, instances of high rates of omission, surplus, and inaccuracies—coupled with variation between MCOs—suggest the noted findings were related to data submission issues with the transmission of data to HSAG.

CY 2019 Encounter Data Validation—HSAG initiated a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 EDV study were addressed and to determine if the completeness and accuracy of DHS' encounter data are sufficient for future MRR activities. The 2019 EDV study was ongoing at the time of this report; therefore, Amerigroup's 2019 EDV study results will be presented in the CY 2020 EQR Technical Report.

UnitedHealthcare

Compliance Monitoring Review—HSAG conducted a review of four of the State's 13 compliance review standards. UnitedHealthcare received a total compliance score of 80 percent. UnitedHealthcare achieved full compliance in the Practice Guidelines standard, indicating strong performance in this area.

UnitedHealthcare scored 81 percent, 88 percent, and 60 percent, respectively, in the Coordination and Continuity of Care, Coverage and Authorization of Services, and Confidentiality of Health Information standards, indicating that additional focus in needed in these areas.

Performance Measures—HSAG validated a set of six state-defined performance measures calculated and reported by the MCOs for the July 1, 2017–June 30, 2018 (SFY 2018) and July 1, 2018–June 30, 2019 (SFY 2019) measurement periods. UnitedHealthcare received a rating of *Report* for the following four performance measures: *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by the Member*, and *Member Choice of HCBS Settings.*

UnitedHealthcare received a rating of *Not Reported* for the following two performance measures: *Receipt of Authorized Services (Informational Only)* and *Receipt of Authorized One-Time Services (Informational Only)*. HSAG identified several measure calculation steps and structural limitations of the data that potentially affected the production of performance measure rates and comparability with other MCOs' reported rates.

UnitedHealthcare also submitted HEDIS IDSS files for HEDIS 2019 (CY 2018). HSAG compared the performance measure results to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019. For HEDIS 2019, 40 of 68 (58.8 percent) of UnitedHealthcare's measure rates were above

the 50th percentile, with 26 (38.2 percent) measure rates above the 75th percentile. Of note, UnitedHealthcare demonstrated positive performance related to access to care for adults and children; ensuring members receive appropriate follow-up services after episodes related to mental illness or AOD abuse and dependence; immunizations and well-care visits for children and adolescents; and medication management for opioids, and cardiovascular and statin medications.

Conversely, UnitedHealthcare demonstrated opportunities to improve care related to preventive care for adults and children, screenings and pregnancy care for women, appropriately treating members for cardiovascular disease and rheumatoid arthritis, appropriately monitoring adults and children on antipsychotics, and prescribing medications to manage chronic respiratory conditions.

Performance Improvement Projects—HSAG validated two PIPs for UnitedHealthcare for the 2019 validation cycle: *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction*. The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received an overall validation score of 85 percent for all applicable evaluation elements and an overall *Met* validation status. The *Member Satisfaction* PIP received an overall validation score of 65 percent for all applicable evaluation elements and an overall *Not Met* validation status.

UnitedHealthcare demonstrated a statistically significant decline over the baseline measurement for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP. While the *Member Satisfaction* PIP demonstrated some improvement, that improvement was not statistically significant. UnitedHealthcare did not meet the plan-specific goals for either PIP topic.

Network Adequacy Validation—UnitedHealthcare exited the IA Health Link program prior to the initiation of the secret shopper telephone survey of OB/GYNs; therefore, there are no results to report.

CY 2018 Encounter Data Validation—HSAG conducted a comparative analysis between DHS' electronic encounter data and the data extracted from UnitedHealthcare's data system. HSAG evaluated the encounter data record omission rate, record surplus rate, element omission rate, element surplus rate, element accuracy rate, and all-element accuracy rate for professional encounters, institutional encounters, and pharmacy encounters with dates of service between January 1, 2017, and December 31, 2017.

- No issues were noted with respect to the professional and pharmacy encounters, where both the record omission and surplus rates were low; however, for institutional encounters, the record omission and record surplus rates were relatively high.
- No issues were noted with regard to data element accuracy rates associated with the evaluated data elements for professional encounters; however, findings were noted for the element omission rate for one data element (*Referring Provider NPI*) and the element surplus rate for one data element (*Rendering Provider NPI*).
- No issues were noted with regard to the data element surplus rates associated with the evaluated data elements; however, findings were noted for the element omission rates for three data elements (*Admission Date*, *Primary Diagnosis* Code, and *Secondary Diagnosis Code*) and the element accuracy rate for one data element (*Header Paid Amount*).

- No major issues were noted with respect to data element completeness and accuracy for pharmacy encounters.

While the comparative analysis results indicated relatively complete and accurate data, instances of high rates of omission, surplus, and inaccuracies—coupled with variation between MCOs—suggest the noted findings were related to data submission issues with the transmission of data to HSAG.

CY 2019 Encounter Data Validation—HSAG initiated a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 EDV study were addressed and to determine if the completeness and accuracy of DHS' encounter data are sufficient for future MRR activities. The 2019 EDV study was ongoing at the time of this report; therefore, UnitedHealthcare's 2019 EDV study results will be presented in the CY 2020 EQR Technical Report.

Iowa Total Care

Compliance Monitoring Review—DHS contracted with HSAG in CY 2019 to complete a follow-up review to the readiness review completed in April 2019, which included 10 of the State's 13 compliance review standards in addition to Program Integrity. Iowa Total Care received a total compliance score of 81 percent. Iowa Total Care scored 90 percent or above in the Availability of Services, Provider Network, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Quality Assessment and Performance Improvement, and Program Integrity standards, indicating strong performance in these areas.

Iowa Total Care's scores in these areas indicate that each needs additional focus: Assurances of Adequate Capacity and Services (60 percent); Coordination and Continuity of Care (67 percent); Coverage and Authorization of Services (50 percent); Member Information and Member Rights (63 percent); and Grievances, Appeals and State Fair Hearings (89 percent).

Caution should be used when interpreting Iowa Total Care's overall performance based on the CY 2019 compliance review scores alone. Iowa Total Care demonstrated compliance with the majority of applicable elements during the CY 2019 readiness review (see Operational Readiness Review and Information Systems Readiness Review summaries below); therefore, those elements were not included in the compliance review.

Performance Measures—As Iowa Total Care joined the IA Health Link program effective July 1, 2019, and did not have data for reporting performance measures for the 2019 measurement period, HSAG conducted an Information Systems Capabilities Assessment (ISCA) for Iowa Total Care. HSAG had no concerns with Iowa Total Care's data processing, integration, and measure production processes. HSAG determined that Iowa Total Care followed the State's specifications and will be able to produce reportable rates for all measures in the scope of the validation of performance measures next year.

Performance Improvement Projects—As Iowa Total Care entered the IA Health Link program effective July 1, 2019, it will participate in future PIP validation activities. HSAG conducted a PIP technical assistance training with Iowa Total Care in preparation for the CY 2020 activity.

Network Adequacy—As Iowa Total Care entered the IA Health Link program effective July 1, 2019, it did not participate in the CY 2019 activity. Iowa Total Care will participate in future network adequacy activities at the request of DHS.

Encounter Data Validation—Because CY 2019 is the first year Iowa Total Care will submit encounter data to DHS, HSAG initiated an information systems (IS) review. The 2019 EDV study was ongoing at the time of this report; therefore, Iowa Total Care's IS review results will be presented in the CY 2020 EQR Technical Report.

Operational Readiness Review—HSAG conducted an operational readiness review of Iowa Total Care, which included a review of 13 operational standards. Iowa Total Care received a score of *Complete* for 92 percent of the elements reviewed. Iowa Total Care achieved 100 percent *Complete* scores for the Confidentiality of Health Information, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Practice Guidelines, and Program Integrity standards, demonstrating readiness to perform applicable requirements in these areas.

Iowa Total Care received *Incomplete* scores for 14 elements (8 percent of all applicable elements) across these standards: Availability of Services; Assurances of Adequate Capacity and Services; Coordination and Continuity of Care; Coverage and Authorization of Services; Provider Network; Member Information and Member Rights; Grievance, Appeals and State Fair Hearings; and Quality Assessment and Performance Improvement. Further, HSAG identified deficiencies in two critical areas: establishment of an adequate and accessible provider network, and the quantity of case managers employed by Iowa Total Care for the LTSS population. Of the 14 elements receiving *Incomplete* scores, nine elements (5 percent of all applicable elements) received *Incomplete—Critical* scores across these standards: Availability of Services; Assurances of Adequate Capacity and Services; Coverage and Authorization of Services; Member Information and Member Rights; Grievance, Appeals and State Fair Hearings; and Quality Assessment and Performance Improvement standards. Iowa Total Care developed a remediation plan to remedy all elements that received a score of *Incomplete* or *Incomplete—Critical* which was accepted by DHS.

Information Systems Readiness Review—HSAG conducted an information systems (IS) readiness review of Iowa Total Care, which included a review of one IS standard and claims system testing scenarios. Iowa Total Care received a score of *Complete* for all elements reviewed under the Health Information Systems standard, demonstrating readiness to perform applicable requirements in this area. Iowa Total Care received a 97.4 percent compliant score for the claims testing scenarios. Further, while a remediation plan was necessary to address one noted deficiency in the claims system testing scenarios, there were no claims processing deficiencies that would have impeded Iowa Total Care's ability and capacity to perform the claims processing responsibilities outlined in its contract with DHS.

Prepaid Ambulatory Health Plans (PAHPs)

For each PAHP reviewed, HSAG provides the following summary of its overall key findings and conclusions based on each entity's performance. Sections 4, 5, 7, 8, and 9 detail activity- and PAHP-specific findings, strengths, and recommendations for the activities conducted.

Delta Dental

Compliance Monitoring Review—HSAG conducted a follow-up review to the CY 2018 compliance review corrective action plans (CAPs). From the combined CY 2018 and CY 2019 results, DDIA received a total compliance score of 91 percent. DDIA scored 90 percent or above in the Availability of Services, Assurances of Adequate Capacity and Services, Provider Network, Enrollee Information and Enrollee Rights, Confidentiality of Health Information, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Practice Guidelines, and Health Information Systems, indicating strong performance in these areas.

DDIA scored 86 percent, 79 percent, 84 percent, and 82 percent, respectively, in the Coordination and Continuity of Care; Coverage and Authorization of Services; Grievance and Appeal System; and Quality Assessment and Performance Improvement standards. These scores indicate that additional focus is needed in these areas.

Performance Measures—DHS identified a set of four performance measures that the PAHPs are required to calculate and report. These measures are required to be reported following the measure descriptions included in the rate reporting templates created by DHS. DHS identified the measurement period as July 1, 2018, through June 30, 2019, reported as rolling quarters. Based on HSAG's validation of performance measures, DDIA demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with DDIA's processes. HSAG did identify some opportunities during primary source verification (PSV) regarding interpretation of the specifications and how that affected the rate calculations. After direction was provided and a corrected performance rate template was resubmitted, DDIA received a measure designation of *Report* for all performance measures included in the PMV activity.

Performance Improvement Projects—HSAG validated the *Annual Dental Visits* PIP for DDIA during the 2019 validation cycle. The PIP received an overall *Met* score for 100 percent of critical evaluation elements and 91 percent overall for evaluation elements across all activities completed and validated. DDIA's performance on this PIP suggests a thorough application of the PIP Design stage (Steps I through VI) and Implementation stage (Step VII). While DDIA performed well for two of the three data analysis and interpretation steps, DDIA had opportunities for improvement relating to factors that may threaten the validity of the data reported. The PIP included only baseline results for this validation cycle and had not progressed to the Outcomes stage.

Network Adequacy Validation—HSAG conducted a provider network analysis that assessed aspects of realized access including member utilization of dental services, provider saturation (i.e., the number of providers contracted with Medicaid PAHPs), and the percentage of active providers. Findings indicated that DDIA contracted with 26.8 percent of general dentists within the State. Over 95 percent of contracted general dentists, oral surgeons, orthodontists, and pedodontists were active providers and had evidence (i.e., claims) of providing services to members during the CY 2018 measurement period. Over 40 percent of DDIA's members had evidence of receiving dental services during the measurement period.

Encounter Data Validation—HSAG conducted a comparative analysis of DHS' electronic dental encounter data completeness and accuracy through a comparative analysis between DHS' electronic dental encounter data and the data extracted from the DDIA's data system.

- No issues were noted with regard to the record omission rate, and the record surplus rate was also relatively low.
- The data element omission rates were very low, and the data element surplus rates were very low except for two data elements (*Tooth Surface 1* and *Tooth Surface 2*). For records that matched between the two data sources and with data element values populated in both sources, all key data elements that were evaluated showed high accuracy rates except for one data element (*Billing Provider NPI*).

MCNA Dental

Compliance Monitoring Review—HSAG conducted a follow-up review to the CY 2018 compliance review CAPs. From the combined CY 2018 and CY 2019 results, MCNA received a total compliance score of 97 percent. MCNA scored 90 percent or above in these areas, indicating strong performance: Availability of Services; Assurance of Adequate Capacity and Services; Coordination and Continuity of Care; Coverage and Authorization of Services; Provider Network; Enrollee Information and Enrollee Rights; Confidentiality of Health Information; Enrollment and Disenrollment; Grievance and Appeal System; Subcontractual Relationships and Delegation; Quality Assessment and Performance Improvement; and Health Information Systems.

MCNA scored 86 percent in the Practice Guidelines standard, indicating that additional focus is needed in this area.

Performance Measures—DHS identified a set of four performance measures that the PAHPs are required to calculate and report. These measures are required to be reported following the measure descriptions included in the rate reporting templates created by DHS. DHS identified the measurement period as July 1, 2018, through June 30, 2019, reported as rolling quarters. Based on HSAG's PMV, MCNA demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with MCNA's processes. HSAG did identify some opportunities during PSV regarding interpretation of the specifications and how that affected the rate calculations. After direction was provided and a corrected performance rate template was resubmitted, MCNA received a measure designation of *Report* for all performance measures included in the PMV activity.

Performance Improvement Projects— HSAG validated the *Increase the Percentage of Dental Services* PIP for MCNA during the 2019 validation cycle. The PIP received an overall *Met* score for 100 percent of critical evaluation elements and 91 percent overall for evaluation elements across all activities completed and validated. MCNA's performance on this PIP suggests a thorough application of the PIP Design stage (Steps I through VI) and Implementation stage (Step VII). While MCNA performed well for three of the four criteria for collecting data in Step VI, MCNA had opportunities for improvement

relating to administrative data completeness. The PIP included only baseline results for this validation cycle and had not progressed to the Outcomes stage.

Network Adequacy Validation—HSAG conducted a provider network analysis that assessed aspects of realized access including member utilization of dental services, provider saturation (i.e., the number of providers contracted with Medicaid PAHPs), and the percentage of active providers. Findings indicated that MCNA contracted with 8.2 percent of general dentists within the State. Over 74 percent of contracted general dentists and oral surgeons were active providers and had evidence (i.e., claims) of providing services to members during the CY 2018 measurement period. Over 20 percent of MCNA's members had evidence of receiving dental services during the measurement period.

Encounter Data Validation—HSAG conducted a comparative analysis of DHS' electronic dental encounter data completeness and accuracy through a comparative analysis between DHS' electronic dental encounter data and the data extracted from the MCNA's data system.

- No issues were noted with regard to the record omission and surplus rates.

The data element omission rates were 0.0 percent for all key dental data elements that were evaluated. The data element surplus rates were very low except for two data elements (*Tooth Surface 1* and *Tooth Surface 2*). For records that matched between the two data sources and with data element values populated in both sources, all key data elements that were evaluated showed high accuracy rates.

2. Overview of Iowa's Managed Care Program

Iowa Medicaid Managed Care Service Delivery Overview

In April 2016, DHS transitioned most Medicaid members to the IA Health Link managed care program. The State of Iowa made this change to bring healthcare delivery under one system, which allows for Medicaid-enrolled family members to receive care from the same health plan. This plan creates one system of care to help deliver efficient, coordinated, and improved healthcare, and creates responsibility in healthcare coordination. The program currently provides health coverage through two contracted MCOs that provide members with comprehensive healthcare services, including physical health, behavioral health, and LTSS. Beginning July 1, 2017, most adult Medicaid members, ages 19 and older, were enrolled in the DWP. Dental benefits through the DWP were administered by two PAHPs. In addition to the DWP, dental benefits are offered through the Hawki program,[2-1] the State's CHIP.

Managed Care Organizations

While the IA Health Link program is currently administered by two MCOs, DHS held contracts with three MCOs during the review period for this annual report. Table 2-1 presents the three MCOs and the dates of participation in the IA Health Link program during this review period. Each MCO provided for the delivery of healthcare services to enrolled IA Health Link members.

Table 2-1—Overview of Iowa MCOs

MCO	Total Enrollment[1,2]	Participation in Iowa Medicaid Market in CY 2019	Covered Services[3]	Service Area
Amerigroup	377,456	January 1, 2019–December 31, 2019	• Preventive Services • Professional Office Services • Inpatient Hospital Admissions • Inpatient Hospital Services • Outpatient Hospital Services • Emergency Care	Statewide
UnitedHealthcare	No current enrollment[4,5,6]	January 1, 2019–June 30, 2019		

[2-1] Dental benefits offered through the Hawki program are administered by DDIA only.

MCO	Total Enrollment[1,2]	Participation in Iowa Medicaid Market in CY 2019	Covered Services[3]	Service Area
Iowa Total Care	257,806	July 1, 2019–December 31, 2019	• Behavioral Health Services • Outpatient Therapy Services • Prescription Drug Coverage • Prescription Drug Copay • Radiology Services • Laboratory Services • Durable Medical Equipment (DME) • LTSS—Community Based • LTSS—Institutional • Hospice • Health Homes	

1 Iowa Department of Human Services. Medicaid Managed Care Monthly Reports: January 2020. Available at: https://dhs.iowa.gov/sites/default/files/MCO%20counts%202020-01.pdf?011320201427. Accessed on: Jan 23, 2020.

2 Enrollment data include members enrolled in Hawki, Medicaid, and the Iowa Health and Wellness Plan (IHAWP).

3 Iowa Medicaid Enterprise. *2017 Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination.* Available at: https://dhs.iowa.gov/sites/default/files/Comm519.pdf. Accessed on: Dec 19, 2019.

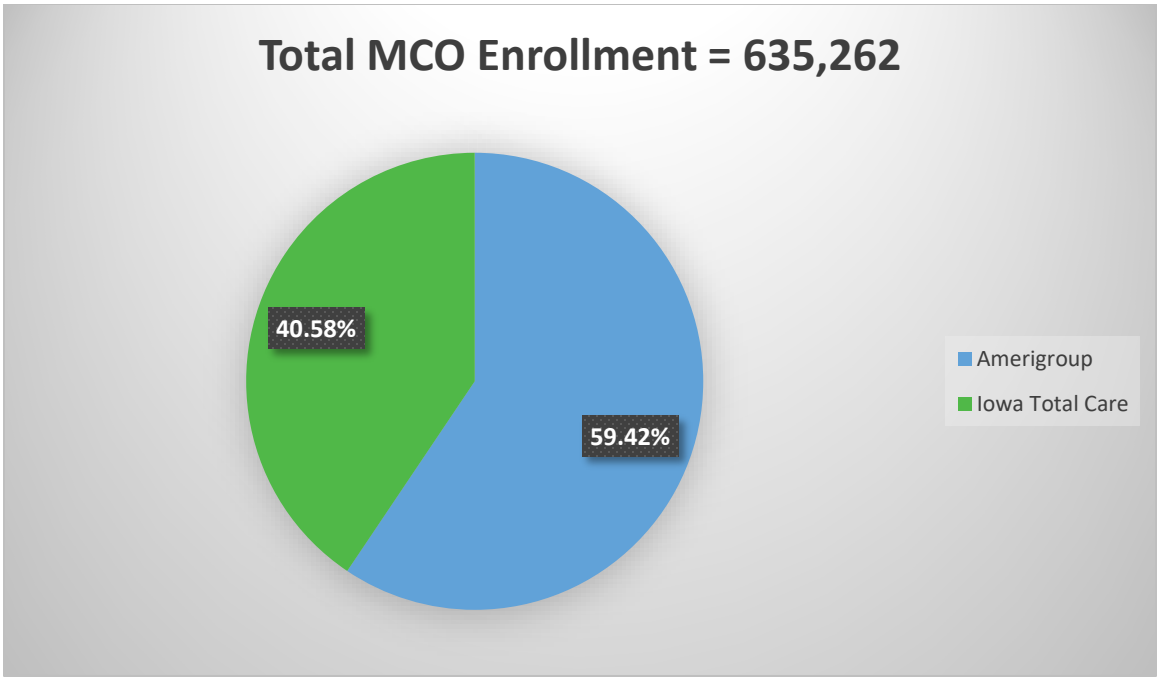
4 UnitedHealthcare had 394,531 enrolled members at the time the MCO exited the IA Health Link program on July 1, 2019.

5 Iowa Medicaid Enterprise. Managed Care Organization Report: SFY 2019, Quarter 4 (April–June) Performance Data published on October 9, 2019. Available at: https://dhs.iowa.gov/sites/default/files/SFY19_Q4_Report.pdf?100920191311. Accessed on: Jan 23, 2020.

6 June 2019 enrollment data as of July 31, 2019—data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

DHS' January 2020 monthly report identified 635,262 members enrolled in the two current MCOs delivering healthcare services for the IA Health Link program. The figure below outlines the total MCO enrollment distribution.

Figure 2-1—MCO Enrollment Distribution[2-2,2-3]



2-2 Iowa Department of Human Services. Medicaid Managed Care Monthly Reports: January 2020. Available at: https://dhs.iowa.gov/sites/default/files/MCO%20counts%202020-01.pdf?011320201427. Accessed on: Jan 23, 2020.

2-3 Enrollment data include members enrolled in Hawki, Medicaid, and the Iowa Health and Wellness Plan (IHAWP).

Prepaid Ambulatory Health Plans

DHS held contracts with two PAHPs during the review period for this annual report. The PAHPs manage the delivery of dental healthcare services to enrolled DWP members.

Table 2-2—Overview of Iowa PAHPs

PAHP	Total Enrollment[1,2]	Covered Services[3]	Service Area
DDIA	277,815	• Diagnostic and Preventive Services (exams, cleanings, x-rays, and fluoride) • Fillings for Cavities • Surgical and Non-Surgical Gum Treatment • Root Canals • Dentures and Crowns • Extractions	Statewide
MCNA	113,275		

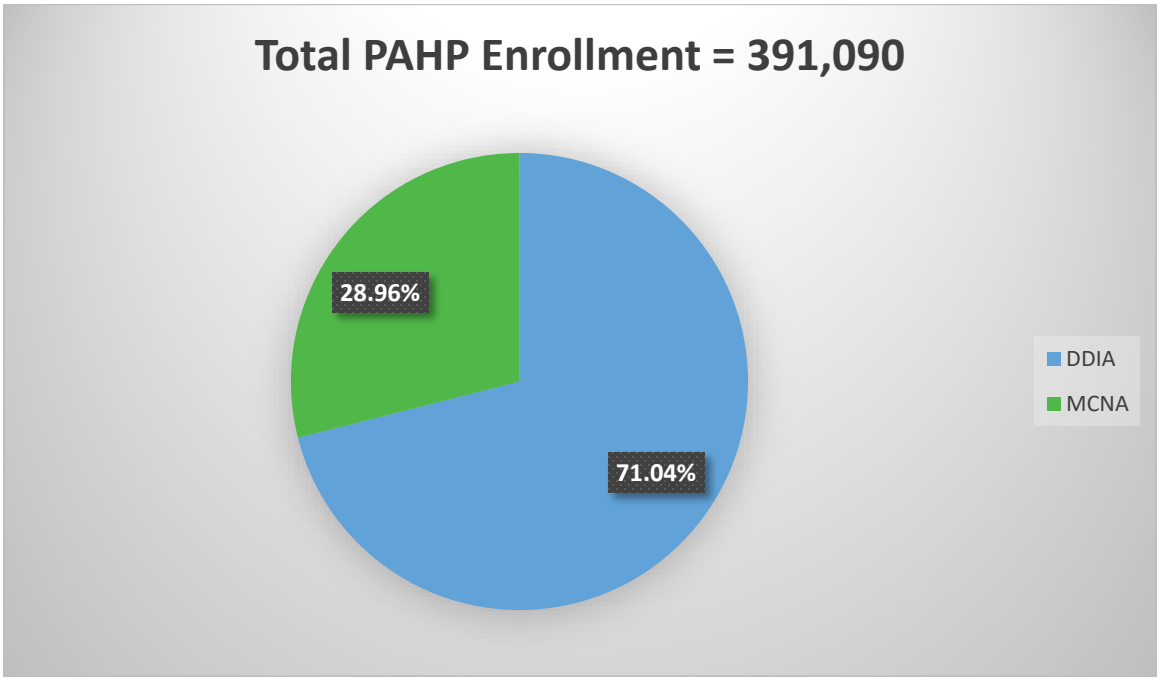
[1] Enrollment data provided by DHS on January 21, 2020. Data displayed presents December 2019 membership reported as of January 10, 2020.

[2] DDIA's enrollment data include members in the Hawki and Iowa Health and Wellness Plan, and Medicaid fee-for-service (FFS). MCNA's enrollment data include members enrolled in the Iowa Health and Wellness Plan and Medicaid FFS only.

[3] DWP members have access to full dental benefits during the first year of enrollment. DWP members must complete "Healthy Behaviors" (composed of both an oral health self-assessment and preventive service) during the first year to keep full benefits and pay no monthly premiums the next year. More information on dental benefits can be found at https://dhs.iowa.gov/dental-wellness-plan/benefits.

December 2019 enrollment data identified 391,090 members enrolled in the two PAHPs. The figure below outlines the total PAHP enrollment distribution.

Figure 2-2—PAHP Enrollment Distribution[2-4,2-5]



2-4 Enrollment data provided by DHS on January 21, 2020. Data displayed presents December 2019 membership reported as of January 10, 2020.

2-5 DDIA's enrollment data include members in the Hawki and Iowa Health and Wellness Plan, and Medicaid FFS. MCNA's enrollment data include members enrolled in the Iowa Health and Wellness Plan and Medicaid FFS only.

Quality Initiatives Driving Improvement

The Iowa Medicaid Managed Care Quality Assurance System[2-6,2-7] outlines DHS' strategy for assessing and improving the quality of managed care services offered by its contracted MCOs and PAHPs using a triple aim framework. The triple aim goal is to improve outcomes, improve patient experience, and ensure that Medicaid programs are financially sustainable. While the overarching goal of the quality plan and managed care is to improve the health of Iowa Medicaid members, DHS' program aims to accomplish the following:

Table 2-3—Iowa Medicaid Managed Care Quality Assurance System

Quality Strategy Objective	MCOs	PAHPs
1. Promote appropriate utilization of services within acceptable standards of medical/dental practice.		
2. 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.	• Timely review of PAHP network adequacy reports. • Incentivizing access to preventive dental services.
3. Comply with State and federal regulatory requirements through the development and monitoring of quality improvement (QI) policies and procedures by: • Annually reviewing and providing feedback on MCO/PAHP quality strategies. • Quarterly reviewing of MCO/PAHP quality meeting minutes.		
4. Reduce healthcare costs while improving quality:	• Increasing provider participation and covered lives in accountable care organizations to 50 percent. • Increasing the utilization of a health risk screening tool that collects standardized social determinants of health (SDOH) data and measures patient confidence, then ties those results to value-based purchasing agreements.	• 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 preventive services.

2-6 Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Managed Care Quality Assurance System*: 2018. Available at: https://dhs.iowa.gov/sites/default/files/2018%20Managed%20Care%20Quality%20Plan.pdf?042320192039. Accessed on: Jan 23, 2020.

2-7 Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019*. Available at: https://dhs.iowa.gov/sites/default/files/2019%20Dental%20PAHP%20Quality%20Strategy.pdf?060520191449. Accessed on: Jan 7, 2020.

Quality Strategy Objective	MCOs	PAHPs
5. Provide care coordination to members based on HRAs by:	• Quarterly monitoring of 70 percent initial HRA completion within 90 days of enrollment.	• Monitoring of HRA completion for members continuously enrolled for 6 months.
6. Ensure that transitions of care do not have adverse effects by:	• Maintaining historical utilization file transfers between DHS and MCOs, including the information needed to effectively transfer members. • Monitoring community rebalancing to ensure that members choosing to live in the community remain in the community.	• Maintaining historical utilization file transfers between the DHS and PAHPs, including the information needed to effectively transfer members.
7. Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist MCOs/PAHPs with implementation of improvement strategies through:	• Chartering a collaborative quality management committee that meets at least quarterly. • Regularly monitoring health outcomes measure performance.	• Regularly monitoring health outcomes measure performance.
8. Promote the use and interoperability of health information technology between providers, MCO/PAHPs, and Medicaid.		

To accomplish its objectives, Iowa has several ongoing activities regarding quality initiatives. These initiatives are discussed below.

Health Home (Integrated Health Homes and Chronic Condition Health Homes)

DHS conducted additional analysis of the Health Home Program based on workgroup recommendations and reconvened the workgroup. DHS and the MCOs restarted the Learning Collaborative, implemented a chart review process and an MCO self-assessment, and plan to implement a Health Home Self-Assessment in 2020. Both State Plan amendments will be updated in 2020 as well as performance measures with a strategic plan of Health Home Program oversight.

Increased Access to Medication Assisted Therapy (MAT)

DHS issued Informational Letters No. 2000-MC-FFS and No. 2025-MC-FFS regarding the coverage of MAT. MAT therapies require that a provider be certified by the Substance Abuse and Mental Health Services Administration (SAMHSA) and accredited by an independent SAMHSA-approved accrediting body to dispense opioid treatment medications. Behavioral health service provider enrollment files have been updated for those providers that dispense opioid treatment to reflect SAMHSA Opioid Treatment Program certification. This is to assure that payment is only made to programs that are certified to

provide opioid treatment. Effective February 1, 2020, the clinical prior authorization (PA) criteria for MAT drugs were removed and PA Form 470-5142 Buprenorphine/Naloxone is no longer required. DHS continued to participate in the Iowa Department of Public Health (IDPH)-sponsored workgroup to complete a substance use disorder (SUD) reimbursement cost study based on projected cost reports completed by the IDPH Integrated Provider Network (IPN).

Increasing Value-Based Purchasing and Expanding to Pilot Programs in LTSS and Behavioral Health

As the State Innovation Model (SIM) test grant concluded, DHS continues to refine its approach to a value-based purchasing (VBP) strategy through its Medicaid managed care plans. The near-term focus is on continuing to increase the Health Care Payment Learning & Action Network (HCP-LAN) maturity model year over year, as well as aligning health plan approaches where possible to help simplify the myriad of changes providers need to understand and execute in order to thrive under VBP relationships. In January, Iowa applied for an Innovation Accelerator Program (IAP) technical assistance opportunity around VBP planning. If approved, this would be a dedicated project in collaboration with external partners and expertise to build a strategic roadmap defining "where the State is at" with VBP currently, where the State wants to go, and how to get it there. Emphasis has also been placed on building the ability to leverage SDOH not only within the clinical care continuum, but also as a way to bring the patient voice into informing quality measurement and oversight of program outcomes. To date, DHS has convened a workgroup of stakeholders that has identified a core group of SDOH questions which will be rolled into managed care screening requirements for data consistency across plans and in other external efforts.

3. Introduction to the Annual Technical Report

Purpose of Report

As required by CFR 42 §438.364,[3-1] the DHS contracts with HSAG, an EQRO, to prepare an annual, independent, technical report. As described in the CFR, the independent report must summarize findings on access, timeliness, and quality of care, including:

- A description of the manner in which the data from all activities conducted in accordance with §438.358 were aggregated and analyzed, and conclusions were drawn as to the quality and timeliness of, and access to the care furnished by the MCO, prepaid inpatient health plan (PIHP), PAHP, or primary care case management (PCCM) entity (described in §438.310[c][2]).
- For each EQR-related activity conducted in accordance with §438.358:
  - Objectives
  - Technical methods of data collection and analysis
  - Description of data obtained, including validated performance measurement data for each activity conducted in accordance with §438.358(b)(1)(i) and (ii)
  - Conclusions drawn from the data
- An assessment of each MCO, PIHP, PAHP, or PCCM entity's strengths and weaknesses for the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Recommendations for improving the quality of healthcare services furnished by each MCO, PIHP, PAHP, and PCCM entity, including how the State can target goals and objectives in the quality strategy, under §438.340, to better support improvement in the quality and timeliness of, and access to healthcare services furnished to Medicaid beneficiaries.
- Methodologically appropriate, comparative information about all MCOs, PIHPs, PAHPs, and PCCM entities, consistent with guidance included in the EQR protocols issued in accordance with §438.352(e).
- An assessment of the degree to which each MCO, PIHP, PAHP, or PCCM entity has effectively addressed the recommendations for QI made by the EQRO during the previous year's EQR.

2019 External Quality Review (EQR) Activities

At the request of DHS, HSAG performed a set of mandatory and optional EQR activities, as described in 42 CFR §438.358. These activities are briefly described below. Refer to Appendix A. MCO Technical

[3-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Federal Register*/Vol. 81, No. 88/Friday, May 6, 2016. 42 CFR Parts 431,433, 438, et al. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability; Final Rule. Available at: https://www.gpo.gov/fdsys/pkg/FR-2016-05-06/pdf/2016-09581.pdf. Accessed on: Jan 23, 2020.

Methods of Data Collection and Analysis, and Appendix B. PAHP Technical Methods of Data Collection and Analysis for a detailed description of each activity's methodology.

MCO Mandatory Activities

Compliance Monitoring—HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews by arranging the State and federal Medicaid managed care requirements into the 13 performance areas also referred to as standards. Beginning in CY 2018, DHS requested that HSAG conduct MCO compliance reviews over a three-year cycle with one-third of the standards being reviewed each year. This report presents the results of the second year of the three-year cycle for Amerigroup and UnitedHealthcare, which includes a review of four of the 13 performance categories.

As this is the first year HSAG has conducted a compliance review for Iowa Total Care, DHS requested that the scope of the review be a follow-up review of the standards and findings from HSAG's readiness review that was conducted in April 2019. The CY 2019 compliance review focused on a review of elements that received a score of *Incomplete* and *Not Applicable* during the readiness review, and a review of elements applicable to the case file reviews.

Performance Measures—HSAG validated a set of six state-defined performance measures calculated and reported by the MCOs (Amerigroup and UnitedHealthcare) for the CY 2018 and/or CY 2019 measurement period. The performance measures selected focused on person-centered care planning for members receiving services through HCBS waiver programs. As Iowa Total Care joined the IA Health Link program effective July 1, 2019, and did not have data for reporting performance measures for the 2019 measurement period, HSAG conducted an ISCA for Iowa Total Care.

The IA Health Link MCOs also submitted HEDIS IDSS files for HEDIS 2019 (CY 2018). To assess MCO performance, HSAG compared the performance measure results to NCQA's Quality Compass national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2019. HSAG displayed results for 68 performance measure rates for CY 2018. Additionally, the measures were grouped into the following six domains of care: Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, Keeping Kids Healthy, and Medication Management.

Validation of Performance Improvement Projects—The MCOs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's and PAHP's PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2019 validation cycle. The goal of HSAG's PIP validation is to ensure that DHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the QI strategies and activities.

Network Adequacy—HSAG conducted a statewide secret shopper telephone survey in August 2019, among a sample of OB/GYN providers enrolled in Amerigroup. The goals of the telephone survey were to ascertain whether the providers were accepting new patients enrolled in Medicaid programs and to assess appointment availability.

MCO Optional Activities

CY 2018 Encounter Data Validation—HSAG conducted an EDV study that included the following two core evaluation activities: 1) Comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems, and 2) Technical assistance—follow-up assistance provided to MCOs that performed poorly in the comparative analysis. HSAG used data from both DHS and the MCOs with dates of service between January 1, 2017, and December 31, 2017, to evaluate the accuracy and completeness of the encounter data.

CY 2019 Encounter Data Validation—For Amerigroup and UnitedHealthcare, HSAG previously conducted an IS review in CY 2016, an administrative profile in CY 2017, and a comparative analysis in CY 2018. An MRR would typically follow a comparative analysis activity. Since an MRR is a complex, resource-intensive process, a sufficient level of completeness and accuracy of DHS' encounter data is recommended based on the comparative analysis results before conducting the MRR activity. As such, based on the CY 2018 comparative analysis results, DHS and HSAG determined that an MRR activity would not be recommended during the CY 2019 EDV study. Therefore, for Amerigroup and UnitedHealthcare, HSAG initiated a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 EDV study were addressed and to determine if the completeness and accuracy of DHS' encounter data are sufficient for future MRR activities. Because CY 2019 is the first year Iowa Total Care submitted encounter data to DHS, HSAG initiated an IS review only with Iowa Total Care in CY 2019.

Calculation of Potentially Preventable Events—HSAG calculated PPEs to assess current statewide performance and identify strengths and weaknesses. HSAG analyzed statewide ED visits for Medicaid members enrolled in managed care to provide performance measure results. These rates will help support DHS target and improve PPEs. HSAG calculated the PPE measure rates for the measurement period January 1, 2018–December 31, 2018, using administrative data only.

Scorecard—The future IA Health Link Scorecard will support DHS' reporting of MCO performance information to be used by consumers to make informed decisions about their healthcare. To support the future IA Health Link Scorecard, HSAG analyzed HEDIS performance measure rates and Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[3-2] survey results from the two Medicaid MCOs. The performance measure rates and CAHPS results were compared to national Medicaid benchmarks, and a star rating was awarded for each individual measure, along with overall star ratings for the following seven reporting categories: Doctors' Communication and Patient Engagement, Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, Keeping Kids Healthy, and Medication Management. The IA Health Link Scorecard is still in the development phase; therefore, results are not included in this report.

[3-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Operational Readiness Review—DHS requested that HSAG conduct an operational readiness review of Iowa Total Care on behalf of DHS. The review included both a desk review of documents and a two-day on-site review of Iowa Total Care to interview key staff and leadership who manage Iowa Total Care's operational areas. HSAG also conducted system demonstrations of multiple information systems used by Iowa Total Care to support activities related to grievance and appeal processing and tracking, case management, utilization review, and QI. The purpose of the operational readiness review was to assess that Iowa Total Care had the structural and operational capacity to perform the Medicaid managed care functions described in DHS' contract and ensure appropriate and timely access to quality healthcare services for Medicaid recipients. The operational readiness review included an assessment of 13 standards based on the requirements of the contract.

Information Systems Readiness Review—DHS requested that HSAG conduct an IS readiness review of Iowa Total Care on behalf of DHS. The IS readiness review included both a desk review of documents and a Web conference to interview key staff and leadership and to test Iowa Total Care's claims systems. The IS readiness review included an assessment of the Health Information Systems standard based on the requirements of the contract and key areas noted in 42 CFR §438.66(d)(4). The purpose of the IS Readiness Review was to evaluate Iowa Total Care's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases.

