



Department of
HUMAN SERVICES

Calendar Year 2018 External Quality Review Technical Report

June 2019



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1. Executive Summary

Overview of Report

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 an 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 and timeliness of, 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 an EQR of the Iowa MCEs and produce this EQR technical report. This is the third year HSAG has produced the report of results for the State of Iowa.

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 administered by two MCEs referred to as managed care organizations (MCOs) which provide members with comprehensive healthcare services, including physical health, behavioral health, and long-term services and supports (LTSS). Calendar year (CY) 2018 marked the third year DHS has contracted with HSAG to conduct EQR activities for Iowa’s MCOs. The two MCOs that delivered managed care and services in Iowa during CY 2018 are displayed in Table 1-1 below.

Table 1-1—IA Health Link MCOs

MCO Name	MCO Short Name
Amerigroup Iowa, Inc.	Amerigroup
UnitedHealthcare Community Plan of the River Valley, Inc.	UnitedHealthcare

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 are offered through the Healthy and Well Kids in Iowa (Hawki) program,¹⁻¹ the State’s Children’s Health Insurance Program (CHIP). CY 2018 marked the first year DHS has contracted with HSAG to conduct EQR activities for the Iowa’s PAHPs. The two PAHPs that delivered managed dental care and services in Iowa during CY 2018 are displayed in Table 1-2 below.

¹⁻¹ 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	DDIA
Managed Care of North America Dental	MCNA

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from CY 2018 to assess the performance of Medicaid MCOs and PAHPs in providing quality, timely, and accessible healthcare services to Iowa Medicaid members. For each activity, HSAG provides the following summary of its overall key findings and conclusions based on each entity’s performance. For MCO- and PAHP-specific findings, strengths, and recommendations for the activities conducted, refer to sections 4, 5, 6, and 7.

Compliance Monitoring

HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews for the MCOs and PAHPs by arranging the State and federal Medicaid managed care requirements into the 13 performance areas referred to as standards.

Managed Care Organizations

Beginning this year (CY 2018), DHS has requested that HSAG conduct MCO compliance reviews over a three-year cycle with one-third of the standards being reviewed each year. The overall compliance scores are presented in Table 1-3 below.

Table 1-3—Summary of MCO Overall Compliance Scores

Compliance Monitoring Activity	Amerigroup	UnitedHealthcare
Review of Standards	95%	96%

Of the four standards reviewed, Amerigroup received a compliance score of 95 percent and UnitedHealthcare a score of 96 percent. The compliance scores demonstrate the MCOs’ strong application of access and availability of services, grievance and appeal system, and quality assessment and performance improvement program requirements.

Prepaid Ambulatory Health Plans

As CY 2018 marked the first year HSAG has conducted compliance reviews for the PAHPs, DHS requested that HSAG conduct a full review of all 13 standards. The overall compliance scores are presented in Table 1-4 below.

Table 1-4—Summary of PAHP Overall Compliance Scores

Compliance Monitoring Activity	DDIA	MCNA
Review of Standards	72%	83%

DDIA received an overall compliance score of 72 percent, while MCNA received an overall score of 83 percent. These findings suggest multiple, program-wide opportunities for improvement, specifically in the areas of coverage and authorization, member information and member rights, grievance and appeal system, and delegation program requirements. These program areas accounted for 62 of the 81 elements that received a *Not Met* score across both PAHPs.

Validation of Performance Measures

Managed Care Organizations

Stemming from the findings of the CY 2017 Care Management Focused Study, DHS contracted with HSAG in CY 2018 to develop a set of state-defined performance measures to be calculated and reported by the MCOs for the July 1, 2017–June 30, 2018 measurement period. The performance measures focus on person-centered care planning for those served in home and community-based services (HCBS) programs in the following key areas:

- Receipt of authorized services
- Distribution of care plan
- Person-centered care plan meeting
- Care team lead
- Choice of HCBS setting

To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year July 1, 2017–June 30, 2018 and measurement year July 1, 2018–June 30, 2019 during the on-site performance measure validation to be completed by HSAG in 2019. The final validation findings for both measurement years will be included in the CY 2019 EQR Technical Report.

Prepaid Ambulatory Health Plans

The purpose of performance measure validation (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. DHS has contracted with HSAG to conduct the PMV for each PAHP, validating the data collection and reporting processes used to calculate the performance measure rates. DHS identified a set of performance measures that the PAHPs are required to calculate and report. Measures are required to be reported following the specifications provided by DHS. DHS identified the measurement period as July 1, 2017–June 30, 2018.

Based on HSAG’s validation of performance measures, HSAG had no concerns with DDIA’s or MCNA’s data processing, integration, and measure production. HSAG determined that both PAHPs followed the State’s specifications and produced *Reportable (R)* rates for all measures in the scope of the validation of performance measures which are presented in Table 1-5 below.

Table 1-5—PAHP Performance Measure Rates

Performance Measures	DDIA		MCNA	
	Count	Percent	Count	Percent
<i>DWP Unique Members with 6+ Month Coverage</i>	198,888 ¹	NA	89,661 ¹	NA
<i>DWP Unique Members with 6+ Month Coverage and Accessing Care</i>	82,120 ²	41.29%	18,915 ²	21.10%
<i>DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation</i>	66,594 ³	81.09%	13,102 ³	69.27%

¹ Represents total count of unique DWP members with six or more months of coverage.

² Represents the number of unique DWP members with six or more months of coverage who accessed care.

³ Represents the number of unique DWP members with six or more months of coverage who accessed care and received an oral health evaluation.

NA = Not applicable

Validation of Performance Improvement Projects

The MCOs and PAHPs are required to conduct performance improvement projects (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 2018 validation cycle.

Managed Care Organizations

For CY 2018, the MCOs submitted their ongoing DHS-mandated PIP topics—*Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS¹⁻² Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*. The final validation status for each PIP/MCO is presented in Table 1-6 below.

¹⁻² Consumer Assessment of Healthcare Providers and Systems (CAHPS[®]) is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Table 1-6—Final MCO PIP Validation Status

PIP Topic	Amerigroup	UnitedHealthcare
<i>Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10</i>	<i>Met</i>	<i>Met</i>
<i>Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life</i>	<i>Met</i>	<i>Met</i>

For the final validation, 100 percent of all PIP activities received an overall *Met* validation status. The performance on these PIPs suggests a thorough application of the Design and Implementation stages (Steps I through VIII) for both MCOs. Both MCOs designed methodologically sound improvement projects and progressed to implementing quality improvement strategies.

Prepaid Ambulatory Health Plans

In 2018, HSAG worked with DHS to determine a relevant and feasible PIP topic for the PAHPs that has the potential to affect member health, functional status, or satisfaction, and for which data were available to be collected. DHS determined that the state-mandated topic to be initiated by the PAHPs would be annual dental visits. This was the first year of submission for the PAHPs. HSAG validated the first six steps of the PIP process known as the Study Design. The final PIP validation status for each PAHP is presented in Table 1-7 below.

Table 1-7—Final PAHP PIP Validation Status

PIP Topic	DDIA	MCNA
<i>Annual Dental Visits</i>	<i>Partially Met</i>	<i>Met</i>

MCNA met 100 percent of the requirements for the Study Design and achieved an overall *Met* validation status. MCNA designed a methodologically sound project and will progress to initiating quality improvement processes and interventions. For DDIA, 88 percent of all applicable evaluation elements validated receiving a *Met* validation score. DDIA designed a methodologically sound project; however, HSAG identified an opportunity for improvement related to documentation of DDIA’s data collection process resulting in the overall validation status of *Partially Met*. This can be corrected by DDIA for the next annual submission.

Network Adequacy

Managed Care Organizations

HSAG conducted a secret shopper telephone survey of primary care providers (PCPs). 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. Results for the MCO secret shopper survey are summarized in Table 1-8 below.

Table 1-8—Summary of MCO Secret Shopper Results

	Amerigroup	UnitedHealthcare
Accepting New Patients	63.8%	75.0%
Provider Locations Offering an Appointment	78.7%	65.6%
Appointments Within Contract Standards	50.0%	54.2%

While 78.7 percent of Amerigroup’s contacted provider locations were able to offer an appointment date for a new Medicaid patient, only 50.0 percent of these appointment wait times were in compliance with contract standards for the applicable appointment type. Almost 90 percent of PCP respondents accepting new patients who were surveyed regarding routine appointments were able to offer an appointment within the contract standard, whereas approximately one-third of PCP respondents accepting new patients who were surveyed regarding appointments for urgent or persistent symptoms were able to offer an appointment within the contract standard.

For UnitedHealthcare, while 65.6 percent of the contacted provider locations were able to offer an appointment date for a new Medicaid patient, only 54.2 percent of these appointment wait times were in compliance with contract standards for the applicable appointment type. Almost 95 percent of PCP respondents accepting new patients who were surveyed regarding routine appointments were able to offer an appointment within the contract standard, whereas 41.9 and 28.9 percent of PCP respondents accepting new patients who were surveyed regarding appointments for persistent or urgent symptoms were able to offer an appointment within the contract standard, respectively.

Prepaid Ambulatory Health Plans

HSAG also conducted a network analysis for each PAHP that manages and delivers dental services to Medicaid members receiving dental coverage. The purpose of the network analysis was to evaluate the degree to which each PAHP had an adequate provider network to deliver dental services to its Medicaid members. Table 1-9 summarizes the results of the PAHP network analysis.

Table 1-9—Summary of PAHP Network Analysis

Provider Category	DDIA		MCNA	
	% of Members Within Standard	Standard Met (Y/N)	% of Members Within Standard	Standard Met (Y/N)
General Dentists	100%	Y	99.5%	N

The network analysis findings showed that 100 percent of DDIA members and over 99 percent of MCNA members had access to a general dentist within DHS’ time/distance standards. Provider ratio analyses and travel time/distance analyses results suggest that both PAHPs’ provider networks have the capacity to meet the needs of the Medicaid member populations for general dentists and oral surgeons. However, the analyses for endodontists, periodontists, and prosthodontists highlight the small volume of those providers currently included in the PAHPs’ networks.

CY 2017 Encounter Data Validation

Managed Care Organizations

HSAG conducted an administrative profile, or analysis, of DHS' electronic encounter data. The goal of the study was to examine the accuracy, completeness, and timeliness of DHS' encounter data with service dates between April 1, 2016, and December 31, 2016. The degree of data completeness and accuracy among the MCOs provided insight into the quality of DHS' overall encounter data system and represented the basis for establishing confidence in reporting and rate setting activities. As the results from CY 2017 were not available at the time the *Calendar Year 2017 External Quality Review Technical Report* was published, the results are presented in this year's CY 2018 report.

Amerigroup and UnitedHealthcare submitted generally complete and accurate encounter data for encounters with dates of service between April 1, 2016, and December 31, 2016. Amerigroup and UnitedHealthcare demonstrated opportunities for improvement regarding timely submission of encounter data to DHS, as the contract requirement for lag days between MCO payment dates and the Medicaid Management Information System (MMIS) date was not met. Additionally, UnitedHealthcare should work with DHS to ensure that all Diagnosis Related Group (DRG) codes for inpatient encounters are submitted to DHS.¹⁻³

CY 2018 Encounter Data Validation

Managed Care Organizations

During CY 2018, HSAG initiated a comparative analysis between DHS' electronic encounter data and the data extracted from the two MCOs' data systems along with technical assistance to the MCOs based on the findings. The goal of the comparative analysis was 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.

The 2018 encounter data validation (EDV) study was ongoing at the time of this report; therefore, Amerigroup's and UnitedHealthcare's results of the 2018 EDV study will be presented in the CY 2019 EQR Technical Report.

Prepaid Ambulatory Health Plans

HSAG also conducted a dental EDV study for DHS PAHPs. DHS and HSAG chose to conduct an information systems (IS) review with both PAHPs. The goal of the study was to examine the extent to which DHS and the PAHPs have appropriate system documentation and the infrastructure to produce,

¹⁻³ On March 26, 2018, DHS noted that UnitedHealthcare was verifying data corrections for missing DRG codes and working to provide the logic to ensure that DHS is mapping its encounters correctly when counting DRG-eligible payments versus per diem/fee-for-service (FFS) payments.

process, and monitor dental encounter data. Since CY 2018 was the first year that HSAG conducted the dental EDV study for DHS, an IS review was performed to examine the extent to which the PAHPs had appropriate system documentation and the infrastructure to produce, process, and monitor encounter data.

Based on contractual requirements and DHS' data submission requirements (e.g., companion guides), DDIA and MCNA had processes and procedures in place to document and guide the encounter data process. Additionally, based on its review, HSAG identified an opportunity for improvement that, once addressed, could improve the quality of the PAHPs' dental encounter data submission to DHS. DDIA and MCNA 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.

Calculation of Performance Measures

Managed Care Organizations

The MCOs submitted Healthcare Effectiveness Data and Information Set (HEDIS[®])¹⁻⁴ Interactive Data Submission System [IDSS] files for HEDIS 2018 (CY 2017). To assess MCO performance, HSAG compared the performance measure results to the National Committee for Quality Assurance's (NCQA's) Quality Compass¹⁻⁵ national Medicaid health maintenance organization (HMO) percentiles for HEDIS 2018. HSAG displayed results for 51 performance measure rates for CY 2017. 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. The performance measures calculated by HSAG were provided for information only to assist DHS in refining its approach to the future IA Health Link Scorecard; therefore, the results are not included in this report.

Calculation of Potentially Preventable Events

Managed Care Organizations

HSAG calculated potentially preventable events (PPEs) to assess current MCO performance and identify strengths and weaknesses for each MCO. HSAG calculated 12 measures related to potentially preventable inpatient admissions, ancillary services, and utilization of emergency departments (EDs). These rates will help support DHS and the MCOs in targeting and improving PPEs. HSAG calculated the PPE measure rates for the measurement period April 1, 2017–March 31, 2018, using administrative

¹⁻⁴ HEDIS[®] is a registered trademark of the National Committee for Quality Assurance (NCQA).

¹⁻⁵ Quality Compass[®] is a registered trademark of the NCQA.

data only. The PPEs calculated by HSAG were provided for information only to assist DHS in refining its approach to the future IA Health Link Scorecard; therefore, the results are not included in this report.

Scorecard

Managed Care Organizations

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 CAHPS survey results from the two Iowa 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 development; therefore, results are not included in this report.

Focused Study—Case Management

Managed Care Organizations

During CY 2017, DHS requested that HSAG conduct a one-time focused study review of MCO case management programs, which included a review of service plans maintained by MCOs for HCBS waiver members. Ten case files for each MCO were reviewed to evaluate compliance with the person-centered care planning requirements for members enrolled in Iowa’s Medicaid 1915(c) and 1915(i) programs. The requirements included in the study were selected by HSAG to reflect significant portions of the contract between DHS and Amerigroup. 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 this year’s CY 2018 report. The overall scores for the focused study are presented in Table 1-10.

Table 1-10—Summary of MCO Overall Focused Study Scores

Focused Study	Amerigroup	UnitedHealthcare
Person-Centered Care Planning: Overall Scores	50%	79%

For the cases included in the study, Amerigroup and UnitedHealth were 50 percent and 79 percent compliant, respectively, for the applicable contract requirements reviewed, indicating several opportunities for improvement. Across both MCOs, the areas with the greatest number of *No* findings were related to the person-centered planning process and service plan content requirements.

2. Introduction to the Annual Technical Report

Purpose of Report

As required by CFR 42 §438.364,²⁻¹ 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 quality improvement made by the EQRO during the previous year's EQR.

²⁻¹ 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: Apr 11, 2019.

Scope of 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—External Quality Review Activities—MCOs and Appendix B—External Quality Review Activities—PAHPs for a detailed description of each activity’s methodology.

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 referred to as standards.

Beginning this year (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 first year of the three-year cycle, which includes a review of four of the 13 standards.

As CY 2018 marked the first year HSAG has conducted compliance reviews for the PAHPs, DHS requested that HSAG conduct a full review of all 13 standards, which are presented in this report.

Validation of Performance Measures—The purpose of PMV is to assess the accuracy of performance measures reported by the MCOs and PAHPs and to determine the extent to which performance measures reported by the plans follow State specifications and reporting requirements.

DHS contracted with HSAG in 2018 to develop a set of state-defined performance measures to be calculated and reported by the MCOs for the July 1, 2017–June 30, 2018 measurement period. To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year (MY) July 1, 2017–June 30, 2018 and measurement year July 1, 2018–June 30, 2019 during the on-site PMV to be completed by HSAG in 2019. The final validation findings for both measurement years will be included in the CY 2019 EQR Technical Report.

DHS contracted with HSAG to conduct the PMV for each PAHP, validating the data collection and reporting processes used to calculate the performance measure rates. DHS identified a set of performance measures that the PAHPs are required to calculate and report. Measures are required to be reported following the specifications provided by DHS. DHS identified the measurement period as July 1, 2017–June 30, 2018.

Validation of Performance Improvement Projects—The MCOs and 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 2018 validation cycle. The results from the CY 2018 PIP validation are presented in this report.

Network Adequacy—HSAG conducted a secret shopper telephone survey of the MCOs’ PCPs. 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.

HSAG also conducted a network analysis for each PAHP that manages and delivers dental services to Medicaid members receiving dental coverage. The purpose of the network analysis was to evaluate the degree to which each PAHP had an adequate provider network to deliver dental services to its Medicaid members.

Optional Activities

CY 2017 Encounter Data Validation—HSAG conducted an administrative profile, or analysis, for DHS’ electronic encounter data. The goal of the study was to examine the accuracy, completeness, and timeliness of DHS’ encounter data with service dates between April 1, 2016, and December 31, 2016. The degree of data completeness and accuracy among the MCOs provided insight into the quality of DHS’ overall encounter data system and represented the basis for establishing confidence in reporting and rate setting activities. The administrative analysis included the following key steps:

- Development of a data submission requirements document for DHS
- Administrative profile

HSAG obtained the encounter data needed to conduct the administrative analysis from DHS. The results of the EDV study are presented in this report for two MCOs, although HSAG conducted the study for three MCOs.²⁻²

CY 2018 Encounter Data Validation—During CY 2018, HSAG initiated a comparative analysis between DHS’ electronic encounter data and the data extracted from the two MCOs’ data systems along with technical assistance to the MCOs based on the findings. The goal of the comparative analysis was 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. The 2018 EDV study was ongoing at the time of this report; therefore, Amerigroup’s and UnitedHealthcare’s results of the 2018 EDV study will be presented in the CY 2019 EQR Technical Report.

HSAG also conducted a dental EDV study for DHS’ PAHPs. DHS and HSAG chose to conduct an IS review with both PAHPs. The goal of the study was to examine the extent to which DHS and the PAHPs have appropriate system documentation and the infrastructure to produce, process, and monitor dental encounter data.

Calculation of Performance Measures—The IA Health Link MCOs submitted HEDIS IDSS files for HEDIS 2018 (CY 2017). To assess MCO performance, HSAG compared the performance measure results to the NCQA’s Quality Compass national Medicaid HMO percentiles for HEDIS 2018. HSAG

²⁻² Effective November 30, 2017, AmeriHealth Caritas withdrew from the IA Health Link Program.

displayed results for 51 performance measure rates for CY 2017. 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. The performance measures calculated by HSAG were provided for information only to assist DHS in refining its approach to the future IA Health Link Scorecard; therefore, the results are not included in this report.

Calculation of Potentially Preventable Events—HSAG calculated PPEs to assess current MCO performance and identify strengths and weaknesses for each MCO. HSAG calculated 12 measures related to potentially preventable inpatient admissions, ancillary services, and utilization of emergency departments (EDs). These rates will help support DHS and the MCOs in targeting and improving PPEs. HSAG calculated the PPE measure rates for the measurement period April 1, 2017–March 31, 2018, using administrative data only. The PPEs calculated by HSAG were provided for information only to assist DHS in refining its approach to the future IA Health Link Scorecard; therefore, the results are not included in this report.

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 CAHPS survey results from the 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 development; therefore, results are not included in this report.

Focused Study—Case Management—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. Ten case files for each MCO were reviewed to evaluate compliance with the person-centered care planning requirements for members enrolled in Iowa’s Medicaid 1915(c) and 1915(i) programs. The requirements included in the study were selected by HSAG to reflect significant portions of the contract between DHS and the MCOs. 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 this year’s CY 2018 report.

Organizational Structure of Report

Section 1—Executive Summary

This section of the report presents a summary of the EQR activities. The section also includes high-level findings and conclusions regarding the performance of each MCO and PAHP.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the scope of the EQRs activities and provides a brief description of each section's content.

Section 3—Overview of Iowa's Managed Care Program

This section of the report presents a brief description of the State's managed care program, services, regions, and populations. This section also presents a brief description of the State's quality initiatives.

Section 4—MCO-Specific Summary—Amerigroup Iowa, Inc.

This section presents Amerigroup-specific results for each of the mandatory and optional EQR activities. It includes an overall summary of Amerigroup's strengths and recommendations for improvement. Also included is an assessment of how effectively Amerigroup has addressed the recommendations for quality improvement made by HSAG during the previous year.

Section 5—MCO-Specific Summary—UnitedHealthcare Community Plan of the River Valley, Inc.

This section presents UnitedHealthcare-specific results for each of the mandatory and optional EQR activities. It includes an overall summary of the UnitedHealthcare's strengths and recommendations for improvement. Also included is an assessment of how effectively UnitedHealthcare has addressed the recommendations for quality improvement made by HSAG during the previous year.

Section 6—PAHP-Specific Summary—Delta Dental of Iowa

This section presents DDIA-specific results for each of the mandatory and optional activities. It includes an overall summary of DDIA's strengths and recommendations for improvement. As CY 2018 was the first year DHS contracted with HSAG to perform EQR activities for DDIA, future reports will also include an assessment of how effectively DDIA has addressed the recommendations for quality improvement made by HSAG during the previous year.

Section 7—PAHP-Specific Summary—Managed Care of North America Dental

This section presents MCNA-specific results for each of the mandatory and optional activities. It includes an overall summary of MCNA's strengths and recommendations for improvement. As CY 2018 was the first year DHS contracted with HSAG to perform EQR activities for MCNA, future reports will also include an assessment of how effectively MCNA has addressed the recommendations for quality improvement made by HSAG during the previous year.

Section 8—MCO Comparative Information

This section presents methodologically appropriate comparative information about all MCOs by activity. State-specific recommendations are also included if applicable.

Section 9—PAHP Comparative Information

This section presents methodologically appropriate comparative information about all PAHPs by activity. State-specific recommendations are also included if applicable.

Appendix A—External Quality Review Activities—MCOs

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the MCOs.

Appendix B—External Quality Review Activities—PAHPs

This section of the report presents the objective(s), technical methods of data collection and analysis, and a description of the data obtained (including the time period to which the data applied) for each mandatory and optional activity for the PAHPs.

3. Overview of Iowa’s Managed Care Program

Iowa Medicaid Managed Care Service Delivery Overview

The IME is the division of DHS that administers the Iowa Medicaid program. 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 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 were offered through the Hawki program, the State’s CHIP.

Managed Care Organizations

DHS held contracts with two MCOs during the review period for this annual report. Each MCO provides for the delivery of healthcare services to enrolled IA Health Link members.

Table 3-1—Overview of Iowa MCOs

MCO	Total Enrollment ^{3-1,3-2}	Covered Services ³⁻³	Service Area
Amerigroup	196,164	<ul style="list-style-type: none"> Preventative Services Professional Office Services Inpatient Hospital Admissions 	Statewide
UnitedHealthcare	426,745	<ul style="list-style-type: none"> Inpatient Hospital Services Outpatient Hospital Services Emergency Care Behavioral Health Services Outpatient Therapy Services 	

³⁻¹ Iowa Medicaid Enterprise. *Managed Care Organization Report: SFY 2019, Quarter 1 (July–September) Performance*. Date published on January 7, 2019. Available at:

https://dhs.iowa.gov/sites/default/files/SFY19_Q1_Report_0.pdf?011420191946. Accessed on: Apr 11, 2019.

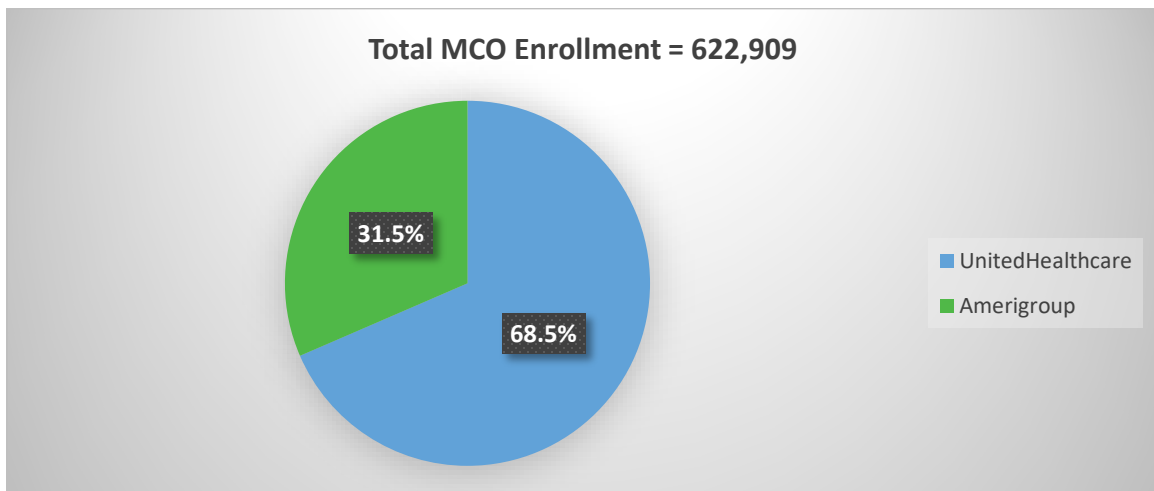
³⁻² September 2018 enrollment data as of October 31, 2018—data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

³⁻³ 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: Apr 11, 2019.

MCO	Total Enrollment ^{3-1,3-2}	Covered Services ³⁻³	Service Area
		<ul style="list-style-type: none"> • Prescription Drug Coverage • Radiology Services • Laboratory Services • Durable Medical Equipment (DME) • LTSS—Community Based • LTSS—Institutional • Hospice • Health Homes 	

As of September 2018, 622,909 members were enrolled in the two MCOs. The figure below outlines the total MCO enrollment distribution.

Figure 3-1—MCO Enrollment Distribution^{3-4,3-5}



³⁻⁴ Iowa Medicaid Enterprise. *Managed Care Organization Report: SFY 2019, Quarter 1 (July–September) Performance*. Date published on January 7, 2019. Available at:

https://dhs.iowa.gov/sites/default/files/SFY19_Q1_Report_0.pdf?011420191946. Accessed on: Apr 11, 2019.

³⁻⁵ September 2018 enrollment data as of October 31, 2018—data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Prepaid Ambulatory Health Plans

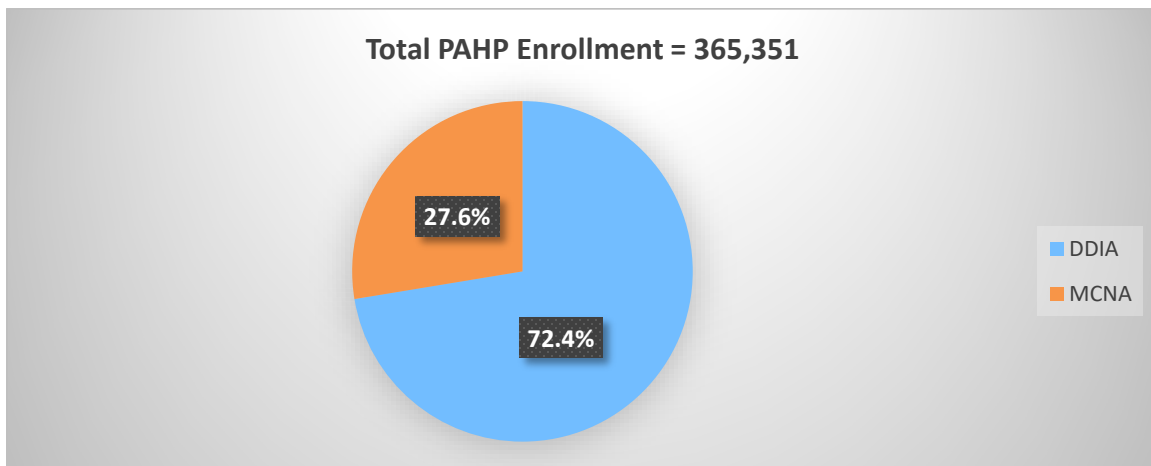
DHS held contracts with two PAHPs during the review period for this annual report. The PAHPs manage the delivery of dental healthcare services to enrolled DWP members.

Table 3-2—Overview of Iowa PAHPs

MCO	Total Enrollment ^{3-6,3-7}	Covered Services ³⁻⁸	Service Area
DDIA	264,507	<ul style="list-style-type: none"> • Diagnostic and Preventative Services (exams, cleanings, x-rays, and fluoride) • Fillings for Cavities • Surgical and Non-Surgical Gum Treatment • Root Canals • Dentures and Crowns • Extractions 	Statewide
MCNA	100,844		

As of January 2019, 365,351 members were enrolled in the two PAHPs. The figure below outlines the total PAHP enrollment distribution.

Figure 3-2—PAHP Enrollment Distribution^{3-9,3-10}



³⁻⁶ Enrollment data provided by DHS on February 27, 2019.

³⁻⁷ DDIA’s enrollment data include 54,385 members enrolled in the Hawki program.

