Iowa Medicaid

Iowa HHS

Calendar Year 2024 External Quality Review Technical Report

April 2025

HSAG HEALTH SERVICES ADVISORY GROUP

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1. Executive Summary

Purpose and Overview of Report

States with Medicaid managed care delivery systems are required to annually provide an assessment of managed care plans' (MCPs') performance related to the quality, timeliness, and accessibility of care and services they provide, as mandated by Title 42 of the Code of Federal Regulations (42 CFR) §438.364. To meet this requirement, the Iowa Department of Health and Human Services (HHS) has contracted with Health Services Advisory Group, Inc. (HSAG), as its external quality review organization (EQRO) to perform the assessment and produce this annual report.

Iowa Medicaid is the division of HHS that administers and oversees the Iowa Managed Care Program, which contracts with three managed care organizations (MCOs) to provide physical health, behavioral health, and long-term services and supports (LTSS) to Medicaid members. The Iowa Managed Care Program consists of two primary coverage groups: (1) IA Health Link and (2) Healthy and Well Kids in Iowa, also known as Hawki (Iowa's Children's Health Insurance Program [CHIP]). HHS also contracts with two prepaid ambulatory health plans (PAHPs) to provide dental benefits for Medicaid (Dental Wellness Plan [DWP] Adults and DWP Kids) and Hawki members. The MCOs and PAHPs contracted with HHS during calendar year (CY) 2024 are displayed in Table 1-1.

Table 1-1—MCPs* in Iowa

MCO Name	MCO Abbreviation
Iowa Total Care, Inc.	ITC
Molina Healthcare of Iowa, Inc.	MOL
Wellpoint Iowa, Inc.	WLP
PAHP Name	**PAHP Abbreviation**
Delta Dental of Iowa	DDIA
Managed Care of North America Dental	MCNA

* Throughout this report, "MCP" is used when collectively referring to MCOs and PAHPs; otherwise, the term "MCO" or "PAHP" is used.

Scope of External Quality Review Activities

To conduct the annual assessment, HSAG used the results of mandatory and optional external quality review (EQR) activities, as described in 42 CFR §438.358. The EQR activities included as part of this assessment were conducted consistent with the associated EQR protocols developed by the Centers for Medicare & Medicaid Services (CMS).[1] The purpose of these activities, in general, is to improve states' ability to oversee and manage MCPs they contract with for services, and help MCPs improve their performance with respect to quality, timeliness, and accessibility of care and services. Effective

[1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Oct 4, 2024.

implementation of the EQR-related activities will facilitate state efforts to purchase cost-effective, high-value care and to achieve higher performing healthcare delivery systems for their Medicaid and CHIP members. For the CY 2024 assessment, no MCPs were exempt from the EQR conducted by HSAG. HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 that were performed during the preceding 12 months to derive conclusions and make recommendations about the quality, timeliness, and accessibility of care and services provided by each MCP. Detailed information about each activity methodology is provided in Appendix A of this report.

Table 1-2—EQR Activities

Activity	Description	CMS Protocol
Validation of Performance Improvement Projects (PIPs)	This activity verifies whether a PIP conducted by an MCP used sound methodology in its design, implementation, analysis, and reporting.	Protocol 1. Validation of Performance Improvement Projects
Performance Measure Validation (PMV)	The activity assesses whether the performance measures calculated by an MCP are accurate based on the measure specifications and state reporting requirements.	Protocol 2. Validation of Performance Measures
Compliance Review	This activity determines the extent to which a Medicaid and CHIP MCP is in compliance with federal standards and associated state-specific requirements, when applicable.	Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations
Network Adequacy Validation (NAV)	This activity assesses the accuracy of the network adequacy indicators reported by an MCP and the extent to which an MCP has met the quantitative network adequacy standards defined by the State.	Protocol 4. Validation of Network Adequacy
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCP.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[2] Analysis	This activity assesses member experience with an MCP and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys
Quality Rating (i.e., Scorecard)	This activity assigns a quality rating (using indicators of clinical quality management; member satisfaction; and/or plan efficiency, affordability, and management) to each MCP serving Medicaid managed care members that enables members and potential members to consider quality when choosing an MCP.	Protocol 10. Assist With Quality Rating of Medicaid and CHIP Managed Care Organizations, Prepaid Inpatient Health Plans, and Prepaid Ambulatory Health Plans*

* CMS has not yet issued the associated EQR protocol.

Iowa Managed Care Program Conclusions and Recommendations

HSAG used its analyses and evaluations of EQR findings from the CY 2024 activities to comprehensively assess the MCPs' performance in providing quality, timely, and accessible healthcare

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

services to Medicaid and Hawki members. For each MCP reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCP's performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCPs were also compared and analyzed to develop overarching conclusions and recommendations for the Iowa Managed Care Program. Table 1-3 highlights substantive conclusions and actionable state-specific recommendations, when applicable, for HHS to drive progress toward achieving the strategic priorities of the Iowa HHS Medicaid Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Medicaid managed care members. Table 1-3 displays each Iowa HHS Medicaid Quality Strategy priority and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the Iowa Managed Care Program's progress toward achieving the applicable priorities, and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. If no trends were identified through an EQR activity that substantially impacted a priority, or EQR activities did not produce data for an Iowa HHS Medicaid Quality Strategy objective, a dash (–) is noted in Table 1-3.

Table 1-3—Iowa Managed Care Program Conclusions and Recommendations

Performance Impact on Strategic Priorities and Objectives		Performance Domain
Strategic Priority 1.0—Access to Care		
✓	The aggregated statewide rate for *Follow-Up After ED Visit for Mental Illness* performance measure was at or above the 90th percentile, positively impacting the Iowa HHS Medicaid Quality Strategy objective to *Improve Behavioral Health Network Adequacy*.	☒ Quality ☒ Timeliness ☒ Access
✗	Both PAHPs demonstrated a decline in performance as compared to the baseline for at least one performance indicator for the preventive dental services PIP activity.	
m	The statewide dental aggregate rate for *Members Who Received A Preventive Examination and a Follow-Up Examination* performance measure for DWP Adults remained unchanged from the CY 2023 rate of 57.36 percent.	
–	Through the NAV activity, the MCOs demonstrated they were not calculating and reporting on appointment wait time standards for one or more of the following: behavioral health services-emergency; behavioral health services-mobile crisis; behavioral health services-substance use disorder and pregnancy; behavioral health services-intravenous drug use; emergency care; general optometry services; or lab and x-ray services. Therefore, access compliance with these provider types could not be assessed.	
–	During CY 2024, *SDOH Screening* PIP topic was initiated for the MCOs, and all MCOs received a designation of High Confidence for Validation Rating 1 of the Design phase. However, while no data were reported for this PIP during CY 2024, this PIP has the potential to impact the identification of SDOH issues that are barriers to accessing care in the future.	
–	The EQR activities do not produce sufficient data to assess the impact of the *Improve Access to Maternal Health* and *Improve Access to LTSS Services* Iowa HHS Medicaid Quality Strategy objectives, or the *Sealant Receipt on Permanent First Molars* indicator under the *Improve Access to Primary Care and Specialty Care* objective.	

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
Strategic Priority 2.0—Whole Person Coordinated Care		
✓	The aggregated statewide HEDIS rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* was 26.94 percent, which was an improvement from the 23.6 percent baseline rate identified in the Iowa HHS Medicaid Quality Strategy, and this performance demonstrates a positive impact for the Iowa HHS Medicaid Quality Strategy objective to *Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis*.	☒ Quality ☐ Timeliness ☐ Access
✓	The aggregated statewide HEDIS rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* was 80.03 percent, which achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*.	
✓	The aggregated statewide HEDIS rate for *Initiation and Engagement of Substance Use Disorder Treatment–Initiation of SUD Treatment—Total* was 47.99 percent and the *Initiation and Engagement of Substance Use Disorder Treatment–Engagement of SUD Treatment—Total* aggregated statewide HEDIS rate was 18.30 percent, indicating progress was made towards achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement By SFY2027.*	
✓	The *Prenatal and Postpartum Care* measure had statewide aggregate rates of 87.16 percent for prenatal care and 83.12 percent for postpartum care, which indicated a positive impact to the two indicators under the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
m	While statewide aggregate rates were reported through the PMV activity for MLTSS measures: *Admission to a Facility from the Community*, *Minimizing Facility Length of Stay* and *Successful Transition After Long-Term Facility Stay*, the Iowa HHS Medicaid Quality Strategy did not include performance targets for these measures. Therefore, the impact to the objective to *Improve Whole Person Coordinated Care for Member Enrolled in LTSS Services* could not be assessed.	
Strategic Priority 3.0—Health Equity		
–	The EQR activities did not produce sufficient data to assess the impact to *Address Disparities in Behavioral Health* and *Address Disparities in Primary and Specialty Care Services* Iowa HHS Medicaid Quality Strategy objectives. Of note, while performance measures that align with the Iowa HHS Medicaid Quality Strategy objectives are collected through the HEDIS audit process, the data included through the technical report process are not stratified by race, ethnicity, age, or geography.	☒ Quality ☐ Timeliness ☒ Access

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that HHS' value-based arrangements have on reducing disparities in care in the focus area of low birth weight.	
Strategic Priority 4.0—Program Administration		
–	The EQR activities did not produce data to assess the impact on the Grievances, Appeals, and Exception to Policy objective.	☒ Quality ☐ Timeliness ☐ Access
Strategic Priority 5.0—Voice of the Customer		
✓	For the child Medicaid population *Rating of All Health Care* CAHPS measure, the statewide aggregate rate was 69.95 percent, which was higher than the CY 2023 rate.	☒ Quality ☐ Timeliness ☒ Access
✓	For the child Medicaid population *Customer Service* CAHPS measure, the statewide aggregate rate was 88.22 percent, which was higher than the CY 2023 rate.	
✓	For the child Medicaid population *Rating of Specialist Seen Most Often* CAHPS measure, the statewide aggregate rate was 74.80 percent, which was higher than the CY 2023 rate.	
✓	For the adult Medicaid population *Rating of Specialist Seen Most Often* CAHPS measure, the statewide aggregate rate was 61.90 percent, which was slightly higher than the CY 2023 rate.	
✗	The MCO Program (i.e., statewide aggregate rate) received a rate of 45.23 percent for the CAHPS measure, *Discussing Cessation Medications* for the adult Medicaid population, which was slightly lower than the CY 2023 rate.	
–	The aggregated findings for the EQR activities did not produce data for HSAG to comprehensively assess the impact to HHS' focus areas through surveys for continuity of care, experience of care stratified by waiver, and questions around grievances and appeals.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in the Iowa HHS Medicaid Quality Strategy, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Iowa Managed Care Program members:

- To further enhance HHS' ability to measure the strategic priorities indicated in the Iowa HHS Medicaid Quality Strategy, HSAG recommends that HHS consider including specific, measurable, attainable, and timely goals and corresponding objectives for each of the strategic priorities and revise the Iowa HHS Medicaid Quality Strategy to reflect these updates. For example, related to the Access to Care strategic priority, HHS could consider adding objectives that tie to HEDIS performance measures for all HHS priority areas including behavioral health, maternal health, LTSS, primary care, and specialty care, and setting benchmarks for each objective.
- As indicated in the Iowa HHS Medicaid Quality Strategy, HHS plans to contractually require that MCOs engage in two additional PIPs per year (two HSAG validated PIPs and two non-HSAG validated PIPs) that focus on prevention and care of acute and chronic conditions, high risk services, oral health, etc. As such, HSAG recommends that HHS consider selecting the topics for the additional PIPs to ensure alignment with the Iowa HHS

Performance Impact on Strategic Priorities and Objectives	Performance Domain
Quality Strategy goals and objectives. Additionally, HHS could also require specific interventions that MCOs must implement for the PIPs that would facilitate comparability amongst the MCOs. • HSAG recommends that HHS issue formal guidance to all MCPs, detailing its expectations for how the MCPs should assess appointment wait time standards and consider revisions to the survey protocol to ensure the MCPs' compliance with State standards are accurately measured. As CMS has implemented appointment timeliness standards effective in 2027, HHS should also ensure that these standards are incorporated into all MCP contracts, as applicable. Specifically, to comply with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F), HHS should implement the following within the required effective dates: – Review the maximum appointment wait times standards (i.e., 15 business days for routine primary care [adult and pediatric] and obstetric/gynecological services; 10 business days for outpatient mental health and SUD appointments). • HHS should contract with an independent vendor to perform secret shopper surveys of MCP compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to HHS within three days of discovery, per the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F). Results from the secret shopper survey will provide assurances to HHS that the MCPs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members. • To also ensure adherence to CMS–2439–F, HHS should ensure that an annual member experience survey for each MCP is conducted and analyze the responses to determine where opportunities for improvement exist and implement initiatives that target improvement. • To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), HHS should update the contracts with its MCPs as follows within the required effective dates for each specific requirement: – Require the MCPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services. – Require the MCPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MCP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MCP, and enables the MCPs to assess trends, identify areas for improvement, and work towards continuous process improvement while maintaining necessary quality checks for quality and appropriateness of care. • Through the PAHP EDV activity, HSAG's dental record reviewers followed the requirements outlined in the *IA Dental Services Provider Manual* (*Appendix B*), which indicated that when procedure code D9999 was billed by a dental provider, supporting documentation for this code must be submitted with the claim. Based on HSAG's review of the submitted dental records, the dental records did not contain sufficient documentation to support the reported procedure code in the encounter data, which was a key factor in HSAG's assessment and impacted the PAHPs' findings through this activity. Following the completion of HSAG's analysis, HHS confirmed that Federally Qualified Health Centers (FQHCs) were not required to include supporting documentation when submitting claims for this procedure code. As such, HSAG recommends that HHS update the *IA Dental Services Provider Manual* (*Appendix B*) to ensure alignment with this direction for FQHC billing.	

2. Overview of the Iowa Managed Care Program

Managed Care in Iowa

Since April 2016, most Medicaid recipients in Iowa receive benefits through a CMS-approved section 1915(b) waiver program called the Iowa High Quality Healthcare Initiative (Initiative). The Initiative also includes §1915(c) waiver and §1115 demonstration recipients and operates statewide. MCOs are contracted by HHS to deliver all medically necessary, Medicaid-covered physical health, behavioral health, and LTSS benefits in a highly coordinated manner. HHS also contracts with PAHPs to deliver dental benefits to members enrolled in the DWP and Hawki program.[3]

Overview of Managed Care Plans (MCPs)

During the CY 2024 review period, HHS contracted with three MCOs and two PAHPs. These MCPs are responsible for the provision of services to Iowa Medicaid and Hawki members. Table 2-1 provides a profile for each MCP.

Table 2-1—MCP Profiles

MCOs	Total Enrollment[4]	Covered Services[5]	Service Area
ITC	243,918	• Preventive Services • Professional Office Services • Inpatient Hospital Admissions • Inpatient Hospital Services • Outpatient Hospital Services • Emergency Care • Behavioral Health Services • Outpatient Therapy Services • Prescription Drug Coverage • Prescription Drug Copay • Radiology Services • Laboratory Services • Durable Medical Equipment (DME) • LTSS—Community Based • LTSS—Institutional • Hospice • Health Homes	Statewide
MOL	174,828		
WLP	257,380		

[3] Dental benefits offered through the Hawki program are administered by **DDIA** only. DWP Adults and DWP Kids benefits are administered by both **DDIA** and **MCNA**.

[4] Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 13, 2025.

[5] Iowa Department of Human Services. *Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination.* Rev. 2/23. Available at: https://hhs.iowa.gov/sites/default/files/Comm519.pdf?092720211503. Accessed on: Jan 31, 2025.

PAHPs[3]	Total Enrollment[6]	Covered Services[7,8]	Service Area
DDIA	460,384	• Diagnostic and Preventive Services (exams, cleanings, x-rays, and fluoride) • Fillings for Cavities • Surgical and Non-Surgical Gum Treatment • Root Canals • Dentures and Crowns • Extractions	Statewide
MCNA	229,935		

Table 2-2 further displays the enrollment data for each MCP separated by enrollment populations.

Table 2-2—MCP Enrollment by Population[9]

MCP		Enrollment Population	Enrollment Count	Total Enrollment
MCOs	ITC	Medicaid	223,144	
		Hawki	20,774	
		Total	**243,918**	
	MOL	Medicaid	160,945	
		Hawki	13,883	
		Total	**174,828**	
	WLP	Medicaid	237,232	
		Hawki	20,148	
		Total	**257,380**	
PAHPs	DDIA	DWP Adults	223,926	
		DWP Kids	173,735	
		Hawki	62,723	
		Total	**460,384**	
	MCNA	DWP Adults	129,394	
		DWP Kids	100,541	
		Hawki	NA*	
		Total	**229,935**	

* Not applicable (NA)–Hawki members are only enrolled in one PAHP, DDIA.

6 Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 13, 2025.
7 State of Iowa Department of Health and Human Services. Dental Wellness Plan. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-medicaid-programs/dental-wellness-plan. Accessed on: Jan 31, 2025.
8 State of Iowa Department of Health and Human Services. Hawki. Available at: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/iowa-health-link/hawki-chip. Accessed on: Jan 31, 2025.
9 Iowa Department of Health and Human Services, Iowa Medicaid. Enrollment data provided by HHS on Feb 13, 2025.

Quality Strategy

The Iowa HHS Medicaid Quality Strategy[10] outlines HHS' strategy for promoting policy and action to effectively improve the Medicaid program. Activities within the Iowa HHS Medicaid Quality Strategy are directed toward outcomes that create healthier members through the development of systems and practices that promote quality and sustainability. Table 2-3 presents the Iowa HHS Medicaid Quality Strategy strategic priorities and key goals for completion by SFY 2027.

Table 2-3—Iowa HHS Medicaid Quality Strategy

Strategic Priority	Goals
1.0 Access to Care	• HHS will work collaboratively with the MCOs and Directed Payments to complete the following projects to completion. – HHS will complete a project to enhance access to behavioral health services for children with complex behavioral health needs. – HHS will complete a comprehensive project around access to care for high-risk pregnancies. – HHS will complete a comprehensive project to address access to primary, specialty and dental care. • Increase Access to Emergency Services. Increase the number of providers that participate in the Ground Emergency Medical Transportation Directed Payment program to 70 providers. • Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last Calendar year.
2.0 Whole Person Coordinated Care	• HHS will increase Metabolic Monitoring for Children and Adolescents on Antipsychotics (Blood Glucose and Cholesterol), (APM) from 23.6% to 30%. • HHS will increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80%. • HHS will increase Initiation and Engagement of Substance Use Disorder All 10 Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement. • HHS will increase prenatal visits in the first trimester by 5% (59%). • HHS will increase Postpartum visits from 5% (32%). • HHS will Improve Community Integration Management by identifying benchmarks, tracking, and trending LTSS 6, 7, & 8. • HHS will Improve LTSS Case Management timeliness of assessments and plans without exemptions to be 95% +/- 5%.

[10] Iowa Department of Human Services. Iowa HHS Medicaid Quality Strategy, July 2024. Available at: https://hhs.iowa.gov/media/14254/download?inline. Accessed on: Jan 22, 2025.

Strategic Priority	Goals
3.0 Health Equity	Managed Care Plans Successfully Create Health Equity Plans and demonstrate a 1% Reduction in Disparities in the following areas: • Behavioral health and substance use disorders. • Maternal Health • Primary and Specialty Care Services • LTSS • Oral Health
4.0 Program Administration	• HHS will complete a comprehensive project around Grievance, Appeals, and Exception to Policy. • Iowa Medicaid will complete a project that works toward integration between the medical and dental programs.
5.0 Voice of the Customer	HHS will complete a comprehensive project around the voice of the customer.

Quality Initiatives

To accomplish the Quality Strategy objectives, Iowa has ongoing activities regarding quality initiatives. These initiatives are discussed below.

Medicaid Enterprise Modernization Effort (MEME) Program: The MEME program continued in 2024. This large, multi-year information technology (IT) systems and business process modernization is focused on achieving outcomes that align with the Medicaid strategic priorities. Focusing on measurable outcomes (e.g., shortening the time required to approve an application) can generate dramatically improved results compared to requirements-based IT procurement approaches from the past. This also aligns with CMS' move to streamlined modular certification that likewise shifts to an outcomes-based mindset. Iowa is actively implementing a module to deliver a modernized enrollment process for providers as well as improve data quality to analyze the provider network.

Two additional large projects are well into planning, including assessment of IT modifications necessary to support waiver redesign that will transition Iowa from a diagnosis-based approach to Home and Community-Based Services (HCBS) to a streamlined, needs-oriented approach beginning sometime in 2026. Finally, a Quality Management System (QMS) is being developed to deliver better insight into Medicaid (and related) data sets focusing on metrics derived from a member-journey perspective that will help guide strategic decision making and oversight of delivery of care.

To learn more about MEME, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/meme.

Iowa REACH (Responsive, Effective, Accessible, Child & Family-centered Health) Initiative: This initiative represents a groundbreaking effort by Iowa HHS to address critical gaps in the mental and behavioral health system for Medicaid-eligible children and youth.

Launched in response to a federal lawsuit (*C.A. v. Garcia*), REACH serves as a model of systemic reform and accountability. It aims to build a child- and family-centered system that delivers timely, equitable, and individualized care through a multi-agency, collaborative approach.

Key highlights of the initiative:

- Court-Monitored Implementation: Overseen by a dedicated Implementation Team, along with a Consumer Steering Committee and subcommittees to ensure transparency, accountability, and progress tracking.
- Guiding principles:
  - *Child-Centered and Family-Driven*: Active family involvement in planning, delivery, and evaluation of services.
  - *Team-Based and Collaborative*: Cross-system coordination for integrated care.
  - *Home and Community-Based*: Emphasis on inclusive, least-restrictive environments.
  - *Natural Supports*: Strength-based focus, leveraging family and community networks.

- *Culturally Responsive and Individualized*: Services tailored to each family's unique needs.
- *Outcome-Focused*: Commitment to flexible, goal-driven, and unconditional care to ensure sustainable impact.

The REACH Initiative exemplifies a best-practice model in system transformation and demonstrates how meaningful stakeholder engagement and structured oversight can lead to lasting improvements in service quality and health equity for vulnerable populations.

To learn more about REACH, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/iowa-reach.

Hope and Opportunity in Many Environments (HOME): Iowa HHS launched the HOME initiative to enhance access to high-quality community-based services for individuals with behavioral health needs, disabilities, or aging-related care needs, as well as for their caregivers and families.

The HOME initiative aims to transform and improve Iowa's community-based service system by:

- Centering efforts around individuals who use services and including their caregivers.
- Engaging stakeholders, including service users, caregivers, case managers, and providers, in shaping the future of care delivery.
- Ensuring person-centered, accessible, and high-quality services across all settings.

Key activities:

1. Community-Based Services Evaluation (2023): A comprehensive review to assess strengths and gaps in the existing service system.
2. Transformation Plan Development: Guided by findings from the evaluation, Iowa HHS created a strategic plan to implement targeted improvements and build a better "HOME."
3. Stakeholder Engagement: Ongoing input was gathered from individuals receiving services, their caregivers, case managers, and providers to refine and guide the transformation plan.
4. Survey and Data Collection: A statewide survey collected valuable insights into the real-life experiences of service recipients and stakeholders, helping inform continuous improvement efforts.

This proactive, inclusive approach demonstrates Iowa's commitment to reimagining community-based services in a way that empowers service users and caregivers. The HOME initiative serves as a promising model for other states seeking to create more responsive, person-centered systems of care.

To learn more about HOME, please visit the following link: https://hhs.iowa.gov/programs/welcome-iowa-medicaid/current-projects/home.

3. Assessment of Managed Care Organization Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2024 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to Iowa Managed Care Program members. Quality, as it pertains to EQR, means the degree to which the MCOs increased the likelihood of members' desired health outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal health outcomes, as evidenced by how effective the MCOs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and access to care furnished by each MCO.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each MCO to identify strengths and weaknesses that pertain to the domains of quality, timeliness, and access to services furnished by the MCO for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and HSAG draws conclusions about overall quality, timeliness, and access to care and services furnished by the MCO.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities related to strengths and weaknesses in one or more of the domains of quality, timeliness, and access to care and services furnished by the MCO.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 3-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 3-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	May 22, 2024	December 9, 2024
PMV	August 5, 2024	January 31, 2025
Compliance Review	April 12, 2024	November 1, 2024
NAV	January 29, 2024	January 31, 2025
EDV	March 13, 2024	February 26, 2025
CAHPS	May 31, 2024	January 17, 2025
Scorecard	April 8, 2024	December 16, 2024

Validation of Performance Improvement Projects

For the CY 2024 validation, the MCOs initiated two HHS-mandated PIP topics, *Social Determinants of Health (SDOH) Screening* and *Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication (ADD-HEDIS)*. HSAG conducted validation of the Design stage (Steps 1–6) for each PIP topic in accordance with the CMS' EQR protocol for validation of PIPs (CMS EQR Protocol 1). Table 3-2 outlines the selected PIP topics and performance indicators for each MCO.

Table 3-2—PIP Topics and Performance Indicators

MCO	PIP Topic	Performance Indicator
ITC	*SDOH Screening*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Follow-up care for children prescribed ADHD medication (ADD-E): Initiation phase
		Follow-Up Care for Children Prescribed ADHD Medication (ADD-E): Continuation and Maintenance (CM) Phase
MOL	*SDOH Screening*	Newly enrolled Medicaid: The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		Existing enrolled Medicaid: The percentage of existing members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Initiation Phase: The percentage of the eligible population that had one follow-up visit during the 30-day initiation phase.
		Continuation and Maintenance Phase: The percentage of the eligible population who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.
WLP	*SDOH Screening*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.
		The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.
		Members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.

Performance Measure Validation

For the EQR time frame under evaluation, HSAG completed PMV activities for **WLP, ITC,** and **MOL** for measurement year (MY) 2023 (January 1, 2023 – December 31, 2023) to validate enrollment and eligibility, claims and encounter, provider data processing, and data integration and validation procedures that contribute to CMS managed long-term services and supports (MLTSS) and Core Set reporting. HSAG also validated data integration and measure production processes of an HHS vendor, IBM Watson (IBM), which is contracted with HHS to provide aggregate performance measure rates for all Medicaid populations for CMS Core Set reporting. As IBM was contracted by HHS to calculate only statewide measure rates, MCO-specific rates for CMS Core Set measures were not available, and therefore, are not displayed in the External Quality Review Activity Results section by MCO.

Table 3-3 shows the list of CMS Core Set performance measures and measurement periods evaluated for MY 2023 for the CY 2024 PMV activity.

Table 3-3—CMS Core Set Performance Measures for Validation

Performance Measure Name and Indicator	Measure Source
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis: Ages 3 Months to 17 Years	CMS Child Core Set
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication	CMS Child Core Set
Ambulatory Care: Emergency Department (ED) Visits	CMS Child Core Set
Antidepressant Medication Management	CMS Adult Core Set
Asthma Medication Ratio: Ages 5 to 18	CMS Child Core Set
Metabolic Monitoring for Children and Adolescents on Antipsychotics	CMS Child Core Set
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics	CMS Child Core Set
Screening for Depression and Follow-Up Plan: Ages 18 and Older	CMS Adult Core Set
Screening for Depression and Follow-Up Plan: Ages 12 to 17	CMS Child Core Set
Chlamydia Screening in Women: Ages 16 to 20	CMS Child Core Set
Childhood Immunization Status	CMS Child Core Set
Developmental Screening in the First Three Years of Life	CMS Child Core Set
Follow-Up After Emergency Department Visit for Substance Use: Age 18 and Older	CMS Adult Core Set
Follow-Up After Emergency Department Visit for Substance Use: Ages 13 to 17	CMS Child Core Set
Follow-Up After Hospitalization for Mental Illness: Age 18 and Older	CMS Adult Core Set
Follow-Up After Hospitalization for Mental Illness: Ages 6 to 17	CMS Child Core Set
Follow-Up After Emergency Department Visit for Mental Illness: Age 18 and Older	CMS Adult Core Set
Follow-Up After Emergency Department Visit for Mental Illness: Ages 6 to 17	CMS Child Core Set
Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)	CMS Adult Core Set

Performance Measure Name and Indicator	Measure Source
Initiation and Engagement of Substance Use Disorder Treatment	CMS Adult Core Set
Immunizations for Adolescents	CMS Child Core Set
Lead Screening in Children	CMS Child Core Set
Oral Evaluation, Dental Services	CMS Child Core Set
Use of Pharmacotherapy for Opioid Use Disorder	CMS Adult Core Set
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	CMS Adult Core Set
Sealant Receipt on Permanent First Molars	CMS Child Core Set
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	CMS Adult Core Set
Topical Fluoride for Children	CMS Child Core Set
Well-Child Visits in the First 30 Months	CMS Child Core Set
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents	CMS Child Core Set
Child and Adolescent Well-Care Visits	CMS Child Core Set

Table 3-4 shows the list of CMS MLTSS performance measures and measurement periods evaluated for MY 2023 for the CY 2024 PMV activity.

