Iowa Department of Human Services

Calendar Year 2017 External Quality Review Technical Report

July 2018

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and 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 organizations (MCOs) are required to arrange for the provision of annual external quality review (EQR) for each Medicaid managed care contractor. The external quality review organization (EQRO) must annually provide an assessment of each MCO's performance related to the quality, timeliness, and access to care and services provided by each MCO and produce the results in an annual EQR technical report (42 CFR §438.364). To meet this requirement, Iowa Department of Health Services (DHS) has contracted with Health Services Advisory Group, Inc. (HSAG), to perform EQR of the Iowa MCOs and produce this EQR technical report. This is the second 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, DHS transitioned most Iowa Medicaid members to a managed care program called IA Health Link. This program is administered by three MCOs which provide members with comprehensive healthcare services, including physical health, behavioral health, and long-term services and supports (LTSS). The three MCOs that delivered managed care and services in Iowa during calendar year (CY) 2017 are displayed in Table 1-1 below.

Table 1-1—IA Health Link MCOs

MCO Name	MCO Short Name
Amerigroup Iowa, Inc.	Amerigroup
AmeriHealth Caritas Iowa, Inc.[1-1]	AmeriHealth
UnitedHealthcare Community Plan of the River Valley Inc.	UnitedHealthcare

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 were:

Mandatory Activities

Compliance Monitoring—HSAG organized, aggregated, and analyzed results from the compliance monitoring reviews by arranging the State requirements for access to care, structure and operations, and quality measurement and improvement into the 13 categories. The CY 2017 compliance review activity was a follow-up review assessing implementation of corrective actions for elements that received a score

[1-1] Effective November 30, 2017, AmeriHealth Caritas withdrew from the IA Health Link Program.

of *Not Met* during the CY 2016 compliance review, to determine whether or not those corrective actions resulted in compliance with State and federal requirements. This report presents the combined results of the CY 2016 and CY 2017 compliance monitoring activities.

Validation of Performance Improvement Projects—The MCOs are required to conduct two performance improvement projects (PIPs). In September 2016, HSAG worked with DHS to determine relevant and feasible PIP topics that have the potential to affect member health, functional status, or satisfaction, and data were available to be collected. DHS determined that the two state-mandated topics to be initiated by the MCOs would be *Member Satisfaction: Overall Satisfaction with Health Plan Related to the CAHPS Survey Question Rating Satisfaction from 0 to 10* and *Improving Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life*.

HSAG obtained the data needed to conduct the PIP validation from the MCOs' PIP Summary Forms. These forms provide detailed information about the MCOs' PIPs related to the steps completed and evaluated by HSAG for the 2017 validation cycle. The results from the CY 2017 PIP validation are presented in this report.

Validation of Performance Measures—The purpose of performance measure validation (PMV) is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. DHS has contracted with HSAG to conduct the PMV for each MCO, validating the data collection and reporting processes used to calculate the performance measure rates. DHS identified a set of performance measures that the MCOs are required to calculate and report. The measures are for various domains of effectiveness, prevention, and outcomes. These measures are required to be reported following the specifications provided in the IME Managed Care Reporting Manual and submitted via DHS templates. DHS identified the measurement period as April 1, 2016–March 31, 2017. The results of the PMV activity are presented in this report.

Network Adequacy—HSAG conducted a provider network analysis ("network analysis") for each MCO's provider network. The IA Health Link contract for MCOs requires that each MCO maintain and monitor its provider network, ensuring a sufficient number, mix, and geographic distribution of providers. The purpose of HSAG's network analysis was to evaluate the degree to which each MCO has in place an adequate provider network to deliver healthcare services to its Medicaid members. This analysis evaluated two dimensions of provider access and availability:

- Provider Capacity: In order to assess the capacity of a given provider network, HSAG compared the number of providers associated with an MCO's provider network relative to the number of enrolled members. This member-to-provider ratio represents a summary statistic used to highlight the overall capacity of an MCO's provider network to deliver services to Medicaid recipients.
- Geographic Network Distribution: The second dimension of this study evaluated the geographic distribution of providers relative to member populations using the percentage of members residing within predefined access standards.

HSAG obtained the Medicaid member demographic information and provider network files from DHS and the MCOs. The results of the network analysis are presented in this report.

Optional Activities

Encounter Data Validation (EDV)—HSAG conducted a follow-up review of each MCO's response to HSAG's recommendations that resulted from the 2016 EDV study. The results of that follow-up are presented in this report. In addition, HSAG initiated an administrative profile, or analysis, for DHS' electronic encounter data. The goal of the study is to examine the accuracy, completeness, and timeliness of DHS' encounter data with service dates between April 1, 2016, and December 31, 2016. Understanding the degree of data completeness and accuracy among the MCOs will provide insight into the quality of DHS' overall encounter data system and assure confidence in reporting and rate setting activities. The administrative analysis includes the following key steps:

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

HSAG obtained the encounter data needed to conduct the administrative analysis from DHS. The EDV study was ongoing at the time of this report; therefore, the results of the EDV study will be presented in the CY 2018 EQR Technical Report.

MCO Enrollee Survey—DHS contracted with HSAG to perform a review and validation of the MCOs' Enrollee and Provider Surveys, specifically the Iowa Participant Experience Survey (IPES). The MCOs were required, as a part of their contract, to administer the IPES to members in the home- and community-based services (HCBS) program and were given the freedom to modify the survey, as needed. The IPES instrument is a customized survey instrument that used the Consumer Assessment of Healthcare Providers and Systems (CAHPS®) HCBS survey as a guideline.[1-2,1-3] AmeriHealth, however, did not administer the IPES and, effective November 30, 2017, AmeriHealth withdrew from the IA Health Link managed care program.[1-4] HSAG validated findings of Amerigroup and UnitedHealthcare's IPES administration and these findings are presented in this report.

Calculation of Performance Measures—To support the future IA Health Link Scorecard, DHS requested that HSAG calculate performance measure rates, using claims and encounter data, in accordance with the *Healthcare Effectiveness Data and Information Set (HEDIS®)*[1-5] *2017 Technical Specifications for Health Plans, Volume 2*. HSAG calculated a total of 22 performance measure rates for the measurement period April 1, 2016–March 31, 2017 using administrative data only. The performance

[1-2] Medicaid.gov. *CAHPS Home and Community Based Services Survey*. Available at: https://www.medicaid.gov/medicaid/quality-of-care/performance-measurement/cahps-hcbs-survey/index.html. Accessed on: April 20, 2018.
[1-3] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).
[1-4] Iowa Department of Human Services. *Medicaid Provider Services.* Available at: http://dhs.iowa.gov/ime/providers. Accessed on April 20, 2018.
[1-5] HEDIS® is a registered trademark of the NCQA.

measures calculated by HSAG were provided for informational purposes to assist DHS refine its approach to the future IA Health Link Scorecard; therefore, the results are not included in this report.

Calculation of Potentially Preventable Events— To support the future IA Health Link Scorecard, DHS requested that HSAG calculate Potentially Preventable Events (PPEs) to assess current MCO performance. HSAG calculated 11 measures related to potentially preventable inpatient admissions, ancillary services, and emergency department (ED) visits for the measurement period April 1, 2016–March 31, 2017 using administrative data only. The PPEs calculated by HSAG were provided for informational purposes to assist DHS refine 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 calculated the performance measure rates and used CAHPS data from the three Iowa Medicaid MCOs. The performance measure rates and CAHPS results were compared to national Medicaid benchmarks and a star rating was awarded for six reporting categories: Doctors' Communication and Patient Engagement, Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy. The IA Health Link Scorecard is still in a development phase; therefore, results are not included in this report.

High-Level Findings and Conclusions

HSAG used its analyses and evaluations of EQR activity findings from CY 2017 to assess the performance of Medicaid MCOs in providing quality, timely, and accessible healthcare services to Iowa Medicaid members. For each MCO reviewed, HSAG provides the following high-level summary of its overall key findings and conclusions based on each MCO's performance. *Sections 5, 6, and 7—Plan Specific Summary* detail the MCO-specific findings, strengths, and recommendations for the activities conducted.

Amerigroup Iowa, Inc. (Amerigroup)

Compliance Monitoring

For the compliance review activity, Amerigroup demonstrated strong results, with an overall score of 96.7 percent. The combined CY 2016 and CY 2017 results demonstrated that Amerigroup was fully compliant in ten of the 13 standards reviewed. Three standards received a score of less than 100 percent and have continued opportunities for improvement: in *Standard I—Availability of Services*, three elements received a score of *Not Met*; in *Standard III—Coordination and Continuity of Care*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.*

Validation of Performance Improvement Projects

For the initial validation of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, Amerigroup performed well meeting 100 percent of the validation requirements for the Design stage (Steps I through VI). For the *Member Satisfaction* PIP, HSAG identified opportunities for improvement related to the documentation of sampling techniques. Amerigroup received technical assistance prior to submitting the PIP for final validation and, upon final validation, Amerigroup met 100 percent of the requirements for the Design stage. Amerigroup designed methodologically sound PIPs that were supported using key research principles. The technical design of the PIPs was sufficient to measure and monitor PIP outcomes.

Validation of Performance Measures

HSAG was unable to validate the accuracy of the performance measure data; therefore, reported rates are considered *Not Reported (NR)* for the measurement period and several areas were identified as opportunities for improvement. Overall, HSAG recommends that Amerigroup work closely with DHS to confirm its understanding and expectations related to specifications for each performance measure provided and required by DHS.

Network Adequacy

Amerigroup met the time and distance contract standards for 34 of 50 provider types within the network adequacy analyses. Specifically, Amerigroup has opportunities for improvement in the non-specialty provider categories, where three of 10 contract standards were met, and among specialty providers for children, where contract standards were met for 10 of 16 provider specialties.

MCO Enrollee Survey

Amerigroup administered a customized IPES instrument quarterly that contained 19 to 22 standard questions. The response rate was approximately 28.8 percent for the January–March 2017 measurement period and 19.5 percent for the April–June 2017 measurement period. The IPES was administered by Amerigroup employees and responses were not confidential between the member and the MCO.

When compared to other MCOs within the Iowa program, Amerigroup did not administer a comparable survey or use a comparable survey administration process; therefore, in order to maximize the utility of the IPES data and to ensure comparable data across all reporting units, a standardized survey approach should be applied. HSAG recommends standardizing the IPES data collection and reporting process.

AmeriHealth Caritas Iowa, Inc. (AmeriHealth)

Compliance Monitoring

For the compliance review activity, AmeriHealth demonstrated strong results, with an overall score of 98.1 percent. The combined CY 2016 and CY 2017 results demonstrated that AmeriHealth was fully compliant in 11 of the 13 standards reviewed. Two standards received a score of less than 100 percent and have continued opportunities for improvement: in *Standard III—Coordination and Continuity of Care*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.*

Validation of Performance Improvement Projects

For the initial validation of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, HSAG identified opportunities for improvement related to AmeriHealth's documentation of the data collection process. For the *Member Satisfaction* PIP, opportunities for improvement were identified with the MCO's documentation of plan-specific data supporting the topic selection. AmeriHealth received technical assistance prior to submitting both PIPs for final validation and, upon final validation, AmeriHealth met 100 percent of the requirements for the Design stage for both PIPs. AmeriHealth designed methodologically sound PIPs that were supported using key research principles. The technical design of the PIPs was sufficient to measure and monitor PIP outcomes.

Validation of Performance Measures

HSAG was unable to validate the accuracy of the performance measure data; therefore, reported rates are considered *NR* for the measurement period and several areas were identified as opportunities for improvement. Overall, HSAG recommends that AmeriHealth work closely with DHS to confirm its understanding and expectations related to specifications for each performance measure provided and required by DHS.

Network Adequacy

AmeriHealth met the time and distance contract standards for 40 of 50 provider types within the network adequacy analyses. Specifically, AmeriHealth has opportunities for improvement in the non-specialty provider categories, where six of 10 contract standards were met. AmeriHealth met the contract standards for 20 of 24 categories of specialty providers for adults and 14 of 16 categories of specialty providers for children.

MCO Enrollee Survey

AmeriHealth did not administer the IPES; therefore, no results are presented.

UnitedHealthcare Community Plan of the River Valley, Inc. (UnitedHealthcare)

Compliance Monitoring

For the compliance review activity, UnitedHealthcare demonstrated strong results, with an overall score of 98.1 percent. The combined CY 2016 and CY 2017 results demonstrated that UnitedHealthcare was fully compliant in 11 of the 13 standards reviewed. Two standards received a score of less than 100 percent and have continued opportunities for improvement: in *Standard IV—Coverage and Authorization of Services*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.*

Validation of Performance Improvement Projects

For the initial validation of the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP, HSAG identified opportunities for improvement related to UnitedHealthcare's documentation associated with sampling. For the *Member Satisfaction* PIP, opportunities for improvement were identified within the structure of the study indicator. UnitedHealthcare received technical assistance prior to submitting both PIPs for final validation and, upon final validation, UnitedHealthcare met 100 percent of the requirements for the Design stage for both PIPs. UnitedHealthcare designed methodologically sound PIPs that were supported by using key research principles. The technical design of the PIPs was sufficient to measure and monitor PIP outcomes.

Validation of Performance Measures

HSAG was unable to validate the accuracy of the performance measure data; therefore, reported rates are considered *NR* for the measurement period and several areas were identified as opportunities for improvement. Overall, HSAG recommends that UnitedHealthcare work closely with DHS to confirm its understanding and expectations related to specifications for each performance measure provided and required by DHS.

Network Adequacy

UnitedHealthcare met the time and distance contract standards for 43 of 50 provider types for the network adequacy analyses. UnitedHealthcare met standards for 22 of 24 categories of specialty providers for adults and 15 of 16 categories of specialty providers for children. However, UnitedHealthcare has opportunities for improvement in the non-specialty provider categories, where only six of 10 contract standards were met.

MCO Enrollee Survey

UnitedHealthcare administered a customized IPES instrument, with 194 total questions and an approximate monthly response rate of 15.7 percent. UnitedHealthcare used a third-party survey vendor for survey administration; however, UnitedHealthcare received identifiable survey results from its survey vendor, if permission is granted by the respondent. When identifiable survey responses are

received, UnitedHealthcare's case managers follow up with members on issues or concerns discussed during the survey.

When compared to other MCOs within the Iowa program, UnitedHealthcare did not administer a comparable survey or use a comparable survey administration process; therefore, in order to maximize the utility of the IPES data and to ensure comparable data across all reporting units, a standardized survey approach should be applied. HSAG recommends standardizing the IPES data collection and reporting process.

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), prepaid ambulatory health plan (PAHP), or primary care case management (PCCM) entity (described in §438.310[c][2]).
- For each external quality review (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 addressed effectively 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: April 20, 2018.

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 each MCO's performance.

Section 2—Introduction to the Annual Technical Report

This section of the report presents the summary of the annual technical report 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—External Quality Review Activities

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.

Section 5—Plan-Specific Summary—Amerigroup

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

Section 6—Plan-Specific Summary—AmeriHealth

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

Section 7—Plan-Specific Summary—UnitedHealthcare

This section presents UnitedHealthcare's results for each of the mandatory and optional activities. It includes an overall summary of the MCO's strengths and weaknesses and recommendations for improvement. Also included is an assessment of how effectively the MCO 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 to better support improvement in quality, timeliness, and access to healthcare services furnished to Medicaid members.

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 three contracted MCOs that provide members with comprehensive healthcare services, including physical health, behavioral health, and LTSS.

Managed Care Organizations

DHS held contracts with three MCOs (Amerigroup, AmeriHealth, and UnitedHealthcare) during the review period for this annual report. All three MCOs provide 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 Iowa, Inc. (Amerigroup)	195,345	• Preventative Services • Professional Office Services • Inpatient Hospital Admissions • Inpatient Hospital Services • Outpatient Hospital Services • Emergency Care • Behavioral Health Services • Outpatient Therapy Services • Prescription Drug Coverage • Radiology Services	Statewide
AmeriHealth Caritas Iowa, Inc.[4-3] (AmeriHealth)	218,441		
UnitedHealthcare Community Plan of the River Valley, Inc. (UnitedHealthcare)	185,447		

3-1 Iowa Medicaid Enterprise. *Managed Care Organization Report: SFY 2018, Quarter 1 (July–September) Performance Date published on December 21, 2017*. Available at: https://dhs.iowa.gov/sites/default/files/SFY18_Q1_Report.pdf. Accessed on: March 12, 2018.