³⁻⁸ 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 preventative 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>.

³⁻⁹ Enrollment data provided by DHS on February 27, 2019.

³⁻¹⁰ DDIA’s enrollment data include 54,385 members enrolled in the Hawki program.

Quality Initiatives Driving Improvement

The Iowa Medicaid Managed Care Quality Assurance System³⁻¹¹ outlines DHS' strategy for assessing and improving the quality of managed care services offered by its contracted MCOs using a triple aim framework. The triple aim goal is to improve outcomes, improve patient experience, and ensure that Medicaid programs are financially sustainable. In alignment with the triple aim framework and efforts to modernize Iowa's Medicaid program, each MCO participates in value-based purchasing activities that effectively move the healthcare system from volume to value and increase cross sector engagement in population health improvement. 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:

- Promote appropriate utilization of services within acceptable standards of medical practice.
- Ensure access to cost-effective healthcare through contract compliance by:
 - Timely review of managed care network adequacy reports.
 - Incentivizing high performance in national Children's Access to Care and Adult Access to Care measures through financial incentives.
- Comply with State and federal regulatory requirements through the development and monitoring of quality improvement policies and procedures by:
 - Annually reviewing and providing feedback on managed care quality strategies.
 - Quarterly reviewing managed care organization quality meeting minutes.
- Reduce healthcare costs while improving quality by the end of 2019 by:
 - Increasing provider participation and covered lives in accountable care organizations to 50 percent.
 - Decreasing total cost of care 15 percent below trend.
 - Reducing the rate of potentially preventable readmissions and potentially preventable emergency department (ED) visits both by 20 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.
- Provide care coordination to members based on health risk assessments (HRAs) by:
 - Quarterly monitoring of 70 percent initial HRA completion within 90 days of enrollment.
- Ensure that transitions of care do not have adverse effects by:
 - Maintaining historical utilization file transfers between DHS and MCOs include the information needed to effectively transfer members.

³⁻¹¹ 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: Apr 23, 2019.

- Monitoring community rebalancing to ensure that members choosing to live in the community remain in the community.
- Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist MCOs with implementation of improvement strategies through:
 - Chartering a collaborative quality management committee that meets at least quarterly.
 - Regularly monitoring health outcomes measure performance.
- Ensure data collection of race and ethnicity, as well as aid category, age, and gender to develop meaningful objectives for improvement in preventive and chronic care by focusing on specific populations. The income maintenance worker collects race and ethnicity as reported by the individual on a voluntary basis during the eligibility process.
- Promote the use and interoperability of health information technology between providers, MCOs, and Medicaid.

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

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

DHS conducted a review of the health home program and convened a workgroup for stakeholder engagement and feedback to identify areas of opportunity for the program. It was identified that further review of the program is needed and will be completed. DHS and the MCOs also plan to restart the Learning Collaborative and create one chart audit tool and guide to increase interrater reliability (IRR) during on-site and desk reviews.

Increased Access to Medication Assisted Therapy (MAT)

DHS has issued informational letters regarding the coverage of MAT and has adopted two additional codes for physician-administered buprenorphine. DHS has also participated in an Iowa Department of Public Health sponsored workgroup to address the reimbursement of substance abuse disorder residential and intensive outpatient services in order to make recommendations regarding reimbursement to the legislature.

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

As the State Innovation Model (SIM) test grant has matured into its fourth and final year, DHS has continued to refine its approach to a value-based purchasing (VBP) strategy through its Medicaid managed care plans. The 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. Additionally, emphasis has 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.

Build of Data Lake and Improved Reporting

A data lake is being constructed to boost analytic capability generally, but also as a way to integrate the results of MCO screening tools (including SDOH data) with claims and other data sets in order to expand the view into population health trends to inform program management. The data lake is part of a broader effort to overhaul the DHS' data warehouse to both modernize technology to allow for better insight and to drill into how the Medicaid program is performing. This, in turn, is part of the overall plan to modernize the Medicaid information technology (IT) ecosystem consistent with CMS' Medicaid Information Technology Architecture (MITA) philosophy and modular approach; this will move DHS away from many of the current analytic constraints that are tied to decades of a FFS mainframe, Medicaid Management Information System (MMIS), environment that rigidly informed a similar data warehouse structure. The move to a full managed care environment has exposed the limitations of that structure and made addressing it a strategic priority with respect to quality oversight.

4. MCO-Specific Summary—Amerigroup Iowa, Inc.

Activity Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for Amerigroup. It provides a discussion of Amerigroup’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 Amerigroup has addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix A—External Quality Review Activities—MCOs.

Compliance Monitoring

Findings

Review of Standards

Table 4-1 presents a summary of Amerigroup’s performance results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed. If a requirement was not applicable to Amerigroup during the period covered by the review, HSAG used a *Not Applicable (NA)* designation.

Table 4-1—Summary of Standard Compliance Scores for Amerigroup

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Availability of Services	21	21	20	1	0	95%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	100%
IX	Grievances, Appeals, and State Fair Hearings	44	44	42	2	0	95%
XII	Quality Assessment and Performance Improvement	12	12	11	1	0	92%
Total		80	80	76	4	0	95%

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: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Checklist Review

HSAG reviewers assigned scores to each element within a checklist review tool. Table 4-2 presents scores for the checklist used to evaluate Amerigroup’s compliance with State and federal requirements related to Quality Management/Quality Improvement (QM/QI) program requirements.

Table 4-2—Summary of Checklist Compliance Scores for Amerigroup

Associated Standard	Description of Material Reviewed	Total Applicable Elements	Number of Elements			Total Compliance Score
			Y	N	NA	
XII	QM/QI Program	19	18	1	0	95%
Total		19	18	1	0	95%

Y = Yes; N = No; NA = Not Applicable

Total Applicable Element—The total number of elements within each standard minus any elements that received designation of *N/A*.

Total Compliance Score—Elements that were scored as Y 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.

Case File Reviews

HSAG reviewers further assigned scores to each element within the file review tools. Table 4-3 presents scores for the file reviews used to evaluate Amerigroup’s compliance with State and federal requirements related to the processing of grievances and appeals.

Table 4-3—Summary of File Review Compliance Scores for Amerigroup

Associated Standard	Description of Files	Total Applicable Element	Number of Elements			Total Compliance Score
			Y	N	NA	
IX	Grievances	40	40	0	40	100%
IX	Appeals	68	67	1	42	99%
Total		108	107	1	82	99%

Strengths and Opportunities for Improvement

Of the 80 applicable elements identified in Table 4-1, Amerigroup received *Met* scores for 76 elements, with a total compliance score of 95 percent. The findings suggest that Amerigroup developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with Amerigroup staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

Of note, Amerigroup achieved full compliance in one of the four standards reviewed; Standard II—Assurances of Adequate Capacity and Services findings demonstrated that Amerigroup had processes in place to ensure the accessibility and adequacy of its provider network.

Amerigroup also demonstrated strong performance related to the processing and implementation of grievance and appeal files. The results of the case file reviews displayed in Table 4-3 suggest that Amerigroup operationalized and followed the policies it developed for the required elements of the contract. Amerigroup demonstrated compliance in 107 of 108 applicable elements, with a compliance score of 99 percent.

For Standard I—Availability of Services, Amerigroup had processes in place to inform providers of and monitor appointment time access standards for all but one provider type as required by its contract with DHS. Amerigroup contracted with SuperiorVision for the provision of optometry services. Documentation did not support that either Amerigroup or SuperiorVision informed optometry providers of the appointment standard for urgent care or monitored provider compliance with this standard.

While overall demonstrating strong performance in the case file reviews, two opportunities for improvement were identified for Standard IX—Grievances, Appeals, and State Fair Hearings. Amerigroup staff members stated that an oral appeal that is not followed up with a written, signed appeal within 10 days of the oral appeal would be dismissed. According to the supplemental information (preamble) that accompanied the final rule of the Medicaid managed care regulations,^{4,1} CMS disagreed that all oral appeals be closed within 10 calendar days if no written, signed follow-up is received and specified that managed care plans should treat oral appeals in the same manner as written appeals. Additionally, the appeal case file review identified one expedited appeal that did not include any documentation to support that reasonable efforts were made to provide oral notice of resolution.

As displayed in Table 4-2, of the 19 elements reviewed for the QM/QI checklist, Amerigroup received compliant scores for 18 elements. Overall, Amerigroup received a compliance score of 95 percent, with one opportunity for improvement. Specifically, Amerigroup's QM/QI program did not include mechanisms to monitor the prescribing patterns of psychotropic medication to children, including children in foster care. This finding was presented and scored in Standard XII—Quality Assessment and Performance Improvement.

In response to the CY 2018 compliance review findings, Amerigroup was required to submit a corrective action plan to DHS for each element scored as *Not Met*.

Recommendations for Improvement

- HSAG recommends that Amerigroup develop and implement mechanisms to ensure that general optometry service appointment times do not exceed 48 hours for urgent care services.
- Amerigroup must ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. HSAG recommends 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 the requirement that an oral appeal must be followed by a written, signed appeal, HSAG recommends

^{4,1} Department of Health and Human Services, Centers for Medicare & Medicaid Services. Federal Register: Vol. 81, No. 88; Friday, May 6, 2016/Rules and Regulations: 27511.

that Amerigroup monitor the proposed rulemaking and implement actions as appropriate when the proposed changes are finalized.

- HSAG recommends that Amerigroup implement mechanisms to ensure that reasonable efforts are made to provide members oral notice of resolution of expedited appeals. These efforts should be documented.
- Amerigroup must monitor the prescribing patterns of psychotropic medication to children, including children in foster care. HSAG recommends that Amerigroup develop ongoing processes to analyze and compare medication utilization for children in foster care with the child population in general. Results from this analysis should drive quality initiatives to promote evidence-based treatment planning, medication utilization, and medication monitoring.
- Amerigroup should further incorporate 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 show 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.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 compliance monitoring review activity, Amerigroup received seven recommendations for improvement across three standards. Table 4-4 below presents the prior recommendations made by HSAG during CY 2017 as well as Amerigroup’s response to those recommendations.

Table 4-4—Compliance Monitoring—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
Standard I—Availability of Services	
Develop a standardized process to monitor wait times once a member presents at a service delivery site for behavioral health providers as required by contract.	Completed. Behavioral health providers were added to the standard process. Providers are informed of the access standards at the time of contracting. The providers are also informed of the requirements through the Provider Manual and reminders sent to providers. The appointment availability survey is conducted each quarter, and those providers who do not score satisfactorily are contacted by the Provider Solutions Department for corrective actions. The Access to Care Standards Iowa policy outlines these requirements.
Implement a standardized process to monitor compliance with appointment standards for all provider types outlined in contract.	Completed. All provider types were added to the standard process. We have an established a state-approved process to monitor providers and ensure

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
	compliance with appointment standards for all provider types. We have provided the 2018 Q3 appointment access survey report as an example of the survey process we utilize. Our Desktop Process and correction action plan letters further describe the process.
Implement a process to communicate findings and require corrective action when providers are found to be noncompliant with access standards.	Completed. The communication of findings and required corrective actions has been implemented. We conduct quarterly surveys and send corrective action plan letters to providers where issues are found. The Desktop Process and corrective action plan letters demonstrate this process. The corrective action plan letter has been approved by the State.
Standard III—Coordination and Continuity of Care	
Implement processes to provide primary care providers (PCPs) a copy of member care plans.	Completed. Processes are in place to provide PCPs a copy of member care plans.
Standard IX—Grievances, Appeals, and State Fair Hearings	
Ensure transportation-related grievances are fully resolved prior to closure of the grievance.	Implemented. Transportation grievances are resolved prior to closure of the grievance. We revised our procedures regarding transportation grievances necessitating the involvement and information from our transportation vendor. Effective October 2017 grievances are not closed and formally resolved with the member until such time as we have obtained all needed information and confirmation of resolution from the transportation vendor.
Obtain member written consent when a provider files an expedited appeal on behalf of the member.	Implemented. Following the 2017 audit, the State developed the uniform state Authorized Representative for Managed Care Appeals form. As the State now requires this form to be used, this has significantly increased the timeliness and compliance of member consent being obtained and provided to the MCO when appeals are filed, and we consider it no longer an issue. The State form number is 470-5526.
Ensure appeal resolution letters are consistently written in easily understood language.	Implemented. Training was conducted following the 2017 audit and continues on an ongoing basis. The topic of “readability” is covered during monthly Grievance and Appeals staff meetings. In addition, “Readability” is a standard in an NCQA requirement, and we monitor and train through our accreditation department also. For example, company medical directors were provided resources on writing easy-to-understand decisions.

Validation of Performance Measures

To initiate the CY 2018 PMV activity, HSAG, in collaboration with DHS, developed Iowa-specific performance measures and associated measure specifications that focus on person-centered care planning for those served in HCBS programs. To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year July 1, 2017–June 30, 2018, and measurement year July 1, 2018–June 30, 2019, during the on-site PMV to be completed by HSAG in 2019. The final validation findings for both measurement years will be included in the CY 2019 EQR Technical Report.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 PMV activity, Amerigroup received one recommendation. Table 4-5 below presents the prior recommendations made by HSAG during CY 2017 as well as Amerigroup’s response to those recommendations.

Table 4-5—PMV—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
<p>HSAG recommends that Amerigroup work closely with DHS to confirm understanding and expectations related to specifications for each performance measure provided by DHS. HSAG also recommends that Amerigroup maintain member-level detail data for all reported measures. This will allow Amerigroup not only to conduct additional edit checks on the quality and accuracy of the data but also to have supporting documentation for measure rate validation.</p>	<p>Amerigroup works closely with DHS to confirm the understanding and expectations regarding performance measures. We attend monthly DHS MCO reporting meetings in addition to conference calls on an as-needed basis. We now maintain member-level data for reported performance measures. Amerigroup did have discussions with DHS about the data maintained for all regulatory reports.</p>

Validation of Performance Improvement Projects

Findings

HSAG’s validation evaluated the technical methods of each PIP (i.e., the study design, and data analysis and implementation). Based on its technical review, HSAG determined the overall methodological validity of each PIP. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, Amerigroup received a *Met* score for 88 percent of applicable evaluation elements and an overall *Partially Met* validation status when originally submitted. For the *Member Satisfaction* PIP, Amerigroup received a *Met* score for 84 percent of the applicable evaluation elements and an overall *Partially Met* validation status when originally submitted. Amerigroup had the opportunity to receive technical assistance, incorporate HSAG’s recommendations, and resubmit the PIPs for final validation. Upon final validation, both PIPs received a *Met* score for 100 percent of the applicable evaluation elements and an overall *Met* validation status.

Table 4-6 illustrates the validation scores for both the initial submission and resubmission.

Table 4-6—2018 PIP Validation Results for Amerigroup

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
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Submission	88%	89%	<i>Partially Met</i>
	Resubmission	100%	100%	<i>Met</i>
<i>Member Satisfaction</i>	Submission	84%	89%	<i>Partially Met</i>
	Resubmission	100%	100%	<i>Met</i>

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 non-critical) 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 4-7 displays the validation results for Amerigroup’s PIPs evaluated during 2018. This table illustrates Amerigroup’s overall application of the PIP process and success in implementing the PIPs. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 4-7 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 4-7—Performance Improvement Projects Validation Results by Step for Amerigroup

Stage	Step		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (4/4)	0% (0/4)	0% (0/4)
	II.	Clearly Defined, Answerable Study Question(s)	100% (2/2)	0% (0/2)	0% (0/2)
	III.	Correctly Identified Study Population	100% (2/2)	0% (0/2)	0% (0/2)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI.	Accurate/Complete Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (22/22)	0% (0/22)	0% (0/22)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (6/6)	0% (0/6)	0% (0/6)
	VIII.	Appropriate Improvement Strategies	100% (7/7)	0% (0/7)	0% (0/7)
Implementation Total			100% (13/13)	0% (0/13)	0% (0/13)
Outcomes	IX.	Real Improvement Achieved	<i>Not Assessed</i>		
	X.	Sustained Improvement Achieved	<i>Not Assessed</i>		
Outcomes Total			<i>Not Assessed</i>		
Percentage Score of Applicable Evaluation Elements Met			100% (35/35)		

Strengths and Opportunities for Improvement

For this year’s 2018 validation, Amerigroup’s PIPs received *Met* validation scores for 100 percent for all evaluation elements validated, demonstrating that no opportunities for improvement were identified. The performance on these PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps I through VIII).

Recommendations for Improvement

- Amerigroup should address 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 be reviewed, and related information should be included in the next annual submission.

- Amerigroup must ensure decisions to continue, revise, or discontinue an intervention are data driven. The supporting data and rationale must be included in Step VIII of the PIP Submission Form.
- Amerigroup should evaluate each intervention to determine its effectiveness and ensure each intervention is logically linked to identified barriers.
- Amerigroup should reference the PIP Completion Instructions annually to ensure all requirements for each completed step have been addressed.
- Amerigroup should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 PIP validation activity, Amerigroup received three recommendations. Table 4-8 below presents the prior recommendations made by HSAG during CY 2017 as well as Amerigroup’s response.

Table 4-8—PIP Validation—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
Amerigroup should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or failure modes and effects analysis (FMEA) to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.	Implemented. This was demonstrated in the CY 2018 PIPs. Please see the 2018 Performance Improvement Projects Validation Report, October 2018.
Amerigroup should develop active, innovative interventions that can directly impact the study indicator outcomes.	Implemented. This was demonstrated in the CY 2018 PIPs. Please see the 2018 Performance Improvement Projects Validation Report, October 2018.
Amerigroup should develop a process to evaluate the effectiveness of each individual intervention. The results of the intervention evaluation should drive Amerigroup’s decision to continue, revise, or discontinue the intervention.	Implemented. This was demonstrated in the CY 2018 PIPs. Please see the 2018 Performance Improvement Projects Validation Report, October 2018.

Network Adequacy

Findings

The secret shopper survey results include the percentage of provider locations that could be reached, the percentage of provider locations accepting new patients, the number of calendar days to the first available appointment, and whether the time to the first available appointment was within the contract standard for the pertinent appointment type.

Figure 4-1 shows the survey response rate regarding whether provider locations (cases) were able to be contacted. A case was considered a “non-respondent” if HSAG callers were unable to contact the office (i.e., the telephone number was disconnected, or the caller was unable to speak with the provider’s office after two call attempts). The figure also shows the response rates related to a case’s status as a PCP, participation with the MCO, and acceptance of new Medicaid patients.

Figure 4-1—Amerigroup Survey Response Rates

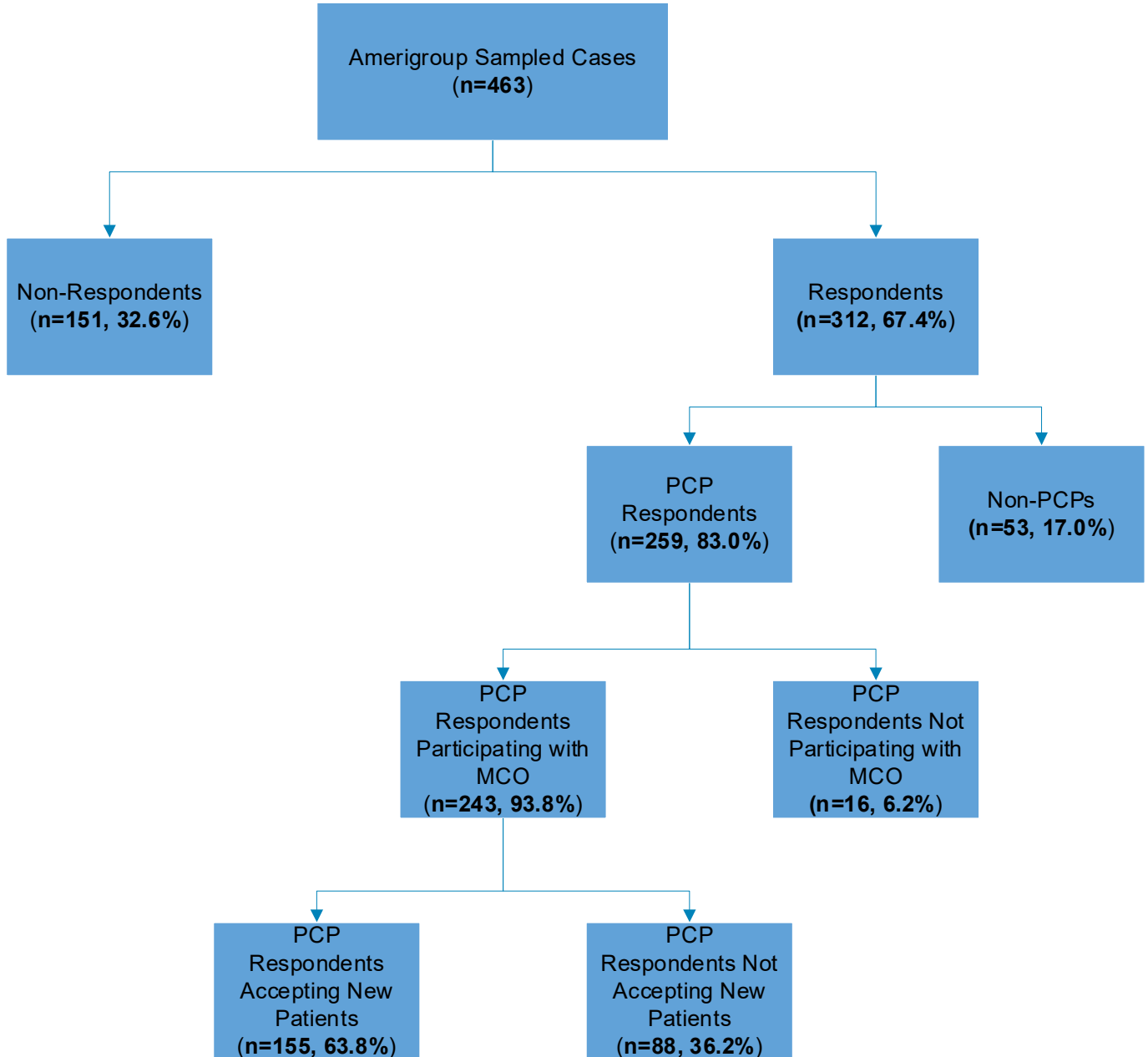


Table 4-9 reports the number and percentage of provider locations offering an appointment date with the sampled provider and location by the requested appointment type (i.e., routine, urgent symptoms, or persistent symptoms), and whether the resulting appointment information met contract standards for the requested appointment type.

Table 4-9—Amerigroup New Patient Appointment Wait Time in Calendar Days—by Visit Type

Appointment Type	Provider Locations Offering an Appointment			Appointment Wait Time in Calendar Days				Appointments Within the Contract Standard ¹		
	N ²	#	%	Min	Max	Median	Average	N ³	#	%
Routine Well-Check	53	36	67.9	0	83	13.5	18.7	36	32	88.9
Persistent Symptoms	57	47	82.5	0	120	5.0	17.0	47	16	34.0
Urgent Symptoms	45	39	86.7	0	77	4.0	10.0	39	13	33.3
Amerigroup	155	122	78.7	0	120	6.0	15.2	122	61	50.0

¹ The contract standard for routine appointments is six weeks, or 42 calendar days. The contract standard for appointments among Medicaid members with persistent symptoms (e.g., a persistent cough) is two calendar days. The contract standard for appointments among Medicaid members with urgent symptoms (e.g., a sore throat with a fever) is one calendar day.

² The denominator is the number of provider locations contacted for an appointment that indicated they were PCPs contracted with Amerigroup and were accepting new patients.

³ The denominator is the number of provider locations that offered appointment availability for a new Medicaid member.

Provider locations may have been unable to offer appointment information for a variety of reasons, and limitations related to providers’ office processes (e.g., providers who require pre-registration with the practice or office prior to scheduling an appointment) may affect members’ access even when these limitations are not communicated to members via provider directories. Thirty-three provider locations were unable to offer appointment information, and common limitations included, but were not limited to, the following:

- The provider location required the patient to pre-register with the office or practice prior to scheduling an appointment.
- The provider needed to review a new patient’s medical records prior to scheduling an appointment.
- Office staff members were unable to access a scheduling calendar without the member completing a questionnaire or providing personal information (e.g., a Social Security number (SSN) or date of birth).
- The provider location only offered walk-in services and could not guarantee that the caller could be seen by the sampled provider.

Strengths and Opportunities for Improvement

While 78.7 percent of the contacted provider locations were able to offer an appointment date for a new Medicaid patient, only 50.0 percent of these appointment wait times were in compliance with contract standards for the applicable appointment type. Almost 90 percent of PCP respondents accepting new patients who were surveyed regarding routine appointments were able to offer an appointment within the contract standard.

Low compliance for appointment timeliness related to urgent or persistent symptoms represented an opportunity for improvement but also may have resulted from the stringent contract requirements under which Iowa providers are expected to see these patients (i.e., one or two days, respectively). Almost one-quarter of provider locations requested that callers take additional actions prior to appointment scheduling. 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 for Improvement

- Amerigroup should demonstrate 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 work with its contracted providers to confirm providers’ awareness of the different appointment availability standards.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 network adequacy activity, Amerigroup received two recommendations. Table 4-10 below presents the prior recommendations made by HSAG during CY 2017 as well as Amerigroup’s response to those recommendations.

Table 4-10—Network Adequacy—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
Collaborate with DHS to define and standardize the provider category definitions to clarify the provider types and specialties that fall under each provider category.	DHS and the MCOs worked together to create a crosswalk that clarifies the provider types and specialties that fall under each provider category for DHS and the MCOs. However, there has not been work to standardize the provider categories.
Conduct a review of the provider categories that did not meet the access standards and strengthen access to those provider categories by expanding the provider network. Additionally, collaborate with DHS to assess if alternate access standards are required for these provider types.	Completed. These categories are continually reviewed in collaboration with DHS.

CY 2017 Encounter Data Validation

Findings

Encounter Data Completeness

HSAG assessed encounter data completeness in three focus areas: (1) record counts by MMIS month, (2) visit/service counts by service month, and (3) paid amounts by service month. Below are Amerigroup's findings for each area.

- The Amerigroup distribution for record counts by MMIS month was generally consistent.
- The visit/service counts by service month for inpatient and long-term care (LTC) data were relatively stable over time.
- The paid amounts by service month generally showed a similar trend to those for the visit/service counts by service month.

Encounter Data Timeliness

HSAG used two measures to evaluate the timeliness of encounter data submission. One measure evaluates the lag days between the date of service and the MMIS date (i.e., date when records are processed by MMIS). The other measure is based on the lag days between the MCO payment dates and the MMIS date. Below are Amerigroup's findings for each measure.

- The lag days between the service date and the MMIS date metric are important as they show how soon DHS may use the encounter data in MMIS for activities such as performance measure calculation and utilization statistics. To obtain 90 percent of the visits/services from Amerigroup for utilization statistics, DHS must wait four months for pharmacy services; about eight months for inpatient, Healthcare Financing Administration (HCFA) 1500, and waiver visits; and more than 10 months for LTC and outpatient encounters.
- For pharmacy and LTC encounters, more than 43 percent of the records were submitted to MMIS within 30 days of the MCO payment date. Additionally, more than 65 percent and 87 percent were submitted to MMIS within 60 days and 90 days of the MCO payment date, respectively, for all encounter types.

Field-Level Encounter Data Completeness and Accuracy

To determine the completeness and accuracy of Amerigroup's encounter data, HSAG evaluated each key data element for the following metrics:

- Percent Present: The required data fields are present on the file and contain information.
- Percent with Valid Values: The values are the expected values.

Overall, the majority of Amerigroup's key data elements were generally both complete and accurate.

Strengths and Opportunities for Improvement

Amerigroup submitted generally both complete and accurate encounter data when evaluating record counts by MMIS month, visit/service counts by service month, and paid amounts by service month. Amerigroup often met or exceeded the statewide rate⁴⁻² for each key data element for field-level completeness and accuracy.

Based on the overall rates for the study period, Amerigroup did not meet the contract requirement for lag days between the MCO payment dates and the MMIS date. However, the monthly timeliness results between April 2016 and June 2017 showed that Amerigroup was improving on this measure.

Recommendations for Improvement

- Amerigroup should ensure timely submission of encounters to meet the contract requirement for lag days between the MCO payment dates and the MMIS date.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 was the first year this the EDV activity, there are no prior recommendations.

CY 2018 Encounter Data Validation

HSAG obtained encounter data needed to conduct a comparative analysis between DHS' electronic encounter data and the data extracted from Amerigroup's data systems. The CY 2018 EDV study was ongoing at the time of this report; therefore, Amerigroup's results of the 2018 EDV study will be presented in the CY 2019 EQR Technical Report.

Focused Study—Case Management

Findings

Ten case files were reviewed to evaluate Amerigroup's compliance with the person-centered care planning requirements. Table 4-11 summarizes the scores by each section reviewed and includes overall findings related to the person-centered care planning requirements. The sections were selected by HSAG to reflect significant portions of the contract between DHS and the MCOs. As displayed below, Amerigroup was 50 percent compliant with the contract requirements reviewed for this study.

⁴⁻² The statewide rates were based on results from Amerigroup, AmeriHealth Caritas Iowa, Inc. (AmeriHealth), and UnitedHealthcare.