Table 3-4—LTSS Performance Measures for Validation

Performance Measure Name	Acronym	Method	Required Specifications
Managed Long-Term Services and Supports Admission to a Facility from the Community	MLTSS-6	Admin	CMS LTSS
Managed Long-Term Services and Supports Minimizing Facility Length of Stay	MLTSS-7	Admin	CMS LTSS
Managed Long-Term Services and Supports Successful Transition after Long-Term Facility Stay	MLTSS-8	Admin	CMS LTSS

HHS required each MCO to contract with an NCQA-certified HEDIS licensed organization to undergo a full audit of its HEDIS reporting process.

Table 3-5 shows the reported measures divided into performance measure domains of care.

Table 3-5—HEDIS Measures Reported by IA MCOs

HEDIS Measure by Domain of Care
Access to Preventive Care
Adults' Access to Preventive/Ambulatory Health Services
Ages 20–44 Years
Ages 45–64 Years
Ages 65 and Older
Use of Imaging Studies for Low Back Pain
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total
Counseling for Nutrition—Total
Counseling for Physical Activity—Total
Women's Health
Breast Cancer Screening
Cervical Cancer Screening
Chlamydia Screening in Women—Total
Non-Recommended Cervical Cancer Screening in Adolescent Females
Prenatal and Postpartum Care
Timeliness of Prenatal Care
Postpartum Care
Living With Illness
Hemoglobin A1c Control for Patients With Diabetes
HbA1c Control (<8%)
HbA1c Poor Control (>9.0%)
Blood Pressure Control for Patients With Diabetes
Blood Pressure Control (<140/90 mm Hg)
Eye Exam for Patients With Diabetes
Eye Exam (Retinal) Performed
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy—Total
Statin Therapy for Patients With Diabetes
Received Statin Therapy

HEDIS Measure by Domain of Care
Behavioral Health
Diabetes Monitoring for People With Diabetes and Schizophrenia
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications
Follow-Up After Emergency Department (ED) Visit for Substance Use
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After ED Visit for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Follow-Up After Hospitalization for Mental Illness
7-Day Follow-Up—Total
30-Day Follow-Up—Total
Initiation and Engagement of Substance Use Disorder (SUD) Treatment
Initiation of SUD Treatment—Total
Engagement of SUD Treatment—Total
Metabolic Monitoring for Children and Adolescents on Antipsychotics
Blood Glucose and Cholesterol Testing—Total
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total
Keeping Kids Healthy
Child and Adolescent Well-Care Visits—Total
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1
Combination 2
Lead Screening in Children
Well-Child Visits in the First 30 Months of Life
Well-Child Visits in the First 15 Months
Well-Child Visits for Age 15 Months-30 Months
Medication Management
Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Antidepressant Medication Management
Effective Acute Phase Treatment
Effective Continuation Phase Treatment

HEDIS Measure by Domain of Care
Appropriate Testing for Pharyngitis—Total
Appropriate Treatment for Upper Respiratory Infection—Total
Asthma Medication Ratio-Total
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Total
Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication
Initiation Phase
Continuation and Maintenance Phase
Persistence of Beta-Blocker Treatment After a Heart Attack
Pharmacotherapy Management of Chronic Obstructive Pulmonary Disease (COPD) Exacerbation
Systemic Corticosteroid
Bronchodilator
Statin Therapy for Patients With Cardiovascular Disease
Statin Adherence 80%—Total
Statin Therapy for Patients With Diabetes
Statin Adherence 80%—Total
Use of Opioids at High Dosage
Use of Opioids From Multiple Providers
Multiple Prescribers
Multiple Pharmacies
Multiple Prescribers and Multiple Pharmacies

Compliance Review

HHS requires its contracted MCOs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The compliance reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in CY 2024 and comprises 14 program areas referred to as standards. At HHS's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (CY 2024) and a review of the remaining federally required seven standards and requirements will be reviewed in Year Two (CY 2025) of the three-year compliance review cycle. In CY 2026 (Year Three), the compliance review activity will consist of a re-review of the standards that were not fully compliant during the CY 2024 (Year One) and CY 2025 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required corrective action plans (CAPs) to remediate the noted deficiencies. Table 3-6 outlines the standards reviewed over the three-year review cycle.

Table 3-6—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each MCO's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

[2] This standard includes a comprehensive assessment of the MCO's information systems (IS) capabilities.

Network Adequacy Validation

In CY 2024, HSAG conducted and completed NAV activities for three MCOs—**ITC**, **MOL**, and **WLP**.

States that contract with MCOs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted MCO provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined

network adequacy standards, the State and the EQRO defined the network adequacy indicators, which the EQRO then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. HHS identified network adequacy indicators to be validated for the reporting period(s) of state fiscal year (SFY) 2024. Table 3-7 through Table 3-9 list the network adequacy standards and the indicators that HSAG validated.

Table 3-7—MCO Network Adequacy Indicators Validated—Time and Distance Standards

Network Category Description	Required Within Standard	Urban Area—Time/Distance Standard	Rural Area—Time/Distance Standard
Provider Types			
Primary Care Physician (PCP)	At least one provider	30 minutes or 30 miles from the personal residences of members	
Specialty Care	At least one provider	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members 90 minutes or 90 miles from the personal residence of members for ALL non-dual members	
Hospitals*	At least one hospital	Not to exceed 30 minutes or 30 miles	30 minutes or 30 miles
Long-Term Care Services—*Institutional Providers*	At least one provider	30 minutes or 30 miles	60 minutes or 60 miles
Long-Term Care Services—*HCBS [Home- and Community-Based Service] Providers***	At least two providers per county for each covered HCBS in the benefit package for each 1915(c) waiver	30 minutes or 30 miles	60 minutes or 60 miles
Behavioral Health Services—*Outpatient Services*	At least one provider	30 minutes or 30 miles from the personal residence of members	
Behavioral Health Services—*Inpatient, Residential, Intensive Outpatient, and Partial Hospitalization*	At least one provider	60 minutes or 60 miles from the personal residence of members	90 minutes or 90 miles from the personal residence of members
General Optometry Services	At least one provider	30 minutes or 30 miles	30 minutes or 30 miles
Lab and X-Ray Services	At least one Clinical Laboratory Improvement Amendments (CLIA)-certified lab provider	30 minutes or 30 miles	

Network Category Description	Required Within Standard	Urban Area—Time/Distance Standard	Rural Area—Time/Distance Standard
Pharmacies	At least two pharmacy providers	30 minutes or 30 miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program	

*Hospitals: Transport time shall be the usual and customary, not to exceed 30 minutes or 30 miles, except in rural areas where access time may be greater. If greater, the standard needs to be the community standard for accessing care, and exceptions shall be justified and documented to the State on the basis of community standards.

**In the event a county has an insufficient number of providers licensed, certified, or available, the access standard shall be based on the community standard and shall be justified and documented to the State.

Table 3-8—MCO Network Adequacy Indicators Validated—Appointment Wait Time Standards

Provider Type	Appointment Wait Time
PCP	Not to exceed four to six weeks from the date of a patient's request for a routine appointment, within 48 hours for persistent symptoms and urgent within one day.
Specialty Care	Not to exceed 30 days for routine care or one day for urgent care for non-dual enrolled members.
Behavioral Health Services—*Emergency*	Members with emergency needs shall be seen or referred to an appropriate provider upon presentation at a service delivery site.
Behavioral Health Services—*Mobile Crisis*	Members in need of mobile crisis services shall receive services within one hour of presentation or request.
Behavioral Health Services—*Urgent*	Members with urgent non-emergency needs shall be seen or referred to an appropriate provider within one hour of presentation at a service delivery site or within 24 hours of telephone contact with the provider or the Contractor.
Behavioral Health Services—*Persistent Symptoms*	Members with persistent symptoms shall be seen or referred to an appropriate provider within 48 hours or reporting symptoms.
Behavioral Health Services—*Routine*	Members with the need for routine services shall be seen or referred to an appropriate provider within three weeks of the request for an appointment.
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	Members who are pregnant women in need of routine substance use disorder services must be admitted within 48 hours of seeking treatment.
Behavioral Health Services—*Intravenous Drug Use*	Members who are intravenous drug users must be admitted not later than 14 days after making the request for admission, or 120 days after the date of such request if no program has the capacity to admit the individual on the date of such request and if interim services are made available to the individual not later than 48 hours after such request.
Emergency Care	All emergency care is immediate, at the nearest facility available, regardless of whether the facility or provider is under contract with the Contractor.

Provider Type	Appointment Wait Time
General Optometry Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.
Lab and X-Ray Services	Not to exceed three weeks for regular appointments and 48 hours for urgent care.

Table 3-9—MCO Network Adequacy Indicators Validated—Minimum Provider Agreements With Specialty Practicing Providers

Provider Type*
Allergy
Cardiology
Dermatology
Endocrinology
Gastroenterology
General Surgery
Neonatology
Nephrology
Neurology
Neurosurgery
Obstetrics and Gynecology
Occupational Therapy
Oncology/Hematology
Ophthalmology
Orthopedics
Otolaryngology
Pathology
Physical Therapy
Pulmonology
Psychiatry
Radiology
Reconstructive Surgery
Rheumatology
Speech Therapy
Urology
Pediatric Specialties

*At least one provider who meets access standards for the percentage of members in the access standard.

Encounter Data Validation

In CY 2024, HSAG conducted and completed EDV activities for the three MCOs (i.e., **ITC**, **MOL**, and **WLP**). The EDV activities included:

- Administrative profile—analysis of HHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in HHS' data warehouse were complete, accurate, and submitted by the MCOs in a timely manner.
- Comparative analysis—analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity was to evaluate the extent to which the encounter data in HHS' data warehouse that were submitted by the MCOs were complete and accurate.

MOL began administering benefits and providing services to Iowa Managed Care Program members on July 1, 2023. As such, since 2024 is only the second year that **MOL** has been submitting encounter data to HHS, HSAG conducted an administrative profile analysis specifically for **MOL** in CY 2024. For **ITC** and **WLP** (formerly known as Amerigroup), HSAG had previously conducted an administrative profile analysis in CY 2020 and CY 2017, respectively. Therefore, HSAG did not conduct an administrative profile analysis for these MCOs in CY 2024. Instead, based on HHS' decision, HSAG conducted a comparative analysis for both **ITC** and **WLP**. Additionally, considering **MOL**'s relatively new status in submitting encounter data to HHS, HSAG also conducted a comparative analysis for **MOL** in CY 2024. Table 3-10 illustrates the CY 2024 core evaluation activities for each MCO.

Table 3-10—Core Evaluation Activities for Each MCO

Calendar Year	MCO	Core Activity	Study Review Period*
CY 2024	**ITC**	Comparative analysis	July 1, 2022–October 31, 2023
	MOL	Administrative profile	July 1, 2023–October 31, 2023
		Comparative Analysis	July 1, 2023–October 31, 2023
	WLP	Comparative analysis	July 1, 2022–October 31, 2023

*Study review period refers to the encounter dates of service that were evaluated. Of note, **MOL** began administering benefits and providing services on July 1, 2023. As such, the study period dates were determined to ensure alignment across all three MCOs.

Consumer Assessment of Healthcare Providers and Systems Analysis

The CAHPS surveys ask members to report on and evaluate their experiences with healthcare. These surveys cover topics that are important to members, such as the communication skills of providers and the accessibility of services. Two MCOs, **ITC** and **WLP**, were responsible for obtaining CAHPS vendors to administer the CAHPS surveys on the MCOs' behalf. **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have CAHPS data for CY 2024. HSAG presents top-box scores, which indicate the percentage of members who responded to the survey with positive

experiences in a particular aspect of their healthcare. Table 3-11 displays the various measures of member experience.

Table 3-11—CAHPS Measures of Member Experience

CAHPS Measures
Composite Measures
Getting Needed Care
Getting Care Quickly
How Well Doctors Communicate
Customer Service
Global Ratings
Rating of All Health Care
Rating of Personal Doctor
Rating of Specialist Seen Most Often
Rating of Health Plan
Medical Assistance With Smoking and Tobacco Use Cessation Items
Advising Smokers and Tobacco Users to Quit
Discussing Cessation Medications
Discussing Cessation Strategies
CCC Composite Measures/Items
Access to Specialized Services
Family Centered Care (FCC): Personal Doctor Who Knows Child
Coordination of Care for Children With Chronic Conditions
Access to Prescription Medicines
FCC: Getting Needed Information

Scorecard

HSAG analyzed MY 2023 HEDIS results and MY 2023 CAHPS data from the two MCOs, **ITC** and **WLP**, for presentation in the 2024 Iowa Medicaid Scorecard.[11] MCO performance was evaluated in the following six reporting categories identified as important to consumers:

- **Doctors' Communication and Patient Engagement:** This category includes adult and child CAHPS composites and HEDIS measures related to patient satisfaction with providers and patient engagement.
- **Access to Preventive Care:** This category consists of CAHPS composites and HEDIS measures related to adults' and children's access to preventive care.
- **Women's Health:** This category consists of HEDIS measures related to screenings for women and maternal health.
- **Living With Illness:** This category consists of HEDIS measures related to diabetes, cardiovascular, and respiratory conditions.
- **Behavioral Health:** This category consists of HEDIS measures related to follow-up care for behavioral health, as well as appropriate care for adults on antidepressants and antipsychotics, and children on antipsychotics and medications for attention-deficit/hyperactivity disorder (ADHD).
- **Medication Management:** This category consists of HEDIS measures related to antibiotic stewardship, as well as medication management for opioid use and behavioral health conditions.

HSAG computed six reporting category summary scores and 15 subcategory summary scores for each MCO, compared each measure to national benchmarks, and assigned star ratings for each measure.

[11] The third MCO, **MOL**, was not included in the analysis as the MCO's Iowa Managed Care Program's contract began in calendar year 2023 and the MCO would only have reportable data for July 2023 through December 2023 for MY 2023.

External Quality Review Activity Results

Iowa Total Care, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **ITC**'s PIP (i.e., the PIP Design stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-12 displays the validation ratings and performance indicators.

Table 3-12—Overall Validation Rating for ITC

PIP Topic	Validation Rating 1*	Validation Rating 2**	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*High Confidence*	*Not Assessed*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	—	—	—
			The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.	—	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*High Confidence*	*Not Assessed*	Follow-up care for children prescribed ADHD medication (ADD-E): Initiation phase	—	—	—
			Follow-Up Care for Children Prescribed ADHD Medication (ADD-E): Continuation and Maintenance (CM) Phase	—	—	—

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to reporting baseline, Remeasurement 1, and Remeasurement 2 results during CY 2024.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
** Not Assessed—HSAG did not assess Validation Rating 2 for CY 2024 as the MCO reported the Design stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Once the MCO has progressed to developing intervention strategies, Table 3-13

will display the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-13—Barriers and Interventions for ITC

SDOH Screening	
Barriers	**Interventions**
—	—
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
—	—

— Expected to be initiated in CY 2026.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ITC designed a methodologically sound PIP as indicated by the high confidence validation rating for the Design phase. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses through the PIP activity.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **ITC** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed ITC's eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, ITC demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. However, during the audit HSAG identified misalignments between ITC's source code and the technical specifications. ITC corrected its source code during the audit and underwent additional primary source verification. All records reviewed aligned with the data output files and the technical specifications for performance measure calculation. ITC was able to report valid and reportable rates. Table 3-14 displays the indicator rates for each performance measure reported by ITC.

Table 3-14—ITC MY 2023 MLTSS Performance Measures

	MLTSS Performance Measures	Performance Measure Rate
1.	*Managed Long-Term Services and Supports Admission to a Facility from the Community*	
	Short-Term Stay—Ages 18 to 64	0.29
	Short-Term Stay—Ages 65 to 74	1.06
	Short-Term Stay—Ages 75 to 84	2.31
	Short-Term Stay—Ages 85+	2.65
	Medium-Term Stay—Ages 18 to 64	1.04
	Medium-Term Stay—Ages 65 to 74	3.17
	Medium-Term Stay—Ages 75 to 84	3.95
	Medium-Term Stay—Ages 85+	7.42
	Long-Term Stay—Ages 18 to 64	4.76
	Long-Term Stay—Ages 65 to 74	20.10
	Long-Term Stay—Ages 75 to 84	36.03
	Long-Term Stay—Ages 85+	64.67
2.	*Managed Long-Term Services and Supports Minimizing Facility Length of Stay*	
	Observed	18.84%
	Risk-Adjusted	21.65%
3.	*Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay*	
	Observed	52.29%
	Risk-Adjusted	49.06%

HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS MY 2023 showed that ITC's HEDIS compliance auditor found ITC's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2023. ITC contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. Table 3-15 displays the indicator rates for each HEDIS MY 2023 performance measure reported by ITC.

Table 3-15—HEDIS MY 2023 Results for ITC

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	78.84%	77.46%	80.15%	↑	★★★★
45–64 Years	85.56%	83.91%	84.84%	↓	★★★
65 Years and Older	85.80%	84.62%	85.51%	↓	★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	68.75%	65.46%	—	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	72.02%	70.07%	79.56%	↑	★★
Counseling for Nutrition—Total	61.80%	58.39%	65.94%	↑	★★
Counseling for Physical Activity—Total	58.15%	54.01%	62.04%	↑	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	44.82%	49.61%	53.98%	↑	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	55.72%	56.69%	57.66%	↑	★★★
Chlamydia Screening in Women					
Total	48.67%	47.89%	47.38%	↓	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.50%	0.48%	0.33%	↑	★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	75.43%	81.75%	86.13%	↑	★★★
Postpartum Care	76.40%	77.86%	82.48%	↑	★★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
HbA1c Control (<8%)	52.31%	48.42%	56.45%	↑	★★
*HbA1c Poor Control (>9.0%)**	39.90%	41.61%	31.14%	↑	★★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control (<140/90 mm Hg)	69.34%	69.10%	72.99%	↑	★★★
Eye Exam for Patients With Diabetes					
Eye Exam (Retinal) Performed	59.37%	56.69%	56.45%	↓	★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	67.88%	61.07%	69.83%	↑	★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	62.03%	69.03%	79.94%	↑	★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	50.19%	56.09%	63.67%	↑	★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	55.15%	58.06%	68.91%	↑	★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.13%	77.59%	78.33%	↑	★★
Follow-Up After Emergency Department Visit for Substance Use					
7 Day Follow-Up—Total	48.63%	56.74%	58.66%	↑	★★★★★
30 Day Follow-Up—Total	54.68%	66.30%	67.87%	↑	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Total	60.85%	63.69%	66.11%	↑	★★★★★
30-Day Follow-Up—Total	72.37%	75.03%	77.70%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	45.06%	52.84%	57.71%	↑	★★★★★
30-Day Follow-Up—Total	66.00%	71.37%	75.84%	↑	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total	—	58.37%	45.26%	—	★★★
Engagement of SUD Treatment—Total	—	20.94%	16.62%	—	★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	23.35%	24.76%	27.81%	↑	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	64.48%	61.74%	61.64%	↓	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	71.05%	74.94%	72.26%	↑	★★★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Combination 10	44.04%	45.50%	40.88%	↓	★★★★
Immunizations for Adolescents					
Combination 1	85.64%	84.43%	85.88%	↑	★★★★
Combination 2	34.06%	34.31%	30.54%	↓	★★
Lead Screening in Children					
Lead Screening in Children	74.81%	74.93%	74.68%	↓	★★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	51.47%	66.01%	67.23%	↑	★★★★
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	55.82%	70.70%	72.93%	↑	★★★
Child and Adolescent Well-Care Visits					
Total	42.20%	50.54%	55.17%	↑	★★★
Medication Management					
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	67.32%	68.79%	62.43%	↓	★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	65.87%	67.79%	62.11%	↓	★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	60.38%	59.99%	61.98%	↑	★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	58.98%	60.82%	63.35%	↑	★★★
Effective Continuation Phase Treatment	42.07%	42.60%	43.91%	↑	★★
Appropriate Testing for Pharyngitis					
Total	77.53%	80.05%	86.89%	↑	★★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	90.99%	89.90%	87.97%	↓	★★
Asthma Medication Ratio					
Total	68.37%	65.87%	65.50%	↓	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	51.10%	59.55%	57.82%	↑	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	42.28%	52.88%	54.92%	↑	★★★★
Continuation and Maintenance Phase	50.11%	57.90%	60.79%	↑	★★★★
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	73.91%	75.14%	58.67%	↓	★★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	58.32%	69.01%	73.45%	↑	★★★
Bronchodilator	67.19%	74.97%	83.82%	↑	★★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	1.72%	1.88%	1.37%	↑	★★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	17.39%	17.07%	20.24%	↓	★★
Multiple Pharmacies	1.63%	1.63%	2.42%	↓	★★★
Multiple Prescribers and Multiple Pharmacies	1.20%	1.16%	1.74%	↓	★★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2023 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for PMV and HEDIS against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of PMV and HEDIS have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ITC's performance in the Keeping Kids Healthy domain improved in CY 2024 in several areas. The *Well-Child Visits in the First 30 Months of Life—Well-Child Visits in the First 15 Months—Six or More Well-Child Visits* indicator rate and the *Childhood Immunization Status—Combination 3* and *Combination 10* indicator rates finished at or above the 75th percentile. Further, the *Immunizations for Adolescents—Combination 1* indicator rate and the *Lead Screening in Children* measure rate also finished at or above the 75th percentile. **[Quality** and **Access]**

Strength #2: ITC's performance in the Behavioral Health domain remained strong for the *Follow-Up After Emergency Department Visit for Substance Use*, *Follow-Up After Emergency Department Visit for Mental Illness,* and *Follow-Up After Hospitalization for Mental Illness* measures. All measure indicators demonstrated rate increases, with all measure indicators finishing at or above the 90th percentile. **[Quality, Timeliness,** and **Access]**

Strength #3: ITC's performance in the Living with Illness domain remained strong for the *Controlling High Blood Pressure* measure. The measure demonstrated a rate increase, finishing at or above the 75th percentile. **[Quality** and **Timeliness]**

Strength #4: ITC demonstrated adequate systems and processes to receive and process enrollment/eligibility data and claims and encounter data prior to ingestion into its Enterprise Data Warehouse. **ITC** also demonstrated multiple methods of validation to ensure the accuracy and completeness of its MLTSS data. **[Quality]**

Weaknesses and Recommendations

Weakness #1: ITC's performance in the Access to Preventive Care Domain remained low for the *Use of Imaging Studies for Low Back Pain* measure, which ranked below the 25th percentile. **[Quality]**

Why the weakness exists: Low rates indicate a high number of Iowa Medicaid members with a principal diagnosis of low back pain had imaging performed that was not essential in improving outcomes, while also causing unnecessary radiation exposure and accrued cost. Best practice is to reduce imaging by identifying the reason for low back pain and to provide other methods of comfort for pain relief, using guidelines for treating back pain at the onset of newly diagnosed low back pain, prior to the use of imaging studies.

Recommendation: HSAG recommends that **ITC** ensure providers are aware of best practices regarding imaging studies for low back pain, including avoiding diagnostic imaging in the first four weeks of new-onset back pain, unless red flags or other conditions are present, and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention. HSAG recommends that **ITC** consider using quality interventions that have been shown to improve appropriate imaging studies for low back pain, including increased provider oversight, providers getting education about HEDIS specifications, specific imaging prompts in the EMR, and quality scorecards for providers.[12]

Weakness #2: ITC's performance in the Behavioral Health domain continued to rank below the 25th percentile for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Diabetes Monitoring for Blood Glucose and Cholesterol Testing—Total*. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. **[Quality]**

Why the weakness exists: The low rate indicates there are barriers to appropriate monitoring for children and adolescents with severe and persistent mental illness who are being treated with psychotropic medication, potentially with behavioral health providers not ordering the correct tests for monitoring.

[12] Al-Hihi, Eyad et al. "Improving appropriate imaging for non-specific low back pain." BMJ open quality vol. 11,1 (2022): e001539. doi:10.1136/bmjoq-2021-001539.

Recommendation: HSAG recommends **ITC** assess how providers are coordinating on antipsychotic care. In one study, members who saw a PCP and mental health provider over the year had a higher rate of receiving metabolic monitoring. Therefore, encouraging joint monitoring might increase the rate of metabolic monitoring.[13] Further, HSAG recommends **ITC** generate provider data reports to identify trends in whether providers are prescribing antipsychotics and not doing metabolic monitoring.

Weakness #3: During source code review and PSV, HSAG identified multiple areas of specification misalignment, specifically pertaining to continuous enrollment criteria and length of stay calculations. **[Quality]**

Why the weakness exists: ITC appeared to misinterpret the specifications on the criteria for member enrollment and length of stay calculation.

Recommendation: HSAG recommends that **ITC** implement a multi-layer peer review approach to source code and data output review and approval, using peer review processes at the analyst and management level to ensure full application and alignment of the specifications. HSAG also recommends that **ITC** conduct ongoing internal PSV on a subset of cases each month for assurance in specification alignment and rate calculations.

[13] Shenkman, Elizabeth et al. "Provider Specialty and Receipt of Metabolic Monitoring for Children Taking Antipsychotics." Pediatrics vol. 147,1 (2021): e20200658. doi:10.1542/peds.2020-0658.

Compliance Review

Performance Results

Table 3-16 presents an overview of the results of the standards reviewed during the CY 2024 compliance review for **ITC**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **ITC** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-16—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	24	24	21	3	0	**88%**
Standard III—Emergency and Poststabilization Services	15	15	15	0	0	**100%**
Standard IV—Availability of Services	18	18	17	1	0	**94%**
Standard V—Assurances of Adequate Capacity and Services	11	11	11	0	0	**100%**
Standard VI—Coordination and Continuity of Care	18	18	15	3	0	**83%**
Standard VII—Coverage and Authorization of Services	42	42	39	3	0	**93%**
Total	**135**	**135**	**125**	**10**	**0**	**93%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Based on the findings from the CY 2024 compliance review activity, **ITC** was required to develop and submit a CAP for each element assigned a score of *Not Met*. The CAP was reviewed by HHS and HSAG for sufficiency, and **ITC** was responsible for implementing each action plan in a timely manner.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the Compliance Review against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the Compliance Review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ITC achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes and procedures in place related to member and MCO requests for disenrollment. **[Quality]**

Strength #2: ITC achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. **[Timeliness** and **Access]**

Strength #3: ITC achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: ITC had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. **[Timeliness** and **Access]**

Why the weakness exists: ITC did not demonstrate that all member materials adhered to State and federal requirements or that it provided timely notification to members for all provider terminations.

Recommendation: While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: ITC had three elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: ITC did not demonstrate that its care management department was consistently developing member service plans. Additionally, the MCO did not demonstrate that it consistently documented a communication plan with providers for non-LTSS case managed members and also had inconsistencies in how service plans were disseminated to PCPs. Further, the

MCO did not demonstrate consistency in documenting prioritized goals and defined outcomes for non-LTSS case-managed members. Lastly, the MCO did not demonstrate that care managers consistently adhered to the face-to-face check-in schedule to monitor member's progress.

Recommendation: While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members.

Weakness #3: ITC had three elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member, and that **ITC** did not meet all UM requirements outlined in its Contract with HHS. **[Quality** and **Timeliness]**

Why the weakness exists: ITC did not consistently adhere to requirements related to the timing of authorization decisions (i.e., expedited) and the timing and content of notices of adverse benefit determination. Additionally, **ITC** did not demonstrate compliance with all UM requirements (i.e., UM policies and program description) outlined in its Contract with HHS.

Recommendation: While **ITC** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

HSAG assessed results submitted by **ITC** which indicated compliance with the network adequacy time and distance standards. Compliance was determined based on the MCO meeting HHS' time and distance standards, with no deficiencies identified for each provider type according to urbanicity. HSAG assessed SFY first quarter (Q1) and second quarter (Q2) reported results. Table 3-17 summarizes the network adequacy indicators for the most recent available results during the reporting period.

Table 3-17—ITC Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Urban/Rural	30 minutes or 30 miles from the personal residences of members	100% adult and pediatric
Specialty Care Provider—Urban/Rural*	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual Members	>97.5%
	90 minutes or 90 miles from the personal residence of members for ALL non-dual Members	100%
Hospitals—Urban/Rural	Not to exceed 30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers*—Urban	30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers*—Rural	60 minutes or 60 miles	100%
Long-Term Care Services—*HCBS Providers*—Urban*	30 minutes or 30 miles	—
Long-Term Care Services—*HCBS Providers*—Rural*	60 minutes or 60 miles	—
Behavioral Health Services—*Outpatient*—Urban/Rural	30 minutes or 30 miles from the personal residence of members	100%
Behavioral Health Services—*Inpatient*—Urban	60 minutes or 60 miles from the personal residence of members	100%

Provider Type	Indicator	Percentage of Members With Access
Behavioral Health Services—*Inpatient*—Rural	90 minutes or 90 miles from the personal residence of members	100%
General Optometry Services—Urban/Rural	30 minutes or 30 miles	100%
Lab and X-Ray Services—Urban/Rural	30 minutes or 30 miles	100%
Pharmacies—Urban/Rural	30 minutes or 30 miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program	100%

*Compliant for a subset of provider types.

The following subset of indicators from the time and distance standards reported in Table 3-18 were determined to be *Not Met*. Table 3-18 displays the time and distance standards by Provider Type and Provider Type Subset which were determined to be *Not Met* by **ITC**.