3-2 September 2017 data as of October 31, 2017–data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

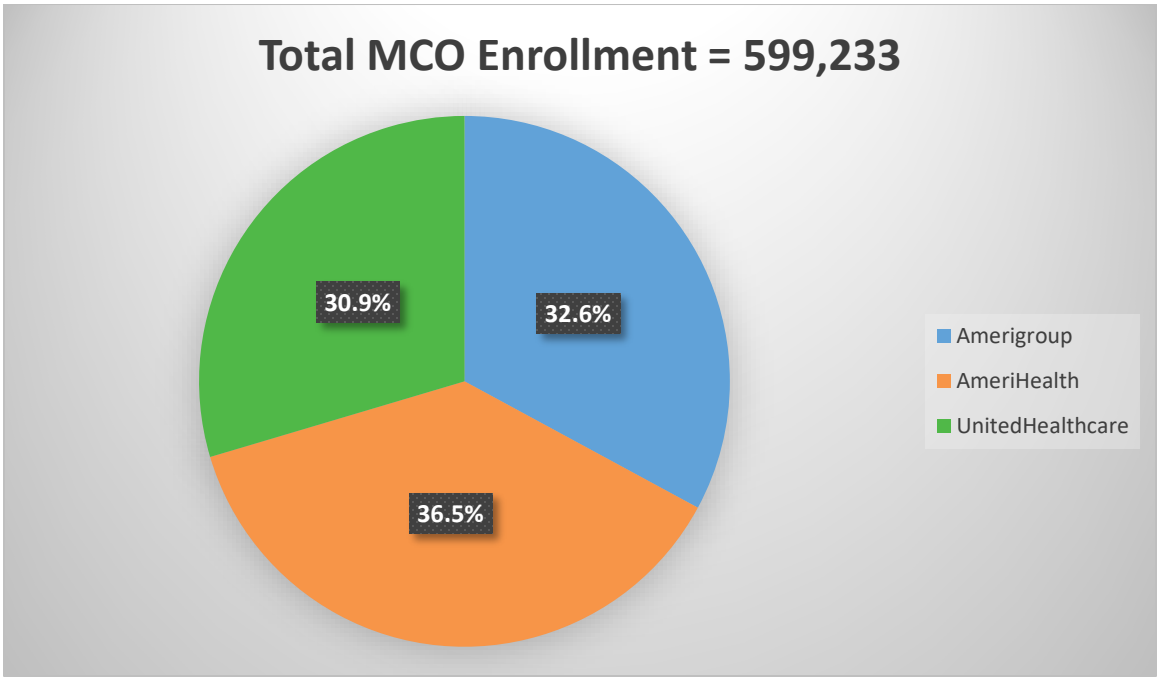
3-3 Iowa Medicaid Enterprise. *2017 Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination.* Available at: https://dhs.iowa.gov/sites/default/files/Comm519.pdf. Accessed on: Aug 31, 2017.

4-3 AmeriHealth withdrew from the IA Health Link Program effective November 30, 2017.

MCO	Total Enrollment[3-1,3-2]	Covered Services[3-3]	Service Area
		• Laboratory Services • Durable Medical Equipment (DME) • LTSS—Community Based • LTSS—Institutional • Hospice • Health Homes	

As of September 2017, 599,233 members were enrolled in the three MCOs. The figure below outlines the total MCO enrollment distribution.

Figure 3-1—MCO Enrollment Distribution[3-5,3-6]



3-5 Iowa Medicaid Enterprise. *Managed Care Organization Report: SFY 2018, Quarter 1 (July–September) Performance Date published on December 21, 2017.* Available at: https://dhs.iowa.gov/sites/default/files/SFY18_Q1_Report.pdf. Accessed on: March 22, 2017.

3-6 September 2017 data as of October 31, 2017—data pulled on other dates will not reflect the same numbers due to reinstatements and eligibility changes.

Quality Initiatives Driving Improvement

The Iowa Medicaid Managed Care Quality Assurance System[3-7] 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 being 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.
- Comply with State and federal regulatory requirements through the development and monitoring of quality improvement policies and procedures.
- 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 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.
- Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist MCOs with implementation of improvement strategies.
- 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.

[3-7] Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Managed Care Quality Assurance System*. 2016.

Expansion of the Dental Wellness Plan

The original Dental Wellness Plan (DWP) was implemented in 2014 as a component of the State's "Iowa Health and Wellness Plan" waivers serving the new, Adult Medicaid Expansion group as allowed under the Affordable Care Act (ACA) in 2014. The novel design leveraged enhanced rates through a commercial carrier to support access for new members and sought to promote better oral health service utilization as members could earn more extensive (restorative type) dental benefits by first demonstrating a commitment to utilizing basic, preventative services appropriately.

During the second quarter of CY 2017, DHS continued building on its goal to improve the original DWP design, based on lessons learned, a review of input from stakeholders responding to a Request for Information (RFI), and negotiation with the Centers for Medicare and Medicaid Services (CMS) on the design of the new plan. Most significantly, the new plan would add the non-expansion adult population into the coverage alongside the ACA expansion adults. The new program would remain named "Dental Wellness Plan" and would drop the earned benefit tiers in favor of a simpler "healthy behaviors" approach through which members could avoid premiums by meeting preventative utilization-based requirements. This was more consistent with what was working under the expansion population's medical coverage and was less administratively burdensome for providers. Adding non-expansion adults also reduced the effect of churn between adult populations. The new DWP PAHP contract was drafted to incorporate the new benefit design for virtually all adults by August 1, 2017. More information on the carrier options for members and plan design, including the use of healthy behaviors and premiums is available here: https://dhs.iowa.gov/dental-wellness-plan.

Progress on Value-Based Purchasing/State Innovation Model

The State Innovation Model (SIM) is a $43 million grant over four years through the Department of Human Services that pursues multi-payer aligned delivery system transformation toward value-based payment (VBP). Currently, DHS is in year three of a four-year grant. CY 2017 concluded a series of meetings with the Medicaid MCOs supporting details of aligned, value-based purchasing strategy described in the SIM grant and carried through the MCO contracting. MCOs submitted contracts for review and approval by DHS to count toward the SIM VBP goals in their contracts. The agreed upon language ensures each MCO has at least one aligned Alternative Payment Model (APM) contract approach that meets State expectations for SIM, which includes alignment on quality, cost measurement, and level of risk. The goal is to mature this aligned approach to an "Other Payer Advance-APM" status (as defined under the Medicare Access and CHIP Reauthorization Act of 2015 [MACRA]) around 2019. For CY 2018, DHS has the MCOs engaged in specific, SIM aligned VBP contracting requirements that were agreed to in 2017. On December 14, 2017, the first SIM "Healthcare Innovation and Visioning Roundtable" was held, bringing together the Governor's Office, key state agency heads, leaders from provider organizations, the delivery system, business, and insurance, to identify, prioritize, and coordinate collective goals to improve the healthcare system in Iowa, including the goal to build an Other Payer Advance-APM.

In related work, Iowa's statewide Heath Information Exchange (HIE), called the Iowa Health Information Network (IHIN), was privatized (to a non-profit) in April of 2017, consistent with earlier legislation aimed at moving this infrastructure from state control (through the Iowa Department of Public Health [IDPH]), in order to speed and mature capability, broaden connectivity, and promote sustainability. DHS is allowing IHIN to leverage the "90/10" funding available through the federal Health Information Technology for Economic and Clinical Health (HITECH) Act in two phases, first to plan and then to build enhanced HIE infrastructure. Phase one funding was secured and is currently in process. Total funding for both phases is expected to be under $20 million and take about two years to complete. The SIM grant is intertwined with this work, as supporting electronic maturity and connectivity (such as alerts) are critical capabilities a transforming delivery system needs, including the integration of SDOH in the delivery of care continuum.

Electronic Visit Verification

In Iowa, Electronic Visit Verification (EVV) is being designed to comply with the 21st Century Cures Act and used to monitor the delivery and utilization of personal care and home health services in non-traditional settings by providing verification of the visit with location information and a time stamp. EVV is used to ensure quality and program integrity (PI). In addition to the PI characteristics associated with EVV, DHS also considers this to be a valuable mechanism to ensure that members are receiving the care they need that is outlined in their service plan. This system can help provide real time alerts when a provider is late or misses a medically necessary service included in a member's service plan.

In June 2017, DHS issued Informational Letter 1805-MC advising Iowa Medicaid Hospice, home health services, and waiver providers of the 21st Century Cures Act passage. The letter also announced the beginning of stakeholder engagement activities, and the launch of the DHS EVV provider survey.

In September 2017, the first EVV stakeholder workgroup was convened. The workgroup serves to inform decisions on key aspects of the Iowa Medicaid EVV program, and to connect stakeholders with needed information and resources.

In November 2017, DHS released an RFI focused on concerns and proposed solutions emerging from the EVV stakeholder workgroup.

DHS plans to launch the EVV program in January 2019, in compliance with the 21st Century Cures Act.

4. External Quality Review Activities

In accordance with 42 CFR §438.356, the 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. Results from second-year activities are included in this report.

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 [managed care organization], PIHP [prepaid inpatient health plan], PAHP [prepaid ambulatory health plan], or PCCM [primary care case management] 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.[4-1]

- **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).[4-2]

- **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 National Committee for Quality Assurance (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."[4-3] It further discusses the intent of this standard to minimize any disruption in the provision of healthcare.

[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.

[4-2] Ibid.

[4-3] National Committee for Quality Assurance: 2016 Standards and Guidelines for the Accreditation of Health Plans.

The following subsections describe the EQR activities that were performed or initiated during the review period. These 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 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 5, 6, and 7—Plan Specific Summary*) and in the comparative analysis presented in *Section 8—MCO Comparative Information* of this report.

Mandatory Activities

Compliance Monitoring

Activity Objectives

According to federal requirements, the State must conduct or arrange for an independent review to determine each Medicaid managed care plan's compliance with standards set forth in CFR Part 438 subpart D and the requirements described in 42 CFR §438.330. DHS contracts with HSAG to conduct an annual compliance review. As this is the second year HSAG has conducted the compliance reviews for DHS, HSAG reviewed the standards that required corrective action from the *Calendar Year 2016 External Quality Review of Compliance with Standards* audit findings.

The primary objective of HSAG's review was to provide meaningful information to DHS and the MCOs regarding the MCOs' progress in achieving compliance with State and federal requirements where the MCO received a score of *Not Met* during the CY 2016 compliance review activity.

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

HSAG conducted the on-site compliance reviews in October 2017, and provided detailed, final reports to DHS and the MCOs in February 2018.

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 MCOs as they related to the scope of the review. For CY 2017, HSAG used *Appendix D—Corrective Action Plan* of the *Calendar Year 2016 External Quality Review of Compliance With Standards* report, now referred to as *Appendix A—Review of the Standards*, which was customized based on each MCO's performance in the CY 2016 review. This customized tool included only those standards for which the MCO had scored less than 100 percent and only those elements for which the MCO had scored *Not Met*. HSAG also followed the

guidelines set forth in CMS' *EQR Protocol 1: Assessment of Compliance with Medicaid Managed Care Regulations: A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[4-4]

HSAG used scores of *Met* (1 point) and *Not Met* (0 points) to indicate the degree to which the 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. The scoring methodology remained consistent between the CY 2016 and CY 2017 compliance review activities. HSAG combined the results of CY 2016 and CY 2017 to demonstrate the MCO's overall compliance scores across all 13 performance areas.

HSAG documented its findings in the data collection tool (*Appendix A—Review of the Standards*), which serves as a comprehensive record of HSAG's findings, performance scores assigned to each requirement, and the actions required to bring each MCO's performance into compliance for those requirements that HSAG assessed as less than fully compliant.

Description of Data Obtained and Related Time Period

HSAG obtained information from a wide range of written documents produced by each MCO, including, but not limited to:

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- The provider manual and other MCO communication to providers/subcontractors.
- The member handbook and other written informational materials.
- Narrative and/or data reports across a broad range of performance and content areas.
- Management/Monitoring reports and audits.
- Member records included in the file review.

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

Validation of Performance Improvement Projects

Activity Objectives

According to the Balanced Budget Act of 1997 (BBA), the quality of healthcare delivered to Medicaid members in MCOs must be tracked, analyzed, and reported annually. PIPs provide a structured method

[4-4] 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: April 23, 2018.

of assessing and improving the processes, and thereby the outcomes, of care for the population that an MCO serves. By assessing PIPs, HSAG assesses each MCO's "strengths and weaknesses with respect to the quality, timeliness, and access to healthcare services furnished to Medicaid recipients," according to 42 CFR §438.240(b)(1).

The primary objective of PIP validation is to determine each MCO's compliance with the requirements of 42 CFR §438.330(b)(1), including:

- Measurement of performance using objective quality indicators.
- Implementation of systematic interventions to achieve improvement in quality.
- Evaluation of the effectiveness of the interventions.
- Planning and initiation of activities for increasing or sustaining improvement.

Technical Methods of Data Collection and Analysis

HSAG conducted the annual PIP validation during July and August 2017, and provided detailed, final reports to DHS and the MCOs in October 2017.

Before the MCOs submitted their PIPs for validation, HSAG conducted PIP training to DHS and the MCOs, and provided templates for the MCOs to document their PIPs. The MCOs also had the opportunity to receive ongoing individual technical assistance throughout the PIP process.

Using its PIP Validation Tool, HSAG validated Steps I through VI for each PIP submitted. Each required step is evaluated on one or more elements that form a valid PIP. HSAG 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*. MCOs would be given a *Partially Met* score if 60 percent to 79 percent of all evaluation elements were *Met* or one or more critical elements were *Partially Met*. HSAG provides a *Point of Clarification* with a *Met* validation score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

In addition to the validation status (e.g., *Met*), HSAG gives 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*.

Description of Data Obtained and Related Time Period

For the annual validation period covering July through September 2017, HSAG obtained the data needed to conduct the PIP validation from each MCO's PIP Summary Forms. These forms provide

detailed information about each MCO's PIPs related to the steps completed and evaluated by HSAG for the 2017 validation cycle. HSAG also obtained additional information for the PIP validation through attachments submitted by each MCO.

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 performance measure validation activities were 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.

HSAG validated a set of 11 performance measures developed and selected by DHS for validation. All measures were to be reported by the MCOs quarterly.

Technical Methods of Data Collection and Analysis

HSAG conducted the performance measure validation 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.

HSAG followed the same process when validating each performance measure for each MCO, 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 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 performance measure validation 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 MCOs during the pre-on-site phase.
- Approximately two weeks prior to the on-site visit, HSAG provided the MCOs with an agenda describing the on-site visit activities and indicating the type of staff needed for each session. HSAG also conducted a pre-on-site conference call with 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 conducted a desk review of the tool and any supporting documentation submitted by the MCOs. 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 MCOs for the performance measures either through a desk review or a WebEx.

On-site Activities

HSAG conducted an on-site visit with each MCO. HSAG collected information using several methods including interviews, system demonstration, review of data output files, 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 included introductions of the validation team and key MCO staff members involved in the performance measure validation 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 MCOs 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 MCO 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 MCO provided HSAG with a listing of the data the MCO had reported to DHS. HSAG selected a random sample from the submitted data and requested that the MCO 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 MCO's systems for verification, which provided the MCO an opportunity to explain its processes regarding any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on on-site clarification and follow-up documentation provided by the MCO.

- Using this technique, HSAG assessed the MCOs' processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected 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 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 MCO. The completed ISCATs provided 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 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 MCO staff members, as well as through onsite systems demonstrations.

Table 4-1 displays the performance measures included in the validation of performance measures and the validation review period to which the data applied.

Table 4-1—List of Performance Measures for MCOs

2017 Performance Measures Selected by DHS for Validation	
Measure name	**Measurement period**
Adult Preventive Care—18–29 Years Old, 30–39 Years Old, 40–49 Years Old, 50–64 Years Old, and 65+ Years Old (count and %)	April 1, 2016–June 30, 2016
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years Old, 45–64 Years Old, and 65+ Years Old (count and %)	July 1, 2016–September 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017
Members Receiving Annual Monitoring of Persistent Medication Use (count and %)	April 1, 2016–June 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017
Members With SMI [Serious Mental Illness] or SED [Seriously Emotionally Disturbed] Receiving Preventive Health Care Visits (count and %)	April 1, 2016–June 30, 2016 July 1, 2016–September 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017
Total Number of Well-Child Visits in the First 15 Months of Life	April 1, 2016–June 30, 2016 July 1, 2016–September 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017
Total number of well-child visits in the third year of life	April 1, 2016–June 30, 2016
Total number of well-child visits in the fourth year of life	April 1, 2016–June 30, 2016
Total number of well-child visits in the fifth year of life	April 1, 2016–June 30, 2016
Total number of well-child visits in the sixth year of life	April 1, 2016–June 30, 2016
Total Number of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	July 1, 2016–September 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017
Total Number of Adolescent Well-Care Visits	April 1, 2016–June 30, 2016 July 1, 2016–September 30, 2016 October 1, 2016–December 31, 2016 January 1, 2017–March 31, 2017

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 performance measure validation review findings, which included recommendations for each MCO reviewed. HSAG forwarded these reports, which complied with 42 CFR §438.364, to DHS and the appropriate MCOs.

Network Adequacy

Activity Objectives

According to federal requirements, DHS must begin conducting provider network adequacy validation as a separate, mandatory external EQR activity, described in the CMS Rule §438.358(b)(1)(iv) (relating to the mandatory activity of validation of network adequacy), no later than one year from the issuance of the associated EQR protocol. While publication of this protocol is anticipated to occur in 2018, the network analyses described in this report, in conjunction with supporting materials from CMS,[4-5] will further prepare DHS to meet the requirements once the provisions go into effect.

The IA Health Link contract for MCOs requires that each MCO maintain and monitor its provider network, ensuring a sufficient number, mix, and geographic distribution of providers. The purpose of HSAG's network analysis was to evaluate the degree to which each MCO has in place an adequate provider network to deliver healthcare services to its Medicaid members.

This analysis evaluated two dimensions of provider access and availability:

- Provider Capacity
- Geographic Network Distribution

[4-5] Lipson, DJ, Libersky J, Bradley K, et. al., *Promoting Access in Medicaid and CHIP Managed Care: A Toolkit for Ensuring Provider Network Adequacy and Service Availability*. Baltimore, MD: Centers for Medicare & Medicaid Services; April 2017. Available at: https://www.medicaid.gov/medicaid/managed-care/downloads/guidance/adequacy-and-access-toolkit.pdf. Accessed on: July 31, 2017.

Technical Methods of Data Collection and Analysis

HSAG obtained, cleaned, processed, and defined the unique lists of providers, provider locations, and members for inclusion in the analysis. HSAG then standardized and geo-coded all Medicaid member and provider files using Quest Analytics Suite software. For all analyses, adults were defined as those members ages 18 years or older, and children were defined as members younger than 18 years of age. Analyses for obstetrics and gynecology (OB/GYN) providers were limited to female members ages 18 years and older.