Table 4-11—Person-Centered Care Planning Requirements—Overall Scores for Amerigroup*

Section	Number of Questions in Section	Number Yes	Number No	Number NA	Percentage Compliant**
Service Plan Development Frequency	2	15	5	0	75%
Provision of Services	2	2	10	8	17%
Service Plan Development: Person-Centered Planning Process	7	20	46	4	30%
Service Plan Content	10	51	44	5	54%
Service Plan Content: Emergency Plan	2	14	6	0	70%
Service Plan Content: Supported Community Living	1	0	1	9	0%
Case Management Contact Guidelines	2	15	5	0	75%
Overall: Person-Centered Care Planning Focused Study—All Results for Amerigroup	26	117	117	26	50%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO’s membership as a whole.

** Percentage Compliant is the percentage of compliant elements excluding any *NA* cases.

Strengths and Opportunities for Improvement

Amerigroup’s highest-scoring areas addressed requirements related to Service Plan Development Frequency and Case Management Contact Guidelines, both receiving an overall score of 75 percent. Overall, Amerigroup achieved 100 percent scores in two program areas which included the following:

- Service plans included evidence of an emergency plan.
- Case managers conducted face-to-face visits with members in their residence within the last quarter.

Opportunities for improvement were identified in each of the seven sections. The two largest sections and subsequently the areas with the greatest number of *No* findings (90 of 117 *No* findings) addressed requirements related to the Person-Centered Planning Process and Service Plan Content requirements. Within these two sections, program requirements with less than a 50 percent score were related to the following requirements:

- The person-centered planning process included people chosen by the member.
- The team lead was chosen by the member; or alternatively, if the member elected not to exercise this choice, the team made the decision regarding who would serve as the lead.
- The person-centered planning process occurred at a time and location that was convenient for the member.
- Alternative HCBS settings were considered by the member.

- The service plan reflected the services and supports, both paid and unpaid, that will assist the individual to achieve identified goals; the frequency of services; and the providers of those services and supports, including natural supports.
- The service plan contained all signatures of individuals and providers responsible for its implementation.
- A copy of the service plan was provided to all people involved in the plan.

Recommendations for Improvement

- Amerigroup could consider 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 could consider 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 has been fully implemented, Amerigroup could consider conducting a self-evaluation to determine if the revised format led to improved documentation and performance.

Assessment of Follow-Up on Prior Recommendations

The Focused Study—Case Management activity was a one-time study completed by HSAG at the request of DHS; therefore, there are no prior recommendations.

MCO Enrollee Survey

While not a CY 2018 activity, DHS contracted with HSAG in CY 2017 to perform a review and validation of Amerigroup’s Enrollee and Provider Surveys, specifically the Iowa Participant Experience Survey (IPES). Amerigroup was required, as a part of its contract, to administer the IPES to members in the HCBS program and was given the freedom to modify the survey, as needed. The IPES instrument is a customized survey instrument that used the CAHPS HCBS survey as a guideline.

Assessment of Follow-Up on Prior Recommendations

Table 4-12 below presents the prior recommendations made by HSAG during CY 2017 as well as Amerigroup’s response to HSAG’s recommendations.

Table 4-12—MCO Enrollee Survey—Prior Recommendations and Amerigroup’s Response

Prior Recommendations (CY 2017)	Amerigroup’s Response to Recommendations
<p>HSAG highly recommends that the IPES be administered by a third-party survey vendor. Survey vendors with survey administration expertise and analysis proficiency are recommended and preferred for a smooth survey administration and accurate analysis of the results. In addition to using a third-party vendor, HSAG recommends that the data coding process be standardized. Standard disposition codes should be developed that allow for the identification of completed surveys, ineligible members, and refusals.</p>	<p>Amerigroup does not utilize a third-party survey vendor for this particular survey. Due to the unique needs of the members, we feel we are able to better answer the members’ questions during the survey. We have also learned through experience that during the course of the survey and following, members have questions about our services and we are able to answer in the moment.</p> <p>The disposition codes are standardized to indicate how many completed, refused, and those who may have termed.</p>

5. MCO-Specific Summary—UnitedHealthcare Community Plan of the River Valley, Inc.

Activity Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for UnitedHealthcare. It provides a discussion of UnitedHealthcare’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 UnitedHealthcare has addressed the recommendations for quality improvement made by HSAG during the previous year. The methodology for each activity can be found in Appendix. A—External Quality Review Activities—MCOs.

Compliance Monitoring

Findings

Review of Standards

Table 5-1 presents a summary of UnitedHealthcare’s performance results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed. If a requirement was not applicable to UnitedHealthcare during the period covered by the review, HSAG used a *Not Applicable (NA)* designation.

Table 5-1—Summary of Standard Compliance Scores for UnitedHealthcare

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Availability of Services	21	21	21	0	0	100%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	100%
IX	Grievances, Appeals, and State Fair Hearings	44	44	41	3	0	93%
XII	Quality Assessment and Performance Improvement	12	12	12	0	0	100%
Total		80	80	77	3	0	96%

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: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Checklist Review

HSAG reviewers assigned scores to each element within a checklist review tool. Table 5-2 presents scores for the checklist used to evaluate UnitedHealthcare’s compliance with State and federal requirements related to QM/QI program requirements.

Table 5-2—Summary of Checklist Compliance Scores for UnitedHealthcare

Associated Standard	Description of Material Reviewed	Total Applicable Elements	Number of Elements			Total Compliance Score
			Y	N	NA	
XII	QM/QI Program	19	19	0	0	100%
Total		19	19	0	0	100%

Y = Yes; N = No; NA = Not Applicable

Total Applicable Element—The total number of elements within each standard minus any elements that received designation of *N/A*.

Total Compliance Score—Elements that were scored as Y 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.

Case File Review

HSAG reviewers further assigned scores to each element within the file review tools. Table 5-3 presents scores for the file reviews used to evaluate UnitedHealthcare’s compliance with State and federal requirements related to the processing of grievances and appeals.

Table 5-3—Summary of File Review Compliance Scores for UnitedHealthcare

Associated Standard	Description of Files	Total Applicable Element	Number of Elements			Total Compliance Score
			Y	N	NA	
IX	Grievances	40	40	0	40	100%
IX	Appeals	67	64	3	43	96%
Total		107	104	3	83	97%

Strengths and Opportunities for Improvement

Of the 80 applicable elements identified in Table 5-1, UnitedHealthcare received *Met* scores for 77 elements, with a total compliance score of 96 percent. The findings suggest that UnitedHealthcare developed the necessary policies, procedures, and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with UnitedHealthcare staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that the MCO employed to meet contractual requirements.

Of note, UnitedHealthcare was fully compliant in three of the four standards reviewed: Standard I—Availability of Services, Standard II—Assurances of Adequate Capacity and Services, and Standard XII—Quality Assessment and Performance Improvement.

UnitedHealthcare had processes in place to ensure members had adequate access to services, including mechanisms to monitor provider network access standards and require corrective action when providers fail to comply.

UnitedHealthcare also demonstrated strong performance related to the processing of grievances. The results of the case file reviews displayed in Table 5-3 suggest that UnitedHealthcare operationalized and followed the policies it developed for the required elements of the contract. UnitedHealthcare demonstrated compliance in 40 of 40 applicable elements, with an overall compliance score of 100 percent.

Additionally, UnitedHealthcare demonstrated strong performance in requirements related to its quality program achieving full compliance in both the QM/QI checklist and in Standard XII—Quality Assessment and Performance Improvement.

Three opportunities for improvement were identified for Standard IX—Grievances, Appeals, and State Fair Hearings. The appeal case file review identified one standard appeal that was initially filed orally. This appeal file contained the autogenerated letter that instructed the member to submit the appeal in writing. This letter also informed the member that if UnitedHealthcare did not receive the appeal in writing by the specified date in the letter, which was 10 days from the date of the letter, the appeal would be denied. According to the supplemental information (preamble) that accompanied the final rule of the Medicaid managed care regulations (cited earlier in this report), CMS disagreed that all oral appeals be closed within 10 calendar days if no written, signed follow-up is received and specified that managed care plans should treat oral appeals in the same manner as written appeals. Further, the appeal case file review demonstrated that UnitedHealthcare did not consistently make reasonable efforts to provide oral notice of resolution for expedited appeals, or oral notice of a decision to deny a request for an expedited appeal.

In response to the CY 2018 compliance review findings, UnitedHealthcare was required to submit a corrective action plan to DHS for each element scored as *Not Met*.

Recommendations for Improvement

- UnitedHealthcare must ensure that oral inquiries seeking to appeal an adverse benefit determination are treated as appeals (to establish the earliest possible filing date for the appeal) and must be confirmed in writing, unless the member or the provider requests expedited resolution. HSAG recommends 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 recommends that UnitedHealthcare monitor the proposed rulemaking and implement actions as appropriate when the proposed changes are finalized.
- HSAG recommends that UnitedHealthcare implement mechanisms to ensure that reasonable efforts are made to provide members oral notice of resolution of expedited appeals. These efforts should be documented.
- When a request for an expedited resolution of an appeal is denied, UnitedHealthcare must make reasonable efforts to give the member prompt oral notice. 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 recommends that UnitedHealthcare complete a self-evaluation to determine if this action improved performance in this area.

- UnitedHealthcare should further incorporate 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 show 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.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 compliance monitoring review activity, UnitedHealthcare received four recommendations for improvement across two standards. Table 5-4 below presents the prior recommendations made during CY 2017 as well as UnitedHealthcare’s response to those recommendations.

Table 5-4—Compliance Monitoring—Prior Recommendations and UnitedHealthcare’s Response

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
Standard IV—Coverage and Authorization of Services	
For the reduction, suspension, or termination of a previously authorized Medicaid-covered service, provide notice on or before the date of action when exceptions to the 10-day notice apply.	Each month, UnitedHealthcare evaluates continuation of Medicaid eligibility for members who receive daily Medicaid-covered services. A notification letter is sent to members whose Medicaid eligibility has terminated, indicating the immediate termination of the Medicaid-covered daily service.
Standard IX—Grievances, Appeals, and State Fair Hearings	
Ensure transportation-related grievances are fully resolved prior to closure of the grievance, and that grievance resolution letters are consistently written in easily understood language.	UHC implemented a new model to address member transportation grievances, where all transportation grievances are being handled by two dedicated grievance coordinators that work closely with the member and the transportation vendor to work through and resolve all the issues that may have resulted from the underlying transportation issue. Typically that involves rescheduling a missed appointment and addressing any additional health issues that may have occurred as a result of the missed appointment. The member grievance is fully reviewed and investigated to ensure all member issues have been addressed in a way that is easily understood by the member.
Obtain member written consent when a provider files an expedited appeal on behalf of the member.	The consent standard operating procedure (SOP) was updated to note that both standard and expedited cases require the member’s consent. An entire team

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
	communication was also sent out to all staff to notify staff of the updated process. Cases are continually monitored to ensure that the consent requirement is consistently applied.
Include the Iowa Administrative Code (IAC) citation to support the non-authorization of services in appeal resolution letters and ensure letters are consistently written in easily understood language.	A prospective letter review process was implemented to validate the IAC was included in all appeal uphold/partial overturn resolution letters. In addition, the letter review checks for grammar, NCQA requirements, and that the determination is written in easily understood language.

Validation of Performance Measures

To initiate the CY 2018 PMV activity, HSAG in collaboration with DHS, developed Iowa-specific performance measures and associated measure specifications that focus on person-centered care planning for those served in HCBS programs. To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year July 1, 2017–June 30, 2018, and measurement year July 1, 2018–June 30, 2019, during the on-site PMV to be completed by HSAG in 2019. The final validation findings for both measurement years will be included in the CY 2019 EQR Technical Report.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 PMV activity, UnitedHealthcare received one recommendation. Table 5-5 below presents the prior recommendations made during CY 2017 as well as UnitedHealthcare’s response to those recommendations.

Table 5-5—PMV—Prior Recommendations and UnitedHealthcare’s Response

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
<p>HSAG recommends that UnitedHealthcare work closely with DHS to confirm understanding and expectations related to specifications for each performance measure provided by DHS. HSAG also recommends that UnitedHealthcare maintain member-level detail data for each rate report generated and submitted to DHS. This will allow UnitedHealthcare to conduct additional edit checks on the quality and accuracy of the data.</p>	<p>UnitedHealthcare has worked closely with the State to clarify and standardize reporting measures through the following efforts:</p> <ul style="list-style-type: none"> • Attendance at monthly reporting meetings during which template changes are reviewed. • Utilizing a formal question and answer (Q&A) process to submit questions about reporting requirements. • Staying current with the DHS reporting manual and promptly submitting any questions regarding changes. • Provide timely responses to State feedback for submitted quarterly and monthly reports, including providing additional details and/or supplemental information as necessary. <p>In addition, UnitedHealthcare has standardized processes for each of the reports submitted to the State. Member-level detail data are maintained for each submitted report, as well as information regarding how the data were calculated. In addition, SOPs for each State reporting template are in the process of being developed.</p> <p>Quality assurance (QA) checks are in place for each submitted report, including:</p> <ul style="list-style-type: none"> • Manager approval of the report completed by the Reporting and/or Clinical Quality Analyst. • The report is then sent to the health services director for review/approval. • A final QA check is completed by the operations reporting analyst prior to submission to DHS.

Validation of Performance Improvement Projects

Findings

HSAG’s validation evaluated the technical methods of each PIP (i.e., the study design, and data analysis and implementation). Based on its technical review, HSAG determined the overall methodological validity of each PIP. For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, UnitedHealthcare received a *Met* score for 93 percent of applicable evaluation elements and an overall *Met* validation status when originally submitted. UnitedHealthcare had the opportunity to receive

technical assistance, incorporate HSAG’s recommendations, and resubmit the PIP for final validation. Upon final validation, the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received a *Met* score for 100 percent of the evaluation elements, and an overall *Met* validation status. The *Member Satisfaction* PIP received a *Met* score for 100 percent of applicable evaluation elements and an overall *Met* validation status when originally submitted; therefore, a resubmission was not required.

Table 5-6 illustrates the validation scores for both the initial submission and resubmission.

Table 5-6—2018 PIP Validation Results for UnitedHealthcare

Name of Project	Type of Annual Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Submission	93%	100%	<i>Met</i>
	Resubmission	100%	100%	<i>Met</i>
<i>Member Satisfaction</i>	Submission	100%	100%	<i>Met</i>
	Resubmission	NA	NA	NA

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 non-critical) 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 5-7 displays the validation results for UnitedHealthcare’s PIPs evaluated during 2018. This table illustrates UnitedHealthcare’s overall application of the PIP process and success in implementing the PIPs. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 5-7 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 5-7—Performance Improvement Projects Validation Results by Step for UnitedHealthcare

Stage	Step		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (4/4)	0% (0/4)	0% (0/4)
	II.	Clearly Defined, Answerable Study Question(s)	100% (2/2)	0% (0/2)	0% (0/2)
	III.	Correctly Identified Study Population	100% (2/2)	0% (0/2)	0% (0/2)
	IV.	Clearly Defined Study Indicator(s)	100% (2/2)	0% (0/2)	0% (0/2)
	V.	Valid Sampling Techniques (if sampling was used)	100% (7/7)	0% (0/7)	0% (0/7)
	VI.	Accurate/Complete Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			100% (22/22)	0% (0/22)	0% (0/22)
Implementation	VII.	Sufficient Data Analysis and Interpretation	100% (6/6)	0% (0/6)	0% (0/6)
	VIII.	Appropriate Improvement Strategies	100% (6/6)	0% (0/6)	0% (0/6)
Implementation Total			100% (12/12)	0% (0/12)	0% (0/12)
Outcomes	IX.	Real Improvement Achieved	<i>Not Assessed</i>		
	X.	Sustained Improvement Achieved	<i>Not Assessed</i>		
Outcomes Total			<i>Not Assessed</i>		
Percentage Score of Applicable Evaluation Elements Met			100% (34/34)		

Strengths and Opportunities for Improvement

For this year’s 2018 validation, UnitedHealthcare’s PIPs received *Met* validation scores for 100 percent for all evaluation elements validated, demonstrating that no opportunities for improvement were identified. The performance on these PIPs suggests a thorough application of the PIP Design and Implementation stages (Steps I through VIII).

Recommendations for Improvement

- UnitedHealthcare should address 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 be reviewed, and related information should be included in the next annual submission.
- UnitedHealthcare must ensure decisions to continue, revise, or discontinue an intervention are data driven. The supporting data and rationale must be included in Step VIII of the PIP Submission Form.
- UnitedHealthcare should evaluate each intervention to determine the effectiveness and ensure each intervention is logically linked to identified barriers.
- UnitedHealthcare should reference the PIP Completion Instructions annually to ensure that all requirements for each completed step have been addressed.
- UnitedHealthcare should seek technical assistance from HSAG throughout the PIP process to address any questions or concerns.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 PIP validation activity, UnitedHealthcare received three recommendations. Table 5-8 below presents the prior recommendations made during CY 2017 as well as UnitedHealthcare’s response.

Table 5-8—PIP Validation—Prior Recommendations and UnitedHealthcare’s Response

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
UnitedHealthcare should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or FMEA to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.	UnitedHealthcare submitted our updated PIPs to HSAG in August 2018. Casual/barrier analysis was included in the baseline data that were required for the 2018 submission. Analysis will be conducted at the time of remeasurement in 2019. HSAG scored both PIPs at 100% compliant.
UnitedHealthcare should develop active, innovative interventions that can directly impact the study indicator outcomes.	UnitedHealthcare submitted our updated PIPs to HSAG in August 2018. Interventions were included in the baseline data that were required for the 2018 submission. Analysis of the effectiveness of the interventions will be conducted at the time of remeasurement in 2019. HSAG scored both PIPs at 100% compliant.
UnitedHealthcare should develop a process to evaluate the effectiveness of each individual intervention. The results of the intervention evaluation should drive UnitedHealthcare’s decision to continue, revise, or discontinue the intervention.	UnitedHealthcare submitted our updated PIPs to HSAG in August 2018. Interventions were included in the baseline data that were required for the 2018 submission. Analysis of the effectiveness of the interventions will be conducted at the time of remeasurement in 2019. HSAG scored both PIPs at 100% compliant.

Network Adequacy

Findings

The secret shopper survey results include the percentage of provider locations that could be reached, the percentage of provider locations accepting new patients, the number of calendar days to the first available appointment, and whether the time to the first available appointment was within the contract standard for the pertinent appointment type.

Figure 5-1 shows the survey response rate regarding whether provider locations (cases) were able to be contacted. A case was considered a “non-respondent” if HSAG callers were unable to contact the office (i.e., the telephone number was disconnected, or the caller was unable to speak with the provider’s office after two call attempts). The figure also shows the response rates related to a case’s status as a PCP, participation with the MCO, and acceptance of new Medicaid patients.

Figure 5-1—UnitedHealthcare Survey Response Rates

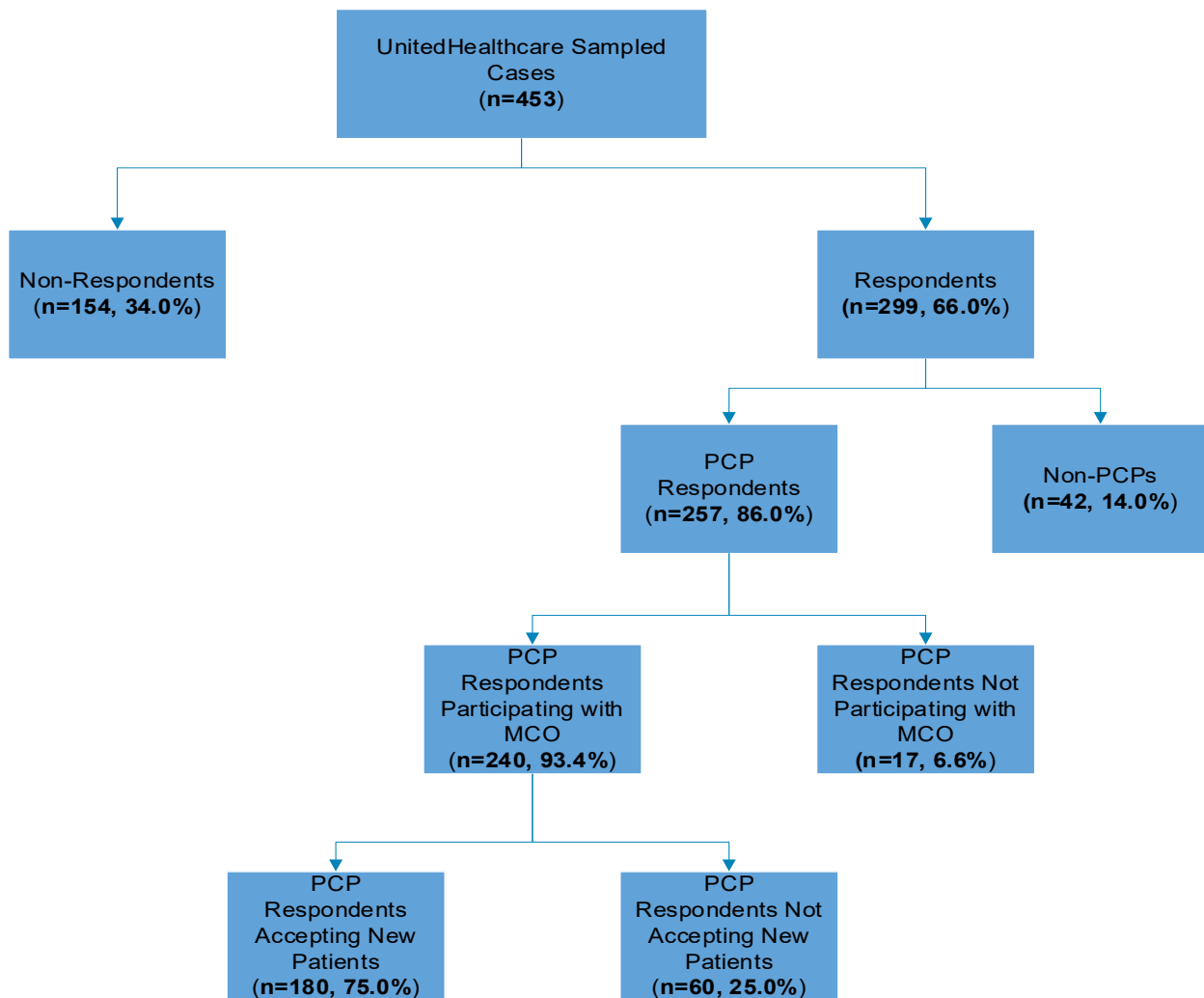


Table 5-9 reports the number and percentage of provider locations offering an appointment date with the sampled provider and location by the requested appointment type (i.e., routine, urgent symptoms, or persistent symptoms), and whether the resulting appointment information met contract standards for the requested appointment type.

Table 5-9—UnitedHealthcare New Patient Appointment Wait Time in Calendar Days—by Visit Type

Appointment Type	Provider Locations Offering an Appointment			Appointment Wait Time in Calendar Days				Appointments Within the Contract Standard ¹		
	N ²	#	%	Min	Max	Median	Average	N ³	#	%
Routine Well-Check	58	37	63.8	0	65	11.0	15.7	37	35	94.6
Persistent Symptoms	61	43	70.5	0	161	4.0	12.3	43	18	41.9
Urgent Symptoms	61	38	62.3	0	150	4.0	11.8	38	11	28.9
UnitedHealthcare	180	118	65.6	0	161	5.0	13.2	118	64	54.2

¹ The contract standard for routine appointments is six weeks, or 42 calendar days. The contract standard for appointments among Medicaid members with persistent symptoms (e.g., a persistent cough) is two calendar days. The contract standard for appointments among Medicaid members with urgent symptoms (e.g., a sore throat with a fever) is one calendar day.

² The denominator is the number of provider locations contacted for an appointment that indicated they were PCPs contracted with UnitedHealthcare and were accepting new patients.

³ The denominator is the number of provider locations that offered appointment availability for a new Medicaid member.

Provider locations may have been unable to offer appointment information for a variety of reasons, and limitations related to providers’ office processes (e.g., providers who require pre-registration with the practice or office prior to scheduling an appointment) may affect members’ access even when these limitations are not communicated to members via provider directories. Sixty-two provider locations were unable to offer appointment information, and common limitations included, but were not limited to, the following:

- The provider location required the patient to pre-register with the office or practice prior to scheduling an appointment.
- The provider needed to review a new patient’s medical records prior to scheduling an appointment.
- Office staff members were unable to access a scheduling calendar without the member completing a questionnaire or providing personal information (e.g., a SSN or date of birth).
- The provider location only offered walk-in services and could not guarantee that the caller could be seen by the sampled provider.

Strengths and Opportunities for Improvement

While 65.6 percent of the contacted provider locations were able to offer an appointment date for a new Medicaid patient, only 54.2 percent of these appointment wait times were in compliance with contract standards for the applicable appointment type. Almost 95 percent of PCP respondents accepting new

patients who were surveyed regarding routine appointments were able to offer an appointment within the contract standard.

Low compliance for appointment timeliness related to urgent or persistent symptoms represented an opportunity for improvement but also may have resulted from the stringent contract requirements under which Iowa providers are expected to see these patients (i.e., one or two days, respectively). More than one-quarter of provider locations requested that callers take additional actions prior to appointment scheduling. 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 for Improvement

- UnitedHealthcare should demonstrate 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 work with its contracted providers to confirm providers’ awareness of the different appointment availability standards.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 network adequacy activity, UnitedHealthcare received two recommendations. Table 5-10 below presents the prior recommendations made during CY 2017 as well as UnitedHealthcare’s response to those recommendations.

Table 5-10—Network Adequacy—Prior Recommendations and UnitedHealthcare’s Response

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
Collaborate with DHS to define and standardize the provider category definitions to clarify the provider types and specialties that fall under each provider category.	Through the Process Improvement Workgroup that IME hosted for member and provider stakeholders as well as the MCOs, we worked collaboratively to create a crosswalk between UnitedHealthcare credentialing provider types and the IME provider types.
Conduct a review of the provider categories that did not meet the access standards and strengthen access to those provider categories by expanding the provider network. Additionally, collaborate with DHS to assess if alternate access standards are required for these provider types.	UnitedHealthcare reviews our access standards on a monthly basis, even though the State reports are only due on a quarterly basis. If we are not meeting access standards, we review if there are other Iowa Medicaid-enrolled providers that we could contract with for the service and outreach to engage in contracting efforts.

CY 2017 Encounter Data Validation

Findings

Encounter Data Completeness

HSAG assessed encounter data completeness in three focus areas: (1) record counts by MMIS month, (2) visit/service counts by service month, and (3) paid amounts by service month. Below are UnitedHealthcare's findings for each area.

- The UnitedHealthcare distribution for record counts by MMIS month was generally consistent.
- The visit/service counts by service month for inpatient and LTC data were relatively stable over time.
- The paid amounts by service month generally showed a similar trend to those for the visit/service counts by service month.

Encounter Data Timeliness

HSAG used two measures to evaluate the timeliness of encounter data submission. One measure evaluates the lag days between the date of service and the MMIS date (i.e., date when records are processed by MMIS). The other measure is based on the lag days between the MCO payment dates and the MMIS date. Below are UnitedHealthcare's findings for each measure.

- The lag days between the service date and the MMIS date metric are important since they show how soon DHS may use the encounter data in MMIS for activities such as performance measure calculation and utilization statistics. To obtain 90 percent of the visits/services from UnitedHealthcare for utilization statistics, DHS needs to wait three months for pharmacy services; about eight months for HCFA-1500 and waiver visits; and more than 10 months for inpatient, LTC, and outpatient encounters.
- For all six encounter types, more than 32 percent of the records were submitted to MMIS within 30 days of the MCO payment date. Additionally, more than 75 percent and 80 percent were submitted to MMIS within 60 days and 90 days of the MCO payment date, respectively, for all encounter types.

Field-Level Encounter Data Completeness and Accuracy

To determine the completeness and accuracy of UnitedHealthcare's encounter data, HSAG evaluated each key data element for the following metrics:

- Percent Present: The required data fields are present on the file and contain information.
- Percent with Valid Values: The values are the expected values.

UnitedHealthcare's percent present rate for the Diagnosis Related Group (DRG) Code field for inpatient encounters was relatively low at 21.7 percent. This likely indicates that DHS is missing the DRG codes

from UnitedHealthcare’s inpatient encounters.⁵⁻¹ Overall, the majority of UnitedHealthcare’s remaining key data elements were generally both complete and accurate.

Strengths and Opportunities for Improvement

UnitedHealthcare submitted generally both complete and accurate encounter data when evaluating record counts by MMIS month, visit/service counts by service month, and paid amounts by service month. UnitedHealthcare often met or exceeded the statewide rate⁵⁻² for nearly all key data elements for field-level completeness and accuracy.

UnitedHealthcare should work with DHS to ensure that all DRG codes for inpatient encounters are submitted to DHS. Based on the overall rates for the study period, UnitedHealthcare did not meet the contract requirement for lag days between the MCO payment dates and the MMIS date. However, the monthly timeliness results between April 2016 and June 2017 showed that UnitedHealthcare was improving on this measure.

Recommendations for Improvement

- HSAG recommends that UnitedHealthcare collaborate with DHS to ensure that all DRG codes for inpatient encounters are submitted to DHS.
- HSAG recommends that UnitedHealthcare ensure timely submission of encounters to meet the contract requirement for lag days between the MCO payment dates and the MMIS date.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 was the first year this the EDV activity, there are no prior recommendations.

CY 2018 Encounter Data Validation

HSAG obtained encounter data needed to conduct a comparative analysis between DHS’ electronic encounter data and the data extracted from UnitedHealthcare’s data systems. The CY 2018 EDV study was ongoing at the time of this report; therefore, UnitedHealthcare’s results of the 2018 EDV study will be presented in the CY 2019 EQR Technical Report.