Table 3-18—ITC Q2 Percentage of Members With Access Across Time and Distance Indicators Subset—*Not Met*

Provider Type	Provider Type Subset	Indicator	Percentage of Members With Access
Long-Term Care Services—*HCBS Providers*—Urban	HD: Counseling Services	30 minutes or 30 miles	0%
Long-Term Care Services—*HCBS Providers*—Rural	HD: Counseling Services	60 minutes or 60 miles	50%

HSAG assessed results submitted by **ITC** which indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-19 summarizes compliance with the minimum provider agreement indicators for **ITC**.

Table 3-19—ITC Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*
General Surgery	*Met*
Neonatology	*Met*

Provider Type	Compliance
Nephrology	*Met*
Neurology	*Met*
Neurosurgery	*Met*
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology/Hematology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

HSAG assessed results submitted by **ITC** reporting appointment wait time standards for ten provider types. Results were determined based on review of **ITC** reporting standards that directly corresponded to HHS' standards and indicators. Table 3-20 summarizes the MCO's compliance with appointment wait times indicators.

Table 3-20—ITC Percent Within Standards for Appointment Wait Times by Provider Type[14]

Provider Type	Indicator	Percent Within Standard
PCP	4 to 6 weeks for routine care	98.9%
	48 hours for persistent care	98.2%
	1 day for urgent care	98.9%
Specialty Care	30 days for routine care	94.2%
	1 day for urgent care	87.0%

[14] **ITC**'s provider survey was completed in Q1 2023.

Provider Type	Indicator	Percent Within Standard
Behavioral Health Services—*Mobile Crisis*	1 hour of presentation or request	100% prescribing 99.4% non-prescribing
Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	98.0% prescribing–1 hour 95.7% non-prescribing–1 hour 100% prescribing–24 hours 100% non-prescribing–24 hours
Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	100% prescribing 99.4% non-prescribing
Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	100% prescribing 98.8% non-prescribing
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours	99.3% prescribing 98.2% non-prescribing
Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours	98.7% prescribing–14 days 96.3% non-prescribing–14 days 98.7% prescribing–120 days 95.1% non-prescribing–120 days
General Optometry Services	3 weeks regular appointments	89.1%
	48 hours urgent care	87.0%
Lab and X-Ray Services	3 weeks regular appointments	100% X-Ray only
	48 hours urgent care	100% X-Ray only

HSAG determined the appointment wait times standards in Table 3-21 required by HHS were not calculated and reported by **ITC**, resulting in an "*Unable to Validate"* rating determination for each associated indicator.

Table 3-21—ITC Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicators
Behavioral Health Services—Emergency	Seen or referred to an appropriate provider upon presentation
Emergency Care	Immediate at nearest facility available

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: ITC demonstrated the ability to maintain accurate and complete member data using daily reports including error reports, member count checks, quality reports, and system-to-system reports to ensure data were uploaded to systems and identify data discrepancies. **[Quality** and **Access]**

Strength #2: ITC had processes in place to maintain provider data including utilizing CenProv to track provider data requests, quality control processes to audit provider updates, and the use of various resources to assist in validating provider data accuracy on an ongoing basis. **[Quality** and **Access]**

Weaknesses and Recommendations

Weakness #1: ITC did not utilize HHS' standards and indicators for appointment wait times when conducting provider surveys. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: ITC did not fully encompass the State's requirements into its provider survey protocol.

Recommendation: HSAG recommends that **ITC** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.

Encounter Data Validation

Performance Results—Comparative Analysis

Table 3-22 displays the percentage of records present in the files submitted by **ITC** that were not found in HHS files (record omission), and the percentage of records present in HHS files but not present in the files submitted by **ITC** (record surplus) by encounter type (i.e., professional, institutional, and pharmacy). **Lower rates indicate better performance for both record omission and record surplus.**

Table 3-22—Record Omission and Surplus, by Encounter Type

Encounter Data Type	Record Omission			Record Surplus		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Professional	13,510,492	14,635	0.1%	13,513,843	17,986	0.1%
Institutional	8,628,300	71,909	0.8%	8,650,471	94,080	1.1%
Pharmacy	6,114,249	157,757	2.6%	5,976,976	20,484	0.3%

Note: Lower rates indicate better performance.

Table 3-23 through Table 3-28 display the results for key data elements related to encounter types: professional, institutional, and pharmacy, respectively. These tables include information on element omission, element surplus, element missing values, and element accuracy. **For the element omission and surplus indicators, lower rates indicate better performance. For the element accuracy indicator, higher rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 3-23—Element Omission, Surplus, and Missing Values: Professional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 13,495,857						
Member ID	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Rendering Provider NPI	0	0.0%	0	0.0%	0	0.0%
Referring Provider NPI	171,525	1.3%	0	0.0%	8,041,822	59.6%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	2	<0.1%	0	0.0%	6,903,092	51.1%
Procedure Code (CPT/HCPCS)	0	0.0%	0	0.0%	0	0.0%
Procedure Code Modifier	73	<0.1%	45	<0.1%	7,316,853	54.2%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Units of Service	0	0.0%	0	0.0%	0	0.0%
Drug Code	10	<0.1%	1	<0.1%	12,839,096	95.1%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in ITC's data.
[3] Indicates the number of records with missing values in HHS' and ITC's data.

Table 3-24—Element Omission, Surplus, and Missing Values: Institutional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 8,556,391						
Member ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date	40,135	0.5%	0	0.0%	6,924,981	80.9%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	0	0.0%	0	0.0%	31,040	0.4%
Referring Provider NPI	6,050	0.1%	295	<0.1%	8,246,822	96.4%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	0	0.0%	0	0.0%	1,441,434	16.8%
Procedure Code (CPT/HCPCS)	7,714	0.1%	13,669	0.2%	1,396,283	16.3%
Procedure Code Modifier	24,579	0.3%	27,045	0.3%	6,485,360	75.8%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Primary Surgical Procedure Code	4	<0.1%	0	0.0%	8,065,309	94.3%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Secondary Surgical Procedure Code(s)	0	0.0%	2,441	<0.1%	8,233,632	96.2%
Drug Code	31,717	0.4%	19,424	0.2%	7,588,671	88.7%
Revenue Code	0	0.0%	2,848	<0.1%	0	0.0%
DRG Code	66	<0.1%	1,937	<0.1%	7,809,156	91.3%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **ITC**'s data.
[3] Indicates the number of records with missing values in HHS' and **ITC**'s data.

Table 3-25—Element Omission, Surplus, and Missing Values: Pharmacy Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 5,956,492						
Member ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Drug Code	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Dispensing Fee	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **ITC**'s data.
[3] Indicates the number of records with missing values in HHS' and **ITC**'s data.

Table 3-26—Element Accuracy: Professional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	13,495,857	13,495,857	100%
Detail Service From Date	13,495,857	13,495,823	>99.9%
Detail Service To Date	13,495,857	13,495,823	>99.9%
Billing Provider NPI	13,495,857	13,493,569	>99.9%
Rendering Provider NPI	13,495,857	13,493,569	>99.9%
Referring Provider NPI	5,282,510	5,282,509	>99.9%
Primary Diagnosis Code	13,495,857	13,495,855	>99.9%
Secondary Diagnosis Code(s)	6,592,763	6,592,727	>99.9%
Procedure Code (CPT/HCPCS)	13,495,857	13,493,798	>99.9%
Procedure Code Modifier	6,178,886	5,982,668	96.8%
Units of Service	13,495,857	13,331,872	98.8%
Drug Code	656,750	656,750	100%
Detail Paid Amount	13,495,857	13,471,210	99.8%

Table 3-27—Element Accuracy: Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	8,556,391	8,556,391	100%
Header Service From Date	8,556,391	8,556,391	100%
Header Service To Date	8,556,391	8,556,391	100%
Admission Date	1,591,275	1,591,238	>99.9%
Billing Provider NPI	8,556,391	8,556,391	100%
Attending Provider NPI	8,525,351	8,525,351	100%
Referring Provider NPI	303,224	303,224	100%
Primary Diagnosis Code	8,556,391	8,556,390	>99.9%
Secondary Diagnosis Code(s)	7,114,957	6,491,261	91.2%
Procedure Code (CPT/HCPCS)	7,138,725	6,964,990	97.6%
Procedure Code Modifier	2,019,407	2,005,896	99.3%
Units of Service	8,556,391	8,193,559	95.8%
Primary Surgical Procedure Code	491,078	491,078	100%
Secondary Surgical Procedure Code(s)	320,318	287,819	89.9%

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Drug Code	916,579	860,414	93.9%
Revenue Code	8,553,543	8,440,986	98.7%
DRG Code	745,232	745,148	>99.9%
Header Paid Amount	8,556,391	8,474,429	99.0%
Detail Paid Amount	8,556,391	8,457,063	98.8%

Table 3-28—Element Accuracy: Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	5,956,492	5,956,492	100%
Header Service From Date	5,956,492	5,956,492	100%
Billing Provider NPI	5,956,492	5,956,302	>99.9%
Prescribing Provider NPI	5,956,492	5,956,488	>99.9%
Drug Code	5,956,492	5,947,276	99.8%
Drug Quantity	5,956,492	5,956,326	>99.9%
Header Paid Amount	5,956,492	5,891,524	98.9%
Dispensing Fee	5,956,492	5,956,492	100%

Table 3-29 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 3-29—All-Element Accuracy by Encounter Type

Encounter Data Type	Number of Records With Values in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Professional	13,495,857	13,021,898	96.5%
Institutional	8,556,391	7,372,258	86.2%
Pharmacy	5,956,492	5,881,952	98.7%

Table 3-30 displays the overall encounter accuracy rates by MCO and encounter type. All results presented are based on the number of claims in the primary file, with a higher match rate indicating better performance.

Table 3-30—Overall Encounter Accuracy by Encounter Type

Encounter Data Type	HHS to ITC			ITC to HHS		
	Match	Partial Match	No Match	Match	Partial Match	No Match
Professional	97.4%	2.5%	0.1%	97.4%	2.5%	0.1%
Institutional	83.2%	16.0%	0.8%	83.8%	16.1%	0.1%
Pharmacy	98.4%	1.2%	0.3%	96.2%	1.2%	2.6%

Note: The sum of Match, Partial Match, and No Match rates may not equal 100 percent due to rounding.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Across all three encounter types (i.e., professional, institutional, and pharmacy encounters), **ITC**-submitted encounters demonstrated complete data with low record omission and surplus rates. **[Quality]**

Strength #2: Among encounters successfully matched between HHS-submitted and **ITC**-submitted encounters, all three encounter types exhibited a high level of element completeness, as indicated by low element omission and surplus rates. **[Quality]**

Strength #3: Across all three encounter types (i.e., professional, institutional, and pharmacy encounters), **ITC**-submitted encounters demonstrated complete data with low record omission and surplus rates. **[Quality]**

Weaknesses and Recommendations

Weakness #1: For institutional encounters, **ITC** had low element accuracy rates (below 95.0 percent) for *Secondary Diagnosis Code(s)*, *Secondary Surgical Procedure Code(s)*, and *Drug Code* data elements. **[Quality]**

Why the weakness exists: The low accuracy rate for the *Secondary Diagnosis Code(s)* was due to a coding error that caused these codes to be missing from **ITC**'s submitted files. For *Secondary Surgical Procedure Code(s)*, discrepancies arose because **ITC** applied a deduplication process to surgical procedure codes in its institutional encounter submissions, whereas HHS did not, leading to mismatches. Regarding *Drug Code* discrepancies, **ITC** and HHS used different data aggregation approaches—HHS rolled up similar detail lines within a claim into a single entry, while **ITC** retained them as separate lines, contributing to accuracy issues. Additionally, **ITC** reported that the

marginally low accuracy rates for *Procedure Code (CPT/HCPCS)* and *Units of Service* were attributed to the same differences in encounter roll-up practices.

Recommendation: HSAG recommends that **ITC** collaborate with HHS to clarify and align encounter submission standards for the affected data elements, ensuring consistency in coding, deduplication, and data aggregation practices. Additionally, **ITC** should implement standardized quality control measures to identify and correct discrepancies before submission, particularly for secondary diagnosis codes, surgical procedure codes, and drug codes. Lastly, **ITC** should review and refine its data extraction processes to ensure reported values are formatted and aggregated in alignment with HHS's expectations. These actions will help improve data accuracy and consistency in future submissions.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-31 presents ITC's 2024 adult Medicaid and general child Medicaid CAHPS top-box scores.[15] Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.

Table 3-31—Summary of CY 2024 CAHPS Top-Box Scores for ITC

	2024 Adult Medicaid	2024 General Child Medicaid
Composite Measures		
Getting Needed Care	82.51%	90.91% ↑
Getting Care Quickly	84.72% ↑	92.63% ↑
How Well Doctors Communicate	95.58% ↑	96.36% ↑
Customer Service	87.67%	90.85%
Global Ratings		
Rating of All Health Care	49.31% ↓	69.86%
Rating of Personal Doctor	63.79%	80.90% ↑
Rating of Specialist Seen Most Often	59.79%	80.45% ↑
Rating of Health Plan	57.52%	71.92%
Medical Assistance With Smoking and Tobacco Use Cessation Items*		
Advising Smokers and Tobacco Users to Quit	66.31% ↓	
Discussing Cessation Medications	46.10%	
Discussing Cessation Strategies	43.42%	

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).

* These scores follow NCQA's methodology of calculating a rolling two-year average.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS survey against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS survey

[15] ITC administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set; therefore, results for the CCC Medicaid population are not available and cannot be presented.

have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Adult members had positive experiences with getting the care they needed and perceived quality communication with their personal doctor, as scores for the *Getting Care Quickly* and *How Well Doctors Communicate* measures were statistically significantly higher than the 2023 NCQA adult Medicaid national averages. **[Quality** and **Timeliness]**

Strength #2: Parents/caretakers of child members had positive experiences with getting the care they needed, getting care quickly, perceived quality communication with their child's personal doctor, and their child's specialist seen most often, as scores for the *Getting Needed Care, Getting Care Quickly, How Well Doctors Communicate, Rating of Personal Doctor,* and *Rating of Specialist Seen Most Often* measures were statistically significantly higher than the 2023 NCQA child Medicaid national averages. **[Quality**, **Timeliness**, and **Access]**

Weaknesses and Recommendations

Weakness #1: Adult members had a less positive overall rating of all healthcare as the score for the *Rating of All Health Care* measure was statistically significantly lower than the 2023 NCQA adult Medicaid national average. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that adult members did not rate overall healthcare received from their health plan highly.

Recommendation: HSAG recommends that **ITC** collect regular feedback throughout the year to identify member input through town halls, focus groups, and short surveys. Member advisory councils might also be considered. HSAG recommends that **ITC** identify trends in the data that might contribute to the lower performance through stratifying by race/ethnicity, age, ZIP code, and gender. Once a root cause or probable reasons for lower ratings are identified, **ITC** can determine appropriate interventions, education, and actions to improve performance.

Weakness #2: Adult members reported they did not receive medical assistance with smoking and tobacco use cessation, as the score for the *Advising Smokers and Tobacco Users to Quit* measure was statistically significantly lower than the 2023 NCQA adult Medicaid national average. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that adult members did not rate receiving medical assistance with smoking and tobacco use cessation highly.

Recommendation: HSAG recommends that **ITC** conduct provider education to ensure providers are documenting conversations about cessation strategies sufficiently and are using appropriate billing codes to do so. In one study of adults aged 65 and older, those who were advised to quit smoking by their physician gave more positive overall ratings of their care and health plan.[16]

[16] Winpenny, Eleanor et al. "Advice to Quit Smoking and Ratings of Health Care among Medicare Beneficiaries Aged 65." Health services research vol. 52,1 (2017): 207-219. doi:10.1111/1475-6773.12491.

Scorecard

The 2024 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2024 Iowa Health Link MCO Scorecard, which is inclusive of **ITC**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of ITC's aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how ITC's overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-32 displays each strategic priority and the EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to ITC's Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for ITC's programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-32—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** ✓ ITC achieved rates at or above the 90th percentile for *Follow-Up After Hospitalization for Mental Illness* for both the 7-day and 30-day indicators. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA During CY 2024, a PIP topic, *SDOH Screening* was initiated, and ITC received a designation of High Confidence for Validation Rating 1 of the Design phase. While no data was reported for this PIP during CY 2024, this PIP has the potential to impact this objective. Performance of this PIP will be assessed in future technical reports as part of the PIP activity. NA The NAV EQR activity did not produce sufficient data to assess the impact of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for PCPs and specialists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** ✓ **ITC**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics–Blood Glucose and Cholesterol Testing–Total* measure rate for MY 2023 (27.81%) indicates it is making progress towards achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Metabolic Monitoring for Children and Adolescents on Antipsychotics* (*Blood Glucose and Cholesterol*), *(APM) from 23.6% to 30% by SFY2027*. ✓ **ITC**'s performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate for MY 2023 (78.33%) indicates it is making progress towards achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*. ✓ **ITC**'s measure rate of 45.26% for *Initiation of SUD Treatment–Total* and 16.62% for *Engagement of SUD Treatment–Total* indicated progress toward achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement By SFY2027.* **Improve Prenatal and Postpartum Comprehensive Care Management** ✓ **ITC** demonstrated an increase over the past three-years for the *Prenatal and Postpartum Care* measure rates indicating it is positively impacting the Iowa HHS Medicaid Quality Strategy objectives to *Increase prenatal visits in the first trimester by 5% (59%) by SFY 2027* and *increase Postpartum visits from 5% (32%) by SFY2027*. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA *LTSS-6: LTSS Admission to a Facility from the Community*-While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **ITC**'s	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*-While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **ITC**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*-While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **ITC**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access

Strategic Priority	Overall Performance Impact	Performance Domain
5.0 Voice of the Customer	✓ Through the 2024 CAHPS activity, **ITC** achieved a score that was statistically significantly higher than the 2023 national average in *Specialist Seen Most Often* for the general child Medicaid which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✓ **ITC** scored 90.85 percent for the general child Medicaid population *Customer Service* composite measure, which aligned with the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ **ITC**'s score for *Rating of All Health Care* for the general child Medicaid population was 69.86 percent which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ For the adult Medicaid population, **ITC** had a score for the *Rating of Specialist Seen Most Often* of 59.79 percent which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ **ITC** achieved a score of 46.10 percent for *Discussing Cessation Medications* for the adult Medicaid population, which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*.	☒ Quality ☐ Timeliness ☐ Access

Molina Healthcare of Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MOL**'s PIP (i.e., the PIP Design stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-33 displays the validation ratings and performance indicators.

Table 3-33—Overall Validation Rating for MOL

PIP Topic	Validation Rating 1*	Validation Rating 2**	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*High Confidence*	*Not Assessed*	Newly enrolled Medicaid: The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	—	—	—
			Existing enrolled Medicaid: The percentage of existing members who received a subsequent screening for SDOH during the measurement period.	—	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*High Confidence*	*Not Assessed*	Initiation Phase: The percentage of the eligible population that had one follow-up visit during the 30-day initiation phase.	—	—	—
			Continuation and Maintenance Phase: The percentage of the eligible population who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	—	—	—

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to reporting baseline, Remeasurement 1, and Remeasurement 2 results during CY 2024.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
** Not Assessed—HSAG did not assess Validation Rating 2 for CY 2024 as the MCO reported the Design stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Once the MCO has progressed to developing intervention strategies, Table 3-34 will display the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-34—Barriers and Interventions for MOL

SDOH Screening	
Barriers	**Interventions**
—	—
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
—	—

— Expected to be initiated in CY 2026.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MOL designed a methodologically sound PIP as indicated by the high confidence validation rating for the Design phase. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses through the PIP activity.

Why the weakness exists: NA

Recommendation: Although there were no identified weaknesses, HSAG recommends **MOL** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **MOL**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **MOL** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. During the interview component of the review, the member-level data used by **MOL** to calculate the performance measure rates were readily available for the auditor's review. **MOL** was not required to report all MLTSS measures in scope of review since it began providing Medicaid coverage mid-measurement year, however, **MOL** was able to report valid rates. Because **MOL** began providing coverage to Medicaid and Hawki members effective July 1, 2023, the eligible populations for the measures in scope of the review were reduced and not all indicator rates were large enough to report valid rates. Table 3-35 displays the indicator rates for each performance measure reported by **MOL**.

Table 3-35—MOL MY 2023 MLTSS Performance Measures

	LTSS Performance Measures	Performance Measure Rate
1.	*Managed Long-Term Services and Supports Admission to a Facility from the Community*	
	Short-Term Stay—Ages 18 to 64	38.23
	Short-Term Stay—Ages 65 to 74	NA
	Short-Term Stay—Ages 75 to 84	NA
	Short-Term Stay—Ages 85+	NA
	Medium-Term Stay—Ages 18 to 64	66.40
	Medium-Term Stay—Ages 65 to 74	NA
	Medium-Term Stay—Ages 75 to 84	NA
	Medium-Term Stay—Ages 85+	NA
	Long-Term Stay—Ages 18 to 64	0.00
	Long-Term Stay—Ages 65 to 74	NA
	Long-Term Stay—Ages 75 to 84	NA
	Long-Term Stay—Ages 85+	NA
2.	*Managed Long-Term Services and Supports Minimizing Facility Length of Stay*	
	Observed	NA
	Risk-Adjusted	NA

LTSS Performance Measures		Performance Measure Rate
3.	*Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay*	
	Observed	NA
	Risk-Adjusted	NA

"NA" indicates that the denominator was too small to report a valid rate.

HEDIS

MOL was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not meet continuous enrollment criteria for HEDIS MY 2023 reporting.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for PMV and HEDIS against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of PMV and HEDIS have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MOL demonstrated adequate systems and processes to receive and process enrollment/eligibility data, claims and encounters, and to accurately integrate the data for performance measure reporting. **[Quality]**

Strength #2: MOL demonstrated multiple levels of validation to ensure the accuracy and completeness of data ingested and processed within its systems. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG identified a discrepancy between **MOL**'s *MLTSS-6* data output files and the numerator counts for short-term stay members across all age stratifications. Numerator counts in the data output files should match those in **MOL**'s calculated rates. **[Quality]**

Why the weakness exists: MOL noted that direct transfers of members caused variations between the rate and the data output files.

Recommendation: HSAG recommends that **MOL** conduct a peer review validation process of all data output files and performance measure rates for numerator and denominator counts and specification alignment prior to auditor or HHS submission.

Compliance Review

Performance Results

Table 3-36 presents an overview of the results of the standards reviewed during the CY 2024 compliance review for **MOL**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MOL** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-36—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	6	1	0	**86%**
Standard II—Member Rights and Member Information	24	24	19	5	0	**79%**
Standard III—Emergency and Poststabilization Services	15	15	15	0	0	**100%**
Standard IV—Availability of Services	18	18	17	1	0	**94%**
Standard V—Assurances of Adequate Capacity and Services	11	11	11	0	0	**100%**
Standard VI—Coordination and Continuity of Care	18	18	16	2	0	**89%**
Standard VII—Coverage and Authorization of Services	42	42	37	5	0	**88%**
Total	**135**	**135**	**121**	**14**	**0**	**90%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the Compliance Review against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the Compliance Review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MOL achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. **[Timeliness** and **Access]**

Strength #2: MOL achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: MOL had five elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. **[Timeliness** and **Access]**

Why the weakness exists: MOL did not demonstrate that the MCO ensured member materials adhered to all State and federal requirements and that paper provider directory updates were made timely, as required. Further, there were inconsistencies between information included in the online and paper provider directories, and inconsistencies between policy and practice specific to member communications (e.g., informing members of their right to select a communication pathway and process to do so, method for maintaining members preferred communication pathway).

Recommendation: While **MOL** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: MOL had five elements within the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: MOL did not consistently adhere to requirements related to the timing of authorization decisions (i.e., expedited, standard, and exceptions to advance notice of a termination, reduction, or suspension of a prior authorized service) and the timing and content of notices of adverse benefit determination.

Recommendation: While **MOL** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

HSAG assessed results submitted by **MOL**, which indicated compliance with the network adequacy time and distance standards. Compliance was determined based on the MCP meeting HHS' time and distance standards, with no deficiencies identified for each provider type according to urbanicity. HSAG assessed SFY Q1 and Q2 reported results. Table 3-37 summarizes percentage of members with access for the time and distance network adequacy indicators for the most recent available results during the reporting period.

Table 3-37—MOL Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Urban/Rural	Thirty (30) minutes or thirty (30) miles from the personal residences of members	99.6% adult 99.8% pediatric
Specialty Care Provider—Urban/Rural*	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual Members	—
	90 minutes or 90 miles from the personal residence of members for ALL non-dual Members	—
Hospitals—Urban/Rural	Not to exceed thirty (30) minutes or thirty (30) miles	99.6%
Long-Term Care Services—*Institutional Providers*—Urban	30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers*—Rural	60 minutes or 60 miles	100%
Long-Term Care Services—*HCBS Providers*—Urban*	30 minutes or 30 miles	—
Long-Term Care Services—*HCBS Providers*—Rural	60 minutes or 60 miles	100%
Behavioral Health Services—*Outpatient*—Urban/Rural	30 minutes or 30 miles from the personal residence of members	99.5%
Behavioral Health Services—*Inpatient*—Urban	60 minutes or 60 miles from the personal residence of members	100%

Provider Type	Indicator	Percentage of Members With Access
Behavioral Health Services—*Inpatient*—Rural	90 minutes or 90 miles from the personal residence of members	100%
General Optometry Services—Urban/Rural	30 minutes or 30 miles	99.6%
Lab and X-Ray Services—Urban/Rural	30 minutes or 30 miles	99.8%
Pharmacies—Urban/Rural	30 minutes or 30 miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program	99.6%

*Compliant for a subset of provider types.

The following subset of indicators from the time and distance standards reported in Table 3-38 were determined to be *Not Met*. Table 3-38 displays the time and distance standards by Provider Type and Provider Type Subset which were determined to be *Not Met* by **MOL**.

Table 3-38—MOL Q2 Percentage of Members With Access Across Time and Distance Indicators Subset—*Not Met*

Provider Type	Provider Type Subset	Indicator	Percentage of Members With Access
Specialty Care Provider—Urban/Rural	Dermatology-Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	0%
Specialty Care Provider—Urban/Rural	Ophthalmology-Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	0%
Specialty Care Provider—Urban/Rural	Urology-Pediatric	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual members	10.8%
Specialty Care Provider—Urban/Rural	Allergy-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	91.5%
Specialty Care Provider—Urban/Rural	Dermatology-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	0%

Provider Type	Provider Type Subset	Indicator	Percentage of Members With Access
Specialty Care Provider—Urban/Rural	Ophthalmology-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	0%
Specialty Care Provider—Urban/Rural	Orthopedics-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	91.6%
Specialty Care Provider—Urban/Rural	Otolaryngology (ENT)-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	91.7%
Specialty Care Provider—Urban/Rural	Urology-Pediatric	90 minutes or 90 miles from the personal residence of members for ALL non-dual members	29.4%
Long-Term Care Services—*HCBS Providers*—Urban	AIDS/HIV-Counseling Services	30 minutes or 30 miles	0%
Long-Term Care Services—*HCBS Providers*—Urban	HD: Adult Day Care	30 minutes or 30 miles	98.6%
Long-Term Care Services—*HCBS Providers*—Urban	HD: Counseling Services	30 minutes or 30 miles	98.6%
Long-Term Care Services—*HCBS Providers*—Urban	HD-IMMT	30 minutes or 30 miles	98.6%
Long-Term Care Services—*HCBS Providers*—Urban	HD-Respite	30 minutes or 30 miles	98.6%

HSAG assessed results submitted by **MOL**, which indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-39 summarizes compliance with the minimum provider agreement indicators for **MOL**.

Table 3-39—MOL Compliance With Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*

Provider Type	Compliance
General Surgery	*Met*
Neonatology	*Met*
Nephrology	*Met*
Neurology	*Met*
Neurosurgery	*Met*
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology/Hematology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

HSAG assessed indicator results submitted by **MOL** for appointment wait time standards and determined across six provider types. Results were determined based on review of **MOL** reporting standards that directly corresponded to HHS' standards and indicators. Table 3-40 summarizes the MCO's compliance with appointment wait times indicators.

Table 3-40—MOL Percent Within Standard for Appointment Wait Time by Provider Type[17]

Provider Type	Indicator	Percent Within Standard
PCP	4 to 6 weeks for routine care	95%
	48 hours for persistent care	95%
	1 day for urgent care	97%

[17] **MOL**'s provider survey was completed in 2024.

Provider Type	Indicator	Percent Within Standard
Specialty Care	30 days for routine care	100%
	1 day for urgent care	100%
Behavioral Health Services—Urgent	1 hour of presentation or within 24 hours of telephone contact	92%
Behavioral Health Services—Persistent Symptoms	Seen or referred to appropriate provider within 48 hours	93%
Behavioral Health Services—Routine	Seen or referred to an appropriate provider within 3 weeks	84%
Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	100%

HSAG determined the appointment wait times standards in Table 3-41 required by HHS were not calculated and reported by **MOL**, resulting in an "*Unable to Validate"* rating determination for each associated indicator.