Focused Study—During CY 2017, DHS requested that HSAG conduct a focused study review of MCO case management programs, which included a review of service plans maintained by MCOs for HCBS waiver members. As the results from the focused study were not available at the time the *Calendar Year 2017 External Quality Review Technical Report*[3-3] was published, the results were presented in the *Calendar Year 2018 External Quality Review Technical Report*.[3-4] While a focused study was not conducted in CY 2019, this section presents the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report* and the MCOs' responses as to how those recommendations were addressed.

PAHP Mandatory Activities

Compliance Monitoring—In CY 2019 HSAG conducted a follow-up review to the CY 2018 compliance review (full review of the State's 13 standards) CAPs, which included a review of all elements that received a score of *Not Met* during the CY 2018 compliance review. This report presents the combined results of the CY 2018 and CY 2019 compliance reviews.

[3-3] Health Services Advisory Group. *Iowa Department of Human Services: Calendar Year 2017 External Quality Review Technical Report*; July 2018. Available at: https://dhs.iowa.gov/sites/default/files/2017%20EQR.pdf?030820191812. Accessed on: Jan 31, 2020.

[3-4] Health Services Advisory Group. *Iowa Department of Human Services: Calendar Year 2018 External Quality Review Technical Report*; June 2019. Available at: https://dhs.iowa.gov/sites/default/files/2018%20EQR.pdf?070820191536. Accessed on: Jan 31, 2020.

Performance Measures—DHS identified a set of four performance measures that the PAHPs are required to calculate and report. These measures are required to be reported following the measure descriptions included in the rate reporting templates created by DHS. DHS identified the measurement period as July 1, 2018, through June 30, 2019, reported as rolling quarters.

Validation of Performance Improvement Projects—The PAHPs are required to conduct PIPs that have the potential to affect member health, functional status, or satisfaction. To validate each PIP, HSAG obtained the data needed from each MCO's and PAHP's PIP Summary Forms. These forms provide detailed information about the PIPs related to the steps completed and validated by HSAG for the 2019 validation cycle. The goal of HSAG's PIP validation is to ensure that DHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the QI strategies and activities conducted by the PAHP during the PIP.

Network Adequacy—HSAG conducted a Dental Provider Network Analysis ("network analysis") to evaluate the utilization of dental services for Iowa Dental Wellness Plan Medicaid members. The analysis evaluated the following dimensions of dental utilization: Provider Saturation, Percentage of Active Providers, Member Service Utilization, and Travel Time/Distance to Providers. HSAG obtained Medicaid member demographic information, dental provider network files, dental encounter data, and the Iowa Dental Board data from DHS.

PAHP Optional Activities

Encounter Data Validation—HSAG conducted an EDV study that included the following two core evaluation activities for the EDV activity: 1) Comparative analysis—analysis of DHS' electronic dental encounter data completeness and accuracy through a comparative analysis between DHS' electronic dental encounter data and the data extracted from the PAHPs' data systems, and 2) Technical assistance—follow-up assistance provided to PAHPs that performed poorly in the comparative analysis. HSAG used data from both DHS and the PAHPs with dates of service between January 1, 2018, and December 31, 2018, to evaluate the accuracy and completeness of the dental encounter data.

4. Compliance Monitoring

This section presents HSAG's findings and conclusions from the compliance monitoring activity conducted for each MCO and PAHP. It provides a discussion of each MCO's and PAHP's overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively each MCO and PAHP has addressed the recommendations for QI made by HSAG during the previous year. The methology for the compliance review activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis, and Appendix B. PAHP Technical Methods of Data Collection and Analysis.

Managed Care Organizations

Overview

As DHS requested that HSAG conduct compliance monitoring reviews over a three-year cycle with one-third of the standards being reviewed each year, for the CY 2019 (the second year of the three-year cycle) review year, Amerigroup and UnitedHealthcare were evaluated in four of the 13 Medicaid managed care program areas (i.e., standards) for the Iowa Medicaid program.

Iowa Total Care was evaluated in all 13 Medicaid managed care standards in addition to program integrity. As Iowa Total Care's compliance monitoring activity was a follow-up review to the CY 2019 readiness review, the 2018–2019 activity focused on a review of elements that received a score of *Incomplete* and *Not Applicable* during the readiness review, and a review of elements applicable to the case file reviews.

Specific Results

Table 4-1 and Table 4-2 present the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 4-1 and Table 4-2 also present Amerigroup's and UnitedHealthcare's overall compliance score for each standard and the aggregated compliance score across all four standards for CY 2019. Table 4-3 presents Iowa Total Care's overall compliance score for each standard and the aggregated compliance score across all standards reviewed.

Amerigroup

Table 4-1—Summary of Standard Compliance Scores—AGP

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Coordination and Continuity of Care	16	16	13	3	0	**81%**
IV	Coverage and Authorization of Services	17	17	14	3	0	**82%**
VII	Confidentiality of Health Information	10	10	8	2	0	**80%**
XI	Practice Guidelines	3	3	3	0	0	**100%**
Total		**46**	**46**	**38**	**8**	**0**	**83%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Amerigroup demonstrated compliance for 38 of 46 elements, with an overall compliance score of 83 percent. Amerigroup demonstrated strong performance, scoring 90 percent or above in Standard XI—Practice Guidelines, with this standard achieving full compliance.

Opportunities for improvement were identified in three of the four standards, including deficiencies related to the following requirements:

- Comprehensive health risk assessments must be completed by appropriate individuals meeting LTSS service coordination requirements required by DHS and the Iowa Administrative Code (IAC).
- Documentation and retrieval of risk stratification levels assigned to a member based on the clinical judgement of a case manager.
- Mechanism for members, their families and/or advocates and caregivers, or others chosen by the member to be actively involved in the care plan development.
- Providing the member with the opportunity to review the care plan as requested.
- Content of the NABD.
- Providing NABDs for the denial of payment at the time of an action affecting a claim.
- Expedited service authorization time frames and notice standards.
- Implementing policies for staff and contract terms with network providers which allow the release of mental health information only as allowed by Iowa Code §228.
- Notification time frame standards for reporting exposed or disclosed confidential information of a member or the Social Security number of a provider to DHS.

Amerigroup was required to submit a CAP to DHS for each deficient element within 30 calendar days of receipt of the final compliance monitoring report.

UnitedHealthcare

Table 4-2—Summary of Standard Compliance Scores—UHC

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Coordination and Continuity of Care	16	16	13	3	0	**81%**
IV	Coverage and Authorization of Services	17	17	15	2	0	**88%**
VII	Confidentiality of Health Information	10	10	6	4	0	**60%**
XI	Practice Guidelines	3	3	3	0	0	**100%**
Total		**46**	**46**	**37**	**9**	**0**	**80%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

UnitedHealthcare demonstrated compliance for 37 of 46 elements, with an overall compliance score of 80 percent. UnitedHealthcare demonstrated strong performance, scoring 90 percent or above in Standard XI—Practice Guidelines, with this standard achieving full compliance.

Opportunities for improvement were identified in three of the four standards, including deficiencies related to the following requirements:

- Time frame for which reassessments must occur for members identified as having a change in medical or functional status.
- Case management information system's capability to share care coordination with a member, his or her authorized representatives, and all relevant treatment providers.
- Mechanism for members, their families and/or advocates and caregivers, or others chosen by the member to be actively involved in the care plan development.
- Prioritization of member goals in the care plan.
- Contact requirements for members engaged in case management.
- Providing the member's primary care provider (PCP) or other significant providers with a copy of the member's care plan.
- Providing the member with the opportunity to review the care plan as requested.
- Providing NABDs for the denial of payment at the time of an action affecting a claim.
- Standard service authorization time frames and notice standards.
- Implementing policies for staff and contract terms with network providers which allow the release of mental health information only as allowed by Iowa Code §228, and allowing the release of substance

use disorder (SUD) information only in compliance with policies set forth in 42 CFR. Part 2 and other applicable State and federal law and regulations.

- Notification time frame standards for reporting exposed or disclosed confidential information or the Social Security number of a provider to DHS and providing DHS with the results of the investigation and draft breach notification letter or risk assessment.
- Content of breach notification letters.
- Substitute notice in the event of a breach.

UnitedHealthcare was required to submit a CAP to DHS for each deficient element within 30 calendar days of receipt of the final compliance monitoring report.

Iowa Total Care

Table 4-3—Summary of Standard Compliance Scores—ITC

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
I	Availability of Services	21	5	5	0	16	**100%**
II	Assurances of Adequate Capacity and Services	12	10	6	4	2	**60%**
III	Coordination and Continuity of Care	16	6	4	2	10	**67%**
IV	Coverage and Authorization of Services	17	6	3	3	11	**50%**
V	Provider Network	16	2	2	0	14	**100%**
VI	Member Information and Member Rights	27	8	5	3	19	**63%**
VII	Confidentiality of Health Information	12	0	–	–	12	–
VIII	Enrollment and Disenrollment	11	2	2	0	9	**100%**
IX	Grievances, Appeals and State Fair Hearings	40	18	16	2	22	**89%**
X	Subcontractual Relationships and Delegation	6	2	2	0	4	**100%**
XI	Practice Guidelines	3	0	–	–	3	–
XII	Quality Assessment and Performance Improvement	18	7	7	0	11	**100%**
XIII	Health Information Systems	18	0	–	–	18	–
XIV	Program Integrity	15	6	6	0	9	**100%**
	Total	**232**	**72**	**58**	**14**	**160**	**81%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*
Dash (–) = No numbers or scores to report as all elements for the standard were scored as *NA* as they received a *Met* score during the CY Operational Readiness Review.
Total Elements: The total number of elements in each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were scored *Complete* during the readiness review and/or elements applicable to case files. This represents the denominator.
Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

Iowa Total Care demonstrated compliance for 58 of 72 elements, with an overall compliance score of 81 percent. Iowa Total Care demonstrated strong performance, scoring 90 percent or above in six standards, with all six standards achieving full compliance: Availability of Services, Provider Network, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Quality Assessment and Performance Improvement, and Program Integrity.

Opportunities for improvement were identified in five of the eleven standards, including deficiencies related to the following requirements:

- General access standards (time and distance) calculated using members' personal residences for PCPs, specialty care, behavioral health, and pharmacy.
- Completing comprehensive HRAs within 30 days of member identification for being eligible for case management.
- Documentation of risk stratification levels assigned to a member based on the clinical judgement of a case manager.
- Documentation of team members chosen by the member to be actively involved in the care plan development, or whether the member declined additional team members.
- Providing the member with the opportunity to review the care plan as requested and documentation of whether the member requested a copy of the care plan and that it was sent, or whether the member declined a copy of the care plan.
- Content of the NABDs.
- Standard service authorization time frames and notice standards.
- Provisions pertaining to the coverage of emergency services (as documented in the billing manual).
- Content of the online and paper provider directory.
- Providing all written materials in Spanish.
- Options for a member's preferred mode of communications; and specifically, electronic communication via a secure Web portal.
- Obtaining a member's written consent or confirming a member's legal representative when an individual files a grievance on behalf of a member.
- Providing appeal resolution letters in an easily understood format and language.

Iowa Total Care was required to submit a CAP to DHS for each deficient element within 30 calendar days of receipt of the final compliance monitoring report.

Caution should be used when interpreting Iowa Total Care's overall performance based on the CY 2019 compliance review scores alone. Iowa Total Care demonstrated compliance with the majority of applicable elements during the CY 2019 readiness review; therefore, only 72 of 232 total elements were reviewed during this year's review. Refer to the Section 10—MCO Readiness Review for additional details on Iowa Total Care's overall performance across all standards and elements.

Plan Comparison

Table 4-4 provides information that can be used to compare the MCOs' performance on each of the four compliance standard areas. The comparison is limited to Amerigroup and UnitedHealthcare. Iowa Total Care's compliance monitoring activity was a follow-up review to the CY 2019 readiness review which was different from the methodology for the two existing MCOs; therefore, the standards and elements included in Iowa Total Care's review differed, and a comparison with Amerigroup and UnitedHealthcare scores is not appropriate. Iowa Total Care will be included in future year comparisons.

Table 4-4—Standards and Compliance Scores: MCO Comparison

Standard		Total Applicable Elements	Amerigroup				UnitedHealthcare			
			M	*NM*	*NA*	Score	*M*	*NM*	*NA*	Score
III	Coordination and Continuity of Care	16	13	3	0	**81%**	13	3	0	**81%**
IV	Coverage and Authorization of Services	17	14	3	0	**82%**	15	2	0	**88%**
VII	Confidentiality of Health Information	10	8	2	0	**80%**	6	4	0	**60%**
XI	Practice Guidelines	3	3	0	0	**100%**	3	0	0	**100%**
Total		**46**	**38**	**8**	**0**	**83%**	**37**	**9**	**0**	**80%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score for each MCO.

Amerigroup and UnitedHealthcare received comparable total compliance scores—83 percent and 80 percent, respectively. Additionally, both MCOs achieved full compliance for Standard XI—Practice Guidelines, demonstrating that both MCOs had implemented sufficient processes for the adoption, dissemination, and application of clinical practice guidelines (CPGs) for the IA Health Link program.

Both MCOs demonstrated challenges to operationalize all case management program requirements (Standard III—Coordination and Continuity of Care); and specifically, requirements pertaining to a member's care plan development. While UnitedHealthcare outperformed Amerigroup in Standard IV—Coverage and Authorization of Services by 6 percentage points, both MCOs had findings related to the NABDs and time frame standards for service authorizations. Additionally, Amerigroup outperformed UnitedHealthcare in Standard VII—Confidentiality of Health Information by 20 percentage points. Overall, UnitedHealthcare did not provide documentation to support that it maintained comprehensive written policies and procedures related to the confidentiality of health information, and staff members had difficulty articulating how these requirements are operationalized.

Table 4-5 provides information that can be used to compare the MCOs' performance on each of the eight compliance standard areas reviewed over the first two years of the three-year cycle. The remaining five standards will be reviewed during the CY 2020 review year.

Table 4-5—Standards and Compliance Scores: Two-Year MCO Comparison

Standard		Total Elements	Amerigroup				UnitedHealthcare			
			M	*NM*	*NA*	Score	*M*	*NM*	*NA*	Score
I	Availability of Services	21	20	1	0	**95%**	21	0	0	**100%**
II	Assurances of Adequate Capacity and Services	3	3	0	0	**100%**	3	0	0	**100%**
III	Coordination of Continuity of Care	16	13	3	0	**81%**	13	3	0	**81%**
IV	Coverage and Authorization of Services	17	14	3	0	**82%**	15	2	0	**88%**
VII	Confidentiality of Health Information	10	8	2	0	**80%**	6	4	0	**60%**
IX	Grievances and Appeals	44	42	2	0	**95%**	41	3	0	**93%**
XI	Practice Guidelines	3	3	0	0	**100%**	3	0	0	**100%**
XII	Quality Assessment and Performance Improvement (QAPI)	12	11	1	0	**92%**	12	0	0	**100%**
Total		**126**	**114**	**12**	**0**	**90%**	**114**	**12**	**0**	**90%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total Elements: The total number of elements in each standard.

Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score for each MCO.

Conclusions and Recommendations for Program Improvement

HSAG concludes that all MCOs demonstrated overall moderate performance (below 90 percent) in the program areas reviewed as part of each MCO's compliance review activity. Amerigroup, UnitedHealthcare, and Iowa Total Care received overall compliance scores of 83 percent, 80 percent, and 79 percent, respectively.

The MCOs were required to develop and submit a CAP to DHS for each element scored as *Not Met* during the compliance monitoring activity.

Recommendations for Amerigroup

In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG made the following recommendations:

- The provider agreement identified conflicting time frames for the retention of records. HSAG recommended that Amerigroup review and update the provider agreement as needed to ensure the time frame for the retention of records is compliant with federal and State requirements.

- Amerigroup should review its current care coordination policies against contract requirements for the care coordination program and enhance language to clearly identify expectations related to state-specific requirements. Additionally, while multiple case management contract requirements apply to both LTSS and non-LTSS members, HSAG recommended that Amerigroup review its care coordination policies to ensure all requirements are reflected in LTSS and non-LTSS policies to which they apply. While Amerigroup required that member contact occur, at minimum, every 30 calendar days or according to a member's acuity level for complex case management, HSAG recommended that Amerigroup consider defining a recommended contact schedule according to group level, similar to Amerigroup's recommended member contact for its Obstetrical and NICU (Neonatal Intensive Care Unit) Case Management Program. Additionally, while the Care Coordination File Review confirmed it was standard practice to offer a member a copy of the care plan and notify a member's PCP that the care plan is available on the portal, HSAG recommended that Amerigroup clarify these expectations in policy or desktop protocol. Amerigroup staff members explained that Amerigroup's information systems maintained the capability to share care coordination information electronically through the member and provider portals. HSAG recommended that Amerigroup enhance the information available to members on the portal such as completed assessments and care plans.
- Amerigroup should confirm what questions trigger a referral to care management, specifically:
  - Do you need help finding a PCP?
  - Do you need assistance in scheduling a PCP appointment?
  - Would you like to talk with us about how we can help you manage your health or your child's health?

    HSAG further recommended that a referral for care coordination and member outreach be triggered if a member answers "Yes" to these questions. Additionally, Amerigroup could have considered mechanisms to adequately document various attempts to complete health risk screenings (HRSs) within 90 days of a member's enrollment.
- Amerigroup should consider alternative mechanisms to document a member's assigned risk stratification level that is readily available and easily retrievable. Of note, Amerigroup's Obstetrical and NICU Case Management Program used a different risk stratification level designation wherein a case manager assigned a complexity score of complex, severe, high, medium, or low in the designated data field.
- While Amerigroup staff members explained that it was standard practice to send a copy of the care plan to a member's PCP and to offer a copy of the care plan to a member, HSAG recommended that these provisions be included in Amerigroup's care coordination policies. Additionally, HSAG recommended that Amerigroup enhance policies to clarify expectations for discussing and developing a communication plan for providers. Further, HSAG recommended that Amerigroup also enhance policies to clarify expectations for disseminating care plans to a member's PCP and/or other significant providers' rendered services to the member; for example, a member who has a care plan is focused on behavioral health interventions and who is activity seeing a psychiatrist, counselor, or therapist. Dissemination of the care plan to providers should have been incorporated into the communication plan with providers that is developed with the member.

- Amerigroup staff members briefly described a reconsideration process that is used when additional clinical information is received after a service authorization denial has been made. HSAG recommended that Amerigroup ensure that this process is clearly documented in a written procedure and complies with any applicable State or federal regulations. Further, HSAG recommended that Amerigroup implement sufficient processes to consult with the requesting provider and obtain any necessary clinical information prior to a denial being made.
- In November 2018, CMS proposed to eliminate the requirement that an oral appeal must be followed by a written, signed appeal. As such, HSAG recommended that Amerigroup monitor the proposed rulemaking and implement actions as appropriate when the proposed changes are finalized.
- The Psychotherapy Notes policy detailed requirements for the use and disclosure of psychotherapy notes that aligned with federal requirements under 45 CFR 164 Subpart E. However, policy specified that Amerigroup will disclose psychotherapy notes to a medical professional designated by a member who is licensed to provide care with respect to the condition to which the information pertains to including physicians, psychologists, dentists, nurses, occupational therapists, optometrists, pharmacists, physical therapists, etc. HSAG recommended that Amerigroup review its policy pertaining to the appropriateness of disclosing psychotherapy notes to all provider types identified in policy as the providers' scope of care rendered to a member relates to the member's condition. Additionally, HSAG recommended that Amerigroup review its policies against the provisions in Iowa Code §228 and update policies accordingly.
- Amerigroup should update its policy to specify that breach notification letters will be sent within 60 "calendar" days.
- Amerigroup should review and update policy to further detail the requirements of providing written notification of a breach and how Amerigroup operationalizes those requirements.

In addition to the above recommendations, HSAG makes the following recommendations for program improvement for Amerigroup to consider if not previously addressed in its CAP. Amerigroup should:

- Enhance internal monitoring of case management requirements for non-LTSS members. The enhanced monitoring should focus on the care plan development requirements identified in contract.
- Enhance case management system capabilities to capture a member's risk stratification level assigned by a case manager as detailed above. Case managers regularly using the system should be involved in this process. Amerigroup should also consider using this risk stratification level for determining case managers' case load assignments.
- Enhance internal monitoring of service authorization requests and NABDs. This process should include a review of a sample of notices to ensure content, readability, and timeliness requirements are met.
- Review processes for monitoring service authorization time frame requirements of its delegates performing utilization management functions. Time frames must be calculated from the date/time the service authorization request is received to the date/time the notice is sent to a member.
- Continue to collaborate with DHS to improve adherence to state-specific disclosure of protected health information and breach notification requirements.

Recommendations for UnitedHealthcare

In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG made the following recommendations:

- While UnitedHealthcare staff members could articulate case management processes, not all state-specific requirements were clearly documented in UnitedHealthcare's care coordination policies. HSAG recommended that UnitedHealthcare review its current care coordination policies against contract requirements for the care coordination program and enhance language to clearly identify expectations related to state-specific requirements. Additionally, while multiple care management contract requirements apply to LTSS and non-LTSS members, HSAG recommended that UnitedHealthcare review its care coordination policies to ensure all requirements are reflected in LTSS and non-LTSS policies to which they apply. Lastly, while the Case Management Process policy, UnitedHealthcare staff members, and the file review confirmed that comprehensive HRAs are completed within 30 days of identification, the Case Management Process policy also included conflicting language that implied comprehensive HRAs are completed within 60 days of identification. HSAG recommended that UnitedHealthcare revise this conflicting language in its policy.
- Staff members explained that during late 2017 and early 2018, UnitedHealthcare had experienced a significant increase in membership due to another MCO leaving the Iowa Medicaid program; as a result, prioritization of member outreach and gaps in outreach attempts occurred. HSAG recommended that UnitedHealthcare enhance mechanisms to ensure timely outreach to members.
- In some instances, UnitedHealthcare developed care plans for members who were not enrolled in active case management and were enrolled in a "monitoring" status. While these members were not receiving case management, a care plan was developed and therefore was expected to comply with care plan requirements. HSAG recommended that UnitedHealthcare enhance processes to ensure compliance with all requirements in its contract with DHS pertaining to care plans. Additionally, HSAG recommends that UnitedHealthcare enhance policies to clarify expectations for discussing and developing a communication plan for providers. Dissemination of the care plan to providers could be incorporated into the communication plan for providers that is developed with the member. For example, records identified a provider (or providers) in the "Care Team," but dissemination of the care plan did not occur with any (or in some cases all) providers. Further, HSAG recommended that UnitedHealthcare enhance policies to clarify expectations for disseminating care plans to other significant providers rendering services to the member; for example, a member whose care plan is focused on behavioral health interventions and who is actively seeing a psychiatrist, counselor, or therapist.
- UnitedHealthcare staff members briefly described a reconsideration process that is used when additional clinical information is received after a service authorization denial has been made. HSAG recommended that UnitedHealthcare ensure that this process is clearly documented in a written procedure and complies with any applicable State or federal regulations. Further, HSAG recommended that UnitedHealthcare implement sufficient processes to consult with the requesting provider and obtain any necessary clinical information prior to a denial being made.

- UnitedHealthcare should review its current policies against state-specific requirements in Iowa Code §228 and consider developing state-specific policies or procedures when appropriate.

UnitedHealthcare is no longer participating in the IA Health Link program; therefore, additional MCO-specific program recommendations are not included in this report.

Recommendations for Iowa Total Care

In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG made the following recommendations:

- As staff members confirmed that Iowa Total Care only uses member ZIP Codes to generate GeoAccess maps, HSAG recommended that Iowa Total Care seek clarification from DHS regarding whether the 30-minute or 30-mile access standard for hospital and emergency services, optometry, and lab and x-ray services is expected to be calculated from members' ZIP Codes versus members' personal residences.
- The risk stratification level identified in the universe file submitted to HSAG did not always align with the risk stratification level assigned to a member by a case manager and documented in the system. During the on-site review, Iowa Total Care staff members reported that the case management information system did not have the capability to pull the risk stratification assigned by a case manager. HSAG recommended that, for future reporting, Iowa Total Care use the risk stratification level assigned by a case manager as it is a more accurate reflection of a member's acuity level according to the case manager's comprehensive assessment.
- While the file review demonstrated that care plans are generally individualized, HSAG recommended that Iowa Total Care continue to educate case managers and monitor care plans to ensure they are tailored to each member's specific needs and are person-centered. Additionally, HSAG recommended that Iowa Total Care enhance policies to clarify expectations for discussing and developing a communication plan for providers. Further, HSAG recommended that Iowa Total Care also enhance policies to clarify expectations for disseminating care plans to a member's PCP and/or other significant providers rendering services to a member; for example, a member whose care plan is focused on behavioral health interventions and who is actively seeing a psychiatrist, counselor, or therapist. Dissemination of the care plan to appropriate providers should have been incorporated into the communication plan with providers that is developed with the member.
- Iowa Total Care staff members briefly described a reconsideration process that is used when additional clinical information is received after a service authorization denial has been made. As a reconsideration process was not under the scope of this year's compliance review, HSAG recommended that Iowa Total Care ensure that this process is clearly documented in a written procedure and complies with any applicable State or federal regulations. Further, HSAG recommended that Iowa Total Care implement sufficient processes to consult with the requesting provider and obtain any necessary clinical information prior to a denial being made.
- The provider directory policy referenced the "provider directory checklist," which cited the checklist used by HSAG for the 2019 Operational Readiness Review. As this was an audit tool used by HSAG to assess compliance, HSAG recommended that Iowa Total Care remove this language and include

the applicable provider directory requirements identified by federal and contract requirements. After the on-site review, Iowa Total Care provided a narrative explaining the corrective actions to remediate the findings as described above. HSAG recommended that Iowa Total Care submit a remediation plan as part of its CAP for the compliance review.

- While Iowa Total Care acknowledged receipt of appeals, for three cases processed by National Imaging Associates, Inc. (NIA), the letter sent to the member acknowledged receipt of an appeal requested by the member. However, it was a provider who requested the appeal with no member written consent, and it is unclear if the member was aware the appeal was requested. Therefore, the acknowledgement letter contained inaccurate information and may be confusing to the member. HSAG recommended that Iowa Total Care consider revising language in acknowledgement letters for circumstances in which a provider requests an appeal without a member's written consent; for example, informing the member that a provider submitted an appeal on his or her behalf but that the member's written consent is required.
- Iowa Total Care should enhance mechanisms to ensure expedited appeals are resolved in a timely manner.
- Iowa Total Care should update its corporate policy in addition to the Iowa-specific addendum as federal requirements allow for appeal rights for NABDs and a grievance resolution is not included in the definition of an adverse benefit determination (ABD).
- The appeal resolution letters sent by NIA had minor formatting issues as some letters appeared to be in a different font type and bolded. HSAG recommended that Iowa Total Care ensure that NIA corrects this issue. After the on-site review, Iowa Total Care provided a narrative explaining the corrective actions to remediate the finding as described above. HSAG recommended that Iowa Total Care submit its remediation plan as part of Iowa Total Care's CAP for the compliance review.
- Iowa Total Care should consider including in policy the frequency of monitoring subcontractor performance, specifically that formal reviews be conducted by Iowa Total Care at least quarterly.
- Iowa Total Care should consider additional ways to promote member involvement in the Stakeholder Advisory Board (SAB); for example, through Iowa Total Care's case management programs. Additionally, HSAG recommended that Iowa Total Care promote additional network provider participation in its Quality Improvement Committee (QIC).
- As Iowa Total Care's documentation provided conflicting information on the person (or persons) or committees (Peer Review Committee [PRC], QIC, and Grievance and Appeals Committee) responsible for reviewing, identifying trends, and making recommendations for improvement related to critical incidents and sentinel events, HSAG recommended that Iowa Total Care revise its quality program description to clearly identify the committee or committees and their respective responsibilities pertaining to critical incidents and sentinel events. As Iowa Total Care makes enhancements to its review of critical incidents and sentinel events, HSAG recommended that Iowa Total Care consider:
  - Quantitative and qualitative analyses.
  - Review of the details of and commonalities between events.
  - Member-specific, provider-specific, and systemic trends.

- A review of data per 1,000 members if appropriate (for example, per incident type, per waiver type, per provider).
- Including staff members with varying credentials and experience in the analyses of critical incidents and sentinel events (for example, physicians, psychologists, and other behavioral health professionals, registered nurses, individuals with LTSS and waiver experience, data analysts).

In addition to the above recommendations, HSAG makes the following recommendations for program improvement for Iowa Total Care to consider if not previously addressed in its CAP. Iowa Total Care should:

- Enhance internal monitoring of case management requirements for non-LTSS members. The enhanced monitoring should focus on the care plan development requirements identified in the contract.
- Enhance case management system capabilities to capture a member's risk stratification level assigned by a case manager as detailed above. Case managers regularly using the system should be involved in this process.
- Enhance internal monitoring of service authorization requests and NABDs. This process should include a review of a sample of notices to ensure requirements (content and readability of notices, and timeliness standards) are met.
- Conduct a thorough review of policies and procedures pertaining to member communications (e.g., provider directory, members' preferred mode of communication, electronic communication, Spanish written materials, and appeal resolution letters). Iowa Total Care should reconcile its policies against specific contract requirements. Iowa Total Care should seek clarification from DHS as needed.

Follow-Up on Prior Recommendations

From the findings of each MCO's performance for the CY 2018 compliance monitoring activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each MCO for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 4-6 and Table 4-7 in addition to each MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation. Iowa Total Care entered the Iowa managed care program effective July 1, 2019; therefore, no prior recommendations exist.

Table 4-6—Compliance Monitoring Recommendations—AGP

Prior Recommendations (CY 2018)
HSAG recommended that Amerigroup develop and implement mechanisms to ensure that general optometry service appointment times do not exceed 48 hours for urgent care services.
HSAG recommended that Amerigroup reevaluate its current process of dismissing an oral request for an appeal if no written, signed appeal is received within 10 days. Additionally, as CMS has proposed to eliminate

Prior Recommendations (CY 2018)
the requirement that an oral appeal must be followed by a written, signed appeal, HSAG recommended that Amerigroup monitor the proposed rulemaking and implement actions as appropriate when the proposed changes are finalized. HSAG recommended that Amerigroup implement mechanisms to ensure that reasonable efforts are made to provide members oral notice of resolution of expedited appeals. These efforts should have been documented. HSAG recommended that Amerigroup develop ongoing processes to analyze and compare psychotropic medication utilization for children in foster care with the child population in general. Results from this analysis should have driven quality initiatives to promote evidence-based treatment planning, medication utilization, and medication monitoring. Amerigroup should have further incorporated state-specific QM/QI program requirements and the results from these activities into its quality program (quality description, quality workplan, and annual quality evaluation) by describing how the activities support the program's overall goals and objectives. For example, the annual quality evaluation should show how the results of quality activities identified strengths and opportunities for improvement within the program. Further, the quality workplan for the subsequent year should have shown the quality activities planned for the year based on the results and opportunities for improvement identified in the annual quality evaluation as well as activities planned to support the achievement of quality goals.
Summary of AGP's Response to Recommendations
Superior Vision, Amerigroup's subcontractor providing optometry services, has updated the Superior Vision provider manual to include an urgent care appointment requirement. While the DHS' requirement is 48 hours, Superior Vision has elected a 24-hour requirement for urgent care appointments. Superior Vision sent a fax blast to providers outlining this requirement and updated the provider manual. Amerigroup is monitoring any changes to federal Medicaid regulations, to include 42 CFR §438.406, to implement any revisions as appropriate. Amerigroup updated the quick reference guide for expedited appeals to address that reasonable efforts must be made to provide oral notice of the resolution of expedited appeals and the attempts to provide verbal notice must be documented. Amerigroup reviewed the requirement and need for documentation in a grievances and appeals staff meeting. Ongoing processes implemented include revisions to the quarterly pharmacy report to include specific reporting of the prescribing patterns of psychotropic medication to children, including children in foster care. The information is presented as part of the pharmacy report to the Quality Management Committee for annual review or more frequently as issues are identified.
HSAG's Assessment of the Degree to Which AGP Effectively Addressed the Recommendations
Based on the responses provided by Amerigroup, Amerigroup partially addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*.

Table 4-7—Compliance Monitoring Recommendations—UHC

Prior Recommendations (CY 2018)
HSAG recommended that UnitedHealthcare reevaluate its current process of denying an oral request for an appeal if no written, signed appeal is received within 10 days. Additionally, as CMS has proposed to eliminate the requirement that an oral appeal must be followed by a written, signed appeal, HSAG recommended that UnitedHealthcare monitor the proposed rulemaking and implement actions as appropriate when the proposed changes are finalized. HSAG recommended that UnitedHealthcare implement mechanisms to ensure that reasonable efforts are made to provide members oral notice of resolution of expedited appeals. These efforts should have been documented. UnitedHealthcare staff members stated that as of November 16, 2018, the grievance and appeal system requires that the oral notification field be completed prior to moving forward with processing the appeal, when appropriate. HSAG recommended that UnitedHealthcare complete a self-evaluation to determine if this action improved performance in this area. UnitedHealthcare should have further incorporated state-specific QM/QI program requirements and the results from these activities into its quality program (quality description, quality workplan, and annual quality evaluation) by describing how the activities support the program's overall goals and objectives. For example, the annual quality evaluation should show how the results of quality activities identified strengths and opportunities for improvement within the program. Further, the quality workplan for the subsequent year should have shown the quality activities planned for the year based on the results and opportunities for improvement identified in the annual quality evaluation as well as activities planned to support the achievement of quality goals.
Summary of UHC's Response to Recommendations
UnitedHealthcare will incorporate recommendations into its other markets as appropriate.
HSAG's Assessment of the Degree to Which UHC Effectively Addressed the Recommendations
Based on the response provided by UnitedHealthcare, UnitedHealthcare did not address the recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*. Of note, UnitedHealthcare exited the IA Health Link program effective July 1, 2019.

Prepaid Ambulatory Health Plan

Overview

The CY 2019 compliance review activity was a follow-up review assessing each PAHP's implementation of corrective actions for elements that received a score of *Not Met* during the CY 2018 compliance review to determine if those corrective actions resulted in compliance with State and federal requirements. Standards that achieved a score of 100 percent in CY 2018 were not included in the CY 2019 follow-up review. Elements in the remaining standards that received a score of *Met* were also excluded.

Specific Results

Table 4-8 and Table 4-9 present the combined results of the CY 2018 and CY 2019 compliance monitoring activity. They include the total number of elements for each standard as well as the number of elements for each standard that received a score of *Met*, *Not Met*, or *Not Applicable (NA*). Table 4-8 and Table 4-9 also present DDIA's and MCNA's overall compliance score for each standard and the aggregated compliance score across all standards for CY 2019.

Delta Dental

Table 4-8—Summary of Standard Compliance Scores—DDIA

Prior Year (CY 2018) and Current Year (CY 2019) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				CY 2018 and 2019 Total Compliance Score
			Prior Year	Current Year			
			M	*M*	*NM*	*NA*	
I	Availability of Services	10	7	3	0	0	**100%**
II	Assurances of Adequate Capacity and Services	3	3	No Follow-up Required			**100%**
III	Coordination and Continuity of Care	7	6	0	1	0	**86%**
IV	Coverage and Authorization of Services	24	14	5	5	0	**79%**
V	Provider Network	12	11	0	1	0	**92%**
VI	Enrollee Information and Enrollee Rights	21	11	9	1	0	**95%**
VII	Confidentiality of Health Information	7	3	4	0	0	**100%**
VIII	Enrollment and Disenrollment	13	12	1	0	0	**100%**
IX	Grievance and Appeal System	43	28	8	7	0	**84%**
X	Subcontractual Relationships and Delegation	8	6	2	0	0	**100%**
XI	Practice Guidelines	7	7	No Follow-up Required			**100%**
XII	Quality Assessment and Performance Improvement (QAPI)	11	8	1	2	0	**82%**
XIII	Health Information Systems	13	13	No Follow-up Required			**100%**
Total		**179**	**129**	**33**	**17**	**0**	**91%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total # of Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

DDIA demonstrated compliance for 162 of 179 applicable elements, with an overall compliance score of 91 percent. DDIA demonstrated strong performance, scoring 90 percent or above in nine standards (Availability of Services, Assurances of Adequate Capacity and Services, Provider Network, Enrollee Information and Enrollee Rights, Confidentiality of Health Information, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Practice Guidelines, and Health Information Systems), with seven standards achieving full compliance.

Continued opportunities for improvement were identified in six of the 13 standards, including deficiencies related to the following requirements:

- Completing an initial oral health assessment within 90 days of enrollment.
- Content of the NABDs.
- Time frames for mailing NABDs.
- Consulting with the requesting provider prior to making service authorizations decisions.
- Notification provisions for the extension of service authorization time frames.
- Providing NABDs when service authorizations are not reached within time frame standards.
- Prohibiting providers from requesting continuation of services during the appeal and State fair hearing process.
- Content of the member handbook.
- Timely acknowledgement of grievances and appeals.
- Documentation of the name and credentials of the clinical reviewers responsible for managing and resolving grievances involving clinical issues.
- Treating an oral request for an appeal as an appeal to establish the earliest possible filing date.
- Notification provisions for the denial of an expedited appeal request.
- Appeal resolution time frame standards.
- Informing members of their grievance rights when an appeal time frame is extended.
- Content of the appeal resolution notices.
- Maintaining a comprehensive documented QAPI program description and workplan.
- Annual evaluation of the impact and effectiveness of the QAPI program.

DDIA was required to submit a CAP to DHS for each deficient element within 30 calendar days of receipt of the final compliance monitoring report.

MCNA Dental

Table 4-9—Summary of Standard Compliance Scores—MCNA

Prior Year (CY 2018) and Current Year (CY 2019) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements	Number of Elements				CY 2018 and 2019 Total Compliance Score
			Prior Year	Current Year			
			M	*M*	*NM*	*NA*	
I	Availability of Services	10	9	1	0	0	**100%**
II	Assurances of Adequate Capacity and Services	3	3	No Follow-up Required			**100%**
III	Coordination and Continuity of Care	11	10	1	0	0	**100%**
IV	Coverage and Authorization of Services	24	22	0	2	0	**92%**
V	Provider Network	12	11	1	0	0	**100%**
VI	Enrollee Information and Enrollee Rights	21	14	7	0	0	**100%**
VII	Confidentiality of Health Information	7	7	No Follow-up Required			**100%**
VIII	Enrollment and Disenrollment	13	12	0	1	0	**92%**
IX	Grievance and Appeal System	43	33	8	2	0	**95%**
X	Subcontractual Relationships and Delegation	8	2	6	0	0	**100%**
XI	Practice Guidelines	7	5	1	1	0	**86%**
XII	Quality Assessment and Performance Improvement (QAPI)	11	11	No Follow-up Required			**100%**
XIII	Health Information Systems	13	13	No Follow-up Required			**100%**
	Total	**183**	**152**	**25**	**6**	**0**	**97%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total # of Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.

Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score.

MCNA demonstrated compliance for 177 of 183 elements, with an overall compliance score of 97 percent. MCNA demonstrated strong performance, scoring 90 percent or above in 12 standards (Availability of Services, Assurances of Adequate Capacity and Services, Coordination and Continuity of Care, Coverage and Authorization of Services, Provider Network, Enrollee Information and Enrollee Rights, Confidentiality of Health Information, Enrollment and Disenrollment, Grievance and Appeal System, Subcontractual Relationships and Delegation, Quality Assessment and Performance Improvement, and Health Information Systems), with nine standards achieving full compliance.

Continued opportunities for improvement were identified in four of the 13 standards, including deficiencies related to the following requirements:

- Content of the NABDs.
- Consulting with the requesting provider prior to making service authorizations decisions.
- Forwarding a member's disenrollment request to DHS following the conclusion of the grievance process should a member remain dissatisfied.
- Notification provisions for the denial of an expedited appeal request.
- Following the grievance process and providing resolution to members for all complaints received, regardless of the time frame for resolving the complaint.
- Dissemination of CPGs to all affected providers.

MCNA was required to submit a CAP to DHS for each deficient element within 30 calendar days of receipt of the final compliance monitoring report.

Plan Comparison

Table 4-10 provides information that can be used to compare the PAHPs' performance on each of the 13 compliance standard areas.

Table 4-10—Standards and Compliance Scores: PAHP Comparison

Standard		Total Elements	DDIA				MCNA			
			M	*NM*	*NA*	Score	*M*	*NM*	*NA*	Score
I	Availability of Services	10	10	0	0	**100%**	10	0	0	**100%**
II	Assurances of Adequate Capacity and Services	3	3	0	0	**100%**	3	0	0	**100%**
III	Coordination and Continuity of Care	11	6	1	4	**86%**	11	0	0	**100%**
IV	Coverage and Authorization of Services	24	19	5	0	**79%**	22	2	0	**92%**
V	Provider Network	12	11	1	0	**92%**	12	0	0	**100%**
VI	Enrollee Information and Enrollee Rights	21	20	1	0	**95%**	21	0	0	**100%**
VII	Confidentiality of Health Information	7	7	0	0	**100%**	7	0	0	**100%**
VIII	Enrollment and Disenrollment	13	13	0	0	**100%**	12	1	0	**92%**
IX	Grievance and Appeal System	43	36	7	0	**84%**	41	2	0	**95%**
X	Subcontractual Relationships and Delegation	8	8	0	0	**100%**	8	0	0	**100%**
XI	Practice Guidelines	7	7	0	0	**100%**	6	1	0	**86%**

Standard		Total Elements	DDIA				MCNA			
			M	*NM*	*NA*	Score	*M*	*NM*	*NA*	Score
XII	Quality Assessment and Performance Improvement (QAPI)	11	9	2	0	**82%**	11	0	0	**100%**
XIII	Health Information Systems	13	13	0	0	**100%**	13	0	0	**100%**
Total		**183**	**162**	**17**	**4**	**91%**	**177**	**6**	**0**	**97%**

M = *Met*; ***NM*** = *Not Met*; ***NA*** = *Not Applicable*

Total Elements: The total number of elements in each standard.

Total Compliance Score: Elements that were *Met* were given full value (1 point). The point values were then totaled, and the sum was divided by the number of applicable elements to derive a percentage score for each PAHP.

DDIA and MCNA received overall compliance scores above 90 percent—91 and 97 percent, respectively. Both PAHPs achieved full compliance for Standard I—Availability of Services, Standard II—Assurances of Adequate Capacity and Services, Standard VII—Confidentiality of Health Information, Standard X—Subcontractual Relationships and Delegation, and Standard XIII—Health Information Systems, demonstrating strong statewide performance in these areas.

Both PAHPs demonstrated challenges in operationalizing all service authorization and grievance and appeal requirements (Standard IV—Coverage and Authorization of Services and Standard IX—Grievance and Appeal System); and specifically, requirements pertaining to the NABDs content, consulting with the requesting provider to obtain missing clinical documentation, and notification provisions for the denial of an expedited appeal request. Additionally, DDIA was further challenged in these two areas with a total of 12 *Not Met* findings compared to four *Not Met* findings for MCNA. DDIA also struggled to develop and implement a comprehensive QAPI program, workplan, and annual evaluation.

Overall, MCNA outperformed DDIA with total compliance scores of 97 percent and 91 percent, respectively. Further, while DDIA received higher compliance scores than MCNA in two standards, MCNA outperformed DDIA in six standards.

Conclusions and Recommendations for Program Improvement

HSAG concluded that the PAHPs demonstrated overall strong performance (90 percent or above) in the program areas reviewed as part of each PAHP's compliance review activity. DDIA and MCNA received overall compliance scores of 91 percent and 97 percent, respectively.

The PAHPs were required to develop and submit a CAP to DHS for each element scored as *Not Met* during the compliance monitoring activity.

Recommendations for DDIA

In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG recommended that DDIA:

- Review policy for spelling and grammar errors. HSAG recommended that DDIA review the appropriateness of the title of its Adverse Benefit Determination Policy, as the content applies to the authorization of services in addition to ABDs. Additionally, HSAG recommended that DDIA enhance its policy to reflect general coverage and authorization requirements; for example, the process for notifying providers of approved services and attempting to obtain missing clinical documentation in order to make decisions based on medical necessity.
- Review NABDs for typographical errors. HSAG also recommended that DDIA revise the term "claim" in the prior authorization (PA) ABD, as the service (or services) had not yet been rendered, and therefore there was no claim. Additionally, HSAG strongly recommended that DDIA revise the NABD to be written in an easily understood language and format.
- Discussion during the on-site review determined that DDIA was voiding previously approved services when a benefit change occurred during the next fiscal year (FY), even though it had been authorized when the service was a covered benefit. HSAG recommended that DDIA seek clarification from DHS regarding the expectations to honor previously approved services when a benefit change is made.
- Add clarifying language to the policy to ensure that the NABD is sent on the date of action. While DDIA staff confirmed that a NABD is sent when there is a change in a member's condition, HSAG recommended that this be added to DDIA's policy in addition to all requirements listed in the federal regulation.
- Adding language to policy that describes DDIA's expectations and process for providing a NABD on the date of determination when the action is a denial of payment.
- Develop a standardized process to obtain missing clinical information for PA requests; for example, making three attempts to collect the documentation within 14 calendar days prior to rendering a decision to deny a service due to a lack of information. Additionally, HSAG recommended that DDIA update its provider manual to specify that decisions will be made within 14 calendar days, as opposed to 14 days.
- Add language to its provider manual related to requirements pertaining to service authorization extensions of time frames.
- Clarify in policy that extension provisions apply to both expedited and standard requests for services. HSAG further recommended that DDIA develop a letter template for when a time frame is extended.
- Revise the provider manual to inform providers that expedited authorization requests are made within 72 hours, as opposed to three business days.
- Clarify in policy, situations for when DDIA fails to make a timely authorization decision (for example, due to a lack of staff) versus when an extension is appropriate and in the best interest of the member (for example, when additional clinical information is pending). Additionally, HSAG recommended that DDIA review its provider manual to ensure information pertaining to untimely authorization decisions required by this element is included.
- In the member handbook, include examples of signs and symptoms indicating when members should seek urgent care versus emergency care.

- Revise the NABDs to inform the member that upon request, the case file will be provided free of charge.
- Revise the language in its acknowledgement letter for denied expedited appeals, clarifying that the member's grievance rights apply to the decision to deny the expedited request.
- Reevaluate its current process regarding when appeals should or should not be expedited.
- Correct the extension letter template title, which HSAG found to be incorrectly titled as an acknowledgement letter.
- Add the actions it has taken to resolve member grievances related to disenrollment requests. Additionally, HSAG recommended that DDIA avoid abbreviations in resolution letters unless previously spelled out in the letter.
- Ensure that clinical reviewers for grievances are consistently documented in each grievance file.
- Consider the following activities in its QAPI program description:
  - Performance measures
  - PIPs
  - Mechanisms to detect under- and overutilization
  - Mechanisms to assess the effectiveness of services for members with special healthcare needs
  - Adoption and dissemination of CPGs: specifically, those adopted from nationally recognized sources, such as the American Dental Association (ADA)
  - Provider network monitoring, such as access standards
  - Grievances and appeals and identified trends
  - Member outreach and education needs and activities
  - Cultural competency
  - SDOH
  - Credentialing activities
  - Oversight of delegated functions
  - Quality of care (QOC) concerns and peer review
- Consider the following when developing its QAPI annual workplan:
  - Measurable goals and objectives. Goals should be related to the activities identified in its QAPI program description and priority areas of DHS and DDIA. DDIA should consider using data from the previous year to identify focus areas and subsequent measurable goals.
  - Targeted completion dates for each goal.
  - Assigned person(s) or department responsible for each goal.
  - Interventions and activities to be implemented to meet each goal.
  - Quarterly reviews and documentation of progress or barriers in meeting each goal.
- Consider the following to improve its QAPI committee:
  - Maintain a standard meeting schedule and meeting minutes.

  - Develop a committee charter. The charter should specify the purpose and functions of the committee, including the committee's responsibility to develop and formally approve the program description, workplan, and annual evaluation.
  - Develop a committee organizational chart (subcommittees or workgroups that report to the QAPI committee).
  - Include dental professionals with varying credentials (dentist, hygienist, etc.) as committee members.
  - Include contracted network providers servicing members in the community as committee members.
  - Include internal staff from various departments (compliance, provider network, utilization management, quality, etc.).
- While not an all-inclusive list, consider the following when developing its methodology for and completing its annual QAPI evaluation:
  - Determine whether established measurable goals have been met. DDIA could consider using "Met" or "Not Met."
  - Identify successes, barriers, and recommendations for improvement, as applicable, for each activity and goal.
  - Solicit input from the assigned persons(s) or department responsible for each goal.
  - Establish new goals when they have been maintained and sustained or when new focus or priority areas have been identified.
  - When goals are not met, complete a barrier analysis and action steps for the upcoming year.
- Develop minimum training requirements for internal staff on cultural competency. DDIA should consider new hire orientation and mandatory annual training on cultural competency.

Recommendations for MCNA

In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG recommended that MCNA:

- In the member handbook, include examples within the definition of "urgent care" and the signs and symptoms that require urgent care versus emergency care.
- Conduct ongoing education with its staff to ensure that when members are informed of the limited time frame to present additional information, it is clearly documented in each expedited appeal record.
- Provide education to providers who meet the 80 percent threshold overall but may have scored poorly in certain areas when provider performance and adherence to CPGs are measured.

Follow-Up on Prior Recommendations

From the findings of each PAHP's performance for the CY 2018 compliance monitoring activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each PAHP for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 4-11 and Table 4-12 in addition to each PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 4-11—Compliance Monitoring Recommendations—DDIA

Prior Recommendations (CY 2018)
DDIA must develop or update written policies and procedures to comply with federal Medicaid managed care regulations and contract requirements. These policies should have followed DDIA's process on policy development and be formally approved by the organization. DDIA should have prioritized policy development and/or revisions for processing requests for initial and continuing authorization of services, member materials, and grievances and appeals. DDIA should have considered developing or enhancing internal audit programs to review compliance with PA, and grievance and appeal program requirements. While DDIA had established CPGs for coverage determination decisions, DDIA should have also adopted CPGs published from national organizations, such as the ADA, to distribute to DDIA's provider network to assist in clinical decision making. DDIA should have developed a formal, written QAPI program which consists of at minimum, a program description, an ongoing workplan, and an annual evaluation. The quality program should have met federal requirements outlined in 42 CFR §438.330. HSAG also recommended that the program include, but not be limited to, measurable goals and objectives; the dedicated resources, data systems, and staffing to support the program; designated committee(s) responsible for the program, including a committee structure (subcommittees that report to the QM committee); and the organization's QI methodologies, activities, and initiatives. DDIA should have participated in efforts to promote the delivery of services in a culturally competent manner to all members. DDIA should have considered developing a cultural competency program. HSAG recommended that this program include at minimum, a cultural self-assessment, initial and ongoing cultural competency training for staff and network providers, and policy statements on cultural competence.
Summary of DDIA's Response to Recommendations
The Government Programs grievances and appeals policies and procedures were updated. The policies and procedures are reviewed every six months to ensure compliance. Each month DDIA' s compliance department reviews all Government Programs grievances and appeals. The reviews are conducted to ensure DDIA is following all federal requirements that are outlined in DDIA's policies and procedures. The finding are sent to the Government Programs director who works with staff to make changes or address common theme compliance issues during monthly meetings. All DDIA-developed Government Programs documents are reviewed by Iowa Medicaid prior to publication. DDIA has updated the member communication policies and procedures to comply with federal standards. DDIA is routinely developing materials and follows reading grade level guidelines to create documents.

Summary of DDIA's Response to Recommendations
The Government Programs authorization of services policies and procedures were updated. DDIA incorporates national standards and CPGs into all clinical processing policies. DDIA is a member of the Delta Dental Plans Association (DDPA). DDPA has a national clinical policy committee of which DDIA's dental director is a member. The DDPA policy committee has numerous dental specialists that comprise the membership. When a specialty is lacking and there is a need for that specialty, DDIA contracts with outside consultants. The DDPA policy committee routinely updates clinical processing policies and reviews all external standards and performs reviews of the new literature. This is accomplished to ensure that the clinical policies are in line with the clinical evidence and CPGs. An advantage of having DDIA as an administrator of DHS' dental programs is that the Medicaid population benefits from DDIA's commercial expertise. DDIA uses the same knowledge garnered from its national work with DDPA to implement dental policies for both commercial and Medicaid members. The QIC is working on developing a QI plan. DDIA is working on a comprehensive plan for cultural competency for members, providers, and staff. DDIA is continuing to implement and develop the following: 1. The Department of Health and Human Services (DHHS) cultural competency training for dental providers has been shared with providers and is posted on the internal resource page for dentists to complete. 2. Cultural competency training for staff is continuing to be planned and implemented. 3. Member videos outlining cultural issues are being developed for DDIA's website.
HSAG's Assessment of the Degree to Which DDIA Effectively Addressed the Recommendations
Based on the responses provided by DDIA and the CY 2019 compliance monitoring activity, DDIA partially addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report* and continues to implement interventions to address the deficiencies identified during the CY 2018 compliance monitoring activity. HSAG recommends that DDIA prioritize the development of its QAPI program.

Table 4-12—Compliance Monitoring Recommendation—MCNA

Prior Recommendations (CY 2018)
MCNA should have considered conducting a thorough review of existing policies, procedures, and member materials against federal managed care regulations and contract requirements. HSAG also recommended that MCNA prioritize the review of member materials, documentation, and processes pertaining to grievances and appeals. It was determined that MCNA's definitions of a "complaint" and a "grievance" were identical, but most complaints received were not processed as grievances. Further, MCNA staff stated that complaints were an expression of dissatisfaction, but the only distinguishing factor between a complaint and a grievance was the timeline for resolving the issue of dissatisfaction expressed by the member. As there was no other complaint categorization or definition that distinguished a complaint from a grievance, other than the period of time it took customer services to resolve the member's issue, it was unclear if all grievances were processed and resolution notices provided in accordance with the contractual standards. HSAG recommended that MCNA reevaluate its process of resolving member complaints. When a complaint was unable to be resolved within 24 hours, customer services would refer the complaint to the grievance department. MCNA should have revised its disenrollment process to comply with contract requirements; specifically, MCNA should have addressed member enrollment requests through its grievance process and complete the review in time to permit the disenrollment to be effective no later than the first day of the second month following the month in which the member requests disenrollment, and forward the member's request to DHS if the member remains dissatisfied following the conclusion of the grievance. MCNA should have considered executing a contract amendment with its subcontractor(s) to include all provisions required by 42 CFR §438.230. MCNA should have disseminated adopted CPGs to its provider network. Mechanisms to distribute guidelines could have included MCNA's website, provider manual, newsletters, etc.
Summary of MCNA's Response to Recommendations
MCNA's compliance department is in the process of finalizing its review on all processes and member materials related to grievances and appeals. Any identified deficiencies will be corrected and the policy or member material will be approved through the appropriate mechanism. This activity should be completed by January 31, 2020. To satisfy the contractual requirement that all grievances are processed and member resolution notices are provided, MCNA created a first call resolution grievance letter that has been approved by DHS. MCNA will be implementing a process to create and mail a grievance resolution letter if the grievance is resolved by the member hotline. This process is being outlined with assistance from the quality team to ensure contractual compliance. Grievances that are unable to be resolved within member services will be forwarded to the grievance department for further research and resolution. MCNA has revised Policy 13.208IA to comply with contractual requirements, and staff have been reeducated on the process. All grievances will be resolved within 30 calendar days from receipt of the grievance, and the grievance and appeals department began forwarding disenrollment requests that have gone through MCNA's grievance process to DHS weekly to permit the disenrollment to be effective no later than the first day of the second month following the month in which the member requests disenrollment. MCNA's subcontracts are compliant with 42 CFR §438.230. A link was added to MCNA's provider manual where providers are able to download adopted CPGs.

HSAG's Assessment of the Degree to Which MCNA Effectively Addressed the Recommendations
Based on the responses provided by MCNA and the CY 2019 compliance monitoring activity, MCNA addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report* and continues to implement interventions to address the deficiencies identified during the CY 2018 compliance monitoring activity.

Validation of Performance Measures

This section presents HSAG's findings and conclusions from the PMV activity conducted for each MCO and PAHP. It provides a discussion of each MCO's and PAHP's overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively each MCO and PAHP has addressed the recommendations for QI made by HSAG during the previous year. The methology for the PMV activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis and Appendix B. PAHP Technical Methods of Data Collection and Analysis.

Managed Care Organizations

Overview

At the request of DHS, HSAG validated a set of six state-defined performance measures (case management measures for the waiver population) calculated and reported by Amerigroup and UnitedHealthcare for the July 1, 2017–June 30, 2018 (SFY 2018) measurement period. As UnitedHealthcare exited the IA Health Link program on June 30, 2019, DHS also requested that HSAG validate the set of six measures for the July 1, 2018–June 30, 2019 (SFY 2019) measurement period. The set of six measures for the SFY 2019 measurement period for Amerigroup is scheduled to occur in CY 2020.

The purpose of the PMV activity was to assess the accuracy of performance measures reported by the MCOs and to determine the extent to which performance measures reported by the MCOs followed State specifications. Based on all validation methods used to collect information during the PMV activity, HSAG determined results for each performance measure and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*.

As Iowa Total Care joined the IA Health Link program effective July 1, 2019, and did not have data for reporting performance measures for the SFY 2019 measurement period, HSAG conducted an ISCA for Iowa Total Care.

Specific Results

Amerigroup

HSAG reviewed Amerigroup's eligibility and enrollment data, claims and encounters and case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, Amerigroup demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture,

access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Amerigroup's processes. HSAG did identify some opportunities during primary source verification (PSV) regarding interpretation of the specifications and how that impacted the rate calculations. Measure designation and measure rates, when reportable, for SFY 2018 are displayed in Table 5-1 and Table 5-2. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed.

Table 5-1—SFY 2018 #1 and #2 Performance Measure Designation and Rates—AGP

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1	*Receipt of Authorized Services (Informational Only)*	*NR*	–	–	–	–	–
2	*Receipt of Authorized One-Time Services (Informational Only)*	*NR*	–	–	–	–	–

NR = Not Reported
Dash (–) = No rate to report as the performance measure received a measure designation of *NR*.

Table 5-2—SFY 2018 #3, #4, #5, and #6 Performance Measure Designation and Rates—AGP

Performance Measure		Measure Designation	Measure Rate
3	*Provision of Care Plan*	*R*	44.86%
4	*Person-Centered Care Plan Meeting**	*R*	22.98%
5	*Care Team Lead Chosen by the Member*	*R*	17.68%
6	*Member Choice of HCBS Settings*	*R*	85.61%

R = Report
* While rates were reported separately for "*Members Who Agreed to the Time of the Meeting*" and "*Members Who Agreed to the Location of the Meeting,*" only the rate for "*Members Who Agreed to the Time and Location of the Meeting*" is displayed.

The *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by the Member*, and *Member Choice of HCBS Settings* performance measures were assigned a *Report* rating. The *Receipt of Authorized Services (Informational Only)* and the *Receipt of Authorized One-Time Services (Informational Only)* performance measures received a *Not Reported* rating because of the following reasons:

- The CareCompass system documented the initial person-centered service plan (PCSP) completion dates and revision PCSP dates. Since PCSPs are viewed as "living documents" and frequently involve modifications to authorized services, selection of the most recent Index Care Plan Effective Date is variable and potentially impacts the numerator of the measure.
- In cases where a PCSP's authorized services exceeded the measurement period for a member, Amerigroup staff included any services obtained during the duration of the authorization. As such both authorizations and rendered services were included in the measure rates regardless of the end of

the measurement period (i.e., June 30, 2018). While this approach ensures the "at risk" period for services received and approved authorizations are in alignment, it is not fully in alignment with the specifications and affect the final rates.

UnitedHealthcare

HSAG reviewed UnitedHealthcare's eligibility and enrollment data, claims and encounters and case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, UnitedHealthcare demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with UnitedHealthcare's processes. HSAG did identify some opportunities during PSV regarding interpretation of the specifications and how that impacted the rate calculations. Measure designation and measure rates, when reportable, for SFY 2018 and SFY 2019 are displayed in Table 5-3, Table 5-4, Table 5-5, and Table 5-6. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed.

Table 5-3—SFY 2018 #1 and #2 Performance Measure Designation and Rates—UHC

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1	*Receipt of Authorized Services (Informational Only)*	*NR*	–	–	–	–	–
2	*Receipt of Authorized One-Time Services (Informational Only)*	*NR*	–	–	–	–	–

NR = Not Reported

Dash (–) = No rate to report as the performance measure received a measure designation of *NR*.

Table 5-4—SFY 2018 #3, #4, #5, and #6 Performance Measure Designation and Rates—UHC

Performance Measure		Measure Designation	Measure Rate
3	*Provision of Care Plan*	*R*	64.33%
4	*Person-Centered Care Plan Meeting**	*R*	26.78%
5	*Care Team Lead Chosen by the Member*	*R*	54.10%
6	*Member Choice of HCBS Settings*	*R*	89.37%

R = Report

* While rates were reported separately for "*Members Who Agreed to the Time of the Meeting*" and "*Members Who Agreed to the Location of the Meeting,*" only the rate for "*Members Who Agreed to the Time and Location of the Meeting*" is displayed.

Table 5-5—SFY 2019 #1 and #2 Performance Measure Designation and Rates—UHC

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1	*Receipt of Authorized Services (Informational Only)*	*NR*	–	–	–	–	–
2	*Receipt of Authorized One-Time Services (Informational Only)*	*NR*	–	–	–	–	–

NR = Not Reported
Dash (–) = No rate to report as the performance measure received a measure designation of *NR*.

Table 5-6—SFY 2019 #3, #4, #5, and #6 Performance Measure Designation and Rates—UHC

Performance Measure		Measure Designation	Measure Rate
3	*Provision of Care Plan*	*R*	70.09%
4	*Person-Centered Care Plan Meeting**	*R*	52.67%
5	*Care Team Lead Chosen by the Member*	*R*	82.51%
6	*Member Choice of HCBS Settings*	*R*	93.32%

R = Report
* While rates were reported separately for "*Members Who Agreed to the Time of the Meeting*" and "*Members Who Agreed to the Location of the Meeting*", only the rate for "*Members Who Agreed to the Time and Location of the Meeting*" is displayed.

The *Provision of Care Plan*, *Person-Centered Care Plan Meeting*, *Care Team Lead Chosen by the Member*, and *Member Choice of HCBS Settings* performance measures were assigned a *Report* rating. The *Receipt of Authorized Services (Informational Only)* and the *Receipt of Authorized One-Time Services (Informational Only)* performance measures received a *Not Reported* rating; reasons for this rating are listed below:

- The Community Care system documented the initial care plan completion dates, care plan addendum dates, and care plan effective dates. Since care plans are viewed as "living documents" and frequently involve modifications to authorized services, selection of the most recent *Index Care Plan Effective Date* is variable and potentially impacts the numerator of the measure.
- In cases where a care plan's authorized services exceeded the measurement period, UnitedHealthcare staff determined the average number of services expected per month by dividing the number of authorized services by the total number of months authorized. This count was then attributed to the number of months within the measurement period to account for the restriction in authorized time to receive services. While this methodology is supported by the specifications, the approach could inflate or underinflate the rates since the actual utilization of some services will vary by month.
- During PSV, one selected case reflected that a greater number of services were provided and paid than were authorized by the member's service plan and PA. The discrepancy was due to a prior lack

of controls over vendors responsible for the Children's Mental Health (CMH) and the Habilitation (HAB) waivers. Since PA was a delegated function of UnitedHealthcare's subcontractor, all claims received were automatically approved. At the time of the audit, UnitedHealthcare staff noted that the discrepancy had been previously identified and steps taken to correct the process. The discrepancy between the number of authorized services and number of submitted claims, though, may impact performance measure rates.

Iowa Total Care

HSAG conducted an ISCA for Iowa Total Care, as it was new to the Medicaid market in Iowa and began providing services on July 1, 2019. HSAG focused on the assessment of the information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates. HSAG reviewed Iowa Total Care's eligibility and enrollment, claims and encounters, provider and case management systems, and its plan of care process. Overall, Iowa Total Care demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures next year. HSAG did not identify any concerns with Iowa Total Care's processes.

Plan Comparison

Amerigroup and UnitedHealthcare both received the rate designations of *Not Reported* for the *Receipt of Authorized Services (Informational Only)* and the *Receipt of Authorized One-Time Services (Informational Only)* performance measures. The rates for these two measures for Amerigroup and UnitedHealthcare cannot be compared, as both MCOs interpreted the performance measure specifications differently, and their rates are representative of the interpretations. The reportable rates for Amerigroup and UnitedHealthcare are displayed in Table 5-7.

Table 5-7—SFY 2018 Performance Measure Rates—MCO Comparison

Performance Measure		Measure Rates	
		Amerigroup	UnitedHealthcare
3	*Provision of Care Plan*	44.86%	64.33%
4	*Person-Centered Care Plan Meeting**	22.98%	26.78%
5	*Care Team Lead Chosen by the Member*	17.68%	54.10%
6	*Member Choice of HCBS Settings*	85.61%	89.37%

* While rates were reported separately for "*Members Who Agreed to the Time of the Meeting*" and "*Members Who Agreed to the Location of the Meeting,*" only the rate for "*Members Who Agreed to the Time and Location of the Meeting*" is displayed.

UnitedHealthcare achieved higher rates than Amerigroup for all four reportable performance measures. While Amerigroup's rates for measures #4 and #6 were within 4 percentage points of UnitedHealthcare's rates, Amerigroup's rates for measures #3 and #5 were significantly lower than UnitedHealthcare's rates—approximately 19 percentage points and 36 percentage points, respectively. DHS has not set a minimum performance standard (MPS) for these measures.

Conclusions and Recommendations

HSAG concludes that there is much ambiguity around performance measures #1 and #2, and without clarification, the MCOs will continually calculate the performance measures incorrectly. This will not only adversely impact their rates, it will impede the ability to compare rates between plans. HSAG recommends that both MCOs work with DHS to define a standard methodology for accounting for authorized services that extend (or end prior to) the end of the measurement period. HSAG also recommends that both MCOs work with DHS to ensure its identification of *Index Care Plan Effective Date* relative to initial and addendum care plan dates meets DHS' intent of the measure.

Follow-Up on Prior Recommendations

As the CY 2018 PMV activity was performed in CY 2019 and included in this report, no MCO-specific recommendations were made in the *Calendar Year 2018 External Quality Review Technical Report*.

Prepaid Ambulatory Health Plan

Overview

At the request of DHS, HSAG validated a set of four dental performance measures selected by DHS for the measurement period July 1, 2018–June 30, 2019. The purpose of the PMV activity was to assess the accuracy of performance measures reported by the PAHPs and to determine the extent to which these measures followed State specifications. Based on all validation methods used to collect information during the PMV activity, HSAG determined results for each performance measure and assigned each an indicator designation of *Report*, *Not Reported*, or *No Benefit*.

Specific Results

Delta Dental

HSAG reviewed DDIA's membership/eligibility data system, encounter data processing system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, DDIA demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with DDIA's processes. HSAG did identify some opportunities during PSV regarding interpretation of the specifications and how that impacted the rate calculations. Discrepancies in the numerator count and the total number of numerator cases listed on Tab 4 of the Rate Reporting Template were observed. The difference was due to 454 members having two dates of service within the allowable time period; DDIA was unsure which date to keep, so both were included. Direction was provided, and the final, corrected performance rate template was resubmitted. Measure designation and measure rates, when reportable, are displayed in Table 5-8. DDIA received a measure designation of *Report* for all performance measures included in the PMV activity.

Table 5-8—Performance Measure Designation and Rates—DDIA

	Performance Measure	Measure Designation	Measure Count	Measure Rate
1	*DWP Unique Members with 6+ Month Coverage*	*R*	212,825	—
2	*DWP Unique Members with 6+ Month Coverage and Accessing Any Dental Care*	*R*	82,350	39%
3	*DWP Unique Members with 6+ Month Coverage Accessing Any Dental Care and an Oral Evaluation*	*R*	65,042	79%
4*	*Distinct Count of DWP Unique Members with 6+ Month Coverage in Fiscal Year Accessing an Oral Evaluation and 12-Month Coverage Prior to an Oral Evaluation*	*R*	51,474	—
	Distinct Count of DWP Unique Members with 6+ Month Coverage Accessing an Oral Evaluation and 6–12-Month Prior Oral Evaluation within the Consecutive Coverage Period		32,537	—
	Percentage: (Distinct Count: [DWP Unique members with 6+ Month Coverage Accessing Oral Eval and 6-12 Month Prior Oral Eval within consecutive coverage period])/(Distinct Count: [DWP unique members with 6+ month coverage in fiscal year accessing oral eval and 12 Month coverage prior to oral eval])		—	63%

R = Report; NR = Not Reported
Dash (–) = A measure count or measure rate is not applicable.
* Performance measure #4 includes three distinct components.

MCNA

HSAG reviewed MCNA's membership/eligibility data system, encounter data processing system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, MCNA demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with MCNA's processes. HSAG did identify some opportunities during PSV regarding interpretation of the specifications and how that affected the rate calculations. Discrepancies in the inclusion criteria in the numerator count were observed. MCNA included denied claims in its original data submission. Direction was provided, and the final, corrected performance rate template was resubmitted. Measure designation and measure rates, when reportable, are displayed in Table 5-9. MCNA received a measure designation of *Report* for all performance measures included in the PMV activity.

Table 5-9—Performance Measure Designation and Rates—MCNA

	Performance Measure	Measure Designation	Measure Count	Measure Rate
1	*DWP Unique Members with 6+ Month Coverage*	*R*	101,580	—
2	*DWP Unique Members with 6+ Month Coverage and Accessing Any Dental Care*	*R*	22,489	22.14%
3	*DWP Unique Members with 6+ Month Coverage Accessing Any Dental Care and an Oral Evaluation*	*R*	15,257	67.84%
4*	*Distinct Count of DWP Unique Members with 6+ Month Coverage in Fiscal Year Accessing an Oral Evaluation and 12-Month Coverage Prior to an Oral Evaluation*	*R*	10,400	—
	Distinct Count of DWP Unique Members with 6+ Month Coverage Accessing an Oral Evaluation and 6–12-Month Prior Oral Evaluation within the Consecutive Coverage Period		4,095	—
	Percentage: (Distinct Count: [DWP Unique members with 6+ Month Coverage Accessing Oral Eval and 6-12 Month Prior Oral Eval within consecutive coverage period])/(Distinct Count: [DWP unique members with 6+ month coverage in fiscal year accessing oral eval and 12 Month coverage prior to oral eval])		—	39.38%

R = Report; NR = Not Reported
Dash (–) = A measure count or measure rate is not applicable.
*Performance measure #4 includes three distinct components.

Plan Comparison

DDIA and MCNA both received the rate designation of *Report* for all performance measures. The rates for DDIA and MCNA are displayed in Table 5-10.

Table 5-10—SFY 2019 Performance Measure Rates—PAHP Comparison

	Performance Measure	Measure Rates	
		DDIA	MCNA
2	*DWP Unique Members with 6+ Month Coverage and Accessing Any Dental Care*	38.69%	22.14%
3	*DWP Unique Members with 6+ Month Coverage Accessing Any Dental Care and an Oral Evaluation*	78.98%	67.84%
4	*Percentage: (Distinct Count: [DWP Unique members with 6+ Month Coverage Accessing Oral Eval and 6-12 Month Prior Oral Eval within consecutive coverage period])/(Distinct Count: [DWP unique members with 6+ month coverage in fiscal year accessing oral eval and 12 Month coverage prior to oral eval])*	63.21%	39.38%

DDIA achieved higher rates than MCNA for all the performance measures. On average, MCNA scored 17 percentage points lower than DDIA, with the greatest difference exhibited in Measure #4 (i.e., 23.83 percentage points). Please note that DHS has not currently established an MPS for these measures.

Conclusions and Recommendations

HSAG concluded that there was some ambiguity surrounding the technical specifications for the selected dental measures. HSAG recommends that both PAHPs work with DHS to refine the specifications to more clearly define denominator and numerator elements, and to ensure the measure meets DHS' intent. Additionally, as appropriate and in alignment with the State's quality objectives, the State should consider expanding the current set of measures to address all key domains—i.e., quality, timeliness, and access to care.

Follow-Up on Prior Recommendations

From the findings of each PAHP's performance for the CY 2018 PMV activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each PAHP for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 5-11 and Table 5-12 in addition to each PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 5-11—PMV Recommendations—DDIA

Prior Recommendations (CY 2018)
HSAG recommended that DDIA continue to work closely with DHS to confirm understanding and expectations related to specifications for each performance measure provided by DHS. HSAG also recommended that DDIA maintain member-level detail data for each rate report submitted to DHS and determine additional data validation checks to ensure continued quality and accuracy of the data.
Summary of DDIA's Response to Recommendations
DDIA has continued to work with DHS to clarify performance measure specifics.
HSAG's Assessment of the Degree to Which DDIA Effectively Addressed the Recommendations
Based on DDIA's response and the documentation provided during the CY 2019 PMV activity, DDIA addressed the prior recommendation.

Table 5-12—PMV Recommendations—MCNA

Prior Recommendations (CY 2018)
HSAG recommended that MCNA identify a point of contact to be responsible for all future PMV activities and responsive to HSAG's inquiries. In addition, MCNA should review all PMV materials and instructions for proper data submission and adhere to all timelines provided by HSAG at the start of the PMV activity. MCNA should have also investigated why only 21.10 percent of members with six or more months of coverage are accessing care. Member feedback through either a survey or a focused group could provide valuable information as to why members with coverage are not accessing dental care and enable MCNA to identify interventions to increase utilization of dental services.
Summary of MCNA's Response to Recommendations
MCNA appointed individuals/staff responsible for all future PMV activities and HSAG inquiries. MCNA implemented a Dental Advisory Committee (DAC) comprised of network providers who meet quarterly and provide feedback to MCNA such as barriers that both members and providers in the community encounter. This feedback is reported back to MCNA's QIC wherein committee members develop interventions.
HSAG's Assessment of the Degree to Which MCNA Effectively Addressed the Recommendations
Based on MCNA's response and the CY 2019 PMV activity, MCNA partially addressed the prior recommendations made in the *CY 2018 External Quality Review Technical Report*.

HEDIS Performance Measures

Overview

The IA Health Link MCOs submitted HEDIS IDSS files for HEDIS 2019 (CY 2018). To assess MCO performance, HSAG compared the performance measure results to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019. HSAG displayed results for 68 performance measure rates for CY 2018. Additionally, the measures were grouped into the following six domains of care: Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, Keeping Kids Healthy, and Medication Management.

Specific Results

Amerigroup

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that Amerigroup's HEDIS compliance auditor found Amerigroup's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. Amerigroup Iowa

contracted with an external software vendor with HEDIS Certified Measures℠[5-1] for measure production and rate calculation.

Table 5-13 displays the rates and percentile ranking for Amerigroup for HEDIS 2018 (CY 2017) and HEDIS 2019 (CY 2018). The CY 2018 rates were compared to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2019 (referred to as "percentiles" in the Performance Measures section of the report).

Table 5-13—HEDIS 2019 (CY 2018) Results—Amerigroup

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Access to Preventive Care				
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	87.13%	84.86%	-2.27%	★★★★
Ages 45–64 Years	91.88%	90.88%	-0.99%	★★★★★
Ages 65 and Older	84.08%	89.01%	4.93%	★★★
Adults Body Mass Index (BMI) Assessment				
Adults Body Mass Index (BMI) Assessment	—	96.84%	NC	★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	97.56%	96.71%	-0.85%	★★★
25 Months–6 Years	91.53%	90.64%	-0.89%	★★★★
7–11 Years	—	92.24%	NC	★★★
12–19 Years	—	92.47%	NC	★★★★
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	68.63%	70.19%	1.55%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	72.02%	78.83%	6.81%	★★
Counseling for Nutrition—Total	63.26%	65.45%	2.19%	★★
Counseling for Physical Activity—Total	57.42%	62.77%	5.35%	★★
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	45.38%	NC	★
Cervical Cancer Screening				
Cervical Cancer Screening	62.29%	63.02%	0.73%	★★★

[5-1] HEDIS Certified Measures℠ is a service mark of the NCQA.