Similarly, provider networks were restricted based on the type of analysis. Ratio analyses were based on unique providers, deduplicated by National Provider Identifier (NPI) and restricted to provider offices located in Iowa and states contiguous to Iowa. Each MCO's full provider network was included in time-distance analyses regardless if providers' offices were located in Iowa (i.e., all locations associated with a provider were included in time-distance analyses).

Table 4-2 displays the provider categories used to assess the adequacy of the MCOs' provider networks and includes non-specialty providers, specialists for adults, and specialists for children/adolescents younger than 18 years of age. Each MCO assigned its providers to the categories requested by DHS; however, there were not standard classification criteria for all MCOs.

Table 4-2—Provider Categories, Member Criteria, and Access Standards

Provider Category	Member Criteria	Access Standard
Non-Specialty		
Primary Care, Adult	All adults (on or after 18th birthday) enrolled in an MCO	30 minutes or 30 miles
Primary Care, Child	All children (up to 18th birthday) enrolled in an MCO	30 minutes or 30 miles
Hospital	All members enrolled in an MCO	30 minutes or 30 miles
Intermediate Care Facility—Skilled Nursing Facility (ICF/SNF)	All members enrolled in an MCO	30 minutes or 30 miles for members in urban areas AND 60 minutes or 60 miles for members in rural areas
Intermediate Care Facility for Individuals with Intellectual Disabilities (ICF/ID)	All members enrolled in an MCO	
Behavioral Health Inpatient	All members enrolled in an MCO	60 minutes or 60 miles for members in urban areas AND 90 minutes or 90 miles for members in rural areas
Behavioral Health Outpatient	All members enrolled in an MCO	30 minutes or 30 miles
General Optometry	All members enrolled in an MCO	30 minutes or 30 miles
Lab and X-ray Services	All members enrolled in an MCO	30 minutes or 30 miles
Pharmacy	All members enrolled in an MCO	At least 2 providers within 30 minutes or 30 miles, excluding pharmacies participating in the Specialty Pharmacy Program

Provider Category	Member Criteria	Access Standard
Specialists for Adults		
Allergy	All adults (after 18th birthday) enrolled in an MCO	60 minutes or 60 miles for at least 75 percent of non-dual members AND 90 minutes or 90 miles for ALL non-dual members
Cardiology		
Dermatology		
Endocrinology		
Gastroenterology		
General Surgery		
Nephrology		
Neurology		
Neurosurgery		
Occupational Therapy		
Oncology/Hematology		
Ophthalmology		
Orthopedics		
Otolaryngology		
Pathology		
Physical Therapy		
Psychiatry		
Pulmonology		
Radiology		
Reconstructive Surgery		
Rheumatology		
Speech Therapy		
Urology		
Obstetrics and Gynecology	Female adults (after 18th birthday) enrolled in an MCO	60 minutes or 60 miles for at least 75 percent of non-dual members AND 90 minutes or 90 miles for ALL non-dual members
Specialists for Children		
Allergy	All children (up to 18th birthday) enrolled in an MCO	60 minutes or 60 miles for at least 75 percent of non-dual members AND 90 minutes or 90 miles for ALL non-dual members
Cardiology		
Dermatology		
Endocrinology		
Gastroenterology		

Provider Category	Member Criteria	Access Standard
General Surgery		
Neonatology		
Nephrology		
Neurology		
Oncology/Hematology		
Ophthalmology		
Orthopedics		
Otolaryngology		
Pulmonology		
Rheumatology		
Urology		

Provider Capacity Analysis

HSAG calculated the member-to-provider ratio (provider ratio) for each provider category listed in Table 4-2 for each MCO. Specifically, the provider ratio measures the number of providers by provider type (e.g., allergists, cardiologists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since more providers were available[4-6] to render services to individuals. Please note, provider counts for this analysis were based on unique providers and not provider locations and the member population was restricted to those members with addresses in Iowa, including members dually eligible for Medicare and Medicaid.

Geographic Network Distribution Analysis

The second dimension of this study evaluated the geographic distribution of providers relative to MCOs' members. While the previously described provider capacity analysis identified the degree to which each MCO's provider network infrastructure was sufficient in both number of providers and variety of specialties, the geographic network distribution analysis evaluated if the number of provider locations in an MCO's provider network was proportional to the size of the MCO's Medicaid population.

[4-6] The availability based on provider ratio does not account for key practice characteristics—i.e., panel status, acceptance of new patients, practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of providers necessary to support a given volume of members.

HSAG calculated the following metric for all provider locations associated with the provider categories listed in Table 4-2:

- Percentage of members within predefined access standards: A higher percentage of members meeting access standards indicates a better geographic distribution of MCO providers relative to Medicaid members.

Description of Data Obtained and Related Time Period

DHS and the MCOs provided Medicaid member demographic information and provider network files to HSAG for use in network adequacy analyses. DHS and the MCOs received separate detailed data requirements documents for the requested data. HSAG requested data meeting the following criteria:

- Member demographic data as of March 31, 2017.
- Member eligibility and enrollment data, including start and end dates for enrollment with the MCO.
- Provider data for providers actively enrolled in an MCO as of March 31, 2017.

Study Limitations

The following limitations should be considered when reviewing the provider network analysis results presented in this report. Variation in results may be affected by one or more of these factors.

- Iowa Medicaid does not currently provide standard definitions for each provider category (e.g., using provider taxonomy codes to assign providers to categories). As such, each MCO reported a combination of individual providers, provider groups, and institutions in each provider category, creating large disparities in the number of providers by category. In the absence of standard provider category definitions, the provider types contained in each provider category may not be comparable across the MCOs; and caution should be used when comparing provider network adequacy results among MCOs.
- Provider ratios represent high-level, aggregate measures of capacity based on the number of unique providers relative to members. This raw count of capacity does not account for the individual status of a provider's panel (i.e., accepting or not accepting new patients) or how active the provider is in the Medicaid program. Further, it is likely that a portion of providers are contracted to provide services for all three MCOs. As such, the provider ratio represents a potential capacity and may not directly reflect the availability of providers at any point in time.
- No national member-to-provider ratios (provider ratios) have been established for Medicaid, and Iowa Medicaid also has not yet defined such ratios. Provider ratio standards are absent for providers serving Iowa Medicaid members; therefore, Iowa Medicaid network adequacy cannot be measured against a State or national benchmark. The lack of national or contractual standards makes monitoring access and availability difficult and limited to relative performance comparisons that may or may not be appropriate.
- Time-distance metrics represent high-level measures of the similarity in geographic distribution of providers relative to members. These raw, comparative statistics do not account for the individual

status of a provider's panel (i.e., accepting or not accepting new patients) at a specific location or how active the provider is in the Medicaid program. It is likely that a portion of providers are contracted to provide services for all three MCOs. As such, the time-distance results only highlight the geographic distribution of a provider network and may not directly reflect the availability of providers at given office locations.

- No national distance-based access standards or time-based access standards have been established for Medicaid. While time- and distance-based access standards are defined for the Iowa Medicaid provider categories noted in the methodology, network adequacy cannot be measured against national benchmarks.
- MCOs are regularly required to verify when there are not enough existing providers of any category within the time and distance limits given. Those verifications are taken into consideration when Iowa Medicaid determines compliance with provider network adequacy standards.

Optional Activities

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*[4-7]. 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

[4-7] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 4 Validation of Encounter Data Reported by the MCO*. Protocol 4. Version 2.0. September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/medicaid-managed-care/external-quality-review/index.html. Accessed on: Mar 8, 2018.

- 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 initiated an EDV study to evaluate 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.

Technical Methods of Data Collection and Analysis

To examine the accuracy, completeness, and timeliness of DHS' encounter data, the EDV study evaluates the following metrics:

- Metrics for encounter data completeness
  - Monthly encounter record counts by Medicaid Management Information System (MMIS) month (i.e., the month when encounters are processed by MMIS).
  - Monthly encounter volume by service month (i.e., the month when services occur). For this metric, encounter volume was evaluated using visit-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 4-3. The last column in Table 4-3 specifies the criteria for validity.

Table 4-3—Key Encounter Data Elements

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
Member ID	✓	✓	✓	• 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	✓	✓	✓	• Detail Service From Date ≤ Detail Service To Date if Detail Service To Date is present;

Key Data Elements	Professional	Institutional	Pharmacy	Criteria for Validity
				• Detail Service From Date ≤ Header Last Date of Service if Detail Service To Date is missing; • Detail Service From Date ≤ Paid Date
Detail Service To Date	✓	✓		• Detail Service From Date ≤ Detail Service To Date; • Detail Service To Date ≤ Paid Date
Paid Date	✓	✓	✓	• Paid Date ≥ Detail Service From Date; • Paid Date ≥ Detail Service To Date if Detail Service To Date is present; • Paid Date ≥ Header Last Date of Service if Detail Service To Date is missing
Legacy Billing Provider Number[1]	✓	✓	✓	• In provider file supplied by DHS
Legacy Rendering Provider Number[1]	✓			• In provider file supplied by DHS
Legacy Attending Provider Number[1]		✓		• In provider file supplied by DHS
Prescribing Provider Number			✓	• In provider file supplied by DHS
Primary Diagnosis Code	✓	✓		• In national ICD-10-CM diagnosis code sets
Secondary Diagnosis Code	✓	✓		• In national ICD-10-CM diagnosis code sets
Current Procedural Terminology (CPT)/ Healthcare Common Procedure Coding System (HCPCS) Code	✓	✓		• In national CPT and HCPCS diagnosis code sets
Surgical Procedure Code		✓		• In national ICD-10-CM surgical procedure code sets
Revenue Code		✓		• In national revenue code sets
Diagnosis-Related Group (DRG) Code[2]		✓		• In national DRG code sets
National Drug Code (NDC)			✓	• 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 is in the process of stratifying 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 an ad hoc file containing the last dates of service on February 1, 2018. DHS provided a supplemental data submission to HSAG in July 2018. The administrative profile analysis will examine the accuracy, completeness, and timeliness of DHS' encounter data with services dates between April 1, 2016, and December 31, 2016.

MCO Enrollee Survey

Activity Objectives

To facilitate a validation of the MCOs' IPES administration, HSAG requested the following seven survey documents of the MCOs:

1. **Sampling methodology**—the MCO's IPES sampling methodology, including (but not limited to): eligible population size, assumptions regarding the MCO's population, total number of anticipated completed surveys, anticipated response rate, and oversampling rates (if applicable).
2. **Administration methodology**—the MCO's IPES administration methodology (e.g., survey vendor, survey administration timeline, survey protocol, final cover letters and final postcards sent to members).
3. **Data collection process**—how the MCO collected the IPES data, including (but not limited to): survey disposition coding (e.g., eligible versus ineligible), response option coding, data replacement, quality checks methodology, how missing addresses/phone numbers were treated).
4. **Sample frame creation process**—details of the sample frame creation process, including (but not limited to): eligible population criteria, sample size, and sample frame file layout.
5. **Survey instrument and computer-assisted telephone interviewing (CATI) script**—a copy of the IPES instrument and CATI script.

6. **Member-level data**—the member-level IPES data and data dictionary.
7. **Prior IPES reports**—previous IPES reports and/or previously received quality improvement recommendations from an external reviewer.

Table 4-4 provides an overview of the requested items received from the participating MCOs. A check mark (✓) is used to indicate those requested IPES documents that were received.

Table 4-4—IPES Documentation Received

Requested IPES Documents	Amerigroup	UnitedHealthcare
IPES sampling methodology	✓	✓
IPES administration methodology	✓	✓
Detailed IPES data collection process	✓	✓
Detailed IPES sample frame creation process	✓	✓
A copy of the survey instrument script administered by the MCO	✓	✓
The MCO's member-level IPES data in an Excel or comma-separated values (.CSV) file format and accompanying data dictionary	✓	✓
MCO's prior IPES reports and/or previously received quality improvement recommendations from an external reviewer	—	✓

— indicates that this information was not received from the MCO.

HSAG performed a validation of all of the documents received from the MCOs for appropriate survey administration practices and methodologies, as well as the accuracy of the member-level data compared to the MCOs' reported response rate.

Technical Methods of Data Collection and Analysis

HSAG validated that Amerigroup and UnitedHealthcare[4-8] administered the IPES appropriately and used sound methodological approaches to obtain valid and accurate results from the survey. HSAG reviewed and validated the seven items listed above and provided recommendations for future survey administrations.

Description of Data Obtained and Related Time Period

Amerigroup and UnitedHealthcare provided HSAG with a copy of the IPES member-level data files. Amerigroup submitted data for the following time periods: SFY 2017 Q3 (January 2017–March 2017) and SFY 2017 Q4 (April 2017–June 2017). UnitedHealthcare submitted monthly data from December 2016–July 2017. The following table provides an overview of the items included in the member-level files.

[4-8] AmeriHealth did not administer the IPES; therefore, results are not included in this report.

Table 4-5—Member-Level Data

	Amerigroup	UnitedHealthcare
Sub Population Data Available		
Aids/HIV	No	No
Behavioral Health	Yes	No
Brain Injury	No	No
Children's Mental Health	No	No
Elderly	Yes	Yes
General	Yes	No
Habilitation	No	No
Health and Disability	No	No
Intellectual Disability	No	No
MFP	No	No
Physical Disability	No	No
Special Needs	Yes	No
Proxy Flag	No	No
Member Results Anonymous	No	No
Valid Values According to Data Dictionary	No[4-9]	No[4-10]
Skip Patterns Followed	No	Yes

Calculation of Performance Measures

Activity Objectives

To support the future IA Health Link Scorecard, DHS requested that HSAG calculate performance measure rates, using claims and encounter data, in accordance with the *HEDIS 2017 Technical Specifications for Health Plans, Volume 2*. The performance measure rates calculated by HSAG were provided for informational purposes to assist DHS refine its approach to the scorecard; therefore, the results are not included in this report.

Technical Methods of Data Collection and Analysis

HSAG requested a data extract from DHS and obtained member, provider, and claims and encounter data for Medicaid eligible individuals and two years' worth of historical fee-for-service (FFS) data. HSAG calculated a total of 22 measures in accordance with the *HEDIS 2017 Technical Specifications*

[4-9] Amerigroup provided data dictionaries for its population-specific reports, not the member-level data provided.
[4-10] UnitedHealthcare provided a data dictionary for the first 12 indicators, but not for every survey question.

for Health Plans, Volume 2. HSAG made slight modifications to the specifications to account for the modified measurement period (i.e., April 1, 2016, through March 31, 2017).

Table 4-6 presents the assignment of performance measures in terms of quality, timeliness, and access to care.

Table 4-6—Assignment of Performance Measures to the Quality, Timeliness, and Access to Care Domains

Performance Measure	Quality	Timeliness	Access
Adults' Access to Preventive/Ambulatory Health Services—Total			✓
Children and Adolescents' Access to Primary Care Practitioners—12–24 Months, 25 Months–6 Years, 7–11 Years, and 12–19 Years			✓
Breast Cancer Screening	✓		
Cervical Cancer Screening	✓		
Chlamydia Screening in Women	✓		
Non-Recommended Cervical Cancer Screening	✓		
Annual Monitoring for Patients on Persistent Medications—Total	✓		
Medication Management for People With Asthma—Medication Compliance 75%—Total	✓		
Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid w and Bronchodilator	✓	✓	
Use of Imaging Studies for Low Back Pain	✓		
Antidepressant Medication Management—Effective Acute Phase Treatment and Effective Continuation Phase Treatment	✓		
Follow-Up After Hospitalization for Mental Illness—7 Day Follow-Up	✓	✓	✓
Initiation and Engagement of Alcohol and Other Drug Dependence Treatment—Initiation of AOD Treatment—Total and Engagement of AOD Treatment—Total	✓	✓	✓
Metabolic Monitoring for Children and Adolescents on Antipsychotics—Total	✓		
Use of Multiple Concurrent Antipsychotics in Children and Adolescents —Total	✓		
Appropriate Treatment for Children With Upper Respiratory Infection	✓		

Description of Data Obtained and Related Time Period

To calculate the performance measures, HSAG requested a data extract from DHS and obtained member, provider, and claims and encounter data for Medicaid eligible individuals and two years' worth of historical FFS data. HSAG calculated the performance measure rates for the measurement period April 1, 2016–March 31, 2017 using administrative data only.

Calculation of Potentially Preventable Events

Activity Objectives

DHS contracted with HSAG to calculate PPEs to assess current MCO performance. The PPEs calculated by HSAG were provided for informational purposes only to assist DHS refine its approach to the scorecard; therefore, the results are not included in this report.

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), HEDIS measures, and the New York University (NYU) Center for Health and Public Service Research's Emergency Department (ED) Utilization Algorithm. HSAG calculated the following measures by MCO and key demographic variables:

- 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:[4-11]
  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.

[4-11] NYU/Wagner. Faculty & Research. Available at: https://wagner.nyu.edu/faculty/billings/nyued-background. Accessed on: Feb 28, 2018.

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 and two years' worth of historical FFS data.

Description of Data Obtained and Related Time Period

HSAG calculated the PPE measure rates for the measurement period April 1, 2016–March 31, 2017 using administrative data only.

Scorecard

Activity Objectives

On May 6, 2016, CMS published the Medicaid and CHIP Managed Care Final Rule (CMS-2390-F) 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) within three years of the final notice of the Medicaid and CHIP QRS. Although the final notice of the QRS has not been released, Medicaid agencies that already have a QRS in place will have an opportunity to utilize their current QRS with CMS approval. The future IA Health Link Scorecard will support DHS' public reporting of MCO performance information to be used by consumers to make informed decisions about their healthcare. To support the development of the future IA Health Link Scorecard, HSAG calculated the performance measure rates for consideration in the scorecard. The results were for informational purposes only and were not published.