Table 3-41—MOL Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicators
Behavioral Health Services—*Emergency*	Seen or referred to an appropriate provider upon presentation
Behavioral Health Services—*Mobile Crisis*	1 hour of presentation or request
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours
Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours
Emergency Care	Immediate at nearest facility available
General Optometry Services	3 weeks regular appointments 48 hours urgent care

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MOL established a robust process to maintain provider data using iServe to track provider data requests, quality control processes to audit provider updates, and vendors to assist in validating provider data accuracy on an ongoing basis. **[Access]**

Strength #2: MOL established a robust process to maintain accurate and complete member data by performing pre- and post-load data validation, and reconciliation processes using exception reports to address data discrepancies. **[Access]**

Weaknesses and Recommendations

Weakness #1: MOL did not use HHS' standards and indicators for appointment wait times when conducting provider surveys, and the survey was conducted outside of the time frame in scope of review. **[Access]**

Why the weakness exists: MOL did not fully encompass the State's requirements into its provider survey protocol.

Recommendation: HSAG recommends that **MOL** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.

Encounter Data Validation

Performance Results—Administrative Profile

Encounter volume was determined using **unique visit keys**, which included fields such as *Member ID*, *Billing Provider NPI*, *Rendering Provider NPI*, and *Last Service Date*. For pharmacy encounters, visit keys included fields such as *Member ID*, *Prescribing Provider NPI*, and *Drug Code*. The service month was defined as the month in which the last service date occurred. To normalize encounter volume, encounters per 1,000 member months (MM) were calculated. MMs were derived from HHS' member enrollment file for **MOL**, covering members enrolled at any point during the review period of July 1, 2023, through October 31, 2023.

Table 3-42 through Table 3-44 display encounter volume trends by service month and encounter volume per 1,000 MM by service month for:

- Professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver).
- Institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover).
- Pharmacy encounters

Table 3-42—Professional Encounter Volume and Encounter Volume per 1,000 MM by Category of Service

Service Month	HCFA-1500		Medicare Part B Crossover		Waiver	
	Encounter Volume	Encounter Volume per 1,000 MM	Encounter Volume	Encounter Volume per 1,000 MM	Encounter Volume	Encounter Volume per 1,000 MM
July 2023	148,703	959.47	10,216	65.92	9,700	62.59
August 2023	162,959	1,199.32	10,835	79.74	7,591	55.87
September 2023	147,092	1,217.29	9,466	78.34	7,224	59.78
October 2023	154,265	1,401.28	9,300	84.48	7,546	68.54

Table 3-43—Institutional Encounter Volume and Encounter Volume per 1,000 MM by Category of Service

Service Month	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Encounter Volume					
July 2023	1,893	299	2,941	36,879	3,327
August 2023	1,863	314	2,701	38,224	3,409
September 2023	1,496	261	2,585	35,428	2,957
October 2023	1,575	289	2,624	36,576	2,719
Encounter Volume per 1,000 MM					
July 2023	12.21	1.93	18.98	237.95	21.47

Service Month	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
August 2023	13.71	2.31	19.88	281.32	25.09
September 2023	12.38	2.16	21.39	293.19	24.47
October 2023	14.31	2.63	23.84	332.24	24.70

Table 3-44—Pharmacy Encounter Volume and Encounter Volume per 1,000 MM

Service Month	Pharmacy	
	Encounter Volume	Encounter Volume per 1,000 MM
July 2023	197,958	1,277.27
August 2023	217,866	1,603.42
September 2023	196,739	1,628.15
October 2023	207,553	1,885.32

Table 3-45 through Table 3-47 display the total paid amounts and paid amounts per member per month (PMPM) trends for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Table 3-45—Professional Encounters Total Paid Amounts and Paid Amounts PMPM By Category of Service

Service Month	HCFA-1500		Medicare Part B Crossover		Waiver	
	Total Paid Amount	Paid Amount PMPM	Total Paid Amount	Paid Amount PMPM	Total Paid Amount	Paid Amount PMPM
July 2023	$20,152,134.45	$130.03	$236,381.68	$1.53	$7,818,912.84	$50.45
August 2023	$21,997,651.44	$161.90	$243,463.46	$1.79	$6,690,123.37	$49.24
September 2023	$19,654,107.97	$162.65	$209,850.72	$1.74	$6,312,013.38	$52.24
October 2023	$20,103,859.25	$182.61	$201,493.57	$1.83	$6,355,058.85	$57.73

Table 3-46—Institutional Encounters Total Paid Amounts and Paid Amounts PMPM By Category of Service

Service Month	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Total Paid Amounts					
July 2023	$12,140,023.27	$195,980.46	$22,598,891.74	$17,713,254.57	$484,810.24
August 2023	$13,001,217.21	$186,117.78	$21,771,166.18	$18,523,305.83	$434,475.26
September 2023	$11,947,150.32	$234,426.29	$21,424,565.84	$16,726,442.88	$415,756.78

Service Month	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
October 2023	$11,965,785.43	$167,562.96	$20,770,256.36	$16,134,858.89	$366,393.75
Paid Amounts PMPM					
July 2023	$78.33	$1.26	$145.81	$114.29	$3.13
August 2023	$95.68	$1.37	$160.23	$136.33	$3.20
September 2023	$98.87	$1.94	$177.30	$138.42	$3.44
October 2023	$108.69	$1.52	$188.67	$146.56	$3.33

Table 3-47—Pharmacy Encounters Total Paid Amounts and Paid Amounts PMPM By Category of Service

Service Month	Pharmacy	
	Total Paid Amount	Paid Amount PMPM
July 2023	$22,365,732.73	$144.31
August 2023	$17,182,545.64	$126.46
September 2023	$14,975,388.43	$123.93
October 2023	$15,651,087.55	$142.17

Table 3-48 shows the percentage of duplicate encounters for professional, institutional, and pharmacy encounters across categories of service. For this analysis, the original encounters in a series of duplicates were not counted as duplicates. For example, if three encounters were identified as duplicates, only the two subsequent duplicates were counted, while the first submission was considered the original encounter.

HSAG assessed the percentage of records identified as duplicates based on the following criteria:

- Professional encounters: Duplicates were identified based on *Member ID*, *Header Service From Date*, *Header Service To Date*, *Line Number*, *Primary Diagnosis Code*, *CPT/HCPCS Code*, *CPT/HCPCS Modifier Code*, *Billing Provider NPI*, and *Rendering Provider NPI* fields.
- Institutional encounters: Duplicates were identified based on *Member ID*, *Header Service From Date*, *Header Service To Date*, *Line Number*, *Primary Diagnosis Code*, *CPT/HCPCS Code*, *CPT/HCPCS Modifier Code*, *Revenue Code*, *Billing Provider NPI*, and *Attending Provider NPI* fields.
- Pharmacy encounters: Duplicates were identified based on *Member ID*, *Date of Service*, *Line Number*, *Billing Provider NPI*, *Prescribing Provider NPI*, *Prescription Number*, and *Drug Code* fields.

Table 3-48—Percentage of Duplicate Encounters by Category of Service

Encounter Type	Category of Service	Percentage of Duplicate
Professional	HCFA-1500	6.3%
	Medicare Part B Crossover	2.7%
	Waiver	2.2%
Institutional	Inpatient	4.4%
	Inpatient Crossover	2.9%
	Long-Term Care	7.7%
	Outpatient	5.3%
	Outpatient Crossover	4.0%
Pharmacy	Pharmacy	10.0%

Table 3-49 through Table 3-51 display the cumulative percentage of encounters submitted to HHS based on two key time frames:

- From the date of service, measured by monthly intervals
- From **MOL**'s paid date, measured by monthly intervals

These tables provide insights for the following encounter types:

- Professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver)
- Institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover)
- Pharmacy encounters

This analysis helps assess submission timeliness and trends in encounter data reporting.

Table 3-49—Cumulative Percentage of Professional Encounters Submitted to HHS From Date of Service and Since MCO Payment Date by Category of Service

Lag Months	HCFA-1500	Medicare Part B Crossover	Waiver
Encounters Submitted to HHS From Date of Service			
Submitted within 1 month	24.7%	8.6%	13.4%
Submitted within 2 months	53.1%	40.6%	36.0%
Submitted within 3 months	75.4%	68.0%	52.5%
Submitted within 4 months	83.9%	79.1%	71.3%
Submitted within 5 months	89.0%	86.1%	90.8%
Submitted within 6 months	93.5%	92.0%	93.6%
Submitted within 7 months	97.6%	96.9%	96.8%
Submitted within 8 months	99.5%	99.1%	99.5%
Submitted within 9 months	100%	100%	100%
Encounters Submitted to HHS Since MCO Payment Date			
Submitted within 1 month	62.6%	67.3%	61.1%
Submitted within 2 months	83.2%	86.1%	67.4%
Submitted within 3 months	94.7%	93.0%	75.7%
Submitted within 4 months	96.2%	94.6%	86.7%
Submitted within 5 months	97.0%	96.9%	96.1%
Submitted within 6 months	97.7%	98.7%	97.3%
Submitted within 7 months	98.6%	99.8%	99.0%
Submitted within 8 months	99.6%	100%	99.7%
Submitted within 9 months	100%	100%	100%

Table 3-50—Cumulative Percentage of Institutional Encounters Submitted to HHS From Date of Service and Since MCO Payment Date by Category of Service

Lag Months	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Encounters Submitted to HHS From Date of Service					
Submitted within 1 month	17.0%	3.2%	9.2%	25.1%	9.3%
Submitted within 2 months	46.0%	34.6%	21.4%	57.5%	44.8%
Submitted within 3 months	73.9%	69.8%	37.5%	82.6%	76.2%
Submitted within 4 months	84.4%	82.7%	54.4%	89.1%	85.8%
Submitted within 5 months	88.9%	89.1%	65.9%	92.4%	90.7%
Submitted within 6 months	93.1%	94.8%	79.6%	95.1%	95.0%

Lag Months	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Submitted within 7 months	96.4%	97.9%	89.9%	97.6%	98.0%
Submitted within 8 months	98.8%	99.2%	97.1%	99.1%	99.4%
Submitted within 9 months	100%	100%	100%	100%	100%
Encounters Submitted to HHS Since MCO Payment Date					
Submitted within 1 month	63.6%	77.2%	74.0%	60.2%	68.2%
Submitted within 2 months	82.9%	95.4%	85.6%	81.2%	89.5%
Submitted within 3 months	94.8%	98.4%	92.3%	95.3%	96.9%
Submitted within 4 months	97.3%	98.8%	92.5%	97.5%	97.6%
Submitted within 5 months	97.9%	99.6%	94.6%	97.9%	98.3%
Submitted within 6 months	98.3%	99.8%	96.8%	98.3%	99.1%
Submitted within 7 months	99.4%	100%	98.7%	99.3%	99.8%
Submitted within 8 months	99.8%	100%	100%	99.8%	100%
Submitted within 9 months	100%	100%	100%	100%	100%

Table 3-51—Cumulative Percentage of Pharmacy Encounters Submitted to HHS From Date of Service and Since MCO Payment Date

Lag Months	Pharmacy
Encounters Submitted to HHS From Date of Service	
Submitted within 1 month	88.6%
Submitted within 2 months	99.8%
Submitted within 3 months	99.9%
Submitted within 4 months	100%
Encounters Submitted to HHS Since MCO Payment Date	
Submitted within 1 month	86.9%
Submitted within 2 months	98.1%
Submitted within 3 months	100%
Submitted within 4 months	100%

Table 3-52 through Table 3-55 display the completeness and accuracy results for key data elements for professional encounters (i.e., HCFA-1500, Medicare Part B crossover, and waiver), institutional encounters (i.e., inpatient, inpatient crossover, long-term care, outpatient, and outpatient crossover), and pharmacy encounters, respectively.

Table 3-52—Professional Encounters Percentage of Present and Valid Values by Category of Service

Key Data Element	HCFA-1500		Medicare Part B Crossover		Waiver	
	Percent Present	Percent Valid	Percent Present	Percent Valid	Percent Present	Percent Valid
Member ID	100%	99.9%	100%	99.9%	100%	>99.9%
Header Service From Date	100%	100%	100%	100%	100%	100%
Header Service To Date	100%	>99.9%	100%	100%	100%	100%
Detail Service From Date	100%	100%	100%	100%	100%	100%
Detail Service To Date	100%	>99.9%	100%	100%	100%	100%
Billing Provider NPI	100%	>99.9%	100%	>99.9%	100%	99.9%
Rendering Provider NPI	100%	94.8%	100%	99.4%	100%	99.9%
Servicing Provider Taxonomy Code	48.8%	99.3%	43.6%	98.7%	57.0%	99.2%
Referring Provider NPI	50.3%	>99.9%	64.7%	>99.9%	1.0%	100%
Primary Diagnosis Code	100%	>99.9%	100%	100%	100%	100%
Secondary Diagnosis Code(s)	52.4%	>99.9%	68.1%	100%	2.0%	100%
CPT/HCPCS code	100%	>99.9%	100%	>99.9%	100%	100%
Drug Code	5.4%	99.0%	1.8%	98.0%	0.0%	100%
MCO Paid Date	100%	>99.9%	100%	100%	100%	100%
MCO Submit Date	100%	100%	100%	100%	100%	100%
Header Paid Amount	100%	99.5%	100%	100%	100%	>99.9%
Detail Paid Amount	100%	100%	100%	100%	100%	100%
Header TPL Paid Amount	100%	>99.9%	100%	96.8%	100%	100%
Detail TPL Paid Amount	100%	100%	100%	100%	100%	100%

Table 3-53—Institutional Encounters Percentage of Present Values by Category of Service

Key Data Element	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Member ID	100%	100%	100%	100%	100%
Header Service From Date	100%	100%	100%	100%	100%
Header Service To Date	100%	100%	100%	100%	100%
Detail Service From Date	100%	100%	100%	100%	100%
Detail Service To Date	0.0%	0.0%	0.0%	0.0%	0.0%
Billing Provider NPI	100%	100%	100%	100%	100%
Attending Provider NPI	89.8%	100%	95.3%	91.0%	99.6%
Servicing Provider Taxonomy Code	25.1%	30.1%	40.2%	25.8%	31.4%
Referring Provider NPI	0.0%	0.1%	0.0%	3.7%	6.5%
Primary Diagnosis Code	100%	100%	100%	100%	100%
Secondary Diagnosis Code(s)	90.6%	97.2%	80.9%	64.9%	74.8%
CPT/HCPCS code	1.2%	43.2%	10.9%	92.7%	92.6%
Primary Surgical Procedure Code	47.7%	28.4%	0.0%	0.0%	0.0%
Secondary Surgical Procedure Code(s)	27.5%	15.9%	0.0%	0.0%	0.0%
Revenue Code	100%	100%	>99.9%	100%	100%
DRG	78.0%	50.2%	0.0%	0.0%	0.0%
Type of Bill Code	100%	100%	100%	100%	100%
Drug Code	0.9%	0.2%	0.0%	7.0%	10.4%
MCO Paid Date	100%	100%	100%	100%	100%
MCO Submit Date	100%	100%	100%	100%	100%
Header Paid Amount	100%	100%	100%	100%	100%
Detail Paid Amount	100%	100%	100%	100%	100%
Header TPL Paid Amount	100%	100%	100%	100%	100%
Detail TPL Paid Amount	100%	100%	100%	100%	100%

Table 3-54—Institutional Encounters Percentage of Valid Values by Category of Service

Key Data Element	Inpatient	Inpatient Crossover	Long-Term Care	Outpatient	Outpatient Crossover
Member ID	99.7%	99.3%	100%	>99.9%	>99.9%
Header Service From Date	100%	100%	100%	100%	100%
Header Service To Date	100%	100%	100%	100%	100%
Detail Service From Date	NA	NA	NA	NA	NA
Detail Service To Date	NA	NA	NA	NA	NA
Billing Provider NPI	99.9%	100%	99.1%	>99.9%	>99.9%
Attending Provider NPI	>99.9%	100%	100%	>99.9%	>99.9%
Servicing Provider Taxonomy Code	99.6%	99.7%	99.9%	99.0%	98.6%
Referring Provider NPI	NA	100%	NA	>99.9%	100%
Primary Diagnosis Code	100%	100%	100%	100%	100%
Secondary Diagnosis Code(s)	100%	100%	100%	100%	100%
CPT/HCPCS code	100%	100%	99.5%	>99.9%	>99.9%
Primary Surgical Procedure Code	100%	100%	NA	NA	NA
Secondary Surgical Procedure Code(s)	100%	100%	NA	NA	NA
Revenue Code	100%	100%	100%	100%	100%
DRG	100%	100%	100%	NA	NA
Type of Bill Code	100%	100%	100%	>99.9%	100%
Drug Code	94.9%	90.9%	NA	96.6%	96.6%
MCO Paid Date	NA	NA	NA	NA	NA
MCO Submit Date	100%	100%	100%	100%	100%
Header Paid Amount	99.2%	100%	>99.9%	99.7%	>99.9%
Detail Paid Amount	100%	100%	100%	100%	100%
Header TPL Paid Amount	94.6%	100%	99.5%	96.9%	99.9%
Detail TPL Paid Amount	100%	100%	100%	100%	100%

Table 3-55—Pharmacy Encounters Percentage of Present and Valid Values

Key Data Element	Pharmacy	
	Percent Present	Percent Valid
Member ID	100%	99.9%
Date of Service	100%	100%

Key Data Element	Pharmacy	
	Percent Present	Percent Valid
Billing Provider NPI	100%	100%
Prescribing Provider NPI	100%	100%
Drug Code	100%	99.9%
MCO Paid Date	100%	100%
MCO Submit Date	100%	100%
Paid Amount	100%	100%
TPL Paid Amount	100%	100%

Performance Results—Comparative Analysis

Table 3-56 displays the percentage of records present in the files submitted by **MOL** that were not found in HHS' files (record omission), and the percentage of records present in HHS' files but not present in the files submitted by **MOL** (record surplus) by encounter type (i.e., professional, institutional, and pharmacy). **Lower rates indicate better performance for both record omission and record surplus.**

Table 3-56—Record Omission and Surplus, by Encounter Type

Encounter Data Type	Record Omission			Record Surplus		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Professional	1,497,381	17,280	1.2%	1,496,455	16,354	1.1%
Institutional	929,151	5,240	0.6%	948,460	24,549	2.6%
Pharmacy	871,073	3,668	0.4%	919,225	51,820	5.6%

Note: Lower rates indicate better performance.

Table 3-57 through Table 3-62 display the results for key data elements related to encounter types: professional. institutional, and pharmacy, respectively. These tables include information on element omission, element surplus, element missing values, and element accuracy. **For the element omission and surplus indicators, lower rates indicate better performance. For the element accuracy indicator, higher rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 3-57—Element Omission, Surplus, and Missing Values: Professional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 1,480,101						
Member ID	0	0.0%	0	0.0%	0	0.0%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	27,341	1.8%	0	0.0%
Rendering Provider NPI	0	0.0%	27,341	1.8%	0	0.0%
Referring Provider NPI	0	0.0%	0	0.0%	787,471	53.2%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	0	0.0%	0	0.0%	695,308	47.0%
Procedure Code (CPT/HCPCS)	0	0.0%	0	0.0%	0	0.0%
Procedure Code Modifier	59	<0.1%	44	<0.1%	839,606	56.7%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Drug Code	0	0.0%	0	0.0%	1,410,335	95.3%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **MOL**'s data.
[3] Indicates the number of records with missing values in HHS' and **MOL**'s data.

Table 3-58—Element Omission, Surplus, and Missing Values: Institutional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 923,911						
Member ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date	0	0.0%	0	0.0%	771,846	83.5%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	0	0.0%	0	0.0%	84,325	9.1%
Referring Provider NPI	0	0.0%	0	0.0%	888,463	96.2%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	34,840	3.8%	5	<0.1%	148,939	16.1%
Procedure Code (CPT/HCPCS)	0	0.0%	0	0.0%	158,137	17.1%
Procedure Code Modifier	0	0.0%	0	0.0%	713,515	77.2%
Units of Service	0	0.0%	0	0.0%	0	0.0%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Primary Surgical Procedure Code	0	0.0%	0	0.0%	872,874	94.5%
Secondary Surgical Procedure Code(s)	0	0.0%	0	0.0%	891,695	96.5%
Drug Code	0	0.0%	0	0.0%	863,558	93.5%
Revenue Code	1	<0.1%	0	0.0%	0	0.0%
DRG Code	45	<0.1%	0	0.0%	850,504	92.1%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **MOL**'s data.
[3] Indicates the number of records with missing values in HHS' and **MOL**'s data.

Table 3-59—Element Omission, Surplus, and Missing Values: Pharmacy Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 867,405						
Member ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Drug Code	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Dispensing Fee	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **MOL**'s data.
[3] Indicates the number of records with missing values in HHS' and **MOL**'s data.

Table 3-60—Element Accuracy: Professional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	1,480,101	1,480,101	100%
Detail Service From Date	1,480,101	1,480,071	>99.9%
Detail Service To Date	1,480,101	1,480,078	>99.9%
Billing Provider NPI	1,452,760	1,452,755	>99.9%
Rendering Provider NPI	1,452,760	1,368,193	94.2%
Referring Provider NPI	692,630	692,630	100%
Primary Diagnosis Code	1,480,101	1,480,101	100%
Secondary Diagnosis Code(s)	784,793	784,793	100%
Procedure Code (CPT/HCPCS)	1,480,101	1,478,681	99.9%
Procedure Code Modifier	640,392	618,482	96.6%
Units of Service	1,480,101	1,470,721	99.4%
Drug Code	69,766	69,766	100%
Detail Paid Amount	1,480,101	1,471,397	99.4%

Table 3-61—Element Accuracy: Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	923,911	923,911	100%
Header Service From Date	923,911	922,386	99.8%
Header Service To Date	923,911	889,986	96.3%
Admission Date	152,065	152,049	>99.9%
Billing Provider NPI	923,911	923,911	100%
Attending Provider NPI	839,586	839,586	100%
Referring Provider NPI	35,448	35,448	100%
Primary Diagnosis Code	923,911	923,911	100%
Secondary Diagnosis Code(s)	740,127	520,119	70.3%
Procedure Code (CPT/HCPCS)	765,774	765,772	>99.9%
Procedure Code Modifier	210,396	210,396	100%
Units of Service	923,911	923,848	>99.9%
Primary Surgical Procedure Code	51,037	50,463	98.9%
Secondary Surgical Procedure Code(s)	32,216	31,486	97.7%

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Drug Code	60,353	60,353	100%
Revenue Code	923,910	922,610	99.9%
DRG Code	73,362	73,352	>99.9%
Header Paid Amount	923,911	919,460	99.5%
Detail Paid Amount	923,911	922,924	99.9%

Table 3-62—Element Accuracy: Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	867,405	867,402	>99.9%
Header Service From Date	867,405	867,405	100%
Billing Provider NPI	867,405	862,392	99.4%
Prescribing Provider NPI	867,405	867,404	>99.9%
Drug Code	867,405	866,536	99.9%
Drug Quantity	867,405	867,360	>99.9%
Header Paid Amount	867,405	866,583	99.9%
Dispensing Fee	867,405	867,405	100%

Table 3-63 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 3-63—All-Element Accuracy by Encounter Type

Encounter Data Type	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values Present in Both Data Sources	Rate
Professional	1,480,101	1,335,520	90.2%
Institutional	923,911	645,092	69.8%
Pharmacy	867,405	860,652	99.2%

Table 3-64 displays the overall encounter accuracy rates by MCO and encounter type. All results presented are based on the number of claims in the primary file, with a higher match rate indicating better performance.

Table 3-64—Overall Encounter Accuracy by Encounter Type

Encounter Data Type	HHS to MOL			MOL to HHS		
	Match	Partial Match	No Match	Match	Partial Match	No Match
Professional	90.5%	8.9%	0.6%	89.9%	8.9%	1.3%
Institutional	79.6%	18.2%	2.2%	81.1%	18.5%	0.4%
Pharmacy	93.6%	0.7%	5.6%	98.8%	0.8%	0.4%

Note: The sum of Match, Partial Match, and No Match rates may not equal 100 percent due to rounding.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: For all three encounter types (i.e., professional, institutional, and pharmacy encounters), encounter data were processed by **MOL** in a timely manner. All encounters were submitted within nine months of service delivery or 270 days of **MOL** paid date. **[Quality]**

Strength #2: For all three encounter types, expected key data elements were generally present and valid. All key data elements across all encounter types and categories of service had a validity rate of 90.9 percent or higher. **[Quality]**

Strength #3: For professional and institutional encounters, **MOL**-submitted encounters exhibited complete data with low record omission and surplus rates. [**Quality]**

Strength #4: For all three encounter types (i.e., professional, institutional, and pharmacy encounters), a high level of element completeness (i.e., low element omission and surplus rates) was exhibited among encounters that could be matched between the HHS-submitted encounters and **MOL**-submitted encounters. **[Quality]**

Strength #5: For pharmacy encounters, all key data elements exhibited a high level of element accuracy among encounters that could be matched between the HHS-submitted encounters and **MOL**-submitted encounters. **[Quality]**

Weaknesses and Recommendations

Weakness #1: A significant weakness identified in **MOL**'s encounter data is the presence of duplicate encounters, particularly within pharmacy encounters, where the duplicate rate reached 10.0

percent. Professional and institutional encounters exhibited moderate duplication rates of 7.7 percent or lower. **[Quality]**

Why the weakness exists: The presence of duplicate encounters in **MOL**'s data may result from several operational and procedural factors. One primary reason is billing system processes that generate multiple submissions for the same service, either due to claim resubmissions, payment adjustments, or provider corrections.

Recommendation: To reduce duplicate encounters, **MOL** should implement enhanced duplicate detection protocols to identify and prevent unnecessary claim resubmissions. Strengthening internal validation processes before submission to HHS can help detect potential duplicates at the provider and system levels. Conducting a root cause analysis to determine whether duplicate submissions stem from billing system workflows, provider resubmissions, or claim adjustments can provide targeted solutions for improvement.

Additionally, **MOL** should collaborate with HHS to refine resubmission guidelines to ensure that necessary claim corrections are captured while avoiding unnecessary duplications. Providing training for providers and internal claims processing teams on proper resubmission procedures and system controls can help minimize duplicate encounter rates. Lastly, regular audits of encounter data can help track and mitigate duplicate trends, improving the accuracy, completeness, and reliability of **MOL**'s data reporting.

By addressing this weakness, **MOL** can enhance the integrity of its encounter data, ensuring that reported service utilization and financial calculations accurately reflect the care provided while reducing potential discrepancies in healthcare program monitoring and evaluation.

Weakness #2: A notable weakness identified in **MOL**'s encounter data is the lower-than-expected validity rates for a certain key data element in professional and institutional encounters. **[Quality]**

Why the weakness exists: The lower validity rate of *Drug Code* field may stem from several systemic and operational challenges. One primary reason is inconsistent provider coding and documentation practices, where drug codes may be entered incorrectly, omitted, or mismatched with the corresponding diagnosis or procedure codes. Additionally, variability in hospital pharmacy billing practices and differences in how inpatient crossover encounters are processed compared to outpatient or pharmacy claims can contribute to inaccuracies.

Recommendation: To improve the validity of drug code reporting, particularly for inpatient crossover encounters, **MOL** should implement a combination of system enhancements, provider training, data audits, and standardized reporting practices. Strengthening system validation rules by incorporating automated cross-checks against NDC, HCPCS, and formulary databases will help detect incorrect or unrecognized drug codes before submission. Additionally, real-time alerts for mismatched or outdated codes can further reduce reporting errors. **MOL** should also provide targeted training for providers and billing staff, ensuring they have clear guidance on proper *Drug Code* usage, formulary alignment, and crosswalk procedures. To further enhance data integrity, regular audits of *Drug Code* submissions should be conducted, with a focus on identifying patterns of incorrect coding and ensuring consistency across high-risk categories such as inpatient crossover encounters. Finally, collaborating with HHS and institutional providers to standardize *Drug Code* reporting requirements will help ensure that inpatient pharmacy claims are accurately captured in encounter data. By implementing these improvements, **MOL** can enhance the accuracy of *Drug*

Code field reporting, reduce errors in encounter data, and ensure a more reliable representation of medication utilization trends.

Weakness #3: The record surplus rate for pharmacy encounters exceeded a 5.0 percent threshold. **[Quality]**

Why the weakness exists: The discrepancy could be attributed to the manner of how corrected encounters were submitted to the HHS, as HHS considered the corrected encounters with different TCNs as separate pharmacy encounters.

Recommendation: HSAG recommends that **MOL** collaborate with HHS to confirm encounter submission standards for adjusted and corrected claims. Aligning submission practices will help ensure that corrected encounters are properly processed and do not contribute to surplus rates.