⁵⁻¹ On March 26, 2018, DHS noted that UnitedHealthcare was verifying data corrections for missing DRG codes and working to provide the logic to ensure that DHS is mapping its encounters correctly when counting DRG-eligible payments versus per diem/FFS payments.

⁵⁻² The statewide rates were based on results from Amerigroup, AmeriHealth Caritas Iowa, Inc. (AmeriHealth), and UnitedHealthcare.

Focused Study—Case Management

Findings

Ten case files were reviewed to evaluate UnitedHealthcare’s compliance with the person-centered care planning requirements. Table 5-11 summarizes the scores by section and includes overall findings related to the person-centered care planning requirements. The sections were selected by HSAG to reflect significant portions of the contract between DHS and the contracted MCOs. As displayed below, UnitedHealthcare was 79 percent compliant for the contract requirements reviewed for this study.

Table 5-11—Person-Centered Care Planning Requirements—Overall Scores for UnitedHealthcare*

Section	Number of Questions in Section	Number Yes	Number No	Number NA	Percentage Compliant**
Service Plan Development Frequency	2	20	0	0	100%
Provision of Services	2	8	5	7	62%
Service Plan Development: Person-Centered Planning Process	7	40	27	3	60%
Service Plan Content	10	80	16	4	83%
Service Plan Content: Emergency Plan	2	19	1	0	95%
Service Plan Content: Supported Community Living	1	2	1	7	67%
Case Management Contact Guidelines	2	19	1	0	95%
Overall: Person-Centered Care Planning Focused Study—All Results for UnitedHealthcare	26	188	51	21	79%

* The results reflected in this table are not statistically significant or representative of performance as related to the MCO’s membership as a whole.

** Percentage Compliant is the percentage of compliant elements excluding any NA cases.

Strengths and Opportunities for Improvement

UnitedHealthcare’s highest-scoring areas addressed requirements related to Service Plan Development Frequency, Service Plan Content: Emergency Plan, and Case Management Contact Guidelines, with scores of 100 percent, 95 percent, and 95 percent, respectively. Overall, UnitedHealthcare achieved 100 percent scores in several program areas which included the following:

- Service plans were completed and approved prior to provision of services.
- Service plans were reviewed and revised at least every 12 months or when there was a significant change in the member’s condition.
- The case manager and member discussed options for meaningful day activities, employment, and educational opportunities.
- Service plans addressed the clinical and support needs that were identified.

- Service plans included the name of each provider who is responsible for carrying out the interventions or supports included in the service plan.
- Service plans indicated if the member has elected to self-direct services and, as applicable, which services the individual elects to self-direct.
- Service plans included evidence of an emergency plan.
- The case manager made monthly contact with members according to contract requirements.

Opportunities for improvement were identified in six of the seven sections. The two largest sections and subsequently the areas with the greatest number of *No* findings (43 of 51 *No* findings) addressed requirements related to the Person-Centered Planning Process and Service Plan Content requirements. Within these two sections, program requirements with less than a 50 percent score were related to the following requirements:

- The team lead was chosen by the member; or alternatively, if the member elected not to exercise this choice, the team made the decision regarding who would serve as the lead.
- The person-centered planning process occurred at a time and location that was convenient for the member.
- Alternative HCBS settings were considered by the member.
- A copy of the service plan was provided to all people involved in the plan.

Recommendations for Improvement

- UnitedHealthcare could consider 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 could consider enhancing auditing processes to monitor performance related to person-centered care planning requirements.

Assessment of Follow-Up on Prior Recommendations

The Focused Study—Case Management activity was a one-time study completed by HSAG at the request of DHS; therefore, there are no prior recommendations.

MCO Enrollee Survey

While not a CY 2018 activity, DHS contracted with HSAG in CY 2017 to perform a review and validation of UnitedHealthcare’s Enrollee and Provider Surveys, specifically the IPES. UnitedHealthcare was required, as a part of its contract, to administer the IPES to members in the HCBS program and was given the freedom to modify the survey, as needed. The IPES instrument is a customized survey instrument that used the CAHPS HCBS survey as a guideline.

Assessment of Follow-Up on Prior Recommendations

From the results of the CY 2017 MCO Enrollee Survey, UnitedHealthcare received one recommendation. Table 5-12 below presents the prior recommendation made by HSAG during CY 2017 as well as UnitedHealthcare’s response to HSAG’s recommendation.

Table 5-12—MCO Enrollee Survey—Prior Recommendations and UnitedHealthcare’s Response

Prior Recommendations (CY 2017)	UnitedHealthcare’s Response to Recommendations
<p>HSAG recommends that UnitedHealthcare continue to administer the IPES by a third-party survey vendor. Survey vendors with survey administration expertise and analysis proficiency are recommended and preferred for a smooth survey administration and accurate analysis of the results. In addition, HSAG recommends that the data coding process be standardized. Standard disposition codes should be developed that allow for the identification of completed surveys, ineligible members, and refusals.</p>	<p>DHS supplies annual quotas to UnitedHealthcare for each population involved in the IPES: AIDS/HIV [acquired immunodeficiency syndrome/human immunodeficiency virus], Brain Injury, Children’s Mental Health, Elderly, Habilitation, Health & Disability, Intellectual Disability, and Physical Disability. UnitedHealthcare utilizes these established quotas to determine the accurate sample size needing completed both annually and per month for the vendor. UnitedHealthcare continues to administer the IPES by a third-party survey vendor with the noted survey administration expertise.</p> <p>Each month, UnitedHealthcare sends a sample of eligible active membership to the survey vendor. The survey vendor eliminates any members who do not have valid contact information, who have completed a survey within the last 6 months, and/or any members who have indicated a refusal to participate in the survey in the last 6 months. The remaining population is the available members who are randomly contacted. As survey responses are received and/or refused, the survey vendor has a standard coding process to notate the outcome of the completed and/or attempted surveys.</p> <p>DHS provides UnitedHealthcare with the State reporting template required to be used when submitting quarterly State reporting. This template includes data definitions to ensure consistency from all entities completing the IPES with their members. Should DHS have questions regarding the submitted quarterly reporting, DHS reaches out to UnitedHealthcare for clarification and/or additional information.</p>

6. PAHP-Specific Summary—Delta Dental of Iowa

Activity Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for DDIA. It provides a discussion of DDIA’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 DDIA has addressed the recommendations for quality improvement made by HSAG during the previous year, if applicable. The methodology for each activity can be found in Appendix B—External Quality Review Activities—PAHPs.

Compliance Monitoring

Findings

Review of Standards

Table 6-1 presents a summary of DDIA’s performance results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed. If a requirement was not applicable to DDIA during the period covered by the review, HSAG used a *Not Applicable (NA)* designation.

Table 6-1—Summary of Standard Compliance Scores

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Availability of Services	10	10	7	3	0	70%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	100%
III	Coordination and Continuity of Care	11	7	6	1	4	86%
IV	Coverage and Authorization of Services	24	24	14	10	0	58%
V	Provider Network	12	12	11	1	0	92%
VI	Enrollee Information and Enrollee Rights	23	21	11	10	2	52%
VII	Confidentiality of Health Information	7	7	3	4	0	43%
VIII	Enrollment and Disenrollment	16	13	12	1	3	92%
IX	Grievance and Appeal System	43	43	28	15	0	65%
X	Subcontractual Relationships and Delegation	8	8	6	2	0	75%
XI	Practice Guidelines	7	7	7	0	0	100%
XII	Quality Assessment and Performance Improvement	11	11	8	3	0	73%

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
XIII	Health Information Systems	13	13	13	0	0	100%
Total		188	179	129	50	9	72%

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: The overall percentages were obtained by adding the number of elements that received a score of Met (1 point), then dividing this total by the total number of applicable elements.

Checklist Review

HSAG reviewers assigned scores to each element within the checklist review tools. Table 6-2 presents scores for the checklists used to evaluate DDIA’s compliance with State and federal requirements related to the Enrollee Handbook and Network Provider Directory.

Table 6-2—Summary of Checklist Compliance Scores

Associated Standard	Description of Material Reviewed	Total Applicable Element	Number of Elements			Total Compliance Score
			Y	N	NA	
VI	Enrollee Handbook	34	31	3	2	91%
VI	Network Provider Directory	8	7	1	0	88%
Total		42	38	4	2	90%

Y = Yes; N = No; NA = Not Applicable

Total Applicable Elements—The total number of elements within each standard minus any elements that received an N/A designation.

Total Compliance Score—Elements that were scored as Y 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.

Case File Review

HSAG reviewers further assigned scores to each element within the file review tools. Table 6-3 presents scores for the file reviews used to evaluate DDIA’s compliance with State and federal requirements related to the processing of denials, grievances, and appeals.

Table 6-3—Summary of File Review Compliance Scores

Associated Standard	Description of Files	Total Applicable Element	Number of Elements			Total Compliance Score
			Y	N	NA	
IV	Denials	40	16	24	10	40%
IX	Grievances	50	36	14	20	72%
IX	Appeals	57	45	12	53	79%
Total		147	97	50	83	66%

Strengths and Opportunities for Improvement

Of the 179 applicable elements identified in Table 6-1, DDIA received *Met* scores for 129 elements, with a total compliance score of 72 percent. Of note, DDIA was fully compliant in three of the 13 standards reviewed: Standard II—Assurances of Adequate Capacity and Services, Standard XI—Practice Guidelines, and Standard XIII—Health Information Systems. DDIA also showed strong performance in Standard V—Provider Network and Standard VIII—Enrollment and Disenrollment each with only one element scoring *Not Met*. DDIA demonstrated that it had processes in place to monitor time and distance standards which were also used to identify geographically underserved areas. DDIA also had established credentialing procedures and a credentialing committee. Further, the information systems demonstration confirmed DDIA's capabilities to collect, integrate, and report data for review and analysis. The findings suggest that DDIA developed the necessary procedures and plans to operationalize the required elements of its contract and demonstrate compliance with the contract. Further, interviews with DDIA staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that DDIA employed to meet contractual requirements.

Ten standards received a score of less than 100 percent. The areas with the greatest opportunity for improvement were related to Standard IV—Coverage and Authorization of Services, Standard VI—Enrollee Information and Enrollee Rights, Standard VII—Confidentiality of Health Information, and Standard IX—Grievance and Appeal System, which all scored 65 percent or less. For Standard IV—Coverage and Authorization of Services, there was a general lack of standardized written policies and procedures for processing requests for initial and continuing authorization of services including, but not limited to, notice of adverse benefit determination (ABD) content requirements and several notice of adverse benefit determination time frame requirements. The denial case file review findings also suggest that DDIA members were not consistently provided a notice of an ABD.

For Standard VI—Enrollee Information and Enrollee Rights, several opportunities for improvement were identified related to the reading level and font size of member materials, the content of the member handbook and provider directory, the format of the online provider directory, written information on advance directives, and written policies on member rights.

Four opportunities for improvement were identified for Standard VII—Confidentiality of Health Information specific to breach notification time frames, the method of notification including substitute notice, and additional notice in urgent situations.

For Standard IX—Grievance and Appeal System, multiple opportunities were identified related to acknowledgement of grievances and appeals; clinical decision-makers; external medical reviews; a process for provider payment disputes; a process for when notice and timing requirements are not met; obtaining a signed, written appeal following an oral request for an appeal; discrepancies between policies and other documentation pertaining to appeals; processes for extensions and denied expedited appeal requests; grievance and appeal time frame requirements; grievance and appeal resolution notices; oral notice of expedited resolutions; and record-keeping requirements. The case file reviews also suggest that DDIA had challenges in implementing several grievance and appeal processing requirements.

Additionally, while DDIA demonstrated moderate performance for Standard XII—Quality Assessment and Performance Improvement, there was no formal documented quality assessment and performance improvement program, workplan, or annual evaluation.

Recommendations for Improvement

- DDIA must develop or update written policies and procedures to comply with federal Medicaid managed care regulations and contract requirements. These policies should follow DDIA’s process on policy development and be formally approved by the organization. DDIA should also prioritize policy development and/or revisions for processing requests for initial and continuing authorization of services, member materials, and grievances and appeals.
- DDIA could consider developing or enhancing internal audit programs to review compliance with prior authorization, and grievance and appeal program requirements.
- While DDIA had established clinical practice guidelines (CPGs) for coverage determination decisions, DDIA should also adopt CPGs published from national organizations, such as the American Dental Association (ADA), to distribute to DDIA’s provider network to assist in clinical decision-making.
- DDIA must develop a formal, written quality improvement and performance improvement program which consists of at minimum, a program description, an ongoing workplan, and an annual evaluation. The quality program must meet federal requirements outlined in 42 CFR §438.330. HSAG also recommends 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 quality improvement methodologies, activities, and initiatives.
- DDIA must participate in efforts to promote the delivery of services in a culturally competent manner to all members. DDIA should also consider developing a cultural competency program. HSAG recommends 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.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Measures

Findings

HSAG identified no concerns with DDIA’s process for receiving and processing eligibility data or receiving and processing claims and encounter data. Further, HSAG had no concerns with DDIA’s data processing, integration, and measure production. HSAG determined that DDIA followed the State’s specifications and produced *Reportable (R)* rates for all measures in the scope of the validation of

performance measures. The rates generated by DDIA for each performance measure are presented in Table 6-4 below.

Table 6-4—DDIA Performance Measure Rates

Performance Measures	DDIA	
	Count	Percent
<i>DWP Unique Members with 6+ Month Coverage</i>	198,888 ¹	NA
<i>DWP Unique Members with 6+ Month Coverage and Accessing Care</i>	82,120 ²	41.29%
<i>DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation</i>	66,594 ³	81.09%

¹ Represents total count of unique DWP members with six or more months of coverage.

² Represents the number of unique DWP members with six or more months of coverage and who accessed care.

³ Represents the number of unique DWP members with six or more months of coverage who accessed care and received an oral health evaluation.

NA = Not applicable.

Of the total population enrolled with DDIA, there were 198,888 unique DWP members with six or more months of coverage during the measurement year. Of the population with six or more months of coverage, 82,120 members (41.29 percent) accessed care. Of the 82,120 unique members accessing care, 66,594 DWP members (81.09 percent) also received an oral evaluation. Since this is the first year that performance measure rates were calculated, comparisons to previous years’ results cannot be made.

HSAG evaluated DDIA’s data systems for processing each data type used for reporting the IME performance measure rates. The findings of HSAG’s validation are detailed below.

Eligibility/Enrollment Data System

HSAG identified no concerns with DDIA’s process for receiving and processing eligibility data. DDIA received enrollment files daily and monthly in the standard 834-file format from IME’s secure file transfer protocol (FTP) site. Enrollment files were automatically uploaded into DDIA’s enrollment and claims processing system, HDS. Each file was subject to a validation process to ensure that only accurate data were loaded into HDS. If any files could not be automatically reconciled or updated, a DDIA data analyst conducted manual data review and uploaded files into HDS. Data analysis staff collaborated with IME to validate any issues; if needed, IME provided an updated file. Adequate validation processes were in place and continued to ensure data accuracy.

Members were uniquely identified in HDS using a system-generated primary key based on the member record number, also known as the Person Number, to ensure that each unique member is counted only once in the performance measure calculations.

During the on-site visit, DDIA demonstrated the HDS system, from which the auditor confirmed the capture of eligibility effective dates, termination dates, and historical eligibility spans. Adequate

reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Medical Service Data System (Claims/Encounters)

HSAG identified no issues with DDIA's process for receiving and processing claims and encounter data. For the current reporting period, DDIA's providers submitted claims and encounters electronically via DDIA's provider portal, mailed paper forms directly to DDIA, or used an intermediary or clearinghouse to submit to DDIA. Paper forms were scanned using optical character recognition (OCR) software, converted to the standard 837-file format, and entered in HDS. All services received through the provider portal and via clearinghouse were also transmitted into the HDS system.

Each file was subjected to a built-in pre-adjudication validation process completed by DDIA's customer relations management team to ensure data completeness and accuracy. Additionally, DDIA's Compliance Department validated all electronic claims monthly.

Provider Data

HSAG identified no concerns with DDIA's process for managing provider data. Prospective providers submitted a completed professional application and credentialing form to DDIA's professional relations (PR) staff, who reviewed the application for initial credentialing for approval to participate in DDIA's dentist networks, monthly monitoring of Office of Inspector General (OIG) and IME lists of excluded individuals and entities (LEIE), and verification of individual and organizational National Provider Identifier (NPI) numbers.

If more information was required for DDIA to make a credentialing determination, it was gathered by the PR staff. Following the validation checks performed by the PR staff, DDIA's dental director and the director of PR, if needed, made the recommendation to approve, deny, or terminate credentialing for a provider. Once the credentialing process was completed for new providers, provider data were entered in HDS. HSAG determined that DDIA had sufficient validation checks in place to ensure integrity of provider data.

Data Integration Process

HSAG identified no concerns with DDIA's data integration and measure calculation processes for performance measure reporting. DDIA transferred enrollment and claim/encounter data nightly to DDIA's Microsoft (MS) Structured Query Language (SQL) data warehouse for measure calculation and analytic reporting. DDIA viewed the pertinent measure information on an encounter into a single record view, and this information was evaluated to calculate the required performance measures. DDIA used peer review as well as dollar, member, and volume reconciliation to ensure that data merges were accurate and complete. Additionally, peer code review and output verification were used to ensure that no extraneous data were captured.

The measure calculations were performed as a SQL script and used the staging tables from combined base tables in the data warehouse. This information was then transmitted into an MS Excel spreadsheet

template to calculate the ratios based on the performance measure. Data validation testing was completed on the data sets used to aggregate the numerators and denominators, and peer review was performed on the outputs. To validate the cases included in the denominators and numerators, a sample of 25 to 30 cases was selected for review. All cases were appropriately identified, and the performance measure requirements were correctly applied as defined in the State's measure specifications. HSAG determined that DDIA's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Strengths and Opportunities for Improvement

DDIA accurately and completely processed transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the performance measure rate calculations have been completed and validated. Samples of data from the performance measure data repository were complete and accurate.

DDIA's processes to consolidate diversified files and to extract required information from the performance measure data repository were appropriate. Actual results of file consolidations or extracts were consistent with those that should have resulted according to documented algorithms or measure descriptions. The performance measure data repository's design, program flow charts, and source code enabled analyses and reports. Proper linkage mechanisms were employed to join data from all necessary sources. Documentation governing the production process, including production activity logs and the DDIA staff review of report runs, was adequate. Prescribed data cutoff dates were followed.

DDIA's processes and documentation complied with the associated reporting program measure descriptions, code review, and testing. For each of the performance measures, all members of the relevant populations identified in the performance measure descriptions were included in the population from which the denominator was produced. Adequate programming logic or source code existed to appropriately identify all relevant members of the specified denominator population for each of the performance measures.

DDIA properly evaluated the completeness and accuracy of codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes were appropriately identified and applied as specified in each performance measure. Time parameters required by performance measure descriptions were followed. DDIA avoided all double-counted members or numerator events.

No opportunities for improvement were identified during this validation year.

Recommendations for Improvement

HSAG recommends that DDIA continue to work closely with IME to confirm understanding and expectations related to specifications for each performance measure provided by IME. HSAG also recommends that DDIA maintain member-level detail data for each rate report submitted to IME and determine additional data validation checks to ensure continued quality and accuracy of the data.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Improvement Projects

Findings

HSAG’s validation evaluated the technical methods of the PIP (i.e., the study design). Based on its technical review, HSAG determined the overall methodological validity of each PIP. For the *Annual Dental Visits* PIP, DDIA received a *Met* score for 38 percent of applicable evaluation elements and an overall *Not Met* validation status when originally submitted. DDIA had the opportunity to receive technical assistance, incorporate HSAG’s recommendations, and resubmit the PIP for final validation. Upon final validation, the PIP received a *Met* score for 88 percent of the evaluation elements and an overall *Partially Met* validation status.

Table 6-5 illustrates the validation scores for both the initial submission and resubmission.

Table 6-5—2018 PIP Validation Results for DDIA

Name of Project	Type of Annual Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
<i>Annual Dental Visits</i>	Submission	38%	40%	<i>Not Met</i>
	Resubmission	88%	80%	<i>Partially Met</i>

¹ **Type of Review**—Designates the PIP review as an annual submission or resubmission. A resubmission means the PAHP 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 non-critical) 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 6-6 displays the validation results for DDIA’s PIP evaluated during 2018. This table illustrates the PAHP’s overall application of the PIP process and success in implementing the PIP. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 6-6 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 6-6—Performance Improvement Project Validation Results by Step for DDIA

Stage	Step		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	<i>Not Assessed</i>		
	VI.	Accurate/Complete Data Collection	67% (2/3)	33% (1/3)	0% (0/3)
Design Total			88% (7/8)	13% (1/8)	0% (0/8)
Implementation	VII.	Sufficient Data Analysis and Interpretation	<i>Not Assessed</i>		
	VIII.	Appropriate Improvement Strategies	<i>Not Assessed</i>		
Implementation Total			<i>Not Assessed</i>		
Outcomes	IX.	Real Improvement Achieved	<i>Not Assessed</i>		
	X.	Sustained Improvement Achieved	<i>Not Assessed</i>		
Outcomes Total			<i>Not Assessed</i>		
Percentage Score of Applicable Evaluation Elements Met			88% (7/8)		

* Percentage totals may not equal 100 due to rounding.

Strengths and Opportunities for Improvement

For this year’s 2018 validation, DDIA submitted one state-mandated PIP topic: *Annual Dental Visits*. The performance on this PIP suggests a thorough application of the PIP Design stage (Steps I through VI); however, HSAG identified an opportunity for improvement related to DDIA’s documentation of the data collection process used to produce the study indicator percentage.

Recommendations for Improvement

- DDIA should address 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 must provide 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 progresses, DDIA’s efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes.
- DDIA should reference the PIP Completion Instructions to ensure all requirements for each completed step have been addressed. HSAG is available for technical assistance.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Network Adequacy

Findings

To assess the capacity of Iowa’s dental provider network and to establish baseline ratios, HSAG calculated the ratio of members to providers for DDIA. As provider ratios assess only one dimension of network adequacy, the provider capacity analysis was coupled with a geographic distribution analysis to provide additional insight into members’ access to providers.

Table 6-7 displays counts of Iowa Medicaid members with dental service coverage included in the network analyses for DDIA and statewide.

Table 6-7—Population of Eligible Members for DDIA

Category	DDIA	Statewide
Members	113,832	155,365

Table 6-8 displays the number of providers and the provider ratios (i.e., the number of members for each contracted provider) for all dental specialties for DDIA.

Table 6-8—Summary of Ratio Analysis Results for General Dentists and Dental Specialists for DDIA, Including Out-of-State Providers in Contiguous States

Provider Category	DDIA	
	Providers	Ratio (Members per Provider)
General Dentists		
General dentists	834	136
Dental Specialists		
Endodontists	12	9,486
Oral surgeons	62	1,836
Orthodontists*	7	N/A
Pedodontists*	33	N/A
Periodontists	8	14,229
Prosthodontists	21	5,421

* HSAG provided counts of the number of orthodontists and pedodontists in DDIA’s provider network because these specialists serve adult members ages 19 to 20 years (pedodontists also serve adult members with behavior management issues). HSAG excluded orthodontists and pedodontists from the provider ratio and time/distance analyses because most of the population served by these providers (i.e., children) are not included in this network analysis report.

Provider ratios for general dentists were relatively low for DDIA, with a ratio of 136 members per provider (136:1). However, provider ratios for dental specialists were relatively high when compared to those for general dentists. Though a relatively small proportion of Medicaid members likely require services from dental specialists, the small number of specialists in DDIA’s network underscore a potential capacity limitation. Of note, DDIA had eight periodontists to serve a population of 113,832 members (provider ratio of 14,229:1).

The geographic network distribution analyses assessed whether DDIA’s provider network placed travel-related burdens on members regarding access to the nearest providers. DHS has established contract standards for the maximum allowable driving distance or driving time that members must travel to receive care from general dentists. PAHPs must ensure that 100 percent of their Medicaid members have access to an in-network general dentist within reasonable driving times or driving distances. Due to the large rural population among Iowa Medicaid members, the time/distance standard has different requirements for members in rural areas compared to urban areas: members with urban addresses must have access to a general dentistry location within 30 miles or 30 minutes, and members with rural addresses should be within 60 miles or 60 minutes.

HSAG used Quest Analytics Suite software to calculate the percentage of DDIA’s members meeting DHS’ time/distance standards using the geocoded data. HSAG conducted the analysis separately for members residing in urban versus rural areas, though overall compliance was based on the percentage of all members meeting the time/distance standards. Approximately 58.1 percent of DDIA’s members were

classified as urban residents. All DDIA members were found to have access to a general dentist within DHS’ time/distance standards.

DHS had no time/distance standards for dental specialists. Consequently, HSAG calculated average driving times and driving distances for the nearest three in-network providers by provider category for DDIA’s members. HSAG used Quest Analytics Suite software to calculate the average travel distances (in miles) and travel times (in minutes) to the nearest three providers. 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. DHS does not currently employ standards for average driving distances or driving times for dental providers; therefore, results should be examined for relative reasonability rather than for compliance.

Table 6-9 displays the average travel distances and travel times for members receiving dental coverage through DDIA.

Table 6-9—Average Travel Distances and Travel Times for DDIA Members

Provider Category	First-Nearest Provider		Second-Nearest Provider		Third-Nearest Provider	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
General Dentists						
General dentists	3.3	3.6	4.0	4.5	5.0	5.6
Dental Specialists						
Endodontists	35.2	44.4	45.1	58.9	51.0	66.6
Oral surgeons	16.8	19.5	17.3	20.1	24.7	29.0
Periodontists	61.3	78.5	70.9	90.5	84.2	112.8
Prosthodontists	67.5	82.7	103.4	135.3	107.8	162.2

Overall, DDIA members had short travel distances and travel times to general dentists and moderate travel distances and travel times to oral surgeons and endodontists. This metric is also supportive of members’ abilities to choose among providers in DDIA’s network without having to travel extensively. Conversely, geographic access to the first-nearest periodontists and prosthodontists required average driving distances exceeding 60 miles and driving times exceeding 70 minutes.

Strengths and Opportunities for Improvement

Provider ratio analysis results suggest that DDIA’s provider network has capacity to meet the needs of respective Medicaid member populations for general dentists and oral surgeons. Geographic distribution analysis results found that all DDIA members have access to a general dentist within DHS’ time/distance standards. Additionally, DDIA members had relatively short travel distances and travel times to oral surgeons and endodontists.

The provider counts and ratios observed for endodontists, periodontists, and prosthodontists highlight the small volume of providers currently included in DDIA's network. Additionally, geographic access to the nearest periodontists and prosthodontists required average driving distances exceeding 60 miles and average driving times exceeding 70 minutes. These areas indicate opportunities for DDIA to assess members' access to dental providers to determine if the provider network needs to be expanded or if the provider counts and travel times are appropriate for these provider specialties.

Recommendations for Improvement

- 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 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.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Encounter Data Validation

Findings

HSAG conducted an IS review with the PAHPs to examine the extent to which the PAHPs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. An IS review is key to understanding whether the infrastructure in place is likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG developed a targeted IS questionnaire to gather both general information and specific procedures for data processing, personnel training requirements, and data acquisition capabilities. This section summarizes DDIA's responses to the questionnaire.

Encounter Data Sources and Systems

For dental services, DDIA receives dental claims through direct Web data entry, claim warehouses, and physical mail. When an encounter data file is generated, it is either placed in mailbox 3005 and an email is sent to Noridian, or the file is placed on Noridian's bulletin board. Noridian then processes the encounter file, generates the 999 and 277CA files, and sends them to DDIA. DDIA reports claims that pass validation to DHS, and manually reviews and addresses any issues for claims that did not pass validation.

DDIA receives dental claims daily, with an average of 1,322 claims per day.

DDIA noted that it submits both paid and denied dental encounters to DHS. When an encounter needs to be adjusted, the adjustments are sent to DHS as replacement claims on the 837D associated with the payment cycle.

DDIA collects and maintains its PAHP's provider data. DDIA's provider data collection begins when it receives an application from a provider for addition into its system. The application undergoes a credentialing process prior to entering provider information into DDIA's system. DDIA reviews provider information through daily processes to comply with contract requirements.

When a dental claim is processed, the provider information contained in the submitted claim is compared to the information in the provider's metadata within DDIA's claims adjudication system.

Provider enrollment information contained within the Master Provider File is evaluated daily for changes. If terminations occur, that provider is flagged as ineligible for payment within DDIA's claims adjudication system. The provider records are maintained as separate metadata against which claims are compared at the time of adjudication. DDIA responded that it does not have a capitated arrangement with any specific provider groups.

DDIA reported the member's eligibility and enrollment data are maintained by DDIA rather than by a subcontracted vendor. DDIA supplied information regarding the process by which these data are received and maintained within its system.

Data Exchange Policies and Procedures (P&Ps)

DDIA dental encounter data exchange operational procedures include the following steps:

- The outbound 837 encounter data file is generated from the data that reside in the production database. This information is formatted to match the general format of the 837 standard files for ease of data load by the receiving entity. The information contained on the encounter data file consists of the claims paid by DDIA within a given month, documented by claim and completed with subscriber and member information as it relates to the processing of the claim.
- On the fifth day of every month, both the DDIA DWP and the DDIA Hawki dental encounter events trigger a process that generates the encounter files through a series of PL/SQL packages. Each generated file is limited to 5,000 claim records per file, allowing the process to generate multiple files. Additionally, each generated file is programmed to follow specific guidelines to keep track of each of the files being generated.
- Once each file is created in the production database utility directory, an Adeptia file event picks up both the DWP and Hawki encounter files and sends them to the file processor (currently Noridian). If this process is completed manually, an FTP tool (such as WinZip or FileZilla) may be used. The current, agreed-upon process for the DWP indicates that the encounter files for each month will be available in this location, in the "Inbound files" directory, for processing by the State by the fifth day of the following month.