Technical Methods of Data Collection and Analysis

HSAG used encounter data from DHS, including two years' worth of historical data, to calculate HEDIS performance measures following the *HEDIS 2017 Technical Specifications for Health Plans, Volume 2*. HSAG utilized 2017 CAHPS data provided by the three Iowa Medicaid MCOs for presentation in the future IA Health Link Scorecard.

MCOs' performance was evaluated by combining and analyzing HEDIS 2017 performance measure results and 2017 CAHPS survey results to assess MCOs' performance in six separate reporting categories that were identified as important to consumers:

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

- Behavioral Health
- Keeping Kids Healthy

HSAG compared each measure to the 2017 Quality Compass national Medicaid benchmarks 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 six reporting categories (Doctors' Communication and Patient Engagement, Access to Preventive Care, Women's Health, Living With Illness, Behavioral Health, and Keeping Kids Healthy) 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 information presented to DHS 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 received encounter data from DHS to calculate the HEDIS performance measures using administrative data only for the measurement period April 1, 2016–March 31, 2017. For the CAHPS data, HSAG received the MCOs' CAHPS results from DHS. The CAHPS 5.0H Adult Medicaid Health Plan Survey and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the Children with Chronic Conditions [CCC] measurement set) were used for the adult and child populations, respectively.

Activity-Specific Findings

This section presents HSAG's findings and conclusions from the EQR activities conducted for Amerigroup. It also provides a discussion of strengths, weaknesses, and recommendations for improvement. The methology for each activity can be found in *Section 4—External Quality Review Activities*.

Compliance Monitoring

Findings

Table 5-1 presents an overview of the combined results of the *CY 2016 External Quality Review of Compliance With Standards* and this year's follow-up review of Amerigroup's corrective action plans (CAPs). The table shows the number of elements for each of the 13 standards that received a score of *Met* in the prior year's (CY 2016) compliance review and the number of elements that received a score of *Met*, *Not Met*, or *Not Applicable* in the current year's (CY 2017) follow-up review. Because only those elements that had received *Not Met* scores were evaluated during the follow-up review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in CY 2016 remained unchanged and were included in the CY 2017 scores.

Table 5-1—Summary of Combined Compliance Scores

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
I	Availability of Services	31	25	3	3	0	**90.3%**
II	Assurance of Adequate Capacity and Services	5	5	No Follow-up Required			**100.0%**
III	Coordination and Continuity of Care	54	42	11	1	0	**98.1%**
IV	Coverage and Authorization of Services	25	20	5	0	0	**100.0%**
V	Provider Selection	8	8	No Follow-up Required			**100.0%**
VI	Member Information	25	24	1	0	0	**100.0%**
VII	Confidentiality of Health Information	5	5	No Follow-up Required			**100.0%**
VIII	Enrollment and Disenrollment	4	4	No Follow-up Required			**100.0%**
IX	Grievance System	29	17	9	3	0	**89.7%**
X	Sub-contractual Relationships and Delegation	5	4	1	0	0	**100.0%**
XI	Practice Guidelines	5	3	2	0	0	**100.0%**

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
XII	Quality Assessment and Performance Improvement	11	9	2	0	0	100.0%
XIII	Health Information Systems	4	4	No Follow-up Required			100.0%
Total Compliance Score		211	170	34	7	0	96.7%

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

* **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

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

Amerigroup demonstrated strong results, with an overall score of 96.7 percent. Overall, the combined CY 2016 and CY 2017 results demonstrated that Amerigroup was fully compliant in 204 of the 211 scoring elements.

Strengths with Respect to Quality, Timeliness and Access to Care

Amerigroup was fully compliant in five of the 13 standards reviewed during the CY 2016 compliance review: *Standard II—Assurance of Adequate Capacity and Services*, *Standard V—Provider Selection*, *Standard VII—Confidentiality of Health Information*, *Standard VIII—Enrollment and Disenrollment*, and *Standard XIII—Health Information Systems*. Of the remaining eight standards reviewed in CY 2017, Amerigroup achieved full compliance in five standards: *Standard IV—Coverage and Authorization of Services*, *Standard VI—Member Information*, *Standard X—Sub-contractual Relationships and Delegation*, *Standard XI—Practice Guidelines*, and *Standard XII—Quality Assessment and Performance Improvement.* These findings suggest that Amerigroup had the necessary policies and procedures and plans to operationalize the required elements of its contract to support the quality and timeliness of, and access to care and services.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Three standards received a score of less than 100 percent and have continued opportunities for improvement to impact the quality and timeliness of, and access to care and services: in *Standard I—Availability of Services*, three elements received a score of *Not Met*; in *Standard III—Coordination and Continuity of Care*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.* More specifically, Amerigroup received recommendations related to access standards, care plans, transportation grievances, member written consent for appeals, and appeal resolution letters.

Assessment of Follow-Up on Prior Recommendations

Amerigroup received recommendations for 41 elements that receive a score of *Not Met* during the CY 2016 compliance review. The CY 2017 follow-up review demonstrated that 34 elements were sufficiently addressed by Amerigroup. The remaining seven elements have continued opportunities for improvement. See *Recommendations for Improvement* for further details.

Validation of Performance Improvement Projects

Findings

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received an overall *Met* validation status when originally submitted with no identified deficiencies. The *Member Satisfaction* PIP received a *Met* score for 92 percent of the applicable evaluation elements and an overall *Met* validation status when originally submitted. The MCO had the opportunity to receive technical assistance, incorporate HSAG's recommendations, and resubmit the PIP. After resubmission, the PIP received a *Met* score for 100 percent of the applicable evaluation elements, and the overall validation status remained *Met*.

Table 5-2 illustrates the validation scores for both the initial submission and resubmission.

Table 5-2—2017 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]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Submission	100%	100%	*Met*
	Resubmission	*NA*	*NA*	*NA*
Member Satisfaction	Submission	92%	100%	*Met*
	Resubmission	100%	100%	*Met*

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

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and 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 5-3 displays the validation results for Amerigroup's PIP evaluated during 2017. This table illustrates the MCO'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 5-3 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 5-3—Performance Improvement Projects Validation Results 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% (5/5)	0% (0/5)	0% (0/5)
	VI.	Accurate/Complete Data Collection	100% (4/4)	0% (0/4)	0% (0/4)
Design Total			**100% 19/19**	**0% (0/19)**	**0% (0/19)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements Met			**100% 19/19**		

Strengths with Respect to Quality, Timeliness and Access to Care

For this year's 2017 validation, Amerigroup submitted two state-mandated PIP topics: *Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life and Member Satisfaction*. The selected topics addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The performance on these PIPs suggests a thorough application of the PIP Design stage (Steps I through VI). A sound study design created the foundation for Amerigroup to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact study indicator outcomes.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

No opportunities for improvement were identified during this validation year.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 was the first year for this activity, no prior recommendations exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Measures

Findings

Table 5-4 presents the results of the validation of performance measures mandatory activity conducted by HSAG.

Table 5-4—Performance Measure Results for Amerigroup

	Measures	Measure Designation
1.	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years,* and *65+ Years* (count and %)	*NR*
2.	*Members Receiving Annual Monitoring of Persistent Medication Use* (count and %)	*NR*
3.	*Members With SMI or SED Receiving Preventive Healthcare Visits* (count and %)	*NR*
4.	*Total Number of Well-Child Visits in the First 15 Months of Life*	*NR*
5.	*Total Number of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*NR*
6.	*Total Number of Adolescent Well-Care Visits*	*NR*

Reported (*R*)—Measure data were compliant with the specifications required by the State and the rate reported was valid.
Not Reported (*NR*)—Measure data were materially biased.

CY 2017 was the first year for this validation activity. Amerigroup received updated guidance from DHS between quarters to facilitate reporting of measure data. The frequency of the changes made to

measure specifications and reporting templates created challenges for Amerigroup in reporting measure rates. Amerigroup was required to update its performance measure coding and report the rates each quarter according to the updated guidance received. In addition, Amerigroup experienced challenges in its understanding of DHS' expectations related to the measure specifications, which resulted in deviations from the specifications during measure calculation. Amerigroup did not retain the data used for measure reporting for each quarter, which was necessary to allow for performance measure validation. As a result, HSAG was unable to validate the accuracy of the performance measure data and reported rates were considered *NR*.

Strengths with Respect to Quality, Timeliness and Access to Care

HSAG was unable to validate the performance measures under the scope of the PMV audit. Information specific to the quality, timeliness and access to care could not be assessed as the rates were considered *NR*.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

HSAG recommends that Amerigroup work diligently with DHS to confirm its understanding and the expectations related to specifications for each performance measure required for reporting 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 the necessary supporting documentation for measure rate validation.

Since the completion of the CY 2017 performance measure validation audit, DHS has shared with HSAG several actions that the State has taken as a result of the audit findings. At the time of this report, HSAG has not confirmed or validated these actions or the impact going forward on performance measures reported by Amerigroup.

- DHS holds monthly meetings with MCO staff members to provide clarification on performance measure reporting expectations and has implemented an ongoing report review process by which MCOs are provided written feedback and clarification regarding submitted reports. DHS has also implemented a question and answer log to provide an ongoing, documented, weekly method for responding to MCO requests for clarification on the performance measure specifications. DHS will begin analysis of MCO reporting including trending of all data elements across measurement periods and across MCOs.
- DHS has maintained consistent measure specifications within its Reporting Manual. DHS plans to update the Reporting Manual, rate templates, and data definitions, at the end of each fiscal year.
- DHS has clarified that MCOs are required to retain all member-level data that support reported rates for purposes of internal quality audits or performance measure validation by either DHS or any third-party analytic vendor designated by DHS.

Network Adequacy

Findings

HSAG calculated the ratio of members to providers (i.e., the provider ratio) for Amerigroup to assess the capacity of Amerigroup's provider network in Iowa and to establish baseline ratios, as provider ratio contract standards are not yet established for Iowa's MCOs. This provider capacity analysis is coupled with a geographic network distribution analysis to identify opportunities to strengthen Amerigroup's provider network.

Due to limitations discussed in *Section 4—External Quality Review Activities*, results presented in this report may not align with the Managed Care Network Geographic Access Reports submitted by Amerigroup to DHS each quarter.

Provider Capacity Analysis

Table 5-5 enumerates the member populations for Iowa's Amerigroup members. Provider ratios for adult specialists are calculated for the adult member population only; similarly, provider ratios for child specialists are calculated for the child member population only. The provider ratios for obstetrics and gynecology providers to members are based on the adult female population only.

Table 5-5—Population of Eligible Members for Amerigroup[5-1]

Member Category	Amerigroup
Member Demographics	
Adults	95,669
Adult Females	*57,553*
Children	85,372
Total Population	**181,041**

Note: "Adult Females" are a subset of "Adults." Therefore, the "Total Population" row contains the sum of the "Adult" and "Children" rows and not the sum of all displayed rows.

The Amerigroup member population consisted of 181,041 members with 47 percent of the population being aged 17 years or younger. Additionally, 60 percent of Amerigroup's adult members were females.

A summary of Amerigroup's ratio analysis is presented in Table 8-2 in *Section 8—MCO Comparative Information*. The ratio analysis results suggest that Amerigroup generally maintains an extensive provider network.

[5-1] Obtained from member demographic information provided by DHS and Amerigroup. Member demographic data as of March 31, 2017.

Geographic Network Distribution Analysis

Geographic network distribution analyses assess whether members are subject to either excessive travel time or excessive travel distance required to reach the nearest provider. The state of Iowa has established contract standards by provider category for the maximum allowable distance a member must travel to receive care (previously presented in Table 4-2). The overall geographic network distribution analysis results demonstrate the degree to which Amerigroup maintains a geographically accessible network.

Table 5-6 lists the number of time and distance contract standards met by Amerigroup for each provider type. While the contract standards vary by provider category, each contract standard requires that 100 percent of Amerigroup's members have access to a provider within the standard time or distance.

Table 5-6—Number of Time and Distance Contract Standards met by Amerigroup for Each Provider Type Category

Provider Category	Amerigroup
	Number of Standards Met
Non-Specialty	3 of 10 Standards Met
Specialists for Adults	21 of 24 Standards Met
Specialists for Children	10 of 16 Standards Met
Total	**34 of 50 Standards Met**

Non-Specialty—Amerigroup met the contract standards in three categories (i.e., Primary Care, Adult; ICF/SNF; and Pharmacy). Additionally, Amerigroup generally met the contract standards for 99 percent or more of the population for Hospitals, ICF/ID, Behavioral Health Inpatient—Rural, and Behavioral Health Outpatient. In general, the findings indicate:

- The three provider categories with the lowest percentages of members with access to non-specialty providers within contract standards were Lab and X-ray Services (71.2 percent); General Optometry (87.5 percent); and Primary Care, Child (86.9 percent).
- Preliminary results from supplemental analyses suggest that Amerigroup's failure to meet the time-distance contract standards for Lab and X-ray Services may be attributed to a lack of provider practice locations in the provider data. Provider data submitted to HSAG by Amerigroup do not appear to show all addresses associated with the physical locations at which members may receive lab or x-ray services.

Specialists for Adults—Amerigroup met contract standards for 21 of 24 adult specialist provider categories. The findings indicate:

- Amerigroup did not meet the contract standards for the following three adult specialist provider categories: Endocrinology, Gastroenterology, and Neurosurgery. However, no provider categories presented results greater than one percentage point below the 100 percent contract standard.

Specialists for Children—Amerigroup met the contract standards for 10 of 16 child specialist provider categories. The findings indicate:

- Amerigroup did not meet the contract standards for the following six child specialist provider categories: Endocrinology, Neonatology, Neurology, Ophthalmology, Orthopedics, and Rheumatology.
- Among the six provider categories in which Amerigroup failed to meet contract standards, only the Endocrinology provider category had results within one percentage point of the contract standards (i.e., 75 percent and 100 percent of child members within appropriate time or distance standards).

Strengths with Respect to Quality, Timeliness and Access to Care

Amerigroup met the time and distance contract standards in 34 of 50 provider categories assessed in the provider network analysis report, including three categories of non-specialty providers, 21 categories of specialty providers for adults, and 10 categories of specialty providers for children. Non-specialty provider categories meeting the contract standards include Primary Care, Adult; ICF/SNF; and Pharmacy. Cardiology, General Surgery, Pathology, and Psychiatry are examples of categories with results meeting the contract standards for specialists for adults. Allergy, Dermatology, Oncology/Hematology, and Otolaryngology are examples of categories with results meeting the contract standards for specialists for children.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Amerigroup did not meet the time and distance contract standards for 16 of 50 provider categories assessed in the provider network analysis report. The results for the following non-specialty provider categories did not meet the contract standards: Primary Care, Child; Hospital; ICF/ID; Behavioral Health Inpatient; Behavioral Health Outpatient; General Optometry; and Lab and X-ray Services. Among the specialists for adults, results for the following provider categories did not meet the contract standards: Endocrinology, Gastroenterology, and Neurosurgery. Among the specialists for children, results for the following provider categories did not meet the contract standards: Endocrinology, Neonatology, Neurology, Ophthalmology, Orthopedics, and Rheumatology. These areas indicate opportunities for Amerigroup to assess members' access to providers to determine if the provider network needs to be expanded or if alternate access standards for these provider types have been approved by DHS.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 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

Assessment of Follow-Up on Prior Recommendations

Based on the results of last year's EDV study, HSAG made the following recommendations for Amerigroup to strengthen its encounter data quality:

- "For HCBS and LTC encounters, Amerigroup responded with 'NA' for the data submission frequency. Amerigroup should ensure that it is submitting HCBS and LTC encounters to IDHS." In response to HSAG's follow-up on prior recommendations, Amerigroup confirmed that it submitted both HCBS and LTC encounters to DHS. In addition, based on the encounter data received for the current EDV study, HSAG confirmed that Amerigroup submitted HCBS and LTC encounters with dates of service between April 1, 2016 and December 31, 2016 to DHS. Therefore, this recommendation has been addressed.

  "Amerigroup produces a weekly aging summary report and assumes that a large volume of missing remit statuses for a period of time typically indicates a rejected file. Therefore, when encountering this scenario, Amerigroup queries the system to check for the specific file, compliance checks the file, and then resubmits it. While this is effective to ensure complete data submissions, Amerigroup should work with IDHS to ensure that Amerigroup's assumption is correct or develop a communication process to avoid duplicated submissions." In response to HSAG's follow-up on prior year recommendations, Amerigroup explained that it made this assumption because the original proprietary response files from DHS contained only rejected records. After DHS updated the proprietary response files to contain both accepted and rejected records, Amerigroup utilized the new response files as well as the "Match" and "Mismatch" files from DHS to confirm whether DHS had received all the records submitted by Amerigroup, as well as their acceptance status (i.e., accepted or rejected). Therefore, Amerigroup addressed this recommendation.

MCO Enrollee Survey

Findings

Amerigroup provided six of the seven requested items (1. IPES sampling methodology, 2. IPES administration methodology, 3. IPES data collection process, 4. IPES sample frame creation process, 5. Survey instrument, and 6. Member-level IPES data).[5-2] Amerigroup administered the IPES quarterly. Amerigroup's eligible population consisted of members who met the following criteria: had a valid telephone number, were less than 18 years of age for child members, and were 18 years of age or older for adult members. A member was not selected to participate in the survey if they were previously contacted in the prior 12 months. Between April 2017 and June 2017, Amerigroup's sampling methodology was a stratified random sample for the following populations: Elderly/General, Special

[5-2] Amerigroup did not submit prior IPES reports and/or previously received quality improvement recommendations from an external reviewer.