Weakness #4: MOL had a low element accuracy rate (below 95.0 percent) for the *Rendering Provider NPI* data element, and a low element accuracy rate for the *Secondary Diagnosis Code(s)* data element for institutional encounters. **[Quality]**

Why the weakness exists: Based on its data discrepancy report response, **MOL** noted that the low accuracy rate for the *Secondary Diagnosis Code(s)* data element within the institutional encounters was due to **MOL** including extra diagnosis in addition to the secondary diagnosis codes. **MOL** also noted that the low accuracy of the *Rendering Provider NPI* data element in the professional encounters could be partially attributed to HHS-submitted encounters used provider Medicaid IDs instead of NPIs for the data element, and partially attributed to a mapping issue on its vendor side.

Recommendation: HSAG recommends that **MOL** collaborate with HHS to confirm encounter submission standards for these data elements to ensure consistency in reporting. Additionally, **MOL** should implement standardized quality control measures to improve data extraction accuracy and prevent discrepancies related to provider identifiers and diagnosis coding. Strengthening internal validation processes will help ensure alignment with HHS expectations and enhance data reliability.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

MOL was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have CAHPS data for CY 2024.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS survey against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS survey have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: NA

Weaknesses and Recommendations

Weakness #1: NA
Why the weakness exists: NA
Recommendation: NA

Scorecard

The 2024 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Due to **MOL** being a new plan in 2023 and would only have reportable data for July 2023 through December 2023 for MY 2023, data were not available yet to include in the 2024 Iowa Health Link MCO Scorecard. **MOL**'s performance will be included in future MCO scorecards.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **MOL**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MOL**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-65 displays each strategic priority and the EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MOL**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **MOL**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-65—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** NA The EQR activities did not produce data to assess the impact of this objective. **MOL** was new to the Iowa Managed Care Program effective July 1, 2023; therefore, did not meet continuous enrollment criteria for HEDIS MY 2023 reporting. Performance will be assessed in future technical reports as part of the PMV activity. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA During CY 2024, a PIP topic, SDOH Screening was initiated, and **MOL** received a designation of High Confidence for Validation Rating 1 of the Design phase. While no data were reported for this PIP during CY 2024, this PIP has the potential to impact this objective. Performance of this PIP will be assessed in future technical reports as part of the PIP activity. NA The NAV EQR activity did not produce sufficient data to assess the impact of provider-to-member	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for PCPs and specialists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** NA The EQR activities did not produce data to assess the impact of this objective. **MOL** was new to the Iowa Managed Care Program so did not meet continuous enrollment criteria for HEDIS MY 2023 reporting. Performance will be assessed in future technical reports as part of the PMV activity. **Improve Prenatal and Postpartum Comprehensive Care Management** NA The EQR activities did not produce data to assess the impact of this objective. **MOL** was new to the Iowa Managed Care Program so did not meet continuous enrollment criteria for HEDIS MY 2023 reporting. Performance will be assessed in future technical reports as part of the PMV activity. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA *LTSS-6: LTSS Admission to a Facility from the Community*-While data were reported and validated through the PMV activity for three indicators, benchmarks for this measure have not been established by HHS so **MOL**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*-**MOL** had a denominator that was too small to report a valid rate. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*-**MOL** had a denominator that was too small to report a valid rate. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	NA The EQR activities did not produce data to assess the impact of this objective. **MOL** was new to the Iowa Managed Care Program effective July 1, 2023; therefore, the MCO did not have CAHPS reporting for CY 2024. Performance will be assessed in future technical reports as part of the CAHPS activity.	☒ Quality ☐ Timeliness ☐ Access

Wellpoint Iowa, Inc.

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **WLP**'s PIP (i.e., the PIP Design stage). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 3-65 displays the validation ratings and performance indicators.

Table 3-66—Overall Validation Rating for WLP

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicator	Performance Indicator Results		
				Baseline	R1	R2
Nonclinical PIP: *SDOH Screening*	*High Confidence*	*Not Assessed*	The percentage of newly enrolled members who were screened for SDOH within 90 days of enrollment.	—	—	—
			The percentage of existing enrolled members who received a subsequent screening for SDOH during the measurement period.	—	—	—
Clinical PIP: *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)*	*High Confidence*	*Not Assessed*	Members 6–12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase.	—	—	—
			Members 6–12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended.	—	—	—

R1 = Remeasurement 1
R2 = Remeasurement 2
— The PIP had not progressed to reporting baseline, Remeasurement 1, and Remeasurement 2 results during CY 2024.
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.
**Not Assessed—HSAG did not assess Validation Rating 2 for CY 2024 as the MCO reported the Design stage for each PIP.

The goal for both PIPs is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Once the MCO has progressed to developing intervention strategies, Table 3-67 will display the barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the MCO to support achievement of the PIP goals and address the barriers.

Table 3-67—Barriers and Interventions for WLP

SDOH Screening	
Barriers	**Interventions**
—	—
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	
Barriers	**Interventions**
—	—

— Expected to be initiated in CY 2026.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: WLP designed a methodology sound PIP as indicated by the high confidence validation rating for the Design phase. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses through the PIP activity.

Recommendation: Although there were no identified weaknesses, HSAG recommends **WLP** ensure that it follows the approved PIP methodology to calculate and report the baseline data accurately in the next annual submission.

Performance Measure Validation

Performance Results

PMV

HSAG reviewed **WLP**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **WLP** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. However, during the audit HSAG identified misalignments between **WLP**'s source code and the technical specifications. **WLP** corrected its source code and underwent additional primary source verification. All records reviewed aligned with the data output files and the measure specifications for performance measure calculation. **WLP** was able to report valid and reportable rates. Table 3-68 displays the indicator rates for each performance measure reported by **WLP**.

Table 3-68—WLP MY 2023 MLTSS Performance Measures

	LTSS Performance Measures	Performance Measure Rate
1.	*Managed Long-Term Services and Supports Admission to a Facility from the Community (MLTSS-6)*	
	Short-Term Stay—Ages 18 to 64	0.74
	Short-Term Stay—Ages 65 to 74	6.30
	Short-Term Stay—Ages 75 to 84	4.26
	Short-Term Stay—Ages 85+	2.12
	Medium-Term Stay—Ages 18 to 64	0.63
	Medium-Term Stay—Ages 65 to 74	3.29
	Medium-Term Stay—Ages 75 to 84	2.33
	Medium-Term Stay—Ages 85+	4.24
	Long-Term Stay—Ages 18 to 64	22.01
	Long-Term Stay—Ages 65 to 74	72.60
	Long-Term Stay—Ages 75 to 84	69.38
	Long-Term Stay—Ages 85+	82.63
2.	*Managed Long-Term Services and Supports Minimizing Facility Length of Stay*	
	Observed	10.80%
	Risk-Adjusted	32.52%
3.	*Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay*	
	Observed	0.00%
	Risk-Adjusted	69.49%

HEDIS

HSAG's review of the FAR for HEDIS MY 2023 showed that **WLP**'s HEDIS compliance auditor found **WLP**'s information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS MY 2023. **WLP** contracted with an external software vendor with HEDIS Certified Measures for measure production and rate calculation. Table 3-69 displays the indicator rates for each HEDIS MY 2023 performance measure reported by **WLP**.

Table 3-69—HEDIS MY 2023 Results for WLP

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Access to Preventive Care					
Adults' Access to Preventive/Ambulatory Health Services					
20–44 Years	79.78%	77.91%	81.26%	↑	★★★★★
45–64 Years	85.53%	84.36%	87.29%	↑	★★★★★
65 Years and Older	89.64%	91.71%	95.45%	↑	★★★★★
Use of Imaging Studies for Low Back Pain					
Use of Imaging Studies for Low Back Pain	—	69.97%	67.02%	—	★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents					
BMI Percentile Documentation—Total	71.78%	81.19%	79.56%	↑	★★
Counseling for Nutrition—Total	64.96%	69.59%	66.42%	↑	★★
Counseling for Physical Activity—Total	62.53%	66.75%	63.26%	↑	★★
Women's Health					
Breast Cancer Screening					
Breast Cancer Screening	52.72%	53.32%	56.07%	↑	★★★
Cervical Cancer Screening					
Cervical Cancer Screening	59.12%	61.56%	60.34%	↑	★★★
Chlamydia Screening in Women					
Total	45.22%	46.68%	44.89%	↓	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*					
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.27%	0.18%	0.17%	↑	★★★
Prenatal and Postpartum Care					
Timeliness of Prenatal Care	81.51%	89.51%	88.08%	↑	★★★
Postpartum Care	76.89%	82.62%	83.70%	↑	★★★★
Living With Illness					
Hemoglobin A1c Control for Patients With Diabetes					
HbA1c Control (<8%)	48.42%	62.29%	64.48%	↑	★★★★★
*HbA1c Poor Control (>9.0%)**	42.34%	27.49%	27.25%	↑	★★★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Blood Pressure Control for Patients With Diabetes					
Blood Pressure Control (<140/90 mm Hg)	71.29%	77.86%	81.75%	↑	★★★★★
Eye Exam for Patients With Diabetes					
Eye Exam (Retinal) Performed	54.99%	59.37%	59.85%	↑	★★★★
Controlling High Blood Pressure					
Controlling High Blood Pressure	64.23%	68.13%	71.29%	↑	★★★★
Statin Therapy for Patients With Cardiovascular Disease					
Received Statin Therapy—Total	80.24%	81.24%	80.99%	↑	★★
Statin Therapy for Patients With Diabetes					
Received Statin Therapy	66.53%	65.21%	67.68%	↑	★★★
Behavioral Health					
Diabetes Monitoring for People With Diabetes and Schizophrenia					
Diabetes Monitoring for People With Diabetes and Schizophrenia	72.32%	72.16%	75.47%	↑	★★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications					
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	79.11%	78.08%	81.38%	↑	★★
Follow-Up After Emergency Department Visit for Substance Use					
7 Day Follow-Up—Total	50.53%	59.35%	49.30%	↓	★★★★★
30 Day Follow-Up—Total	56.33%	69.09%	60.75%	↑	★★★★★
Follow-Up After Emergency Department Visit for Mental Illness					
7-Day Follow-Up—Total	67.10%	65.45%	70.81%	↑	★★★★★
30-Day Follow-Up—Total	77.99%	76.06%	81.66%	↑	★★★★★
Follow-Up After Hospitalization for Mental Illness					
7-Day Follow-Up—Total	57.61%	63.54%	67.73%	↑	★★★★★
30-Day Follow-Up—Total	75.50%	79.03%	81.78%	↑	★★★★★
Initiation and Engagement of Substance Use Disorder Treatment					
Initiation of SUD Treatment—Total	—	65.28%	49.83%	—	★★★★
Engagement of SUD Treatment—Total	—	24.17%	19.43%	—	★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics					
Blood Glucose and Cholesterol Testing–Total	24.68%	26.29%	26.43%	↑	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics					
Total	62.73%	62.92%	61.18%	↓	★★★
Keeping Kids Healthy					
Childhood Immunization Status					
Combination 3	73.24%	71.78%	69.59%	↓	★★★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Combination 10	49.15%	42.09%	36.98%	↓	★★★★
Immunizations for Adolescents					
Combination 1	85.89%	83.94%	86.62%	↑	★★★★
Combination 2	35.77%	35.77%	31.39%	↓	★★
Lead Screening in Children					
Lead Screening in Children	77.62%	73.72%	77.86%	↑	★★★★
Well-Child Visits in the First 30 Months of Life					
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	60.51%	62.75%	67.39%	↑	★★★★
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	70.08%	68.46%	72.19%	↑	★★★
Child and Adolescent Well-Care Visits					
Total	49.75%	49.65%	54.62%	↑	★★★
Medication Management					
Statin Therapy for Patients With Cardiovascular Disease					
Statin Adherence 80%—Total	69.30%	71.71%	69.01%	↓	★★
Statin Therapy for Patients With Diabetes					
Statin Adherence 80%—Total	68.86%	69.92%	66.42%	↓	★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia					
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	64.67%	64.78%	67.54%	↑	★★★
Antidepressant Medication Management					
Effective Acute Phase Treatment	60.15%	62.38%	65.35%	↑	★★★
Effective Continuation Phase Treatment	42.52%	44.24%	46.04%	↑	★★★
Appropriate Testing for Pharyngitis					
Total	78.09%	80.61%	87.13%	↑	★★★★
Appropriate Treatment for Upper Respiratory Infection					
Total	90.21%	89.71%	87.61%	↓	★★
Asthma Medication Ratio					
Total	70.27%	67.36%	66.25%	↓	★★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis					
Total	46.65%	56.12%	56.97%	↑	★★
Follow-Up Care for Children Prescribed ADHD Medication					
Initiation Phase	43.41%	49.29%	48.26%	↑	★★★
Continuation and Maintenance Phase	47.83%	53.55%	50.48%	↑	★★

Measures	HEDIS 2021 (MY 2021) Rate	HEDIS MY 2022 Rate	HEDIS MY 2023 Rate	Three-Year Trend	Star Rating
Persistence of Beta-Blocker Treatment After a Heart Attack					
Persistence of Beta-Blocker Treatment After a Heart Attack	81.19%	83.68%	57.69%	↓	★★★
Pharmacotherapy Management of COPD Exacerbation					
Systemic Corticosteroid	72.33%	75.21%	72.35%	↑	★★★
Bronchodilator	81.67%	79.66%	79.18%	↓	★★
Use of Opioids at High Dosage*					
Use of Opioids at High Dosage	2.07%	2.34%	2.66%	↓	★★★
Use of Opioids From Multiple Providers*					
Multiple Prescribers	18.27%	17.09%	17.55%	↑	★★★
Multiple Pharmacies	1.07%	1.24%	1.66%	↓	★★★★
Multiple Prescribers and Multiple Pharmacies	0.81%	0.88%	0.99%	↓	★★★★

* For this indicator, a lower rate indicates better performance.
—This symbol indicates that NCQA recommended a break in trending; therefore, the rate is not displayed.
"NC" indicates that NCQA recommended a break in trending; therefore, the rate could not be compared to the national Medicaid MY 2023 benchmarks.
↓ Indicates performance worsened over a three-year time period.
↑ Indicates performance improved over a three-year time period.
HEDIS MY 2023 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for PMV and HEDIS against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of PMV and HEDIS have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: WLP's performance in the Living with Illness domain remained strong for most measures. The *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Control (<8%)* indicator and the *Blood Pressure Control for Patients With Diabetes—Blood Pressure Control (<140/90 mm Hg)* indicator both finished at or above the 90th percentile. Additionally, the *Hemoglobin A1c Control for Patients With Diabetes—HbA1c Poor Control (>9.0%)* indicator, the *Eye Exam for Patients With Diabetes—Eye Exam (Retinal) Performed* indicator, and the *Controlling High Blood Pressure* measure all finished at or above the 75th percentile. **[Quality]**

Strength #2: WLP's performance in the Behavioral Health domain remained strong for the *Follow-Up After Emergency Department Visit for Substance Use*, *Follow-Up After Emergency Department Visit for Mental Illness,* and *Follow-Up After Hospitalization for Mental Illness* measures. All measures finished at or above the 90th percentile. Additionally, the *Diabetes Monitoring for People With Diabetes and Schizophrenia* and *Initiation and Engagement of Substance Use Disorder Treatment* measures finished at or above the 75th percentile. **[Quality, Timeliness,** and **Access]**

Strength #3: WLP demonstrated multiple methods of validation and tracking to ensure the accuracy of enrollment data, claim adjudication, and claim conversion into 837 encounter files for submission to HHS. **[Quality]**

Weaknesses and Recommendations

Weakness #1: WLP's performance in the Access to Preventive Care domain remained low, as the *Use of Imaging Studies for Low Back Pain* measure ranked below the 25th percentile. **[Quality]**

Why the weakness exists: Low rates indicate a high number of Iowa Medicaid members with a principal diagnosis of low back pain had imaging performed that was not essential in improving outcomes, while also causing unnecessary radiation exposure and accrued cost. Best practice is to reduce imaging by identifying the reason for low back pain and to provide other methods of comfort for pain relief, using guidelines for treating back pain at the onset of newly diagnosed low back pain, prior to the use of imaging studies.

Recommendation: HSAG recommends that **WLP** ensure providers are aware of best practices regarding imaging studies for low back pain, such as avoiding diagnostic imaging in the first four weeks of new-onset back pain, unless red flags or other conditions are present, and encouraging management of back pain through regular physical activity, healthy back exercises, and education on injury prevention. HSAG recommends that **WLP** consider using quality interventions that have been shown to improve appropriate imaging studies for low back pain, including increased provider oversight, providers getting education about HEDIS specifications, specific imaging prompts in the EMR, and quality scorecards for providers.[18]

Weakness #2: WLP's performance in the Women's Health domain remained low, as the *Chlamydia Screening in Women* measure ranked below the 25th percentile. [**Quality**]

Why the weakness exists: Chlamydia is the most commonly reported bacterial sexually transmitted infection among teens and young adults in the United States. Untreated cases can potentially cause severe and irreversible complications. Low screening rates suggest that barriers continue to exist for sexually active women 16 to 24 years of age in accessing this important health screening, or potentially may stem from missed opportunities during in-office visits, such as those for pregnancy testing, contraception services, annual exams, or when addressing members with a history of sexual abuse or prior sexually transmitted infections.

Recommendation: HSAG recommends that **WLP** research interventions discussed in an NCQA performance improvement article, including provider outreach and education, member education and

[18] Al-Hihi, Eyad et al. "Improving appropriate imaging for non-specific low back pain." BMJ open quality vol. 11,1 (2022): e001539. doi:10.1136/bmjoq-2021-001539.

outreach, the tracking of chlamydia screening rates and reporting those results to physicians and large practices. HSAG recommends that **WLP** consider requiring providers to use Logical Observation Identifiers Names and Codes (LOINC), which creates an electronic record of the screening test. HSAG recommends that **WLP** consider requiring labs to report tests directly to health plans, in addition to the usual reports sent to providers.

Weakness #3: WLP's performance in the Behavioral Health domain remained low, as the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* indicator ranked below the 25th percentile. [**Quality**]

Why the weakness exists: The low rate indicates there are barriers to appropriate monitoring for children and adolescents with severe and persistent mental illness who are being treated with psychotropic medication, potentially with behavioral health providers not ordering the correct tests for monitoring.

Recommendation: HSAG recommends **WLP** assess how providers are coordinating on antipsychotic care. In one study, members who saw a PCP and mental health provider over the year had a higher rate of receiving metabolic monitoring. Therefore, encouraging joint monitoring might increase the rate of metabolic monitoring.[19] Further, HSAG recommends **WLP** generate provider data reports to identify trends in whether providers are prescribing antipsychotics and not doing metabolic monitoring.

Weakness #4: During source code review and PSV, HSAG noted multiple areas of specification misalignment. **WLP** also noted the omission of the measure value sets within its source code and use of the same continuous enrollment criteria across all three MLTSS measures. **[Quality]**

Why the weakness exists: WLP appeared to misinterpret the specifications when programming its source code.

Recommendation: HSAG recommends that **WLP** implement a multi-layer peer review approach to source code and data output review and approval, using peer review processes at the developer, analytics, and management level to ensure full application and alignment of the specifications. HSAG also recommends that **WLP** conduct ongoing internal PSV on a subset of cases each month for assurance in specification alignment and rate calculations.

[19] Shenkman, Elizabeth et al. "Provider Specialty and Receipt of Metabolic Monitoring for Children Taking Antipsychotics." Pediatrics vol. 147,1 (2021): e20200658. doi:10.1542/peds.2020-0658.

Compliance Review

Performance Results

Table 3-70 presents an overview of the results of the standards reviewed during the CY 2024 compliance review for **WLP**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **WLP** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 3-70—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	24	24	19	5	0	**79%**
Standard III—Emergency and Poststabilization Services	15	15	15	0	0	**100%**
Standard IV—Availability of Services	18	18	17	1	0	**94%**
Standard V—Assurances of Adequate Capacity and Services	11	11	11	0	0	**100%**
Standard VI—Coordination and Continuity of Care	18	18	14	4	0	**78%**
Standard VII—Coverage and Authorization of Services	42	42	38	4	0	**90%**
Total	**135**	**135**	**121**	**14**	**0**	**90%**

M = Met*; *NM = Not Met*; *NA = Not Applicable
Total Elements: The total number of elements within each standard.
Total Applicable Elements: The total number of elements within each standard minus any elements that were *NA*. This represents the denominator.
Total Compliance Score: The overall percentages were obtained by adding the number of elements that received a score of *Met* (1 point), then dividing this total by the total number of applicable elements.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the Compliance Review against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the Compliance Review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: WLP achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the MCO had appropriate processes and procedures in place related to member and MCO requests for disenrollment. **[Quality]**

Strength #2: WLP achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the MCO had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. **[Timeliness** and **Access]**

Strength #3: WLP achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the MCO had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., primary care, specialty care, hospital and emergency services, behavioral health, and prenatal care) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: WLP had five elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. **[Timeliness** and **Access]**

Why the weakness exists: WLP did not demonstrate that all member materials adhered to State and federal requirements, that it provided timely notification to members for all provider terminations, that its paper provider directory included all required components, or that a member is provided timely information (i.e., within five business days) upon the member's request.

Recommendation: While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: WLP had four elements in the Coordination and Continuity of Care program area that received a score of *Not Met*, indicating members' care may not be effectively coordinated through the care management program. **[Quality**, **Timeliness**, and **Access]**

Why the weakness exists: WLP did not demonstrate that its care management department was consistently completing the initial screening timely, documenting a clear communication plan with members or providers, or that prioritized goals were consistently documented in members' service plans. Additionally, there were inconsistent practices for consulting with providers caring for members in the development of service plans and meeting required time frames for service plan completion. Lastly, the MCO did not demonstrate that care managers consistently adhered to the check-in schedule to monitor member's progress.

Recommendation: While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and

monitoring efforts to ensure compliance with all federal and State obligations specific to care coordination and care management of members.

Weakness #3: WLP had four elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: WLP did not consistently adhere to requirements related to the timing of authorization decisions (i.e., exception to advance notice for a termination, suspension, or reduction of a previously authorized service) and content of notices of adverse benefit determination.

Recommendation: While **WLP** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the MCO continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the MCO begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

HSAG assessed results submitted by **WLP** which indicated compliance with the network adequacy time and distance standards. Compliance was determined based on the MCO meeting HHS' time and distance standards, with no deficiencies identified for each provider type according to urbanicity. HSAG assessed SFY Q1 and Q2 reported results. Table 3-71 summarizes the percentage of members with access for the time and distance network adequacy indicators for the most recent available results during the reporting period.

Table 3-71—WLP Q2 Percentage of Members With Access Across Time and Distance Indicators

Provider Type	Indicator	Percentage of Members With Access
PCP—Urban/Rural	Thirty (30) minutes or thirty (30) miles from the personal residences of members	100% adult and pediatric
Specialty Care Provider-Urban/Rural	60 minutes or 60 miles from the personal residence of members for at least 75% of non-dual Members	>91.6%
	90 minutes or 90 miles from the personal residence of members for ALL non-dual Members	100%
Hospitals—Urban/Rural	Not to exceed thirty (30) minutes or thirty (30) miles	100%
Long-Term Care Services—*Institutional Providers*—Urban	30 minutes or 30 miles	100%
Long-Term Care Services—*Institutional Providers*—Rural	60 minutes or 60 miles	100%
Long-Term Care Services—*HCBS Providers*—Urban*	30 minutes or 30 miles	—
Long-Term Care Services—*HCBS Providers*—Rural*	60 minutes or 60 miles	—
Behavioral Health Services—*Outpatient*—Urban/Rural	30 minutes or 30 miles from the personal residence of members	100%
Behavioral Health Services—*Inpatient*—Urban	60 minutes or 60 miles from the personal residence of members	100%
Behavioral Health Services—*Inpatient*—Rural	90 minutes or 90 miles from the personal residence of members	100%

Provider Type	Indicator	Percentage of Members With Access
General Optometry Services—Urban/Rural	30 minutes or 30 miles	100%
Pharmacies—Urban/Rural	30 minutes or 30 miles from a member's residence in each county, excluding pharmacies participating in the Specialty Pharmacy Program	100%

*Compliant for a subset of provider types.

The following subset of indicators from the time and distance standards reported in Table 3-72 were determined to be *Not Met*. Table 3-72 displays the time and distance standards by Provider Type and Provider Type Subset which were determined to be *Not Met* by **WLP**.

Table 3-72—WLP Q2 Percentage of Members With Access across Time and Distance Indicators Subset—*Not Met*

Provider Type	Provider Type Subset	Indicator	Percentage of Members With Access
Lab and X-Ray Services—Urban/Rural	Not applicable	30 minutes or 30 miles	94.7%
Long-Term Care Services—*HCBS Providers*—Urban	BI-Transportation	30 minutes or 30 miles	50%
Long-Term Care Services—*HCBS Providers*—Urban	Elderly-Transportation	30 minutes or 30 miles	90%
Long-Term Care Services—*HCBS Providers*—Urban	ID: Day Habilitation	30 minutes or 30 miles	99.9%
Long-Term Care Services—*HCBS Providers*—Urban	ID-Transportation	30 minutes or 30 miles	61.5%
Long-Term Care Services—*HCBS Providers*—Urban	PD-Transportation	30 minutes or 30 miles	50%
Long-Term Care Services—*HCBS Providers*—Rural	BI: Adult Day Care	60 minutes or 60 miles	75%
Long-Term Care Services—*HCBS Providers*—Rural	ID-Transportation	60 minutes or 60 miles	84.1%

HSAG assessed results submitted by **WLP** which indicated compliance with the minimum provider agreement requirements for all provider types. Compliance was determined based on the MCO meeting HHS' minimum provider agreement standard of at least one provider. Table 3-73 summarizes compliance with the minimum provider agreement indicators for **WLP**.

Table 3-73—WLP Minimum Provider Agreements by Provider Type

Provider Type	Compliance
Allergy	*Met*
Cardiology	*Met*
Dermatology	*Met*
Endocrinology	*Met*
Gastroenterology	*Met*
General Surgery	*Met*
Neonatology	*Met*
Nephrology	*Met*
Neurology	*Met*
Neurosurgery	*Met*
Obstetrics and Gynecology	*Met*
Occupational Therapy	*Met*
Oncology/Hematology	*Met*
Ophthalmology	*Met*
Orthopedics	*Met*
Otolaryngology	*Met*
Pathology	*Met*
Physical Therapy	*Met*
Pulmonology	*Met*
Psychiatry	*Met*
Radiology	*Met*
Reconstructive Surgery	*Met*
Rheumatology	*Met*
Speech Therapy	*Met*
Urology	*Met*
Pediatric Specialties	*Met*

HSAG assessed indicator results submitted by **WLP** for appointment wait time standards across ten provider types. Results were determined based on review of **WLP** reporting standards that directly corresponded to HHS' standards and indicators. Table 3-74 summarizes the MCO's compliance with appointment wait times indicators for **WLP**.

Table 3-74—WLP Percent Within Standard for Appointment Wait Time by Provider Type[20]

Provider Type	Indicator	Percent Within Standard
PCP	4 to 6 weeks for routine care	100%
	48 hours for persistent care	87%
	1 day for urgent care	95%
Specialty Care	30 days for routine care	86%
	1 day for urgent care	86%
Behavioral Health Services—*Emergency*	Seen or referred to an appropriate provider upon presentation	71% prescribing—non-life threatening 70% prescribing—life threatening 70% non-prescribing—non-life threatening 39% non-prescribing—life threatening
Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	53% prescribing 66% non-prescribing
Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	86% prescribing 87% non-prescribing
Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	85% prescribing—initial visit 95% prescribing—follow up 79% non-prescribing—initial visit 95% non-prescribing—follow up
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours	93% prescribing 83% non-prescribing
Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours	95% prescribing 92% non-prescribing
General Optometry Services	3 weeks regular appointments 48 hours urgent care	88%
Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	100%

HSAG determined the appointment wait times standards in Table 3-75 required by HHS were not calculated and reported by **WLP**, resulting in an "*Unable to Validate"* rating determination for each associated indicator.

[20] **WLP**'s provider survey was completed during September 28–November 29, 2023.

Table 3-75—WLP Appointment Wait Time Indicators *Unable to Validate*

Provider Type	Indicators
Behavioral Health Services—Mobile Crisis	1 hour of presentation or request
Emergency Care	Immediate at nearest facility available

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: WLP had thorough processes in place to mitigate missing or incomplete data from the 834 eligibility and enrollment files by generating exception reports, which were reviewed and resolved within two business days following receipt. **[Access]**

Weaknesses and Recommendations

Weakness #1: WLP did not use HHS' standards and indicators for appointment wait times when conducting provider surveys. **[Access]**

Why the weakness exists: WLP did not fully encompass the State's requirements into its provider survey protocol.

Recommendation: HSAG recommends that **WLP** work with HHS to fully understand the appointment wait time standards and indicators and revise its survey protocol to accurately measure compliance with State standards.

Encounter Data Validation

Performance Results—Comparative Analysis

Table 3-76 displays the percentage of records present in the files submitted by **WLP** that were not found in HHS' files (record omission), and the percentage of records present in HHS' files but not present in the files submitted by **WLP** (record surplus) by encounter type (i.e., professional, institutional, and pharmacy). **Lower rates indicate better performance for both record omission and record surplus.**

Table 3-76—Record Omission and Surplus, by Encounter Type

Encounter Data Type	Record Omission			Record Surplus		
	Denominator	Numerator	Rate	Denominator	Numerator	Rate
Professional	17,291,078	80,822	0.5%	17,431,329	221,073	1.3%
Institutional	10,080,235	38,958	0.4%	10,082,002	40,725	0.4%
Pharmacy	8,819,951	52,184	0.6%	8,799,209	31,442	0.4%

Note: Lower rates indicate better performance.