- Currently for the DWP, after the State’s entity has processed the file, response files 277CA and 999 files are delivered to an “Outbound reports” directory for review by DDIA. In addition, an email is generated by Noridian and sent to an email distribution group to notify DDIA personnel that the acknowledgment files are available in the exchange location and ready for review.
- The 999 documents are functional acknowledgements and verify that the incoming 837 file follows the X12 standards. If a file is rejected via a 999, the electronic data interchange (EDI) administrators are notified via email and will be investigated further.
- The 277CA document contains responses to the data within the 837 files. Since there can be multiple 837 files, multiple 277CA documents are also possible. An Adeptia process picks up all 277CA response documents and concatenates the results to a spreadsheet, which is then emailed to the proper contact at DDIA. The spreadsheet includes information such as rejected items and totals. Any rejected claims are manually reviewed to identify the issue causing the failure. A separate file would then be generated to reprocess the claims that had failed the initial validation. Once all claims have been verified as being successfully submitted to the receiving entity's system (i.e. the State’s), the process is complete.

Management of Encounter Data: Collection, Storage, and Processing

Dental claims are paid line by line based on a standardized fee schedule less coordination of benefits, frequency availability, and other program restrictions.

In response to whether any services are submitted under bundle-payment structures, DDIA noted that the federally qualified health centers (FQHCs) are paid on an encounter (prospective payment system [PPS] rate) basis. The encounter is billed with services performed along with ADA code D9999. Service lines are evaluated for payment, and if services are deemed payable, the negotiated PPS rate is paid to the FQHC under D9999.

Regarding the collection of third-party liability (TPL) data, DDIA noted that during the 834 load processes, TPL records are submitted from the State with effective time periods for the member. If a TPL claim is effective, according to those dates, for a member on a specific date of service, that claim is denied until other carrier payment information is submitted. To verify the accuracy of other TPL claims information, data are verified against the state-provided information on the 834 eligibility files. When DDIA is identified as not responsible for the payment from a service due to a primary carrier, it reports both the primary carrier’s payment information and a zero-paid amount for itself in the submitted encounters.

Encounter Data Quality Monitoring and Reporting

To monitor the completeness of the dental encounter data submitted by providers, DDIA’s dental encounter data checks included but were not limited to the following: validity of the procedure codes, accurate provider information, appropriate modifiers for the associated procedures, and accurate member information.

For timeliness metrics, DDIA noted that encounter data submission is required by IME reporting monthly. As with many other insurers, timely filing is a requirement for both fiscal year payments. As such, DDIA uses a timeliness filing standard of 90 days.

DDIA noted that its reporting mechanisms are in place during the file creation in PL/SQL. During the creation processes, if a record is unable to be written an analyst is notified to intervene and troubleshoot the concern. After the file is created, a total amount is produced and compared to claims warehouse information to determine the completeness of the file. After the data file is transmitted to Noridian, an email is generated with processing logs and counts that are compared to data warehouse information. Additionally, during the file creation processes, data reconciliation ensures that total dollars, volume, and claims that are being transmitted are appropriate for that month.

Regarding the average percentage of dental encounters submitted to DHS that are rejected, DDIA responded that less than 1 percent are rejected.

Claims information is used to meet IME monthly and quarterly reporting; conduct a utilization review; monitor fraud, waste, and abuse; and analyze for rate setting.

Strengths and Opportunities for Improvement

Based on contractual requirements and DHS' data submission requirements (e.g., companion guides), DDIA has processes and procedures in place to guide its dental encounter process. HSAG also identified a recommended area for improvement, which is described below. Addressing this area could improve the quality of DDIA's dental encounter data submissions to DHS.

Recommendations for Improvement

- 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.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

7. PAHP-Specific Summary—Managed Care of North America Dental

Activity Specific Findings

This section presents HSAG’s findings and conclusions from the EQR activities conducted for MCNA. It provides a discussion of MCNA’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 MCNA has addressed the recommendations for quality improvement made by HSAG during the previous year, if applicable. The methodology for each activity can be found in Appendix B—External Quality Review Activities—PAHPs.

Compliance Monitoring

Findings

Review of Standards

Table 7-1 presents a summary of MCNA’s performance results. HSAG assigned a score of *Met* or *Not Met* for each of the individual elements it reviewed. If a requirement was not applicable to MCNA during the period covered by the review, HSAG used a *Not Applicable (NA)* designation.

Table 7-1—Summary of Standard Compliance Scores

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				<i>M</i>	<i>NM</i>	<i>NA</i>	
I	Availability of Services	10	10	9	1	0	90%
II	Assurances of Adequate Capacity and Services	3	3	3	0	0	100%
III	Coordination and Continuity of Care	11	11	10	1	0	91%
IV	Coverage and Authorization of Services	24	24	22	2	0	92%
V	Provider Network	12	12	11	1	0	92%
VI	Enrollee Information and Enrollee Rights	23	21	14	7	2	67%
VII	Confidentiality of Health Information	7	7	7	0	0	100%
VIII	Enrollment and Disenrollment	16	13	12	1	3	92%
IX	Grievance and Appeal System	43	43	33	10	0	77%
X	Subcontractual Relationships and Delegation	8	8	2	6	0	25%
XI	Practice Guidelines	7	7	5	2	0	71%
XII	Quality Assessment and Performance Improvement	11	11	11	0	0	100%

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	NM	NA	
XIII	Health Information Systems	13	13	13	0	0	100%
Total		188	183	152	31	5	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: The overall percentages were obtained by adding the number of elements that received a score of Met (1 point), then dividing this total by the total number of applicable elements.

Checklist Review

HSAG reviewers assigned scores to each element within the checklist review tools. Table 7-2 presents scores for the checklists used to evaluate MCNA’s compliance with State and federal requirements related to the Enrollee Handbook and Network Provider Directory.

Table 7-2—Summary of Checklist Compliance Scores

Associated Standard	Description of Material Reviewed	Total Applicable Elements	Number of Elements			Total Compliance Score
			Y	N	NA	
VI	Enrollee Handbook	34	30	4	2	88%
VI	Network Provider Directory	8	7	1	0	88%
Total		42	37	5	2	88%

Y = Yes; N = No; NA = Not Applicable

Total Applicable Elements—The total number of elements within each standard minus any elements that received an NA designation.

Total Compliance Score—Elements that were scored as Y 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.

Case File Review

HSAG reviewers further assigned scores to each element within the file review tools. Table 7-3 presents scores for the file reviews used to evaluate MCNA’s compliance with State and federal requirements related to the processing of denials, grievances, and appeals.

Table 7-3—Summary of File Review Compliance Scores

Associated Standard	Description of Files	Total Applicable Elements	Number of Elements			Total Compliance Score
			Y	N	NA	
IV	Denials	40	33	7	10	83%
IX	Grievances	32	31	1	38	97%
IX	Appeals	69	57	12	41	83%
Total		141	121	20	89	86%

Strengths and Opportunities for Improvement

Of the 183 applicable elements identified in Table 7-1, MCNA received *Met* scores for 152 elements, with a total compliance score of 83 percent. Of note, MCNA was fully compliant in four of the 13 standards reviewed: Standard II—Assurance of Adequate Capacity and Services, Standard VII—Confidentiality of Health Information, Standard XII—Quality Assessment and Performance Improvement, and Standard XIII—Health Information Systems. MCNA also showed strong performance in Standard I—Availability of Services, Standard III—Coordination and Continuity of Care, Standard V—Provider Network, and Standard VIII—Enrollment and Disenrollment, each with only one element scored as *Not Met*. MCNA demonstrated having processes in place for ongoing monitoring and evaluation of its provider network including recruitment efforts. Additionally, MCNA’s policy for investigating and reporting breaches included procedures for evaluating the seriousness of the reported breach of information, providing timely written notification to affected individuals, and providing substitute notices when applicable.

MCNA also established a quality improvement program consisting of a formal program description, workplan, and evaluation which included, but was not limited to, the evaluation of key performance indicators, utilization trends and irregularities, and case management activities. Further, MCNA’s information systems demonstration confirmed the organization’s capabilities to collect, analyze, integrate, and report data such as enrollment and eligibility, provider records, encounter and claims processing, benefit tracking, finance, utilization, quality improvement, and third-party liability. The findings suggest that MCNA developed the necessary procedures and plans to operationalize the required elements of its contract that demonstrate compliance with the contract. Further, interviews with MCNA staff showed that staff members were knowledgeable about the requirements of the contract and the policies and procedures that MCNA employed to meet contractual requirements.

Nine standards received a score of less than 100 percent. The areas with the greatest opportunity for improvement were related to Standard VI—Enrollee Information and Enrollee Rights, Standard IX—Grievance and Appeal System, Standard X—Subcontractual Relationships and Delegation; and Standard XI—Practice Guidelines, which all scored 77 percent or less. For Standard VI—Enrollee Information and Enrollee Rights, several opportunities for improvement were identified related to the reading level of member materials, content of the member handbook and provider directory, format of the online provider directory, time frame for providing information in paper form upon request, definition for “urgent care,” and written policies on member rights.

For Standard IX—Grievance and Appeal System, multiple opportunities were identified related to the acknowledgement of grievances and appeals; the disenrollment process; obtaining a member’s written consent when a provider requests an appeal on behalf of the member; obtaining a signed, written appeal following an oral request for an appeal; informing members of the limited time available to present evidence sufficiently in advance of the resolution time frame for expedited appeals; informing members of their right to file a grievance if they disagree with a decision to deny a request for an expedited appeal or extend the time frame for processing a grievance or appeal; appeal resolution notices; and the grievance resolution process. While multiple opportunities were identified for Standard IX, the grievance case file review demonstrated strong performance with a score of 97 percent, suggesting that MCNA had implemented many required elements of its contract for the processing of member grievances.

MCNA’s lowest-scoring area was Standard X—Subcontractual Relationships and Delegation. MCNA received a compliance score of 25 percent, with six *Not Met* elements. Specifically, MCNA’s subcontract agreement did not include all provisions required by the State and federal managed care regulations.

Lastly, two opportunities for improvement were identified for Standard XI—Practice Guidelines. MCNA’s policy described processes to annually measure performance against at least two aspects of clinical practice guidelines. MCNA staff members were unable to speak to this process or provide documentation to demonstrate that MCNA had implemented this process as required by its policy. Additionally, documentation did not support that MCNA disseminated its practice guidelines to providers.

Recommendations for Improvement

- MCNA should consider conducting a thorough review of existing policies, procedures, and member materials against federal managed care regulations and contract requirements. HSAG also recommends that MCNA prioritize the review of member materials, documentation, and processes pertaining to grievances and appeals.
- HSAG recommends 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. It was further 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.
- MCNA must revise its disenrollment process to comply with contract requirements; specifically, MCNA must address 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 consider executing a contract amendment with its subcontractor(s) to include all provisions required by 42 CFR §438.230.
- MCNA must disseminate adopted CPGs to its provider network. Mechanisms to distribute guidelines could include MCNA’s website, provider manual, newsletters, etc.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, there are no prior recommendations. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Measures

Findings

HSAG identified no concerns with MCNA’s process for receiving and processing eligibility data or receiving and processing claims and encounter data. Further, HSAG had no concerns with MCNA’s data processing, integration, and measure production. HSAG determined that MCNA followed the State’s specifications and produced *Reportable (R)* rates for all measures in the scope of the validation of performance measures. The rates generated by MCNA for each performance measure are presented in Table 7-4 below.

Table 7-4—MCNA Performance Measure Rates

Performance Measures	MCNA	
	Count	Percent
<i>DWP Unique Members with 6+ Month Coverage</i>	89,661 ¹	NA
<i>DWP Unique Members with 6+ Month Coverage and Accessing Care</i>	18,915 ²	21.10%
<i>DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation</i>	13,102 ³	69.27%

¹ Represents total count of unique DWP members with six or more months of coverage.

² Represents the number of unique DWP members with six or more months of coverage who accessed care.

³ Represents the number of unique DWP members with six or more months of coverage who accessed care and received an oral health evaluation.

NA = Not applicable.

Of the total population enrolled with MCNA, there were 89,661 unique DWP members with six or more months of coverage during the measurement year. Of the population with six or more months of coverage, 18,915 members (21.10 percent) accessed care. Of the 18,915 unique members accessing care, 13,102 DWP members (69.27 percent) also received an oral evaluation. Since this is the first year that performance measure rates were calculated, comparisons to previous years’ results cannot be made.

HSAG evaluated MCNA's data systems for processing each data type used for reporting the IME performance measure rates. The findings of HSAG's validation are detailed below.

Eligibility/Enrollment Data System

HSAG identified no issues with MCNA's process for receiving and processing eligibility data.

MCNA received enrollment files daily and monthly in the standard 834-file format from IME's secure FTP site. MCNA used DentalTrac, a proprietary dental system, to process and store member enrollment data. MCNA used DentalTrac to automatically connect to IME's secure FTP site several times daily to verify existence of any new files to be downloaded. Once DentalTrac located a new file, the file was downloaded from the FTP site and uploaded to DentalTrac. MCNA's eligibility team was then notified that a new file was received, along with the number of DentalTrac records processed as well as the number of enrollments terminated, added, or changed.

Each file was subject to a validation process to ensure that only accurate data were loaded into DentalTrac. MCNA's EDI team supervised the processing of eligibility files and reviewed all system logs associated with eligibility files to ensure compliance. DentalTrac generated a pre-processing validation report upon receipt of the eligibility files, and MCNA's EDI team reviewed the reports to identify any issues. If an issue was identified, the eligibility team manually reviewed the record in DentalTrac and compared it to the enrollment file. The eligibility team worked with the health plan's IME enrollment liaison to correct the record. Adequate validation processes were in place and continued to ensure data accuracy.

MCNA used DentalTrac to ensure that no two members had the same subscriber ID and performed several verification processes to remove any duplicate subscriber IDs (i.e., one member with two unique ID numbers). As potential duplicate IDs were identified, an exception report was generated and reviewed by the Eligibility and Enrollment Department. The eligibility team then manually reviewed the records, verified the information with the health plan's IME enrollment liaison, and merged the member's information into one record to ensure that each unique member was counted only once in performance measure calculations.

During the on-site visit, MCNA demonstrated the DentalTrac system, from which the auditor confirmed the capture of eligibility effective dates, termination dates, and historical eligibility spans. Adequate reconciliation and validation processes were in place at each point of data transfer to ensure data completeness and accuracy.

Medical Services Data System (Claims/Encounters)

HSAG identified no issues with MCNA's process for receiving and processing claims and encounter data. MCNA received claims and encounters from providers via MCNA's provider portal, paper forms mailed directly to MCNA, or an intermediary or clearinghouse. Services received via clearinghouse and through the provider portal were transferred into DentalTrac. Paper claims and encounters were mailed to MCNA where, upon receipt, they were separated, date stamped, sorted, and batched to be entered in DentalTrac by MCNA's document management processing team.

Claims and encounters were subjected to a built-in pre-adjudication validation process completed by MCNA, whereby claims/encounters were required to receive a 97 percent procedural accuracy rate and a 98 percent financial accuracy rate. Audits were also conducted at both processor and plan levels. Audits were performed monthly on the adjudication system to ensure accuracy.

Provider Data

HSAG identified no concerns with MCNA's process for managing provider data. Prospective providers each submitted an electronic application via MCNA's credentialing portal or paper application to MCNA's provider configuration and credentialing team, which reviewed the application for completeness. The application contained the provider license number, affiliate number, provider name, education, tax ID number, and other information. This provider information was received by MCNA's provider configuration team, which performed the first-level validation to ensure completeness of data. If any information was missing, the team coordinated with the provider to ensure the data were complete. Once this validation check was passed, MCNA's credentialing system performed primary source verification while the credentialing team verified other data elements required to deem a provider record verified and credentialed. Once verification was completed and registration was verified with the State, the provider was manually entered in DentalTrac.

MCNA submitted a monthly network report and a quarterly credentialing and termination report to IME to ensure compliance with the State's provider data requirements. HSAG determined that MCNA had sufficient validation checks in place to ensure integrity of provider data.

Data Integration Process

HSAG identified no concerns with MCNA's data integration and measure calculation process for performance measure reporting. MCNA used the enrollment and claims/encounters stored and maintained in DentalTrac for performance measure reporting. MCNA staff used the business intelligence reporting tool in DentalTrac to generate the performance measure rates. All cases were appropriately identified, and the performance measure requirements were correctly applied as defined in the State's measure specifications. The rates were reviewed by the IT report analysts as well as MCNA's Business Department, Compliance Department, and the chief information officer (CIO) prior to final rates being submitted to IME. HSAG determined that MCNA's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Strengths and Opportunities for Improvement

MCNA accurately and completely processed transfer data from the transaction files (e.g., membership, provider, encounter/claims) into the performance measure data repository used to keep the data until the calculations of the performance measure rates have been completed and validated. Samples of data from the performance measure data repository were complete and accurate.

MCNA's processes to consolidate diversified files and to extract required information from the performance measure data repository were appropriate. Actual results of file consolidations or extracts were consistent with those that should have resulted according to documented algorithms or measure

descriptions. The performance measure data repository's design, program flow charts, and source code enabled analyses and reports. Proper linkage mechanisms were employed to join data from all necessary sources. Documentation governing the production process, including production activity logs and the MCNA staff review of report runs, was adequate. Prescribed data cutoff dates were followed.

MCNA's processes and documentation complied with the associated reporting program measure descriptions, code review, and testing. For each of the performance measures, all members of the relevant populations identified in the performance measure descriptions were included in the population from which the denominator was produced. Adequate programming logic or source code existed to appropriately identify all relevant members of the specified denominator population for each of the performance measures.

MCNA properly evaluated the completeness and accuracy of codes used to identify medical events, such as diagnoses, procedures, or prescriptions, and these codes were appropriately identified and applied as specified in each performance measure. Time parameters required by the performance measure descriptions were followed. MCNA avoided all double-counted members or numerator events.

Member-level data used by MCNA to calculate the performance measure rates were not readily available for the auditor's review during the on-site visit; however, the data file was located, and this issue had no impact on MCNA's ability to report valid, reportable rates.

MCNA's responses to auditor requests were inconsistent and untimely throughout the audit process. MCNA did not upload documents requested by HSAG in a timely manner, and MCNA was nonresponsive to emails with regard to data requests or on-site audit scheduling. HSAG auditors had to make multiple requests to obtain responses from MCNA.

MCNA demonstrated challenges with the start of the on-site portion of the audit. There were operational difficulties, and staff were not present at the location designated by MCNA. Specifically, there appeared to be miscommunication as to which staff would be available and present on-site to participate in the review. The MCNA staff members were not prepared to ensure that the auditor would have access to information at the on-site location, which delayed the start of the on-site audit. MCNA's initial rate submission was not in the required format; therefore, MCNA was required to resubmit data.

Recommendations for Improvement

HSAG recommends 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 also investigate as to 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.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, prior recommendations do not exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Improvement Projects

Findings

HSAG’s validation evaluated the technical methods of the PIP (i.e., the study design). Based on its technical review, HSAG determined the overall methodological validity of each PIP. For the *Annual Dental Visit* PIP, MCNA received a *Met* score for 25 percent of applicable evaluation elements and an overall *Not Met* validation status when originally submitted. MCNA had the opportunity to receive technical assistance, incorporate HSAG’s recommendations, and resubmit the PIP for final validation. Upon final validation, the PIP received a *Met* score for 100 percent of the evaluation elements and an overall *Met* validation status.

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

Table 7-5—2018 PIP Validation Results for MCNA

Name of Project	Type of Annual Review ¹	Percentage Score of Evaluation Elements <i>Met</i> ²	Percentage Score of Critical Elements <i>Met</i> ³	Overall Validation Status ⁴
<i>Annual Dental Visit</i>	Submission	25%	0%	<i>Not Met</i>
	Resubmission	100%	100%	<i>Met</i>

¹ **Type of Review**—Designates the PIP review as an annual submission, or resubmission. A resubmission means the PAHP 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 non-critical) 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 the validation results for MCNA’s PIP evaluated during 2018. This table illustrates the PAHP’s overall application of the PIP process and success in implementing the PIPs. Each step is composed of individual evaluation elements scored as *Met*, *Partially Met*, or *Not Met*. Elements receiving a *Met* score have satisfied the necessary technical requirements for a specific element. The validation results presented in Table 7-6 show the percentage of applicable evaluation elements that received each score by step. Additionally, HSAG calculated a score for each stage and an overall score across all steps.

Table 7-6—Performance Improvement Project Validation Results by Step? for MCNA

Stage	Step		Percentage of Applicable Elements		
			Met	Partially Met	Not Met
Design	I.	Appropriate Study Topic	100% (2/2)	0% (0/2)	0% (0/2)
	II.	Clearly Defined, Answerable Study Question(s)	100% (1/1)	0% (0/1)	0% (0/1)
	III.	Correctly Identified Study Population	100% (1/1)	0% (0/1)	0% (0/1)
	IV.	Clearly Defined Study Indicator(s)	100% (1/1)	0% (0/1)	0% (0/1)
	V.	Valid Sampling Techniques (if sampling was used)	<i>Not Assessed</i>		
	VI.	Accurate/Complete Data Collection	100% (3/3)	0% (0/3)	0% (0/3)
Design Total			100% (8/8)	0% (0/8)	0% (0/8)
Implementation	VII.	Sufficient Data Analysis and Interpretation	<i>Not Assessed</i>		
	VIII.	Appropriate Improvement Strategies	<i>Not Assessed</i>		
Implementation Total			<i>Not Assessed</i>		
Outcomes	IX.	Real Improvement Achieved	<i>Not Assessed</i>		
	X.	Sustained Improvement Achieved	<i>Not Assessed</i>		
Outcomes Total			<i>Not Assessed</i>		
Percentage Score of Applicable Evaluation Elements Met			100% (8/8)		

Strengths and Opportunities for Improvement

For this year’s 2018 validation, MCNA submitted one state-mandated PIP topic: *Annual Dental Visit*. The performance on the PIP suggests a thorough application of the PIP Design stage (Steps I through VI). A sound study design created the foundation for MCNA to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact study indicator outcomes.

Recommendations for Improvement

- MCNA should address 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 progresses, MCNA’s efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes.
- MCNA should reference the PIP Completion Instructions to ensure all requirements for each completed step have been addressed. HSAG is available for technical assistance.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, prior recommendations do not exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Network Adequacy

Findings

To assess the capacity of Iowa’s dental provider network and to establish baseline ratios, HSAG calculated the ratio of members to providers for MCNA. As provider ratios assess only one dimension of network adequacy, the provider capacity analysis was coupled with a geographic distribution analysis to provide additional insight into members’ access to providers.

Table 7-7 displays counts of Iowa Medicaid members with dental service coverage included in the network analyses for MCNA and statewide.

Table 7-7—Population of Eligible Members for MCNA

Category	MCNA	Statewide
Members	41,533	155,365

Table 7-8 displays the number of providers and the provider ratios (i.e., the number of members for each contracted provider) for all dental specialties for MCNA.

Table 7-8—Summary of Ratio Analysis Results for General Dentists and Dental Specialists for MCNA, Including Out-of-State Providers in Contiguous States

Provider Category	MCNA	
	Providers	Ratio (Members per Provider)
General Dentists		
General dentists	366	113
Dental Specialists		
Endodontists	7	5,933
Oral surgeons	27	1,538
Orthodontists*	11	N/A
Pedodontists*	24	N/A
Periodontists	7	5,933
Prosthodontists	19	2,186

* HSAG provided counts of the number of orthodontists and pedodontists in MCNA’s provider network because these specialists serve adult members ages 19 to 20 years (pedodontists also serve adult members with behavior management issues). HSAG excluded orthodontists and pedodontists from the provider ratio and time/distance analyses because most of the population served by these providers (i.e., children) are not included in this network analysis report.

Provider ratios for general dentists were relatively low for MCNA, with a ratio of 113 members per provider (113:1). However, provider ratios for dental specialists were relatively high when compared to those for general dentists. Though a relatively small proportion of Medicaid members likely require services from dental specialists, the small number of specialists in MCNA’s network underscores a potential capacity limitation. Of note, MCNA had seven endodontists and seven periodontists to serve a population of 41,533 members (provider ratios of 5,933:1).

The geographic network distribution analyses assessed whether MCNA’s provider network placed travel-related burdens on members regarding access to the nearest providers. DHS has established contract standards for the maximum allowable driving distance or driving time that members must travel to receive care from general dentists. PAHPs must ensure that 100 percent of their Medicaid members have access to an in-network general dentist within reasonable driving times or driving distances. Due to the large rural population among Iowa Medicaid members, the time/distance standard has different requirements for members in rural areas compared to urban areas: members with urban addresses must have access to a general dentistry location within 30 miles or 30 minutes, and members with rural addresses should be within 60 miles or 60 minutes.

HSAG used Quest Analytics Suite software to calculate the percentage of MCNA’s members meeting DHS’ time/distance standards using the geocoded data. HSAG conducted the analysis separately for members residing in urban areas versus in rural areas, though overall compliance was based on the percentage of all members meeting the time/distance standards. Approximately 60.9 percent of MCNA’s members were classified as urban residents. MCNA’s provider network was found to be slightly below

the standard, with 99.5 percent of its Medicaid members having access to a general dentist within the time/distance standard.

DHS had no time/distance standards for dental specialists. Consequently, HSAG calculated average driving times and driving distances for the nearest three in-network providers by provider category for MCNA’s members. HSAG used Quest Analytics Suite software to calculate the average travel distances (in miles) and travel times (in minutes) to the nearest three providers. 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. DHS does not currently employ standards for average driving distances or driving times for dental providers; therefore, results should be examined for relative reasonability rather than for compliance.

Table 7-9 displays the average travel distances and travel times for members receiving dental coverage through MCNA.

Table 7-9—Average Travel Distances and Travel Times for MCNA Members

Provider Category	First-Nearest Provider		Second-Nearest Provider		Third-Nearest Provider	
	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)	Distance (Miles)	Time (Minutes)
General Dentists						
General dentists	7.7	8.6	10.7	12.1	11.7	13.2
Dental Specialists						
Endodontists	54.7	77.9	100.4	130.8	104.6	139.4
Oral surgeons	27.8	33.9	38.2	47.1	60.6	77.3
Periodontists	107.9	163.7	107.9	163.7	107.9	163.7
Prosthodontists	78.0	118.8	107.9	163.6	107.9	163.7

Overall, MCNA members had short travel distances and travel times to general dentists. Members also had reasonable access to the first-nearest 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 all three specialist categories, indicating that provider access and choice may be heavily affected by travel burden.

Strengths and Opportunities for Improvement

Provider ratio analysis results suggest that MCNA’s provider network has the capacity to meet the needs of respective Medicaid member populations for general dentists and oral surgeons. Geographic distribution analysis results found that over 99 percent of MCNA’s members have access to a general dentist within DHS’ time/distance standards. Additionally, MCNA’s members had relatively short travel distances and travel times to oral surgeons.

The provider counts and ratios observed for endodontists, periodontists, and prosthodontists highlight that the small volume of providers currently included in MCNA's network. Additionally, geographic access to the nearest periodontists and prosthodontists required average driving distances exceeding 75 miles and average driving times exceeding 115 minutes. These areas indicate opportunities for MCNA to assess members' access to dental providers to determine if the provider network needs to be expanded or if the provider counts and travel times are appropriate for these provider specialties.

Recommendations for Improvement

- 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.

Assessment of Follow-Up on Prior Recommendations

As CY 2018 is the first year for this activity, prior recommendations do not exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Encounter Data Validation

Findings

HSAG conducted an IS review with the PAHPs to examine the extent to which the PAHPs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data. An IS review is key to understanding whether the infrastructure in place is likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG developed a targeted IS questionnaire to gather both general information and specific procedures for data processing, personnel training requirements, and data acquisition capabilities. This section summarizes MCNA's responses to the questionnaire.

Encounter Data Sources and Systems

For dental services, MCNA receives dental claims through direct data entry via its provider portal, from various clearinghouses in the 837D format, and as paper claims in the ADA claim format. MCNA manages its dental claims and other relevant data (e.g., enrollment and provider data) on its fully integrated MIS, DentalTrac. MCNA receives dental claims daily—approximately 19,000 dental claims per week.

MCNA reported that it submits both paid and denied dental encounters to DHS. When an encounter needs to be adjusted, MCNA transmits an 837D transaction with a frequency code of “7” (i.e., replacement of prior claim). As mandated in the IA Medicaid companion guide, the internal control number (ICN) being adjusted is transmitted in Loop 2300, which holds the current ICN. MCNA’s response deviates from the implementation guide (IG) in that normally, the current ICN would be sent in Loop 2330B.

MCNA collects and maintains its PAHP’s provider data. Incoming claims are validated against MCNA’s provider system by a unique matching of provider NPI, taxonomy, employer identification number (EIN), address, and phone number. If a mismatch occurs, the claim is pended for denial; then, a claim examiner reviews the case and coordinates with MCNA’s provider relations and credentialing team to verify the information. Once confirmed, the claim may be left in a denied state or may be processed for payment.