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Chlamydia Screening in Women				
Total	47.67%	47.44%	-0.24%	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.37%	0.26%	-0.12%	★★★★★
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	81.27%	86.60%	5.33%	★★★
Postpartum Care	62.53%	62.63%	0.10%	★★
Living With Illness				
Comprehensive Diabetes Care				
Hemoglobin A1c (HbA1c) Testing	91.24%	91.48%	0.24%	★★★★
HbA1c Control (<8.0%)	55.47%	59.85%	4.38%	★★★★
*HbA1c Poor Control (>9.0%)**	34.06%	27.98%	-6.08%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	72.75%	76.40%	3.65%	★★★★
Eye Exam (Retinal) Performed	57.42%	61.31%	3.89%	★★★
Medical Attention for Nephropathy	88.32%	91.00%	2.68%	★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	—	69.59%	NC	★★★★
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	53.87%	57.06%	3.19%	★
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	—	46.15%	NC	★
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	—	41.80%	NC	★
Behavioral Health				
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	44.29%	44.80%	0.51%	★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.09%	77.59%	-1.50%	★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence				
7-Day Follow-Up—Total	42.67%	44.04%	1.37%	★★★★★
30-Day Follow-Up—Total	48.80%	50.55%	1.75%	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	—	59.11%	NC	★★★★
30-Day Follow-Up—Total	—	73.57%	NC	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	37.40%	41.57%	4.17%	★★★
30-Day Follow-Up—Total	60.96%	65.69%	4.73%	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	64.63%	70.94%	6.31%	★★★★★
Engagement of AOD Treatment—Total	24.95%	26.06%	1.11%	★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	25.56%	25.57%	0.02%	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	65.76%	65.03%	-0.72%	★★★
Keeping Kids Healthy				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	54.74%	61.80%	7.06%	★★★
Childhood Immunization Status				
Combination 3	72.51%	76.89%	4.38%	★★★★
Combination 10	37.23%	46.47%	9.25%	★★★★
Immunizations for Adolescents				
Combination 1	76.40%	87.83%	11.44%	★★★★
Combination 2	30.17%	37.47%	7.30%	★★★
Lead Screening in Children				
Lead Screening in Children	76.40%	81.02%	4.62%	★★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	—	69.59%	NC	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	75.18%	76.04%	0.86%	★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Medication Management				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.32%	62.76%	-0.56%	★★★
Annual Monitoring for Patients on Persistent Medications				
Total	90.76%	90.57%	-0.19%	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	50.69%	52.31%	1.63%	★★
Effective Continuation Phase Treatment	34.88%	35.33%	0.45%	★★
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	77.65%	81.04%	3.38%	★★
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	81.82%	83.65%	1.84%	★
Asthma Medication Ratio				
Total	—	61.10%	NC	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	36.11%	NC	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	36.20%	NC	★
Continuation and Maintenance Phase	—	40.93%	NC	★
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	63.41%	80.45%	17.04%	★★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	42.76%	38.96%	-3.80%	★
Bronchodilator	48.74%	45.54%	-3.21%	★
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total	—	65.56%	NC	★★★
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%—Total	—	63.37%	NC	★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	4.13%	4.32%	0.19%	★
Use of Opioids at High Dosage				
Use of Opioids at High Dosage	—	2.78%	NC	★★★
Use of Opioids From Multiple Providers				
Multiple Prescribers	—	22.74%	NC	★★
Multiple Pharmacies	—	3.24%	NC	★★★★
Multiple Prescribers and Multiple Pharmacies	—	2.08%	NC	★★★★

** For this indicator, a lower rate indicates better performance.*
***May not equal the difference between HEDIS 2018 and HEDIS 2019 due to rounding.*
— indicates that the CY 2018 rate is not presented because the MCOs were not required to report the measure until CY 2019. This symbol may also indicate that NCQA recommended a break in trending; therefore, the CY 2018 rate is not displayed.
NC indicates that a comparison is not appropriate, or the prior year's rate was unavailable.
HEDIS 2019 star ratings represent the following percentile comparisons:
★★★★★ *= At or above the 90th percentile*
★★★★ *= At or above the 75th percentile but below the 90th percentile*
★★★ *= At or above the 50th percentile but below the 75th percentile*
★★ *= At or above the 25th percentile but below the 50th percentile*
★ *= Below the 25th percentile*

For HEDIS 2019 (CY 2018), Amerigroup performed at or above the 75th percentile for the following measure rates, demonstrating strength:

- Adult's Access to Preventive/Ambulatory Health Services—Ages 20–44 Years and Ages 45–64 Years
- Adult BMI Assessment
- Children and Adolescents' Access to Primary Care Practitioners—25 Months–6 Years and 12–19 Years
- Non-Recommended Cervical Cancer Screening in Adolescent Females
- Comprehensive Diabetes Care—HbA1c Testing, HbA1c Control (<8.0%), HbA1c Poor Control (>9.0%), and Blood Pressure Control (<140/90 mm Hg)
- Controlling High Blood Pressure
- Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up—Total
- Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total
- Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Total

- Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total
- Childhood Immunization Status—Combination 3 and Combination 10
- Immunizations for Adolescents—Combination 1
- Lead Screening in Children
- Use of Opioids From Multiple Providers—Multiple Pharmacies and Multiple Prescribers and Multiple Pharmacies

For HEDIS 2019 (CY 2018), Amerigroup performed below the 25th percentile for the following measure rates, demonstrating opportunities for improvement:

- Breast Cancer Screening
- Chlamydia Screening in Women—Total
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total
- Stain Therapy for Patients With Diabetes—Received Statin Therapy
- Diabetes Monitoring for People With Diabetes and Schizophrenia
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total
- Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total
- Appropriate Treatment for Children With Upper Respiratory Infection
- Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents—Total

UnitedHealthcare

HSAG's review of the FAR for HEDIS 2019 based on CY 2018 data showed that UnitedHealthcare's HEDIS compliance auditor found UnitedHealthcare's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2019. UnitedHealthcare contracted with an external software vendor with HEDIS Certified Measures℠ for measure production and rate calculation.

Table 5-14 displays the rates and percentile ranking for UnitedHealthcare for HEDIS 2018 (CY 2017) and HEDIS 2019 (CY 2018). The CY 2018 rates were compared to percentiles for HEDIS 2019.

Table 5-14—HEDIS 2019 (CY 2018) Results—UnitedHealthcare

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Access to Preventive Care				
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	86.90%	84.56%	-2.34%	★★★★
Ages 45–64 Years	90.69%	90.73%	0.05%	★★★★
Ages 65 and Older	91.11%	87.36%	-3.75%	★★
Adults BMI Assessment				
Adults BMI Assessment	—	86.37%	NC	★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	98.58%	98.07%	-0.51%	★★★★★
25 Months–6 Years	93.07%	91.63%	-1.44%	★★★★
7–11 Years	—	93.90%	NC	★★★★
12–19 Years	—	94.29%	NC	★★★★
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	68.83%	68.69%	-0.14%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents				
BMI Percentile Documentation—Total	68.37%	61.56%	-6.81%	★
Counseling for Nutrition—Total	61.31%	57.91%	-3.41%	★
Counseling for Physical Activity—Total	55.72%	55.96%	0.24%	★★
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	—	57.10%	NC	★★
Cervical Cancer Screening				
Cervical Cancer Screening	65.21%	56.93%	-8.27%	★★
Chlamydia Screening in Women				
Total	47.64%	46.79%	-0.85%	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.94%	0.83%	-0.10%	★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Prenatal and Postpartum Care				
Timeliness of Prenatal Care	73.97%	80.05%	6.08%	★★
Postpartum Care	62.77%	60.58%	-2.19%	★★
Living With Illness				
Comprehensive Diabetes Care				
HbA1c Testing	93.43%	94.89%	1.46%	★★★★★
HbA1c Control (<8.0%)	52.80%	50.12%	-2.68%	★★
*HbA1c Poor Control (>9.0%)**	35.52%	36.74%	1.22%	★★★
Blood Pressure Control (<140/90 mm Hg)	78.10%	66.18%	-11.92%	★★★
Eye Exam (Retinal) Performed	64.23%	69.59%	5.35%	★★★★★
Medical Attention for Nephropathy	92.46%	94.16%	1.70%	★★★★★
Controlling High Blood Pressure				
Controlling High Blood Pressure	62.04%	63.02%	0.97%	★★★
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis				
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	83.96%	58.80%	-25.15%	★
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy—Total	—	52.64%	NC	★
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	—	44.63%	NC	★
Behavioral Health				
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	73.40%	69.42%	-3.98%	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.96%	77.96%	0.01%	★
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence				
7-Day Follow-Up—Total	45.63%	42.42%	-3.20%	★★★★★
30-Day Follow-Up—Total	52.39%	48.72%	-3.68%	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness				
7-Day Follow-Up—Total	60.47%	58.98%	-1.49%	★★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
30-Day Follow-Up—Total	73.62%	72.53%	-1.09%	★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	44.00%	45.20%	1.20%	★★★★
30-Day Follow-Up—Total	69.16%	69.35%	0.19%	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	60.01%	73.33%	13.32%	★★★★★
Engagement of AOD Treatment—Total	23.50%	26.46%	2.95%	★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Total	26.83%	25.56%	-1.26%	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	60.08%	62.63%	2.56%	★★★
Keeping Kids Healthy				
Adolescent Well-Care Visits				
Adolescent Well-Care Visits	48.48%	59.37%	10.89%	★★★
Childhood Immunization Status				
Combination 3	78.35%	75.18%	-3.16%	★★★★
Combination 10	45.26%	41.61%	-3.65%	★★★
Immunizations for Adolescents				
Combination 1	71.12%	90.02%	18.91%	★★★★★
Combination 2	25.48%	30.41%	4.94%	★★
Lead Screening in Children				
Lead Screening in Children	78.59%	81.75%	3.16%	★★★★
Well-Child Visits in the First 15 Months of Life				
Six or More Well-Child Visits	—	71.78%	NC	★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	72.58%	70.56%	-2.02%	★★
Medication Management				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	63.90%	63.44%	-0.47%	★★★
Annual Monitoring for Patients on Persistent Medications				
Total	90.80%	91.26%	0.46%	★★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Antidepressant Medication Management				
Effective Acute Phase Treatment	66.23%	61.15%	-5.08%	★★★★
Effective Continuation Phase Treatment	54.13%	45.73%	-8.40%	★★★★
Appropriate Testing for Children With Pharyngitis				
Appropriate Testing for Children With Pharyngitis	77.40%	81.88%	4.47%	★★★
Appropriate Treatment for Children With Upper Respiratory Infection				
Appropriate Treatment for Children With Upper Respiratory Infection	90.09%	84.78%	-5.31%	★
Asthma Medication Ratio				
Total	—	59.53%	NC	★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis				
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	—	34.23%	NC	★★★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	—	56.57%	NC	★★★★★
Continuation and Maintenance Phase	—	64.77%	NC	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	78.26%	77.18%	-1.08%	★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	76.35%	42.57%	-33.78%	★
Bronchodilator	84.23%	46.16%	-38.07%	★
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total	—	70.16%	NC	★★★★
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%—Total	—	65.29%	NC	★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*				
Total	1.27%	2.99%	1.73%	★★
Use of Opioids at High Dosage*				
Use of Opioids at High Dosage	—	3.17%	NC	★★★
Use of Opioids From Multiple Providers*				
Multiple Prescribers	—	21.72%	NC	★★
Multiple Pharmacies	—	4.78%	NC	★★★

Measures	HEDIS 2018 (CY 2017) Rate	HEDIS 2019 (CY 2018) Rate	Difference**	Star Rating
Multiple Prescribers and Multiple Pharmacies	—	3.21%	NC	★★★

** For this indicator, a lower rate indicates better performance.*
***May not equal the difference between HEDIS 2018 and HEDIS 2019 due to rounding.*
— indicates that the CY 2018 rate is not presented because the MCOs were not required to report the measure until CY 2019. This symbol may also indicate that NCQA recommended a break in trending; therefore, the CY 2018 rate is not displayed.
NC indicates that a comparison is not appropriate, or the prior year's rate was unavailable.
HEDIS 2019 star ratings represent the following percentile comparisons:
★★★★★ *= At or above the 90th percentile*
★★★★ *= At or above the 75th percentile but below the 90th percentile*
★★★ *= At or above the 50th percentile but below the 75th percentile*
★★ *= At or above the 25th percentile but below the 50th percentile*
★ *= Below the 25th percentile*

For HEDIS 2019 (CY 2018), UnitedHealthcare performed at or above the 75th percentile for the following measure rates, demonstrating strength:

- Adults' Access to Preventive/Ambulatory Health Services—Ages 20–44 Years and Ages 45–64 Years
- Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years
- Comprehensive Diabetes Care—HbA1c Testing, Eye Exam (Retinal) Performed, and Medical Attention for Nephropathy
- Follow-Up After ED Visit for AOD Abuse or Dependence—7-Day Follow-Up—Total and 30-Day Follow-Up—Total
- Follow-Up After ED Visit for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total
- Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Total and 30-Day Follow-Up—Total
- Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation of AOD Treatment—Total
- Childhood Immunization Status—Combination 3
- Immunizations for Adolescents—Combination 1
- Lead Screening in Children
- Well-Child Visits in the First 15 Months of Life—Six or More Well-Child Visits
- Annual Monitoring for Patients on Persistent Medications—Total
- Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment
- Follow-Up Care for Children Prescribed ADHD Medication—Initiation Phase and Continuation and Maintenance Phase

- Statin Therapy for Patients With Cardiovascular Disease—Statin Adherence 80%—Total

For HEDIS 2019 (CY 2018), UnitedHealthcare performed below the 25th percentile for the following measure rates, demonstrating opportunities for improvement:

- Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile Documentation—Total and Counseling for Nutrition—Total
- Chlamydia Screening in Women—Total
- Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis
- Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy—Total
- Statin Therapy for Patients With Diabetes—Received Statin Therapy
- Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
- Initiation and Engagement of AOD Abuse or Dependence Treatment—Engagement of AOD Treatment—Total
- Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total
- Appropriate Treatment for Children With Upper Respiratory Infection
- Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid and Bronchodilator

Iowa Total Care

Iowa Total Care joined the IA Health Link program effective July 1, 2019, and did not have data for reporting HEDIS 2019 performance measures.

Plan Comparison

Both Amerigroup and UnitedHealthcare were found compliant with all IS standards and the HEDIS reporting requirements for 2019. Additionally, Table 5-15 displays the rates and percentile ranking for each MCO for HEDIS 2019 (CY 2018). The CY 2018 rates were compared to percentiles for HEDIS 2019.

Table 5-15—HEDIS 2019 (CY 2018) Results

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Access to Preventive Care		
Adults' Access to Preventive/Ambulatory Health Services		
Ages 20–44 Years	84.86% ★★★★	84.56% ★★★★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Ages 45–64 Years	90.88% ★★★★★	90.73% ★★★★
Ages 65 and Older	89.01% ★★★	87.36% ★★
Adults BMI Assessment		
Adults BMI Assessment	96.84% ★★★★★	86.37% ★★
Children and Adolescents' Access to Primary Care Practitioners		
12–24 Months	96.71% ★★★	98.07% ★★★★★
25 Months–6 Years	90.64% ★★★★	91.63% ★★★★
7–11 Years	92.24% ★★★	93.90% ★★★★
12–19 Years	92.47% ★★★★	94.29% ★★★★
Use of Imaging Studies for Low Back Pain[1]		
Use of Imaging Studies for Low Back Pain	70.19% ★★	68.69% ★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents		
BMI Percentile Documentation—Total	78.83% ★★	61.56% ★
Counseling for Nutrition—Total	65.45% ★★	57.91% ★
Counseling for Physical Activity—Total	62.77% ★★	55.96% ★★
Women's Health		
Breast Cancer Screening		
Breast Cancer Screening	45.38% ★	57.10% ★★
Cervical Cancer Screening		
Cervical Cancer Screening	63.02% ★★★	56.93% ★★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Chlamydia Screening in Women		
Total	47.44% ★	46.79% ★
Non-Recommended Cervical Cancer Screening in Adolescent Females*		
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.26% ★★★★★	0.83% ★★★
Prenatal and Postpartum Care		
Timeliness of Prenatal Care	86.60% ★★★	80.05% ★★
Postpartum Care	62.63% ★★	60.58% ★★
Living With Illness		
Comprehensive Diabetes Care		
HbA1c Testing	91.48% ★★★★	94.89% ★★★★★
HbA1c Control (<8.0%)	59.85% ★★★★	50.12% ★★
*HbA1c Poor Control (>9.0%)**	27.98% ★★★★★	36.74% ★★★
Blood Pressure Control (<140/90 mm Hg)	76.40% ★★★★	66.18% ★★★
Eye Exam (Retinal) Performed	61.31% ★★★	69.59% ★★★★★
Medical Attention for Nephropathy	91.00% ★★★	94.16% ★★★★★
Controlling High Blood Pressure		
Controlling High Blood Pressure	69.59% ★★★★	63.02% ★★★
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis		
Disease-Modifying Anti-Rheumatic Drug Therapy for Rheumatoid Arthritis	57.06% ★	58.80% ★
Statin Therapy for Patients With Cardiovascular Disease		
Received Statin Therapy—Total	46.15% ★	52.64% ★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Statin Therapy for Patients With Diabetes		
Received Statin Therapy	41.80% ★	44.63% ★
Behavioral Health		
Diabetes Monitoring for People With Diabetes and Schizophrenia		
Diabetes Monitoring for People With Diabetes and Schizophrenia	44.80% ★	69.42% ★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications		
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.59% ★	77.96% ★
Follow-Up After Emergency Department Visit for AOD Abuse or Dependence		
7-Day Follow-Up—Total	44.04% ★★★★★	42.42% ★★★★★
30-Day Follow-Up—Total	50.55% ★★★★★	48.72% ★★★★★
Follow-Up After Emergency Department Visit for Mental Illness		
7-Day Follow-Up—Total	59.11% ★★★★	58.98% ★★★★
30-Day Follow-Up—Total	73.57% ★★★★	72.53% ★★★★
Follow-Up After Hospitalization for Mental Illness		
7-Day Follow-Up—Total	41.57% ★★★	45.20% ★★★★
30-Day Follow-Up—Total	65.69% ★★★★	69.35% ★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment		
Initiation of AOD Treatment—Total	70.94% ★★★★★	73.33% ★★★★★
Engagement of AOD Treatment—Total	26.06% ★	26.46% ★
Metabolic Monitoring for Children and Adolescents on Antipsychotics		
Total	25.57% ★	25.56% ★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics		
Total	65.03% ★★★	62.63% ★★★
Keeping Kids Healthy		
Adolescent Well-Care Visits		
Adolescent Well-Care Visits	61.80% ★★★	59.37% ★★★
Childhood Immunization Status		
Combination 3	76.89% ★★★★	75.18% ★★★★
Combination 10	46.47% ★★★★	41.61% ★★★
Immunizations for Adolescents		
Combination 1	87.83% ★★★★	90.02% ★★★★★
Combination 2	37.47% ★★★	30.41% ★★
Lead Screening in Children		
Lead Screening in Children	81.02% ★★★★	81.75% ★★★★
Well-Child Visits in the First 15 Months of Life		
Six or More Well-Child Visits	69.59% ★★★	71.78% ★★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life		
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.04% ★★★	70.56% ★★
Medication Management		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia		
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.76% ★★★	63.44% ★★★
Annual Monitoring for Patients on Persistent Medications		
Total	90.57% ★★★	91.26% ★★★★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Antidepressant Medication Management		
Effective Acute Phase Treatment	52.31% ★★	61.15% ★★★★
Effective Continuation Phase Treatment	35.33% ★★	45.73% ★★★★
Appropriate Testing for Children With Pharyngitis		
Appropriate Testing for Children With Pharyngitis	81.04% ★★	81.88% ★★★
Appropriate Treatment for Children With Upper Respiratory Infection		
Appropriate Treatment for Children With Upper Respiratory Infection	83.65% ★	84.78% ★
Asthma Medication Ratio		
Total	61.10% ★★	59.53% ★★
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis		
Avoidance of Antibiotic Treatment in Adults With Acute Bronchitis	36.11% ★★★	34.23% ★★★
Follow-Up Care for Children Prescribed ADHD Medication		
Initiation Phase	36.20% ★	56.57% ★★★★★
Continuation and Maintenance Phase	40.93% ★	64.77% ★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack		
Persistence of Beta-Blocker Treatment After a Heart Attack	80.45% ★★★	77.18% ★★
Pharmacotherapy Management of COPD Exacerbation		
Systemic Corticosteroid	38.96% ★	42.57% ★
Bronchodilator	45.54% ★	46.16% ★
Statin Therapy for Patients With Cardiovascular Disease		
Statin Adherence 80%—Total	65.56% ★★★	70.16% ★★★★

Measures	Amerigroup HEDIS 2019 (CY 2018) Rate	UnitedHealthcare HEDIS 2019 (CY 2018) Rate
Statin Therapy for Patients With Diabetes		
Statin Adherence 80%	63.37% ★★★	65.29% ★★★
Use of Multiple Concurrent Antipsychotics in Children and Adolescents*		
Total	4.32% ★	2.99% ★★
Use of Opioids at High Dosage*		
Use of Opioids at High Dosage	2.78% ★★★	3.17% ★★★
Use of Opioids From Multiple Providers*		
Multiple Prescribers	22.74% ★★	21.72% ★★
Multiple Pharmacies	3.24% ★★★★	4.78% ★★★
Multiple Prescribers and Multiple Pharmacies	2.08% ★★★★	3.21% ★★★

** For this indicator, a lower rate indicates better performance.*
HEDIS 2019 star ratings represent the following percentile comparisons:
★★★★★ *= At or above the 90th percentile*
★★★★ *= At or above the 75th percentile but below the 90th percentile*
★★★ *= At or above the 50th percentile but below the 75th percentile*
★★ *= At or above the 25th percentile but below the 50th percentile*
★ *= Below the 25th percentile*

For HEDIS 2019, both Amerigroup and UnitedHealthcare ranked at or above the 50th percentile for 35 of 68 (51.5 percent) measure rates, with 14 (20.6 percent) measure rates at or above the 75th percentile for both MCOs. Of note, both Amerigroup and UnitedHealthcare demonstrated positive performance related to access to care for adults and children; ensuring members receive appropriate follow-up services after episodes related to mental illness or AOD abuse and dependence; care for children and adolescents; outcomes for members with diabetes; and medication management for opioids, and cardiovascular and statin medications.

Conversely, both Amerigroup and UnitedHealthcare fell below the 25th percentile for 10 of 68 (14.7 percent) measure rates. Both Amerigroup and UnitedHealthcare demonstrated opportunities for improvement, particularly related to preventive care for adults and children, appropriately treating members for cardiovascular disease and rheumatoid arthritis, appropriately monitoring adults on antipsychotics, appropriate use of antibiotic medications, and prescribing medications to manage chronic respiratory conditions.

Of note, while Amerigroup and UnitedHealthcare performed similarly in most areas of care, UnitedHealthcare demonstrated better performance than Amerigroup in measures related to managing members with behavioral health conditions through appropriate follow-up care or pharmacotherapy. Conversely, Amerigroup demonstrated better performance than UnitedHealthcare in measures related to pregnancy care and appropriate screenings for women.

Conclusions and Recommendations

While this section includes overall conclusions of the performance of both MCOs, as UnitedHealthcare is no longer participating in the IA Health Link program, recommendations are specific to Amerigroup.

For HEDIS 2019, 43 of Amerigroup's 68 measure rates (63.2 percent) were above the 50th percentile, with 23 (33.8 percent) measure rates at or above the 75th percentile. Of note, Amerigroup demonstrated positive performance related to access to care for adults and children, outcomes for members with diabetes, ensuring members receive appropriate follow-up services after episodes related to mental illness or AOD abuse and dependence, care for children and adolescents, and managing opioid and cardiovascular medications.

Conversely, Amerigroup demonstrated opportunities for improvement in several areas, particularly related to preventive care for children, medication management, appropriately monitoring adults on antipsychotics, and managing members with behavioral health conditions through appropriate follow-up care or pharmacotherapy. Amerigroup should work with providers to ensure that children and adults with behavioral health conditions receive appropriate medications and receive appropriate monitoring to identify any adverse effects (e.g., type 2 diabetes, concerning changes in mood).

For HEDIS 2019, 40 of 68 (58.8 percent) of UnitedHealthcare's measure rates were above the 50th percentile, with 26 (38.2 percent) measure rates at or above the 75th percentile. Of note, UnitedHealthcare demonstrated positive performance related to access to care for adults and children; ensuring members receive appropriate follow-up services after episodes related to mental illness or AOD abuse and dependence; immunizations and well-care visits for children and adolescents; and medication management for opioids, and cardiovascular and statin medications.

Conversely, UnitedHealthcare demonstrated opportunities to improve care related to preventive care for adults and children, screenings and pregnancy care for women, appropriately treating members for cardiovascular disease and rheumatoid arthritis, appropriately monitoring adults and children on antipsychotics, and prescribing medications to manage chronic respiratory conditions.

Overall, 14 of 68 (20.6 percent) measure rates performed at or above the 75th percentile for both MCOs. These measures were mostly related to the Access to Preventive Care, Behavioral Health, and Keeping Kids Healthy domains.

Conversely, 10 of 68 (14.7 percent) measure rates fell below the 25th percentile for both MCOs, indicating opportunities for improvement. Of note, members with chronic physical conditions such as rheumatoid arthritis, cardiovascular disease, asthma, or COPD did not consistently receive appropriate medications to

manage these conditions. Amerigroup should ensure that members with chronic physical conditions receive appropriate medications to control exacerbations and prevent further health complications.

Additionally, while children have high rates of access to primary care and documented well-care visits, the rates for both MCOs for the three *Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents* indicators fell below the 50th percentile, indicating that children and adolescents are not receiving appropriate weight monitoring and counseling. Amerigroup should work to improve these rates to reduce the risk of members developing childhood obesity or type 2 diabetes later in life.[5-2]

HSAG recommends that Amerigroup incorporate efforts for improvement for performance measures that fell below the 25th percentile and decreased by more than 5 percentage points from the following year's rates (HEDIS 2018 [CY 2017]). To prioritize its efforts, Amerigroup should identify a specific subset of these measures and develop initiatives to improve the performance of selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of Amerigroup's QAPI program.

Amerigroup should include within its next annual QAPI program review the results of analyses for the performance measures selected from those listed above that answer the following questions:

- What were the root causes associated with low-performing areas?
- What unexpected outcomes were found within the data?
- What disparities were identified in the analyses?
- What are the most significant areas of focus (or populations) for which improvement initiatives are planned? What is the highest impact area(s) to make an improvement(s) (low effort/high yield)?
- What intervention(s) is Amerigroup considering or has already implemented to improve rates and performance for each identified performance measure?

Based on the information presented above, Amerigroup should include the following within its QI workplan:

- Measurable goals and benchmarks for each performance measure.
- Mechanisms to measure performance.
- Mechanisms to review data trends to identify improvement, decline, or stability in the performance rates.
- Identified opportunities for improvement.
- Ongoing analysis to identify factors that impact adequacy of rates.
- QI interventions that address the root cause of the deficiency.

[5-2] Haemer MA, Grow HM, Fernandez C, et al. Addressing prediabetes in childhood obesity treatment programs: support from research and current practice. *Child Obes*. 2014;10(4):292-303. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4120814/. Accessed on: Feb 10, 2020.

- A plan to monitor the QI interventions to detect whether they effect improvement.

Follow-Up on Prior Recommendations

This is the first year for including the MCOs' HEDIS IDSS performance measure results in the annual EQR technical report; therefore, there were no prior recommendations.

6. Calculation of Potentially Preventable Events

This section presents HSAG's findings and conclusions from the calcuation of PPEs. It provides a discussion of statewide results and recommendations for improvement related to the quality and timeliness of, and access to care and services. The methology for the calcuation of PPE activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis.

Managed Care Organizations

Overview

DHS contracted with HSAG to calculate PPEs. For the 2019 PPE calculations, HSAG analyzed ED use by Medicaid members enrolled in managed care to provide results that are meaningful and actionable to DHS.

HSAG analyzed ED utilization using enrollment, demographic, medical claim/encounter, pharmacy, and provider specialty data provided by DHS for CY 2018 (i.e., January 1, 2018–December 31, 2018). HSAG used the CMS Core Set of Health Care Quality Measures for Medicaid specifications,[6-1] the AHRQ Healthcare Cost and Utilization Project (HCUP) Clinical Classifications Software (CCS),[6-2] and the New York University (NYU) Center for Health and Public Service Research's ED Visit Classification Algorithm[6-3] to analyze ED use.

Specific Results

Demographic Stratifications

Table 6-1 shows the ED utilization for members in different age groups as well as the overall statewide utilization rate for CY 2018.

6-1 Centers for Medicare & Medicaid Services. Core Set of Adult Health Care Quality Measures for Medicaid and CHIP Technical Specifications and Resource Manual for Federal Fiscal Year 2019 Reporting. Feb 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/medicaid-and-chip-child-core-set-manual.pdf. Accessed on: Jan 22, 2020.

6-2 HCUP CCS. Healthcare Cost and Utilization Project (HCUP). Mar 2017. Agency for Healthcare Research and Quality, Rockville, MD. Available at: www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Accessed on: Jan 22, 2020.

6-3 NYU/Wagner. Faculty & Research. Available at: https://wagner.nyu.edu/faculty/billings/nyued-background. Accessed on: Jan 22, 2020.

Table 6-1—ED Utilization by Age, CY 2018

Age Group	Number of ED Visits	Member Months (MM)	Rate per 1,000 MM
<1 Year	23,544	238,602	98.67
1–9 Years	79,676	1,765,431	45.13
10–19 Years	66,272	1,603,622	41.33
20–44 Years	198,402	2,093,152	94.79
45–64 Years	105,840	1,119,775	94.52
65–74 Years	13,783	130,977	105.23
75–84 Years	7,739	88,697	87.25
85+ Years	4,876	83,306	58.53
Unknown/Missing	5,116	265,612	19.26
Total	**505,248**	**7,389,174**	**68.38**

When compared to national Medicaid benchmarks,[6-4] the total CY 2018 ED utilization rate ranked between the 50th and 75th percentiles, indicating utilization rates that are on the high end of the normal range. Despite fluctuations in the ED utilization rates across different age groups, the rates for members under 65 years of age mostly fell within the normal range (i.e., between the 25th and 75th percentiles) compared to national Medicaid benchmarks. However, the ED utilization for the 65 years and older age groups were above the 90th percentile compared to national Medicaid benchmarks. Given the small denominator sizes for the 65 years and older population, larger fluctuations in rates were expected.

NYU ED Classification

The NYU algorithm classifies ED visits into four main classifications:[6-5]

1. **Non-emergent**—This measure approximates the percentage of admissions where immediate medical care was not required within 12 hours.
2. **Emergent—Primary Care Treatable**—This measure approximates the percentage of admissions where treatment was required within 12 hours, but care could have been provided by a PCP in a primary care setting.
3. **Emergent—ED Care Needed—Preventable/Avoidable**—This measure approximates the percentage of admissions where ED care was required based on the diagnosis, but the emergent nature of the condition was potentially preventable/avoidable if appropriate care had been received.

6-4 Rates were compared to the NCQA's national Medicaid health maintenance organization Audit Means and Percentiles benchmarks.

6-5 NYU/Wagner. Faculty & Research. Available at: https://wagner.nyu.edu/faculty/billings/nyued-background. Accessed on: Jan 22, 2020.

4. **Emergent—ED Care Needed—Not Preventable/Avoidable**—This measure approximates the percentage of admissions where ED care was required, and appropriate treatment could not have prevented the condition.

Table 6-2 presents the NYU ED Classifications for the most common CCS categories by the number of ED visits.

Table 6-2—NYU ED Classification—Top 10 CCS Categories, CY 2018

CCS Category	Total ED Visits	ED Care Needed—Not Preventable/ Avoidable	ED Care Needed—Preventable/ Avoidable	Emergent—PCP Treatable	Non-Emergent
Other Upper Respiratory Infections	31,169	1,308 (4.20%)	3,550 (11.39%)	17,133 (54.97%)	8,720 (27.98%)
Abdominal Pain	22,746	7,484 (32.90%)	0 (0.00%)	15,177 (66.72%)	0 (0.00%)
Superficial Injury; Contusion	19,356	0 (0.00%)	0 (0.00%)	93 (0.48%)	0 (0.00%)
Nonspecific Chest Pain	15,196	7,742 (50.95%)	0 (0.00%)	7,454 (49.05%)	0 (0.00%)
Sprains and Strains	15,152	0 (0.00%)	0 (0.00%)	77 (0.51%)	0 (0.00%)
Headache; including migraine	14,646	2,493 (17.02%)	0 (0.00%)	1,034 (7.06%)	8,865 (60.53%)
Spondylosis; intervertebral disc disorders; other back problems	13,357	3,106 (23.25%)	0 (0.00%)	2,147 (16.07%)	7,443 (55.72%)
Other Injuries and Conditions Due to External Causes	12,087	20 (0.17%)	0 (0.00%)	65 (0.54%)	0 (0.00%)
Mood Disorders	11,671	18 (0.15%)	0 (0.00%)	0 (0.00%)	0 (0.00%)
Other Complications of Pregnancy	10,783	190 (1.76%)	0 (0.00%)	142 (1.32%)	607 (5.63%)
Total	**505,248**	**68,016 (13.46%)**	**33,283 (6.59%)**	**111,453 (22.06%)**	**95,618 (18.92%)**

Table 6-2 shows that approximately 19 percent of total ED visits were classified as non-emergent and another 22 percent were classified as PCP treatable, which aligns with national averages.[6-6] Additionally, ED visits for five of the 10 most common CCS categories (1. Other Upper Respiratory Infections, 2. Abdominal Pain, 3. Nonspecific Chest Pain, 4. Headache; including migraine, and 5. Spondylosis; intervertebral disc disorders; other back problems) were commonly classified as non-emergent or PCP treatable. Of note, over 70 percent of ED visits with a diagnosis of either Other Upper Respiratory Infections (the most common reason for an ED visit) or Spondylosis; intervertebral disc disorders; other back problems (the seventh most common reason) were considered non-emergent or PCP treatable.

Follow-Up Care

HSAG analyzed the number of prescriptions and the percentage of members who received a new prescription for an opioid or an antibiotic during an ED visit, as shown in Table 6-3.

Table 6-3—Prescriptions for Medications of Concern, CY 2018

Medication	Total ED Visits	Number of New Prescriptions	Percentage of Members Receiving a Prescription
Opioids	505,248	13,746	2.72%
Antibiotics	505,248	76,024	15.05%

The statewide ED antibiotic prescription rate was higher than the national average of 13.8 percent,[6-7] indicating potential overprescribing of antibiotics in the ED setting. For opioid prescriptions, the statewide average fell below the national average of 3.54 percent,[6-8] indicating appropriate opioid stewardship.

Plan Comparison

The CY 2019 calculation of PPEs activity included statewide results; therefore, there is no plan comparison.

6-6 Rui P, Kang K, Ashman JJ. National Hospital Ambulatory Medical Care Survey: 2016 emergency department summary tables. 2016. Available at: https://www.cdc.gov/nchs/data/nhamcs/web_tables/2016_ed_web_tables.pdf. Accessed on: Jan 22, 2020.

6-7 Palms DL, Hicks LA, Bartoces M, et al. Comparison of Antibiotic Prescribing in Retail Clinics, Urgent Care Centers, Emergency Departments, and Traditional Ambulatory Care Settings in the United States. *JAMA Intern Med.* 2018;178(9):1267–1269. doi:10.1001/jamainternmed.2018.1632.

6-8 Rui P, Schappert SM. Opioids Prescribed at Discharge or Given During Emergency Department Visits Among Adults in the United States, 2016. *NCHS Data Brief*, no 338. Hyattsville, MD: National Center for Health Statistics. 2019.

Conclusions and Recommendations

When compared to national Medicaid benchmarks, the overall CY 2018 ED utilization rate ranked between the 50th and 75th percentiles, indicating utilization rates that are on the high end of the normal range. Additionally, the NYU classification rates for statewide ED visits aligned with national trends. However, the overutilization and inappropriate use of ED services is a noted problem for the national Medicaid population.[6-9] Of note, when looking at the 10 most common CCS categories seen in the ED, five of these categories are commonly classified as either non-emergent or emergent but PCP treatable. DHS should investigate further into whether this inappropriate ED utilization is due to members being unable to access primary care effectively or due to member conditions being ineffectively treated or managed in a primary care setting.

When looking at medications of concern prescribed during an ED visit, the percentage of ED visits that resulted in a prescription of antibiotics was above the national ED antibiotic prescription rate. Additionally, none of the 10 most common CCS categories for ED visits are appropriately treated by the use of antibiotics. While the analysis did not tie antibiotic prescriptions to specific CCS categories, this high antibiotic prescription rate could be indicative of inappropriate antibiotic use. DHS should work with the MCOs and hospitals to assist with developing or evaluating hospital antibiotic stewardship programs. Conversely, the statewide ED opioid prescription rate was lower than the national average. This indicates appropriate opioid stewardship within the ED setting.

6-9 Department of Health and Human Services. Reducing Nonurgent Use of Emergency Departments and Improving Appropriate Care in Appropriate Settings. Jan 2014. Available at: https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-16-14.pdf. Accessed on: Jan 22, 2020.

7. Validation of Performance Improvement Projects

This section presents HSAG's findings and conclusions from the validation of PIPs conducted for each MCO and PAHP. It provides a discussion of each MCO's and PAHP's overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively each MCO and PAHP has addressed the recommendations for QI made by HSAG during the previous year. The methology for each activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis and Appendix B. PAHP Technical Methods of Data Collection and Analysis.

Managed Care Organizations

Overview

For CY 2019, the MCOs submitted their ongoing DHS-mandated PIP topics *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 Six Years of Life*. As Iowa Total Care entered the IA Health Link program effective July 1, 2019, it will participate in future PIP activities.

To initiate the process, the MCOs submit the PIPs for initial validation. Once the MCOs receive the initial validation findings, they have the opportunity to receive technical assistance from HSAG, make any necessary corrections or revisions and resubmit for final validation. It is important to note that UnitedHealthcare withdrew from the IA Health Link managed care program effective July 1, 2019, and elected not to resubmit for final validation accepting the initial validation findings as final.

Specific Results

Table 7-1 includes the PIP topic, the initial submission and resubmission evaluation elements, and the overall validation status.

Table 7-1—2019 PIP Validation Results

MCO Name	PIP Topic	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
Amerigroup	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	Submission	45%	60%	***Not Met***
		Resubmission	85%	90%	***Partially Met***
	Member Satisfaction	Submission	50%	58%	***Not Met***
		Resubmission	85%	92%	***Not Met***
UnitedHealthcare	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	Submission	85%	100%	***Met***
	Member Satisfaction	Submission	65%	83%	***Not Met***

[1] **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the MCO was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 7-2 displays baseline and Remeasurement 1 results and MCO-designated goals for each PIP topic.

Table 7-2—Study Indicator Results—MCOs

MCO Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Plan-Designated Goal
Amerigroup	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	The percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year.	53.9%	64.5% ↑*	64.7%
	Member Satisfaction	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.	58.7%	61.9% ⇔	64.4%

MCO Name	PIP Topic	Study Indicator	Baseline Rate	Remeasurement 1 Rate	Plan-Designated Goal
UnitedHealthcare	*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	The percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year.	72.6%	69.1% ↓*	75.6%
	Member Satisfaction	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.	63.2%	65%	60.1%

↑* Designates statistically significant improvement over the baseline measurement period (*p* value < 0.05).

⇔ Designates an improvement or a decline from the baseline measurement period that was not statistically significant (*p* value ≥ 0.05)

↓* Designates statistically significant decline over the baseline measurement period (*p* value < 0.05).

Plan Comparison

For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, Amerigroup reported 64.5 percent of members 3 to 6 years of age had one or more well-child visits with a PCP during the first remeasurement period. The reported rate for the study indicator did not meet the plan-selected Remeasurement 1 goal of 64.7 percent; however, Amerigroup demonstrated a statistically significant improvement over the baseline measurement.