Table 3-77 through Table 3-82 display the results for key data elements related to encounter types: professional. institutional, and pharmacy, respectively. These tables include information on element omission, element surplus, element missing values, and element accuracy. **For the element omission and surplus indicators, lower rates indicate better performance. For the element accuracy indicator, higher rates indicate better performance.** However, for the element missing values indicator, lower or higher rates do not indicate better or worse performance.

Table 3-77—Element Omission, Surplus, and Missing Values: Professional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 17,210,256						
Member ID	0	0.0%	0	0.0%	0	0.0%
Detail Service From Date	0	0.0%	0	0.0%	0	0.0%
Detail Service To Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Rendering Provider NPI	0	0.0%	0	0.0%	0	0.0%
Referring Provider NPI	0	0.0%	359,327	2.1%	10,367,089	60.2%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	0	0.0%	0	0.0%	9,439,637	54.8%
Procedure Code (CPT/HCPCS)	0	0.0%	0	0.0%	0	0.0%
Procedure Code Modifier	0	0.0%	0	0.0%	9,120,511	53.0%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Units of Service	0	0.0%	0	0.0%	0	0.0%
Drug Code	0	0.0%	0	0.0%	16,412,548	95.4%
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **WLP**'s data.
[3] Indicates the number of records with missing values in HHS' and **WLP**'s data.

Table 3-78—Element Omission, Surplus, and Missing Values: Institutional Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 10,041,277						
Member ID	0	0.0%	0	0.0%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Header Service To Date	0	0.0%	0	0.0%	0	0.0%
Admission Date	0	0.0%	0	0.0%	8,211,495	81.8%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Attending Provider NPI	0	0.0%	0	0.0%	4,559	<0.1%
Referring Provider NPI	0	0.0%	0	0.0%	9,682,826	96.4%
Primary Diagnosis Code	0	0.0%	0	0.0%	0	0.0%
Secondary Diagnosis Code(s)	302,887	3.0%	0	0.0%	1,439,426	14.3%
Procedure Code (CPT/HCPCS)	10,303	0.1%	0	0.0%	1,443,870	14.4%
Procedure Code Modifier	1	<0.1%	0	0.0%	7,442,169	74.1%
Units of Service	0	0.0%	0	0.0%	0	0.0%
Primary Surgical Procedure Code	0	0.0%	0	0.0%	9,588,162	95.5%
Secondary Surgical Procedure Code(s)	0	0.0%	0	0.0%	9,745,791	97.1%
Drug Code	1	<0.1%	0	0.0%	8,929,952	88.9%
Revenue Code	14	<0.1%	0	0.0%	0	0.0%
DRG Code	18	<0.1%	0	0.0%	9,331,082	92.9%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Detail Paid Amount	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **WLP**'s data.
[3] Indicates the number of records with missing values in HHS' and **WLP**'s data.

Table 3-79—Element Omission, Surplus, and Missing Values: Pharmacy Encounters

Key Data Element	Element Omission		Element Surplus		Element Missing Values	
	Number of Records[1]	Rate	Number of Records[2]	Rate	Number of Records[3]	Rate
Number of Matched Records: 8,767,767						
Member ID	0	0.0%	4	<0.1%	0	0.0%
Header Service From Date	0	0.0%	0	0.0%	0	0.0%
Billing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Prescribing Provider NPI	0	0.0%	0	0.0%	0	0.0%
Drug Code	0	0.0%	0	0.0%	0	0.0%
Drug Quantity	0	0.0%	0	0.0%	0	0.0%
Header Paid Amount	0	0.0%	0	0.0%	0	0.0%
Dispensing Fee	0	0.0%	0	0.0%	0	0.0%

Note: Lower rates indicate better performance for element omission and element surplus.
[1] Indicates the number of records with values not in HHS' data.
[2] Indicates the number of records with values not in **WLP**'s data.
[3] Indicates the number of records with missing values in HHS' and **WLP**'s data.

Table 3-80—Element Accuracy: Professional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	17,210,256	17,210,256	100%
Detail Service From Date	17,210,256	17,210,256	100%
Detail Service To Date	17,210,256	17,210,256	100%
Billing Provider NPI	17,210,256	17,210,256	100%
Rendering Provider NPI	17,210,256	17,188,318	99.9%
Referring Provider NPI	6,483,840	6,483,840	100%
Primary Diagnosis Code	17,210,256	17,210,256	100%

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Secondary Diagnosis Code(s)	7,770,619	7,770,619	100%
Procedure Code (CPT/HCPCS)	17,210,256	17,210,253	>99.9%
Procedure Code Modifier	8,089,745	8,089,745	100%
Units of Service	17,210,256	17,210,250	>99.9%
Drug Code	797,708	797,708	100%
Detail Paid Amount	17,210,256	17,210,250	>99.9%

Table 3-81—Element Accuracy: Institutional Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	10,041,277	10,041,277	100%
Header Service From Date	10,041,277	10,041,277	100%
Header Service To Date	10,041,277	10,041,277	100%
Admission Date	1,829,782	1,829,775	>99.9%
Billing Provider NPI	10,041,277	10,041,277	100%
Attending Provider NPI	10,036,718	10,036,718	100%
Referring Provider NPI	358,451	358,451	100%
Primary Diagnosis Code	10,041,277	9,645,066	96.1%
Secondary Diagnosis Code(s)	8,298,964	6,048,395	72.9%
Procedure Code (CPT/HCPCS)	8,587,104	8,587,094	>99.9%
Procedure Code Modifier	2,599,107	2,599,107	100%
Units of Service	10,041,277	10,041,266	>99.9%
Primary Surgical Procedure Code	453,115	453,115	100%
Secondary Surgical Procedure Code(s)	295,486	292,500	99.0%
Drug Code	1,111,324	1,111,313	>99.9%
Revenue Code	10,041,263	10,027,887	99.9%
DRG Code	710,177	704,737	99.2%
Header Paid Amount	10,041,277	10,041,277	100%
Detail Paid Amount	10,041,277	10,041,265	>99.9%

Table 3-82—Element Accuracy: Pharmacy Encounters

Key Data Element	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values in Both Data Sources	Rate
Member ID	8,767,763	8,767,084	>99.9%
Header Service From Date	8,767,767	8,767,767	100%
Billing Provider NPI	8,767,767	8,731,529	99.6%
Prescribing Provider NPI	8,767,767	8,767,738	>99.9%
Drug Code	8,767,767	8,754,413	99.8%
Drug Quantity	8,767,767	8,767,119	>99.9%
Header Paid Amount	8,767,767	8,752,724	99.8%
Dispensing Fee	8,767,767	8,767,767	100%

Table 3-83 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (missing or non-missing) for all key data elements relevant to each encounter data type.

Table 3-83—All-Element Accuracy by Encounter Type

Encounter Data Type	Number of Records With Values Present in Both Data Sources	Number of Records With Same Values Present in Both Data Sources	Rate
Professional	17,210,256	16,829,017	97.8%
Institutional	10,041,277	7,462,104	74.3%
Pharmacy	8,767,767	8,701,839	99.2%

Table 3-84 displays the overall encounter accuracy rates by MCO and encounter type. All results presented are based on the number of claims in the primary file, with a higher match rate indicating better performance.

Table 3-84—Overall Encounter Accuracy by Encounter Type

Encounter Data Type	HHS to WLP			WLP to HHS		
	Match	Partial Match	No Match	Match	Partial Match	No Match
Professional	96.3%	2.4%	1.3%	97.2%	2.4%	0.5%
Institutional	84.4%	15.3%	0.3%	84.4%	15.3%	0.3%
Pharmacy	98.9%	0.7%	0.4%	98.7%	0.7%	0.6%

Note: The sum of Match, Partial Match, and No Match rates may not equal 100 percent due to rounding.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Across all three encounter types (i.e., professional, institutional, and pharmacy encounters), **WLP**-submitted encounters demonstrated complete data with low record omission and surplus rates, indicating strong data integrity. **[Quality]**

Strength #2: Among encounters successfully matched between HHS-submitted and **WLP**-submitted encounters, all three encounter types exhibited a high level of element completeness, as reflected by consistently low element omission and surplus rates. **[Quality]**

Strength #3: For professional and pharmacy encounters, all key data elements showed a high level of element accuracy, reinforcing the reliability of **WLP**'s data submissions for these encounter types. **[Quality]**

Weaknesses and Recommendations

Weakness #1: WLP had a low element accuracy rate (below 95.0 percent) for the *Secondary Diagnosis Code(s)* data element and lower-than-expected element accuracy rate for the *Primary Diagnosis Code* data element within the institutional encounters. **[Quality]**

Why the weakness exists: The discrepancy in accuracy rates for both the *Primary* and *Secondary Diagnosis Code(s)* data elements stems from **WLP**'s approach to data extraction. According to its data discrepancy report response, **WLP** extracted all available diagnosis codes from the encounter, rather than limiting extraction to only those expected per submission standards. This comprehensive extraction process resulted in discrepancies when comparing **WLP**-submitted encounters with HHS-submitted encounters, as the latter may have applied more restrictive inclusion criteria. The over-inclusion of diagnosis codes led to mismatches, contributing to the lower element accuracy rates observed in the validation process.

Recommendation: HSAG recommends that **WLP** collaborate with HHS to clarify and align encounter submission standards for diagnosis coding. This includes confirming expectations for the number and type of diagnosis codes that should be reported to ensure consistency in data processing. Additionally, **WLP** should refine its data extraction protocols by implementing validation checks that distinguish between required and supplemental diagnosis codes. Establishing clear internal guidelines for diagnosis code inclusion will help reduce discrepancies, improve alignment with HHS standards, and enhance the accuracy of encounter data submissions. Regular audits and monitoring of extracted diagnosis codes can further ensure compliance with standardized reporting expectations and reduce future data integrity issues.

Consumer Assessment of Healthcare Providers and Systems Analysis

Performance Results

Table 3-85 presents **WLP**'s 2024 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores. Arrows (↓ or ↑) indicate 2024 scores that were statistically significantly higher or lower than the 2023 national average.

Table 3-85—Summary of CY 2024 CAHPS Top-Box Scores for WLP

	2024 Adult Medicaid	2024 General Child Medicaid	2024 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	85.02%	84.77%	85.22%
Getting Care Quickly	84.53%	89.38% ↑	91.70%
How Well Doctors Communicate	95.02% ↑	94.27%	95.90% ↑
Customer Service	NA	NA	NA
Global Ratings			
Rating of All Health Care	52.38%	70.07%	68.63%
Rating of Personal Doctor	68.38%	76.32%	75.49%
Rating of Specialist Seen Most Often	66.00%	68.14%	69.89%
Rating of Health Plan	57.41%	67.71%	62.92%
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	75.32%		
Discussing Cessation Medications	43.67%		
Discussing Cessation Strategies	40.13%		
CCC Composite Measures/Items			
Access to Specialized Services			69.50%
Family Centered Care (FCC): Personal Doctor Who Knows Child			92.14%
Coordination of Care for Children With Chronic Conditions			72.96% ↓
Access to Prescription Medicines			88.96%
FCC: Getting Needed Information			91.59%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).

* These scores follow NCQA's methodology of calculating a rolling two-year average.

↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.

↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the CAHPS survey against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the CAHPS survey have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: Adult members reported positive experiences with perceived quality communication with their personal doctor, as the score for the *How Well Doctors Communicate* measure was statistically significantly higher than the 2023 NCQA adult Medicaid national average. **[Quality]**

Strength #2: Parents/caretakers of child members in the general child population reported positive experiences getting care quickly for their child, as the score for the *Getting Care Quickly* measure was statistically significantly higher than the 2023 NCQA child Medicaid national average. **[Quality** and **Timeliness]**

Strength #3: Parents/caretakers of child members in the CCC Medicaid population reported positive experiences with communication with their child's personal doctor, as score for the *How Well Doctors Communicate* measure was statistically significantly higher than the 2023 NCQA CCC Medicaid national average. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Parents/caretakers of child members in the CCC Medicaid population reported less positive overall experiences in coordinating their child's chronic conditions, as the *Coordination of Care for Children With Chronic Conditions* measure was statistically significantly lower than the 2023 NCQA CCC Medicaid national average. **[Quality]**

Why the weakness exists: When compared to national benchmarks, the results indicate that parents/caretakers of child members in the CCC Medicaid population did not rate their experience in coordinating their child's care highly.

Recommendation: HSAG recommends that **WLP** solicit feedback from parents/caretakers through surveys or town halls to identify specific concerns for follow up. HSAG recommends that **WLP** consider family and child members co-design of interventions involving care coordination, as that can broaden the range of ideas and might improve overall effectiveness. One study discusses care coordination approaches shown to be effective for child members with chronic conditions, which include having a team-based organization of care, a designated care coordinator, digital information sharing, as well as completing care plans and member registries.[21] Examples of information that can be shared digitally with children, family, and the care team include pre-visit summaries, care plans, and medical summaries.[22]

[21] Chow, Andrea J et al. "Family-centered care interventions for children with chronic conditions: A scoping review." Health expectations: an international journal of public participation in health care and health policy vol. 27,1 (2024): e13897. doi:10.1111/hex.13897.

[22] Council on Children with Disabilities and Medical Home Implementation Project Advisory Committee. "Patient- and family-centered care coordination: a framework for integrating care for children and youth across multiple systems." *Pediatrics* vol. 133,5 (2014): e1451-60. doi:10.1542/peds.2014-0318.

Scorecard

The 2024 Iowa Managed Care Program MCO Scorecard was designed to compare MCO-to-MCO performance using HEDIS and CAHPS measure indicators. As such, MCO-specific results are not included in this section. Refer to the Scorecard activity in Section 7—MCP Comparative Information to review the 2024 Iowa Health Link MCO Scorecard, which is inclusive of **WLP**'s performance.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **WLP**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **WLP**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 3-86 displays each applicable performance area and the EQR activity results that indicate whether the MCO positively (✓) or negatively (✗) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **WLP**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **WLP**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 3-86—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
2.0 Access to Care	**Improve Behavioral Health Network Adequacy** ✓ **WLP** achieved rates at or above the 90th percentile for *Follow-Up After Hospitalization for Mental Illness* for both the 7-day and 30-day indicators. **Improve Access to Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Access to Primary Care and Specialty Care** NA During CY 2024, a PIP topic, *SDOH Screening* was initiated, and **WLP** received a designation of High Confidence for Validation Rating 1 of the Design phase. While no data were reported for this PIP during CY 2024, this PIP has the potential to impact this objective. Performance of this PIP will be assessed in future technical reports as part of the PIP activity. NA The NAV EQR activities did not produce data to assess the impact of provider-to-member ratios for this objective. However, as the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for PCPs and specialists. As such, performance of these measures	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** ✓ **WLP**'s performance for the *Metabolic Monitoring for Children and Adolescents on Antipsychotics–Blood Glucose and Cholesterol Testing–Total* measure rate for MY 2023 (26.43%) indicates that it is making progress towards achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Metabolic Monitoring for Children and Adolescents on Antipsychotics* (*Blood Glucose and Cholesterol*), *(APM) from 23.6% to 30% by SFY2027.* ✓ **WLP**'s performance for the *Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* measure rate for MY 2023 (81.38%) indicates it achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027.* ✓ **WLP**'s measure rate of 49.23% for *Initiation of SUD Treatment–Total* and 19.43% *Engagement of SUD Treatment–Total* indicated progress toward achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement by SFY2027.* **Improve Prenatal and Postpartum Comprehensive Care Management** ✓ **WLP** demonstrated improvement over the three-year time period for the *Prenatal and Postpartum Care* measure rates indicating that it is impacting the Iowa HHS Medicaid Quality Strategy objectives to *Increase prenatal visits in the first trimester by 5% (59%) by SFY 2027* and *increase Postpartum visits from 5% (32%) by SFY2027.* **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA *LTSS-6: LTSS Admission to a Facility from the Community*-While data were reported and validated through the PMV activity, benchmarks for this	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-7: LTSS Minimizing Facility Length of Stay*-While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity. NA *LTSS-8: LTSS Successful Transition After Long-Term Facility Stay*-While data were reported and validated through the PMV activity, benchmarks for this measure have not been established by HHS so **WLP**'s impact on this objective could not be assessed. Performance of this measure will be assessed in future technical reports, when data are available, and as part of the PMV activity.	
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Maternal Health** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in LTSS Services** NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☒ Timeliness ☒ Access
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access

Strategic Priority	Overall Performance Impact	Performance Domain
5.0 Voice of the Customer	✗ **WLP**'s score for *Rating of All Health Care* for the general child Medicaid population was 70.07 percent which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ For the adult Medicaid population, **WLP** had a score for the *Rating of Specialist Seen Most Often* of 66.00 percent, 68.14 percent for the general child Medicaid population, and 69.89 percent for the CCC Medicaid supplemental population, which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. ✗ **WLP** achieved a score of 43.67 percent for *Discussing Cessation Medications* for the adult Medicaid population, which could indicate a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Use the national average as a benchmark for CAHPS survey questions*. NA The EQR activities did not produce sufficient data to assess the impact of this objective. **WLP** did not have a minimum of 100 responses for the *Customer Service* measure for the general child Medicaid population. Performance of this measure will be assessed in future technical reports as part of the CAHPS activity.	☒ Quality ☐ Timeliness ☐ Access

4. Assessment of Prepaid Ambulatory Health Plan Performance

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2024 review period to evaluate the performance of PAHPs on providing quality, timely, and accessible healthcare services to DWP and Hawki members. Quality, as it pertains to EQR, means the degree to which the PAHPs increased the likelihood of members' desired outcomes through structural and operational characteristics; the provision of services that were consistent with current professional, evidenced-based knowledge; and interventions for performance improvement. Timeliness refers to the elements defined under §438.68 (adherence to HHS' network adequacy standards) and §438.206 (adherence to HHS' standards for timely access to care and services). Access relates to members' timely use of services to achieve optimal outcomes, as evidenced by how effective the PAHPs were at successfully demonstrating and reporting on outcomes for the availability and timeliness of services.

HSAG follows a step-by-step process to aggregate and analyze data collected from all EQR activities and draw conclusions about the quality, timeliness, and access to care furnished by each PAHP.

- **Step 1**: HSAG analyzes the quantitative results obtained from each EQR activity for each PAHP to identify strengths and weaknesses that pertain to the domains of quality, timeliness, and access to services furnished by the PAHP for the EQR activity.
- **Step 2**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across EQR activities for each domain and HSAG draws conclusions about overall quality, timeliness, and access to care and services furnished by the PAHP.
- **Step 3**: From the information collected, HSAG identifies common themes and the salient patterns that emerge across all EQR activities related to strengths and weaknesses in one or more of the domains of quality, timeliness, and access to care and services furnished by the PAHP.

Objectives of External Quality Review Activities

This section of the report provides the objectives and a brief overview of each EQR activity conducted in CY 2024 to provide context for the resulting findings of each EQR activity. For more details about each EQR activity's objectives and the comprehensive methodology, including the technical methods for data collection and analysis, a description of the data obtained and the related time period, and the process for drawing conclusions from the data, refer to Appendix A. Table 4-1 provides HSAG's timeline for conducting each of the EQR activities.

Table 4-1—Timeline for EQR Activities

Activity	EQR Activity Start Date	EQR Activity End Date
PIPs	July 30, 2024	January 13, 2025
PMV	August 5, 2024	February 28, 2025
Compliance Review	April 12, 2024	November 1, 2024
NAV	January 18,2024	January 31, 2025
EDV	March 14, 2024	February 24, 2025

Validation of Performance Improvement Projects

For the CY 2024 validation, the PAHPs continued the HHS-mandated PIP topic to address annual preventive dental visits, reporting Remeasurement 2 data for the performance indicators. HSAG conducted validation on the PIP Design (Steps 1 through 6, which included a review of each PAHP's selected PIP topic, aim statement, identified population, sampling method, performance indicator(s), and data collection procedures, as applicable), Implementation (Step 7—Review the Data Analysis and Interpretation of PIP Results and Step 8—Assess the Improvement Strategies), and Outcomes (Step 9—Assess the Likelihood that Significant and Sustained Improvement Occurred) stages of the selected PIP topic for each PAHP. Table 4-2 outlines the selected PIP topics and performance indicators for the PAHPs.

Table 4-2—PIP Topics and Performance Indicators

PAHP	PIP Topic	Performance Indicators
DDIA	*Annual Preventative Dental Visits*	1. (DWP adults) The percentage of members 19 years of age and older [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.
		2. (Hawki) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.
		3. (DWP kids) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.
MCNA	*Increase the Percentage of Dental Services*	1. The percentage of members 19 years of age and older who had at least one preventive dental visit during the measurement year.
		2. The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.

Performance Measure Validation

For the EQR time frame under evaluation, HSAG completed PMV activities for **DDIA** and **MCNA** to validate enrollment and eligibility, claims and encounter, provider data processing, and data integration and validation procedures that contribute to CMS Core Set and HHS state-specific reporting. HSAG also validated data integration and measure production processes of an HHS vendor, IBM Watson (IBM), who is contracted with HHS to provide aggregate performance measure rates for all Medicaid populations for CMS Core Set reporting. HSAG validated data from MY 2023 (January 1, 2023 – December 31, 2024) for the CMS Core Set measures and SFY 2024 (July 1, 2023 – June 30, 2024) for the state-specific performance measures.

Table 4-3 lists the CMS Core Set performance measures validated during the MY 2023 during the PMV activity.

Table 4-3—PAHP Core Set Performance Measures Validated

Performance Measure Name and Indicator	Measure Source
Oral Evaluation, Dental Services	CMS Child Core Set
Sealant Receipt on Permanent First Molars	CMS Child Core Set
Topical Fluoride for Children	CMS Child Core Set

Table 4-4 lists the PAHP state-specific performance measures that HSAG validated, the Iowa populations reported, the method chosen by HHS for data collection, and the specification steward.

Table 4-4—PAHP State-Specific Performance Measures Validated

Performance Measure Name	Program	Method	Required Specification Steward
Members With at Least Six Months of Coverage	DWP, DWP Kids, Hawki	Administrative	HHS
Members Who Accessed Dental Care	DWP	Administrative	HHS
Members Who Received Preventive Dental Care	DWP, DWP Kids, Hawki	Administrative	HHS
Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation	DWP	Administrative	HHS
Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation	DWP	Administrative	HHS
Members Who Received a Preventive Examination and a Follow-Up Examination	DWP	Administrative	HHS
Providers Seeing Patients	DWP Kids	Administrative	HHS

Compliance Review

HHS requires its contracted PAHPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet mandatory EQR requirements. The compliance reviews focus on standards identified in 42 CFR §438.358(b)(1)(iii) and applicable state-specific contract requirements. The current three-year compliance review cycle was initiated in CY 2024 and comprises 14 program

areas referred to as standards. At HHS's direction, HSAG conducted a review of the first seven federally required standards and requirements in Year One (CY 2024) and a review of the remaining federally required seven standards and requirements will be reviewed in Year Two (CY 2025) of the three-year compliance review cycle. In CY 2026 (Year Three), the compliance review activity will consist of a re-review of the standards that were not fully compliant during the CY 2024 (Year One) and CY 2025 (Year Two) compliance review activities, as indicated by the elements (i.e., requirements) that received *Not Met* scores and required corrective action plans (CAPs) to remediate the noted deficiencies. Table 4-5 outlines the standards reviewed over the three-year review cycle.

Table 4-5—Compliance Review Standards

Standard	Associated Federal Citation[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each PAHP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross-referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

[2] This standard includes a comprehensive assessment of the PAHP's information systems (IS) capabilities.

Network Adequacy Validation

In CY 2024, HSAG conducted and completed NAV activities for two PAHPs—**DDIA** and **MCNA**.

States that contract with PAHPs to provide Medicaid or CHIP services are required to develop quantitative network adequacy standards across a subset of provider types to set expectations for each contracted PAHP provider networks. States may elect to use a variety of quantitative standards including, but not limited to, minimum provider-to-member ratios, time and distance, percentage of providers accepting new patients, and/or combinations of these quantitative measures. Based on the state-defined network adequacy standards, the State and the EQRO defined the network adequacy indicators, which the EQRO then validated. The indicators are metrics used to assess adherence to the quantitative network adequacy standards required and set forth by the State. HHS identified network adequacy indicators to be validated for the reporting period(s) of SFY 2024. Table 4-6 lists the network adequacy standards and the indicators that HSAG validated.

Table 4-6—PAHP Network Adequacy Indicators Validated—PAHP Plan Time and Distance Standards

Network Category Description	Required Within Standard	Urban Area—Time/Distance Standard	Rural Area—Time/Distance Standard
Provider Type			
Dentist	At least one provider	30 minutes or 30 miles from the Dental Wellness Plan (DWP) member place of residence	60 minutes or 60 miles from the DWP member place of residence

Encounter Data Validation

In CY 2024, HSAG conducted and completed EDV activities for the two PAHPs (i.e., **DDIA** and **MCNA**). The EDV activity included:

- **Dental record review (DRR)**—analysis of HHS' electronic encounter data completeness and accuracy through a comparison of HHS' electronic encounter data to the information documented in the corresponding member's dental records.

External Quality Review Activity Results

Delta Dental of Iowa

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **DDIA**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 4-7 displays the validation ratings and performance indicators.

Table 4-7—Overall Validation Rating for DDIA

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicators	Performance Indicator Results		
				Baseline	R1	R2
Annual Preventative Dental Visits	*High Confidence*	*Moderate Confidence*	1. (DWP adults) The percentage of members 19 years of age and older [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	79.21%	79.05% ⇔	78.74% ↓
			2. (Hawki) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	61.09%	61.94% ↑	59.45% ↓
			3. (DWP kids) The percentage of members 18 years of age and younger [for six or more months of the measurement period] who had at least one preventive dental visit during the measurement year.	49.88%	50.79% ↑	51.18% ↑

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.

The goal for **DDIA**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 4-8 displays barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-8—Remeasurement 2 Barriers and Interventions for DDIA

Barriers	Interventions
Members are calling into the member services helpline multiple times in a short period of time. This creates additional burden on member services staff and creates additional barriers to accessing care and information about member benefits.	Changed member service representative talking points, developed internal procedural changes, improved customer service notes, and developed a provider information resource log and a probing questions resource document.
Young adult DWP members may not understand their benefits, the importance of regular dental services, and effective oral hygiene. Additionally, these members are undergoing many transitions, including moving out of their guardian's homes and moving away to college, which means there is a lack of updated contact information (i.e., phone numbers and addresses) on file for them.	Outbound calls consist of identified members receiving an outbound call from a live representative to educate them about their benefits, help them answer any questions and find a provider, and encourage members to update their contact information.
Members may not be receiving fluoride services and/or education because they are not regularly seeing a dentist.	Provided an informational article and webinar on fluoride varnish application.
Members are unaware of Open Choice period and resources that are available.	Hosted additional staff huddles to provide training on Open Choice changes, provided talking points and a resource hub on these changes for staff, and created additional online resources staff can refer members to.
Incorrect addresses among the Medicaid population	Care coordinators conducted outbound calls to the members to obtain updated information.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DDIA conducted accurate statistical testing between the baseline and Remeasurement 2 and provided a narrative interpretation of the comparison. The PAHP used appropriate QI tools to conduct its causal/barrier analysis. **[Quality]**

Strength #2: DDIA sustained statistically significant improvement over the baseline for the third performance indicator during the second remeasurement period. [**Quality**, **Timeliness**, and **Access**]

Weaknesses and Recommendations

Weakness #1: DDIA demonstrated a statistically significant decrease in performance for the first and second performance indicators. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: While it is unclear why the performance indicators declined as compared to the baseline, the data suggest that there are barriers for the adult and Hawki population in the receipt of preventive dental care.

Recommendation: HSAG recommends that **DDIA** revisit its causal barrier analysis to determine if any new barriers exist for the adult and Hawki populations that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

HSAG reviewed **DDIA**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **DDIA** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. HSAG did not identify any concerns with **DDIA**'s data management and reporting processes. HSAG identified minor concerns with source code logic for one measure; however, **DDIA** was able to update its source code to align with the specifications. **DDIA** was able to report valid and reportable rates.

Table 4-9 displays measure designations and reportable measure rates for DWP Adults, Table 4-10 displays measure designations and reportable measure rates for DWP Kids, and Table 4-11 displays measure designations and reportable measure rates for the Hawki program. **DDIA** received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-9—2022, 2023, and 2024 DDIA Performance Measure Designations and Rates for DWP Adults

Performance Measure		2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	268,860	287,814	*R*	230,634	—	—
2	*Members Who Accessed Dental Care*	29.09%	29.02%	*R*	230,634	66,663	28.90%
3	*Members Who Received Preventive Dental Care*	71.93%	75.21%	*R*	66,663	49,808	74.72%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	49,259	55,817	*R*	42,943	—	—
5	*Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral*	29,405	33,850	*R*	—	26,429	—

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
	Evaluation 6–12 Months Prior to the Oral Evaluation						
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	59.69%	60.64%	*R*	42,943	26,429	61.54%

— A value is not applicable to the performance measure.