Needs, and Behavioral Health.[5-3] Starting in July 2017, Amerigroup employed a simple random sample of eligible adult and child members for the following populations: Aids/HIV, Brain Injury, Children's Mental Health, Elderly, Habilitation, Intellectual Disability, Money Follows the Person (MFP), and Physical Disability.[5-4] Table 5-7 presents the following information for Amerigroup:

- **Total eligible population**—the total number of members eligible for the survey.
- **Sample size**—the total number of members who were selected for the survey.
- **Extrapolated annual sample size**—anticipated sample size for an annual time period.
- **Response rate**—response rate achieved during survey administration.
- **Anticipated completes annually**—anticipated number of surveys that will be completed annually.
- **Margin of Error at a 95% Confidence Interval**—the margin of error at a 95 percent confidence interval.[5-5]

Table 5-7—Amerigroup Sample Sizes

Time Period	Total Eligible Population	Sub Populations	Quarterly Sample Size	Extrapolated Annual Sample Size	Response Rate	Anticipated Completes Annually	Margin of Error at a 95% Confidence Interval
April 2016 – June 2017	12,100	Elderly/General	1,000	4,000	28.8%	1,152	2.48%
		Special Needs	100	400		115	
		Behavioral Health	100	400		115	
SFY 2018	10,376	N/A	151	604	19.5%	117	9.01%

Strengths with Respect to Quality, Timeliness and Access to Care

Sampling Methodology

For results to be generalizable to the entire population, the sample selection process must allow each member in the population an equal chance of being selected for inclusion in the study. Therefore, Amerigroup's use of a simple random sample was an appropriate sampling method for selecting a representative sample.

Survey Protocols

Amerigroup's approach of administering the IPES via telephone was appropriate for the IPES and the HCBS populations. To ensure that response rates are adequate, it is important that members are

[5-3] A "stratified random sample" is a sampling technique where populations are divided into subgroups. A random sample is then selected from these subgroups.
[5-4] A "simple random sample" is a sampling technique where each person has an equal opportunity of being selected for the sample.
[5-5] HSAG calculated the margin of error using the *Raosoft Sample Size Calculator*. Available at: http://www.raosoft.com/samplesize.html. Accessed on: November 16, 2017.

informed that a survey is planned. A survey notification, in the form of a letter or an email prior to survey administration, could be used to inform members of the upcoming survey, estimated timeline for administration, and when and how the survey results will be made available.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Sample Frame Generation

Given that Amerigroup identified its own eligible (i.e., target) population without specific sample frame instructions or an audit of this process, there was the potential for coverage error. Coverage error is the non-observational gap between the actual target population and the sampling frame.[5-6] In other words, if the sampling frame is not representative of the entire target population, then coverage error will be introduced into the survey process and potentially introduce coverage bias of the sampling frame.

Sample Sizes

Since every member in an MCO's population cannot be surveyed, HSAG recommended statistical techniques that ensure that the unknown actual result lies within a given interval, called the confidence interval, 95 percent of the time (i.e., within a 95 percent confidence interval). To reduce sampling error, HSAG recommended a sample size that targets a margin of error of 5 percent or less. Based on Amerigroup's current sample size and response rates, the MCO should increase its sample size.

Survey Instrument

Amerigroup's IPES administration could be strengthened by standardizing a core survey instrument. A core survey instrument allows for data to be analyzed over time and to be compared across the MCOs. Additionally, to further increase the number of respondents to the survey (and reduce non-response bias), Amerigroup should make the survey available in additional languages (e.g., Spanish).

Data Collection

Amerigroup did not use a third-party vendor for survey administration. Additional bias can be introduced into survey results when a systematic survey administration process is not utilized. Experienced third-party survey vendors have experience employing methods through training and quality assurance protocols to reduce bias and maximize response rates.

Member-Level Data

Amerigroup processed identifiable survey results. Amerigroup used internal staff to administer the survey; therefore, survey answers were not confidential.

[5-6] The sampling frame refers to the total eligible population of members from which the sample is selected.

Assessment of Follow-Up on Prior Recommendations

HSAG requested that Amerigroup provide information on how previous quality improvement (QI) recommendations were addressed. Amerigroup did not have previous QI recommendations made regarding the IPES results; therefore, no findings can be reported.

Recommendations for Improvement

Compliance Monitoring

Based on the findings of the desk and on-site reviews, HSAG's specific recommendations for Amerigroup are to:

- 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.
- Implement a standardized process to monitor compliance with appointment standards for all provider types outlined in contract.
- Implement a process to communicate findings and require corrective action when providers are found to be noncompliant with access standards.
- Implement processes to provide PCPs a copy of member care plans.
- Ensure transportation-related grievances are fully resolved prior to closure of the grievance.
- Obtain member written consent when a provider files an expedited appeal on behalf of the member.
- Ensure appeal resolution letters are consistently written in easily understood language.

Validation of Performance Improvement Projects

As the PIPs progress, HSAG recommends the following:

- Amerigroup should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or Failure Modes and Effects Analysis to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- Amerigroup should develop active, innovative interventions that can directly impact the study indicator outcomes.
- 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.

Validation of Performance Measures

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.

Network Adequacy

Based on the results of the network provider capacity and geographic network distribution analyses, HSAG's specific recommendations for Amerigroup are to:

- Collaborate with DHS to define and standardize the provider category definitions to clarify the provider types and specialties that fall under each provider category.
- 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.

MCO Enrollee Survey

- A standardized eligible population and sampling protocol should be stipulated by DHS. This will be dependent on the reporting requirements of the State. In addition, the sampling specifications should clearly outline the sampling protocols that should be employed.
- For purposes of capturing accurate and reliable IPES data, HSAG recommends the administration of a core survey instrument. A core survey instrument allows for data to be analyzed over time and to be compared across the MCOs. Where possible, the core instrument should align as closely as possible to a validated survey instrument, such as the HCBS CAHPS survey.
- 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 and 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.
- HSAG recommends a standard data layout should be created so that data are collected and provided to DHS in a uniform format, including consistently reporting sub populations. Furthermore, a formal reporting process should be employed by DHS. Additionally, decision rules for capturing survey data and standardized definitions should be established prior to survey administration (e.g., what is considered a completed survey, how are ineligible members defined). Standardized data collection definitions allow for more comparable results within the MCO and across MCOs.
- HSAG recommends that Amerigroup submit the IPES member-level data on a regular reporting schedule (e.g., quarterly, annually) to DHS. DHS should use these data to develop standard

reporting, which would include the identification of measures, a scoring methodology, analyses that would be performed, and how the results would be reported back to the MCOs. HSAG recommends that DHS provide feedback to the MCOs on its results and recommendations on areas needing improvement.

Activity-Specific Findings

This section presents HSAG's findings and conclusions from the EQR activities conducted for AmeriHealth. It also provides a discussion of strengths, weaknesses, and recommendations for improvement. The methology for each activity can be found in *Section 4—External Quality Review Activities*.

Compliance Monitoring

Findings

Table 6-1 presents an overview of the combined results of the *CY 2016 External Quality Review of Compliance With Standards* and this year's follow-up review of AmeriHealth's CAPs. The table shows the number of elements for each of the 13 standards that received a score of *Met* in the prior year's (CY 2016) compliance review and the number of elements that received a score of *Met*, *Not Met*, or *Not Applicable* in the current year's (CY 2017) follow-up review. Because only those elements that had received *Not Met* scores were evaluated during the follow-up review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in CY 2016 remained unchanged and were included in the CY 2017 scores.

Table 6-1—Summary of Combined Compliance Scores

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
I	Availability of Services	31	26	5	0	0	**100.0%**
II	Assurance of Adequate Capacity and Services	5	5	No Follow-up Required			**100.0%**
III	Coordination and Continuity of Care	54	46	7	1	0	**98.1%**
IV	Coverage and Authorization of Services	25	23	2	0	0	**100.0%**
V	Provider Selection	8	8	No Follow-up Required			**100.0%**
VI	Member Information	25	22	3	0	0	**100.0%**
VII	Confidentiality of Health Information	5	4	1	0	0	**100.0%**
VIII	Enrollment and Disenrollment	4	4	No Follow-up Required			**100.0%**
IX	Grievance System	29	20	6	3	0	**89.7%**
X	Sub-contractual Relationships and Delegation	5	4	1	0	0	**100.0%**
XI	Practice Guidelines	5	0	5	0	0	**100.0%**

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
XII	Quality Assessment and Performance Improvement	11	9	2	0	0	**100.0%**
XIII	Health Information Systems	4	4	No Follow-up Required			**100.0%**
Total Compliance Score		**211**	**175**	**32**	**4**	**0**	**98.1%**

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

* **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

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

AmeriHealth demonstrated strong results, with an overall score of 98.1 percent. Overall, the combined CY 2016 and CY 2017 results demonstrated that AmeriHealth was fully compliant in 207 of the 211 scoring elements.

Strengths with Respect to Quality, Timeliness and Access to Care

AmeriHealth was fully compliant in four of the 13 standards reviewed during the CY 2016 compliance review: *Standard II—Assurance of Adequate Capacity and Services*, *Standard V—Provider Selection*, *Standard VIII—Enrollment and Disenrollment*, and *Standard XIII—Health Information Systems*. Of the remaining nine standards reviewed in CY 2017, AmeriHealth achieved full compliance in seven standards: *Standard I—Availability of Services*, *Standard IV—Coverage and Authorization of Services*, *Standard VI—Member Information*, *Standard VII—Confidentiality of Health Information*, *Standard X—Sub-contractual Relationships and Delegation*, *Standard XI—Practice Guidelines*, and *Standard XII—Quality Assessment and Performance Improvement.* These findings suggest that AmeriHealth had the necessary policies and procedures and plans to operationalize the required elements of its contract to support the quality and timeliness of, and access to care and services.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Two standards received a score of less than 100 percent and have continued opportunities for improvement to impact the quality and timeliness of, and access to care and services: in *Standard III—Coordination and Continuity of Care*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.* More specifically, AmeriHealth received recommendations related to comprehensive health risk assessment timeframes, grievance resolution letters, member written consent for appeals, and appeal resolution letters.

Assessment of Follow-Up on Prior Recommendations

AmeriHealth received recommendations for 36 elements that received a score of *Not Met* during the CY 2016 compliance review. The CY 2017 follow-up review demonstrated that 32 elements were sufficiently addressed by AmeriHealth. The remaining four elements have continued opportunities for improvement. See *Recommendations for Improvement* for further details.

Validation of Performance Improvement Projects

Findings

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received a *Met* score of 85 percent of applicable evaluation elements and a *Not Met* overall validation status when originally submitted. The *Member Satisfaction* PIP received a *Met* score of 92 percent of applicable evaluation elements and a *Partially Met* overall validation status when originally submitted. AmeriHealth had the opportunity to receive technical assistance, incorporate HSAG's recommendations, and resubmit both PIPs for final validation. For the final validation, both PIPs received a *Met* score for 100 percent of the applicable evaluation elements, and an overall *Met* validation status.

Table 6-2 illustrates the validation scores for both the initial submission and resubmission.

Table 6-2—2017 PIP Validation Results for AmeriHealth

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]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Submission	85%	71%	*Not Met*
	Resubmission	100%	100%	*Met*
Member Satisfaction	Submission	92%	83%	*Partially Met*
	Resubmission	100%	100%	*Met*

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

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and 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 6-3 displays the validation results for AmeriHealth's PIPs evaluated during 2017. This table illustrates the MCO'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 6-3 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 6-3—Performance Improvement Projects Validation Results for AmeriHealth

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% (10/10)	0% (0/10)	0% (0/10)
	VI.	Accurate/Complete Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			**100% 25/25**	**0% 0/25**	**0% 0/25**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements Met			**100% 25/25**		

Strengths with Respect to Quality, Timeliness and Access to Care

For this year's 2017 validation, AmeriHealth submitted two state-mandated PIP topics: *Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life* and *Member Satisfaction*. The selected topics addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The performance on these PIPs suggests a thorough application of the PIP Design stage (Steps I through VI). A sound study design created the foundation for AmeriHealth to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact study indicator outcomes.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

No opportunities for improvement were identified during this validation year.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 was the first year for this activity, no prior recommendations exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Measures

Findings

Table 6-4 presents the results of the validation of performance measures mandatory activity conducted by HSAG.

Table 6-4—Performance Measure Results for AmeriHealth

	Performance Measures	Measure Designation
1.	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years,* and *65+ Years* (count and %)	*NR*
2.	*Members Receiving Annual Monitoring of Persistent Medication Use* (count and %)	*NR*
3.	*Members With SMI or SED Receiving Preventive Healthcare Visits* (count and %)	*NR*
4.	*Total Number of Well-Child Visits in the First 15 Months of Life*	*NR*
5.	*Total Number of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*NR*
6.	*Total Number of Adolescent Well-Care Visits*	*NR*

Report (*R*)—Measure data were compliant with the specifications required by the State and the rate reported was valid.
Not Reported (*NR*)—Measure data were materially biased.

CY 2017 was the first year for this validation activity. AmeriHealth received updated guidance from DHS between quarters to facilitate reporting of measure data. The frequency of the changes made to

measure specifications and reporting templates created challenges for AmeriHealth in reporting measure rates. AmeriHealth was required to update its performance measure coding and report the rates each quarter according to the updated guidance received. In addition, AmeriHealth experienced challenges in its understanding of DHS' expectations related to the measure specifications, which resulted in deviations from the specifications during measure calculation. AmeriHealth did not retain the data used for measure reporting for each quarter, which was necessary to allow for performance measure validation. As a result, HSAG was unable to validate the accuracy of the performance measure data and reported rates were considered *NR*.

Strengths with Respect to Quality, Timeliness and Access to Care

HSAG was unable to validate the performance measures under the scope of the PMV audit. Information specific to the quality, timeliness and access to care could not be assessed as the rates were considered *NR*.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

HSAG recommends that AmeriHealth work diligently with DHS to confirm its understanding and the expectations related to specifications for each performance measure required for reporting by DHS. HSAG also recommends that AmeriHealth maintain member-level detail data for all reported measures. This will allow AmeriHealth not only to conduct additional edit checks on the quality and accuracy of the data but also to have the necessary supporting documentation for measure rate validation.

Since the completion of the CY 2017 performance measure validation audit, DHS has shared with HSAG several actions that the State has taken as a result of the audit findings. At the time of this report, HSAG has not confirmed or validated these actions or the impact going forward on performance measures reported by AmeriHealth.

- DHS holds monthly meetings with MCO staff members to provide clarification on performance measure reporting expectations and has implemented an ongoing report review process by which MCOs are provided written feedback and clarification regarding submitted reports. DHS has also implemented a question and answer log to provide an ongoing, documented, weekly method for responding to MCO requests for clarification on the performance measure specifications. DHS will begin analysis of MCO reporting including trending of all data elements across measurement periods and across MCOs.
- DHS has maintained consistent measure specifications within its Reporting Manual. DHS plans to update the Reporting Manual, rate templates, and data definitions at the end of each fiscal year.
- DHS has clarified that MCOs are required to retain all member-level data that support reported rates for purposes of internal quality audits or performance measure validation by either DHS or any third-party analytic vendor designated by DHS.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 is the first year for this activity, no prior recommendations exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Network Adequacy

Findings

HSAG calculated the ratio of members to providers (i.e., the provider ratio) for AmeriHealth to assess the capacity of AmeriHealth's provider network in Iowa and to establish baseline ratios, as provider ratio contract standards are not yet established for Iowa's MCOs. This provider capacity analysis was coupled with a geographic network distribution analysis to identify opportunities to strengthen AmeriHealth's provider network.

Due to limitations discussed in *Section 4—External Quality Review Activities*, results presented in this report may not align with the Managed Care Network Geographic Access Reports submitted by AmeriHealth to DHS each quarter.

Provider Capacity Analysis

Table 6-5 enumerates the member populations for Iowa's AmeriHealth members. Provider ratios for adult specialists are calculated for the adult member population only; similarly, provider ratios for child specialists are calculated for the child member population only. The provider ratios for obstetrics and gynecology providers to members are based on the adult female population only.

Table 6-5—Populations of Eligible Members[6-1]

Member Category	AmeriHealth
Member Demographics	
Adults	112,819
Adult Females	*67,445*
Children	91,830
Total Population	**204,649**

Note: "Adult Females" are a subset of "Adults." Therefore, the "Total Population" row contains the sum of the "Adult" and "Children" rows and not the sum of all displayed rows.

[6-1] Obtained from member demographic information provided by DHS and AmeriHealth. Member demographic data as of March 31, 2017.

The AmeriHealth member population consisted of 204,649 members with 45 percent of the population being aged 17 years or younger. Additionally, 60 percent of AmeriHealth's adult members were female.

A summary of AmeriHealth's ratio analysis is presented in Table 8-2 in *Section 8—MCO Comparative Information*. The ratio analysis results suggest that AmeriHealth in Iowa generally maintains an extensive provider network.

Geographic Network Distribution Analysis

Geographic network distribution analyses assess whether members are subject to either excessive travel time or excessive travel distance required to reach the nearest provider. The state of Iowa has established contract standards by provider category for the maximum allowable distance a member will travel to receive care (refer to Table 4-2). The overall geographic network distribution analysis results demonstrate the degree to which AmeriHealth maintains a geographically accessible network.

Table 6-6 lists the number of time and distance contract standards met by AmeriHealth for each provider type. While the contract standards vary by provider category, each contract standard requires that 100 percent of AmeriHealth's members have access to a provider within the standard time or distance.