UnitedHealthcare's Remeasurement 1 performance reported that 69.1 percent of members 3 to 6 years of age had one or more well-child visits with a PCP. The reported rate for the study indicator demonstrated a statistically significant decline over the baseline and did not meet the plan-selected Remeasurement 1 goal of 75.6 percent.

For the *Member Satisfaction* PIP, 61.9 percent of Amerigroup's members answered CAHPS adult survey Question #35 (overall satisfaction with the MCO) with a score of 9 or 10. The reported rate for the study indicator did not meet the plan-selected Remeasurement 1 goal of 64.4 percent. While the study indicator showed improvement, that improvement was not considered statistically significant.

UnitedHealthcare's Remeasurement 1 performance reported that 65 percent of members answered CAHPS adult survey Question #35 with a score of 9 or 10. The reported rate for the study indicator demonstrated an increase that is not considered statistically significant. The MCOs set Remeasurement 1 goals based on the baseline measurement performance; however, UnitedHealthcare set a goal for the *Member Satisfaction* PIP that was below the baseline measurement. MCOs should select a goal that demonstrates statistically significant improvement over the baseline performance.

Conclusions and Recommendations

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction* PIPs each received a *Met* validation score for 79 percent of all evaluation elements (Steps I through IX). For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, the MCOs developed methodologically sound improvement projects, as evidenced by the scores for the Design stage (Steps I through VI). For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, Amerigroup demonstrated statistically significant improvement, while UnitedHealthcare demonstrated a statistically significant decline. For the *Member Satisfaction* PIP, both MCOs have opportunities for improvement in Step V, Valid Sampling Techniques. Additionally, neither MCO demonstrated statistically significant improvement over the baseline. Both MCOs had areas in need of improvement for both PIP topics across the Implementation and Outcomes stages. Because UnitedHealthcare withdrew from the IA Health Link managed care program, the following recommendations were applicable to Amerigroup only, as it progresses to Remeasurement 2.

- Amerigroup should ensure the accuracy of the statistical test performed, and the p value should be reported in the Step VII study indicator data table.
- Amerigroup should revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions.
- Amerigroup should develop and implement timely interventions targeting the associated identified barriers.
- Amerigroup should have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical. Decisions to revise, continue, or discontinue an intervention should be data-driven.

Follow-Up on Prior Recommendations

From the findings of each MCO's performance for the CY 2018 PIP activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each MCO for the PIP activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 7-3 and Table 7-4 in addition to each MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation. Iowa Total Care entered the Iowa managed care program effective July 1, 2019; therefore, no prior recommendations exist.

Table 7-3—PIP Recommendations—AGP

Prior Recommendations (CY 2018)
Amerigroup should have addressed all *Points of Clarification* documented in the PIP Validation Tool prior to the next annual submission. *Points of Clarification* are associated with *Met* validation scores. If not addressed, the evaluation element may be scored down and no longer be *Met*. Feedback provided in *Not Applicable* comments should have also been reviewed, and related information should have been included in the next annual submission. Amerigroup must have ensured decisions to continue, revise, or discontinue an intervention are data-driven. The supporting data and rationale must have been included in Step VIII of the PIP Submission Form. Amerigroup should have evaluated each intervention to determine its effectiveness and ensure each intervention is logically linked to identified barriers. Amerigroup should have referenced the PIP Completion Instructions annually to ensure all requirements for each completed step have been addressed. Amerigroup should have sought technical assistance from HSAG throughout the PIP process to address any questions or concerns.
Summary of AGP's Response to Recommendations
These recommendations have been implemented in the 2019 PIP submission.
HSAG's Assessment of the Degree to Which AGP Effectively Addressed the Recommendations
Based on Amerigroup's response and the CY 2019 PIP activity, Amerigroup addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*.

Table 7-4—PIP Recommendations—UHC

Prior Recommendations (CY 2018)
UnitedHealthcare should have addressed all *Points of Clarification* documented in the PIP Validation Tool prior to the next annual submission. *Points of Clarification* are associated with *Met* validation scores. If not addressed, the evaluation element may be scored down and no longer be *Met*. Feedback provided in *Not Applicable* comments should also have been reviewed, and related information should be included in the next annual submission. UnitedHealthcare must have ensured decisions to continue, revise, or discontinue an intervention are data-driven. The supporting data and rationale must have been included in Step VIII of the PIP Submission Form. UnitedHealthcare should have evaluated each intervention to determine the effectiveness and ensure each intervention is logically linked to identified barriers. UnitedHealthcare should have referenced the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed. UnitedHealthcare should have sought technical assistance from HSAG throughout the PIP process to address any questions or concerns.
Summary of UHC's Response to Recommendations
UnitedHealthcare will incorporate [these recommendations] into its other markets as appropriate.

HSAG's Assessment of the Degree to which UHC Effectively Addressed the Recommendations
Based on the response provided by UnitedHealthcare, UnitedHealthcare did not address the recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*. Of note, UnitedHealthcare exited the IA Health Link program effective July 1, 2019.

Prepaid Ambulatory Health Plan

Overview

For CY 2019, the PAHPs submitted their ongoing DHS-mandated dental PIP topics. DDIA's PIP, *Annual Dental Visits*, includes two study indicators: one for the adult population, and one for the Hawki population. MCNA's PIP, *Increase the Percentage of Dental Services*, has only one study indicator, which is for the adult population.

To initiate the process, the PAHPs submit the PIPs for initial validation. Once the PAHPs receive the initial validation findings, they have the opportunity to receive technical assistance from HSAG, make any necessary corrections or revisions, and resubmit for final validation.

Specific Results

Table 7-5 illustrates the validation scores for both the initial submission and resubmission.

Table 7-5—2019 PIP Validation Results for PAHPs

MCO Name	Name of Project	Type of Annual Review[1]	Percentage Score of Evaluation Elements *Met*[2]	Percentage Score of Critical Elements *Met*[3]	Overall Validation Status[4]
DDIA	*Annual Dental Visits*	Submission	91%	100%	***Met***
		Resubmission	91%	100%	***Met***
MCNA	*Increase the Percentage of Dental Services*	Submission	82%	83%	***Partially Met***
		Resubmission	91%	100%	***Met***

[1] **Type of Review**—Designates the PIP review as an annual submission or resubmission. A resubmission means the MCO was required to resubmit the PIP with updated documentation because it did not meet HSAG's validation criteria to receive an overall *Met* validation status.

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and noncritical) by the sum of the total elements of all categories (*Met*, *Partially Met*, and *Not Met)*.

[3] **Percentage Score of Critical Elements *Met***—The percentage score of critical elements *Met* is calculated by dividing the total critical elements *Met* by the sum of the critical elements *Met*, *Partially Met*, and *Not Met*.

[4] **Overall Validation Status**—Populated from the PIP Validation Tool and based on the percentage scores.

Table 7-6 displays baseline results and the PAHP-designated goal for each PIP topic.

Table 7-6—Study Indicator Results

MCO Name	PIP Topic	Study Indicator	Baseline Rate	Plan-Designated Goal
DDIA	*Annual Dental Visits*	1. The percentage of members 19 years of age and older who had at least one dental visit during the measurement year. 2. The percentage of Hawki members 1 to 18 years of age who had at least one preventive dental visit during the measurement year.	44.2% 73.3%	47.7% 76.5%
MCNA	*Increase the Percentage of Dental Services*	The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.	24.4%	26.4%

Plan Comparison

For the *Annual Dental Visits* PIP, DDIA reported that 44.2 percent of Medicaid members 19 years of age and older had at least one dental visit during the measurement year, and 73.3 percent of Hawki members 1 to 18 years of age had at least one preventive dental visit during the measurement year.

For the *Increase the Percentage of Dental Services* PIP, MCNA reported that 24.4 percent of members 19 years of age and older had at least one dental visit during the measurement year.

Conclusions and Recommendations

Both PIPs received a *Met* validation score for 91 percent of all evaluation elements in Steps I through VII. The PAHPs developed methodologically sound improvement projects and should continue efforts toward achieving the desired outcomes and goals. As the PAHPs progress through the PIP process, each will conduct QI activities leading to the implementation of active innovative interventions with the potential to impact study indicator outcomes. The PAHPs must address identified deficiencies noted in this year's validation prior to submitting PIPs for the next annual validation in 2020.

- The PAHPs should ensure that the approved PIP methodology to calculate and report Remeasurement 1 data is followed and data are reported accurately in next year's annual submission.

- The PAHPs should document the process and steps used to determine and prioritize barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis.
- As the PIP progresses, the PAHPs' efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes.
- The PAHPs should have a process in place for evaluating the performance of each intervention and impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical. Decisions to revise, continue, or discontinue an intervention should be data-driven.

Follow-Up on Prior Recommendations

From the findings of each PAHP's performance for the CY 2018 PIP activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each PAHP for the PIP activity in the Calendar Year 2018 External Quality Review Technical Report are summarized in Table 7-7 and Table 7-8 in addition to each PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 7-7—PIP Recommendations—DDIA

Prior Recommendations (CY 2018)
DDIA should have addressed all *Points of Clarification* documented in the PIP Validation Tool prior to the next annual submission. *Points of Clarification* are associated with *Met* validation scores. If not addressed, the evaluation element may be scored down and no longer be *Met*. In addition to the claims processing information documented in Step VI, DDIA should have provided the step-by-step data collection process that results in the production of the study indicator outcomes percentage and describe how the percentage is calculated. As the PIP progressed, DDIA's efforts in the Implementation stage should have supported the development of active interventions and sound measurement results leading to improved outcomes. DDIA should have referenced the PIP Completion Instructions to ensure all requirements for each completed step have been addressed.
Summary of DDIA's Response to Recommendations
DDIA is updating the PIP Validation Tool to address *Points of Clarification* and provide additional detail for HSAG to review. Additionally, DDIA continues to document in more detail the data collection process post adjudication and clarify the calculation of the study indicators. DDIA will continue to reach out to HSAG while completing the PIP Validation Tool and continues to use the Interim PIP Progress Tables.
HSAG's Assessment of the Degree to Which DDIA Effectively Addressed the Recommendations
Based on DDIA's response and the CY 2019 PIP activity, DDIA addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report.*

Table 7-8—PIP Recommendations—MCNA

Prior Recommendations (CY 2018)
MCNA should have addressed all *Points of Clarification* documented in the PIP Validation Tool prior to the next annual submission. *Points of Clarification* are associated with *Met* validation scores. If not addressed, the evaluation element may be scored down and no longer be *Met*. As the PIP progressed, MCNA's efforts in the Implementation stage should have supported the development of active interventions and sound measurement results leading to improved outcomes. MCNA should have referenced the PIP Completion Instructions to ensure all requirements for each completed step have been addressed.
Summary of MCNA's Response to Recommendations
MCNA addressed all of the general comments in the last PIP submission and received *Met* validation scores in all areas except Step VI regarding administrative completeness. This will be corrected in the next annual submission in addition to the inclusion of reporting the outcomes of all active interventions implemented during the measurement period.
HSAG's Assessment of the Degree to Which MCNA Effectively Addressed the Recommendations
Based on MCNA's response and the CY 2019 PIP activity, MCNA addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report.*

8. Network Adequacy

This section presents HSAG's findings and conclusions from the network adequacy activity conducted for each MCO and PAHP. It provides a discussion of each MCO's and PAHP's overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively each MCO and PAHP has addressed the recommendations for QI made by HSAG during the previous year. The methology for the network adequacy activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis and Appendix B. PAHP Technical Methods of Data Collection and Analysis.

Managed Care Organizations

Overview

DHS contracted HSAG to conduct a secret shopper telephone survey of OB/GYN providers, including physicians specializing in OB/GYN, certified nurse midwives (CNMs), and advanced registered nurse practitioners (ARNPs) specializing in OB/GYN.

HSAG conducted the statewide secret shopper telephone survey in August 2019 among a sample of OB/GYN providers enrolled with Amerigroup that provide care to Medicaid members in Iowa. HSAG originally planned to survey providers contracted with UnitedHealthcare. However, UnitedHealthcare exited the Iowa Medicaid market prior to initiation of the survey.

The objectives of this study included the following:

- Determine whether OB/GYN providers are accepting new Medicaid patients who are enrolled in the Medicaid program.
- Determine whether appointment availability for Medicaid patients who are enrolled in the Medicaid program meets the contract standard.

Specific Results

The study results presented in this report are for the sample of Amerigroup providers. The findings include the percentage of OB/GYN provider locations that could be reached, the percentage of OB/GYN providers accepting new patients, the average time to the first available appointment, and whether the time to the first available appointment was within the contract standard.

Of the 336 sampled providers, 254 (75.6 percent) were study respondents (i.e., able to be contacted). A provider was considered a "non-respondent" if HSAG callers were unable to contact the office (i.e., the telephone was disconnected, or the caller was unable to speak with the provider's office after two call attempts). Table 8-1 displays the number and percentage of survey respondents participating with

Amerigroup at the time of the survey. Among the 254 respondents, 92.9 percent reported participation with Amerigroup. All respondents who reported participating with Amerigroup also confirmed acceptance of Medicaid.

Table 8-1—MCO Participation Distribution for Respondents

MCO	Respondents	Participating With MCO	Not Participating With MCO	Participation Rate
Amerigroup	254	236	18	92.9%

Table 8-2 displays the number and percentage of respondents that were accepting new patients. Of the 236 providers that reported accepting Amerigroup, 212 reported being an OB/GYN provider. Among these 212 OB/GYN providers, 190 (89.6 percent) reported accepting new patients.

Table 8-2—Number and Percentage of Confirmed OB/GYN Providers and New Patient Acceptance Rate

MCO	OB/GYN Providers Participating With MCO	Is an OB/GYN Provider		OB/GYN Provider Is Accepting New Patients	
		Number	Percent	Number	Percent
Amerigroup	236	212	89.8%	190	89.6%

Table 8-3 displays the appointment availability information by visit type (i.e., first or second trimester). Among those surveyed for a first trimester appointment, 54.7 percent of provider locations provided an appointment date, and 98.1 percent of these appointments were within the 30-day contract standard, whereas for those surveyed for a second trimester appointment, 41.1 percent of provider locations provided an appointment, and 82.1 percent of these were within the 30-day contract standard.

Table 8-3—Appointment Availability for All Appointment Types by Visit Type

Visit Type	Providers Contacted and Accepting New Patients	Calls With an Appointment		Appointments in Compliance With Standard	
		Number	Percent	Number	Percent
Amerigroup					
First Trimester	95	52	54.7%	51	98.1%
Second Trimester[1]	95	39	41.1%	32	82.1%
All Appointments	**190**	**91**	**47.9%**	**83**	**91.2%**

[1] A provider location provided an appointment date 337 days after the survey call date. As this would be after the completion of the pregnancy, this was not counted as an appointment in this analysis.

Surveyed provider locations may have been unable to offer appointment information for a variety of reasons. Most reasons were related to processes that were in place at the providers' offices. For example:

- The provider location required the patient to pre-register prior to scheduling an appointment.
- The provider needed to review a new patient's medical record prior to scheduling an appointment.
- The office required that the patient meet with a nurse practitioner first.

Plan Comparison

As the secret shopper survey was conducted for a sample of Amerigroup providers only, a plan comparison is not applicable at this time. A plan comparison will be included in future reports when appropriate.

Conclusions and Recommendations

Overall, HSAG achieved a response rate of 75.6 percent for this study. Survey results indicated a relatively high rate of data accuracy, with over 90 percent of contacted provider locations accepting Amerigroup and almost 90 percent of participating providers confirming their provider type (i.e., OB/GYN provider) and acceptance of new patients.

While HSAG callers were able to contact 254 out of 336 provider locations in the survey sample, they were only able to obtain an appointment date for a new Medicaid patient at 91 provider locations. HSAG's ability to obtain an appointment was limited by the ability to contact the provider locations, the confirmation of the provider as a prenatal provider who is accepting new patients, and various processes in place at provider locations. For example, some provider locations required a patient to pre-register prior to scheduling an appointment, while other provider locations required a review of patient medical records prior to scheduling. Among those calls that received an appointment, 98.1 percent and 82.1 percent of the first and second trimester calls, respectively, were in compliance with the 30-day contract standard. Prior surveys conducted by HSAG in other states have shown that timelier appointments are typically offered to existing Medicaid members compared to appointments among new Medicaid patients. It is possible that improved compliance with the standard would be achieved for existing Medicaid members, particularly for second trimester appointments.

In general, secret shopper survey results suggest that appointments for prenatal visits are generally available for Iowa Medicaid members once the caller contacts a valid OB/GYN provider that accepts new Medicaid patients. However, new Medicaid patients who are seeking care in the second trimester of their pregnancy may find it more difficult to obtain an appointment in a timely manner. These results highlight opportunities for improved access to care in terms of accurate provider information, the ability to successfully schedule an appointment, and the timeliness of available appointments relative to the members' needs.

Recommendations

Based on the survey results presented in this report, HSAG identified several opportunities for improvement related to accurate provider information, members' ability to successfully schedule an appointment, and the timeliness of available appointments relative to members' needs. While secret

shopper survey results suggest that appointments for prenatal care are generally available for Iowa Medicaid members, HSAG offers the following recommendations to address potential opportunities to improve access among members covered by Iowa Medicaid managed care:

- With the addition of a new MCO, Iowa Total Care, HSAG recommends that DHS monitor appointment availability to assess changes in the member experience based on the changes to the provider networks by conducting follow-up telephone surveys after the implementation of the new provider network. Monitoring activities may also include validation of the MCOs' network adequacy efforts, in alignment with federal regulations relating to the mandatory EQR-related activity described in the CMS rule §438.358(b)(1)(iv).
  - Surveys focusing on PCPs, OB/GYN, and/or other provider specialties would allow DHS to assess appointment availability. If specific contract standards do not exist for the surveyed provider types, survey responses could be used to generate a baseline understanding of members' level of access and to establish contract standards.
  - DHS should consider using a revealed shopper survey approach to assess the differences in appointment availability for existing and new Medicaid members. Revealed shopper surveys allow for additional information to be obtained regarding appointment availability for existing Medicaid members.
- DHS should consider reviewing the appointment availability standards and determine if prenatal-specific standards are appropriate for its member population. Compliance with appointment availability for specialist providers, i.e., 30 days, may not be clinically appropriate for a member seeking care in the second or third trimester of a pregnancy.
- DHS should consider expanding the current appointment availability surveys to assess provider data accuracy. In addition to evaluating the timeliness of appointments, the survey could verify providers' demographic information, including physician name, telephone number, and address. These responses could then be compared to DHS' provider data or the MCOs' electronic provider directories. Quantifying discrepancies between the electronic provider data and the providers' self-reported feedback would provide a foundation from which DHS could aid the MCOs in improving data quality, and subsequently, the accuracy of provider information available to Medicaid members.

Follow-Up on Prior Recommendations

From the findings of each MCO's performance for the CY 2018 network adequacy activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each MCO for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 8-4 and Table 8-5 in addition to each MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation. Iowa Total Care entered the Iowa managed care program effective July 1, 2019; therefore, no prior recommendations exist.

Table 8-4—Network Adequacy Recommendations—AGP

Prior Recommendations (CY 2018)
Amerigroup should have demonstrated its provider network oversight pertaining to the following: • Ensuring appointment availability standards are being met. • Addressing questions or reeducating providers and office staff on DHS standards. • Incorporating appointment availability standards into educational materials. Specifically, Amerigroup should have worked with its contracted providers to confirm providers' awareness of the different appointment availability standards.
Summary of AGP's Response to Recommendations
Amerigroup has fully implemented its provider network oversight program for appointment availability for all types of providers. Appropriate questions have been added to the quarterly provider survey following Exhibit B of the contract. If a provider does not demonstrate compliance in the survey, we have implemented our CAP program to educate the provider and outline corrective action steps if needed. While the oversight program has been fully implemented, education of providers is an ongoing process, and we continue to work with providers to communicate the requirements of Exhibit B.
HSAG's Assessment of the Degree to Which AGP Effectively Addressed the Recommendations
Based on Amerigroup's response and the CY 2019 network adequacy activity, Amerigroup addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report* and continues to provide ongoing education to its providers.

Table 8-5—Network Adequacy Recommendations—UHC

Prior Recommendations (CY 2018)
UnitedHealthcare should have demonstrated its provider network oversight pertaining to the following: • Ensuring appointment availability standards are being met. • Addressing questions or reeducating providers and office staff on DHS standards. • Incorporating appointment availability standards into educational materials. Specifically, UnitedHealthcare should have worked with its contracted providers to confirm providers' awareness of the different appointment availability standards.
Summary of UHC's Response to Recommendations
UnitedHealthcare will incorporate recommendations into its other markets as appropriate.
HSAG's Assessment of the Degree to Which UHC Effectively Addressed the Recommendations
Based on UnitedHealthcare's response and the CY 2019 network adequacy activity, UnitedHealthcare did not address the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*. Of note, UnitedHealthcare exited the IA Health Link program effective July 1, 2019.

Prepaid Ambulatory Health Plan

Overview

DHS contracted with HSAG to conduct a Dental Provider Network Analysis (network analysis). The purpose of the network analysis was to conduct an analysis of the utilization of dental services for Iowa Dental Wellness Plan Medicaid members.

The proposed analysis evaluated the following dimensions of dental utilization:

- **Provider Saturation:** The provider saturation analysis assessed the percentage of dental providers licensed in the State of Iowa that were contracted with at least one of the PAHPs to provide dental services to Medicaid members.
- **Percentage of Active Providers:** This dimension evaluated the percentage of providers contracted with the PAHPs who had evidence (i.e., encounters) of providing services to Medicaid members within the study period.
- **Member Service Utilization:** The member utilization dimension assessed 1) the percentage of Medicaid members enrolled in a PAHP who received a dental service during the study period, and 2) the frequency of the most commonly administered services by provider type.
- **Travel Time/Distance to Providers:** This dimension evaluated the time/distance to the dental providers.

Specific Results

HSAG conducted a baseline dental provider network analysis in CY 2018 that established provider ratios and time/distance results for the PAHPs in Iowa. To augment these results and assess other aspects of provider network adequacy, the CY 2019 analysis focused on member utilization of dental services, provider saturation (i.e., the number of providers contracted with Medicaid PAHPs), and the percentage of active providers. Additionally, HSAG conducted time/distance analyses to ensure member access to dental providers. By moving beyond traditional network adequacy metrics (i.e., provider ratios and time/distance analyses), DHS is able to ascertain the members' access to services using measures of realized access.

Provider Saturation Analysis

DHS supplied HSAG with provider data from the Iowa Dental Board, DDIA, and MCNA. HSAG determined how many providers were contracted with the PAHPs that were listed in the Iowa Dental Board data. Results from this analysis should be interpreted with some caution as HSAG's ability to deduplicate and link providers identified from the Iowa Dental Board data was limited due to incomplete data in the NPI field in the Iowa Dental Board data. Additionally, all data sources had inconsistent collection of the statewide license number which limited HSAG's ability to link the data. The likely results of these issues are an over-estimation of the unique providers in the Iowa Dental Board data and

an underrepresentation of the PAHP provider counts, resulting in artificially low percentages. Statewide counts are not complementary, as some providers are contracted with both DDIA and MCNA.

Table 8-6 illustrates the results of the provider saturation analysis by PAHP and provider type.

Table 8-6—Percentage of Providers Licensed With the Iowa Dental Board That Are Contracted With a PAHP

Provider Category	Iowa Dental Board	Participation in a PAHP*	
	Provider Count	Provider Count	Percentage
General Dentists			
General Dentists	2,817	886	31.5%
Dental Specialists			
Endodontists	41	11	26.8%
Oral Surgeons	152	64	42.1%
Orthodontists**	137	16	11.7%
Pedodontists**	74	46	62.2%
Periodontists	42	9	21.4%
Prosthodontists	NA	20	NA

* Since providers may contract with both PAHPs, the statewide provider count may not equal the sum of the PAHPs.

** Pedodontists and orthodontists were included in the provider saturation analysis. However, results should be interpreted with caution since they provide services to limited populations within the Dental Wellness Plan (e.g., adults with behavior management issues).

NA: No prosthodontists were identified in the Iowa Dental Board data.

Overall, statewide study results showed under one-third of all general dental providers were contracted with either DDIA, MCNA, or both. Pedodontists had the highest rate of participation, with 62.2 percent of providers contracted with at least one PAHP.

Member Service Utilization

Table 8-7 displays the statewide percentage of members receiving dental services during the 2018 measurement period.

Table 8-7—Statewide Percentage of Members Receiving Dental Services by Dental Service Category

Dental Service Category	Count of Members Receiving Dental Services	Percentage of PAHP Population (n=311,070)
Any Dental Services	**105,143**	**33.8%**
Diagnostic Services	99,859	32.1%
Preventive Services	67,176	21.6%
Restorative Services	43,706	14.1%
Surgery or Extractions	24,466	7.9%
Adjunctive Services	22,200	7.1%
Periodontics	13,394	4.3%
Prosthodontics	10,158	3.3%
Endodontics	6,953	2.2%
Orthodontics	66	<0.1%

According to HSAG's findings, 105,143 members statewide received a dental service during the study period. Members' utilization of any service statewide was 33.8 percent. Among both PAHPs, diagnostic and preventive services were the most utilized services.

Plan Comparison

Provider Saturation Analysis

Table 8-8 illustrates the results of the provider saturation analysis by PAHP and provider type.

Table 8-8—Percentage of Providers Licensed With the Iowa Dental Board That Are Contracted With a PAHP

Provider Category	Iowa Dental Board	DDIA		MCNA	
	Provider Count	Provider Count	Percentage	Provider Count	Percentage
General Dentists					
General Dentists	2,817	754	26.8%	232	8.2%
Dental Specialists					
Endodontists	41	11	26.8%	8	19.5%
Oral Surgeons	152	55	36.2%	25	16.4%
Orthodontists**	137	8	5.8%	8	5.8%
Pedodontists**	74	35	47.3%	16	21.6%

Provider Category	Iowa Dental Board	DDIA		MCNA	
	Provider Count	Provider Count	Percentage	Provider Count	Percentage
Periodontists	42	9	21.4%	8	19.0%
Prosthodontists	NA	17	NA	15	NA

* Since providers may contract with both PAHPs, the statewide provider count may not equal the sum of the PAHPs.

** Pedodontists and orthodontists were included in the provider saturation analysis. However, results should be interpreted with caution since they provide services to limited populations within the Dental Wellness Plan (e.g., adults with behavior management issues).

NA: No prosthodontists were identified in the Iowa Dental Board data.

Across both PAHPs, relatively low percentages of providers were contracted with the PAHPs out of all providers licensed by the Iowa Dental Board. A larger percentage of the available providers were contracted with DDIA than with MCNA across all provider types except orthodontists, where 5.8 percent of available providers were contracted with each PAHP. Both DDIA and MCNA have contracted with higher percentages of available pedodontists compared to other provider categories. Across the State, only 31.5 percent of available general dentists were contracted with a PAHP, indicating significant opportunities to expand provider networks.

Percentage of Active Providers

HSAG determined the number of active providers by PAHP through dental encounter data as provided by DHS. Providers who had at least one claim during the study period were determined to be active providers.

Table 8-9 displays the percentage of providers who are in each PAHP's provider network and have provided services to at least one member during the 2018 measurement period.

Table 8-9—Percentage of Active Providers by PAHP—All Providers

Provider Category	DDIA			MCNA		
	Active Providers	Provider Count	Percentage of Active Providers	Active Providers	Provider Count	Percentage of Active Providers
General Dentists						
General Dentists	783	817	95.8%	234	313	74.8%
Dental Specialists						
Endodontists	8	11	72.7%	5	8	62.5%
Oral Surgeons	55	57	96.5%	21	27	77.8%

Provider Category	DDIA			MCNA		
	Active Providers	Provider Count	Percentage of Active Providers	Active Providers	Provider Count	Percentage of Active Providers
Orthodontists*	9	9	100.0%	4	12	33.3%
Pedodontists*	39	39	100.0%	15	22	68.2%
Periodontists	6	10	60.0%	1	9	11.1%
Prosthodontists	16	21	76.2%	7	19	36.8%

* Pedodontists and orthodontists are included in the percentage of active providers analysis. However, results should be interpreted with caution since they provide services to limited populations within the Dental Wellness Plan (e.g., adults with behavior management issues).

Generally, most of the providers contracted with DDIA were considered active providers. The providers with the highest percentages of active providers for DDIA were orthodontists and pedodontists. Since these provider types only provide services to limited populations within the Dental Wellness Plan, they may have a higher rate of active providers because DDIA is only contracting with providers as needed. General dentists and oral surgeons also had high percentages of active providers, at 95.8 percent and 96.5 percent, respectively.

Among providers contracted with MCNA, periodontists and orthodontists had the lowest percentages of active providers, at 11.1 percent and 33.3 percent, respectively. General dentists and oral surgeons also had high percentages of active providers, at 74.8 percent and 77.8 percent, respectively.

Member Service Utilization

Table 8-10 displays the percentage of members receiving dental services by PAHP.

Table 8-10—Percentage of Members Receiving Dental Services by Dental Service Category and PAHP

Dental Service Category	DDIA		MCNA	
	Count of Members Receiving Dental Services	Percentage of PAHP Population (n=210,638)	Count of Members Receiving Dental Services	Percentage of PAHP Population (n=100,432)
Any Dental Services	**84,471**	**40.1%**	**20,672**	**20.6%**
Diagnostic Services	80,243	38.1%	19,616	19.5%
Preventive Services	56,792	27.0%	10,384	10.3%
Restorative Services	35,957	17.1%	7,749	7.7%
Adjunctive Services	19,300	9.2%	2,900	2.9%
Surgery or Extractions	18,692	8.9%	5,774	5.7%
Periodontics	10,950	5.2%	2,444	2.4%
Prosthodontics	8,114	3.9%	2,044	2.0%

Dental Service Category	DDIA		MCNA	
	Count of Members Receiving Dental Services	Percentage of PAHP Population (n=210,638)	Count of Members Receiving Dental Services	Percentage of PAHP Population (n=100,432)
Endodontics	5,475	2.6%	1,478	1.5%
Orthodontics	62	<0.1%	4	<0.1%

Among both PAHPs, diagnostic and preventive services were the most utilized services; however, 40.1 percent of DDIA members received a dental service compared to just 20.6 percent of MCNA members.

Geographic Network Distribution Analysis

HSAG used Quest Analytics Suite software to calculate the average travel distances (in miles) and travel times (in minutes) to the nearest three providers for each PAHP using previously obtained geocoded member and provider location data. Members' residential status (urban versus rural) was not factored into this analysis. HSAG limited this analysis to general dentists, endodontists, oral surgeons, periodontists, and prosthodontists.

Table 8-11 displays the average travel distances and travel times for members receiving dental coverage through DDIA.

Table 8-11—Average Travel Distances (Miles) and Travel Times (Minutes)—DDIA

Provider Category	First-Nearest	Second-Nearest	Third-Nearest
	Distance (Miles)/ Time (Minutes)	Distance (Miles)/ Time (Minutes)	Distance (Miles)/ Time (Minutes)
General Dentists			
General Dentists	8.8/10.4	9.6/11.3	10.7/12.5
Dental Specialists			
Endodontists	51.5/71.9	63.0/89.1	67.3/99.1
Oral Surgeons	23.1/27	25.9/30.7	29.4/35.4
Periodontists	67.1/86.1	77.1/98.6	90.1/120.3
Prosthodontists	56.0/70.1	85.2/108.5	110.3/146.1

Overall, DDIA members had short travel distances and travel times to general dentists and moderate travel distances and travel times to oral surgeons. This metric is also supportive of members' ability to choose among providers in DDIA's network without having to travel extensively. Conversely, geographic access to the first-nearest endodontists, periodontists, and prosthodontists required average driving distances exceeding 50 miles or driving times exceeding 70 minutes.

Table 8-12 displays the average travel distances and travel times for members receiving dental coverage through MCNA.

Table 8-12—Average Travel Distances (Miles) and Travel Times (Minutes)—MCNA

Provider Category	First-Nearest Distance (Miles)/ Time (Minutes)	Second-Nearest Distance (Miles)/ Time (Minutes)	Third-Nearest Distance (Miles)/ Time (Minutes)
General Dentists			
General Dentists	16.2/18.8	18.5/21.4	19.8/22.9
Dental Specialists			
Endodontists	67.5/100.1	67.5/100.1	67.5/100.1
Oral Surgeons	38.5/47.5	46.4/57.4	67.2/85.5
Periodontists	114.8/174.1	114.8/174.1	114.8/174.1
Prosthodontists	56.8/79.0	95.5/139.8	114.8/174.1

Overall, MCNA members had short travel distances and travel times to general dentists. Members also had reasonable access to the first- and second-nearest in-network oral surgeons. On average, geographic access to endodontists, periodontists, and prosthodontists required more extensive travel distances and times. Average travel times to the first-nearest provider exceeded 70 minutes for endodontists, periodontists, and prosthodontists, indicating that provider access and choice may be heavily affected by travel burden.

Conclusions and Recommendations

Results from the CY 2019 Dental Provider Network Analysis suggest that PAHPs have provider networks with general dentists who have the capacity to adequately serve respective Medicaid members while providing members with reasonable geographic access to service locations.

Provider saturation analysis results suggest that DDIA's and MCNA's provider networks could contract with more providers across the State. However, given the limitations of the analysis, it is challenging to estimate the true magnitude of the available providers. Analyses from a comparison of DDIA's and MCNA's network suggest that some providers are choosing to contract with one PAHP but not the other, indicating the potential to increase provider networks. However, the analysis of the percentage of active providers indicates that most providers contracted with the plans are, in fact, providing services to the members. Across all provider categories, DDIA had higher rates of active providers than MCNA, indicating that MCNA may have providers who are contracted with the plan but are not providing services to Medicaid members.

HSAG's analysis of member utilization indicates that general dentists are providing a range of dental services. Of all the Iowa Wellness Plan members, 33.8 percent of the members received at least one dental service during the measurement period. Of the DDIA members, 40.1 percent received a dental service compared to 20.6 percent of MCNA members. For both PAHPs, the most utilized services were diagnostic, preventive, and restorative services.

The analysis of travel time and distance to the nearest three providers by PAHP indicates that the network is adequate for general dentists for both PAHPs. However, for endodontists, periodontists, and prosthodontists, the travel time exceeded one hour, with longer travel times for MCNA members. This

could also indicate that the PAHPs are not contracted with enough specialists to improve the time or distance findings. As determined in the saturation analysis, both PAHPs could contract with more providers identified in the Iowa Dental Board data.

Recommendations

Based on the results and conclusions presented in this report, HSAG recommends the following for DHS and the PAHPs to strengthen provider networks and ensure members' access to dental services:

- DHS should consider a review of underlying issues to determine the differences between MCNA and DDIA members' service utilization. Since MCNA members had significantly lower service utilization, HSAG recommends conducting either a secret shopper survey of dental providers to assess appointment availability or a provider directory audit to review the online provider information available to members. DHS should consider adding these future network adequacy studies to assess if the difference in utilization rates could be related to either the members' ability to contact the provider (i.e., is the contact information available and accurate?) or the members' ability to obtain an appointment when they call the provider.
- DHS should encourage MCNA to review its provider directory and identify providers who have not delivered services to any members in the past year to determine if the provider should remain contracted with the PAHP and why the provider has not provided any services to Medicaid members.
- DHS should continue to collaborate with the PAHPs to identify and contract with additional providers in those areas with exceptionally long drive times and distances, as available. The provider categories of highest concern include endodontics, periodontics, and prosthodontics.

Follow-Up on Prior Recommendations

From the findings of each PAHP's performance for the CY 2018 network adequacy activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each PAHP for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 8-13 and Table 8-14 in addition to each PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 8-13—Network Adequacy Recommendations—DDIA

Prior Recommendations (CY 2018)
The analyses for endodontists, periodontists, and prosthodontists highlight the small volume of providers currently included in DDIA's network. To determine if the ratios of contracted providers to enrolled members are consistent with the ratios of providers providing care to members accessing care, DDIA should have conducted an analysis using provider data from the performance measure, *DWP Unique Members with 6+ Months Coverage and Accessing Care*, to determine those providers who are providing dental services and compare to the member-level data of those persons accessing care. This would have provided information on how many members are seeking services from a dental provider and how many network providers are providing services, which can be compared to the number of contracted providers in the network.

Summary of DDIA's Response to Recommendations
There are a small amount of specialty providers living and practicing within the State of Iowa. DDIA contracts with most of the specialty providers within the State for the Dental Wellness Plan. DDIA provides a monthly provider listing to DHS that includes providers by clinic location. At each clinic location, the report displays how many members, services, and amount paid per provider per location for the last 12 months. Additionally, DDIA provides GeoAccess maps quarterly that demonstrate adequate access as defined in the DWP contract.
HSAG's Assessment of the Degree to Which DDIA Effectively Addressed the Recommendations
Based on DDIA's response and the CY 2019 network activity, DDIA addressed the prior recommendations listed in the *Calendar Year 2018 External Quality Review Technical Report*.

Table 8-14—Network Adequacy Recommendations—MCNA

Prior Recommendations (CY 2018)
The analyses for endodontists, periodontists, and prosthodontists highlight the small volume of providers currently included in MCNA's network. To determine if the ratios of contracted providers to enrolled members are consistent with the ratios of providers furnishing care to members accessing care, MCNA should conduct an analysis using provider data from the performance measure, *DWP Unique Members with 6+ Months Coverage and Accessing Care*, to determine those providers who are providing dental services and compare to the member-level data of those persons accessing care. This will provide information on how many members are seeking services from a dental provider and how many network providers are providing services, which can be compared to the number of contracted providers in the network.
Summary of MCNA's Response to Recommendations
MCNA initiated analysis based on HSAG's recommendation to run the measure for *DWP Unique Members with 6+ Months Coverage and Accessing Services* and compare those providers actually seeing members against the entire network of providers to ensure ratios remain consistent. However, MCNA expanded on that recommendation to analyze which providers were seeing members regardless of whether the member met the six-month continuous enrollment as outlined in the measure specifications. Using the measure as designed to assess which members are accessing care is appropriate. However, it was not an effective means to identify the accurate number of providers/portion of our network that is providing care. When removing the members' six-month continuous enrollment requirement, we found that many more providers were indeed seeing members during that same time frame. All providers without record of recently seeing MCNA members are targeted for outreach to identify and remove barriers. This intervention strategy is ongoing. MCNA recognizes that there are geographic limitations; for example, there are very few specialists in rural areas of the State. Specialty services such as endodontics, periodontics and oral surgery are performed by general dentists and are within the scope of the practice of a general dentist. As an example, most D7000–D7999 series codes (oral surgery code set) are performed by general dentists statewide and the vice president of network development monitors data whereby general dentists provide access to members in rural areas by specialty care codes. The Network Development team will identify specialists throughout the State of Iowa, and recruitment efforts will also be ongoing.
HSAG's Assessment of the Degree to Which MCNA Effectively Addressed the Recommendations
Based on MCNA's response and the CY 2019 network adequacy activity, MCNA addressed the prior recommendations made in the *Calendar Year 2018 External Quality Review Technical Report*.