Table 4-10—2022, 2023, and 2024 Performance Measure Designations and Rates for Dental Wellness Plan Kids

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	189,938	204,658	*R*	179,547	—	—
3	*Members Who Received Preventive Dental Care*	47.20%	51.15%	*R*	179,547	95,493	53.19%
7	*Providers Seeing Patients*	**	84.67%	*R*	870	753	86.55%

— A value is not applicable to the performance measure.
** The measure was not yet reported in the measurement year.

Table 4-11—2022, 2023, and 2024 Performance Measure Designations and Rates for Hawki Dental Plan

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	60,642	53,976	*R*	64,353	—	—
3	*Members Who Received Preventive Dental Care*	56.23%	61.21%	*R*	64,353	39,624	61.57%

— A value is not applicable to the performance measure.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to

and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DDIA applies quality standards through peer reviews to ensure programming code alignment with measure technical specifications. Additionally, **DDIA** analysts conduct monthly reviews of measure rates using PowerBI to monitor rate trends to drive quality improvement. **[Quality]**

Strength #2: DDIA ensures data accuracy in performance reporting by validating data from an MS SQL Server warehouse and applying version control for programming integrity. Its security includes offsite backups, a disaster recovery system, and strict access controls for data protection. These measures maintain high standards of reliability and operational resilience. **[Quality]**

Weaknesses and Recommendations

Weakness #1: During review of the Rate Reporting Template with member-level detail, HSAG observed source code restrictions applied to numerator compliance for the *DWP Unique Members With 6+ Months Coverage and Accessing Any Dental Care* and *DWP Members Who Received Preventive Dental Care* measures. **[Quality]**

Why the weakness exists: DDIA indicated that the measurement specifications did not indicate services must be completed within six months of the continuous enrollment period, which resulted in the error of incorrectly identifying numerator compliant services. **DDIA** made updates to its source code to align with the measure specifications and HSAG validated the updated code.

Recommendation: HSAG recommends that **DDIA** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications.

Weakness #2: During review of the Rate Reporting Template with member-level detail, HSAG observed that **DDIA** included third party liability claims for members who had commercial insurance, but for which Medicaid did not pay for any secondary coverage. **[Quality]**

Why the weakness exists: DDIA indicated that the third party liability (TPL) claims should not have been included in the original data pull, and that it was a gap in the source code. **DDIA** made updates to its source code to align with the measure specifications and HSAG validated the updated code.

Recommendation: HSAG recommends that **DDIA** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications.

Compliance Review

Performance Results

Table 4-12 presents an overview of the results of the standards reviewed during the CY 2024 compliance review for **DDIA**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **DDIA** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 4-12—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	20	20	17	3	0	**85%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	10	10	10	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	3	3	0	1	**100%**
Standard VI—Coordination and Continuity of Care	11	8	7	1	3	**88%**
Standard VII—Coverage and Authorization of Services	21	21	19	2	0	**90%**
Total	**86**	**82**	**76**	**6**	**4**	**93%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the Compliance Review against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the Compliance Review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DDIA achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the PAHP had appropriate processes and procedures in place related to member and PAHP requests for disenrollment. **[Quality]**

Strength #2: DDIA achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the PAHP had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. **[Timeliness** and **Access]**

Strength #3: DDIA achieved full compliance for the Availability of Services program area, demonstrating that the PAHP had policies and processes in place to ensure members could receive services timely from its network providers. **[Timeliness** and **Access]**

Strength #4: DDIA achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the PAHP had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., dental care, specialty care, dental emergency services) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: DDIA had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. **[Timeliness** and **Access]**

Why the weakness exists: DDIA did not demonstrate that all member materials adhered to State and federal requirements or that its paper provider directory included all required components.

Recommendation: While **DDIA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Network Adequacy Validation

Performance Results

HSAG assessed results submitted by **DDIA** which indicated compliance with the network adequacy requirements for dental providers. Compliance was determined based on the dental PAHP meeting HHS' time and distance standards, with no deficiencies identified. HSAG assessed SFY Q1 and Q2 reported results. Table 4-13 summarizes the percentage of members with access for the time and distance network adequacy indicators for the most recent available results during the reporting period.

Table 4-13—DDIA Q2 Percentage of Members With Access Across Time and Distance Indicators

Line of Business	Provider Type	Indicator	Percentage of Members With Access
Hawki	Dental Provider—Urban	30 minutes or 30 miles from the member place of residence	99.9%
Hawki	Dental Provider—Rural	60 minutes or 60 miles from the member place of residence	99.9%
DWP	Dental Provider—Urban	30 minutes or 30 miles from the member place of residence	99.9%
DWP	Dental Provider—Rural	60 minutes or 60 miles from the member place of residence	99.9%

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: DDIA had robust processes in place to maintain member data including outreaching directly to members if an issue with a member's address or telephone number was identified. **DDIA** staff members submitted member address and telephone number updates to HHS via an established change request portal process, which it updated in the Dental Benefit Administration System (DBAS) when the next 834 file was received. **[Access]**

Weaknesses and Recommendations

Weakness #1: No specific opportunities were identified related to the data collection and management processes that **DDIA** had in place to inform network adequacy standard and indicator calculations.

Why the weakness exists: NA

Recommendation: NA

Encounter Data Validation

Performance Results

Table 4-14 shows the dental record procurement status for **DDIA**, detailing the number of dental records requested, as well as the number and percentage of dental records submitted by **DDIA**, as indicated in the submitted tracking sheets.

Table 4-14—Dental Record Procurement Status

Number of Dental Records Requested	Number of Dental Records Submitted[1]	Percentage of Dental Records Submitted
146	146	100%

[1] The number of dental records submitted was based on **DDIA**'s responses indicated in the submitted tracking sheets.

The dental record procurement rate was **100 percent**, indicating that all requested records were successfully procured and submitted.

Table 4-15 displays the dental record and encounter data omission rates for each key data element.

Table 4-15—DRR: Encounter Data Completeness

	Dental Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	146	0.0%		
Dental Procedure Code (Current Dental Terminology [CDT]) [1]	675	9.6%	611	0.2%

* Lower rates indicate better performance.
Cells shaded in gray indicate that the study indicator is not applicable to the data element.
[1] Further clarification regarding dental record omissions related to procedure codes D9999 is provided in the narrative below.

The *Dental Procedure Code* data element had a relatively high dental record omission rate of **9.6 percent** compared to **0.0 percent** for the *Dates of Service* data element. This indicates that the *Dental Procedure Code* data element in the encounter data were not adequately supported by the members' dental records.

HSAG's review process is designed to validate whether values reported in the encounter data are supported by documentation in the dental records. Several of the dental record omissions for the *Dental Procedure Code* data element were attributed to procedure code D9999. The validation process identified higher omission rates due to the absence of supporting dental record documentation, as required by the *IA Dental Services Provider Manual (Appendix B)*. Following the completion of HSAG's analysis, HHS provided additional guidance indicating that such documentation is not required for FQHCs. As a result, the dental record omission rate for this data element may not fully reflect HHS'

intent regarding the FQHC documentation requirements. To ensure alignment with this guidance, HSAG has recommended that the *IA Dental Services Provider Manual (Appendix B)* be updated to clarify documentation expectations for FQHCs.

The *Dental Procedure Code* data element exhibited a relatively low encounter data omission rate of **0.2 percent**, suggesting that the information in the dental records was generally present in the encounter data.

Table 4-16 displays the element accuracy rates for the key data element *Dental Procedure Code* and the all-element accuracy rates.

Table 4-16—DRR: Encounter Data Accuracy

	Accuracy Results	
Data Element	**Denominator**	**Percent**
Dental Procedure Code	610	99.5%
All-Element Accuracy[1]	146	78.1%

[1] The denominator for the element accuracy rate of the key data element was defined differently from that of the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate of the data element.

The *Dental Procedure Code* data element, when evaluated independently, were accurate in **99.5 percent** of instances where codes were present in both the dental records and encounter data. However, only **78.1 percent** of dates of service present in both data sources (i.e., encounter data and dental records) contained accurate values for the key data element (i.e., *Dental Procedure Code*).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The *Dates of Service* data element identified in the encounter data were generally present in the dental records, as evidenced by the 0.0 percent dental record omission rate. **[Quality]**

Strength #2: When the *Dental Procedure Code* data element was present in both the encounter data and the members' dental records and evaluated independently, the data element was found to be accurate in 99.5 percent of records. **[Quality]**

Weaknesses and Recommendations

Weakness #1: Almost 10.0 percent of the *Dental Procedure Code* data element identified in the encounter data were not supported by the members' dental records. **[Quality]**

Why the weakness exists: Incomplete provider documentation, errors during data submission, coding inaccuracies, and data processing issues may have contributed to dental record omissions.

Recommendation: To address this finding, **DDIA** should introduce a pre-submission checklist for providers to verify the completeness of their dental records before submission. Enhancing internal validation processes in **DDIA**'s workflows could also help identify incomplete or inaccurate records prior to submission to HHS. Finally, **DDIA** should establish clear documentation standards for the *Dental Procedure Code* data element and consider linking provider performance metrics to adherence to these standards to drive improvements in record accuracy and completeness.

Weakness #2: More than 20.0 percent of the dates of service present and matching in both data sources did not contain accurate values for the dental procedure code(s). **[Quality]**

Why the weakness exists: The low overall all-element accuracy rate was caused by the dental record omission, encounter data omission, and element inaccuracy from the dental procedure code.

Recommendation: **DDIA** should focus on directly improving coding accuracy. This effort should include conducting targeted audits of *Dental Procedure Code* data element submissions to identify common errors, particularly for providers with high omission rates. Additionally, **DDIA** should develop specialized training modules for providers, focusing on accurate coding practices and addressing common mistakes with actionable guidance. Utilizing data analytics to monitor patterns of inaccuracies in the *Dental Procedure Code* data element would provide valuable insights to guide training efforts and process improvements. Finally, **DDIA** should enhance its communication with providers by offering regular feedback on coding accuracy and providing tailored recommendations to address specific issues.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **DDIA**'s aggregated performance and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **DDIA**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 4-17 displays each applicable performance area and the EQR activity results that indicate whether the PAHP positively (✓) or negatively (✗) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **DDIA**'s Medicaid and Hawki members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **DDIA**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 4-17—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Access to Primary Care and Specialty Care** ✓ During CY 2024, for the *Annual Preventative Dental Visits* PIP, **DDIA** demonstrated a statistically significant improvement over the baseline measurement period for Validation Rating 2 for the DWP kids performance indicator. ✗ **DDIA** demonstrated a statistically significant decline over the baseline measurement period for the PIP Validation Rating 2 for the DWP Adults and Hawki performance indicators.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year. ✗ Through the PMV activity, **DDIA** achieved a rate of 28.59 percent for the *Members Who Accessed Dental Care* performance measure indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last Calendar year*. NA The NAV EQR activities did not produce data to assess the impact for of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for dentists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Prenatal and Postpartum Comprehensive Care Management** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective.	☒ Quality ☒ Timeliness ☒ Access
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective. **Address Disparities in Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Address Disparities in LTSS Services NA The EQR activities did not produce data to assess the impact of this objective. **Address Disparities in Primary and Specialty Care Services** NA The EQR activities did not produce data to assess the impact of this objective.	
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators for the PAHP program under this indicator objective.	☒ Quality ☐ Timeliness ☐ Access

Managed Care of North America Dental

Validation of Performance Improvement Projects

Performance Results

HSAG's validation evaluated the technical methods of **MCNA**'s PIP (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG assigned Validation Rating 1 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence of adherence to acceptable methodology for all phases of the PIP and Validation Rating 2 (i.e., *High Confidence, Moderate Confidence, Low Confidence, No Confidence*) based on overall confidence that the PIP achieved significant improvement. Table 4-18 displays the validation ratings and performance indicators.

Table 4-18—Overall Validation Rating for MCNA

PIP Topic	Validation Rating 1*	Validation Rating 2*	Performance Indicators	Performance Indicator Results		
				Baseline	R1	R2
Increase the Percentage of Dental Services	*High Confidence*	*Moderate Confidence*	1. The percentage of members 19 years of age and older who had at least one preventive dental visit during the measurement year.	61.70%	60.19% ↓	61.13% ⇔
			2. The percentage of members 18 years of age and younger who had at least one preventive dental visit during the measurement year.	35.86%	37.88% ↑	42.28% ↑

R1 = Remeasurement 1
R2 = Remeasurement 2
↑ = Statistically significant improvement over the baseline measurement period (p value < 0.05).
⇔ = Improvement or decline from the baseline measurement period that was not statistically significant (p value ≥ 0.05).
↓ = Designates statistically significant decline over the baseline measurement period (p value < 0.05).
* Based on the scores assigned for individual evaluation elements in the PIP Validation Tool and the confidence level definitions provided in Appendix A.

The goal for **MCNA**'s PIP is to demonstrate statistically significant improvement over the baseline for the remeasurement periods. Table 4-19 displays barriers identified through QI and causal/barrier analysis processes and the interventions initiated by the PAHP to support achievement of the PIP goals and address the barriers.

Table 4-19—Remeasurement 2 Barriers and Interventions for MCNA

Barriers	Interventions
Member's lack of knowledge of benefit coverage, lack of knowledge about the importance of routine dental checkups and its ability to prevent oral	Conduct outbound calls to members who have not completed a preventive dental visit to educate them on their available benefits for dental checkups as well as the importance of routine dental care to prevent further

Barriers	Interventions
diseases, and their lack of knowing of the need to see a dentist when not in pain.	problems such as gum disease. Members are also encouraged to schedule an appointment and are offered assistance if needed.
	Members who have not received a preventive service within the last six months receive an educational postcard educating them on the importance of preventive services and encouraging them to schedule a preventive checkup.
Low provider reimbursement rates as compared to program administrative costs.	Providers receive an additional $10 when they see members for a recall visit.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PIP validation against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PIP validation have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCNA conducted accurate statistical testing between the baseline and second remeasurement period and provided a narrative interpretation of the comparison. The PAHP used appropriate QI tools to conduct its causal/barrier analysis. **[Quality]**

Strength #2: MCNA sustained statistically significant improvement over the baseline for the second performance indicator during the second remeasurement period. [**Quality, Timeliness,** and **Access**]

Weaknesses and Recommendations

Weakness #1: MCNA demonstrated a decline in performance as compared to the baseline for the first performance indicator. **[Quality, Timeliness,** and **Access]**

Why the weakness exists: While it is unclear why the performance indicator declined as compared to the baseline, the data reported demonstrated improvement as compared to the prior year.

Recommendation: HSAG recommends that **MCNA** revisit its causal barrier analysis to determine whether any new barriers exist for the adult population that require the development of targeted strategies to improve performance.

Performance Measure Validation

Performance Results

HSAG reviewed **MCNA**'s eligibility and enrollment data system, claims and encounter data processing system, provider data system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, **MCNA** demonstrated it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report accurate encounter data and performance measure rates to HHS. HSAG did not identify any concerns with **MCNA**'s processes. **MCNA** was able to report valid and reportable rates.

Table 4-20 displays measure designation and reportable measure rates for DWP Adults, and Table 4-21 displays designation and reportable measure rates for DWP Kids. **MCNA** received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-20—2022, 2023, and 2024 Performance Measure Designations and Rates for Dental Wellness Plan

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	160,048	174,100	*R*	136,683	—	—
2	*Members Who Accessed Dental Care*	17.29%	16.00%	*R*	136,683	22,554	16.50%
3	*Members Who Received Preventive Dental Care*	61.70%	60.66%	*R*	22,554	13,777	61.08%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	13,729	14,819	*R*	13,777	—	—
5	*Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation*	5,439	6,156	*R*	—	4,868	—

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	39.62%	41.54%	*R*	11,623	4,868	41.88%

— A value is not applicable to the performance measure.

Table 4-21—2022, 2023, and 2024 Performance Measure Designations and Rates for Dental Wellness Plan Kids

	Performance Measure	2022 Rate	2023 Rate	2024 Measure Designation	2024 Rate		
					Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	122,314	125,471	*R*	102,435	—	—
3	*Members Who Received Preventive Dental Care*	35.86%	38.33%	*R*	102,435	44,114	43.07%
7	*Providers Seeing Patients*	**	63.78%	*R*	319	283	88.71%

— A value is not applicable to the performance measure.
** The measure was not yet published in the measurement year.

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the PMV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the PMV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCNA's strong data quality and well-structured comprehensive database management system effectively supported performance indicators, reporting, and data validation, ensuring quick access to accurate data for timely error identification and reporting. **[Quality]**

Weaknesses and Recommendations

Weakness #1: HSAG did not identify any weaknesses during the 2024 activity.
Why the weakness exists: NA
Recommendation: NA

Compliance Review

Performance Results

Table 4-22 presents an overview of the results of the standards reviewed during the CY 2024 compliance review for **MCNA**. HSAG assigned a score of *Met* or *Not Met* to each of the individual elements it reviewed based on a scoring methodology, which is detailed in Appendix A. If a requirement was not applicable to **MCNA** during the period covered by the review, HSAG used a *Not Applicable* (*NA*) designation. In addition to an aggregated score for each standard, HSAG assigned an overall percentage-of-compliance score across all seven standards.

Table 4-22—Summary of Standard Compliance Scores

Standard	Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
			M	*NM*	*NA*	
Standard I—Disenrollment: Requirements and Limitations	7	7	7	0	0	**100%**
Standard II—Member Rights and Member Information	20	20	17	3	0	**85%**
Standard III—Emergency and Poststabilization Services	13	13	13	0	0	**100%**
Standard IV—Availability of Services	10	10	10	0	0	**100%**
Standard V—Assurances of Adequate Capacity and Services	4	3	3	0	1	**100%**
Standard VI—Coordination and Continuity of Care	11	8	7	1	3	**88%**
Standard VII—Coverage and Authorization of Services	21	21	17	4	0	**81%**
Total	**86**	**82**	**74**	**8**	**4**	**90%**

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

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

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

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

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the Compliance Review against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the Compliance Review have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCNA achieved full compliance for the Disenrollment: Requirements and Limitations program area, demonstrating that the PAHP had appropriate processes and procedures in place related to member and PAHP requests for disenrollment. **[Quality]**

Strength #2: MCNA achieved full compliance for the Emergency and Poststabilization Services program area, demonstrating that the PAHP had adequate processes in place to ensure appropriate coverage of and payment for emergency and poststabilization care services. **[Timeliness** and **Access]**

Strength #3: MCNA achieved full compliance for the Availability of Services program area, demonstrating that the PAHP had policies and processes in place to ensure members could receive services timely from its network providers. **[Timeliness** and **Access]**

Strength #4: MCNA achieved full compliance for the Assurances of Adequate Capacity and Services program area, demonstrating that the PAHP had policies and processes in place to maintain and monitor an adequate provider network to provide adequate access to all services (e.g., dental care, specialty care, dental emergency services) for its membership. **[Timeliness** and **Access]**

Weaknesses and Recommendations

Weakness #1: MCNA had three elements in the Member Rights and Member Information program area that received a score of *Not Met*, indicating that members may not be notified of or receive required member materials and information timely. **[Timeliness** and **Access]**

Why the weakness exists: MCNA did not demonstrate that all member materials adhered to State and federal requirements or that it provided timely notification to members for all provider terminations.

Recommendation: While **MCNA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP conduct a comprehensive review of its member-facing materials and its processes and procedures related to member information to identify whether additional opportunities for improvement in this program area exist and take remedial action as necessary.

Weakness #2: MCNA had four elements in the Coverage and Authorization of Services program area that received a score of *Not Met*, indicating members may not consistently receive timely and adequate notice of authorization decisions, including decisions that result in an adverse benefit determination to the member. **[Quality** and **Timeliness]**

Why the weakness exists: MCNA did not consistently adhere to requirements related to the timing of authorization decisions (e.g., expedited, exception to advance notice for a termination, suspension, or reduction of a previously authorized service) and content of notices of adverse benefit determination.

Recommendation: While **MCNA** was required to develop a CAP to address the deficiencies identified, HSAG recommends that the PAHP continually evaluate its processes, procedures, and monitoring efforts to ensure compliance with all federal and State obligations specific to coverage and authorization of services. Further, HSAG recommends that the PAHP begin preparations to implement the new seven calendar day authorization time frame, including but not limited to, updating policies, procedures, the member handbook, and the provider manual.

Network Adequacy Validation

Performance Results

HSAG assessed results submitted by **MCNA** which indicated compliance with the network adequacy requirements for dental providers. Compliance was determined based on the dental PAHP meeting HHS' time and distance standards, with no deficiencies identified. HSAG assessed SFY Q1 and Q2 reported results. Table 4-23 summarizes the percentage of members with access for the time and distance network adequacy indicators for the most recent available results during the reporting period.

Table 4-23—MCNA Q2 Percentage of Members With Access Across Time and Distance Indicators

Line of Business	Provider Type	Indicator	Percentage of Members With Access
DWP	Dental Provider—Urban	30 minutes or 30 miles from the member place of residence	96.3%
DWP	Dental Provider—Rural	60 minutes or 60 miles from the member place of residence	99.9%

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the NAV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the NAV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: MCNA had established a robust process to maintain the accuracy and completeness of member information by combining member-reported data along with data from the 834 file. Although the 834 file was the source of truth, member-reported data were always recorded and saved within DentalTrac. **[Access]**

Weaknesses and Recommendations

Weakness #1: MCNA checked provider Medicaid exclusion at credentialing and recredentialing (every three years), as well as on an ad hoc basis. **[Access]**

Why the weakness exists: MCNA utilizes minimum requirements for verification of provider exclusion status.

Recommendation: HSAG recommends that **MCNA** implement a monthly regular check of providers against Medicaid exclusion resources.

Encounter Data Validation

Performance Results

Table 4-24 shows the dental record procurement status for **MCNA**, detailing the number of dental records requested, as well as the number and percentage of dental records submitted by **MCNA**, as indicated in the submitted tracking sheets.

Table 4-24—Dental Record Procurement Status

Number of Dental Records Requested	Number of Dental Records Submitted[1]	Percentage of Dental Records Submitted
146	143	97.9%

[1] The number of dental records submitted was based on **MCNA**'s responses indicated within the submitted tracking sheets.

The dental record procurement rate was **97.9 percent**, indicating that nearly all requested records were successfully procured and submitted.

Table 4-25 displays the dental record and encounter data omission rates for each key data element.

Table 4-25—DRR: Encounter Data Completeness

	Dental Record Omission		Encounter Data Omission	
Data Element	Denominator	Percent*	Denominator	Percent*
Date of Service	146	2.7%		
Dental Procedure Code (CDT) [1]	621	10.3%	557	0.0%

* Lower rates indicate better performance.
Cells shaded in gray indicate that the study indicator is not applicable to the data element.
[1] Further clarification regarding dental record omissions related to procedure codes D9999 and D0999 is provided in the narrative below.

The *Dental Procedure Code* data element had a relatively high dental record omission rate of **10.3 percent** compared to **2.7 percent** for the *Dates of Service*. This indicates that the *Dental Procedure Code* data element in the encounter data were not adequately supported by the members' dental records.

HSAG's review process is designed to validate whether values reported in the encounter data are supported by documentation in the dental records. Several of the dental record omissions for the *Dental Procedure Code* data element were attributed to procedure codes D9999 and D0999. For D9999, the validation process identified higher omission rates due to the absence of supporting dental record documentation, as required by the *IA Dental Services Provider Manual (Appendix B)*. Following the completion of HSAG's analysis, HHS provided additional guidance indicating that such documentation is not required for FQHCs. As a result, the dental record omission rate for this data element may not fully reflect HHS' intent regarding the FQHC documentation requirements. To ensure alignment with this guidance, HSAG has recommended that the *IA Dental Services Provider Manual (Appendix B)* be

updated to clarify documentation expectations for FQHCs. For D0999, MCNA informed HHS in July 2024 that an FQHC had been inadvertently billing D0999 for encounter submissions instead of D9999, as directed by HHS. By that time, HSAG had already received data from HHS to conduct the dental record review based on the documentation requirements outlined in the *IA Dental Services Provider Manual*. HSAG's review determined that, according to the available data, the submitted dental records did not contain documentation supporting the procedure code reported in the encounter data. Following the completion of HSAG's analysis, HHS clarified that documentation for this procedure code would not typically be expected in the dental records. To ensure alignment with this guidance, HSAG has recommended that the *IA Dental Services Provider Manual (Appendix B)* be updated to clarify documentation expectations for FQHCs.

The *Dental Procedure Code* data element exhibited a **0.0 percent** encounter data omission rate, suggesting that the information in the dental records was also present in the encounter data.

Table 4-26 displays the element accuracy rates for the key data element *Dental Procedure Code* and the all-element accuracy rates.

Table 4-26—DRR: Encounter Data Accuracy

	Accuracy Results	
Data Element	**Denominator**	**Percent**
Dental Procedure Code	557	99.1%
All-Element Accuracy	142	67.6%

[1] The denominator for the element accuracy rate of the key data element was defined differently from that of the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate of the data element

The *Dental Procedure Code* data element, when evaluated independently, were accurate in **99.1 percent** of instances where codes were present in both the dental records and encounter data. However, only **67.6 percent** of dates of service present in both data sources (i.e., encounter data and dental records) contained accurate values for the key data element (i.e., *Dental Procedure Code*).

Strengths, Weaknesses, and Recommendations

Through the EQR, HSAG assessed the findings for the EDV against the domains of quality, timeliness, and access. Substantial strengths and weaknesses within the findings of the EDV have been linked to and impacted one or more of these domains. If a domain is not associated with an identified strength or weakness, the findings did not determine significant impact to the quality, timeliness, and/or accessibility of care.

Strengths

Strength #1: The *Dates of Service* identified in the encounter data were generally present in the dental records, as evidenced by the **2.7 percent** dental record omission rate. **[Quality]**

Strength #2: When the *Dental Procedure Code* data element was present in both the encounter data and the members' dental records and evaluated independently, the data element was found to be accurate in 99.1 percent of records. **[Quality]**

Weaknesses and Recommendations

Weakness #1: More than 10.0 percent of the *Dental Procedure Code* data element identified in the encounter data were not supported by the members' dental records**. [Quality]**

Why the weakness exists: Non-submitted dental records and incomplete provider documentation contribute to dental record omissions, as the expected information in the dental records cannot be compared to the encounter data. Additional contributing factors include errors during data submission, coding inaccuracies, and data processing issues.

Recommendation: To address this finding, **MCNA** should focus on improving dental record procurement processes. This includes working with providers to ensure the submission of complete and accurate dental records for all requested cases. Strategies could include targeted outreach to non-responsive providers or implementing contractual penalties for non-compliance. Additionally, **MCNA** should introduce a pre-submission checklist for providers to verify the completeness of their dental records before submission. Enhancing internal validation processes in **MCNA**'s workflows could also help identify incomplete or inaccurate records prior to submission to HHS. Finally, **MCNA** should establish clear documentation standards for the *Dental Procedure Code* data element and consider linking provider performance metrics to adherence to these standards to drive improvements in record accuracy and completeness.

Weakness #2: Almost 30.0 percent of the dates of service present and matching in both data sources did not contain accurate values for the dental procedure code(s). **[Quality]**

Why the weakness exists: The low overall all-element accuracy rate was caused by the dental record omission, encounter data omission, and element inaccuracies in the dental procedure code.

Recommendation: To address this finding, **MCNA** should focus on directly improving coding accuracy. This effort should include conducting targeted audits of *Dental Procedure Code* data element submissions to identify common errors, particularly for providers with high omission rates. Additionally, **MCNA** should develop specialized training modules for providers, focusing on accurate coding practices and addressing common mistakes with actionable guidance. Utilizing data analytics to monitor patterns of inaccuracies in *Dental Procedure Code* and *Dates of Service* data elements would provide valuable insights to guide training efforts and process improvements. Finally, **MCNA** should enhance its communication with providers by offering regular feedback on coding accuracy and providing tailored recommendations to address specific issues.

Overall Conclusions for Quality, Timeliness, and Access to Healthcare Services

HSAG performed a comprehensive assessment of **MCNA**'s aggregated performance, and its overall strengths and weaknesses related to the provision of healthcare services that impacted, or will have the likelihood to impact, member health outcomes. HSAG also considered how **MCNA**'s overall performance contributed to the Iowa Managed Care Program's progress in achieving the Iowa HHS Medicaid Quality Strategy strategic priorities and objectives. Table 4-27 displays each applicable performance area and the EQR activity results that indicate whether the PAHP positively (✓) or negatively (✗) impacted the Iowa Managed Care Program's progress toward achieving the applicable strategic priorities and the overall performance impact related to the quality, timeliness, and accessibility of care and services provided to **MCNA**'s Medicaid members. Additionally, not applicable (**NA**) was used if an Iowa HHS Medicaid Quality Strategy priority or related objective did not include any quality measures for **MCNA**'s programs or the EQR activities did not produce data to assess the impact under an Iowa HHS Medicaid Quality Strategy objective.