During enrollment processing, MCNA noted that its credentialing team also verifies the provider information against the IME provider enrollment file received regularly from DHS. Discrepancies are addressed by reviewing them with the providers. Credentialing would not be finalized until all discrepancies are addressed. MCNA responded that it does not have a capitated arrangement with any specific provider groups.

MCNA reported that it receives the member’s eligibility and enrollment data from DHS’ MMIS, which is maintained within its MIS. MCNA supplied information regarding the process by which these data are received and maintained within its system.

Data Exchange Policies and Procedures (P&Ps)

MCNA’s encounter processing controls are initiated when it receives a paper claim in the mailroom or when an EDI file is available from the clearinghouses; the process continues until the remittance advice is issued to the provider. MCNA’s claims management system converts paper claims to electronic 837D files using advanced OCR technologies, with 99.5 percent accuracy. This ensures that all applicable edits, business rules, and validations implemented on electronic claims files are also applied to all paper claims.

Encounter data include all new claims and claim adjustments performed and paid to providers during the reporting period, along with value-added services without any associated costs. As a fully Health Insurance Portability and Accountability Act of 1996 (HIPAA)-compliant claims management system, DentalTrac requires the use of HIPAA-approved and industry standard taxonomies and code sets. These include NPI, place of service codes, diagnosis codes (International Classification of Diseases, Tenth Revision [ICD-10]), procedure codes (Code on Dental Procedures and Nomenclature [CDT] and others) and Claim Adjustment Reason Codes (CARCs). MCNA also captures member ID, date of service, provider ID (Medicaid ID number), adherence to hard benefit limits, date of claim processing, and date of claim payment.

As a fully integrated MIS, MCNA’s DentalTrac encounter administration system is responsible for the complete processing of encounter data. The encounter administration system is architected with its own

data management system, which allows MCNA to receive and poll data from a multitude of sources to ensure encounter data are 100 percent accurate. All data are stored in MCNA's proprietary data repository using extensible markup language (XML) structure, which provides the flexibility to accommodate an unlimited number of custom attributes and mappings required by its trading partners.

DentalTrac's encounter administration system uses all code sets and data mappings to validate the encounter data prior to submission. Any violation of MCNA's extensible rules management system triggers an exception notification for its EDI team, who then addresses the exception promptly and ensures that the encounter data are acceptable for submission. The encounter administration system performs any mapping and transformation to the XML data required to meet the trading partners' specifications, including the generation of HIPAA ASC X12N 837D files or any other proprietary file format. The data flow is guided by DentalTrac's business process management (BPM) engine which contains detailed process definitions for handling encounter data that are specific to each trading partner, ensuring uniformity, consistency, and accuracy of all processes and encounter submissions.

DentalTrac's Automated Communication Module (ACM) interfaces with external systems to securely exchange information using multiple protocols supported by MCNA's trading partners. DentalTrac's ACM can be configured to exchange information with external systems monthly, weekly, daily, or hourly, or at any other frequency mutually agreed upon with its trading partners. MCNA's ACM subsystem also continuously monitors for the corresponding ASC X12N TA1 and 997 or 999 functional acknowledgment files, as well as ASC X12N 277CA/277U claims acknowledgment files. These files are immediately processed to ensure all encounter data are submitted and accepted by MCNA's trading partners.

Any encounter records not accepted by IME are evaluated by MCNA's EDI and Claims teams, and all repairable errors are corrected immediately. MCNA's teams analyze all rejections to identify root causes and implement measures to prevent them from occurring in future submissions. All resubmittals of rejected files are completed within two business days of receipt. Any individual claims or encounters rejected or reported for failing certain edits are immediately reviewed and corrected to resolve the identified errors or problems.

Management of Encounter Data: Collection, Storage, and Processing

MCNA's dental claims are processed against state-approved benefit guidelines and priced using a state-approved fee schedule. All providers are paid line by line using the FFS payment model. Based on MCNA's questionnaire responses, no services are submitted under bundled payment services. Additionally, when a claim with other insurance data is received, MCNA's Coordination of Benefits (COB) team reaches out to the member and the other insurance carrier to verify eligibility and coverage and ensure that IME is the payer of last resort.

Information received from other insurance carriers is stored in MCNA's MIS along with each member's information and respective claim. When other insurance carriers are identified, these are reported in the appropriate segment of the encounter data.

When other insurance carriers are responsible for payment, their payment is deducted from the allowable amount on the claim. Any remaining balance owed to the provider is paid by MCNA. In either case, a claim adjustment segment (CAS) adjustment is included in the encounter data to reflect the amount covered by the other insurance carrier and the amount covered by MCNA, even if it is a zero-dollar amount. MCNA reported that it does not subcapitate providers.

Encounter Data Quality Monitoring and Reporting

MCNA noted that it submits encounter data to clients in a HIPAA ASC X12N 837D format. The encounter administration system performs any mapping and transformation to XML data required to meet the trading partners' specifications. The data flow is guided by MCNA's BPM engine which contains detailed process definitions for the handling of encounter data that are specific to each trading partner, ensuring uniformity, consistency, and accuracy of all processes and encounter submissions. MCNA also noted that it uses OptumInsight Claredi and Edifecs XEngine validation engines when processing HIPAA X12N files. MCNA noted that its EDI subsystem seamlessly integrates with these HIPAA validation engines as an additional checkpoint when verifying the content and completeness of files it receives or that will be transmitted.

According to MCNA's response, the maintenance of separate repositories of claims transactional data and encounter data is designed strategically to enforce quality control and checks and balances. DentalTrac performs different levels of edits and controls to ensure the accuracy, quality, and completeness of encounter data it submits 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 MCNA's encounter data files is cross-referenced with payment reports and financial information, which further validates the accuracy and completeness of the data provided.

Upon generation of the encounter files, DentalTrac does the following:

- Compares the contents of the encounter file generated against its transactional database (OLTP [On-line Transaction Processing]) and its data warehouse database (OLAP [On-line Analytical Transaction Processing]) to validate that all transactions, edits, and other critical encounter-related data are complete.
- Performs a SNIP [Strategic National Implementation Process] Level 7 validation to confirm that all business rules and data dictionary elements were properly applied to the encounter file produced.
- Interfaces with Claredi and XEngine to perform additional compliance checking on the file.
- Runs the encounter file against the state-provided Ramp Manager system for validation.

These controls are further monitored by MCNA's EDI analysts and Business Intelligence team to ensure all encounters are submitted. This monitoring is presented in various reports and dashboards that describe the status of MCNA's claims and encounter inventory, such as acceptance versus rejected status, SNIP validations, financial reconciliation, or completion rate. MCNA provided a sample of its SNIP compliance verification and sample encounter control reports.

MCNA noted that its process for monitoring submission timeliness is very similar to (and uses the same reporting mechanisms as) its process for monitoring the accuracy and completeness of dental claims and encounter data submitted by providers. MCNA's EDI analysts place special emphasis on its financial reconciliation or completion rate reports to ensure that 100 percent of the claims that are processed and paid are fully reported to the IME. These reports and dashboards are monitored weekly to ensure compliance. DentalTrac, MCNA's MIS, automatically submits encounter data within 24 hours after claims processing, and its claims and encounter inventory reports allow MCNA to monitor the levels of pending encounters to be submitted, or corrected and resubmitted.

MCNA noted that less than 0.5 percent of dental encounters submitted to DHS are rejected.

In describing MCNA's process for reconciling rejected files (transactions), MCNA noted that DentalTrac is configured to automatically poll IME's secure FTP server, where encounter submissions are made and response files are deposited. DentalTrac maintains an audit trail of every encounter file submission along with the time of receipt and metadata information of the respective response file. If a response file is not received within 24 hours, DentalTrac will alert MCNA's EDI analyst to investigate. The alert will be raised again every 24 hours until a response file is received from IME. MCNA's EDI analyst will reach out to IME to inquire about the status of a response file; if MCNA is instructed to cancel the submission by IME, MCNA's EDI analyst will document this instruction in DentalTrac, which will cause the submission to be cancelled.

When a response file is received indicating the file is rejected, DentalTrac will flag the rejected encounter file and alert its EDI analyst. The EDI analyst reviews the cause for rejection and makes the necessary corrections to resubmit the encounter file within two business days.

When the encounter file is submitted but specific transactions within the file are rejected, MCNA's EDI analyst receives a detailed report of the rejected encounters and reasons for rejection. This report would be analyzed in conjunction with MCNA's business analysts, claims team, and provider relations team to determine the correct course of action to make the necessary corrections and resubmit the rejected encounter. DentalTrac maintains a log of the rejected encounters along with each resubmission until the encounter is accepted. MCNA's EDI analysts maintain adherence to resubmitting rejected encounter data within 30 days from the date of rejection.

In response to describing how dental data in MCNA's encounter data system/data warehouse are used, MCNA noted that its claims/encounter data are primarily used for compliance with contractual reports as well as to monitor the efficacy of MCNA's quality improvement programs in its efforts to improve members' oral health. These data are also used for financial reporting and reconciliation of claims paid and cash disbursements.

Strengths and Opportunities for Improvement

Based on contractual requirements and DHS's data submission requirements (e.g., companion guides), MCNA has processes and procedures in place to guide its dental encounter process. HSAG also identified a recommended area for improvement, which is described below. Addressing this area could improve the quality of MCNA's dental encounter data submissions to DHS.

Recommendations for Improvement

MCNA described encounter data quality monitoring activities that were reliant on response files from DHS. MCNA 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.

Assessment of Follow-Up on Prior Recommendations

- As CY 2018 is the first year for this activity, prior recommendations do not exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

8. MCO Comparative Information

Comparative Analysis of the MCOs by Activity

In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the quality, timeliness, and accessibility of the IA Health Link program.

Compliance Monitoring

Table 8-1 provides information that can be used to compare the MCOs' performance on each of the four compliance standard areas.

Table 8-1—Standards and Compliance Scores: MCO Comparison

Standard	Total Elements	Amerigroup				UnitedHealthcare			
		<i>M</i>	<i>NM</i>	<i>NA</i>	Score	<i>M</i>	<i>NM</i>	<i>NA</i>	Score
I	21	20	1	0	95%	21	0	0	100%
II	3	3	0	0	100%	3	0	0	100%
IX	44	42	2	0	95%	41	3	0	93%
XII	12	11	1	0	92%	12	0	0	100%
Total	80	76	4	0	95%	77	3	0	96%

Standard I—Availability of Services

Standard II—Assurances of Adequate Capacity and Services

Standard IX—Grievances, Appeals, and State Fair Hearings

Standard XII—Quality Assessment and Performance Improvement

Amerigroup and UnitedHealthcare received comparable total compliance scores , 95 percent and 96 percent, respectively. Additionally, both MCOs achieved full compliance for Standard II—Assurances of Adequate Capacity and Services.

The MCOs received similar findings in the following two areas:

- Both MCOs either dismissed or denied an oral request for an appeal if a written, signed appeal was not received within 10 days.
- Both MCOs did not demonstrate that oral notices of expedited appeal resolutions were consistently provided.

Validation of Performance Measures

HSAG, in collaboration with DHS, developed Iowa-specific performance measures and associated measure specifications that focus on person-centered care planning for those served in HCBS programs. To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year July 1, 2017–June 30, 2018, and measurement year July 1, 2018–June 30, 2019, during the on-site PMV to be completed by HSAG in 2019. The final validation findings and rates for both measurement years will be included in the CY 2019 EQR Technical Report.

Validation of Performance Improvement Projects

In addition to performing individual MCO PIP validations, HSAG compared the final validation findings and conclusions across both MCOs for both PIP topics. The final validation findings are shown in Table 8-2.

Table 8-2—2018 PIP Validation Results for MCOs

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
<i>Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life</i>	Amerigroup	100%	100%	<i>Met</i>
	UnitedHealthcare	100%	100%	<i>Met</i>
<i>Member Satisfaction</i>	Amerigroup	100%	100%	<i>Met</i>
	UnitedHealthcare	100%	100%	<i>Met</i>

The purpose of a PIP is to achieve statistically significant and sustained improvement in an area that has been identified as requiring improvement. The following section provides a comparison of the baseline performance for each PIP topic conducted by the MCOs. The PIPs for both MCOs have not yet progressed to the remeasurement stage. HSAG will report the first remeasurement study indicator performance and whether statistically significant improvement was achieved in the CY 2019 EQR Technical Report.

Baseline Study Indicator Rates

Table 8-3 displays the baseline measurement performance and MCO-designated goals for Amerigroup and UnitedHealthcare for both the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction* PIPs.

Table 8-3—Baseline Study Indicator Rates by MCO

MCO Name	PIP Topic	Study Indicator	Baseline Rate	Plan-designated Goal
Amerigroup	<i>Well-Child Visits in the third, Fourth, Fifth, and Sixth Years of Life</i>	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%	64.7%
	<i>Member Satisfaction</i>	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.	58.7%	64.4%
UnitedHealthcare	<i>Well-Child Visits in the third, Fourth, Fifth, and Sixth Years of Life</i>	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%	75.6%
	<i>Member Satisfaction</i>	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.	63.2%	63.5%

For the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, Amerigroup reported that 53.9 percent of members 3 to 6 years of age had one or more well-child visits with a PCP during the measurement period. For UnitedHealthcare, the baseline performance showed that 72.6 percent of members 3 to 6 years of age had one or more well-child visits with a PCP.

For the *Member Satisfaction* PIP, 58.7 percent of Amerigroup’s members and 63.2 percent of UnitedHealthcare’s members answered CAHPS adult survey Question #35 (overall satisfaction with the MCO) with a score of 9 or 10. Both MCOs set Remeasurement 1 goals based on the baseline outcomes.

Network Adequacy

Survey results are presented statewide and by MCO, including the percentage of provider locations that could be reached, the percentage of provider locations accepting new patients, the number of calendar days to the first available appointment, and whether the time to the first available appointment was within the contract standard for the pertinent appointment type.

Table 8-4 reports the survey response rate by MCO regarding whether provider locations (cases) were able to be contacted. A case was considered a “non-respondent” if HSAG callers were unable to contact

the office (i.e., the telephone number was disconnected, or the caller was unable to speak with the provider’s office after two call attempts).

Table 8-4—Telephone Survey Response Rate, by MCO

MCO	Total Number of Sampled Cases	Respondents	Non-Respondents	Response Rate (%)
Amerigroup	463	312	151	67.4
UnitedHealthcare	453	299	154	66.0
Statewide	916	611	305	66.7

Table 8-5 reports survey responses related to cases’ status as a PCP and participation with the MCO. Among the 611 respondent cases, 95 indicated that the provider location did not offer primary care, and HSAG excluded these cases from subsequent analyses (i.e., 516 cases confirmed to be PCPs were included as the denominator for the MCO participation rate).

Table 8-5—Plan Participation Distribution for Respondents, by MCO

MCO	Total Number of Respondents	PCP Respondents	PCP Respondents Participating With MCO	PCP Respondents Not Participating With MCO	MCO Participation Rate (%)
Amerigroup	312	259	243	16	93.8
UnitedHealthcare	299	257	240	17	93.4
Statewide	611	516	483	33	93.6

Table 8-6 presents survey responses related to PCP respondents’ acceptance of new Medicaid patients.

Table 8-6—New Patient Acceptance Rates, by MCO

MCO	PCP Respondents Participating With MCO ¹	Accepting New Patients	
		#	%
Amerigroup	243	155	63.8
UnitedHealthcare	240	180	75.0
Statewide	483	335	69.4

¹ The denominator is the number of contacted provider locations that indicated they were PCPs contracted with the specified MCO.

Table 8-7 reports the number and percentage of provider locations offering an appointment date with the sampled provider and location for the requested appointment type (i.e., routine, urgent symptoms, or persistent symptoms), and whether the resulting appointment information met contract standards for the requested appointment type.

Table 8-7—Aggregate Appointment Availability, by MCO

MCO	N ¹	Provider Locations Offering an Appointment		Appointments Within Contract Standards	
		#	%	#	%
Amerigroup	155	122	78.7	61	50.0
UnitedHealthcare	180	118	65.6	64	54.2
Statewide	335	240	71.6	125	52.1

¹ The denominator is the number of contacted provider locations that indicated they were PCPs contracted with the specified MCO and were accepting new patients.

Table 8-8 summarizes appointment availability for Medicaid members requesting a routine well-check, including the percentage of cases in which the appointment offered met the contract standard for this appointment type (i.e., six weeks).

Table 8-8—New Patient Appointment Wait Time in Calendar Days—Routine Well-Check, by MCO

MCO	Provider Locations Offering an Appointment			Appointment Wait Time in Calendar Days				Appointments Within Six Weeks ¹		
	N ²	#	%	Min	Max	Median	Average	N ³	#	%
Amerigroup	53	36	67.9	0	83	13.5	18.7	36	32	88.9
UnitedHealthcare	58	37	63.8	0	65	11.0	15.7	37	35	94.6
Statewide	111	73	65.8	0	83	13.0	17.2	73	67	91.8

¹ Six weeks, or 42 calendar days, is the contract standard for routine appointments.

² The denominator is the number of provider locations contacted for a routine well-check appointment that indicated they were PCPs contracted with the specified MCO and were accepting new patients.

³ The denominator is the number of provider locations that offered appointment availability for a routine well-check with a new Medicaid patient.

Table 8-9 summarizes appointment availability for Medicaid members with persistent symptoms, including the percentage of cases in which the appointment offered met the contract standard for this appointment type (i.e., two days).

Table 8-9—New Patient Appointment Wait Time in Calendar Days—Persistent Symptoms, by MCO

MCO	Provider Locations Offering an Appointment			Appointment Wait Time in Calendar Days				Appointments Within Two Days ¹		
	N ²	#	%	Min	Max	Median	Average	N ³	#	%
Amerigroup	57	47	82.5	0	120	5.0	17.0	47	16	34.0
UnitedHealthcare	61	43	70.5	0	161	4.0	12.3	43	18	41.9
Statewide	118	90	76.3	0	161	5.0	14.8	90	34	37.8

¹ Two calendar days is the contract standard for appointments among Medicaid members with persistent symptoms (e.g., a persistent cough).

² The denominator is the number of provider locations contacted for a persistent symptoms appointment that indicated they were PCPs contracted with the specified MCO and were accepting new patients.

³ The denominator is the number of provider locations that offered appointment availability for a new Medicaid member with persistent symptoms.

Table 8-10 summarizes appointment availability for Medicaid members with urgent symptoms, including the percentage of cases in which the appointment offered met the contract standard for this appointment type (i.e., one day).

Table 8-10—New Patient Appointment Wait Time in Calendar Days—Urgent Symptoms, by MCO

MCO	Provider Locations Offering an Appointment			Appointment Wait Time in Calendar Days				Appointments Within One Day ¹		
	N ²	#	%	Min	Max	Median	Average	N ³	#	%
Amerigroup	45	39	86.7	0	77	4.0	10.0	39	13	33.3
UnitedHealthcare	61	38	62.3	0	150	4.0	11.8	38	11	28.9
Statewide	106	77	72.6	0	150	4.0	10.9	77	24	31.2

¹ One calendar day is the contract standard for appointments among Medicaid members with urgent symptoms (e.g., a sore throat with a fever).

² The denominator is the number of provider locations contacted for an urgent symptoms appointment that indicated they were PCPs contracted with the specified MCO and were accepting new patients.

³ The denominator is the number of provider locations that offered appointment availability for a new Medicaid member with urgent symptoms.

Overall, HSAG achieved a response rate of 66.7 percent for this study. Survey results show a high rate of MCO accuracy with minimal variation by MCO, as 93.6 percent of provider locations that could be reached and identified as PCPs were still contracted with the sampled MCO. However, only approximately two-thirds of contacted provider locations were able to corroborate the new patient acceptance information noted in the provider data. Specifically, new patients were only accepted for 63.8 percent of Amerigroup’s contacted provider locations and 75.0 percent of UnitedHealthcare’s contacted provider locations.

While 71.6 percent of the contacted provider locations were able to offer an appointment date for a new Medicaid patient, only 52.1 percent of these appointment wait times were in compliance with contract standards for the applicable appointment type. Low compliance for appointment timeliness related to urgent or persistent symptoms may result from the stringent contract requirements under which Iowa providers are expected to see these patients (i.e., one or two days, respectively). Additionally, prior surveys conducted by HSAG in other states have shown that timelier appointments are typically offered to existing Medicaid members when requesting either a well-check or problem-focused (“sick”) visit from a PCP-type provider, when compared to appointment timeliness among new patients with Medicaid.

For future studies, DHS could consider expanding the current appointment availability survey among PCPs 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.

CY 2017 Encounter Data Validation

The following summarizes and compares MCO performance on the administrative analysis conducted for the CY 2017 EDV activity.

Encounter Volume by Service Month

- The visit/service counts by service month for inpatient and LTC data were relatively stable over time, indicating that the encounter data volume is relatively complete.
- For the outpatient, pharmacy, and HCFA-1500 encounter types, the visit/service counts in July 2016 were consistently lower than in other months. Since both MCOs showed this pattern, seasonality may have been a contributing factor. However, DHS should continue to monitor this pattern to ensure data completeness.

Paid Amount by Service Month

- The paid amounts by service month generally showed a similar trend to those for the visit/service counts by service month.

Data Completeness Variation Among MCOs

- The MCOs submitted generally both complete and accurate encounter data, when evaluating record counts by MMIS month, visit/service counts by service month, and paid amounts by service month.

Lag Days Between MCO Payment Date and MMIS Date

- DHS requires the MCOs to submit encounters by the 20th of the month subsequent to the month in which data are reflected. Based on the overall rates for the study period, neither of the MCOs met the contract requirement; however, the monthly timeliness results between April 2016 and June 2017 showed that both MCOs were improving on this measure.

Field-Level Encounter Data Completeness and Accuracy

- The percent present rates for the Secondary Diagnosis Code and the Surgical Procedure Code fields had minimal variation among the MCOs.
- For the CPT/HCPCS code, the MCOs' percent present rates were 63.3 percent for UnitedHealthcare and 65.4 percent for Amerigroup for the LTC encounters.
- For the DRG Code field, the percent present rate for UnitedHealthcare for inpatient encounters was 21.7 percent while the percent present rate for Amerigroup was above 93 percent. This likely indicates that DHS is missing DRG codes from UnitedHealthcare's inpatient encounters.
- The relatively low statewide percent present rates for the legacy billing and rendering provider numbers in the HCFA-1500 encounters were contributed by both MCOs.

In analyzing the encounter files submitted by MCOs, HSAG identified the following areas for DHS' consideration:

- DHS should evaluate whether it is reasonable to have had higher inpatient visits and payments in April 2016.
- DHS should evaluate whether it is missing pharmacy encounters with dates of service in April and July 2016 from all MCOs.
- DHS should continue to monitor the monthly visits and paid amounts per 1,000 member months for the outpatient and HCFA-1500 encounter types, to evaluate whether it was normal to have had lower utilization rates in July 2016.
- DHS should continue to encourage MCOs to submit encounters to DHS in a timely manner.
- DHS should continue to work with MCOs to resolve issues regarding the billing/rendering/attending/prescribing provider NPIs.

CY 2018 Encounter Data Validation

To conduct the comparative analysis, HSAG obtained the encounter data needed from DHS and the MCOs. The CY 2018 EDV study was ongoing at the time of this report; therefore, comparative information regarding the MCOs' performance will be presented in the CY 2019 EQR Technical Report.

Focused Study—Case Management

Table 8-11 provides information that can be used to compare the MCOs' performance in each of the areas reviewed during the focused study.

Table 8-11—MCO Overall Score Comparison*

Section	Total Elements	Amerigroup				UnitedHealthcare			
		Y	N	NA	Score	Y	N	NA	Score
B	20	15	5	0	75%	20	0	0	100%
C	20	2	10	8	17%	8	5	7	62%
D	70	20	46	4	30%	40	27	3	60%
E	100	51	44	5	54%	80	16	4	83%
F	20	14	6	0	70%	19	1	0	95%
G	10	0	1	9	0%	2	1	7	67%
H	20	15	5	0	75%	19	1	0	95%
Total	260	117	117	26	50%	188	51	21	79%

Section A—Member Information (section not scored and therefore not presented in the table)
 Section B—Service Plan Development Frequency
 Section C—Provision of Services
 Section D—Service Plan Development: Person-Centered Planning Process
 Section E—Service Plan Content
 Section F—Service Plan Content: Emergency Plan
 Section G—Service Plan Content: Supported Community Living
 Section H—Case Management Contact Guidelines

*The results reflected in this table are not statistically significant or representative of performance as related to the MCO’s membership as a whole.

While the results of the focused study identified several opportunities for both MCOs, UnitedHealthcare outperformed Amerigroup in each of the seven areas reviewed. Additionally, UnitedHealthcare demonstrated strong performance, scoring 95 percent or above in three areas, whereas all scores for Amerigroup were at or below 75 percent. Overall, Amerigroup received a score of 50 percent and UnitedHealthcare a score of 79 percent.

The two largest sections (Section D and Section E), which accounted for 324 of the 473 total applicable scoring elements, also accounted for the majority of *No* findings (133) across both MCOs and demonstrated the greatest need for improvement related to implementation and documentation of the person-center planning process and service plan content requirements. Amerigroup also demonstrated a need to improve processes related to the provision of services, specifically for monitoring and ensuring that members are receiving services as authorized in the service plan.

Based on the results of the focused study, HSAG recommends the use of performance measures aimed at care management services for persons enrolled in HCBS waiver programs. In collaboration with DHS, HSAG developed state-specific performances measures applicable to the HCBS waiver programs. HSAG recommends that DHS use the rates calculated for CY 2018 as a baseline to which future rates may be compared. The rates generated for these performance measures will allow DHS and the MCOs to identify opportunities to achieve higher quality in the care management and services coordinated for persons served in the HCBS programs.

9. PAHP Comparative Information

Comparative Analysis of the PAHPs by Activity

In addition to performing a comprehensive assessment of the performance of each PAHP, HSAG compared the findings and conclusions established for each PAHP to assess the quality, access, and timeliness of the DWP.

Compliance Monitoring

Table 9-1 provides information that compares the PAHPs' performance for each of the 13 compliance standard areas.

Table 9-1—Standards and Compliance Scores: PAHP Comparison

Standard	Total Elements	DDIA				MCNA			
		M	NM	NA	Score	M	NM	NA	Score
I	10	7	3	0	70%	9	1	0	90%
II	3	3	0	0	100%	3	0	0	100%
III	11	6	1	4	86%	10	1	0	91%
IV	24	14	10	0	58%	22	2	0	92%
V	12	11	1	0	92%	11	1	0	92%
VI	23	11	10	2	52%	14	7	2	67%
VII	7	3	4	0	43%	7	0	0	100%
VIII	16	12	1	3	92%	12	1	3	92%
IX	43	28	15	0	65%	33	10	0	77%
X	8	6	2	0	75%	2	6	0	25%
XI	7	7	0	0	100%	5	2	0	71%
XII	11	8	3	0	73%	11	0	0	100%
XIII	13	13	0	0	100%	13	0	0	100%
Total	188	129	50	9	72%	152	31	5	83%

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—Enrollee Information and Enrollee Rights
 Standard VII—Confidentiality of Health Information
 Standard VIII—Enrollment and Disenrollment
 Standard IX—Grievance and Appeal System
 Standard X—Subcontractual Relationships and Delegation
 Standard XI—Practice Guidelines
 Standard XII—Quality Assessment and Performance Improvement
 Standard XIII—Health Information Systems

While performance across the PAHPs varied, both PAHPs achieved full compliance for Standard II—Assurances of Adequate Capacity and Services and Standard XIII—Health Information Systems. Both PAHPs also received the same compliance scores of 92 percent for Standard V—Provider Network and Standard VIII—Enrollment and Disenrollment. Of the remaining nine standards, MCNA outperformed DDIA in five standards, while DDIA achieved higher compliance scores for two standards. Overall, MCNA outscored DDIA by 11 percentage points. Collectively, the two areas with the greatest number of opportunities for improvement for both PAHPs include Standard VI—Enrollee Information and Enrollee Rights, with 17 *Not Met* findings, and Standard IX—Grievance and Appeal System, with 25 *Not Met* findings.

Validation of Performance Measures

Based on HSAG’s validation of performance measures, HSAG had no concerns with DDIA’s or MCNA’s data processing, integration, and measure production. HSAG determined that both PAHPs followed the State’s specifications and produced *Reportable (R)* rates for all measures in the scope of the validation of performance measures, which are presented in Table 9-2 below.

Table 9-2—PAHP Performance Measure Rates

Performance Measures	DDIA		MCNA	
	Count	Percent	Count	Percent
<i>DWP Unique Members with 6+ Month Coverage</i>	198,888 ¹	NA	89,661 ¹	NA
<i>DWP Unique Members with 6+ Month Coverage and Accessing Care</i>	82,120 ²	41.29%	18,915 ²	21.10%
<i>DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation</i>	66,594 ³	81.09%	13,102 ³	69.27%

¹ Represents total count of unique DWP members with six or more months of coverage.

² Represents the number of unique DWP members with six or more months of coverage who accessed care.

³ Represents the number of unique DWP members with six or more months of coverage who accessed care and received an oral health evaluation.

NA = Not applicable.

The number of unique DWP members enrolled with DDIA was more than double MCNA’s enrollment. DDIA’s measure rates for *DWP Unique Members with 6+ Month Coverage and Accessing Care* and *DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation* were 41.29 percent and 81.09 percent, respectively, which exceeded MCNA’s rates for both measures.