Table 6-6—Number of Time and Distance Contract Standards met by AmeriHealth for Each Provider Type Category

Provider Category	AmeriHealth
	Number of Standards Met
Non-Specialty	6 of 10 Standards Met
Specialists for Adults	20 of 24 Standards Met
Specialists for Children	14 of 16 Standards Met
Total	**40 of 50 Standards Met**

Non-Specialty—AmeriHealth met the contract standards in six categories (i.e., Primary Care, Adult; Primary Care, Child; ICF/SNF, Behavioral Health Inpatient; Behavioral Health Outpatient; and Pharmacy). The findings indicate:

- AmeriHealth met contract standards for six non-specialty provider categories. However, for nearly all remaining non-specialty provider categories, more than 99 percent of members had access to providers within contract standards (i.e., 30 minutes or 30 miles).
- Of rural members, 99.8 percent had access to ICF/ID providers within contract standards; 97.8 percent of urban members had access to ICF/ID providers within contract standards.
- For Lab and X-ray Services, only 65.6 percent of AmeriHealth members had access to providers within contract standards.

Specialists for Adults—AmeriHealth met the contract standards for 20 adult specialist provider categories. The findings indicate:

- AmeriHealth did not meet the contract standards for the following four adult specialist provider categories: Endocrinology, Pathology, Reconstructive Surgery, and Speech Therapy.
- Reconstructive Surgery was the only provider category with results (42.4 percent and 91.7 percent) greater than one percentage point from the contract standard.

Specialists for Children—AmeriHealth met the contract standards for 14 child specialist provider categories. The findings indicate:

- AmeriHealth did not meet the contract standards for the Endocrinology and Neonatology child specialist provider categories.
- Only the Neonatology provider category had results (42.9 percent and 73.4 percent) greater than one percentage point from the contract standard.

Strengths with Respect to Quality, Timeliness and Access to Care

AmeriHealth met the time and distance contract standards in 40 of 50 provider categories assessed in the provider network analysis report, including six categories of non-specialty providers, 20 categories of specialty providers for adults, and 14 categories of specialty providers for children. Non-specialty provider categories with results meeting the contract standards include Primary Care, Adult; Primary Care, Child; ICF/SNF; Behavioral Health Inpatient; Behavioral Health Outpatient; and Pharmacy. Cardiology, Gastroenterology, Neurosurgery, and Psychiatry are examples of provider categories with results meeting the contract standards for specialists for adults. Allergy, Neurology, Orthopedics, and Otolaryngology are examples of provider categories with results meeting the contract standards for specialists for children.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

AmeriHealth did not meet the time and distance contract standards for 10 of 50 provider categories assessed in the provider network analysis report. The results for the following non-specialty provider categories did not meet the contract standards: Hospital, ICF/ID, General Optometry, and Lab and X-ray Services. Among the specialists for adults, results for the following provider categories did not meet the contract standards: Endocrinology, Pathology, Reconstructive Surgery, and Speech Therapy. Among the specialists for children, results for the Endocrinology and Neonatology provider categories did not meet the contract standards. These areas indicate opportunities for AmeriHealth to assess member access to providers to determine if the provider network needs to be expanded or if alternate access standards for these provider types have been approved by DHS.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 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

Assessment of Follow-Up on Prior Recommendations

Based on the results of last year's EDV study, HSAG made the following recommendation for AmeriHealth to strengthen its encounter data quality:

- "More than 75 percent of AmeriHealth's inpatient and outpatient encounters were priced under 'HCP Code 10—Other Pricing.'" AmeriHealth should work with IDHS to evaluate whether having a large unspecified group meets IDHS' expectations." As AmeriHealth is no longer part of the IA Health Link program, an assessment of follow-up for this recommendation could not be completed.

MCO Enrollee Survey

AmeriHealth did not administer the IPES. AmeriHealth only provided information advising how the IPES would have been administered; therefore, AmeriHealth's information was excluded from this report since the survey was not administered.

Recommendations for Improvement

Compliance Monitoring

Based on the findings of the desk and on-site reviews, AmeriHealth received recommendations for improvement for the following standards: *Standard III—Coordination and Continuity of Care* and *Standard IX—Grievance System*. HSAG's specific recommendations for AmeriHealth are to:

- Demonstrate that comprehensive health risk assessments are completed within 30 days and according to DHS' expectations.
- Ensure grievance resolution letters are consistently written in easily understood language.
- Obtain written signed appeals and member written consent when a provider files an appeal on behalf of a member.
- 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.

Validation of Performance Improvement Projects

As the PIPs progress, HSAG recommends the following:

- AmeriHealth should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or Failure Modes and Effects Analysis to determine barriers, drivers,

and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.

- AmeriHealth should develop active, innovative interventions that can directly impact the study indicator outcomes.
- AmeriHealth should develop a process to evaluate the effectiveness of each individual intervention. The results of the intervention evaluation should drive AmeriHealth's decision to continue, revise, or discontinue the intervention.

Validation of Performance Measures

HSAG recommends that AmeriHealth work closely with IME to confirm understanding and expectations related to specifications for each performance measure provided by IME. HSAG also recommends that AmeriHealth maintain member-level detail data for each rate report generated that is submitted to IME. This will allow AmeriHealth to conduct additional edit checks on the quality and accuracy of the data.

Network Adequacy

Based on the results of the network provider capacity and geographic network distribution analyses, HSAG's specific recommendations for AmeriHealth are to:

- Collaborate with DHS to define and standardize the provider category definitions to clarify the provider types and specialties that fall under each provider category.
- 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.

MCO Enrollee Survey

As AmeriHealth did not administer the IPES, HSAG did not provide recommendations.

Activity-Specific Findings

This section presents HSAG's findings and conclusions from the EQR activities conducted for UnitedHealthcare. It also provides a discussion of strengths, weaknesses, and recommendations for improvement. The methology for each activity can be found in *Section 4—External Quality Review Activities*.

Compliance Monitoring

Findings

Table 7-1 presents an overview of the combined results of the *CY 2016 External Quality Review of Compliance With Standards* and this year's follow-up review of UnitedHealthcare's CAPs. The table shows the number of elements for each of the 13 standards that received a score of *Met* in the prior year's (CY 2016) compliance review and the number of elements that received a score of *Met*, *Not Met*, or *Not Applicable* in the current year's (CY 2017) follow-up review. Because only those elements that had received *Not Met* scores were evaluated during the follow-up review, all elements that received scores of *Met* and/or standards with scores of 100 percent compliance in CY 2016 remained unchanged and were included in the CY 2017 scores.

Table 7-1—Summary of Combined Compliance Scores

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
I	Availability of Services	31	24	7	0	0	100.0%
II	Assurance of Adequate Capacity and Services	5	4	1	0	0	100.0%
III	Coordination and Continuity of Care	54	50	4	0	0	100.0%
IV	Coverage and Authorization of Services	25	19	5	1	0	96.0%
V	Provider Selection	8	7	1	0	0	100.0%
VI	Member Information	25	19	6	0	0	100.0%
VII	Confidentiality of Health Information	5	5	No Follow-up Required			100.0%
VIII	Enrollment and Disenrollment	4	3	1	0	0	100.0%
IX	Grievance System	29	18	8	3	0	89.7%
X	Sub-contractual Relationships and Delegation	5	4	1	0	0	100.0%
XI	Practice Guidelines	5	4	1	0	0	100.0%

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores							
Compliance Monitoring Standard		Total # of Applicable Elements*	Number of Elements				CY 2016 and 2017 Total Compliance Score**
			Prior Year	Current Year			
			M	M	NM	NA	
XII	Quality Assessment and Performance Improvement	11	10	1	0	0	100.0%
XIII	Health Information Systems	4	4	No Follow-up Required			100.0%
Total Compliance Score		211	171	36	4	0	98.1%

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

* **Total # of Applicable Elements:** The total number of elements within each standard minus any elements that received a designation of *NA*.

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

UnitedHealthcare demonstrated strong results, with an overall score of 98.1 percent. Overall, the combined CY 2016 and CY 2017 results demonstrated that UnitedHealthcare was fully compliant in 207 of the 211 scoring elements.

Strengths with Respect to Quality, Timeliness and Access to Care

UnitedHealthcare was fully compliant in two of the 13 standards reviewed during the CY 2016 compliance review: *Standard VII—Confidentiality of Health Information* and *Standard XIII—Health Information Systems*. Of the remaining 11 standards reviewed in CY 2017, UnitedHealthcare achieved full compliance in nine standards: *Standard I—Availability of Services*, *Standard II—Assurance of Adequate Capacity and Services*, *Standard III—Coordination and Continuity of Care*, *Standard V—Provider Selection*, *Standard VI—Member Information*, *Standard VIII—Enrollment and Disenrollment*, *Standard X—Sub-contractual Relationships and Delegation*, *Standard XI—Practice Guidelines*, and *Standard XII—Quality Assessment and Performance Improvement.* These findings suggest that UnitedHealthcare had the necessary policies and procedures and plans to operationalize the required elements of its contract to support the quality and timeliness of, and access to care and services.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Two standards received a score of less than 100 percent and have continued opportunities for improvement to impact the quality and timeliness of, and access to care and services: in *Standard IV—Coverage and Authorization of Services*, one element received a score of *Not Met*; and in *Standard IX—Grievance System*, three elements received a score of *Not Met.* More specifically, UnitedHealthcare received recommendations related to notice of action timeframes, transportation grievances, grievance resolution letters, member written consent for appeals, and appeal resolution letters.

Assessment of Follow-Up on Prior Recommendations

UnitedHealthcare received recommendations for 40 elements that received a score of *Not Met* during the CY 2016 compliance review. The CY 2017 follow-up review demonstrated that 36 elements were sufficiently addressed by UnitedHealthcare. The remaining four elements have continued opportunities for improvement. See *Recommendations for Improvement* for further details.

Validation of Performance Improvement Projects

Findings

The *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP received a *Met* score for 83 percent of applicable evaluation elements and an overall *Not Met* validation status when originally submitted. The *Member Satisfaction* PIP received a *Met* score for 91 percent of applicable evaluation elements and an overall *Partially Met* validation status when originally submitted. UnitedHealthcare had the opportunity to receive technical assistance, incorporate HSAG's recommendations, and resubmit both PIPs for final validation. After resubmission, both PIPs received a *Met* score for 100 percent of the evaluation elements, and an overall *Met* validation status.

Table 7-2 illustrates the validation scores for both the initial submission and resubmission.

Table 7-2—2017 PIP Validation Results for UnitedHealthcare

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]
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	Submission	83%	83%	*Not Met*
	Resubmission	100%	100%	*Met*
Member Satisfaction	Submission	91%	83%	*Partially Met*
	Resubmission	100%	100%	*Met*

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

[2] **Percentage Score of Evaluation Elements *Met***—The percentage score is calculated by dividing the total elements *Met* (critical and 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 7-3 displays the validation results for UnitedHealthcare's PIPs evaluated during 2017. This table illustrates the MCO'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 7-3 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 7-3—Performance Improvement Projects Validation Results 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% (4/4)	0% (0/4)	0% (0/4)
	VI.	Accurate/Complete Data Collection	100% (5/5)	0% (0/5)	0% (0/5)
Design Total			**100% 19/19**	**0% (0/19)**	**0% (0/19)**
Implementation	VII.	Sufficient Data Analysis and Interpretation	*Not Assessed*		
	VIII.	Appropriate Improvement Strategies	*Not Assessed*		
Implementation Total			***Not Assessed***		
Outcomes	IX.	Real Improvement Achieved	*Not Assessed*		
	X.	Sustained Improvement Achieved	*Not Assessed*		
Outcomes Total			***Not Assessed***		
Percentage Score of Applicable Evaluation Elements Met			**100% 19/19**		

Strengths with Respect to Quality, Timeliness and Access to Care

For this year's 2017 validation, UnitedHealthcare submitted two state-mandated PIP topics: *Well-Child Visits in the Third, Fourth, Fifth, and Six Years of Life* and *Member Satisfaction*. The selected topics addressed CMS' requirements related to quality outcomes—specifically, the quality, timeliness, and accessibility of care and services.

The performance on these PIPs suggests a thorough application of the PIP Design stage (Steps I through VI). A sound study design created the foundation for UnitedHealthcare to progress to subsequent PIP stages—collecting data and implementing interventions that have the potential to impact study indicator outcomes.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

No opportunities for improvement were identified during this validation year.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 was the first year for this activity, no prior recommendations exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Validation of Performance Measures

Findings

Table 7-4 presents the results of the validation of performance measures mandatory activity conducted by HSAG.

Table 7-4—Performance Measure Results for UnitedHealthcare

	Performance Measures	Measure Designation
1.	*Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years,* and *65+ Years* (count and %)	*NR*
2.	*Members Receiving Annual Monitoring of Persistent Medication Use* (count and %)	*NR*
3.	*Members With SMI or SED Receiving Preventive Healthcare Visits* (count and %)	*NR*
4.	*Total Number of Well-Child Visits in the First 15 Months of Life*	*NR*
5.	*Total Number of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life*	*NR*
6.	*Total Number of Adolescent Well-Care Visits*	*NR*

Report (*R*)—Measure data were compliant with the specifications required by the State and the rate reported was valid.
Not Reported (*NR*)—Measure data were materially biased.

CY 2017 was the first year for this validation activity. UnitedHealthcare received updated guidance from DHS between quarters to facilitate reporting of measure data. The frequency of the changes made

to measure specifications and reporting templates created challenges for UnitedHealthcare in reporting measure rates. UnitedHealthcare was required to update its performance measure coding and report the rates each quarter according to the updated guidance received. In addition, UnitedHealthcare experienced challenges in its understanding of DHS' expectations related to the measure specifications, which resulted in deviations from the specifications during measure calculation. UnitedHealthcare did not retain the data used for measure reporting for each quarter, which was necessary to allow for performance measure validation. As a result, HSAG was unable to validate the accuracy of the performance measure data and reported rates were considered *NR*.

Strengths with Respect to Quality, Timeliness and Access to Care

HSAG was unable to validate the performance measures under the scope of the PMV audit. Information specific to the quality, timeliness and access to care could not be assessed.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

HSAG recommends that UnitedHealthcare work diligently with DHS to confirm its understanding and the expectations related to specifications for each performance measure required for reporting by DHS. HSAG also recommends that UnitedHealthcare maintain member-level detail data for all reported measures. This will allow UnitedHealthcare not only to conduct additional edit checks on the quality and accuracy of the data, but also to have the necessary supporting documentation for measure rate validation.

Since the completion of the CY 2017 performance measure validation audit, DHS has shared with HSAG several actions that the State has taken as a result of the audit findings. At the time of this report, HSAG has not confirmed or validated these actions or the impact going forward on performance measures reported by UnitedHealthcare.

- DHS holds monthly meetings with MCO staff members to provide clarification on performance measure reporting expectations and has implemented an ongoing report review process by which MCOs are provided written feedback and clarification regarding submitted reports. DHS has also implemented a question and answer log to provide an ongoing, documented, weekly method for responding to MCO requests for clarification on the performance measure specifications. DHS will begin analysis of MCO reporting including trending of all data elements across measurement periods and across MCOs.
- DHS has maintained consistent measure specifications within its Reporting Manual. DHS plans to update the Reporting Manual, rate templates, and data definitions at the end of each fiscal year.
- DHS has clarified that MCOs are required to retain all member-level data that support reported rates for purposes of internal quality audits or performance measure validation by either DHS or any third-party analytic vendor designated by DHS.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 is the first year for this activity, no prior recommendations exist. The assessment of follow-up on prior recommendations will be included in subsequent reports, when applicable.

Network Adequacy

Findings

HSAG calculated the ratio of members to providers (i.e., the provider ratio) for UnitedHealthcare to assess the capacity of UnitedHealthcare's provider network in Iowa and to establish baseline ratios, as provider ratio contract standards are not yet established for Iowa's MCOs. This provider capacity analysis was coupled with a geographic network distribution analysis to identify opportunities to strengthen UnitedHealthcare 's provider network.

Due to limitations discussed in *Section 4—External Quality Review Activities*, results presented in this report may not align with the Managed Care Network Geographic Access Reports submitted by UnitedHealthcare to DHS each quarter.

Provider Capacity Analysis

Table 7-5 enumerates the member populations for Iowa's UnitedHealthcare members. Provider ratios for adult specialists are calculated for the adult member population only; similarly, provider ratios for child specialists are calculated for the child member population only. The provider ratios for obstetrics and gynecology providers to members are based on the adult female population only.

Table 7-5—Populations of Eligible Members[7-1]

Member Category	UnitedHealthcare
Member Demographics	
Adults	85,402
Adult Females	*50,640*
Children	76,992
Total Population	**162,394**

Note: "Adult Females" are a subset of "Adults." Therefore, the "Total Population" row contains the sum of the "Adult" and "Children" rows and not the sum of all displayed rows.

[7-1] Obtained from member demographic information provided by DHS and UnitedHealthcare. Member demographic data as of March 31, 2017.

The UnitedHealthcare member population consisted of 162,394 members with 47 percent of the population being aged 17 years or younger. Additionally, almost 60 percent of UnitedHealthcare's adult members were females.

A summary of UnitedHealthcare's ratio analysis is presented in Table 8-2 in *Section 8—MCO Comparative*. The ratio analysis results suggest that UnitedHealthcare generally maintains an extensive provider network.

Geographic Network Distribution Analysis

Geographic network distribution analyses assess whether members are subject to either excessive travel time or excessive travel distance required to reach the nearest provider. The state of Iowa has established contract standards by provider category for the maximum allowable distance a member must travel to receive care (refer to Table 4-2). The overall geographic network distribution analysis results demonstrate the degree to which UnitedHealthcare maintains a geographically accessible network.

Table 7-6 lists the number of time and distance contract standards met by UnitedHealthcare for each provider type. While the contract standards vary by provider category, each contract standard requires that 100 percent of UnitedHealthcare's members have access to a provider within the standard time or distance.