9. Encounter Data Validation

Managed Care Organizations

This section presents HSAG's findings and conclusions from the EDV activity conducted for each MCO and PAHP. It provides a discussion of each MCO's and PAHP's overall strengths and recommendations for improvement related to the quality and timeliness of, and access to care and services. Also included is an assessment of how effectively each MCO and PAHP has addressed the recommendations for QI made by HSAG during the previous year. The methology for the EDV activity can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis and Appendix B. PAHP Technical Methods of Data Collection and Analysis.

Calendar Year 2018 EDV Study

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, the DHS required its contracted MCOs to submit high-quality encounter data. DHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, establish performance measure rates, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

As the CY 2018 EDV study was not completed during 2018, this activity is being included in this year's report. During CY 2018, DHS contracted with HSAG to conduct an EDV study. In alignment with CMS' *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR),* Version 2.0, September 2012,[9-1] HSAG conducted the following two core evaluation activities for the EDV activity:

- Comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems
- Technical assistance—follow-up assistance provided to MCOs that performed poorly in the comparative analysis

[9-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO*. Protocol 4. Version 2.0. September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf. Accessed on: Feb 6, 2020.

Two MCOs were included in the CY 2018 EDV activity: Amerigroup and UnitedHealthcare. This section presents findings from the results of the comparative analysis of the professional, institutional, and pharmacy encounter data maintained by DHS and the MCOs.

Specific Results

Record Completeness

Table 9-1 presents the percentage of records present in the files submitted by the MCOs that were not found in DHS' files (record omission) and the percentage of records present in DHS' files but not present in the files submitted by the MCOs (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 9-1—Record Omission and Surplus Rates by MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
Amerigroup	1.7%	0.7%	4.0%	10.5%	5.8%	0.8%
UnitedHealthcare	2.2%	0.0%	9.6%	11.3%	0.2%	3.1%

Data Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the DHS data files and the MCO data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rates represent the percentage of records with values present in the MCO's submitted data files but not in the DHS data files. Similarly, the element surplus rates report the percentage of records with values present in the DHS data files but not in the MCO's submitted data files. **The data elements are considered relatively complete when they have low element omission and surplus rates**.

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. **Higher data element accuracy rates indicate that the values populated for a data element in DHS' submitted encounter data are more accurate**.

For records that matched in both the DHS files and the MCO's files, the percentage of records with values absent in both data sources was also calculated as supplemental information. It is important to note that for element absence, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., secondary diagnosis code, procedure code modifier, etc. Records with values absent from both data sources were not included in the denominator for the data element accuracy rates.

Table 9-2 presents the element omission, element surplus, element absence, and element accuracy for each key data element from the professional encounters.

Table 9-2—Data Element Omission, Surplus, Absence, and Accuracy: Professional Encounters

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	AGP	UHC	AGP	UHC	AGP	UHC	AGP	UHC
Member ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Header Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Billing Provider NPI	0.6%	0.0%	2.8%	1.9%	0.0%	0.0%	100%	100%
Rendering Provider NPI	0.0%	0.0%	40.8%	41.5%	0.3%	0.0%	99.5%	100%
Referring Provider NPI	31.8%	34.4%	0.6%	0.0%	60.0%	57.5%	100%	100%
Primary Diagnosis Code	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Secondary Diagnosis Code	0.0%	0.0%	0.0%	0.0%	48.1%	51.0%	100%	100%
Procedure Code	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Procedure Code Modifier	0.0%	0.0%	0.0%	0.0%	58.8%	59.5%	100%	100%
Detail Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%

Table 9-3 presents the element omission, element surplus, element absence, and element accuracy for each key data element from the institutional encounters.

Table 9-3—Data Element Omission, Surplus, Absence, and Accuracy: Institutional Encounters

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	AGP	UHC	AGP	UHC	AGP	UHC	AGP	UHC
Member ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	98.2%	97.7%
Header Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	96.5%	95.3%
Admission Date	12.7%	5.8%	0.0%	0.0%	77.9%	77.7%	39.6%	100%
Billing Provider NPI	1.6%	1.7%	0.0%	0.0%	0.0%	0.0%	100%	100%
Attending Provider NPI	1.2%	1.7%	0.0%	0.0%	1.7%	0.7%	100%	100%
Referring Provider NPI	0.0%	1.0%	0.0%	0.0%	100%	98.4%	—	100%
Primary Diagnosis Code	34.0%	37.4%	0.0%	0.0%	0.0%	0.0%	100%	100%
Secondary Diagnosis Code	29.4%	31.4%	0.0%	0.0%	20.1%	19.5%	100%	100%
Procedure Code	0.0%	0.1%	0.0%	0.0%	17.2%	16.3%	99.8%	100%
Procedure Code Modifier	0.0%	0.0%	0.0%	0.0%	77.4%	77.5%	99.8%	100%
Primary Surgical Procedure Code	0.0%	0.1%	5.0%	0.0%	94.6%	95.0%	100%	100%

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	AGP	UHC	AGP	UHC	AGP	UHC	AGP	UHC
Secondary Surgical Procedure Code	0.0%	0.0%	3.1%	0.0%	96.7%	97.0%	100%	100%
Revenue Code	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.7%	99.7%
DRG Code	0.0%	0.0%	2.1%	0.0%	91.1%	94.6%	98.8%	99.1%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	70.2%	73.6%
Detail Paid Amount	0.0%	0.3%	0.0%	0.0%	0.0%	0.0%	99.8%	94.5%

"—" denotes that no values for this field are present in the data source.

Table 9-4 presents the element omission, element surplus, element absence, and element accuracy for each key data element from the pharmacy encounters.

Table 9-4—Data Element Omission, Surplus, Absence, and Accuracy: Pharmacy Encounters

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	AGP	UHC	AGP	UHC	AGP	UHC	AGP	UHC
Member ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Billing Provider NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.8%	99.9%
Prescribing Provider NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
NDC	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Drug Quantity	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100%	100%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	37.0%	100%
Dispensing Fee	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	76.9%	100%

All-Element Accuracy

Table 9-5 presents the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to each encounter data type.

Table 9-5—All-Element Accuracy by MCO and Encounter Type

MCO	Professional Encounters	Institutional Encounters	Pharmacy Encounters
Amerigroup	32.6%	50.5%	28.5%
UnitedHealthcare	31.9%	48.7%	99.9%

Plan Comparison

Record Omission and Surplus

Amerigroup's professional encounters exhibited the most complete data with the lowest record omission and record surplus rates—i.e., 1.7 percent and 0.7 percent, respectively. The institutional record surplus rate and record omission rate for pharmacy encounters were relatively high at 10.5 percent and 5.8 percent, respectively.

UnitedHealthcare's professional and pharmacy encounters exhibited relatively complete data where both the record omission and record surplus rates were low for each of the respective encounter types. For institutional encounters, the record omission and record surplus rates were relatively high at 9.6 percent and 11.3 percent, respectively.

Data Element Completeness and Accuracy

Pharmacy encounters were the most complete at the data-element level, with all key data elements exhibiting 0.0 percent omission and surplus rates for both MCOs.

Professional encounter data were mostly complete for all data elements except *Referring Provider NPI* and *Rendering Provider NPI.* Amerigroup and UnitedHealthcare each had an omission rate of more than 30.0 percent for *Referring Provider NPI*. However, DHS noted that the discrepancy was due to DHS' data extract not having a one-to-one mapping of the NPI for the referring provider data element to the legacy provider record in the Iowa Medicaid Management Information System (MMIS) provider master file. Amerigroup and UnitedHealthcare each had a surplus rate of more than 40.0 percent for *Rendering Provider NPI*. However, the discrepancies were due to DHS' MMIS processing of this data element where *Billing Provider NPI* was used in instances of missing *Rendering Provider NPI*.

Institutional encounters were also mostly complete for all data elements with a few exceptions: *Admission Date*, *Primary Diagnosis Code*, and *Secondary Diagnosis Code* data elements showed relatively high omission rates for both Amerigroup and UnitedHealthcare. It is important to note that the high element omission and/or element surplus rates for these data elements (i.e., from the institutional encounters) were due to DHS' systemic issues with the data extract for the study.

A high level of accuracy was observed in all key data elements for the professional encounters. Amerigroup's institutional encounters displayed a high level of accuracy in all data elements except *Admission Date* and *Header Paid Amount* data elements, while UnitedHealthcare displayed a high level of accuracy in all data elements except *Header Paid Amount*. These data element inaccuracies were due to issues associated with DHS' supplemental data extract for the study. Similarly, both MCOs' pharmacy encounters presented a high level of data element accuracy among all key data elements except for Amerigroup's *Header Paid Amount* and *Dispensing Fee*. These data element inaccuracies were due to Amerigroup's submitted file for the study containing data mapping errors.

All-Element Accuracy

Among encounters that could be matched between DHS' and the MCOs' submitted encounter data, the all-element accuracy rates varied by encounter type. UnitedHealthcare's pharmacy encounters had the highest all-element accuracy rate at 99.9 percent, while Amerigroup's pharmacy encounters had the lowest all-element accuracy rate at 28.5 percent. In contrast, both Amerigroup's and UnitedHealthcare's professional encounters had relatively low all-element accuracy rates at 32.6 percent and 31.9 percent, respectively. Similarly, both MCOs' institutional encounters also showed low all-element accuracy rates of less than 51.0 percent. The low all-element accuracy rates for these encounters were attributed to one or more of the key data elements having either high element omission or element surplus rates, or low accuracy rates.

Conclusions and Recommendations

For the comparative analysis, HSAG evaluated the encounter data record omission rate, record surplus rate, element omission rate, element surplus rate, element accuracy rate, and all-element accuracy rate for professional encounters, institutional encounters, and pharmacy encounters with dates of service between January 1, 2017, and December 31, 2017, and submitted the results to DHS on or before June 30, 2018.

Record omission and surplus rates varied between the two MCOs and among the three encounter types. All MCO-specific record omission and surplus rates for the professional and pharmacy encounters were very low (i.e., below 6.0 percent). However, the record omission and surplus rates for the institutional encounters were slightly higher (i.e., above 8.0 percent), except for Amerigroup's record omission rate of 4.0 percent.

Overall, among encounters that could be matched between DHS' and the MCOs' submitted encounter data, a high level of completeness (i.e., low omission and surplus rates) was exhibited for most of the key data elements that were evaluated, with a few exceptions. Similarly, a high level of accuracy (i.e., high element accuracy) was exhibited for most of the key data elements that were evaluated, with a few exceptions.

Based on HSAG's review of the encounter data submitted by DHS and the MCOs, HSAG identified several opportunities for continued improvement in the overall quality of Iowa's encounter data. While the comparative analysis results indicated relatively complete and accurate data, instances of high rates of omission, surplus, and inaccuracies—coupled with variation between MCOs—suggest the noted findings were related to data submission issues with the transmission of data to HSAG. To improve the quality of encounter data submissions from contracted MCOs, HSAG offers the following recommendations to assist DHS and the MCOs in addressing opportunities for improvement:

- HSAG identified, from both DHS and the MCOs, errors in the data files extracted for the study. HSAG recommends that DHS and the MCOs consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced, leading to the elimination of multiple data pulls. Moreover, stored procedures can be reused with minimal changes for future studies. HSAG recommends DHS having sufficient processes in place to ensure data are thoroughly validated for accuracy and completeness prior to submission and delivery. HSAG suggests that minimum data quality checks include the following:

  - Extract data according to the data submission requirements document.
  - Verify that control totals are reasonable for each requested data file.
  - Determine if duplicate records are expected and/or reasonable.
  - Conduct for all records a check to identify any data fields with missing values.
  - Determine if data fields were populated with reasonable values.
- HSAG recommends that DHS continue efforts to monitor encounter data submissions and address any identified data issues (e.g., pharmacy encounters' dispensing fee) with the MCOs' encounter file submissions.
- Based on reviews of data submitted by the MCOs, the Iowa MMIS Internal Control Number (ICN) field values were not well populated within the submitted data for the study. While the field values were not required to be used in the MCOs' reconciliation or any of the 837 processes, HSAG recommends that the MCOs retain the ICN from the response file in their current processing systems to track transactions that have been accepted, rejected, or reconciled.

Follow-Up on Prior Recommendations

From the findings of each MCO's performance for the CY 2017 EDV activity,[9-2] HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each MCO for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 9-6 and Table 9-7 in addition to each MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation. Iowa Total Care entered the Iowa managed care program effective July 1, 2019; therefore, no prior recommendations exist.

Table 9-6—EDV Recommendations—AGP

Prior Recommendations (CY 2018)
Amerigroup should ensure timely submission of encounters to meet the contract requirement for lag days between the MCO payment dates and the MMIS date.
Summary of AGP's Response to Recommendations
Amerigroup submits production encounters every two weeks with a one-week look-back on paid dates. This supports the requirement for data to be submitted by the 20th of the month subsequent to the month of which data are reflected. Amerigroup has a timeliness dashboard to monitor timeliness between paid date and submission date. If the rate drops below the requirement, there are operational processes to review the issue and remediate. Amerigroup's information technology (IT) Department also generates a daily report that lists the vendor and files received. These are monitored by vendor management, and action is taken with the vendor to address missing or late files.

[9-2] The CY 2017 EDV activity was completed in CY 2018; therefore, the CY 2017 findings and recommendations were included in the *Calendar Year 2018 External Quality Review Technical Report*. This report contains the CY 2018 and CY 2019 EDV activity findings.

HSAG's Assessment of the Degree to Which AGP Effectively Addressed the Recommendations
Based on Amerigroup's response and the CY 2018 EDV activity, Amerigroup addressed the prior recommendations made by HSAG in the *Calendar Year 2017 External Quality Review Technical Report*.

Table 9-7—EDV Recommendations—UHC

Prior Recommendations (CY 2018)
HSAG recommends that UnitedHealthcare collaborate with DHS to ensure that all Diagnosis-Related Group (DRG) codes for inpatient encounters are submitted to DHS.
Summary of UHC's Response to Recommendations
UnitedHealthcare will incorporate recommendations into its other markets as appropriate.
HSAG's Assessment of the Degree to Which UHC Effectively Addressed the Recommendations
Based on the CY 2018 EDV activity, UnitedHealthcare addressed the prior recommendations made by HSAG in the *Calendar Year 2017 External Quality Review Technical Report*. Of note, UnitedHealthcare exited the IA Health Link program effective July 1, 2019.

Calendar Year 2019 EDV Study

Overview

For Amerigroup and UnitedHealthcare, HSAG previously conducted an IS review in CY 2016, an administrative profile in CY 2017, and a comparative analysis in CY 2018. An MRR would typically follow a comparative analysis activity. Since an MRR is a complex, resource-intensive process, a sufficient level of completeness and accuracy of DHS' encounter data is recommended based on the comparative analysis results before conducting the MRR activity. As such, based on the CY 2018 comparative analysis results, DHS and HSAG determined that an MRR activity would not be recommended during the CY 2019 EDV study. Therefore, for Amerigroup and UnitedHealthcare, HSAG initiated a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 EDV study were addressed and to determine if the completeness and accuracy of DHS' encounter data are sufficient for future MRR activities. Because CY 2019 is the first year Iowa Total Care submitted encounter data to DHS, HSAG initiated an IS review only with Iowa Total Care in CY 2019. The 2019 EDV study was ongoing at the time of this report; therefore, the results of the 2019 EDV study will be presented in the CY 2020 EQR Technical Report.

Prepaid Ambulatory Health Plan

Overview

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DHS required its dental PAHPs to submit high-quality encounter data. DHS relies on the quality of these encounter data submissions to accurately and effectively monitor and improve the program's quality of care, establish performance measure rates, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2019, DHS contracted with HSAG to conduct a dental EDV study. In alignment with CMS' *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR),* Version 2.0, September 2012 (cited earlier in this section), HSAG conducted the following two core evaluation activities for the EDV activity:

- Comparative analysis—analysis of DHS' electronic dental encounter data completeness and accuracy through a comparative analysis between DHS' electronic dental encounter data and the data extracted from the PAHPs' data systems
- Technical assistance—follow-up assistance provided to PAHPs that performed poorly in the comparative analysis

HSAG conducted the dental EDV activity for the following two PAHPs: DDIA and MCNA. This section presents findings from the results of the comparative analysis of the dental encounter data maintained by DHS and the PAHPs.

Specific Results

Record Completeness

Table 9-8 presents the percentage of dental records present in the files submitted by the PAHPs that were not found in DHS' files (record omission) and the percentage of dental records present in DHS' files but not present in the files submitted by the PAHPs (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 9-8—Dental Record Omission and Surplus Rates by PAHP

PAHP	Record Omission	Record Surplus
DDIA	0.4%	4.9%
MCNA	0.4%	0.1%

Element Completeness and Accuracy

Data element completeness measures were based on the number of records that matched in both the DHS data files and the PAHP data files. Element-level completeness is evaluated based on element omission and element surplus rates. The element omission rate represents the percentage of records with values present in the PAHP's submitted data files but not in the DHS data files. Similarly, the element surplus rate reports the percentage of records with values present in the DHS data files but not in the PAHP's submitted data files. **The data elements are considered relatively complete when they have low element omission and surplus rates.**

Data element accuracy is limited to those records present in both data sources with values present in both data sources. Records with values missing in both data sources were not included in the denominator. The numerator is the number of records with the same non-missing values for a given data element. **Higher data element accuracy rates indicate that the values populated for a data element in DHS' submitted encounter data are more accurate.**

For records that matched in both the DHS files and the PAHP's files, the percentage of records with values absent in both data sources was also calculated as supplemental information. Records with values absent from both data sources were not included in the denominator for the data element accuracy rates. It is important to note that for element absence, in general, lower rates would be preferred, indicating fewer records had values not populated in both data sources. However, higher rates do not indicate poor performance since some data elements are not required for every encounter transaction. Some examples include data elements that are characterized by situational reporting requirements—e.g., *oral cavity code 2, oral cavity code 3*.

Table 9-9 presents the element omission, element surplus, element absence, and element accuracy for each key data element from the dental encounters.

Table 9-9—Data Element Omission, Surplus, Absence, and Accuracy: Dental Encounters

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	DDIA	MCNA	DDIA	MCNA	DDIA	MCNA	DDIA	MCNA
Member ID	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	>99.9%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.7%	100.0%
Header Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.9%	100.0%
Billing Provider NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	30.3%	100.0%
Rendering Provider NPI	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Dental Procedure Code (CDT)	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.3%	>99.9%
Units of Service	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%
Tooth Number	0.1%	0.0%	0.1%	<0.1%	72.6%	64.0%	99.2%	99.9%

	Element Omission		Element Surplus		Element Absence		Element Accuracy	
Key Data Elements	DDIA	MCNA	DDIA	MCNA	DDIA	MCNA	DDIA	MCNA
Oral Cavity Code 1	0.1%	0.0%	<0.1%	<0.1%	95.5%	97.0%	94.3%	100.0%
Oral Cavity Code 2	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	NA	NA
Oral Cavity Code 3	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	NA	NA
Oral Cavity Code 4	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	NA	NA
Oral Cavity Code 5	0.0%	0.0%	0.0%	0.0%	100.0%	100.0%	NA	NA
Tooth Surface 1	<0.1%	0.0%	4.5%	3.0%	81.6%	84.2%	99.3%	100.0%
Tooth Surface 2	<0.1%	0.0%	4.5%	3.0%	86.3%	88.5%	99.6%	100.0%
Tooth Surface 3	<0.1%	0.0%	<0.1%	<0.1%	96.1%	96.4%	99.6%	100.0%
Tooth Surface 4	<0.1%	0.0%	<0.1%	<0.1%	98.8%	98.9%	99.7%	100.0%
Tooth Surface 5	<0.1%	0.0%	<0.1%	<0.1%	99.8%	99.8%	100.0%	100.0%
Detail Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.1%	>99.9%
Header Paid Amount	0.0%	0.0%	0.0%	0.0%	0.0%	0.0%	99.6%	97.9%

NA = All data sources had these data elements not populated (i.e., not present). Therefore, there were no values to compare between the sources.

All-Element Accuracy

Table 9-10 presents the all-element accuracy results for the percentage of records present in both data sources with the same values (missing and non-missing) for all key data elements relevant to the dental encounter data type.

Table 9-10—All-Element Accuracy for Dental Encounters

PAHP	Rate
DDIA	28.5%
MCNA	95.0%

Plan Comparison

DDIA and MCNA each had very low record omission rates of 0.4 percent, suggesting that nearly all of the PAHPs' submitted dental encounters were also present in DHS' dental encounters. The record surplus rate for MCNA was very low, where only 0.1 percent of records present in DHS' encounter data file were not present in MCNA's submitted data file for the study, while the record surplus rate for DDIA was higher at 4.9 percent.

Among encounters that could be matched between DHS' and the PAHPs' submitted dental encounter data, a high level of completeness (i.e., low omission and surplus rates) was exhibited for all key data elements that were evaluated except *Tooth Surface 1* and *Tooth Surface 2*. Both DDIA and MCNA had element surplus rates of 4.5 percent and 3.0 percent, respectively, for each of the two data elements.

The accuracy rates for all data elements evaluated within the dental encounters were high except for DDIA's *Billing Provider NPI*. Among records wherein the *Billing Provider NPI* data element did not match, DDIA's encounter data had this data element's values populated with the same values as the *Rendering Provider NPI* data element values. Based on DDIA's investigation into the example discrepant records, DDIA noted that there were issues related to the source code used to extract data from DDIA's claims system for the study. DDIA also noted that IME was able to confirm that DDIA's transmission via the 837 matched the NPIs in DHS' data, as provided in the example discrepant records.

Conclusions and Recommendations

For the comparative analysis, HSAG evaluated the encounter data record omission rate, record surplus rate, element omission rate, element surplus rate, element accuracy rate, and the all-element accuracy rate for dental encounters with dates of service between January 1, 2018, and December 31, 2018, and submitted the results to DHS on or before May 31, 2019.

The record omission and record surplus rates were low for each of the PAHPs, suggesting that DHS' dental encounters are complete. Additionally, among encounters that could be matched between DHS' and the PAHPs' submitted encounter data, the level of completeness for key data elements was high (i.e., low omission and surplus rates). The accuracy rates for all data elements evaluated within the dental encounters were very high, except DDIA's *Billing Provider NPI*. DDIA noted that the discrepancy was due to issues related to its data extract process for the study.

Based on HSAG's review of the dental encounter data submitted by DHS and the PAHPs, HSAG offers the following recommendations for DHS and the PAHPs for continued improvement in the overall quality of Iowa's dental encounter data:

- The comparative analysis results indicate a high degree of complete and accurate data. As such, HSAG recommends that DHS continue its current efforts in monitoring encounter data submissions and addressing any identified data issues with the PAHPs' encounter file submissions.
- Similar to the CY 2018 MCO encounter data validation study findings, based on reviews of data submitted by the PAHPs, the Iowa MMIS *ICN* field values were not well populated within the submitted data for the study. While the field values were not required to be used in the PAHPs' reconciliation or any of the 837 processes, HSAG recommends that the PAHPs retain the *ICN* from the response file in their current processing systems to track transactions that have been accepted, rejected, or reconciled.

Follow-Up on Prior Recommendations

From the findings of each PAHP's performance for the CY 2018 EDV activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each PAHP for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 9-11 and Table 9-12 in addition to each PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation.

Table 9-11—EDV Recommendations—DDIA

Prior Recommendations (CY 2018)
DDIA described encounter data quality monitoring activities that were reliant on response files from DHS. DDIA could add more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHS. For example, a review of encounter volume by service month would add a dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.
Summary of DDIA's Response to Recommendations
DDIA is working toward pre-submission validation standards for the encounter data. These efforts include total claims reconciliation between the system and files submitted, total dollars, and procedure code and surface validation.
HSAG's Assessment of the Degree to Which DDIA Effectively Addressed the Recommendations
Based on DDIA's response and the CY 2019 EDV activity, DDIA did not address the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report* as it is currently developing a validation status for certain data elements of the encounter data it submits to DHS.

Table 9-12—EDV Recommendations—MCNA

Prior Recommendations (CY 2018)
MCNA described encounter data quality monitoring activities that were reliant on response files from DHS. MCNA could have added more metrics to actively monitor encounter data completeness and accuracy before submitting files to DHS. For example, a review of encounter volume by service month would add a dimension to current completeness metrics through highlighting abnormally high (e.g., due to duplicate records) or low (e.g., due to submission lags or incomplete data) volumes once trends have been established.

Summary of MCNA's Response to Recommendations
MCNA relies on encounter submission response files from DHS in order to ensure a mutual understanding of the encounter data submitted, the encounter data DHS accepts, and the reasons for rejecting any encounter data. This information is processed by MCNA's system to help identify any corrected encounters that may need resubmitting or to properly refer to encounter data that need to be adjusted or voided. As acknowledged by HSAG, these controls have been presented and discussed at length. However, MCNA has extensive encounter data quality monitoring activities that span beyond the processing of response files. The encounter administration system housed within MCNA's integrated management information system (MIS) is designed to maintain separate repositories for claims and encounter data to enforce better controls and have greater transparency to ensure the completeness and accuracy of encounter data. The encounter administration system uses all code sets and data mappings to validate the encounter data prior to submission. The encounter administration system performs the necessary mapping and transformation to our XML [Extensible Markup Language] claims data required to meet DHS' specifications. The data flow is guided by the business process management (BPM) engine which contains detailed process definitions for the handling of encounter data specific to each trading partner, ensuring uniformity, consistency, and accuracy of all processes and encounter submissions. MCNA also uses other validation engines when processing HIPAA [Health Insurance Portability and Accountability Act of 1996] X12N files. The electronic data interchange (EDI) subsystem seamlessly integrates with these HIPAA validation engines as an additional checkpoint when verifying the content and completeness of files that are received or that we will transmit. Any violation of the extensible rules management system triggers an exception notification for the EDI team, who then addresses the exception promptly and verifies that the encounter data are acceptable for submission. The maintenance of separate repositories of claims transactional data and encounter data is designed strategically to enforce quality control and checks and balances. The MIS performs different levels of edits and controls to ensure the accuracy, quality, and completeness of encounter data that is submitted to clients. The system applies edits and business rules to confirm that all applicable elements of the EDI file conform to the business rules and data dictionaries defined for each trading partner or client. Additionally, the information reported in the encounter data files is cross-referenced with payment reports and financial information, which further validates the accuracy and completeness of the data provided. MCNA uses quality control procedures to help ensure it submits timely, accurate, and complete encounters to clients. The internal data analytics/business intelligence team tracks, trends, and monitors both claims and encounters. This helps ensure consistent documentation between all stakeholders involved in providing and paying for services for Iowa Medicaid members. MCNA performs a number of quality control procedures focusing on tracking, trending, and monitoring of our encounter submissions to DHS. MCNA runs reports from claims, encounter, and financial management data. These reports show the volume of encounters and the associated paid and billed totals by provider, provider type, current dental terminology (CDT), and diagnosis for a specified incurred time frame. The reports are then compared to ensure that the totals match and all data tie to MCNA's financial reporting. When discrepancies are identified, MCNA drills down to the claims level to identify the root cause, whether it be a missing encounter submission, a DHS-rejected encounter that has not been resubmitted, a duplicate encounter, etc. Once a cause has been identified, MCNA takes necessary steps to establish accuracy and consistency and to implement controls and edits to prevent future occurrences. These process improvement steps may include working with providers, provider enrollment, or claims teams as well as working with the

Summary of MCNA's Response to Recommendations
encounter team to identify lessons learned from any discrepancies or errors and further improve encounter accuracy and completeness. There are many times when an encounter needs to be revised due to retroactivity or erroneous/incomplete data. Anytime a revision is made, the MIS logs the revision and maintains the history of events so that all changes and modifications can be clearly identified. This level of tracking allows MCNA to better troubleshoot encounter data discrepancies between systems and between providers. Changes in an existing claim in the MIS will generate an adjusted or voided corresponding encounter that will be sent to DHS in the next encounter processing cycle. The encounter will contain the original encounter ICN and will indicate whether it is an adjustment or void of the initial encounter. Any encounter record not accepted by DHS will be evaluated by the EDI and claims teams. These teams analyze all rejections to identify root causes and implement measures that prevent recurrence in future submissions. The MIS automatically processes response files provided by DHS after MCNA's encounter submissions. These response files are used to measure encounter acceptance rates and to identify causes for any encounter rejections. The MIS offers real-time visibility of the status of each encounter submission to EDI analysts. Additionally, the MIS business intelligence system provides real-time trending of accepted encounters to ensure completeness of encounter submitted data and reconciling against financial reporting. These trending reports present information under various perspectives, including volume of claims, dollar amounts paid, and percent completion rates.
HSAG's Assessment of the Degree to Which MCNA Effectively Addressed the Recommendations
Based on MCNA's response and the CY 2019 EDV activity, MCNA addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*.

10. MCO Readiness Review

This section presents HSAG's findings and conclusions from the operational and information systems readiness review conducted for Iowa Total Care. It provides a discussion of Iowa Total Care's ability and capacity to satisfactorily perform in the areas of operations and administration, service delivery, and systems management. The methology for the readiness review activities can be found in Appendix A. MCO Technical Methods of Data Collection and Analysis.

Overview

DHS requested that HSAG conduct an operational and an IS readiness review of Iowa Total Care on behalf of DHS. The operational readiness review included both a desk review of documents and a two-day on-site review of Iowa Total Care to interview key staff and leadership who manage Iowa Total Care's operational areas. HSAG also conducted system demonstrations of multiple information systems used by Iowa Total Care to support activities related to grievance and appeal processing and tracking, case management, utilization review, and QI.

The IS readiness review included both a desk review of documents and a Web conference for interviewing key staff and leadership and testing Iowa Total Care's claims systems. The IS readiness review included an assessment of the Health Information System standards based on the requirements of the contract and key areas noted in 42 CFR §438.66(d)(4).

The purpose of the operational readiness review was to assess that Iowa Total Care had the structural and operational capacity to perform the Medicaid managed care functions described in DHS' contract and ensure appropriate and timely access to quality healthcare services for Medicaid recipients. The purpose of the IS Readiness Review was to evaluate Iowa Total Care's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases.

Specific Results—Operational Readiness Review

Table 10-1 details the overall scores for the operational readiness review. Table 10-1 details the scores for all elements contained in each of the 13 operational review standards.

Table 10-1—Summary of Scores for the Operational Readiness Review Standards

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
				Complete	Incomplete	Incomplete—Critical*
I	Availability of Services	18	14	**16**	**2**	**2**
II	Assurances of Adequate Capacity and Services	3	3	**2**	**1**	**1**
III	Coordination and Continuity of Care	11	3	**10**	**1**	**0**

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements	Number of Elements		
				Complete	Incomplete	Incomplete—Critical*
IV	Coverage and Authorization of Services	17	11	**15**	**2**	**1**
V	Provider Network	15	13	**14**	**1**	**0**
VI	Member Information and Member Rights	23	15	**19**	**4**	**3**
VII	Confidentiality of Health Information	12	4	**12**	**0**	**0**
VIII	Enrollment and Disenrollment	9	3	**9**	**0**	**0**
IX	Grievance, Appeals and State Fair Hearings	38	12	**36**	**2**	**1**
X	Subcontractual Relationships and Delegation	4	2	**4**	**0**	**0**
XI	Practice Guidelines	3	0	**3**	**0**	**NA**
XII	Quality Assessment and Performance Improvement	12	6	**11**	**1**	**1**
XIII	Health Information Systems**					
XIV	Program Integrity	9	3	**9**	**0**	**0**
Total Readiness Review Elements		**174**	**89**	**160**	**14**	**9**
Percent Complete (No Action Required)				**92% (160/174)**		
Percent Incomplete (Action Required)				**8% (14/174)**		
Percent Incomplete—Critical (Action Required)				**5% (9/174)**		

* Incomplete Critical elements were required to be completed prior to enrolling members.

** Review of Standard XIII was completed as part of the information systems component of the readiness review.

Total Applicable Elements: The total number of elements in each standard minus any elements that were *NA*.

Total Critical Elements: The total number of elements designated as critical within the standard.

Of the 13 standard areas reviewed, Iowa Total Care demonstrated readiness to perform most of the required functions and operational activities outlined in its contract with DHS. **Iowa Total Care** completed 160 of 174 elements, with an overall percent complete of 92 percent. Iowa Total Care achieved 100 percent *Complete* scores for five standards, demonstrating readiness to perform applicable requirements in the following areas: Confidentiality of Health Information, Enrollment and Disenrollment, Subcontractual Relationships and Delegation, Practice Guidelines, and Program Integrity.

Iowa Total Care received a score of *Incomplete* for 14 elements across the eight remaining standards and a score of *Incomplete—Critical* for nine elements across six of those standards. These elements addressed the following requirements:

- Network adequacy—ensuring all covered services are available and accessible to members in a timely manner; ensuring a network of appropriate providers supported by written agreements that is sufficient to provide adequate access to all covered services for all members; and ensuring a network of providers that is sufficient in the number, mix, and geographic distribution to meet the needs of Iowa Total Care's anticipated number of members.
- Risk stratification levels—using risk stratification levels to determine the intensity and frequency of follow-up care that is required for LTSS members.
- NABDs—mailing the notice for the denial of payment at the time of an action affecting a claim.
- Emergency services—identification of coverage and payment provisions for emergency services in Iowa Total Care' online billing manual.
- Credentialing—credentialing 100 percent of providers within 45 calendar days.
- Provider directory—content of the English and Spanish versions of the provider directory.
- Language requirements—documentation of a member's primary language and distribution of all member-generated materials in a member's primary language.
- New member communication—cost-sharing information and patient liability responsibilities for waiver members in the member handbook.
- Electronic communication—collection and documentation of a member's preferred mode of communication and distribution of materials in a member's selected format.
- General appeal and State fair hearing requirements—allowing a request for a State fair hearing only after receiving a NABD.
- Handling of grievances and appeals—ensuring grievances that involve clinical issues are reviewed by an individual with the appropriate clinical expertise.
- Staffing plan—ensure that staff delivering care coordination and community-based case management services are based in Iowa at locations that will facilitate the delivery of in-person services as appropriate.

Iowa Total Care developed a remediation plan to address the preceding *Incomplete* and *Incomplete—Critical* findings, which was accepted by DHS.

Conclusions and Recommendations

Of the 13 standard areas reviewed, Iowa Total Care demonstrated readiness to perform most of the required functions and operational activities outlined in its contract with DHS.

HSAG identified deficiencies in two critical areas. Specifically, HSAG identified significant deficiencies in the establishment of an adequate and accessible provider network that would gravely impede Iowa Total Care's ability and capacity to furnish timely and accessible services to members. A

lack of specialty providers (mainly LTSS and HCBS) and hospitals were among the largest network gaps identified. Additionally, Iowa Total Care had yet to secure contracts or conduct proactive outreach with the integrated health homes that provide community-based case management for 1915(i) Habilitation Program Services and 1915(c) Children's Mental Health Services waiver members. Prior to July 1, 2019, Iowa Total Care was required to demonstrate to DHS that Iowa Total Care has secured an adequate and sufficient provider network for Iowa Medicaid members to access and receive timely services.

The second area of deficiency related to the quantity of case managers employed by Iowa Total Care to coordinate the care of Iowa Total Care's most vulnerable LTSS populations. While the contract does not prescribe specific community-based case manager-to-member ratios, Iowa Total Care staff members reported that the member-to-LTSS case manager ratio is 60:1. This ratio is approximately one-third higher than those of the two existing MCOs serving Iowa Medicaid managed care members. While Iowa Total Care provided documentation after the on-site review indicating that it will consider an average of 40–60 members per caseload depending on the specific needs of members, close monitoring of staffing ratios and Iowa Total Care's ability to service the needs of LTSS members is warranted. Additionally, as of the on-site review, while Iowa Total Care has employed ongoing recruitment efforts, 109 of 294 LTSS case manager positions remained open. At the conclusion of the readiness review, HSAG recommended that DHS continue to monitor Iowa Total Care's staffing to ensure case managers are hired and trained prior to the contract implementation date. Lastly, Iowa Total Care identified a 13,500:1 member to non-LTSS case manager ratio. HSAG recommended that DHS compare this ratio to that of the existing MCOs.

Iowa Total Care developed a remediation plan to remedy all elements that received a score of *Incomplete* or *Incomplete—Critical*, which was accepted by DHS.

Specific Results—Information Systems Readiness Review

Table 10-2 details the scores for all elements contained in the IS readiness desk review tool using the *Complete* and *Incomplete* rating methodology.

Table 10-2—Summary of Scores for the IS Readiness Desk Review

Standard Number	Readiness Review Standard	Total Elements	Number of Elements	
			Complete	Incomplete*
XIII	Health Information Systems	18	18	0
Percent Complete (No Action Required)			**100% (18/18)**	
Percent Incomplete (Action Required)			**0% (0/18)**	

* *Incomplete* elements must be completed prior to enrolling members.
Total Elements: The total number of elements in the standard.

Iowa Total care received a score of *Complete* for all 18 elements reviewed; therefore, no elements required remediation.

Table 10-3 details the scores assigned to the remote claims system testing using behavioral health, physical health, care coordination, and LTSS and HCBS test claims.

From the ratings assigned to each of the claim system testing scenarios, HSAG calculated a summary score by assigning 1 point if *Met*, 0.5 point if *Partially Met*, and 0 points if *Not Met*. The points were summed and divided by the total possible points.

Table 10-3—Claims System Testing Results

Service Type	# of Scenarios	# of Claims Scored as *Met*	# of Claims Scored as *Partially Met*	# of Claims Scored as *Not Met*	% of Compliant Claims*
Behavioral Health	18	18	0	0	**100%**
Physical Health	13	12	0	1	**92.3%**
Care Coordination	2	2	0	0	**100%**
LTSS and HCBS	5	5	0	0	**100%**
Total	**38**	**37**	**0**	**1**	**97.4%**

* Totals rounded to the nearest tenth of a percent.

While Iowa Total Care demonstrated that its claims systems and operational processes were ready for beginning the new contract, HSAG identified the following deficiency that resulted from Iowa Total Care's claims processing functions.

The physical health test scenario #10 involved a new adult member who received an acupuncture treatment with manual manipulation as fertility treatment. Iowa Total Care staff members stated that the service was a noncovered benefit and that the claim was denied. Iowa Total Care staff members stated that there was an amount in the fee schedule provided by DHS, which resulted in an amount displayed in the claim detail. While the claim denied as expected, there was an allowed amount seen for a noncovered benefit. According to DHS' claims payment procedures, the claim system should not display an allowed amount in the claim edit detail for a noncovered benefit. HSAG recommended that Iowa Total Care submit screen shots of another processed test claim with this benefit to validate that no allowed amounts display for a noncovered benefit.