Validation of Performance Improvement Projects

In addition to performing individual PAHP PIP validations, HSAG compared the final validation findings and conclusions across both PAHPs for the PIP topic. The final validation findings are shown in Table 9-3.

Table 9-3—2018 PIP Validation Results for PAHPs

Name of Project	Type of Annual Review	Percentage Score of Evaluation Elements Met	Percentage Score of Critical Elements Met	Overall Validation Status
<i>Annual Dental Visits</i>	DDIA	88%	80%	<i>Partially Met</i>
	MCNA	100%	100%	<i>Met</i>

After resubmission of the Design stage of the PIP, DDIA received a *Met* score for 88 percent of the evaluation elements, resulting in an overall *Partially Met* validation status. MCNA received a *Met* score for 100 percent of the evaluation elements, which resulted in an overall *Met* validation status. Both PAHPs were advised to proceed to the next stage of the PIP, which is the Implementation stage.

For CY 2018, the PAHPs did not progress to reporting study indicator data; therefore, study indicator results are not included. The CY 2019 technical report will include a comparison of the PAHPs’ baseline performance for each study indicator.

Network Adequacy

To assess the capacity of Iowa’s dental provider network and to establish baseline ratios, HSAG calculated the ratio of members to providers for each Iowa PAHP. As provider ratios assess only one dimension of network adequacy, the provider capacity analysis was coupled with a geographic distribution analysis to provide additional insight into members’ access to providers.

Table 9-4 displays counts of Iowa Medicaid members with dental service coverage included in the network analyses, by PAHP and statewide.

Table 9-4—Population of Eligible Members by PAHP

Category	Delta Dental	MCNA	Statewide
Members	113,832	41,533	155,365

Member volume varied between the two PAHPs, with DDIA managing services for 73.3 percent of Iowa’s adult Medicaid population with dental coverage.

Table 9-5 displays the number of providers and the provider ratios (i.e., the number of members for each contracted provider) for all dental specialties by PAHP. Statewide provider totals do not equal the sum of the PAHP provider counts because some providers are contracted with both DDIA and MCNA.

Table 9-5—Summary of Ratio Analysis Results for General Dentists and Dental Specialists by PAHP, Including Out-of-State Providers in Contiguous States

Provider Category	DDIA		MCNA		Statewide	
	Providers	Ratio (Members per Provider)	Providers	Ratio (Members per Provider)	Providers	Ratio (Members per Provider)
General Dentists						
General dentists	834	136	366	113	905	172
Dental Specialists						
Endodontists	12	9,486	7	5,933	12	12,947
Oral surgeons	62	1,836	27	1,538	64	2,428
Orthodontists*	7	N/A	11	N/A	15	N/A
Pedodontists*	33	N/A	24	N/A	42	N/A
Periodontists	8	14,229	7	5,933	9	17,263
Prosthodontists	21	5,421	19	2,186	22	7,062

* HSAG provided counts of the number of orthodontists and pedodontists in each PAHP’s provider network because these specialists serve adult members ages 19 to 20 years (pedodontists also serve adult members with behavior management issues). HSAG excluded orthodontists and pedodontists from the provider ratio and time/distance analyses because most of the population served by these providers (i.e., children) are not included in this network analysis report.

Statewide provider counts indicated significant overlap between DDIA’s and MCNA’s provider networks for many specialists. Generally, MCNA had relatively few specialists also contracted with DDIA. For example, based on the total number of providers in the statewide network, almost all endodontists, periodontists, and prosthodontists contracted with MCNA were also contracted with DDIA. Consequently, for those provider specialty categories with substantial overlap of providers between DDIA and MCNA, the statewide ratio may provide a more accurate representation of the Medicaid provider ratio.

Provider ratios for general dentists were relatively low for both DDIA and MCNA, with ratios of 136 members per provider (136:1) and 113 members per provider (113:1), respectively. However, provider ratios for dental specialists were relatively high when compared to those for general dentists. Though a relatively small proportion of Medicaid members likely require services from dental specialists, the small number of specialists in each PAHP’s network underscore a potential capacity limitation. Of note, both PAHPs had few periodontists to serve their member populations. For example, DDIA had eight periodontists to serve a population of 113,832 members (provider ratio of 14,229:1), and MCNA had seven periodontists to serve a population of 41,533 members (provider ratio of 5,933:1).

Geographic Network Distribution Analyses

The geographic network distribution analyses assessed whether PAHP provider networks placed travel-related burdens on members regarding access to the nearest providers. DHS has established contract

standards for the maximum allowable driving distance or driving time that members must travel to receive care from general dentists. PAHPs must ensure that 100 percent of its Medicaid members have access to an in-network general dentist within reasonable driving times or driving distances. Due to the large rural population among Iowa Medicaid members, the time/distance standard has different requirements for members in rural areas compared to urban areas: members with urban addresses must have access to a general dentistry location within 30 miles or 30 minutes, and members with rural addresses should be within 60 miles or 60 minutes.

HSAG used Quest Analytics Suite software to calculate the percentage of each PAHP's members meeting DHS' time/distance standards using the previously geocoded data. HSAG conducted the analysis separately for members residing in urban versus rural areas, though overall compliance was based on the percentage of all members meeting the time/distance standards. All DDIA members were found to have access to a general dentist within DHS' time/distance standards. MCNA's provider network was found to be slightly below the standard, with 99.5 percent of its Medicaid members having access to a general dentist within the time/distance standard.

DHS had no time/distance standards for dental specialists. Consequently, HSAG calculated average driving times and driving distances for the nearest three in-network providers by provider category. 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. DHS did not employ standards for average driving distances or driving times for dental providers; therefore, results should be examined for relative reasonability rather than for compliance.

Overall, DDIA members had short travel distances and travel times to general dentists and moderate travel distances and travel times to oral surgeons and endodontists. 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 periodontists and prosthodontists required average driving distances exceeding 60 miles and driving times exceeding 70 minutes (full results shown in Section 6).

Overall, MCNA members had short travel distances and travel times to general dentists. Members also had reasonable access to the first-nearest 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 all three specialist categories, indicating that provider access and choice may be heavily affected by travel burden (full results shown in Section 7).

To determine if the ratios of contracted providers to enrolled members are consistent with the ratios of providers providing care to members accessing care, DHS might consider requiring the PAHPs to conduct an analysis using provider data from the *DWP Unique Members with 6+ Months Coverage and Accessing Care* performance measure 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.

Encounter Data Validation

The IS review provided self-reported qualitative information from each PAHP regarding dental encounter data processes. This section summarizes and compares PAHP performance on the IS review conducted for the CY 2018 EDV activity.

Based on contractual requirements and DHS' data submission requirements (e.g., companion guides), each PAHP demonstrated dental encounter submission and oversight processes, though formal documentation (e.g., policies and procedures) may not have been submitted with each PAHP's questionnaire response. Each PAHP submits dental encounters in the 837D format to DHS monthly. However, PAHPs may originally receive dental claims through different media (e.g., direct Web data entry, claim warehouses, and paper claims in ADA claim format). Each PAHP submits paid, denied, and adjusted dental encounters to DHS. While each PAHP is able to submit adjusted dental encounters to DHS after the original dental encounters have been submitted, the PAHPs' processes for submitting adjusted encounters differ slightly. As a result, DHS has identified that DDIA had not been submitting replacement transactions for adjustments as expected by the current MMIS encounter data processing. DHS noted that while DDIA has implemented the necessary changes to send full replacement transactions, historical transactions have not been addressed.

Each PAHP collects and maintains its respective PAHP provider data and verifies whether these data match the provider information on the claims/encounters. Each PAHP compares its provider data with the IME provider master file and selects certain records for review and correction, where necessary. These activities are driven by the requirements that all PAHPs' dental providers must be enrolled with IME Provider Services, and encounters without a valid provider ID (e.g., NPI and tax ID) are rejected in the MMIS.

Each PAHP's dental claims are processed against state-approved benefit guidelines and priced using a state-approved fee schedule. Each PAHP's providers are paid line by line using the FFS payment model. Before finalizing the claims adjudication cycle, each PAHP uses TPL data to determine the applicability of TPL claims. When PAHPs are not responsible for payment from a service due to a primary carrier, each PAHP reports the primary carrier's payment information and a zero-paid amount for itself in the encounter submitted to DHS.

To monitor the completeness and accuracy of dental encounters submitted by the providers, DDIA performs data validation to include (but not limited to) validation of the procedure codes, verifying accurate provider information, verifying modifiers are appropriate for the associated procedures, and verifying the accuracy of member information. Similarly, MCNA's fully integrated MIS, DentalTrac, performs different levels of edits and controls to ensure the accuracy, quality, and completeness of encounter data it submits 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.

For timeliness metrics, each PAHP monitors encounter data on set dates or frequencies for data submissions. Each PAHP has processes in place to track encounters sent to DHS. Each PAHP processes the 999 response files and the 277CA response files received from DHS so that it can monitor the rejections/errors and handle the corrections and resubmissions, if necessary.

Based on its review, HSAG identified recommended areas of improvement that, once addressed, could improve the quality of dental encounter data submissions from the contracted PAHPs to DHS:

- DHS requires the PAHPs to maintain an encounter submission schedule that ensures monthly dental encounter data transmissions. However, standards for submission time after date of service administration are not currently in place. Though each PAHP employs time standards for submission of claims and encounters from its providers, neither currently monitors the timeliness of its encounter submission schedules in relation to the date the service was rendered. DHS should work with the PAHPs to establish timeliness metrics to facilitate general monitoring activities beyond basic submission frequency.
- The current dental encounter data process focuses on the submission and acceptance of the dental encounter data, rather than on the quality and completeness of these data. To provide a measurable way to ensure quality and completeness of the submissions, DHS should consider developing encounter data metrics and documentation specific to dental data in alignment with DHS' institutional objectives. Metrics could include performance measures (i.e., encounter data volume and associated standards) as well as the publication of enhanced companion guides and submission requirement documents. Submission requirements could provide specific instructions as to how PAHPs should identify and transmit adjusted claims. Further, DHS should consider requiring the submission of all records of interest. If DHS creates or revises submission requirements documents, it should consider forming a dental encounter data group consisting of PAHPs and their vendors to ensure requirements are developed within the parameters of existing dental encounter data systems.
- DHS should continue to work with DDIA to address the historical replacement transactions for adjustments that were not submitted as expected by the current MMIS encounter data processing.

Appendix A. External Quality Review Activities—MCOs

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 our 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 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 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. Beginning this year (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 is displayed below 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 included requirements that addressed the following performance areas:

- Standard I—Availability of Services
- Standard II—Assurances of Adequate Capacity and Services
- Standard IX—Grievances, Appeals, and State Fair Hearings
- Standard XII—Quality Assessment and Performance Improvement

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.

^{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/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Apr 22, 2019.

- Generating a list of 10 sample cases for both grievances and appeals for the on-site MCO audit from the list of such members submitted to HSAG from each MCO.
- Developing the agenda for the one-day 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 review of the grievance and appeal case files HSAG requested from the MCO.
- A review of the data systems that the MCO used in its operation such as grievance and appeal tracking.
- 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.

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 checklist reviewed, 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 grievances and appeals 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. 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 grievances and appeals.

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
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during the on-site review	January 1, 2018—September 30, 2018
Information obtained through interviews	November 27, 2018—November 28, 2018
Information obtained from a review of a sample of the MCO’s records for file reviews	July 1, 2018—September 30, 2018

Validation of Performance Measures

Activity Objectives

As set forth in 42 CFR §438.358, validation of performance measures is one of the mandatory EQR activities. The primary objectives of the PMV activities are to:

- Evaluate the accuracy of the performance measure data collected by the MCO.
- Determine the extent to which the specific performance measures calculated by the MCO (or on behalf of the MCO) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

To initiate the CY 2018 PMV activity, HSAG, in collaboration with DHS, developed Iowa-specific performance measures and associated measure specifications that focus on person-centered care

planning for those served in HCBS programs. Person-centered care planning recognizes the importance of preserving the individual choices and goals of persons served in HCBS programs, and now Iowa will have a mechanism to monitor and highlight the important work of each MCO's person-centered care planning approach. These measures focus on the following key areas:

- Receipt of authorized services
- Distribution of care plan
- Person-centered care plan meeting
- Care team lead
- Choice of HCBS setting

To accommodate the time needed to fully implement the measures and gather data, DHS requested HSAG to review rates from measurement year July 1, 2017–June 30, 2018, and measurement year July 1, 2018–June 30, 2019, during the on-site PMV to be completed by HSAG in 2019. The final validation findings for both measurement years will be included in the CY 2019 EQR Technical Report.

The following section describes the process HSAG will use to validate the measures calculated and reported by the MCOs in CY 2019.

Technical Methods of Data Collection and Analysis

HSAG will conduct the PMV activities in accordance with CMS guidelines in *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.^{A-5}

HSAG will follow the same process when validating each performance measure for each MCO, which includes the following steps that have been or will be completed in the next year:

Pre-Audit Strategy

- HSAG obtained a list of the performance measures that were selected by DHS for validation. Performance measure definitions and reporting templates were also provided by DHS for review by the HSAG validation team.
- HSAG then prepared a documentation request letter that was submitted to the MCOs outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, a completed Information Systems Capabilities Assessment Tool (ISCAT), Appendix V of the CMS PMV protocol, any additional supporting documentation necessary to complete the audit, a timetable for completion, and instructions for submission. HSAG

^{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, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>. Accessed on: Apr 23, 2019.

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 will provide the MCOs with an agenda describing the on-site visit activities and indicating the type of staff needed for each session. HSAG will also conduct a pre-on-site conference call with the MCOs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the MCOs.
- Upon receiving the completed ISCATs from the MCOs, HSAG will conduct a desk review of the tool and any supporting documentation submitted by the MCOs. HSAG will identify any potential issues, concerns, or items that require additional clarification. HSAG will also conduct a line-by-line review of the source code submitted by the MCOs for the performance measures either through a desk review or a WebEx.

On-Site Activities

HSAG will conduct an on-site visit with each MCO. HSAG will collect information using several methods including interviews, system demonstration, review of data output files, primary source verification (PSV), observation of data processing, and review of data reports. The on-site visit activities are described as follows:

- Opening session—The opening session will include introductions of the validation team and key MCO staff members involved in the PMV activities. Discussion during the session will cover the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- Evaluation of system compliance—The evaluation will include a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG will evaluate the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which will evaluate whether the MCOs performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of the ISCAT(s), HSAG will conduct interviews with key MCO staff members familiar with the processing, monitoring, and calculation of the performance measures. HSAG will use interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that written policies and procedures were used and followed in daily practice.
- Overview of data integration and control procedures—The overview will include discussion and observation of source code logic, a review of how all data sources were combined, and how the analytic file was produced for reporting the selected performance measure data. HSAG will review backup documentation on data integration and addressed data control and security procedures during this session.
- Primary Source Verification—HSAG will perform 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 will provide HSAG with a listing of the data the MCO will report to DHS. HSAG will select a random sample from the submitted data and request that the MCO provide proof-of-service documents or system screenshots

that allow for validation against the source data in the system. During the on-site review, these data will also be reviewed live in the MCO's systems for verification, which will provide 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 will assess the MCOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG will select cases across measures to verify that the MCOs have 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 are detected, the outcome is 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 will include a summation of preliminary findings based on the review of the ISCAT and the on-site visit and will revisit the documentation requirements for any post-on-site activities.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, HSAG will obtain and review the following key types of data as part of the validation of performance measures:

- Information Systems Capabilities Assessment Tool—HSAG will receive this tool from each MCO. The completed ISCATs provide HSAG with background information on the MCOs' policies, processes, and data in preparation for the on-site validation activities.
- Source Code (Programming Language) for Performance Measures—HSAG requested source code from each MCO. If the MCO did not produce source code to generate the performance measures, it will submit a description of the steps taken for measure calculation from the point the service was rendered through the final calculation process. HSAG will review the source code or process description to determine compliance with the performance measure specifications provided by DHS.
- Supporting Documentation—This documentation will provide additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- Current Performance Measure Results—HSAG will obtain the calculated results from DHS.
- On-site Interviews and Demonstrations—HSAG will also obtain information through interaction, discussion, and formal interviews with key MCO staff members, as well as through onsite systems demonstrations.

Table A-3 displays the performance measures included in the validation of performance measures and the validation review period to which the data applied.

Table A-3—List of Performance Measures for MCOs

Performance Measures Selected by DHS for Validation	
Measure	Measurement Periods
Performance Measure #1: <i>Receipt of Authorized Services</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019
Performance Measure #2: <i>Receipt of Authorized One-Time Services</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019
Performance Measure #3: <i>Provision of Care Plan</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019
Performance Measure #4: <i>Person-Centered Care Plan Meeting</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019
Performance Measure #5: <i>Care Team Lead Chosen by the Member</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019
Performance Measure #6: <i>Member Choice of HCBS Settings</i>	July 1, 2017–June 30, 2018 July 1, 2018–June 30, 2019

Based on all validation activities, HSAG will determine results for each performance measure. The CMS PMV protocol identifies two possible validation finding designations for performance measures: *Report (R)* or *Not Reported (NR)*.

According to the CMS protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of “NR” because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of “R.”

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure “NR.”

After completing the validation process, HSAG will prepare a report of the PMV review findings, which will include recommendations for each MCO reviewed. HSAG will send these reports, which comply with 42 CFR §438.364, to DHS and the appropriate MCOs.

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 MCO 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 quality improvement
- 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-6} HSAG's validation of PIPs includes two key components of the quality improvement process:

1. 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.
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 MCOs improve rates through implementation of effective processes (i.e., evaluation of outcomes, barrier analyses, and interventions).

^{A-6} 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.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Apr 23, 2019.

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 quality improvement 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 CMS’ EQR Protocol 3, cited above. 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.

For the calendar year (CY) 2018 submissions, MCOs reported baseline data and were validated for Steps I through VIII in the validation tool.

The 10 steps included in the PIP Validation Tool are listed below:

- Step I. Review the Selected Study Topic
- Step II. Review the Study Question(s)
- Step III. Review the Identified Study Population
- Step IV. Review the Selected Study Indicator(s)
- Step V. Review Sampling Methods
- Step VI. Review the Data Collection Procedures
- Step VII. Review Data Analysis and Interpretation of Study Results
- Step VIII. Assess the 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 *Point of Clarification* 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 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*, 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 and 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 MCO. These reports, which complied with 42 CFR §438.364, were provided to DHS and the MCOs.

Description of Data Obtained and Related Time Period

For CY 2018, the MCOs submitted baseline data. The study indicator measurement period dates are listed below.

Table A-4—Data Obtained and MCO Measurement Period

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 PCP locations statewide to evaluate the average length of time to an appointment for a Medicaid beneficiary scheduling an appointment with an Iowa-licensed PCP. 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 PCPs are accepting new Medicaid patients.
- Determine whether appointment availability meets the contract standards.

Technical Methods of Data Collection and Analysis

HSAG obtained Medicaid provider information, including practice location and provider specialty, from the MCOs during May 2018.^{A-7} Out-of-state provider locations in counties contiguous to Iowa were included in the sample frame, as these provider locations may serve Iowa Medicaid members. Upon receipt of the data, HSAG defined a subgroup of active, office-based PCPs according to provider category, status as a PCP, and acceptance of new patients. The list of PCPs eligible for inclusion in the survey was deduplicated by NPI and location for each MCO (i.e., the sample frame).

To identify provider locations for inclusion in the survey, HSAG used a two-stage random sampling approach. First, HSAG selected a statistically valid sample from the list of unique providers for each MCO based on a 95 percent confidence level and ± 5 percent margin of error.^{A-8} A 30 percent oversample was added to the sample size for each MCO to increase the probability of capturing appointment availability information from a statistically valid number of providers. For the second sampling stage, HSAG identified all locations contracted with the specific MCO for each sampled provider and randomly selected one location to be surveyed (i.e., the “provider location” or “survey case”). The selected provider locations were unique to each MCO, and a provider location may have been included in the survey for more than one MCO.

HSAG randomly distributed the sampled provider locations equally across the following appointment types:

- Routine (e.g., annual well-check appointment)
- Persistent symptoms (e.g., persistent cough or sore throat without a fever)

^{A-7} HSAG requested data for all providers enrolled with the MCO as of March 31, 2018.

^{A-8} This sampling approach allows the survey results to be generalized to the overall population of PCPs contracted with each MCO.

- Urgent symptoms (e.g., sore throat with a fever)

HSAG surveyed the sampled provider locations by telephone, using the information collected to assess the acceptance of new patients, evaluate appointment availability, and determine whether appointment availability aligned with the MCO contract standards presented in Table A-5.

Table A-5—Access Standards for Appointment Availability

Appointment Type	Appointment Availability Standard
Routine	6 weeks
Persistent Symptoms	2 days
Urgent Symptoms	1 day

Description of Data Obtained and Related Time Period

Survey calls were placed during July 2018, and responses from sampled provider locations were entered into an electronic data collection tool. Prior to analyzing the results, HSAG reviewed the responses to ensure complete and accurate data entry. Survey responses from each sampled provider location were used to assess appointment availability and validate selected information from the provider file. HSAG’s callers assessed the following information during 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**
 - The sampled provider accepts the contracted MCO at the sampled location (Note: if the provider did not accept the MCO at the sampled location, the survey stopped)
 - The sampled provider accepts new patients at the sampled location (Note: if the provider did not accept new patients at the sampled location, the survey stopped)
- **Appointment Availability**
 - Number of calendar days to the first available appointment with the sampled provider for a new Medicaid patient (Note: the provider location was only asked for availability for one of the following randomly assigned appointment types: routine well-check, persistent symptoms, or urgent symptoms)

Due to the nature of the survey script, data may have been unavailable for some provider locations. For example, if the telephone number was incorrect for the location and a corrected telephone number could not be obtained from the person responding to the survey, the survey stopped, and remaining survey elements would be missing.

Results from the sampled provider locations were aggregated by MCO for analysis and reporting.

MCO Optional Activities

CY 2017 Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, DHS requires 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, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2017, DHS continued to contract with HSAG to conduct an EDV study 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-9} One or more of the following core evaluation activities could be incorporated into an EDV activity:

- Information systems (IS) review—assessment of DHS' and/or MCOs' information systems and processes
- Administrative profile—analysis of DHS' electronic encounter data completeness and accuracy
- 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
- Medical records review—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the medical records

During CY 2017, HSAG evaluated the administrative profile for DHS' electronic encounter data. The goal of the study was to examine the accuracy, completeness, and timeliness of DHS' encounter data. HSAG conducted the administrative profile analysis for three MCOs.^{A-10}

Technical Methods of Data Collection and Analysis

To examine the accuracy, completeness, and timeliness of DHS' encounter data, HSAG evaluated the following metrics:

- Metrics for encounter data completeness

^{A-9} 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.medicare.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html>.

Accessed on: Apr 23, 2019.

^{A-10} The three MCOs are Amerigroup, AmeriHealth, and UnitedHealthcare.

- Monthly encounter record counts (i.e., line items) by Medicaid Management Information System (MMIS) month (i.e., the month when encounters are processed by MMIS). For this metric, the adjudication history was included in the evaluation to show the original line items processed by MMIS. For the remaining metrics in this report, the analyses were based on final adjudicated records.
- Monthly encounter volume by service month (i.e., the month when services occur). For this metric, encounter volume was evaluated using visit/service-level variables (i.e., member, date of service, and provider) to avoid double counting.
- Monthly encounter volume per 1,000 member months by service month to account for variation on the member counts from month to month.
- Monthly paid amount per 1,000 member months by service month.
- Metrics for encounter data timeliness
 - Claims lag triangle to illustrate the percentage of encounters accepted into DHS’ data system within two months, three months, ..., and such from the service month.
 - Percentage of encounters processed by MMIS within 30 days, 60 days, 90 days, ..., and such from the MCO payment date.
- Metrics for field-level encounter data completeness and accuracy
 - Percent present and percent with valid values for selected key data elements listed in Table A-6. The last column in Table A-6 specifies the criteria for validity.

Table A-6—Key Encounter Data Elements

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Member ID	✓	✓	✓	<ul style="list-style-type: none"> • In member file supplied by DHS • Eligible for Medicaid on the date of service • Enrolled in a specific MCO on the date of service
Detail Service From Date	✓	✓	✓	<ul style="list-style-type: none"> • Detail Service From Date ≤ Detail Service To Date if Detail Service To Date is present • Detail Service From Date ≤ Header Last Date of Service if Detail Service To Date is missing • Detail Service From Date ≤ Paid Date

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Detail Service To Date	✓	✓		<ul style="list-style-type: none"> Detail Service From Date ≤ Detail Service To Date Detail Service To Date ≤ Paid Date if Detail Service To Date is present Paid Date ≥ Header Last Date of Service if Detail Service To Date is missing
Paid Date	✓	✓	✓	<ul style="list-style-type: none"> Paid Date ≥ Detail Service From Date; Paid Date ≥ Detail Service To Date
Legacy Billing Provider Number ¹	✓	✓	✓	<ul style="list-style-type: none"> In provider file supplied by DHS
Legacy Rendering Provider Number ¹	✓			<ul style="list-style-type: none"> In provider file supplied by DHS
Legacy Attending Provider Number ¹		✓		<ul style="list-style-type: none"> In provider file supplied by DHS
Prescribing Provider Number			✓	<ul style="list-style-type: none"> In provider file supplied by DHS
Primary Diagnosis Code	✓	✓		<ul style="list-style-type: none"> In national ICD-10-CM diagnosis code sets
Secondary Diagnosis Code	✓	✓		<ul style="list-style-type: none"> In national ICD-10-CM diagnosis code sets
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Code	✓	✓		<ul style="list-style-type: none"> In national CPT and HCPCS diagnosis code sets
Surgical Procedure Code		✓		<ul style="list-style-type: none"> In national ICD-10-CM surgical procedure code sets
Revenue Code		✓		<ul style="list-style-type: none"> In national revenue code sets
Diagnosis-Related Group (DRG) Code ²		✓		<ul style="list-style-type: none"> In national DRG code sets
National Drug Code (NDC)			✓	<ul style="list-style-type: none"> In national NDC code sets

¹ The data element contains legacy provider numbers which were derived within MMIS based on the national provider identifiers (NPIs) received from MCOs. While the extracted data did not contain NPIs for analysis purpose, DHS is monitoring the NPI fields. For example, DHS noted that the data element Attending Provider NPI is missing values for nursing facility encounters and DHS is addressing this issue.

² Data element DRG is missing values for encounters and DHS is addressing this issue.

HSAG also stratified the results by the appropriate encounter types, such as HCFA-1500, waiver, inpatient, long-term care (LTC), outpatient, and pharmacy. Overall, results from these metrics will help DHS evaluate encounter data accuracy, completeness, and timeliness, as well as set up future monitoring metrics, as appropriate.

Description of Data Obtained and Related Time Period

The CY 2017 EDV study used numerous data sources including encounter data, member demographic/enrollment data, and provider data. Based on the study objectives and data elements evaluated in this study, HSAG submitted a data submission requirements document to notify DHS of the required data. The data submission requirements included a brief description of the study, the review period, required data elements, and information regarding the submission of the requested files. Moreover, since the EDV study included similar data as those requested for the Calculation of Performance Measures and PPEs activities, the data submission requirements document only requested additional data fields needed for the EDV study.

After DHS reviewed and approved the data submission requirements document, DHS extracted the requested data from its MMIS and submitted them to HSAG between July and September of 2017 for the administrative profile analysis. In addition, DHS provided on February 1, 2018, one ad hoc file containing the last dates of service and on July 12, 2018, another ad hoc file used to identify final adjudication records. The administrative profile analysis examined the accuracy, completeness, and timeliness of DHS' encounter data with services dates between April 1, 2016, and December 31, 2016.

CY 2018 Encounter Data Validation

Activity Objectives

During CY 2018, DHS continued to contract with HSAG to conduct an EDV study. In alignment with the CMS EQR Protocol 4 cited earlier in this section, 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 perform poorly in the comparative analysis

During CY 2018, HSAG initiated a comparative analysis between DHS' electronic encounter data and the data extracted from the two MCOs^{A-11} data systems along with technical assistance to the MCOs based on the findings. The goal of the comparative analysis was to evaluate the extent to which

^{A-11} The two MCOs are Amerigroup and UnitedHealthcare.

encounters submitted to DHS by the MCOs are complete and accurate, based on corresponding information stored in the MCOs’ data systems.

Technical Methods of Data Collection and Analysis

To examine the extent to which encounters submitted to DHS by the MCOs are complete and accurate, the comparative analysis of the EDV study is 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 further examined completeness and accuracy for key data elements listed in Table A-7. The analyses focused on an element-level comparison for each data element.

Table A-7—Key Data Elements for Comparative Analysis

Key Data Elements	Professional	Institutional	Pharmacy
Member ID	√	√	√
Header Service From Date	√	√	√
Header Service To Date	√	√	
Admission Date		√	
Billing Provider NPI	√	√	√
Rendering Provider NPI	√		
Attending Provider NPI		√	
Prescribing Provider NPI			√
Referring Provider NPI	√	√	
Primary Diagnosis Code	√	√	
Second Diagnosis Code	√	√	
Procedure Code	√	√	
Procedure Code Modifier	√	√	
Primary Surgical Procedure Code		√	
Second Surgical Procedure Code		√	
National Drug Code (NDC)			√
Drug Quantity			√
Revenue Code		√	

Key Data Elements	Professional	Institutional	Pharmacy
Diagnosis related group (DRG)		√	
Header Paid Amount		√	√
Detail Paid Amount	√	√	
Dispensing Fee			√

Element-level completeness was 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 was limited to those records with values present in both the MCOs’ submitted files and DHS’ data warehouse. For a particular data element, HSAG determined:

- 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).