Table 7-6—Number of Time and Distance Contract Standards met by UnitedHealthcare for Each Provider Type Category

Provider Category	UnitedHealthcare
	Number of Standards Met
Non-Specialty	6 of 10 Standards Met
Specialists for Adults	22 of 24 Standards Met
Specialists for Children	15 of 16 Standards Met
Total	**43 of 50 Standards Met**

Non-Specialty—UnitedHealthcare met the contract standards in six categories (i.e., Primary Care, Adult; Primary Care, Child; ICF/SNF, Behavioral Health Inpatient; Behavioral Health Outpatient; and Pharmacy). The findings indicate:

- For all remaining UnitedHealthcare non-specialty provider categories, with the exception of ICF/ID—Rural, more than 99 percent of members had access to providers within contract standards (i.e., 30 minutes or 30 miles for members in urban areas and 60 minutes or 60 miles for members in rural areas).
- Of urban members, 99.3 percent had access to ICF/ID providers within the contract standard areas; 97.8 percent of rural members had access to ICF/ID providers within contract standards.

Specialists for Adults—UnitedHealthcare met the contract standards for 22 adult specialist provider categories. The findings indicate:

- UnitedHealthcare did not meet the contract standards for the Endocrinology and Neurosurgery adult specialist provider categories. However, no provider categories presented results greater than one percentage point below the 100 percent contract standard.

Specialists for Children—UnitedHealthcare met the contract standards for 15 child specialist provider categories. The findings indicate:

- While UnitedHealthcare did not meet the contract standards for the Neonatology child specialist provider category, results for this provider category were within one percentage point of the contract standards.

Strengths with Respect to Quality, Timeliness and Access to Care

UnitedHealthcare met the time and distance contract standards in 43 of 50 provider categories assessed in the provider network analysis report, including six categories of non-specialty providers, 22 categories for specialty providers for adults, and 15 categories of specialty providers for children. Non-specialty provider categories with results meeting the contract standards include Primary Care, Adult; Primary Care, Child; ICF/SNF; Behavioral Health Inpatient; Behavioral Health Outpatient; and Pharmacy. Cardiology, Gastroenterology, Pathology, and Speech Therapy are examples of provider categories with results meeting the contract standards for specialists for adults. Allergy, Endocrinology, Neurology, and Rheumatology are examples of provider categories with results meeting the contract standards for specialists for children.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

UnitedHealthcare did not meet the time and distance contract standards for seven of 50 provider categories assessed in the provider network analysis report. The results for the following non-specialty provider categories did not meet the contract standards: Hospital, ICF/ID, General Optometry, and Lab and X-ray Services. Among the specialists for adults, results for the following provider categories did not meet the contract standards: Endocrinology and Neurosurgery. Among the specialists for children, only results for Neonatology did not meet the contract standards. These areas indicate opportunities for UnitedHealthcare to assess member access to providers to determine if the provider network needs to be expanded or if alternate access standards for these provider types have been approved by DHS.

Assessment of Follow-Up on Prior Recommendations

As CY 2017 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

Assessment of Follow-Up on Prior Recommendations

Based on the results of last year's EDV study, HSAG made the following recommendations for UnitedHealthcare to strengthen its encounter data quality:

- "IDHS requires pharmacy encounters to be submitted weekly. UnitedHealthcare receives denied pharmacy encounters from its subcontractor weekly and twice a month for paid encounters. UnitedHealthcare should work with IDHS to evaluate whether the MCO should receive paid encounters weekly from its subcontractor." In response to HSAG's follow-up on prior year recommendations, UnitedHealthcare reported that Contract Amendment 3 allows for drug encounter data to be submitted by the Contractor once every other week. Therefore, this recommendation has been addressed.
- "UnitedHealthcare noted that IDHS requires providers' Medicaid IDs to match the length of an NPI (e.g., 10 digits) in the encounters; therefore, UnitedHealthcare adds "X00" to the beginning of the seven-digit state provider Medicaid IDs (e.g., provider Medicaid ID 1234567 will be represented as X001234567 on the encounter file). UnitedHealthcare should work with IDHS to evaluate whether the newly created 10-digit provider ID meets IDHS' expectations." Through email communication with DHS on December 9, 2016, DHS confirmed that UnitedHealthcare is following DHS protocol. Therefore, this recommendation has been addressed.

MCO Enrollee Survey

Findings

UnitedHealthcare provided all seven requested items (1. IPES sampling methodology, 2. IPES administration methodology, 3. IPES data collection process, 4. IPES sample frame creation process, 5. Survey instrument, 6. Member-level IPES data, and 7. Prior IPES reports). UnitedHealthcare administered the IPES monthly. UnitedHealthcare's eligible population consisted of members who met the following criteria: were currently enrolled in the HCBS program or receiving habilitation services, and had a valid telephone number. UnitedHealthcare reported that some members were unintentionally excluded from the eligible population, which likely introduced bias into the survey results.[7-2] UnitedHealthcare performed a simple random sample for the following populations: Aids/HIV, Brain Injury, Children's Mental Health, Elderly, Health and Disability, Intellectual Disability, and Physical Disability.[7-3] Table 7-7 presents the following information for UnitedHealthcare:

- **Total eligible population**—the total number of members eligible for the survey.

[7-2] The following populations were unintentionally excluded from UnitedHealthcare's eligible population: IA Dual LTSS Elderly, IA Dual HCBS Brain Injury, IA Medicaid HCBS Physical Disability, and Long-Term Care.

[7-3] A "simple random sample" is a sampling technique where each person has an equal opportunity of being selected for the sample.

- **Sample size**—the total number of members who were selected for the survey.
- **Extrapolated annual sample size**—anticipated sample size for an annual time period.
- **Response rate**—response rate achieved during survey administration.
- **Anticipated completes annually**—anticipated number of surveys that will be completed annually.
- **Margin of Error at a 95% Confidence Interval**—the margin of error at a 95 percent confidence interval.[7-4]

Table 7-7—UnitedHealthcare Sample Sizes[7-5]

Total Eligible Population	Monthly Sample Size	Extrapolated Annual Sample Size	Response Rate	Anticipated Completes Annually	Margin of Error at a 95% Confidence Interval
5,159	200	2,400	15.7%	376	4.87%

Strengths with Respect to Quality, Timeliness and Access to Care

Sampling Methodology

For results to be generalizable to the entire population, the sample selection process must give each member in the population an equal chance of being selected for inclusion in the study. Therefore, UnitedHealthcare's use of a simple random sample was an appropriate sampling method for selecting a representative sample.

Survey Instrument

UnitedHealthcare utilized a core survey instrument, the entire IPES instrument with supplemental questions, which allows for data to be analyzed over time and to be compared across the MCOs. Additionally, to further increase the number of respondents to the survey (and reduce non-response bias), UnitedHealthcare should make the survey available in additional languages (e.g., Spanish).

Survey Protocols

UnitedHealthcare's approach of administering the IPES via telephone was appropriate for the IPES and the HCBS population. To ensure that response rates are adequate, it is important that members are informed that a survey is planned. UnitedHealthcare sent members a pre-notification letter, informing members about the upcoming survey.

[7-4] HSAG calculated the margin of error using the *Raosoft Sample Size Calculator*. Available at: http://www.raosoft.com/samplesize.html. Accessed on: November 16, 2017.

[7-5] UnitedHealthcare's results in this table should be interpreted with caution, as the results may be biased based on some members being excluded from the eligible population.

Data Collection

UnitedHealthcare used a third-party vendor to administer the survey. As additional bias can be introduced into survey results when a systematic survey administration process is not used, HSAG recommended that UnitedHealthcare continue to use a third-party vendor. Experienced third-party survey vendors have experience employing methods through training and quality assurance protocols to reduce bias and maximize response rates.

Opportunities for Improvement with Respect to Quality, Timeliness and Access to Care

Sample Frame Generation

Given that UnitedHealthcare identified its own eligible (i.e., target) population without specific sample frame instructions or an audit of this process, there was the potential for coverage error. Coverage error is the non-observational gap between the actual target population and the sampling frame.[7-6] In other words, if the sampling frame is not representative of the entire target population, then coverage error will be introduced into the survey process and potentially introduce coverage bias of the sampling frame.

Sample Sizes

Since every member in an MCO's population cannot be surveyed, HSAG recommended statistical techniques that ensure that the unknown actual result lies within a given interval, called the confidence interval, 95 percent of the time (i.e., within a 95 percent confidence interval). To reduce sampling error, HSAG recommended that UnitedHealthcare identify a sample size that targets a margin of error of 5 percent or less.

Member-Level Data

UnitedHealthcare received identifiable survey results. UnitedHealthcare's external survey vendor asked the member if they have permission to link the member's name to their survey responses so that any necessary follow-up can occur. When identifiable survey responses were received, UnitedHealthcare's case managers followed up with members on issues or concerns discussed during the survey. While permission was requested from members, this approach may lead to respondents feeling uncomfortable providing honest answers or pressured to give permission to link their name to their responses. The impact of collecting responses that were not confidential should be considered when evaluating survey responses.

Assessment of Follow-Up on Prior Recommendations

HSAG requested that UnitedHealthcare provide information on how previous QI recommendations were addressed. While UnitedHealthcare provided documentation of how survey results are utilized, the MCO

[7--6] The sampling frame refers to the total eligible population of members from which the sample is selected.

did not have previous QI recommendations made regarding the IPES results; therefore, no findings can be reported.

Recommendations for Improvement

Compliance Monitoring

Based on the findings of the desk and on-site reviews, UnitedHealthcare received recommendations for improvement for the following standards: *Standard IV—Coverage and Authorization of Services* and *Standard IX—Grievance System*. HSAG's specific recommendations for UnitedHealthcare are to:

- 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.
- 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.
- Obtain member written consent when a provider files an expedited appeal of behalf of the member.
- Include the IAC citation to support the non-authorization of services in appeal resolution letters and ensure letters are consistently written in easily understood language.

Validation of Performance Improvement Projects

As the PIPs progress, HSAG recommends the following:

- UnitedHealthcare should use quality improvement tools such as a causal/barrier analysis, key driver diagram, process mapping, or Failure Modes and Effects Analysis to determine barriers, drivers, and/or weaknesses within processes which may inhibit the health plan from achieving the desired outcomes.
- UnitedHealthcare should develop active, innovative interventions that can directly impact the study indicator outcomes.
- 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.

Validation of Performance Measures

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.

Network Adequacy

Based on the results of the network provider capacity and geographic network distribution analyses, HSAG's specific recommendations for UnitedHealthcare are to:

- Collaborate with DHS to define and standardize the provider category definitions to clarify the provider types and specialties that fall under each provider category.
- 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.

MCO Enrollee Survey

- A standardized eligible population and sampling protocol should be stipulated by DHS. This will be dependent on the reporting requirements of the State. In addition, the sampling specifications should clearly outline the sampling protocols that should be employed.
- 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.
- HSAG recommends a standard data layout should be created so that data are collected and provided to DHS in a uniform format, including consistently reporting sub populations. Furthermore, a formal reporting process should be employed by DHS. Additionally, decision rules for capturing survey data and standardized definitions should be established prior to survey administration (e.g., what is considered a completed survey, how are ineligible members defined). Standardized data collection definitions allow for more comparable results within the MCO and across MCOs.
- HSAG recommends that UnitedHealthcare submit the IPES member-level data on a regular reporting schedule (e.g., quarterly, annually) to DHS. DHS should use these data to develop standard reporting that would include the identification of measures, a scoring methodology, analyses that would be performed, and how the results would be reported back to the MCOs. HSAG recommends that DHS provide feedback to the MCOs on their results and recommendations on areas needing improvement.

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 IA Health Link program as a whole.

Compliance Monitoring

Table 8-1 provides information that can be used to compare the MCOs' performance on each of the 13 compliance standard areas. As the compliance monitoring activity completed in CY 2017 was a follow-up review to the one completed in CY 2016, the table presents the combined results for both years.

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

Prior Year (CY 2016) and Current Year (CY 2017) Combined Scores				
Compliance Monitoring Standard		**Amerigroup**	**AmeriHealth**	**UnitedHealthcare**
I	Availability of Services	90.3%	100.0%	100.0%
II	Assurance of Adequate Capacity and Services	100.0%	100.0%	100.0%
III	Coordination and Continuity of Care	98.1%	98.1%	100.0%
IV	Coverage and Authorization of Services	100.0%	100.0%	96.0%
V	Provider Selection	100.0%	100.0%	100.0%
VI	Member Information	100.0%	100.0%	100.0%
VII	Confidentiality of Health Information	100.0%	100.0%	100.0%
VIII	Enrollment and Disenrollment	100.0%	100.0%	100.0%
IX	Grievance System	89.7%	89.7%	89.7%
X	Sub-contractual Relationships and Delegation	100.0%	100.0%	100.0%
XI	Practice Guidelines	100.0%	100.0%	100.0%
XII	Quality Assessment and Performance Improvement	100.0%	100.0%	100.0%
XIII	Health Information Systems	100.0%	100.0%	100.0%
	Total Compliance Score	**96.7%**	**98.1%**	**98.1%**

The MCOs received similar overall compliance scores ranging between 96.7 and 98.1 percent, indicating that the MCOs had the policies and procedures, and operational structure in place to meet almost all of the federal and State requirements.

All three MCOs received a compliance score of 100 percent for *Standard II—Assurance of Adequate Capacity and Services, Standards V—Provider Selection, Standard VI—Member Information, Standard VII—Confidentiality of Health Information, Standard VIII—Enrollment and Disenrollment, Standard X—Sub-contractual Relationships and Delegation, Standard XI—Practice Guidelines, Standard XII—Quality Assessment and Performance Improvement* and *Standard XIII—Health Information Systems*, indicating areas of strength statewide.

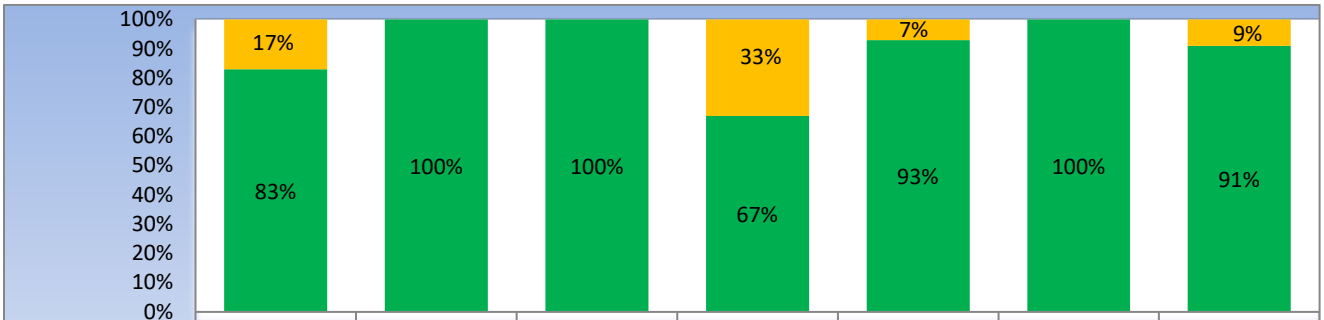
Amerigroup received a compliance score of 90.3 percent for *Standard I—Availability of Services*, while both AmeriHealth and UnitedHealthcare achieved full compliance. UnitedHealthcare achieved full compliance for *Standard III—Coordination and Continuity of Care*, while Amerigroup and AmeriHealth both received a compliance score of 98.1 percent. However, UnitedHealthcare received a compliance score of 96.0 percent for *Standard IV—Coverage and Authorization of Services*, where both Amerigroup and AmeriHealth achieved full compliance. Overall, the lowest-scored area statewide was in *Standard IX—Grievance System*, with all three MCOs scoring 89.7 percent. All three MCOs received similar findings; each had a finding related to obtaining member written consent when required for appeals. Additionally, all three MCOs had a finding as the appeal resolution letters were not consistently written in easily understood language. A detailed explanation of findings can be found in *Sections 5, 6,* and *7—Plan-Specific Summary* of this report.

Validation of Performance Improvement Projects

In addition to performing individual MCO PIP validations, HSAG compared the initial and final validation findings and conclusions across MCOs for both PIP topics.

Figure 8-1 displays the initial validation percentage of *Met*, *Partially Met*, and *Not Met* validation scores for all three MCOs combined, and the overall percentage score for the *Member Satisfaction* PIP.

Figure 8-1—*Member Satisfaction* PIP—Initial Validation Scores, Overall Validation Percentage

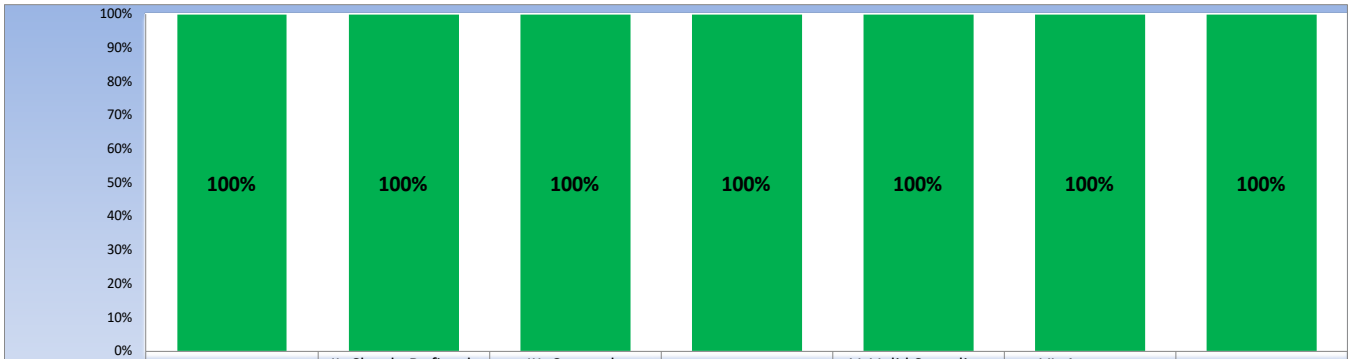


	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	17%	0%	0%	33%	7%	0%	9%
Met	83%	100%	100%	67%	93%	100%	91%

The initial validation findings show opportunities for improvement in three of the six steps of the Design stage. Defining the study indicator, Step IV, had the lowest percentage of *Met* validation scores. Each MCO had the opportunity to seek technical assistance from HSAG to discuss the initial validation findings, and obtain any clarification needed to make the necessary corrections prior to submitting the PIP for final validation.