Conclusions and Recommendations

While a remediation plan was necessary to address the deficiency noted in the claims system testing scenarios, there were no claims processing deficiencies that would impede Iowa Total Care's ability and capacity to perform the claims processing responsibilities outlined in its contract with DHS.

HSAG recommended that Iowa Total Care ensure that it is able to receive and load Medicaid recipient enrollment files in Iowa prior to July 1, 2019. DHS was in the process of testing 834 files of eligibility and enrollment data with Iowa Total Care and continued testing the encounter files.

11. Focused Study

During CY 2017, DHS requested that HSAG conduct a focused study review of MCO case management programs, which included a review of service plans maintained by MCOs for HCBS waiver members. As the results from the focused study were not available at the time the *Calendar Year 2017 External Quality Review Technical Report* was published, the results are presented in the *Calendar Year 2018 External Quality Review Technical Report*. As such, HSAG provided recommendations specific to the findings of the focused study to each MCO in the *Calendar Year 2018 External Quality Review Technical Report*. This section presents each MCO's response as to how the prior recommendations were addressed and assessment of how effectively each MCO addressed the recommendations for QI made by HSAG during the previous year. The methodology and results for the focused study can be found in the *2017 Focused Study Report*.

Managed Care Organizations

Follow-Up on Prior Recommendations

From the findings of each MCO's performance for the CY 2018 compliance monitoring activity, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Health Link program. The recommendations provided to each MCO for the compliance monitoring activity in the *Calendar Year 2018 External Quality Review Technical Report* are summarized in Table 11-1 and Table 11-2 in addition to each MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation. Iowa Total Care entered the Iowa managed care program effective July 1, 2019; therefore, no prior recommendations exist.

Table 11-1—Focused Study Recommendations—AGP

Prior Recommendations (CY 2018)
Amerigroup should have considered evaluating its case management training programs specific to the person-centered care planning requirements for members enrolled in Iowa's Medicaid 1915(c) and 1915(i) HCBS programs.
Amerigroup should have considered enhancing auditing processes to evaluate performance related to person-centered care planning requirements.
During the on-site focused study, Amerigroup staff members explained that a revised service plan format was being developed. Once the revised service plan had been fully implemented, Amerigroup should have considered conducting a self-evaluation to determine if the revised format led to improved documentation and performance.

Summary of AGP's Response to Recommendations
Amerigroup has implemented and completed substantial work and improvements on care plan requirements since the 2018 Focused Study on Person-Centered Planning. We have revised the care plan format, conducted training of all case managers in 2019, and have instituted an internal audit program of care plans. Much of this improvement was discussed with HSAG during the 2019 Performance Measure Validation Audit on-site on November 13, 2019.
HSAG's Assessment of the Degree to Which AGP Effectively Addressed the Recommendations
Based on the responses provided by Amerigroup, Amerigroup addressed the prior recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*.

Table 11-2—Focused Study Recommendations—UHC

Prior Recommendations (CY 2018)
UnitedHealthcare should have considered evaluating its case management training programs specific to the person-centered care planning requirements for members enrolled in Iowa's Medicaid 1915(c) and 1915(i) HCBS programs. UnitedHealthcare should have considered enhancing auditing processes to monitor performance related to person-centered care planning requirements.
Summary of UHC's Response to Recommendations
UnitedHealthcare will incorporate recommendations into its other markets as appropriate.
HSAG's Assessment of the Degree to Which UHC Effectively Addressed the Recommendations
Based on the response provided by UnitedHealthcare, UnitedHealthcare did not address the recommendations made by HSAG in the *Calendar Year 2018 External Quality Review Technical Report*. Of note, UnitedHealthcare exited the IA Health Link program effective July 1, 2019.

Appendix A. MCO Technical Methods of Data Collection and Analysis

In accordance with 42 CFR §438.356, DHS contracted with HSAG as the EQRO for the State of Iowa to conduct the mandatory and certain optional EQR activities as set forth in 42 CFR §438.358.

CMS has chosen the domains of quality, access, and timeliness as keys to evaluating MCO performance. For each of the EQR activities HSAG used the following definitions to evaluate and draw conclusions about the performance of the MCOs in each of these domains:

- **Quality**—CMS defines "quality" in the final rule at 42 CFR §438.320 as follows:

  > Quality, as it pertains to external quality review, means the degree to which an MCO PIHP, PAHP, or PCCM entity (described in §438.310[c][2]) increases the likelihood of desired health outcomes of its enrollees through:
  >
  > (1) Its structural and operational characteristics.
  >
  > (2) The provision of services that are consistent with current professional, evidenced-based-knowledge.
  >
  > (3) Interventions for performance improvement.[A-1]

- **Access**—CMS defines "access" in the final rule at 42 CFR §438.320 as follows:

  > Access, as it pertains to external quality review, means the timely use of services to achieve optimal outcomes, as evidenced by managed care plans successfully demonstrating and reporting on outcome information for the availability and timeliness elements defined under §438.68 (Network adequacy standards) and §438.206 (Availability of services).[A-2]

- **Timeliness—**Federal managed care regulations at 42 CFR §438.206 require the State to define its standards for timely access to care and services. These standards must take into account the urgency of the need for services. HSAG extends the definition of "timeliness" to include other federal managed care provisions that impact services to members and that require timely response by the managed care entity—e.g., processing member grievances and appeals and providing timely follow-up care. In addition, the NCQA defines "timeliness" relative to utilization decisions as follows: "The organization makes utilization decisions in a timely manner to accommodate the clinical urgency of a situation."[A-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

This appendix describes the EQR activities that were performed or initiated during the review period. These EQR activities provided findings for use in HSAG's evaluation of each MCO's performance. For each activity, this section describes the objectives, technical methods of data collection and analysis, and

[A-1] Department of Health and Human Services Centers for Medicare & Medicaid Services. *Federal Register*, Vol. 81, No. 88, Friday May 6, 2016/Rules and Regulations.

[A-2] Ibid.

[A-3] National Committee for Quality Assurance: 2016 Standards and Guidelines for the Accreditation of Health Plans.

a brief description of the data obtained during the activity. The findings and conclusions drawn from the data obtained from each activity can be found in the MCO specific summary sections (sections 4 and 5) and in the comparative analysis presented in Section 8 of this report.

MCO Mandatory Activities

Compliance Monitoring

Activity Objectives

The primary objective of HSAG's review was to provide meaningful information to DHS and the MCO regarding compliance with State and federal requirements. HSAG assembled a team to:

- Collaborate with DHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and on-site review agenda.
- Collect and review data and documents before, during, and after the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective and based on the results of collaborative planning with DHS, HSAG developed and used a data collection tool to assess and document the MCO's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHS contractual requirements.

Amerigroup and UnitedHealthcare

Beginning in CY 2018, DHS has requested that HSAG conduct compliance reviews over a three-year cycle with one-third of the standards being reviewed each year. The division of standards over the next three years can be found in Table A-1.

Table A-1—Three-Year Cycle of Compliance Reviews

Year One (CY 2018)	Year Two (CY 2019)	Year Three (CY 2020)
Standard I—Availability of Services	Standard III—Coordination and Continuity of Care	Standard V—Provider Selection
Standard II—Assurances of Adequate Capacity and Services	Standard IV—Coverage and Authorization of Services	Standard VI—Member Information and Member Rights
Standard IX—Grievances, Appeals and State Fair Hearings	Standard VII—Confidentiality of Health Information	Standard VIII—Enrollment and Disenrollment
Standard XII—Quality Assessment and Performance Improvement	Standard XI—Practice Guidelines	Standard X—Subcontractual Relationships and Delegation
		Standard XIII—Health Information Systems

The review tool developed for this year's review (CY 2019) included requirements that addressed the following performance areas:

- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard VII—Confidentiality of Health Information
- Standard XI—Practice Guidelines

Iowa Total Care

As this is the first year (CY 2019) HSAG has conducted a compliance review for Iowa Total Care, DHS requested that the scope of the review be a follow-up review of the standards and findings from HSAG's readiness review that was conducted in April 2019. The CY 2019 compliance review focused on a review of elements that received a score of *Incomplete* and *Not Applicable* during the readiness review, and a review of elements applicable to the case file reviews. The review tools developed for this year's review included requirements that addressed the following performance areas:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Network
- Standard VI—Member Information and Member Rights
- Standard VII—Confidentiality of Health Information
- Standard VIII—Enrollment and Disenrollment
- Standard IX—Grievances, Appeals and State Fair Hearings
- Standard X—Subcontractual Relationships and Delegation
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement
- Standard XIII—Health Information Systems
- Standard XIV—Program Integrity

DHS and the MCOs will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between the DHS and the MCO as they related to the scope of the review. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[A-4] for the following activities:

Pre-On-Site Review Activities

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to each MCO a pre-audit information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-audit preparation session with each MCO.
- Scheduling the on-site reviews.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHS, and of documents the MCOs submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of each MCO's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Generating a list of 10 sample cases for non-LTSS care coordination (all MCOs), service authorization denials (all MCOs), grievances (Iowa Total Care), and appeals (Iowa Total Care) from the list of universe files submitted to HSAG from the MCO.
- Developing the agenda for the on-site review.
- Providing the detailed agenda to each MCO to facilitate preparation for HSAG's review.

On-Site Review Activities

On-site review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the MCO have available on-site.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Jan 23, 2020.

- A review of the non-LTSS care coordination (all MCOs), service authorization denial (all MCOs), grievance (Iowa Total Care), and appeal files (Iowa Total Care) HSAG requested from the MCO.
- A review of the data systems that the MCO used in its operation such as care coordination tracking and PA (all MCOs), grievance (Iowa Total Care), and appeal processing (Iowa Total Care).
- Interviews conducted with the MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which each MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, EQR Protocol 1 (cited above). The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements *Not Applicable* to the MCO were scored *NA* and were not included in the denominator of the total score.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the total values of the scores and dividing the result by the total number of applicable elements).

For the care coordination checklist reviewed (Amerigroup and UnitedHealthcare), HSAG scored each applicable element within the checklist as either (1) *Yes*, the element was contained within the associated document(s), or (2) *No*, the element was not contained within the document(s). Elements *Not Applicable* to the MCO were scored *NA* and were not included in the denominator of the total score. To obtain a percentage score, HSAG totaled the number of elements that received *Yes* scores, then divided this total by the number of applicable elements.

HSAG conducted file reviews of the MCO's records for non-LTSS care coordination (all MCOs), service authorization denials (all MCOs), grievances (Iowa Total Care), and appeals (Iowa Total Care) to verify that the MCO had put into practice what the MCO had documented in its policy. HSAG selected 10 files of each type of record from the full universe of records provided by the MCO. The file reviews were not intended to be a statistically significant representation of all the MCO's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCO staff. The file review for care coordination was a focused review of non-LTSS care coordination program requirements. Based on the results of the file reviews, the MCO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality and timeliness of, and access to, care and services the MCO provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCO's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCO's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- The total percentage-of-compliance score calculated for each checklist.
- The overall percentage-of-compliance score calculated across the checklists.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to DHS for review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess the MCO's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the MCO, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.

- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCO-maintained files for the case file reviews.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the MCO's key staff members.

Table A-2 lists the major data sources HSAG used in determining the MCO's performance in complying with requirements and the time period to which the data applied.

Table A-2—Description of MCO Data Sources

Data Obtained	Time Period to Which the Data Applied	
	AGP and UHC	ITC
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	January 1, 2019—September 30, 2019	July 1, 2019—September 30, 2019
Information obtained through interviews	November 20, 2018	November 19, 2019
Information obtained from a review of a sample of non-LTSS case management records for file reviews	Members enrolled in case management as of June 30, 2018	July 1, 2019—September 30, 2019
Information obtained from a review of a sample of the MCO's records for file reviews	Cases closed between January 1, 2019—June 20, 2019	Cases closed between July 1, 2019—September 30, 2019

Validation of Performance Measures

Activity Objectives

Amerigroup and UnitedHealthcare

The purpose of PMV is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 1, 2012.[A-5]

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0,

Iowa Total Care

Since Iowa Total Care did not have data for reporting performance measures for the SFY 2018 measurement period, HSAG conducted an ISCA for Iowa Total Care. In accordance with CMS' *Appendix V, Attachment A: Information Systems Capabilities Assessment (ISCA) Tool*, September 2012,[A-6] the ISCA focused on the assessment of the information systems and processes used for data collection and reporting that will be used to calculate future performance measure rates.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that should be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed these data:

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The MCOs completed and submitted an ISCAT for HSAG's review of the required DHS-developed measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures** (Amerigroup and UnitedHealthcare only)**—**MCOs were required to submit the source code used to identify the eligible population for each performance measure being validated. The eligible population was the same for performance measures #1 and #2, and the same for performance measures #3, #4, #5, and #6. The MCOs submitted two sets of source code to HSAG. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DHS. HSAG identified areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any).
- **Supporting documentation—**HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Pre-On-Site Strategy

To complete the validation activities for the MCOs, HSAG obtained a list of the performance measures that were selected by DHS for validation.

HSAG then prepared and submitted a document request letter to the MCOs outlining the steps in the PMV process. The document request letter included requests for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the

September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf. Accessed on: Feb 5, 2020.

[A-6] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Appendix V, Attachment A: Information Systems Capabilities Assessment (ISCA) Tool.* September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/app5-attacha-isca.pdf. Accessed on: Feb 5, 2020.

audit; a timetable for completion; and instructions for submission. HSAG responded to any audit-related questions received directly from the MCOs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided the MCOs with an agenda describing the on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with each MCO to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from them.

On-Site Activities

HSAG conducted an on-site visit with each MCO. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The on-site visit activities are described as follows:

Amerigroup and UnitedHealthcare

- **Opening meeting**—The opening meeting included an introduction of the validation team and key MCO staff members involved in the PMV activities. The purpose of the review, required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT documentation**—This session was designed to be interactive with key MCO staff so that the validation team could obtain a complete understanding of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether the MCO had performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of each ISCAT, HSAG conducted interviews with key MCO staff familiar with the processing, monitoring, and calculation of the performance indicators. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that the MCO used and followed written policies and procedures in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG reviewed backup documentation on data integration and addressed data control and security procedures during this session.
- **Primary source verification**—HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each MCO provided HSAG with a listing of the data the MCO had reported to IME. HSAG selected a random sample from the submitted data and requested that the MCO provide proof of service documents or system screen shots that allowed

for validation against the source data in the system. During the on-site review, these data were also reviewed live in the MCO's systems for verification, which provided the MCO an opportunity to explain its processes regarding any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the MCO.

Using this technique, HSAG assessed the MCO's processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the MCO had system documentation which supports that the MCO appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

- **Closing conference**—The closing conference included a summation of preliminary findings based on the ISCAT review and on-site visit, and revisited the documentation requirements for any post-on-site activities.

Iowa Total Care

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key Iowa Total Care staff involved in the support of the MCO's information systems and its calculation and reporting of performance measures. HSAG reviewed expectations for the on-site audit, discussed the purpose of the PMV activity, and reviewed the agenda and general audit logistics. This session also allowed Iowa Total Care to provide an overview of its organizational operations and any important factors regarding its information systems or performance measure activities.
- **Review of key information systems and data processes**—Drawing heavily on HSAG's desk review of Iowa Total Care's ISCAT responses, these interview sessions involved key MCO staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice. Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.
  - **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCO data used in producing performance measures.
  - **Overview of data integration and control procedures**—This session included a review of the database management systems processes used to integrate key source data and the MCO's

calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).

  - **System demonstrations**—HSAG staff requested that Iowa Total Care staff members demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

- **Closing conference**—At the end of the on-site visit, HSAG summarized preliminary findings, discussed follow-up items, and revisited the documentation requirements for any post-on-site activities.

Description of Data Obtained and Related Time Period

Table A-3 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-3—Description of MCO Data Sources

Data Obtained	Time Period to Which the Data Applied		
	AGP	UHC	ITC
Completed ISCAT	SFY 2018	SFY 2018 and SFY 2019	SFY 2019
Source code for each performance measure			
Performance measure results			
Supporting documentation			SFY 2019
Virtual on-site interviews and systems demonstrations	November 13, 2019	November 14, 2019	November 15, 2019

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory EQR activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), the MCO entities are required to have a QAPI program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of PIPs required by the state and underway during the preceding 12 months.

In its annual PIP validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-7] HSAG's validation of PIPs includes two key components of the QI process:

- Evaluation of the technical structure of the PIP to ensure that the MCOs design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's review determines whether the PIP design (e.g., study question, population, study indicator(s), sampling techniques, and data collection methodology/processes) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.
- Evaluation of the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCOs improve rates through implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

The goal of HSAG's PIP validation is to ensure that DHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the QI strategies and activities conducted by the MCOs during the PIP.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on the CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (cited earlier in this section). Using this protocol, HSAG, in collaboration with DHS, developed the PIP Summary Form. Each MCO completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with DHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs per the CMS protocols. The CMS protocols identify ten steps that should be validated for each PIP.

[A-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 5, 2020.

For the calendar year (CY) 2019 submissions, MCOs reported Remeasurement 1 data and were validated for Steps I through IX in the validation tool. The 10 steps included in the PIP Validation Tool are listed below:

Step I.	Select the Study Topic(s)
Step II.	Define the Study Question(s)
Step III.	Define the Identified Study Population
Step IV.	Select the Study Indicator(s)[A-8]
Step V.	Use Sound Sampling Techniques
Step VI.	Reliably Collect Data
Step VII.	Analyze Data and Interpret Study Results
Step VIII.	Improvement Strategies
Step IX.	Assess for Real Improvement
Step X.	Assess for Sustained Improvement

HSAG used the following methodology to evaluate PIPs conducted by the MCOs to determine whether a PIP was valid and the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The MCOs are assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a General Comment with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the improvement project's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.

[A-8] DDIA's PIP will have two study indicators: one for the adult population, and one for the Hawki population.

- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met*.

The MCOs had an opportunity to resubmit a revised PIP Summary Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met* and to address any General Comments, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCO that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each MCO. These reports, which complied with 42 CFR §438.364, were provided to DHS and MCOs.

Description of Data Obtained and Related Time Period

For CY 2019, the MCOs submitted Remeasurement 1 data. The study indicator measurement period dates are listed below.

Table A-4—Data Obtained and MCO Measurement Periods

Data Obtained	Measurement Period
Baseline	January 1, 2017—December 31, 2017
Remeasurement 1	January 1, 2018—December 31, 2018
Remeasurement 2	January 1, 2019—December 31, 2019

Network Adequacy

Activity Objectives

HSAG conducted a secret shopper telephone survey of OB/GYN locations statewide to evaluate the average length of time to an appointment for Medicaid members scheduling an appointment with an OB/GYN provider. A secret shopper is a person employed to pose as a client or patient to evaluate the quality of customer service or the validity of information (e.g., accurate prices or location information). The secret shopper telephone survey allows for objective data collection from healthcare providers without potential bias introduced by knowing the identity of the surveyor. The objectives of this study included the following:

- Determine whether OB/GYN providers are accepting new Medicaid patients who are enrolled in the Medicaid program.
- Determine whether appointment availability for Medicaid patients who are enrolled in the Medicaid program meets the contract standard.

Technical Methods of Data Collection and Analysis

HSAG obtained Medicaid provider information, including practice location and provider specialty, from the MCOs. Upon receipt of the data, HSAG defined a subgroup of active, office-based OB/GYN providers based on provider type, specialty, and acceptance of new patients. The list of providers eligible for inclusion in the survey was deduplicated by NPI and location (i.e., the sample frame).

HSAG identified Amerigroup OB/GYN providers for inclusion in the survey by using a two-stage random sampling approach. First, HSAG selected a statistically valid sample from the list of unique Amerigroup providers based on a 95 percent confidence level and ±5 percent margin of error. A 30 percent oversample was added to the sample size to increase the probability of capturing appointment availability information from a statistically valid number of providers. Second, HSAG identified all locations contracted for each sampled provider and randomly selected one location to be surveyed (i.e., the "provider location").

HSAG randomly distributed the sampled provider locations equally across first trimester and second trimester appointments. The first trimester provider locations were asked about the first available appointment for a member who was eight weeks pregnant, while the second trimester provider locations were asked about the first available appointment for a member who was 18 weeks pregnant. All remaining survey questions were identical.

The sampled Amerigroup providers were surveyed by telephone, and the information collected was used to evaluate the appointment availability, assess the acceptance of new patients, and determine whether appointment availability meets the routine appointment standard established by DHS contracts. The appointment standard for a routine appointment with a specialty provider is 30 days.[A-9]

Description of Data Obtained and Related Time Period

HSAG obtained Medicaid provider information (including practice location and provider specialty) from Amerigroup for all providers enrolled as of April 30, 2019. Upon receipt of the data, HSAG defined a subgroup of active, office-based OB/GYN providers based on provider type, specialty, and acceptance of new patients.

During the completion of the secret shopper survey, HSAG callers gathered the following information during survey calls:

- Telephone Number (Note: If the telephone number was incorrect for the location and the correct number could not be obtained at the time of the survey; the survey stopped.)
- Provider Information

[A-9] Exhibit B of the MCO contract lists appointment availability standards for specialty providers. However, MCOs are responsible for ensuring that members have access to a specialty provider within the contract standards, rather than requiring that each individual specialty provider offer appointments within the defined time frames.

  - The sampled provider accepts Amerigroup at the sampled location. (Note: If the provider did not accept Amerigroup at the sampled location, the survey stopped.)
  - The sampled provider accepts Medicaid at the sampled location. (Note: If the provider did not accept Medicaid, the survey stopped.)
  - The sampled provider accepts new patients at the sampled location. (Note: If the provider did not accept new patients, the survey stopped.)
- Appointment availability
  - Number of calendar days to the first available prenatal appointment (i.e., first or second trimester) with the sampled provider for a new Medicaid patient

MCO Optional Activities

CY 2018 Encounter Data Validation

Activity Objectives

In alignment with the CMS *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[A-10] during CY 2018, HSAG conducted the following two core evaluation activities for the EDV activity:

- Comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems
- Technical assistance—follow-up assistance provided to MCOs that performed poorly in the comparative analysis

HSAG conducted an information system review with all three MCOs[A-11] in CY 2016 since 2016 was the first year the MCOs submitted encounter data to DHS. In CY 2017, HSAG evaluated the administrative profile for DHS' electronic encounter data. During CY 2018, HSAG conducted a comparative analysis between DHS' electronic encounter data and the data extracted from two MCOs'[A-12] data systems as well as provided technical assistance to the MCOs based on the findings.

[A-10] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf. Accessed on: Feb 5, 2020.

[A--11] The three MCOs are Amerigroup Iowa, Inc. (Amerigroup), AmeriHealth Caritas Iowa, Inc. (AmeriHealth), and UnitedHealthcare Plan of the River Valley, Inc. (UnitedHealthcare).

[A-12] The two MCOs are Amerigroup and UnitedHealthcare. AmeriHealth terminated its contract with DHS during CY 2017.

The goal of the comparative analysis was to evaluate the extent to which encounters submitted to DHS by the MCOs were complete and accurate, based on corresponding information stored in the MCOs' data systems. This step corresponded to an important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting. Based on the study findings from the comparative analysis, HSAG initiated a series of follow-up activities with the MCOs that performed poorly in the comparative analysis. The goal of these follow-up activities was to assist the MCOs in addressing and resolving major encounter data issues identified by the study.

Technical Methods of Data Collection and Analysis

Comparative Analysis

In this activity, HSAG developed a data requirements document requesting claims/encounter data from both DHS and the MCOs. A follow-up technical assistance session occurred approximately two weeks after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values; e.g., valid International Classification of Diseases, 10th Revision (ICD-10) codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DHS' data warehouse and the MCOs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring both DHS and the MCOs to resubmit data.

Once HSAG received and processed the final set of data from DHS and each MCO, HSAG conducted a series of comparative analyses that were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in DHS' data warehouse (record omission).
- The number and percentage of records present in DHS' data warehouse but not in the MCOs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG examined completeness and accuracy for key data elements listed in Table A-5. The analyses focused on an element-level comparison for each element.

Table A-5—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member Identification (ID)	√	√	√
Header Service From Date	√	√	√
Header Service To Date	√	√	
Admission Date		√	
Billing Provider National Provider Identifier (NPI)	√	√	√
Rendering Provider NPI	√		
Attending Provider NPI		√	
Prescribing Provider NPI			√
Referring Provider NPI	√	√	
Primary Diagnosis Code	√	√	
Secondary Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	
Primary Surgical Procedure Code		√	
Secondary Surgical Procedure Code		√	
National Drug Code (NDC)			√
Drug Quantity			√
Revenue Code		√	
Diagnosis-Related Group (DRG) Code		√	
Header Paid Amount		√	√
Detail Paid Amount	√	√	
Dispensing Fee			√

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in DHS' data warehouse (element omission).
- The number and percentage of records with values present in DHS' data warehouse but not in the MCOs' submitted files (element surplus).

Element-level accuracy was limited to those records with values present in both the MCOs' submitted files and DHS' data warehouse. For any given data element, HSAG determined:

- The number and percentage of records with the same values in both the MCOs' submitted files and DHS' data warehouse (element accuracy).
- The number and percentage of records present in both data sources with the same values for select data elements relevant to each encounter data type (all-element accuracy).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to DHS and the MCOs regarding the top three issues from the comparative analysis. First, HSAG drafted MCO-specific encounter data discrepancy reports highlighting three key areas for investigation. Second, upon DHS' review and approval, HSAG distributed the discrepancy reports to the MCOs, as well as data samples to assist with their internal investigations. HSAG then worked with DHS and the MCOs to review the potential root causes of the key issues and requested written responses from the MCOs. Lastly, HSAG reviewed the written responses, followed up with the MCOs, and worked with DHS to determine whether the issues were addressed.

Description of Data Obtained and Related Time Period

HSAG used data from both DHS and the MCOs with dates of service between January 1, 2017, and December 31, 2017, to evaluate the accuracy and completeness of the encounter data. Both paid and denied encounters were included in the analysis. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters submitted to DHS on or before June 30, 2018. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHS data warehouse.

CY 2019 Encounter Data Validation

Activity Objectives

DHS has contracted HSAG to conduct an annual EDV study since 2016. HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in CMS' EQR Protocol 4 (cited earlier in this section). In general, the following core evaluation steps describe HSAG's approach to conducting the EDV activity:

- IS Review—assessment of the State's and/or MCOs' information systems and processes
- Administrative profile—analysis of the State's electronic encounter data completeness, accuracy, and timeliness
- Comparative analysis—analysis of the State's electronic encounter data completeness and accuracy through a comparative analysis between the State's electronic encounter data and the data extracted from the MCOs' data systems
- Technical assistance—follow-up assistance provided to the MCOs that perform poorly in the comparative analysis
- MRR—analysis of the State's electronic encounter data completeness and accuracy through a comparative analysis between the State's electronic encounter data and the medical records

Because CY 2019 is the first year Iowa Total Care submitted encounter data to DHS, HSAG conducted an IS review with Iowa Total Care in CY 2019. For Amerigroup and UnitedHealthcare, HSAG had conducted an IS review in CY 2016, an administrative profile in CY 2017, and a comparative analysis in

CY 2018. As described above, an MRR would typically follow a comparative analysis activity. Since an MRR is a complex, resource-intensive process, a sufficient level of completeness and accuracy of DHS' encounter data is recommended based on the comparative analysis results before conducting the MRR activity. As such, based on the CY 2018 comparative analysis results, DHS and HSAG determined that an MRR activity would not be recommended during the CY 2019 EDV study. Therefore, for Amerigroup and UnitedHealthcare, HSAG initiated a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 EDV study were addressed and to determine if the completeness and accuracy of DHS' encounter data are sufficient for future MRR activities.

The goal of the comparative analysis is to evaluate the extent to which encounters submitted to DHS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs' data systems. This step corresponds to an important validation activity described in the CMS protocol—i.e., analyses of MCO electronic encounter data for accuracy and completeness on reporting.

Technical Methods of Data Collection and Analysis

In this activity, HSAG developed a data requirements document requesting claims/encounter data from both DHS and the MCOs. A follow-up technical assistance session occurred approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure that the submitted data were adequate to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values; e.g., valid ICD-10 codes in the diagnosis field.
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DHS' data warehouse and the MCOs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlights major findings requiring DHS and the MCOs to resubmit data.

The 2019 EDV study was ongoing at the time of this report. Once HSAG has received and processed the final set of data from DHS and each MCO, HSAG will conduct a series of comparative analyses. To facilitate the presentation of findings, the comparative analysis will be divided into two analytic sections.

First, HSAG will assess record-level data completeness using the following metrics for each encounter data type:

- The number and percentage of records present in the MCOs' submitted files but not in DHS' data warehouse (record omission).

- The number and percentage of records present in DHS' data warehouse but not in the MCOs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG will further examine completeness and accuracy for the key data elements listed in Table A-6. The analyses will focus on an element-level comparison for each data element.

Table A-6—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member Identification (ID)	√	√	√
Header Service From Date	√	√	√
Header Service To Date	√	√	
Admission Date		√	
Billing Provider National Provider Identifier (NPI)	√	√	√
Rendering Provider NPI	√		
Attending Provider NPI		√	
Prescribing Provider NPI			√
Referring Provider NPI	√	√	
Primary Diagnosis Code	√	√	
Secondary Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	
Units of Service	√	√	
Primary Surgical Procedure Code		√	
Secondary Surgical Procedure Code		√	
National Drug Code (NDC)	√	√	√
Drug Quantity			√
Revenue Code		√	
Diagnosis-Related Group (DRG) Code		√	
Header Paid Amount		√	√
Detail Paid Amount	√	√	
Dispensing Fee			√

Element-level completeness will be evaluated based on the following metrics:

- The number and percentage of records with values present in the MCOs' submitted files but not in DHS' data warehouse (element omission).
- The number and percentage of records with values present in DHS' data warehouse but not in the MCOs' submitted files (element surplus).

Element-level accuracy will be limited to those records with values present in both the MCOs' submitted files and DHS' data warehouse. For any given data element, HSAG will determine:

- The number and percentage of records with exactly the same values in both the MCOs' submitted files and DHS' data warehouse (element accuracy).
- The number and percentage of records present in both data sources with exactly the same values for select data elements relevant to each encounter data type (all-element accuracy).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG will provide technical assistance to DHS and the MCOs regarding the top three issues from the comparative analysis. First, HSAG will draft MCO-specific encounter data discrepancy reports highlighting three key areas for investigation. Second, upon DHS' review and approval, HSAG will distribute the discrepancy reports to the MCOs, as well as data samples, to assist with their internal investigations. HSAG will then work with DHS and the MCOs to review the potential root causes of the key issues and request written responses from the MCOs. Lastly, once HSAG reviews the written responses, it will follow up with the MCOs, if appropriate, and work with DHS to determine whether the issues have been addressed.

Description of Data Obtained and Related Time Period

HSAG used data from both DHS and the MCOs with dates of service between January 1, 2018, and December 31, 2018, to evaluate the accuracy and completeness of the encounter data. Both paid and denied encounters are included in the analysis. To ensure that the extracted data from both sources represent the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters submitted to DHS on or before June 30, 2019. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHS data warehouse. Of note, since Iowa Total Care had no encounters with dates of service in the study period, Iowa Total Care was not be included in the comparative analysis.

Calculation of Potentially Preventable Events

Activity Objectives

DHS contracted with HSAG to calculate PPEs. For the 2019 PPE calculations, HSAG analyzed statewide ED use by Medicaid members enrolled in managed care to provide results that are meaningful and actionable to DHS.

Technical Methods of Data Collection and Analysis

While HSAG's analyses included the following, only notable findings are included in this report:

- HSAG analyzed ED utilization per 1,000 member months at the regional (e.g., county, ZIP code, rural/urban) level and stratified the results by race/ethnicity, age, and gender. The goal was to identify geographical regions of concern and any disparities in care for members in order to help DHS and the MCOs implement targeted interventions aimed at reducing disparities in care.
- HSAG analyzed ED utilization at the facility level to identify facilities and specific geographic regions that have disproportionally high nonemergent ED utilization. HSAG's strategy for accomplishing this was to calculate the percentage of total ED visits that are classified as nonemergent based on the NYU ED Visit Algorithm,[A-13] stratified at the facility level. Additionally, HSAG assessed the number of nonemergent ED visits that occur on weekends compared to weekdays to determine if the inability to access primary care on weekends is a factor in nonemergent ED visits. HSAG compared the rates of ED visits for nonemergent conditions to the utilization of urgent care for those same conditions to identify if members are receiving care in a more appropriate setting.
- HSAG looked at patterns in ED visits. HSAG analyzed the top diagnoses that resulted in ED visits and classified these visits based on the NYU ED Visit Algorithm. HSAG also assessed whether patients received appropriate follow-up care after an ED visit (i.e., prescription rates for opioids and antibiotics, and percentage of members who followed up with a PCP within 30 days of the ED visit).

Description of Data Obtained and Related Time Period

HSAG used administrative data sources, including demographic, enrollment, professional claims/encounters, institutional claims/encounters, and pharmacy data for Medicaid managed care-eligible individuals from DHS for CY 2018 (i.e., January 1, 2018–December 31, 2018) to calculate ED and non-ED utilization and the top primary diagnoses. HSAG included ED visits that result in an inpatient stay, as these visits may be preventable in a primary care setting.

Scorecard

Activity Objectives

On November 8, 2018, CMS published the Medicaid and CHIP Managed Care Proposed Rule (CMS-2408-P) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid beneficiaries must adopt and implement a quality rating system (QRS). Although the final technical specifications for the QRS have not been released, Medicaid agencies that already have a QRS in place will have an opportunity to use their current QRS to meet CMS

[A-13] NYU Wagner. Faculty & Research: Background/Introduction. Available at: https://wagner.nyu.edu/faculty/billings/nyued-background. Accessed on: Feb 5, 2020.

requirements. CMS will require states wanting to use an alternative QRS to submit their methodology, including the list of performance measures included in the QRS to CMS.

UnitedHealthcare exited Iowa's Medicaid Managed Care Program effective July 1, 2019; however, UnitedHealthcare was still included in the 2019 MCO Scorecard analysis. The third Iowa MCO, Iowa Total Care, began providing services on July 1, 2019; therefore, this MCO will not be included in the 2019 MCO Scorecard analysis. The MCO Scorecard analysis helps support DHS' public reporting of MCO performance information. The 2019 results were for information only, and the 2019 MCO Scorecard will not be made publicly available.

Technical Methods of Data Collection and Analysis

HSAG received CAHPS member-level data files and HEDIS data from DHS and/or the MCOs. The *HEDIS 2019 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2019 Technical Specifications for Health Plans, Volume 2* was used to collect and report on the HEDIS measures.

MCOs' performance was evaluated in seven separate reporting categories identified as important to consumers. Each reporting category consists of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the types of measures they contain are as follows:

- Doctors' Communication and Patient Engagement
- Access to Preventive Care
- Women's Health
- Living With Illness
- Behavioral Health
- Keeping Kids Healthy
- Medication Management

HSAG compared each measure to NCQA's Quality Compass national Medicaid HMO percentiles for HEDIS 2018 and assigned star ratings for each measure. Star ratings were assigned as follows:

- One star—The MCO's measure rate is below the national Medicaid 25th percentile.
- Two stars—The MCO's measure rate was between the national Medicaid 25th percentile and 49th percentile.
- Three stars—The MCO's measure rate was between the national Medicaid 50th percentile and 74th percentile.
- Four stars—The MCO's measure rate was between the national Medicaid 75th percentile and 89th percentile.
- Five stars—The MCO's performance was at or above the national Medicaid 90th percentile.

Summary scores for the seven reporting categories (Doctors' Communication and Patient Engagement, Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, Keeping Kids Healthy, and Medication Management) were then calculated by taking the weighted average of all star ratings for all measures within the category and then rounding to the nearest whole star.

The Iowa Health Link MCO Scorecard included a five-level rating scale that provided an easy-to-read "picture" of quality performance across MCOs and presented data in a manner that emphasized meaningful differences between MCOs.

Description of Data Obtained and Related Time Period

HSAG analyzed 2019 HEDIS results, including 2019 CAHPS data from two MCOs for presentation in the 2019 Iowa Health Link MCO Scorecard.

Operational Readiness Review

Activity Objectives

According to 42 CFR §438.66(d)(1)(ii), which describes the activities related to state monitoring requirements, the State must assess the readiness of each MCO entity with which it contracts when the specific MCO has not previously contracted with the State. DHS requested that HSAG conduct an operational readiness review of Iowa Total Care on behalf of DHS.

In accordance with 42 CFR §438.66(d)(3), the operational readiness review included both a desk review of documents and a two-day on-site review of Iowa Total Care to interview key staff and leadership who manage Iowa Total Care's operational areas. HSAG also conducted system demonstrations of multiple information systems used by Iowa Total Care to support activities related to grievance and appeal processing and tracking, case management, utilization review, and QI. The purpose of the operational readiness review was to assess that Iowa Total Care had the structural and operational capacity to perform the Medicaid managed care functions described in DHS' contract and ensure appropriate and timely access to quality healthcare services for Medicaid recipients.

The operational readiness review included an assessment of 13 standards based on the requirements of the contract. These standards incorporated the key areas noted in 42 CFR §438.66(d)(4) and are presented in Table A-7 below.

Table A-7—Crosswalk of Readiness Review Standards to Federal Readiness Review Areas

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)*
Standard I—Availability of Services	Provider network management
Standard II—Assurances of Adequate Capacity and Services	Provider network management
Standard III—Coordination and Continuity of Care	Case management/care coordination/service planning

Operational Readiness Review Standards	Federal Readiness Review Areas 42 CFR §438.66(d)(4)*
Standard IV—Coverage and Authorization of Services	Utilization review
Standard V—Provider Network	Provider network management Enrollee and provider communications
Standard VI—Member Information and Member Rights	Enrollee and provider communications Member services and outreach
Standard VII—Confidentiality of Health Information	Program integrity/compliance
Standard VIII—Enrollment and Disenrollment	Enrollee and provider communications Member services and outreach
Standard IX—Grievances, Appeals and State Fair Hearings	Grievance and appeals
Standard X—Subcontractual Relationships and Delegation	Delegation and oversight of MCO responsibilities
Standard XI—Practice Guidelines	Case management/care coordination/service planning Utilization review
Standard XII—Quality Assessment and Performance Improvement	Administrative staffing and resources QI
Standard XIII—Health Information Systems**	Claims management
Standard XIV—Program Integrity	Program integrity/compliance

* An assessment of the MCO's financial reporting and monitoring and financial solvency was performed by DHS and was not part of the readiness review performed by HSAG.

** Review of Standard XIII was completed as part of the IS component of the readiness review.

Technical Methods of Data Collection and Analysis

Before beginning the readiness reviews, HSAG developed data collection tools to document the review. The requirements in the tools were based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHS and Iowa Total Care as they related to the scope of the review. In February 2019, HSAG initiated the operational readiness review activities by providing a cover letter to Iowa Total Care that described the activities and critical dates associated with the operational readiness review. The cover letter also included the operational readiness review tools associated with the review.