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. Then, 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 will now 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

The CY 2018 EDV study 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 represent 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.

HSAG developed a data requirements document requesting claims/encounter data from both DHS and the MCOs. Follow-up technical assistance sessions occurred approximately two weeks after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the sessions.

Once HSAG received data files from both data sources between August and December 2018, the analytic team conducted a preliminary file review to ensure enough data were available 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 matching 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 the MCOs to resubmit data, as needed. HSAG received final data for the analysis in January 2019.

Calculation of Performance Measures

Activity Objectives

HSAG analyzed performance measure results for HEDIS 2018 (i.e., data collected from January 1, 2017, through December 31, 2017) for Amerigroup and UnitedHealthcare. HSAG developed conclusions and made recommendations for the MCOs and DHS to develop strategic, tactical changes required to improve overall services provided by the MCO.

Technical Methods of Data Collection and Analysis

MCO-specific performance displayed in the CY 2018 EQR Technical Report was based on data elements obtained from the IDSS files supplied by the MCOs. MCOs collected CY 2017 data using the administrative (i.e., claims and encounter data) and hybrid (i.e., administrative data and medical record review) methods. Prior to HSAG’s receipt of the MCOs’ IDSS files, both MCOs were required by DHS to have their HEDIS 2018 results examined and verified through an NCQA HEDIS Compliance Audit.^{TM A-12}

HEDIS 2018 measure indicator rates received one of seven predefined audit results: *Reportable (R)*, *Small Denominator (NA)*, *Biased Rate (BR)*, *No Benefit (NB)*, *Not Required (NQ)*, *Unaudited (UN)*, and *Not Reported (NR)*. Rates designated as *BR*, *NB*, *NQ*, *UN*, or *NR* are not presented in this report. All measure indicator rates that are presented in this report have been verified as an unbiased estimate of the measure.

Measure rates were compared to the corresponding NCQA Quality Compass national Medicaid HMO percentiles for HEDIS 2018, which are expressed in percentiles of national performance for different

^{A-12} NCQA HEDIS Compliance AuditTM is a trademark of the National Committee for Quality Assurance (NCQA).

measures and referred to as “national Medicaid percentiles” throughout this report. Additionally, benchmarking data (i.e., NCQA’s Quality Compass) are the proprietary intellectual property of NCQA; therefore, this report does not display any actual percentile values. As a result, rate comparisons to benchmarks are illustrated within this report using proxy displays. Table A-8 displays the percentile ranking performance levels and star ratings.

Table A-8—Percentile Ranking Performance Levels

Star Rating	Performance Level
★★★★★	At or above the national Medicaid 90th percentile
★★★★	At or above the national Medicaid 75th percentile but below the national Medicaid 90th percentile
★★★	At or above the national Medicaid 50th percentile but below the national Medicaid 75th percentile
★★	At or above the national Medicaid 25th percentile but below the national Medicaid 50th percentile
★	Below the national Medicaid 25th percentile

HSAG then analyzed the data to determine if common themes or patterns existed that would allow conclusions about overall services to be drawn for each MCO independently.

Description of Data Obtained and Related Time Period

HSAG analyzed the audited IDSS files for HEDIS 2018 (CY 2017) submitted by Amerigroup and UnitedHealthcare.

Calculation of Potentially Preventable Events

Activity Objectives

DHS contracted with HSAG to calculate PPEs to assess current MCO performance.

Technical Methods of Data Collection and Analysis

HSAG worked with DHS to identify key PPE measures. HSAG utilized the Agency for Healthcare Research and Quality’s (AHRQ’s) Prevention Quality Indicators (PQIs), CMS Core Set of Health Care Quality Measures for Medicaid specifications, and the New York University (NYU) Center for Health

and Public Service Research’s ED Utilization Algorithm.^{A-13} HSAG calculated the following measures by MCO and key demographic variables:

- Inpatient Utilization
- Diabetes Long-Term Complications Admission Rate (PQI 03)
- Hypertension Admission Rate (PQI 07)
- Heart Failure Admission Rate (PQI 08)
- Uncontrolled Diabetes Admission Rate (PQI 14)
- Asthma in Younger Adults Admission Rate (PQI 15)
- Plan All-Cause Readmissions (HEDIS)
- Non-Recommended Cervical Cancer Screening in Adolescent Females (HEDIS)
- Appropriate Treatment for Children With Upper Respiratory Infection (HEDIS)
- Use of Imaging Studies for Low Back Pain (HEDIS)
- Use of Multiple Concurrent Antipsychotics in Children and Adolescents (HEDIS)
- NYU ED Utilization Algorithm, which classifies ED visits into the following four classifications:^{A-14}
 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 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.
 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.
- To calculate the PPE measures, HSAG requested a data extract from DHS and obtained member, provider, and claims and encounter data for Medicaid eligible individuals.

^{A-13} NYU/Wagner. Faculty & Research. Available at: <https://wagner.nyu.edu/faculty/billings/nyued-background>. Accessed on: Jan 16, 2019.

^{A-14} NYU/Wagner. Faculty & Research. Available at: <https://wagner.nyu.edu/faculty/billings/nyued-background>. Accessed on: Apr 23, 2019.

Description of Data Obtained and Related Time Period

HSAG calculated each measure using claims data provided by DHS for measure year 2016–2017 (i.e., April 1, 2016–March 31, 2017) and 2017–2018 (i.e., April 1, 2017–March 31, 2018) for Amerigroup and UnitedHealthcare.

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 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.

The Iowa Health Link MCO Scorecard was developed to help support DHS’ public reporting of MCO performance information to be used by consumers to make informed decisions about their healthcare. The 2018 Iowa Health Link MCO Scorecard enabled DHS to gain feedback from the MCOs and stakeholders to evaluate the program design and methodology and determine any changes that would be implemented for future years. The 2018 results were for information only and were not published.

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 2018 Specifications for Survey Measures, Volume 3* was used to collect and report on the CAHPS measures. The *HEDIS 2018 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.^{A-15}

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

^{A-15} National Committee for Quality Assurance. “Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers.” Washington, DC: NCQA; Oct 1998.

- 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 performance was below the national Medicaid 25th percentile.
- Two stars—The MCO’s performance was at or above the national Medicaid 25th percentile, but below the 50th percentile.
- Three stars—The MCO’s performance was at or above the national Medicaid 50th percentile, but below the 75th percentile.
- Four stars—The MCO’s performance was at or above the national Medicaid 75th percentile, but below the 90th 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 finalized 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 2018 HEDIS results, including 2018 CAHPS data from two MCOs for presentation in the 2018 Iowa Health Link MCO Scorecard.

Focused Study—Case Management

Activity Objectives

HSAG collaborated with DHS to design a focused review of MCO case management programs, which included an on-site review of service plans maintained by MCOs for HCBS waiver members and a summary of results. HSAG conducted pre-on-site and on-site activities during this focused review.

The primary objective of HSAG’s review was to provide meaningful information to DHS and its contracted MCOs regarding performance surrounding the person-centered service planning process. To accomplish this objective, HSAG developed and used a data collection tool, the Case Management Evaluation Tool, to assess and document the MCO’s performance. The Case Management Evaluation Tool is separated into eight sections as follows:

- **Section A:** Member Information
- **Section B:** Service Plan Development: Frequency
- **Section C:** Provision of Services
- **Section D:** Service Plan Development: Person-Centered Planning Process
- **Section E:** Service Plan Content
- **Section F:** Service Plan Content: Emergency Plan
- **Section G:** Service Plan Content: Supported Community Living
- **Section H:** Case Management Contact Guidelines

Technical Methods of Data Collection and Analysis

Study Questions

The two study questions HSAG considered for this focused study were:

1. To what extent are members actively involved in the person-centered planning process?
2. To what extent are the services described in the service plan reflective of the services agreed to by the member and the interdisciplinary team?

Population and Case File Selection

The eligible population for this study consisted of Iowa Medicaid members enrolled in a HCBS waiver program as of September 30, 2017, who were continuously enrolled with the MCO in a HCBS waiver program for the previous 14 months. Iowa’s Medicaid 1915(c) and 1915(i) HCBS waiver programs include:

- Health and Disability Waiver (HD)
- Human immunodeficiency virus (HIV) Waiver (members in this waiver will not be included in the sample selection due to privacy considerations)
- Elderly Waiver (EW)
- Intellectual Disability Waiver (ID)
- Brain Injury Waiver (BI)
- Physical Disability Waiver (PD)
- Children’s Mental Health Waiver (CMH)
- Habilitation Waiver (HAB)

HSAG selected the following 10 cases across the HCBS waiver programs, with an oversample of five cases.

- Children’s Mental Health Waiver—two cases
- Habilitation Waiver—two cases
- All other waiver populations—total of six cases

Population and Case File Selection

The Case Management Evaluation Tool served as the primary record of HSAG’s findings. During an on-site study, the Case Management Evaluation Tool was completed for each of the selected files.

HSAG used the following data sources:

- Case Management Evaluation Tool.
- The MCO’s case management information system.
- The MCO’s prior authorization and claims information systems.
- On-site interviews with MCO case management/subject matter experts during the case file review sessions.

Pre-On-Site Study Activities

Prior to the on-site study, the HSAG team requested and reviewed internal policies and procedures from the MCOs pertaining to person-centered service planning. This allowed HSAG reviewers to increase their knowledge and understanding of the MCO’s processes and identify areas needing further clarification.

HSAG provided the evaluation tool to the MCOs prior to the on-site study. The MCOs provided their preliminary scores for each element included in the Case Management Evaluation Tool for each of the HSAG-selected case management files. The information provided by the MCOs was reviewed and verified during the on-site portion of the study.

On-Site Study Activities

HSAG completed an on-site review of each of the selected case management files in collaboration with the MCO. MCO staff presented the cases, navigated the member record, and responded to all questions posed by the review team. HSAG reviewed the evaluation tools completed by the MCO and reviewed the MCO’s information systems to validate the MCO’s findings. HSAG documented its findings in the Case Management Evaluation Tool, which serves as a comprehensive record of HSAG’s findings. Only the final findings verified by HSAG are included in HSAG’s findings.

Data Aggregation and Analysis

HSAG documented the case file review results with a *Yes*, *No*, or *Not Applicable (N/A)* finding:

- *Yes*—The case file contained all review elements, and they complied with federal, State, and MCO policies.
- *No*—The case file did not contain all review elements, or the elements did not comply with federal, State, or MCO policies.
- *N/A*—The review element was not applicable to the case file.

HSAG calculated an overall score and section scores by adding the score for each requirement in the study receiving a score of *Yes* (1 point), *No* (0 points), and *Not Applicable* and dividing by the number of applicable elements.

Description of Data Obtained and Related Time Period

The eligible population for this study consisted of Iowa Medicaid members enrolled in a HCBS waiver program as of September 30, 2017, who were continuously enrolled with the MCO in a HCBS waiver program for the previous 14 months. Table A-9 lists the major data sources HSAG used in determining the MCO’s performance surrounding the person-centered service planning process.

Table A-9—Description of Data Sources for Person-Centered Service Planning

Data Source
Documentation submitted by the MCOs on the Case Management Evaluation Tool
Documentation in the MCO’s case management, prior authorization, and claims information systems
Information obtained through interviews

Appendix B. External Quality Review Activities—PAHPs

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 PAHP performance. For each of our activities HSAG used the following definitions to evaluate and draw conclusions about the performance of the PAHPs 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.^{B-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).^{B-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.”^{B-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 PAHP’s performance. For each activity, this section describes the objectives, technical methods of data collection and analysis, and

^{B-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.

^{B-2} Ibid.

^{B-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 PAHP-specific summary sections (sections 6 and 7) and in the comparative analysis presented in Section 9 of this report.

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 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 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 DHS, HSAG developed and used a data collection tool to assess and document the PAHP’s compliance with certain federal Medicaid managed care regulations and the associated DHS contractual requirements. The review tool included requirements that addressed the following 13 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—Enrollee Information and Enrollee Rights
- Standard VII—Confidentiality of Health Information
- Standard VIII—Enrollment and Disenrollment
- Standard IX—Grievance and Appeal System
- Standard X—Subcontractual Relationships and Delegation
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement
- Standard XIII—Health Information Systems

The information and findings that resulted from the HSAG review will be used by DHS and the PAHP 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.

The review was the first of the current three-year cycle of PAHP compliance reviews.

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 DHS and the PAHP 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^{B-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 PAHP 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 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 DHS, and of documents that the PAHP submitted to HSAG. 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.
- Generating a list of 10 sample cases plus an oversample for the grievance, appeal, and denial case file reviews.
- Developing the agenda for the two-day on-site review.
- Providing the detailed agenda to the PAHP to facilitate preparation for HSAG's review.

^{B-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/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Apr 23, 2019.

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 two-day review activities.
- A review of the documents HSAG requested that the PAHP have available on-site.
- A review of the grievance, appeal, and service denial files HSAG requested from the PAHP.
- A review of the data systems that the PAHP used in its operation such as care management, grievance and appeal tracking, quality improvement tracking, and quality measure reporting.
- Interviews conducted with PAHP key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate, and explained the corrective action process.

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 the PAHP during the period covered by HSAG's review. This scoring methodology is consistent with CMS' final protocol, EQR Protocol 1 (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, was present.
- Staff members were able to provide responses to reviewers that were consistent with each other and with the documentation.

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

- There was compliance with all documentation requirements, but staff members were unable to consistently articulate processes during interviews.
- Staff members could describe and verify the existence of processes during the interview, but documentation was incomplete or inconsistent with practice.
- No documentation was present and 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 *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 PAHP 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 checklists reviewed, 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 PAHP were scored *NA* and were not included in the denominator of the total score. To obtain a percentage score, HSAG added the total number of elements that received a *Yes* score, then divided by the total number of applicable elements.

HSAG conducted file reviews of the PAHP's records for grievances, appeals, and denials to verify that the PAHP had put into practice what the PAHP had documented in its policy. HSAG selected 10 files of each type of record from the full universe of records provided by the PAHP. The file reviews were not intended to be a statistically significant representation of all the PAHP's files. Rather, the file reviews highlighted instances in which PAHP staff did not follow procedures described in policy. Based on the results of the file reviews, the PAHP 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 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 performance in complying with each of the requirements.
- 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.
- The overall 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 to 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 and to the PAHPs for their 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, the following:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other PAHP communication to providers/subcontractors.
- The enrollee handbook, provider directory, and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- PAHP-maintained files for grievances, appeals, and service denials.

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

Table B-1 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-1—Description of PAHP Data Sources

Data Source	Time Period to Which the Data Applied
Documentation submitted for HSAG’s desk review and additional documentation available to HSAG during the on-site review	August 1, 2017–September 30, 2018
Information obtained from a review of a sample of the PAHP’s records related to file reviews	August 1, 2017–September 30, 2018
Information obtained through interviews	October 22, 2018–October 26, 2018

Validation of Performance Measures

Activity Objectives

As set forth in 42 CFR §438.358, the validation of performance measures was one of the mandatory EQR activities. The primary objectives of the PMV activities were to:

- Evaluate the accuracy of the performance measure data collected by the PAHP.
- Determine the extent to which the specific performance measures calculated by the PAHP (or on behalf of the PAHP) followed the specifications established for each performance measure.
- Identify overall strengths and areas for improvement in the performance measure calculation process.

HSAG validated a set of three performance measures developed and selected by DHS for validation. All measures were to be reported by the PAHPs annually.

Technical Methods of Data Collection and Analysis

HSAG conducted the PMV activities in accordance with CMS guidelines found in *EQR Protocol 2: Validation of Performance Measures Reported by the MCO: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.^{B-5}

HSAG followed the same process when validating each performance measure for each PAHP, which included the following steps:

Pre-Audit Strategy

- HSAG obtained a list of the performance measures that were selected by DHS for validation. Performance measure definitions and reporting templates were also provided by DHS for review by the HSAG validation team.
- HSAG then prepared a documentation request letter that was submitted to the PAHPs outlining the steps in the PMV process. The document request letter included a request for the source code for each performance measure, a completed ISCAT, Appendix V of the CMS PMV protocol, any additional supporting documentation necessary to complete the audit, a timetable for completion, and instructions for submission. 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 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 the PAHPs to discuss on-site logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the PAHPs.
- Upon receiving the completed ISCATs from the PAHPs, HSAG conducted a desk review of the tool and any supporting documentation submitted by the PAHPs. HSAG identified any potential issues, concerns, or items that required additional clarification. HSAG also conducted a line-by-line review of the source code submitted by the PAHPs for the performance measures either through a desk review or a WebEx.

^{B-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, September 2012. Available at: <https://www.medicare.gov/medicaid/quality-of-care/downloads/eqr-protocol-2.pdf>. Accessed on: Apr 11, 2019.

On-Site Activities

HSAG conducted an 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 are described as follows:

- Opening session—The opening session included introductions of the validation team and key PAHP staff members involved in the PMV activities. Discussion during the session covered the review purpose, the required documentation, basic meeting logistics, and queries to be performed.
- 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 PAHPs had performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of the ISCAT(s), HSAG conducted interviews with key PAHP staff members 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 written policies and procedures were used and followed 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 how the analytic file was produced for reporting the 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 DHS. HSAG selected a random sample from the submitted data and requested that the PAHP provide proof of service documents or system screenshots 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 PAHPs' 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 the on-site visit and revisited the documentation requirements for any post-on-site activities.

Description of Data Obtained and Related Time Period

As identified in the CMS protocol, HSAG obtained and reviewed the following key types of data as part of the validation of performance measures:

- Information Systems Capabilities Assessment Tool—HSAG received this tool from each PAHP. The completed ISCATs provided HSAG with background information on the PAHPs’ policies, processes, and data in preparation for the on-site validation activities.
- Source Code (Programming Language) for Performance Measures—HSAG requested source code from each PAHP. If the PAHP did not produce source code to generate the performance measures, it submitted a description of the steps taken for measure calculation from the point the service was rendered through the final calculation process. HSAG reviewed the source code or process description to determine compliance with the performance measure specifications provided by DHS.
- Supporting Documentation—This documentation provided additional information needed by HSAG reviewers to complete the validation process, including performance measure definitions, file layouts, system flow diagrams, system log files, policies and procedures, data collection process descriptions, and file consolidations or extracts.
- Current Performance Measure Results—HSAG obtained the calculated results from DHS.
- On-site Interviews and Demonstrations—HSAG also obtained information through interaction, discussion, and formal interviews with key PAHP staff members, as well as through onsite systems demonstrations.

Table B-2 displays the performance measures included in the validation of performance measures and the validation review period to which the data applied.

Table B-2—List of Performance Measures for PAHPs

Performance Measures Selected by DHS for Validation	
Measure	Measurement Periods
<i>DWP Unique Members with 6+ Month Coverage</i>	July 1, 2017–June 30, 2018
<i>DWP Unique Members with 6+ Month Coverage and Accessing Care</i>	July 1, 2017–June 30, 2018
<i>DWP Unique Members with 6+ Month Coverage Accessing Care and an Oral Evaluation</i>	July 1, 2017–June 30, 2018

Based on all validation activities, HSAG determined results for each performance measure. The CMS PMV protocol identifies two possible validation finding designations for performance measures: *Report (R)*, or *Not Reported (NR)*.

According to the CMS protocol, the validation designation for each performance measure is determined by the magnitude of the errors detected for the audit elements, not by the number of audit elements determined to be noncompliant based on the review findings. Consequently, an error for a single audit element may result in a designation of “NR” because the impact of the error biased the reported performance measure by more than 5 percentage points. Conversely, it is also possible that several audit element errors may have little impact on the reported rate, leading to a designation of “R.”

Any suggested corrective action that is closely related to accurate rate reporting that could not be implemented in time to produce validated results may render a particular measure “NR.”

After completing the validation process, HSAG prepared a report of the PMV review findings, which included recommendations for each PAHP reviewed. HSAG forwarded these reports, which complied with 42 CFR §438.364, to DHS and the appropriate PAHPs.

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 quality improvement
- 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 CMS publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.^{B-6} HSAG’s validation of PIPs includes two key components of the quality improvement process:

^{B-6} 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/medicaid-managed-care/external-quality-review/index.html>. Accessed on: Apr 11, 2019.

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 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 quality improvement 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 according to the CMS protocols. The CMS protocols identify 10 steps that should be validated for each PIP.

For the calendar year (CY) 2018 submissions, PAHPs reported the study design and were validated for Steps I through VI in the validation tool.

The 10 steps included in the PIP Validation Tool are listed below:

- Step I. Review the Selected Study Topic
- Step II. Review the Study Question(s)
- Step III. Review the Identified Study Population
- Step IV. Review the Selected Study Indicator(s)^{B-7}

^{B-7} The DDIA PIP has two study indicators: one for the adult population, and one for the Hawki population.

- Step V. Review Sampling Methods
- Step VI. Review the Data Collection Procedures
- Step VII. Review Data Analysis and Interpretation of Study Results
- Step VIII. Assess the 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 *Point of Clarification* 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 2018, the PAHPs submitted the study design. The study indicator measurement period dates are listed below in Table B-3.

Table B-3—Data Obtained and PAHP Measurement Period

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”). DHS contracts with dental PAHPs to manage and deliver dental services to Medicaid members receiving dental coverage. Consequently, PAHPs are required to maintain a network of providers with the capacity to sufficiently meet access standards developed by DHS. The purpose of the network analysis was to evaluate the degree to which each PAHP has an adequate provider network to deliver dental services to its Medicaid members.

This analysis evaluated two dimensions of provider access:

- Provider Capacity Analysis:** To assess the capacity of a given provider network, HSAG compared the number of dental providers associated with a PAHP’s provider network relative to the number of enrolled members. This member-to-provider ratio (provider ratio) represents a summary statistic used to highlight the overall capacity of a PAHP’s dental provider network to deliver dental services to Medicaid members.
- Geographic Network Distribution Analysis:** The second dimension of this study evaluated the **geographic** distribution of dental providers relative to member populations using two different geographic network distribution analyses: the percentage of members residing within predefined access standards for general dentists, and the average travel distances and travel times to the nearest three providers for each dental provider category.

Technical Methods of Data Collection and Analysis

To complete the network analysis, HSAG collected Medicaid member demographic information and dental provider network files from DHS. Though HSAG initially produced detailed data requirements documents for DHS and the two participating PAHPS,^{B-8} DHS ultimately provided the member and provider files including the following information:

- A member file with demographic and PAHP enrollment data for Medicaid members with dental service coverage as of June 30, 2018. The file included key data elements such as member identifier, age, and residential address.
- A single provider file with administrative and enrollment data for each PAHP as of June 30, 2018. The file included key data elements such as the National Provider Identifier (NPI), enrollment status, provider type, provider specialty, and service address.

The first dimension of this network analysis evaluated **provider capacity** through the calculation of provider ratios. Once the data files were cleaned and processed for inclusion in the analysis, HSAG calculated the provider ratio for each dental provider specialty. The provider ratios include the number of unique providers (stratified by specialty) in the selected network in relation to the number of members that the network served. HSAG identified unique providers included in individual PAHP networks by unique NPI, PAHP enrollment status, and specialty classification. Providers included in the statewide network were identified by unique NPI and specialty classification across PAHP enrollment (i.e., if a dental specialist was listed in both DDIA's and MCNA's networks, it was counted once in the statewide provider network).

Though DHS has no network access standards based on provider ratios, these metrics provide a broad level of insight into network capacity. A lower provider ratio suggests a higher number of providers available to render services to members.^{B-9}

The second dimension of the network analysis evaluated the **geographic network distribution** of providers relative to the PAHPS' enrolled members. The time/distance portion of the analysis evaluated PAHP compliance with DHS' time/distance standards for general dentists. Using the geospatial data collected for each PAHP's enrolled members and service location network providers, HSAG calculated the following two spatially derived metrics:

- Percentage of members within predefined access standards for general dentists: A higher percentage of members meeting access standards indicates a better geographic distribution of PAHP providers relative to Medicaid members. Compliance with access standards was assessed separately for urban (i.e., residence in metropolitan statistical areas [MSAs]) and rural residents.

^{B-8} The two PAHPS included in this study are DDIA and MCNA.

^{B-9} Availability based on provider ratio does not account for key practice characteristics—i.e., panel status, acceptance of new patients, or practice restrictions. Instead, the provider ratio should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

- Average travel distances (driving distances in miles) and travel times^{B-10} (driving times in minutes) to the nearest three providers: a shorter driving distance or travel time indicates greater accessibility to providers.

HSAG used Quest Analytics Suite software to calculate the duration of travel times and physical distances between the residences of individual members and the service locations of their nearest three providers. All study results were stratified by PAHP.

Description of Data Obtained and Related Time Period

HSAG cleaned, processed, and defined the unique sets of data related to dental providers, dental provider locations, and PAHP members for inclusion in the analysis. HSAG then standardized and geo-coded all Medicaid member and dental provider files using the Quest Analytics Suite software. The final member population was limited to members actively enrolled in PAHPs using residential addresses within the State of Iowa.

The final dental provider networks for DDIA and MCNA were limited to providers offering services at locations within the State of Iowa or in counties contiguous to the State. Table B-4 shows the provider specialties included in the network adequacy assessment.

Table B-4—Dental Providers and Access Standards by Specialty

Provider Specialty	Criteria for Members	Access Standard
General Dentists		
General dentists	All members enrolled in a PAHP	Defined as 30 minutes or 30 miles for members in urban areas AND 60 minutes or 60 miles for members in rural areas. ^{B-11}
Dental Specialists		
Endodontists	All members enrolled in a PAHP	No access standard available
Oral surgeons	All members enrolled in a PAHP	No access standard available
Orthodontists*	N/A	N/A
Pedodontists*	N/A	N/A
Periodontists	All members enrolled in a PAHP	No access standard available
Prosthodontists	All members enrolled in a PAHP	No access standard available

* Provider counts for orthodontists and pedodontists in the PAHPs’ provider networks are shown in the report because orthodontists may provide services for adult members ages 19 and 20 years, and pedodontists may provide services for adult members ages 19 to 20 years as well as for adult members with behavior management issues. These providers were excluded from the provider ratio and time/distance analyses because most of the population served by these providers (i.e., children) were excluded from this network analysis study. In the table, access standards have values of “NA” for these provider types.

^{B-10} Average drive time may not mirror driver experience, based on varying traffic conditions. Instead, average drive time should be interpreted as a standard measure of the geographic distribution of providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers relative to members.

^{B-11} Urban areas are defined as MSAs. Rural areas are defined as any areas not designated as MSAs.

DHS supplied HSAG with a member file containing demographic and PAHP enrollment data for adult Medicaid members (i.e., at least 19 years of age) with dental service coverage. For the capacity analysis, HSAG restricted member eligibility to Iowa Medicaid members enrolled with a PAHP and who had residential address information that could be geocoded and was located within the State of Iowa. Of the 155,952 members initially included in the member file, 568 (0.4 percent) had residential address information that indicated a residence outside the State of Iowa, and an additional 19 members (fewer than 0.01 percent) had residential information that could not be geocoded. Consequently, HSAG included 155,365 members in the study population for the network analyses.

PAHP Optional Activities

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. DHS requires 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, generate accurate and reliable reports, develop appropriate capitated rates, and obtain complete and accurate utilization information.

During CY 2018, DHS contracted with HSAG to conduct a dental EDV study. Because CY 2018 was the first year that HSAG was to conduct a dental EDV for DHS, DHS and HSAG chose to conduct an IS review with both PAHPs consistent 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-12} The goal of the study was to examine the extent to which DHS and the PAHPs have appropriate system documentation and the infrastructure to produce, process, and monitor encounter data.

Technical Methods of Data Collection and Analysis

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the flow of data from the PAHPs to DHS is understood. An IS review is key to understanding whether the IS infrastructure in place is likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employed a three-stage review

^{B-12} 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: Apr 23, 2019.

process that included a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members.

Description of Data Obtained and Related Time Period

Stage 1—Document Review

HSAG initiated the IS review with a thorough desk review of documents related to dental encounter data initiatives/validation activities completed by DHS. Documents requested for review included, among others, policies and procedures, data dictionaries, process flow charts, data system diagrams, encounter system edits, sample rejection reports, workgroup meeting minutes, and DHS' current dental encounter data submission requirements. The information obtained from this review helped develop a targeted questionnaire to address specific topics of interest for DHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

To conduct a customized encounter data assessment, HSAG developed a targeted IS questionnaire, customized in collaboration with DHS, to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this questionnaire included a review of supplemental documentation regarding other data systems, including enrollment, claims processing, and providers. Lastly, the questionnaire included specific topics of interest to DHS.

The questionnaire domains for the PAHPs are listed below:

- Encounter Data Sources and Systems
- Data Exchange Policies and Procedures
- Management of Encounter Data: Collection, Storage, and Processing
- Encounter Data Quality Monitoring and Reporting

Stage 3—Key Personnel Interviews

After reviewing the completed assessments, HSAG conducted follow-up interviews with key PAHP information technology personnel to clarify questions from the questionnaire responses.

The IS review allowed HSAG to document current processes and develop a thematic process map identifying critical points that impact the submission of quality dental encounter data. From this review, HSAG provided actionable opportunities for improvement based on the existing dental encounter data systems.

However, it is also important to note that information obtained from the PAHPs' questionnaire responses was self-reported, and HSAG did not confirm the statements made in the questionnaire. Additionally, changes may have been implemented since questionnaire responses and documents were received and collected. As such, findings may not reflect the most recent status of the data submission.