Figure 8-2 displays the final validation percentage of *Met*, *Partially Met*, and *Not Met* validation scores for all three MCOs combined, and the overall percentage score for the *Member Satisfaction* PIP.

Figure 8-2—*Member Satisfaction* PIP—Final Validation Scores, Overall Validation Percentage

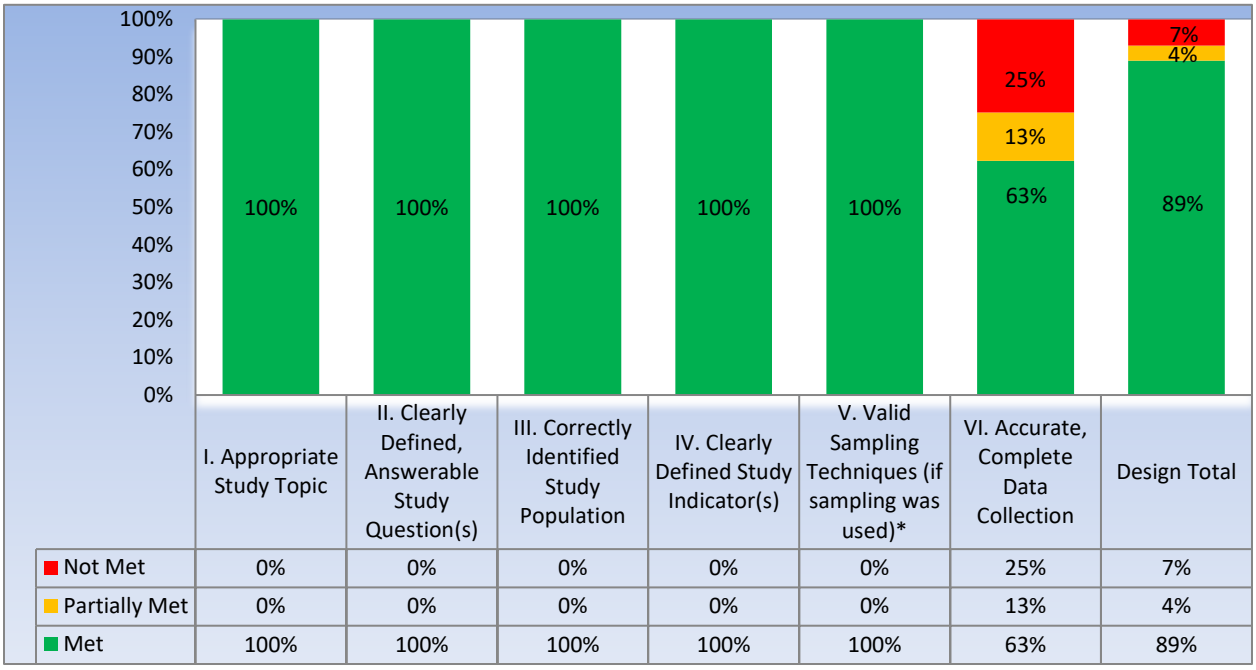


	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	0%	0%	0%	0%	0%	0%
Met	100%	100%	100%	100%	100%	100%	100%

Across all plans, 100 percent of all PIP activities received an overall *Met* validation status for the final validation. The performance on these PIPs suggests a thorough application of the Design stage (Steps I through VI) by all three MCOs. A sound study design creates the foundation for the MCOs to progress to subsequent PIP stages—collecting data and implementing active interventions that have the potential to impact study indicator outcomes.

Figure 8-3 displays the initial validation percentage of *Met*, *Partially Met*, and *Not Met* validation scores for all three MCOs combined, and the overall percentage score for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Figure 8-3—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP—Initial Validation Scores, Overall Validation Percentage

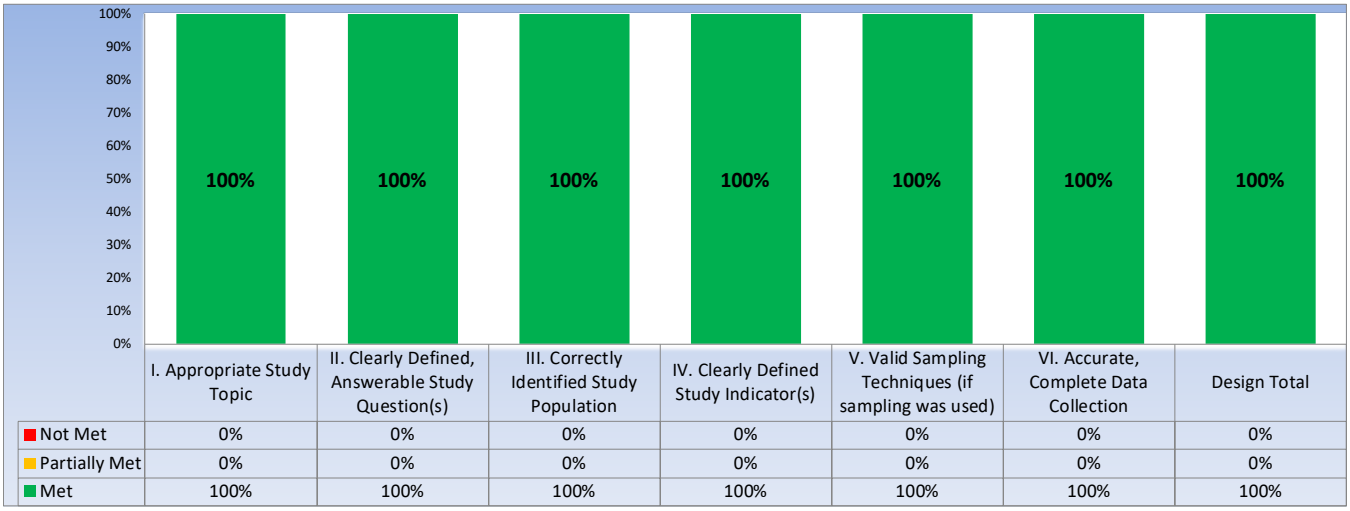


	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)*	VI. Accurate, Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	25%	7%
Partially Met	0%	0%	0%	0%	0%	13%	4%
Met	100%	100%	100%	100%	100%	63%	89%

The initial validation findings show opportunities for improvement in one of the six steps of the Design stage. Defining the data collection process, Step VI, had the lowest percentage of *Met* validation scores. As with the *Member Satisfaction* PIP, each MCO had the opportunity to seek technical assistance from HSAG to discuss the initial validation findings, and obtain any clarification needed to make the necessary corrections prior to submitting the PIP for final validation.

Figure 8-4 displays the final validation percentage of *Met*, *Partially Met*, and *Not Met* validation scores for all three MCOs combined, and the overall percentage score for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP.

Figure 8-4—*Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP—Final Validation Scores, Overall Validation Percentage



	I. Appropriate Study Topic	II. Clearly Defined, Answerable Study Question(s)	III. Correctly Identified Study Population	IV. Clearly Defined Study Indicator(s)	V. Valid Sampling Techniques (if sampling was used)	VI. Accurate, Complete Data Collection	Design Total
Not Met	0%	0%	0%	0%	0%	0%	0%
Partially Met	0%	0%	0%	0%	0%	0%	0%
Met	100%	100%	100%	100%	100%	100%	100%

Across all plans, 100 percent of all PIP activities received an overall *Met* validation status for the final validation. The performance on these PIPs suggests a thorough application of the Design stage (Steps I through VI) by all three MCOs. A sound study design creates the foundation for the MCOs to progress to subsequent PIP stages—collecting data and implementing active interventions that have the potential to impact study indicator outcomes.

Validation of Performance Measures

DHS identified a set of performance measures that the MCOs are required to calculate and report. The measures are for various domains of effectiveness, prevention, and outcomes. These measures are required to be reported following the specifications provided in the IME Managed Care Reporting Manual and submitted via DHS templates. DHS identified the measurement period as April 1, 2016, through March 31, 2017. Rates were reported to DHS quarterly and on a schedule provided by DHS. The MCOs received updated guidance from DHS between quarters to facilitate reporting of measure data as required by DHS. Table 8-2 displays the performance measure validation results for all MCOs.

Table 8-2—Performance Measure Results

Performance Measure	Amerigroup	AmeriHealth	UnitedHealthcare
Adults' Access to Preventive/Ambulatory Health Services—20–44 Years, 45–64 Years, and 65+ Years (count and %)	*NR*	*NR*	*NR*
Members Receiving Annual Monitoring of Persistent Medication Use (count and %)	*NR*	*NR*	*NR*
Members With SMI or SED Receiving Preventive Healthcare Visits (count and %)	*NR*	*NR*	*NR*
Total Number of Well-Child Visits in the First 15 Months of Life	*NR*	*NR*	*NR*
Total Number of Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	*NR*	*NR*	*NR*
Total Number of Adolescent Well-Care Visits	*NR*	*NR*	*NR*

Reported (*R*)—Measure data were compliant with the specifications required by the State and the rate reported was valid.
Not Reported (*NR*)—Measure data were materially biased.

CY 2017 was the first year for this validation activity. The MCOs received updated guidance from DHS between quarters to facilitate reporting of measure data. The frequency of the changes made to measure specifications and reporting templates created challenges for the MCOs in reporting rates as the plans were required to update performance measure coding and report the rates each quarter according to the updated guidance received.

As a result, HSAG had concerns associated with the data integration and measure calculation process for performance measure reporting for all three MCOs. Interpretation of the measure specification requirements varied among the MCOs. Additionally, during PSV all three MCOs were unable to produce an accurate member-level detail file for any performance measures in the scope of the audit; therefore, validation of measure data could not be performed.

HSAG was unable to validate the accuracy of the performance measure data; therefore, reported rates were considered *NR* for all performance measures for each MCO. As a result, a comparison of rates could not be completed or conducted between the MCOs.

Network Adequacy

Table 8-3 presents information on the number of providers and the member-to-provider ratios (i.e., the number of members for each contracted provider) stratified by MCO and provider category.

Table 8-3—Summary of Ratio Analysis Results for Medicaid Providers, Including Out-of-State Providers in Contiguous States

Provider Category	Amerigroup		AmeriHealth		UnitedHealthcare	
	Providers	Ratio	Providers	Ratio	Providers	Ratio
Non-Specialty Providers						
Primary Care, Adult	4,398	22	2,709	42	3,705	23
Primary Care, Child	503	170	2,426	38	3,575	22
Hospital	251	721	246	832	147	1,105
ICF/SNF	390	464	295	694	455	357
ICF/ID	119	1,521	108	1,895	123	1,320
Behavioral Health Inpatient	40	4,526	26	7,871	59	2,752
Behavioral Health Outpatient	234	774	2,199	93	301	540
General Optometry	117	1,547	385	532	678	240
Lab and X-ray Services	63	2,874	30	6,822	226	719
Pharmacy	963	188	873	234	979	166
Specialists for Adults						
Allergy	58	1,649	67	1,684	56	1,525
Cardiology	373	256	347	325	429	199
Dermatology	112	854	103	1,095	106	806
Endocrinology	77	1,242	87	1,297	76	1,124
Gastroenterology	162	591	198	570	158	541
General Surgery	386	248	400	282	389	220
Nephrology	111	862	114	990	87	982
Neurology	227	421	209	540	189	452
Neurosurgery	84	1,139	138	818	76	1,124
Obstetrics and Gynecology	720	80	525	128	497	102
Occupational Therapy	212	451	152	742	215	397
Oncology/Hematology	247	387	126	895	239	357
Ophthalmology	219	437	214	527	223	383
Orthopedics	414	231	289	390	394	217
Otolaryngology	182	526	174	648	143	597

Provider Category	Amerigroup		AmeriHealth		UnitedHealthcare	
	Providers	Ratio	Providers	Ratio	Providers	Ratio
Pathology	238	402	165	684	194	440
Physical Therapy	1,088	88	882	128	1,354	63
Psychiatry	2,434	39	334	338	345	248
Pulmonology	151	634	188	600	177	482
Radiology	601	159	604	187	428	200
Reconstructive Surgery	53	1,805	14	8,059	51	1,675
Rheumatology	51	1,876	60	1,880	57	1,498
Speech Therapy	147	651	103	1,095	275	311
Urology	128	747	124	910	125	683
Specialists for Children						
Allergy	62	1,377	67	1,371	57	1,351
Cardiology	422	202	344	267	473	163
Dermatology	112	762	103	892	106	726
Endocrinology	97	880	87	1,056	90	855
Gastroenterology	191	447	200	459	182	423
General Surgery	411	208	401	229	410	188
Neonatology	3	28,457	38	2,417	82	939
Nephrology	126	678	112	820	99	778
Neurology	22	3,881	209	439	207	372
Oncology/Hematology	274	312	123	747	264	292
Ophthalmology	2	42,686	210	437	224	344
Orthopedics	6	14,229	289	318	395	195
Otolaryngology	183	467	174	528	146	527
Pulmonology	175	488	186	494	196	393
Rheumatology	8	10,672	60	1,531	63	1,222
Urology	131	652	125	735	126	611

Note: The values in the "Ratio" column are rounded to whole numbers. For example, "350" in any "Ratio" column indicates 350 members for each provider.

Lower provider ratio values may indicate better provider capacity (i.e., a greater number of providers contracted to service the MCOs' Medicaid members). As Iowa Medicaid does not yet have managed care contract standards for provider ratios, HSAG was not able to compare the provider ratios with contract standards, and the analysis results may be used to compare provider ratios across the MCOs, but with certain cautions (refer to *Section 4* for study limitations). Ratio analysis results indicate that MCOs

contract with the required provider categories, although the number of providers per category varied by MCO. Wide variation in the number of providers within selected categories (e.g., Behavioral Health Outpatient, Lab and X-ray Services, and Psychiatry—Adult) may also reflect the need for standardized provider category definitions. Not all members require specialty care; therefore, higher provider ratios for specialty care categories may be acceptable. For example, most members are not likely to require intermediate care facilities; therefore, higher ratio thresholds for these provider types may be appropriate (e.g., one provider per 10,000 members). Additionally, ratio results are not adjusted to account for the distribution of demographic and clinical member characteristics represented within each MCO. An MCO with a greater number of members with comorbidities may require a greater number of specialty providers.

HSAG conducted supplemental analyses for selected provider categories with a wide range of provider ratio results. Preliminary analysis results indicated that variation in MCOs' provider ratios for Lab and X-ray Services can be attributed to provider categorization discrepancies. Specifically, UnitedHealthcare categorized hospitals with lab and x-ray services as Lab and X-ray Services Providers, while Amerigroup and AmeriHealth did not appear to make this provider category assignment for hospital facilities. Similarly, discrepancies in the MCOs' categorization of provider subspecialties contributed to the wide range of provider ratio results for General Optometry. Provider data files show that Amerigroup only attributed optometry providers to the General Optometry category, AmeriHealth assigned providers from multiple subspecialties, and UnitedHealthcare attributed both optometrists and ophthalmologists to General Optometry.

Table 8-4 lists the number of time and distance contract standards that each MCO met for non-specialty providers, specialists for adults, and specialists for children. A detailed explanation of findings is presented in *Sections 5, 6* and *7* of this report.

Table 8-4—Number of Time and Distance Contract Standards met by MCO for Each Provider Type Category

Provider Category	Amerigroup	AmeriHealth	UnitedHealthcare
	Number of Standards Met	Number of Standards Met	Number of Standards Met
Non-Specialty	3 of 10 Standards Met	6 of 10 Standards Met	6 of 10 Standards Met
Specialists for Adults	21 of 24 Standards Met	20 of 24 Standards Met	22 of 24 Standards Met
Specialists for Children	10 of 16 Standards Met	14 of 16 Standards Met	15 of 16 Standards Met
Total	**34 of 50 Standards Met**	**40 of 50 Standards Met**	**43 of 50 Standards Met**

Geographic network distribution analysis results indicate that each MCO generally maintains a geographically accessible network, with greater than 99.9 percent of members having access to providers within time and distance standards for most provider categories. Results for UnitedHealthcare met the largest number of time and distance contract standards (43 of 50 standard) compared to Amerigroup and AmeriHealth (34 of 50 standards and 40 of 50 standards, respectively). All MCOs had lower compliance among the non-specialty provider categories, demonstrating an opportunity for improvement across all MCOs.

MCO Enrollee Survey

The following tables provide an overview of the number of completed surveys and response rates for Amerigroup and UnitedHealthcare, respectively.[8-1]

Table 8-5—Survey Dispositions—Amerigroup

Quarter	Sample Size	Completed Surveys	Response Rate
SFY 2017 Q3 (January 2017 – March 2017)	1,200	345	28.8%
SFY 2017 Q4 (April 2017 – June 2017)	1,200	234	19.5%

Table 8-6—Survey Dispositions—UnitedHealthcare

Month	Sample Size	Completed Surveys	Response Rate
December 2016	200	30	15.0%
January 2017	200	30	15.0%
February 2017	200	30	15.0%
March 2017	200	42	21.0%
April 2017	200	30	15.0%
May 2017	200	28	14.0%
June 2017	200	31	15.5%
July 2017	200	30	15.0%
Total	**1,600**	**251**	**15.7%**

Amerigroup and UnitedHealthcare did not administer a comparable survey or use a comparable survey administration process.

[8-1] AmeriHealth only provided information advising how the IPES would have been administered; therefore, AmeriHealth's information was excluded from this report as the survey was not administered.