Data Collection Tools

Operational Readiness Review Evaluation Tool—The Operational Readiness Review Evaluation Tool contained 13 standards that were organized based on the requirements of DHS' managed care contract. A total of 174 applicable elements within the 13 standards were reviewed as part of the operational readiness review. Other elements included in the Operational Readiness Review Evaluation Tool were marked *Not Applicable* (*NA*). Elements marked as *NA* were for information only because they involved requirements that

can only be evaluated once an MCO is operational and serving members. These elements may be reviewed during future compliance reviews but were not reviewed as part of the readiness review. HSAG included the *NA* elements to familiarize Iowa Total Care with all of the operational elements included in the contract to be reviewed as part of the future comprehensive compliance review. Certain elements were considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, and contracting with providers. DHS and HSAG designated those elements as "critical" elements with the expectation that Iowa Total Care prioritize the functions associated with those elements prior to commencing services. Table A-8 lists the total number of applicable elements reviewed within each of the operational readiness review standards and the subset of critical elements within each standard.

Table A-8—Operational Readiness Review Evaluation Tool—Total Elements Reviewed

Standard Number	Readiness Review Standard	Total Applicable Elements	Total Critical Elements
I	Availability of Services	18	14
II	Assurances of Adequate Capacity and Services	3	3
III	Coordination and Continuity of Care	11	3
IV	Coverage and Authorization of Services	17	11
V	Provider Network	15	13
VI	Member Information and Member Rights	23	15
VII	Confidentiality of Health Information	12	4
VIII	Enrollment and Disenrollment	9	3
IX	Grievance, Appeals and State Fair Hearings	38	12
X	Subcontractual Relationships and Delegation	4	2
XI	Practice Guidelines	3	NA
XII	Quality Assessment and Performance Improvement	12	6
XIII	Health Information Systems*		
XIV	Program Integrity	9	3
	Total Operational Readiness Review Elements	**174**	**89**

* Review of Standard XIII was completed as part of the IS component of the readiness review, and findings are detailed in the IS Readiness Review report.

Readiness Review Checklists—Readiness review checklists were used to review sub-elements within four of the 13 standards. HSAG used the checklists to determine Iowa Total Care's compliance with the respective documentation requirements. The total number of applicable elements associated with each checklist are listed in Table A-9.

Table A-9—Operational Readiness Review Checklists—Total Elements Reviewed

Associated Standard #	Checklist Name	Total Applicable Elements
III	Care Coordination	19
V	Provider Manual	11
VI	Member Handbook	22
VI	Provider Directory	9
VI	New Member Communication	15
VI	Member Rights	8
XII	QM/QI [Quality Management/Quality Improvement] Program	16
XII	Staffing Plan	24
	Total Checklist Elements	**124**

File Review Tools—HSAG reviewed a sampling of written subcontracts (or delegation agreements) and credentialing files to evaluate Iowa Total Care's compliance with delegation and credentialing requirements. Table A-10 shows the total applicable elements for the reviews and the associated standard.

Table A-10—File Review Tools—Total Elements Reviewed

Associated Standard #	File Review	Total Applicable Elements
V	Credentialing	162
X	Subcontracts	50
	Total File Review Elements	**212**

Pre-On-Site Review Activities

Pre-on-site activities included:

- Developing the operational readiness review tools (Operational Readiness Review Evaluation Tool, Operational Readiness Review Checklists, File Review Tools, and MCO Questionnaire).
- Preparing and forwarding to Iowa Total Care a customized desk review form with instructions for completing it and for submitting the requested documentation to HSAG for its desk review.
- Scheduling the on-site review.
- Developing an agenda for the two-day on-site review.
- Providing a cover letter with detailed instructions about the operational readiness review, key dates for the review, and data collection tools to Iowa Total Care to facilitate preparation for HSAG's review.

- Conducting an operational readiness review preparation webinar.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of the information obtained from Iowa Total Care. The desk review enabled HSAG reviewers to increase their knowledge and understanding of Iowa Total Care's operations, identify areas needing clarification, and begin compiling information before the on-site and system demonstration reviews.
- Generating a list of five sample subcontractors for the subcontracts file review.
- Generating a list of 10 sample cases plus an oversample of three cases for the credentialing file review.

On-Site Review Activities

On-site activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and logistics for HSAG's on-site review activities.
- Reviewing the documents HSAG requested that Iowa Total Care have available on-site.
- Reviewing the credentialing files HSAG requested from Iowa Total Care and completing the credentialing file review tool.
- Reviewing Iowa Total Care's data systems used in its operations, which included:
  - Grievance and appeal processing and tracking.
  - Case management.
  - Utilization management (UM).
  - QI.
- Interviewing Iowa Total Care's key administrative and program staff members.
- Facilitating a closing conference during which HSAG reviewers summarized their preliminary findings.

Post-On-Site Review Activities

HSAG reviewers aggregated findings to produce this comprehensive operational readiness review report. In addition, HSAG created a template for Iowa Total Care to detail its plan to remedy the deficiencies noted. The remediation plan template contained the findings and recommendation for each element found to be *Incomplete* during the readiness review. Iowa Total Care was required to use the template provided to submit its plan to DHS to remediate all elements scored *Incomplete* or *Incomplete—Critical*. DHS maintained ultimate authority for critical element designation and approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the on-site operational readiness review, the HSAG surveyors assigned a score for each element and an aggregate score for

each standard for the Operational Readiness Review Evaluation Tool. Certain elements were considered more critical to the successful launch of a managed care program, such as the ability to notify individuals of the services available and how to obtain those services, processing grievances and appeals, contracting with providers, and capturing enrollment and service information from DHS' MIS in order to process claims. Each element was given a score of *Complete*, *Incomplete*, or *Incomplete—Critical*.

HSAG's scoring included the following:

- ***Complete*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members provided responses to reviewers that were consistent with each other and with the policies and/or processes described in documentation.
- ***Incomplete*** indicates noncompliance defined as *either* of the following:
  - No documentation was present or documentation was unclear or contained conflicting information that did not address the regulatory requirement.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any findings of *Incomplete* would result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.
- ***Incomplete—Critical*** indicates noncompliance (defined above) and requires that the MCO correct a deficiency prior to commencing services.

From the scores it assigned for each of the requirements, HSAG calculated a total percentage-of-complete score for each of the standards and an overall percentage-of-complete score across the 13 standards. HSAG also calculated scores for each of the checklists reviewed, the credentialing files, and written subcontracts reviewed.

Description of Data Obtained

To assess Iowa Total Care's ability and capacity to perform managed care activities consistent with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by Iowa Total Care, including, but not limited to, the following:

- Committee charters and descriptions
- Written policies and procedures
- The provider and billing manuals and other communication to providers/subcontractors
- The member handbook and other written informational materials to members
- Narrative and/or reporting templates across a broad range of performance and content areas
- MCO-maintained files for practitioner contracting and credentialing
- Written subcontracts and delegation agreements

- MCO questionnaire

HSAG obtained additional information for the readiness review through interactive discussions and interviews with Iowa Total Care's key staff members and system demonstrations provided by Iowa Total Care's staff members.

Information Systems Readiness Review

Activity Objectives

According to 42 CFR §438.66(d)(1)(ii), which describes the activities related to state monitoring requirements, the State must assess the readiness of each MCO entity with which it contracts when the specific MCO has not previously contracted with the State. DHS requested that HSAG conduct an IS readiness review of Iowa Total Care on behalf of DHS.

In accordance with 42 CFR §438.66(d)(3), the 2019 IS readiness review included both a desk review of documents and a Web conference to interview key staff and leadership and test Iowa Total Care's claims systems. The IS readiness review included an assessment of the Health Information Systems standard based on the requirements of the contract and key areas noted in 42 CFR §438.66(d)(4). The purpose of the IS Readiness Review was to evaluate Iowa Total Care's ability to adjudicate a set of test claims to pay providers and subsequently prepare encounters based on the adjudicated test cases.

Technical Methods of Data Collection and Analysis

Before beginning the readiness review, HSAG developed data collection tools to document the review. The requirements in the tools were based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHS and Iowa Total Care. In January 2019, HSAG initiated the systems readiness review activities by providing a cover letter to Iowa Total Care that described the activities and critical dates associated with the information systems readiness review. The cover letter included the review tool associated with the systems readiness review.

Data Collection Tools

IS Readiness Desk Review Tool—HSAG used the IS Readiness Desk Review Tool to document its evaluation of Iowa Total Care's key policies, procedures, and processes related to the enrollment, claims, and encounter systems. Table A-11 shows the total elements for the review.

Table A-11—IS Readiness Desk Review Tool—Total Elements Reviewed

Standard Number	Readiness Review Standard	Total Elements
XIII	Health Information Systems	18

Acute Care Claims Testing Tool—The Acute Care Claims Testing Tool was used to test claims processing accuracy for acute care claims. This tool was used to document the findings from the remote

systems claims testing conducted in April 2019. The test scenarios included a range of behavioral health, physical health, and care coordination claims designed to encompass Iowa Medicaid benefits and billing requirements. Iowa Total Care was provided test recipients, providers, and claim scenarios to load into its test systems to review with HSAG via Webex. The Acute Care Claims Testing tool provides a record of HSAG's findings regarding Iowa Total Care's ability to process claims according to the scenarios.

LTSS and HCBS Claims Testing Tool—The LTSS and HCBS Claims Testing tool was used to document the findings from the remote systems claims testing conducted in May 2019. The test scenarios were developed from encounters provided by DHS to represent Iowa Medicaid LTSS and HCBS benefits. Iowa Total Care was provided test recipients, providers, and claim scenarios to load into its test systems to review with HSAG via Webex. The LTSS and HCBS Claims Testing tool provides a record of HSAG's findings regarding Iowa Total Care's ability to process LTSS claims according to the scenarios.

Pre-On-Site Review Activities

Pre-on-site activities included:

- Developing the readiness review tools.
- Scheduling the Web conferences for claims testing.
- Developing agendas for the remote claims systems testing.
- Providing a cover letter with detailed instructions about the readiness review, key dates for the readiness review, and data collection tools to facilitate Iowa Total Care's preparation for HSAG's systems review.
- Conducting a systems readiness review preparation webinar.
- Conducting a desk review of documents. HSAG conducted a desk review of the information obtained from Iowa Total Care. The desk review enabled HSAG reviewers to increase their knowledge and understanding of Iowa Total Care's operational areas that support enrollment, claims, and encounter data processing and the corresponding systems.
- Responding to Iowa Total Care's questions regarding systems testing and DHS' data requirements.

Information Systems and Claims Testing Activities

Information systems and claims testing activities included:

- Facilitating an opening conference, with introductions and a review of the agenda and systems testing activities.
- Interviewing Iowa Total Care staff members to clarify HSAG's understanding of the policies and procedures provided by Iowa Total Care as part of the desk review.
- Processing test claims in a live claims adjudication environment using behavioral health, physical health, and LTSS and HCBS scenarios provided by HSAG.
- Reviewing claims monitoring and audit controls.
- Reviewing Iowa Total Care's encounter data processes and systems.

HSAG documented its findings in the data collection tools which serve as the comprehensive records of HSAG's findings.

Post-On-Site Review Activities

HSAG reviewers aggregated findings to produce the IS Readiness Review report. In addition, HSAG created a template for Iowa Total Care to detail its plan to remedy the deficiencies noted. The remediation plan template contained the findings and recommendations for each element found to be deficient during the readiness review. Iowa Total Care used the template provided to submit a remediation plan to DHS to propose its plan to remediate all deficiencies. DHS maintained ultimate authority for approving remediation plans submitted in response to the readiness review.

Data Aggregation and Analysis

From a review of documents, observations, and interviews with key staff during the systems testing, the HSAG reviewers assigned a score for each element and an aggregate score for the IS Readiness Desk Review tool. Each element was given a score of *Complete* or *Incomplete*.

IS Readiness Desk Review Scoring—HSAG's scoring included the following:

- ***Complete*** indicates full compliance defined as *both* of the following:
  - All documentation listed under a regulatory provision, or component thereof, was present.
  - Staff members provided responses to reviewers that were consistent with each other and with the policies and/or processes described in documentation.
- ***Incomplete*** indicates noncompliance defined as *either* of the following and requires that Iowa Total Care prioritize the element in its remediation plan:
  - No documentation was present or documentation was unclear or contained conflicting information that did not address the regulatory requirement.
  - Staff members had little or no knowledge of processes or issues addressed by the regulatory provisions.
  - For those provisions with multiple components, key components of the provision could be identified and any findings of *Incomplete* would result in an overall provision finding of incomplete, regardless of the findings noted for the remaining components.

From the scores assigned for each of the requirements, HSAG calculated an overall percentage-of-complete score for the IS Readiness Desk Review tool. HSAG also calculated scores for the IS claims systems testing.

IS Readiness Claims System Testing Scoring—The claims systems testing requires a different rating scale from the IS Readiness Desk Review tool. Although the test claims are based on fictional scenarios, the final claims adjudication must be consistent with the anticipated outcome. While the scenarios are designed to be representative of the behavioral health benefits, physical health benefits, LTSS and HCBS benefits, and administrative requirements, the scope of testing is limited to determining whether Iowa Total Care processed the test claims according to expectations. Therefore, HSAG's scoring methodology for the test claims is based on the following ratings:

- ***Met*** indicates Iowa Total Care processed the test claim as follows:

  - All Medicaid covered services were paid based on the correct billing codes and procedures.
  - Any noncovered service was denied, and the explanation of payment did not calculate patient liability for the noncovered service.
  - Any service billed incorrectly or that was missing the required documentation or a PA was pended and/or denied.
  - The claims system captured the ICD-10 codes.
  - The claims system configuration produced the expected paid or denied outcome for every claim line, and the applicable denial code reasons were reflective of the expected outcome.
  - The explanation of payment reflected the approved and paid amounts, with detailed denial reasons for any service that was denied.
  - Staff members demonstrated proficiency in the Iowa Medicaid procedures, billing requirements, and/or the policies and processes described in the desk review documentation.
- ***Partially Met*** indicates Iowa Total Care processed the test claim as follows:
  - At least one of the Medicaid covered services was paid based on the correct billing codes and procedures.
  - At least one of the noncovered services or services billed incorrectly was pended and/or denied.
  - At least one noncovered service was denied, and the explanation of payment did not calculate patient liability for the noncovered service.
  - The claims system configuration produced the expected paid or denied outcome for at least one of the claim lines, and the applicable denial code reasons were reflective of the expected outcome.
  - The explanation of payment reflected the approved and paid amounts, with detailed denial reasons for any service that was denied.
  - Staff members had little knowledge of processes or issues addressed by the regulatory provisions or the Iowa Medicaid billing procedures and requirements.
- ***Not Met*** indicates Iowa Total Care processed the test claim as follows:
  - The processed claim did not align with the claim outcome expectations, and Iowa Total Care staff did not account for circumstances that impacted the claim outcome.
  - Staff members did not demonstrate proficiency with processes or issues addressed by the regulatory provisions or the Iowa Medicaid billing procedures and requirements.

Description of Data Obtained

To assess Iowa Total Care's systems functionality and capacity to support managed care activities consistent with federal regulations, State rules, and contract requirements, HSAG obtained information from written documents and systems information produced by Iowa Total Care, including, but not limited to, the following:

- Technical documents and workflow diagrams
- Written policies and procedures
- Systems manuals
- Real-time review of systems

HSAG obtained additional information for the readiness review through interactive discussions and interviews with Iowa Total Care's key staff members.

Appendix B. PAHP Technical Methods of Data Collection and Analysis

PAHP Mandatory Activities

Compliance Monitoring

Activity Objectives

The primary objective of HSAG's review was to provide meaningful information to DHS and the PAHP regarding the PAHP's progress in achieving compliance with State and federal requirements that received a score of *Not Met* during the CY 2018 compliance review activity. HSAG assembled a team to:

- Collaborate with DHS to determine the scope of the review as well as the scoring methodology, data collection methods, desk review schedules, on-site review activities schedules, and on-site review agenda.
- Collect and review data and documents before and during the on-site review.
- Aggregate and analyze the data and information collected.
- Prepare the findings report.

To accomplish its objective and based on the results of collaborative planning with the DHS, HSAG developed and used a data collection tool to assess and document the PAHP's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHS contractual requirements. The complete review tool included requirements that addressed the following 13 performance areas:

- Standard I—Availability of Services
- Standard II—Assurance of Adequate Capacity and Services
- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard V—Provider Network
- Standard VI—Member Information
- Standard VII—Confidentiality of Health Information
- Standard VIII—Enrollment and Disenrollment
- Standard IX—Grievance System
- Standard X—Subcontractual Relationships and Delegation
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement
- Standard XIII—Health Information Systems

The DHS and the PAHP will use the information and findings that resulted from HSAG's review to:

- Evaluate the quality and timeliness of, and access to, care and services furnished to members.
- Identify, implement, and monitor interventions to improve these aspects of care and services.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between the DHS and the PAHP as they related to the scope of the review. For CY 2019, HSAG used the CAP of the *CY 2018 External Quality Review of Compliance With Standards* report, which was customized based on each PAHP's performance in the CY 2018 review. This customized tool included only those standards for which the PAHP had scored less than 100 percent and only those elements for which the PAHP had scored *Not Met*. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012[B-1] for the following activities:

Pre-On-Site Review Activities

Pre-on-site review activities included:

- Developing the compliance review tools.
- Preparing and forwarding to the PAHP a pre-audit information packet and instructions for submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-audit preparation session with the PAHP.
- Scheduling the on-site reviews.
- Conducting a pre-on-site desk review of documents. HSAG conducted a desk review of key documents and other information obtained from the DHS and of documents the PAHP submitted to HSAG to support its CY 2018 CAPs. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PAHP's operations, identify areas needing clarification, and begin compiling information before the on-site review.
- Conducting a collaborative review of the PAHP's CAP submission with DHS.
- Preparing and forwarding to the PAHP a customized form outlining the outstanding items to the PAHP's CAP response.
- Developing the agenda for the one-day on-site review.

B-1 Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR),* Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-1.pdf. Accessed on: Feb 5, 2020.

- Providing the detailed agenda to the PAHP to facilitate preparation for HSAG's review.
- Generating a list of 10 sample cases, plus an oversample of three cases, for grievances, appeals, and service authorization denials for the file review portion of the audit from the list of such members submitted to HSAG from the PAHP.
- A review of the grievance, appeal, and service denial case files HSAG requested from the PAHP.

On-Site Review Activities

On-site review activities included:

- An opening session, with introductions and a review of the agenda and logistics for HSAG's one-day review.
- A review of the documents HSAG requested that the PAHP have available on-site.
- A review of the grievance, appeal, and service denial case files HSAG requested from the PAHP.
- Interviews conducted with the PAHP's key administrative and program staff members.
- A closing session, during which HSAG reviewers summarized their preliminary findings and verified additional documentation requested from the PAHP.

Data Aggregation and Analysis

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the PAHP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to a PAHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012, cited earlier in this section. The protocol describes the scoring as follows:

Met indicates full compliance defined as *both* of the following:

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.

Not Met indicates noncompliance defined as *one or more* of the following:

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interview, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

- For those provisions with multiple components, key components of the provision could be identified and any *Not Met* findings would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

From the scores that it assigned for each of the requirements, HSAG calculated a total percentage-of-compliance score for each of the standards and an overall percentage-of-compliance score across the standards. HSAG determined the total score for each standard by totaling the number of *Met* (1 point) elements from both the CY 2018 and CY 2019 reviews, and the number of *Not Met* (0 points) and *Not Applicable* elements for the standard from the follow-up review, then dividing the summed score by the total number of applicable elements for that standard.

HSAG determined the overall percentage-of-compliance score across the areas of review by following the same method used to calculate the scores for each standard (i.e., by summing the weighted values of the scores and dividing the result by the total number of applicable requirements).

The scoring methodology remained consistent between the CY 2018 and CY 2019 compliance review activities. HSAG combined the results of the CY 2018 and CY 2019 reviews to demonstrate the PAHP's overall compliance scores across all 13 performance areas.

To draw conclusions about the quality and timeliness of, and access to, care and services the PAHP provided to members, HSAG aggregated and analyzed the data resulting from its desk and on-site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the PAHP's progress in achieving compliance with State and federal requirements through the CAP process.
- Scores assigned to the PAHP's performance for each requirement.
- The total percentage-of-compliance score calculated for each of the standards.
- The overall percentage-of-compliance score calculated across the standards.
- Documentation of the actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.

Based on the results of the data aggregation and analysis, HSAG prepared and forwarded the draft reports to the DHS for review and comment prior to issuing final reports.

Description of Data Obtained and Related Time Period

To assess the PAHP's compliance with federal regulations, State rules, and contract requirements, HSAG obtained information from a wide range of written documents produced by the PAHP, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other PAHP communication to providers/subcontractors.

- The member handbook and other written informational materials.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- PAHP-maintained files for the case file reviews.

HSAG obtained additional information for the compliance review through interaction, discussions, and interviews with the PAHP's key staff members.

Table A-2 lists the major data sources HSAG used in determining the PAHP's performance in complying with requirements and the time period to which the data applied.

Table B-12—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the on-site review	March 27, 2019 (due date for CY 2018 CAP submission)	
Information obtained through interviews	October 8, 2019	October 11, 2019
Information obtained from a review of a sample of the PAHP's records for file reviews	Cases closed between May 1, 2019–July 31, 2019	

Validation of Performance Measures

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by PAHPs and to determine the extent to which performance measures reported by the PAHPs follow State specifications and reporting requirements. HSAG followed CMS' *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 1, 2012.

Technical Methods of Data Collection and Analysis

The CMS PMV protocol identifies key types of data that are to be reviewed as part of the validation process. The following list describes the type of data collected and how HSAG analyzed these data:

- **Information Systems Capabilities Assessment Tool (ISCAT):** PAHPs completed and submitted an ISCAT for HSAG's review of the required IME-developed measures. HSAG used the responses from the ISCAT to complete the pre-on-site assessment of information systems.
- **Source code (programming language) for performance measures:** PAHPs that calculated the performance measures using source code were required to submit the source code used to generate each performance measure validated. HSAG completed a line-by-line review of the supplied source

code to ensure compliance with the measure descriptions required by DHS. HSAG identified any areas of deviation from the descriptions, evaluating the impact to the measure and assessing the degree of bias (if any). PAHPs that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.

- **Supporting documentation:** HSAG requested documentation that would provide reviewers with additional information to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation, identifying issues or areas needing clarification for further follow-up.

Pre-On-Site Strategy

HSAG conducted the validation activities as outlined in the CMS PMV protocol. To complete the validation activities for the PAHPs, HSAG obtained a list of the performance measures that were selected by DHS for validation. HSAG prepared a document request letter that was submitted to the PAHPs, which outlined the steps in the PMV process. The document request letter included a request for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the audit. The letter also included a timetable for completion and instructions for the PAHP to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the PAHPs during the pre-on-site phase.

Approximately two weeks prior to the on-site visit, HSAG provided the PAHPs with an agenda describing all on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with each PAHP to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the PAHPs.

On-Site Activities

HSAG conducted a virtual on-site visit with each PAHP. HSAG collected information using several methods, including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The on-site visit activities included the following:

- **Opening meeting:** The opening meeting included an introduction of the validation team and key PAHP staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT documentation:** This session was designed to be interactive with key PAHP staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of system compliance:** The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the

processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether the PAHP performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of each ISCAT, HSAG conducted interviews with key PAHP staff familiar with the processing, monitoring, and calculation of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that the PAHP used and followed written policies and procedures in daily practice.

- **Overview of data integration and control procedures:** The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG reviewed backup documentation on data integration and addressed data control and security procedures during this session.
- **Primary source verification:** HSAG performed additional validation using PSV to further validate the output files. PSV is a review technique used to confirm that the information from the primary source matches the output information used for reporting. Each PAHP provided HSAG with a listing of the data the PAHP had reported to IME, from which HSAG selected a sample. HSAG selected a random sample from the submitted data and requested that the PAHP provide proof of service documents or system screen shots that allowed for validation against the source data in the system. During the on-site review, these data were also reviewed live in the PAHP's systems for verification, which provided the PAHP an opportunity to explain its processes regarding any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the PAHP.

  Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the PAHPs have system documentation which supports that the PAHP appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.
- **Closing conference:** The closing conference included a summation of preliminary findings based on the review of the ISCAT and on-site visit and revisited the documentation requirements for any post-on-site activities.

Description of Data Obtained and Related Time Period

Table B-13 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table B-13—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2019	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	December 3, 2019	December 5, 2019

Validation of Performance Improvement Projects

Activity Objectives

Validating PIPs is one of the mandatory external quality review activities described at 42 CFR §438.330(b)(1). In accordance with §438.330(d), the PAHP entities are required to have a quality assessment and performance improvement program which includes PIPs that focus on both clinical and nonclinical areas. Each PIP must be designed to achieve significant improvement, sustained over time, in health outcomes and enrollee satisfaction, and must include the following:

- Measuring performance using objective quality indicators
- Implementing system interventions to achieve QI
- Evaluating effectiveness of the interventions
- Planning and initiating activities for increasing and sustaining improvement

The EQR technical report must include information on the validation of PIPs required by the state and underway during the preceding 12 months.

In its annual PIP validation, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[B-2] HSAG's validation of PIPs includes two key components of the QI process:

1. Evaluation of the technical structure of the PIP to ensure that the PAHPs design, conduct, and report the PIP in a methodologically sound manner, meeting all State and federal requirements. HSAG's

[B-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 5, 2020.

review determines whether the PIP design (e.g., study question, population, study indicator(s), sampling techniques, and data collection methodology/processes) is based on sound methodological principles and could reliably measure outcomes. Successful execution of this component ensures that reported PIP results are accurate and capable of measuring sustained improvement.

2. Evaluation of the implementation of the PIP. Once designed, a PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the PAHPs improve rates through implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

The goal of HSAG's PIP validation is to ensure that DHS and key stakeholders can have confidence that any reported improvement is related and can be directly linked to the QI strategies and activities conducted by the PAHPs during the PIP.

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. The methodology used to validate PIPs was based on the CMS guidelines as outlined in *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012 (cited earlier in this section). Using this protocol, HSAG, in collaboration with DHS, developed the PIP Summary Form. Each PAHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

HSAG, with DHS' input and approval, developed a PIP Validation Tool to ensure uniform validation of PIPs. Using this tool, HSAG evaluated each of the PIPs per the CMS protocols. The CMS protocols identify ten steps that should be validated for each PIP.

For CY 2019 submissions:

- PAHPs reported baseline data and were validated for Steps I through VII in the validation tool.

The ten steps included in the PIP Validation Tool are listed below:

Step I.	Select the Study Topic(s)
Step II.	Define the Study Question(s)
Step III.	Define the Identified Study Population
Step IV.	Select the Study Indicator(s)[B-3]
Step V.	Use Sound Sampling Techniques

[B-3] DDIA's PIP will have two study indicators: one for the adult population, and one for the Hawki population.

Step VI.	Reliably Collect Data
Step VII.	Analyze Data and Interpret Study Results
Step VIII.	Improvement Strategies
Step IX.	Assess for Real Improvement
Step X.	Assess for Sustained Improvement

HSAG used the following methodology to evaluate PIPs conducted by the PAHPs to determine whether a PIP was valid and the percentage of compliance with CMS' protocol for conducting PIPs.

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable,* or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as critical elements. For a PIP to produce valid and reliable results, all critical elements must be *Met*. Given the importance of critical elements to the scoring methodology, any critical element that receives a *Not Met* score results in an overall validation rating for the PIP of *Not Met*. The PAHPs are assigned a *Partially Met* score if 60 percent to 79 percent of all evaluation elements are *Met* or one or more critical elements are *Partially Met*. HSAG provides a General Comment with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*) HSAG assigns the PIP an overall percentage score for all evaluation elements (including critical elements). HSAG calculates the overall percentage score by dividing the total number of elements scored as *Met* by the total number of elements scored as *Met*, *Partially Met*, and *Not Met*. HSAG also calculates a critical element percentage score by dividing the total number of critical elements scored as *Met* by the sum of the critical elements scored as *Met*, *Partially Met*, and *Not Met*.

HSAG assessed the implications of the improvement project's findings on the likely validity and reliability of the results as follows:

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*

The PAHPs had an opportunity to resubmit a revised PIP Summary Form and additional information in response to HSAG's initial validation scores of *Partially Met* or *Not Met*, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any PAHP that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

Upon completion of the final validation, HSAG prepared a report of its findings and recommendations for each PAHP. These reports, which complied with 42 CFR §438.364, were provided to DHS and the PAHPs.

Description of Data Obtained and Related Time Period

For CY 2019, the PAHPs submitted baseline data. The study indicator measurement period dates are listed below.

Table B-14—Data Obtained and PAHP Measurement Periods

Data Obtained	Measurement Period
Baseline	January 1, 2018—December 31, 2018
Remeasurement 1	January 1, 2019—December 31, 2019
Remeasurement 2	January 1, 2020—December 31, 2020

Network Adequacy

Activity Objectives

HSAG conducted a Dental Provider Network Analysis ("network analysis") to evaluate the utilization of dental services for Iowa Dental Wellness Plan Medicaid members.

The proposed analysis evaluated the following dimensions of dental utilization:

- **Provider Saturation:** The provider saturation analysis assessed the percentage of dental providers licensed in the State of Iowa that were contracted with at least one of the Iowa PAHPs to provide dental services to Medicaid members.
- **Percentage of Active Providers:** This dimension evaluated the percentage of providers contracted with the Iowa PAHPs who had evidence (i.e., encounters) of providing services to Medicaid members within the study period.
- **Member Service Utilization:** The member utilization dimension assessed 1) the percentage of Medicaid members enrolled in a PAHP who received a dental service during the study period, and 2) the frequency of the most commonly administered services by provider type.
- **Travel Time/Distance to Providers accepting new patients:** This dimension evaluated the time/distance to providers who indicate they are accepting new patients compared to providers who indicate they are not accepting new patients.

Technical Methods of Data Collection and Analysis

HSAG cleaned, processed, and defined the unique set of dental providers, dental provider locations, and study-eligible members for inclusion in the analysis. Dental encounters were limited to services

provided during CY 2018. For the time/distance analysis, all Medicaid member and dental provider files were standardized and geo-coded using Quest Analytics software. The final Medicaid population was limited to the PAHP members residing within the State of Iowa. Table B-15 shows the provider specialties included in the analyses.

Table B-15—Dental Provider Specialties Included in the CY 2019 Dental Network Analyses

Provider Specialty
General Dental Providers
General Dentist
Dental Specialists
Orthodontist*
Endodontist
Oral Surgeon
Pedodontist*
Periodontist
Prosthodontist

* Pedodontists and orthodontists were included in the analyses as appropriate since they may provide services to limited populations (e.g., adults with behavior management issues).

Provider Saturation Analysis: Calculation of the provider saturation rate allowed HSAG to examine the extent to which licensed dental providers in the State of Iowa were contracted with Iowa Medicaid and the PAHPs. Drawing from the Dental Board data, HSAG calculated by PAHP and statewide the percentage of licensed dental providers contracted with one or more PAHPs.

Percentage of Active Providers: HSAG evaluated the percentage of providers contracted with a PAHP that had evidence of providing services to a Medicaid member (i.e., evidence through submitted encounters). The percentage of providers providing services to members was assessed by PAHP and statewide for all provider types listed in Table B-15.

Member Service Utilization: HSAG determined members' utilization of dental services by assessing 1) the percentage of members receiving dental services and 2) the types of services received by the members. For each provider type listed in Table B-15, HSAG evaluated the most frequently provided services by PAHP and statewide. Additionally, by PAHP and statewide, HSAG evaluated the percentage of members who received at least one dental service, by type of service. The types of services considered in this analysis are listed in Table B-16.

Table B-16—Dental Services Categories Defined by Current Dental Terminology (CDT) Codes

Dental Services	CDT Codes Identifying Services
Diagnostic Services, including clinical evaluations, pre-diagnostic services, and diagnostic imaging	D0100–D0999
Preventive Services, including dental prophylaxis, topical fluoride treatment, space maintenance, and other preventive services	D1000–D1999
Restorative Services, including fillings, crowns, and other restorative services	D2000–D2999
Endodontics, including root canals, endodontic therapy and treatment, and apicoectomy/periradicular services	D3000–D3999
Periodontics, including surgical services and other periodontal services	D4000–D4999
Prosthodontics, including dentures, maxillofacial prosthetics, and other dental implants	D5000–D6999
Surgery or Extractions, including extractions, excisions, and other surgical procedures	D7000–D7999
Orthodontics, including limited and comprehensive orthodontic services	D8000–D8999
Adjunctive Services, including IV sedation and emergency services provided for relief of dental pain	D9000–D9999

Travel Time/Distance to Providers accepting new patients: HSAG evaluated the geographic distribution of dental providers accepting new patients relative to the PAHPs' members. The geographic network distribution analysis assessed whether the number of dental provider locations for providers accepting new patients in a PAHP's provider network was proportional to the PAHP's Medicaid population. To provide a comprehensive view of geographic access, HSAG calculated the following spatial-derived metrics for the provider specialties listed in Table B-17:

- Average travel distance (in miles) and travel time[B-4] (in minutes) to the nearest one to three dental providers: A smaller distance or shorter travel time indicates greater accessibility to dental providers since individuals must travel fewer miles or minutes to access care.

[B-4] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of dental providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members.

Table B-17—Dental Provider Categories and Members Considered for Time/Distance Analysis*

Provider Specialty	Criteria for Members
General Dental Providers	
General Dentist	All members enrolled in a PAHP
Dental Specialists	
Endodontist	All members enrolled in a PAHP
Oral Surgeon	All members enrolled in a PAHP
Periodontist	All members enrolled in a PAHP
Prosthodontist	All members enrolled in a PAHP

* Pedodontists and orthodontists were excluded from the time/distance analyses since most of the population served by these providers, i.e., children, are not included in this network analysis for the Dental Wellness Plan members.

Description of Data Obtained and Related Time Period

HSAG obtained Medicaid member demographic information, dental provider network files, dental encounter data, and the Iowa Dental Board data from DHS. The list below is a high-level summary of the data:

- The member demographic data included key data elements such as the unique member identifier, gender, age, and residential address as of December 31, 2018.
- The member eligibility and enrollment files included the start and end dates for the PAHP enrollment.
- The dental provider data included providers actively enrolled in a PAHP as of December 31, 2018. Some of the key data elements are the unique provider identifier, enrollment status with the PAHPs, provider type, provider specialty, and service address as of December 31, 2018.
- The encounter data included all encounters for CY 2018, for dental services with service dates between January 1, 2018, and December 31, 2018.
- The Iowa Dental Board data (provider name, address, license number, status, and specialty) included all providers registered with the Iowa Dental Board.

PAHP Optional Activities

Encounter Data Validation

Activity Objectives

In alignment with the CMS *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012,[B-5] during CY 2019, HSAG conducted the following two core evaluation activities for the EDV activity:

[B-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4: Validation of Encounter Data Reported by the MCO: A Voluntary Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-4.pdf. Accessed on: Feb 5, 2020.

- Comparative analysis—analysis of DHS' electronic dental encounter data completeness and accuracy through a comparative analysis between DHS' electronic dental encounter data and the data extracted from the PAHPs' data systems
- Technical assistance—follow-up assistance provided to PAHPs that performed poorly in the comparative analysis

The goal of the comparative analysis was to evaluate the extent to which dental encounters submitted to DHS by the PAHPs were complete and accurate, based on corresponding information stored in the PAHPs' data systems. This step corresponds to an important validation activity described in the CMS protocol—i.e., analyses of PAHP electronic encounter data for accuracy and completeness on reporting. Based on the study findings from the comparative analysis, HSAG initiated a series of follow-up activities with the PAHPs that performed poorly in the comparative analysis. The goal of these activities was designed to assist the PAHPs in addressing and resolving major encounter data issues identified by the study.

Technical Methods of Data Collection and Analysis

Comparative Analysis

In this activity, HSAG developed a data requirements document requesting dental claims/encounter data from both DHS and the PAHPs. A follow-up technical assistance session occurred approximately two weeks after distributing the data requirements documents, thereby allowing the PAHPs time to review and prepare their questions for the session. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values; e.g., valid CDT codes in the procedure code field.
- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DHS' data warehouse and the PAHPs' data submitted to HSAG.

Based on the results of the preliminary file review, HSAG generated a report that highlighted major findings requiring both DHS and the PAHPs to resubmit data, if applicable.

Once HSAG received and processed the final set of data from DHS and each PAHP, HSAG conducted a series of comparative analyses that were divided into two analytic sections.

First, HSAG assessed record-level data completeness using the following metrics:

- The number and percentage of records present in the PAHPs' submitted files but not in DHS' data warehouse (record omission).

- The number and percentage of records present in DHS' data warehouse but not in the PAHPs' submitted files (record surplus).

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table B-18. The analyses focused on an element-level comparison for each data element.

Table B-18—Key Data Elements for Comparative Analysis

Key Data Elements	Dental
Member Identification (ID)	√
Header Service From Date	√
Header Service To Date	√
Billing Provider National Provider Identifier (NPI)	√
Rendering Provider NPI	√
Dental Procedure Code (CDT)	√
Units of Service	√
Tooth Number	√
Oral Cavity Code (1 through 5)	√
Tooth Surface (1 through 5)	√
Detail Paid Amount	√
Header Paid Amount	√

HSAG evaluated element-level completeness based on the following metrics:

- The number and percentage of records with values present in the PAHPs' submitted files but not in DHS' data warehouse (element omission).
- The number and percentage of records with values present in DHS' data warehouse but not in the PAHPs' submitted files (element surplus).

Element-level accuracy was limited to those records with values present in both the PAHPs' submitted files and DHS' data warehouse. For any given data element, HSAG determined:

- The number and percentage of records with the same values in both the PAHPs' submitted files and DHS' data warehouse (element accuracy).
- The number and percentage of records present in both data sources with the same values for select data elements relevant to each encounter data type (all-element accuracy).

Technical Assistance

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to DHS and the PAHPs regarding the top three issues from the comparative analysis. First, HSAG drafted PAHP-

specific encounter data discrepancy reports highlighting three key areas for investigation. Second, upon DHS' review and approval, HSAG distributed the discrepancy reports to the PAHPs, as well as data samples to assist with their internal investigations. HSAG then worked with DHS and the PAHPs to review the potential root causes of the key issues and requested written responses from the PAHPs. Lastly, HSAG reviewed the written responses, followed up with the PAHPs, and worked with DHS to determine whether the issues were addressed.

Description of Data Obtained and Related Time Period

HSAG used dental encounter data received from both DHS and the PAHPs with dates of service between January 1, 2018, and December 31, 2018, to evaluate the accuracy and completeness of the dental encounter data. Both paid and denied encounters were included in the analysis. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted dental encounters submitted to DHS on or before May 31, 2019. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHS data warehouse.