Table 4-27—Overall Performance Impact to Iowa HHS Medicaid Quality Strategy and Quality, Timeliness, and Access

Strategic Priority	Overall Performance Impact	Performance Domain
1.0 Access to Care	**Improve Behavioral Health Network Adequacy** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP for this service. **Improve Access to Primary Care and Specialty Care** ✓ During CY 2024, for the *Increase the Percentage of Dental Services* PIP, **MCNA** demonstrated a statistically significant improvement over the baseline measurement period for Validation Rating 2 for the percentage of members 18 years of age and younger performance indicator. ✓ During CY 2024, for the *Increase the Percentage of Dental Services* PIP, **MCNA** demonstrated a slight improvement for Validation Rating 2 (61.13%) when compared to Validation Rating 1 (60.19%) for the percentage of members 19 years of age and older performance indicator.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year. ✗ Through the PMV activity, **MCNA** achieved a rate of 16.50 percent for the *Members Who Accessed Dental Care* indicating a negative impact on the Iowa HHS Medicaid Quality Strategy objective to *Increase the number of members with 6+ month coverage accessing care who accessed dental care within the last calendar year*. NA The NAV EQR activities did not produce data to assess the impact for of provider-to-member ratios for this objective. However, the Iowa HHS Medicaid Quality Strategy indicated that HHS would update the network adequacy standards to include minimum required provider-to-member ratios for dentists. As such, performance of these measures will be assessed in future technical reports when included as part of the NAV and compliance activities.	
2.0 Whole Person Coordinated Care	**Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Improve Prenatal and Postpartum Comprehensive Care Management** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Improve Whole Person Coordinated Care for Members Enrolled in LTSS Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP.	☒ Quality ☒ Timeliness ☒ Access
3.0 Health Equity	**Address Disparities in Behavioral Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Address Disparities in Maternal Health** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP.	☒ Quality ☒ Timeliness ☒ Access

Strategic Priority	Overall Performance Impact	Performance Domain
	Address Disparities in LTSS Services NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP. **Address Disparities in Primary and Specialty Care Services** NA The Iowa HHS Medicaid Quality Strategy does not include specific indicators that are applicable to the PAHP.	
4.0 Program Administration	**Grievances, Appeals, and Exception to Policy** NA The EQR activities did not produce data to assess the impact of this objective. **Improve Coordination and Continuity of Care Between Medical MCOs and Dental PAHPs** NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access
5.0 Voice of the Customer	NA The EQR activities did not produce data to assess the impact of this objective.	☒ Quality ☐ Timeliness ☐ Access

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2024 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Managed Care Program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2023 External Quality Review Technical Report* are summarized in Table 5-1, Table 5-2 and Table 5-3. The MCO's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identified performance improvement, and/or barriers identified are also provided in Table 5-1, Table 5-2, and Table 5-3.

Iowa Total Care, Inc.

Table 5-1—Prior Year Recommendations and Responses for ITC

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • The *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP demonstrated a statistically significant decrease in performance compared to the baseline. HSAG recommends that **ITC** revisit its causal barriers analysis to determine if any new barriers exist that require the development of targeted strategies to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **ITC** reviewed CY2023 child CAHPS survey results during a Member and Provider Experience Council meeting in July 2023. Council members identified that the transition to a new telephony system for **ITC**'s Customer Service department may have caused member abrasion with their health plan's customer service which was reflected on CAHPS survey responses. The transition to a new telephony system, Amazon Workforce Solutions (AWS), caused the following impacts to the Customer Service team: incidents of calls not connecting properly, reduced audio quality, and IVR misrouting. • For 2023, the Member Services department focused on repeat caller reduction and call quality to improve the member experience and maximize member retention via daily Integrated Voice Response (IVR) checks and repeat caller identification. • For daily IVR checks, Member Services staff utilized an IVR test map to check the functionality of each IVR option listed when a member called into Member Services. Initial analysis of call data showed that 18.5% of callers in a month called more than 1 time and 6.0% called 5 or more times. The Member Services team developed an improvement initiative to resolve system and operator errors that interfere with call continuity and develop processes to assist repeat callers and permanently resolve their concerns.

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
• As a result, the team resolved 5 routing errors in the IVR routing system that drove members to call multiple times. Additionally, an IT Swat Team assisted individual front line staff to set their systems to the optimal configuration, replaced and updated malfunctioning or incompatible equipment, and educated staff on system use. • Additionally, the Member Services department identified a small percentage of members who called 5 or more times a month. To strive towards resolving all member questions and issues in the first call, Member Services began identifying repeat callers on a weekly basis and conducting outreach to these members to resolve issues causing frequent calls. • Outreach to repeat callers began in December 2023 and will continue into 2024. Member Services will share repeat caller outreach data and findings with Quality Improvement to identify opportunities to address members' concerns when calling into their health plan's Member Services department.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The initiatives mentioned above decreased the percentage of members making five or more calls in a month from 6% to 3.7% by the end of calendar year 2023. • For CY2024, **ITC**'s final rate for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* was 87.2%, an increase from 79.4% from the year before.
c. Identify any barriers to implementing initiatives: • One barrier identified in the repeat caller outreach is that many **ITC** members may not have consistent access to a phone, which could impede outreach efforts. For instance, some members may lose phone service before contact is made, while others may rely on family or friends' phones to reach **ITC**, without having a personal phone of their own.
HSAG Assessment: HSAG has determined that **ITC** addressed the prior year's recommendations by conducting a review of the data, developing targeted interventions, and demonstrating improvement in the performance indicator rate as compared to the prior year, as reported above. However, the CY 2024 PIP topic changed from what was reported in CY 2023; therefore, HSAG was unable to validate any performance improvement.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **ITC**'s performance in the Women's Health domain remained low, as the *Chlamydia Screening in Women—Total* measure ranked below the 25th percentile. Continually low rates indicate that a large percentage of women were not being seen or screened by their providers for chlamydia. Chlamydia is one of the most frequently reported bacterial sexually transmitted infections in the United States. Early detection of chlamydia can help reduce or eliminate adverse health problems associated with untreated conditions. HSAG recommends that **ITC** partner with primary care and obstetrics/gynecology (OB/GYN) providers to determine why some females were not screened for chlamydia. **ITC** should also evaluate access to primary care and OB/GYN services in its network for females who were noncompliant for the measure. Further, HSAG also recommends that **ITC** conduct an analysis to evaluate whether particular age groups or racial/ethnic groups have a significantly different rate for accessing chlamydia screenings. Upon identification of a root cause, **ITC** should implement appropriate interventions (member education, transportation assistance, member rewards program, etc.) to improve low performance rates within the Women's Health domain.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• **ITC**'s performance in the Behavioral Health domain continued to rank below the 25th percentile for *Diabetes Monitoring for People with Diabetes and Schizophrenia* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*. These low rates indicate that patients receiving behavioral health treatment and using antipsychotic medication were not always being monitored properly. Addressing the physical health needs of members diagnosed with mental health conditions is an important way to improve overall health, quality of life, and economic outcomes. Additionally, monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications. HSAG recommends that **ITC** conduct an analysis of member and provider data to identify ongoing trends in noncompliance after integration of behavioral health initiatives, reviewing data for elements such as geographic location, age groups or racial and ethnic groups, and provider-associated noncompliance. Upon identification of the root cause for ongoing noncompliance, **ITC** should implement appropriate interventions (member education campaigns, transportation assistance, member rewards program, provider education, care coordination, etc.) to improve low performance rates within the Behavioral Health domain.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: *Chlamydia Screening in Women—Total* (CHL) - In October 2023, an analysis of the CHL denominator was completed. Based on the findings barriers and opportunities were identified and interventions implemented Barriers and Opportunities - 1. Lack of medical records or claims data captured in our systems - capturing Chlamydia testing for members in the denominator that also delivered during the measurement year. 2. Limited of provider knowledge on Chlamydia screenings, clinical practice guidelines or best practices - Opportunity to Identify Best practices from high performing provider groups to share best practices. 3. Member Lack of knowledge of preventive care services or age range for this service 4. Member lack of transportation for service due to member location Interventions implemented. 1. Quality Practice Advisors surveyed high performing provider groups for best practices. Once identified, their best practices were added to CHL training, and offered training to lower performing provider groups. Completed 3 snack chats (short educational learnings provided at provider offices during breaks or office meetings) in 2023. 2. Women's Preventive Health Text sent to members includes link to website with information on transportation and my health pay rewards. 3. Medical Record Abstraction of OBGYN records for non-compliant PPC and CHL members - • October 2023 - Provider Education on CHL HEIDS measure with Member Care gap list to providers by Quality Practice Advisors during routine PCP and OBGYN visits from October to December 2023. Information about the Members Value Added services and My Health pay rewards was also shared. In Development – Lab Claim review – CPT 87801 is a bundled lab code for Chlamydia and Gonorrhea testing of the urine and not an acceptable code to close the CHL care gap for HEDIS. Analysis is currently being

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
completed to determine if providers are using this code versus the Chlamydia codes accepted in the NCQA value set. If provider trends are identified, education on proper coding will be completed. *Diabetes Monitoring for People with Diabetes and Schizophrenia (SMD)* and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* -Analysis of member data identified members completing glucose test more often than cholesterol. When cholesterol test is completed, providers are ordering total cholesterol for adults instead of LDL -C. BH and Health Home providers identified during 2023 Quality Practice Advisor outreach visits that they were unaware for the need for annual lab monitoring, while others indicated they let the PCP order. When communicating with PCP, the Quality Practice Advisors identified lack of coordination of care between the PCP and BH provider on with the who is will be ordering the lab (completing the metabolic monitoring) as a potential barrier. Barriers and Opportunities • BH provider and PCP not coordinating care on who is ordering labs annually. • Only one of the two required labs (blood glucose and cholesterol testing) being complete. • BH and Health Home providers lack of knowledge on clinical practice guidelines and HEDIS measures for APM and SMD Interventions 1. Provider education flyer explaining the importance of the APM measure as children can develop diabetes or high cholesterol due to medication and checking lab values to help with early detection and management of potential complications. Additionally, education for adult members needing LDL-C and not total cholesterol. 2. Quarterly BH provider outreach from Quality Practice Advisor – educating BH providers on HEDIS measures – including SMD and APM – Explaining the need for monitoring lab values for certain medication and coordinating care with PCP providers. 3. Increase Supplemental Data including Standard files and EMR connectivity to increase lab capture. 4. BH Microlearning's offered through **ITC** – sent out through provider alerts for all provider types- on demand trainings, such - Strategies to Improve Cardiovascular, Diabetes, and Metabolic Monitoring: APM, SSD, SMC, and SMD HEDIS Measures. In development for 2024 include: • Coordination of Care letter addressed to Assigned PCP and Attributed BH provider for members that need Glucose and Cholesterol testing with greater than 1 year gap, signed by our CMO educating the providers that the member is on Antipsychotic medication and has not had the annual metabolic monitoring as recommended by clinical practice guidelines
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • CHL- There was no noted improvement in 2023 final rates. • SMD/APM – SMD- 10%-point increase from MY2022 to MY2023 final results. APM – 3%-point increase from MY2022 to MY2023 final results,
c. Identify any barriers to implementing initiatives: • CHL - Providers indicate additional initiatives may not be the solution - they identified members go to public health to receive testing and do not have the results shred with PCP or do not indicate Sexually active on Screening- per the clinical practice guidelines, if not sexually active, providers should educate and not test. • SMD/APM – No Barriers identified

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG Assessment: HSAG has determined that **ITC** partially addressed the prior year's recommendations and made improvements in two performance measures, *Diabetes Monitoring for People with Diabetes and Schizophrenia and Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*. While the *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* measure increased by 3 percentage points, plan performance for this measure remained under the 25th percentile. In addition, interventions to increase *Chlamydia Screening in Women—Total* did not affect MY 2023 performance. HSAG recommends that **ITC** continue to focus on improvement strategies and targeted interventions for those measures that continued to demonstrate low performance.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **ITC** did not remediate one of the two CAP elements for the Coverage and Authorization standard, indicating continued gaps in the MCO's processes for issuing an ABD for payment denials. HSAG recommends that **ITC** proceed with its existing plans of action to implement the ABD for denial of payment process to comply with federal rule.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **Collaboration and Mapping:** After collaborating with other MCOs (Molina and WellPoint), **ITC** mapped our internal explanation codes to the standardized CARC and RARC codes, ensuring consistency in ABD notifications across all plans. • **Submission and Approval:** The finalized list was submitted to HHS for review and approval, ensuring regulatory compliance. • **System Configuration and Testing:** We updated our claims processing system to generate ABD notifications automatically for relevant denials, performing thorough testing to ensure accuracy. • **Training and Implementation:** Staff were trained on the new process, and the ABD notification procedure was fully implemented on 2/1/2024.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **Effective Implementation:** As of February 1, 2024, ABD notifications have been successfully sent to members without any complaints from providers or members, indicating the process is working effectively. • **Clear Communication:** The use of standardized codes has improved clarity, reducing follow-up inquiries and ensuring compliance with federal regulations. • **No Enhancements Needed:** Due to the lack of reported issues or concerns, no further enhancements have been necessary since the launch.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
c. Identify any barriers to implementing initiatives: • N/A.
HSAG Assessment: HSAG has determined that **ITC** has addressed the prior recommendations based on the MCO's reported initiatives.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • Approximately 76 percent of **ITC** behavioral health providers did not have a visit with at least one new member in CY 2022. HSAG recommends combining the findings from this analysis with member experience reports to determine if there may be an access issue for pediatric patients seeking new behavioral health services. The results of this analysis, along with member experience and grievance information, can help **ITC** assess whether this represents adequate access or a potential network adequacy concern for pediatric members seeking behavioral health services.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • In 2023 **ITC**'s network team developed a process to target those not enrolled in Medicaid and noncontract providers to contract with **ITC**. This process is now integrated into our network contracting process going forward. In addition, ensuring that behavioral health providers met access and availability standards for patients with nonemergent services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Member appeals and grievances related to behavioral health services went from 18 in 2022 to 2 in 2023. • Pediatric new patient visits increased by 14% from 11.87 visits per 1000 members in 2022 to 13.53 per 1000 members in 2023. • Zero behavioral health providers surveyed for access and availability had a corrective action plan in 2023 for not meeting the standards. • Approximately 170 behavioral health providers were added to the network including 5 facility locations and 1 CMHC. • Approximately 40 additional location/providers had a new pediatric patient visit.
c. Identify any barriers to implementing initiatives: • Number of providers in rural parts of the state • Patient no shows to provider offices. • Transportation to behavioral health visits
HSAG Assessment: HSAG determined that **ITC** addressed the prior year's recommendations based on the MCO's reported initiatives. **ITC** also provided an explanation about the barriers (i.e., lack of providers in rural parts of the state) that contributed to the MCO not meeting all state-established network adequacy standards. Because the CY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
2023 release of the CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the SFY 2023 NAV activity, HSAG has provided additional recommendations to **ITC** in the "External Quality Review Activity Results" section, as necessary, based on the findings from the CY 2024 NAV audit.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: • The record omission and surplus rates for professional encounters were 5.0 percent or greater. HSAG recommends that **ITC** align its data submission practices, adhering closely to the specified data requirements and ensuring a more seamless integration into the analytical process. This adjustment will facilitate accurate and efficient data handling during subsequent phases of analysis and evaluation. • The record omission rate for institutional encounters was greater than 5.0 percent. HSAG recommends that **ITC** actively address and resolve this issue, ensuring all data are submitted accurately and completely. • **ITC** had low accuracy rates for *Billing Provider ZIP Code* for professional encounters and for Billing Provider ZIP Code and *Billing Provider Taxonomy Code* for institutional encounters. HSAG recommends that **ITC** work with HHS to ensure that provider data are sourced from the same or a similar platform. • **ITC** had a lower *Surgical Procedure Codes* accuracy rate for institutional encounters. HSAG recommends that **ITC** implement standardized quality controls to ensure accurate data extraction from its encounter data system.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Record omission and surplus variances on professional encounters: o Driven primarily by the ICN and TCN numbers being switched for the NEMT data submissions. This was remedied by confirming proper data placement on future files. o **ITC** matched ICN at 99.1% and matched TCN at 99.5% on the current CY2024 EDV audit being completed by HSAG. o **ITC** will collaborate with the State of Iowa on the audit results to ensure the recommendations are remediated. • Record omission variances for institutional encounters: o Driven primarily by data submissions with Claim frequency of "8" indicating they were voided. More than 75% of these records were found in HHS' data, therefore, **ITC** did confirm with HSAG for CY2024 EDV audit that Claim frequency 8 was to be included. o **ITC** matched ICN at 99.9% and matched TCN at 99.9% on the current CY2024 EDV audit being completed by HSAG. o **ITC** will collaborate with the State of Iowa on the audit results to ensure the recommendations are remediated. • Low accuracy rates for *Billing Provider ZIP Code* for professional and institutional encounters:

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
○ ITC sourced the billing provider zip code from the incorrect source while preparing the MCO data files for the HSAG audit. ITC validated the zip code submitted on the encounter file matches the HHS zip code. ITC will ensure this is resolved for future HSAG audits. • Low accuracy rates for *Billing Provider Taxonomy Code* for institutional encounters: ○ Iowa Total Care sourced the billing provider taxonomy from the incorrect location while preparing the MCO data files for the HSAG audit. ITC validated the taxonomy submitted on the encounter file matches the HHS billing taxonomy. ITC will ensure this is resolved for future HSAG audits. • Lower *Surgical Procedure Codes* accuracy rate for institutional encounters: • ITC only included up to 5 surgical codes, and repeated duplicate codes as submitted on the claim. ITC has notated to include up to 25 surgical codes and remove duplicated surgical codes on the data files for future HSAG audits.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • All issues were remedied via process updates or configuration changes.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG has determined that ITC partially addressed the prior year's recommendations. The record omission and surplus variances in professional encounters have been fully addressed. ITC identified that the primary issue stemmed from the misplacement of internal control numbers (ICNs) and TCNs in non-emergency medical transportation (NEMT) data submissions. This issue was corrected by ensuring proper data placement in future files. ITC's most recent EDV results show a high match rate (ICN: 99.1 percent, TCN: 99.5 percent), indicating significant improvement. Continued collaboration with HHS is necessary to prevent similar errors in future submissions. For institutional encounters, record omission variances have also been fully addressed. The discrepancies were primarily due to voided claims (claim frequency "8"), which led to these records being omitted. ITC has since confirmed with HSAG that these records should be included, which has resulted in an improved match rate (ICN: 99.9 percent, TCN: 99.9 percent) in the ongoing CY 2024 EDV activity. While these updates have significantly improved data accuracy, continued collaboration with HHS will be necessary to ensure ongoing adherence to data submission requirements. The issue of low accuracy rates for the billing provider ZIP codes in professional and institutional encounters has been fully addressed. ITC had previously sourced billing provider ZIP codes from an incorrect location when preparing the MCO data files for the HSAG audit. ITC has now validated that the ZIP codes submitted match those maintained by HHS, ensuring accurate submissions moving forward. Similarly, the issue of low accuracy rates for billing provider taxonomy codes in institutional encounters has been fully addressed. ITC initially sourced this data from the wrong location, leading to inaccuracies. ITC has since corrected this by ensuring that the taxonomy code in its data files aligns with the HHS billing taxonomies. With these corrective measures in place, ITC has resolved this issue for future HSAG EDV activities. For surgical procedure code accuracy in institutional encounters, the recommendation has been partially addressed. ITC previously included up to five surgical codes while allowing duplicate entries in its data submissions. To correct this, ITC has committed to expanding its data submission to include up to 25 surgical

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
codes and eliminating duplicate values. While this is a positive step toward improving data accuracy, the effectiveness of this correction remains to be fully validated in the upcoming activities. **ITC** did not report any barriers to implementing these recommendations. However, to ensure long-term improvements, **ITC** should establish ongoing monitoring and validation processes to prevent future discrepancies. Standardizing data submission protocols will also be beneficial in maintaining accuracy and consistency in data reporting. Additionally, maintaining close collaboration with HHS and HSAG will be essential in ensuring continued compliance with evolving data submission standards. In conclusion, **ITC** has demonstrated a strong commitment to addressing HSAG's recommendations, with some issues being fully resolved while others remain in progress. Continued oversight and validation will be necessary to ensure that the partially addressed concerns are fully remediated, and that data accuracy and compliance are maintained in future submissions.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • Parents/caretakers of child members in the general child population had less positive overall experiences with their child's health plan, as the score for the *Rating of Health Plan* measure was statistically significantly lower than the 2022 NCQA child Medicaid national average. HSAG recommends that **ITC** conduct root cause analyses or focus studies to determine why parents/caretakers of child members in the general child population are potentially perceiving a lack of overall quality of care from their child's health plan. Once a root cause or probable reasons for lower ratings are identified, **ITC** can determine appropriate interventions, education, and actions to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **ITC** reviewed CY2023 CAHPS survey data pertaining to health equity and member demographics to identify root causes as to why some members may have rated **ITC** lower than others. **ITC** found that parents/caretakers who rated their child's mental health as either good or fair/poor also rated their health plan below the plan score by 10% and 21% respectively. Additionally, parents/caretakers who rated their child's overall health as good or fair/poor also rated their health plan below the plan score by 15% and 7% respectively. • Recent studies have shown that parents/caretakers of children with special healthcare needs may rate their health plan more negatively when compared to those without special healthcare needs (Fifolt, Patel, Rucks, & Ford, 2021). Common reasons for lower health plan ratings by this group include difficulty finding in-network providers and greater need for direct assistance or help by their health plan. • **ITC** chose to promote its health plan benefits, services, and programs to the parents/caregivers of our child members in effort to improve health plan ratings through two different outreach campaigns. • The first campaign included a member mailing which consisted of a pocket calendar and member appreciation letter. The pocket calendar included information on ways members can request direct support from their health plan, including how to request care management, language assistance, and housing and community resources support. The pocket calendar also included information on how to

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
contact **ITC**'s Member Services for assistance, including how to contact Member Services by phone or by email. This information was reiterated in the accompanying member appreciation letter sent out with the calendar as well. • The second campaign included a text message outreach to members with information on **ITC**'s Doc's Kids Club and a direct link to **ITC**'s website. Doc's Kids Club is an **ITC** initiative that promotes healthy living through healthy living. Parents/caretakers who sign up receive monthly newsletters which detail **ITC** benefits and services for children. • Both the calendar and text message were sent to **ITC** members who had joined the health plan in 2023. **ITC** chose these members for these outreach campaigns as newer members may be most unfamiliar with **ITC** benefits, programs, and services. • In March 2024, 2,000 parents/caregivers of child members who had not completed an annual well visit in the past year received the Docs Kids Club text message. • In January 2024, 10,000 members who were up to date with their annual well visits were sent a pocket calendar along with a member appreciation letter.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • For CY2024, **ITC**'s child CAHPS survey measure on Rating of Health Plan increased to 71.9%, up from the previous year's rating of 67.7%. • **ITC**'s CY2024 child Rating of Health Plan scored above the 2023 QC.
c. Identify any barriers to implementing initiatives: • **ITC** will continue to outreach to new members via text message and member mailings. However, some barriers have been identified which could impact these initiatives. For example, members who are experiencing homelessness or who lack stable housing may not be able to be reached by mail. Additionally, members who do not have access to reliable telephone services may not be able to be reached by phone or text message. **ITC** will work on sharing member pocket calendars and appreciation letters during community events in order to reach members within the communities they live in.
HSAG Assessment: HSAG has determined that **ITC** addressed the prior year's recommendations, as the general child rate for *Rating of Health Plan* was not statistically significantly lower than the 2023 NCQA child Medicaid national average.

Molina Healthcare of Iowa, Inc.

Table 5-2—Prior Year Recommendations and Responses for MOL

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have sufficient data to conduct PIPs in CY 2023.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG did not identify any recommendations for **MOL** for the prior year; therefore, this section is not applicable.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, an audit was not conducted since the MCO did not have any MY 2022 performance measure data for review.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG did not identify any recommendations for **MOL** for MY 2022 performance measure data. Therefore, this section is not applicable.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the compliance review activity was not conducted. Instead, the MCO went through a comprehensive readiness review process in CY 2023 that included all federal compliance review standards. Results of the readiness review were provided to CMS, as required.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG did not identify any recommendations for **MOL** for the prior year; therefore, this section is not applicable.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, NAV was not conducted since the MCO did not have any MY 2021 and MY 2022 behavioral health utilization data for review in alignment with the CY 2023 scope for this activity. Of note, the MCO went through a comprehensive readiness review process in CY 2023 that included an assessment of **MOL**'s network. Results of the readiness review, including information about **MOL**'s network, were provided to CMS.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG did not identify any recommendations for **MOL** for the prior year; therefore, this section is not applicable.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:

HSAG recommended the following:
• **MOL** did not indicate that timeliness checks were performed for claims/encounters originating from the NEMT and pharmacy subcontractors. **MOL** should enhance its timeliness quality checks by considering, among other actions:
  ○ Implementing regular timeliness audits.
  ○ Adopting automated monitoring systems capable of tracking submission dates and generating alerts or reports for delayed submissions.
• Periodically reviewing and adjusting timeliness quality checks based on performance data and any alterations in regulations or contractual requirements.

MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MOL** receives weekly and monthly reports from subcontractors. Any discrepancies are reviewed and addressed on priority basis with the subcontractors. • **MOL** uploads the subcontractor encounter data to its Encounter Management System (EMS). Molina tracks the encounter data metrics, including timeliness and accuracy of submissions, from automated dashboards that are created based on the data that is loaded to EMS. Any discrepancies are reviewed with subcontractors during monthly meetings.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MOL**'s subcontractors have been very responsive, both timeliness and accuracy metrics for subcontractor data have been consistently above 99%.
c. Identify any barriers to implementing initiatives: • **MOL** has not experienced any barriers with the implementation of the initiatives.
HSAG Assessment: HSAG has determined that **MOL** has partially addressed the prior year's recommendations. **MOL** partially addressed HSAG's recommendations regarding timeliness checks for claims and encounters from NEMT and pharmacy subcontractors. While **MOL** implemented automated dashboards to track timeliness and accuracy, holds monthly subcontractor reviews, and reports strong compliance (above 99 percent), it has not explicitly confirmed the implementation of regular timeliness audits, automated alerts for delayed submissions, or periodic adjustments to quality checks based on performance data. No barriers were reported in implementing these initiatives. However, to fully address the recommendations, **MOL** should enhance its monitoring by incorporating automated alerts for delays, structured timeliness audits, and documented adjustments based on evolving data trends. In conclusion, **MOL** has taken meaningful steps toward improving its timeliness tracking, particularly through EMS dashboards and subcontractor engagement, but additional enhancements are needed to fully meet HSAG's recommendations. Implementing structured audits, real-time monitoring alerts, and documented quality check adjustments will further strengthen **MOL**'s data submission oversight and ensure sustained compliance with timeliness requirements.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • **MOL** did not start providing services until July 2023; therefore, CAHPS results were not available for CY 2023.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • N/A
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG did not identify any recommendations for **MOL** for the prior year; therefore, this section is not applicable.

Wellpoint Iowa, Inc.

Table 5-3—Prior Year Recommendations and Responses for WLP

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **WLP** demonstrated a statistically significant decline in performance from the baseline measurement period for the *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed* PIP. HSAG recommends that **WLP** revisit its causal/barrier analysis to determine if any new barriers exist that require the development of targeted strategies to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • As a result of the recommendations, several initiatives have been successfully implemented and are currently ongoing. Community health workers, customer service representatives, and other Health Coordinators have been actively addressing members' needs, covering a wide range of areas such as Social Determinants of Health, Care Gaps, and Social Services. In addition, efforts to enhance member engagement with care coordination have been prioritized. Additionally, ongoing education and feedback is provided to customer service/call center associates to improve the accuracy of information provided.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • No barriers have been identified.
HSAG Assessment: HSAG has determined that **WLP** addressed the prior year's recommendations by implementing updated interventions. However, the CY 2024 PIP topic changed from what was reported in CY 2023; therefore, HSAG was unable to validate any performance improvement.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • **WLP**'s performance under the Women's Health domain ranked below the 25th percentile for the *Chlamydia Screening in Women* measure, indicating that a large percentage of women were not being seen or screened by their providers. Untreated chlamydia infections can lead to serious and irreversible complications. HSAG recommends that **WLP** continue its work with providers on educational efforts, as materials may be most effective when distributed by providers in conjunction with office visits. Additionally, HSAG recommends that **WLP** conduct further analysis to evaluate whether particular racial/ethnic groups have a significantly different rate for accessing care. Upon identification of a root cause, **WLP** should implement appropriate interventions (contracting efforts, transportation assistance, care coordination, etc.) to improve the low performance rate for the *Chlamydia Screening in Women* measure. • **WLP**'s performance under the Behavioral Health domain ranked below the 25th percentile again this year for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total*. The low rate indicates that patients receiving behavioral health treatment using

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
antipsychotic medication were not always being screened or monitored properly. Monitoring of blood glucose and cholesterol testing are important components of ensuring appropriate management of children and adolescents on antipsychotic medications due to the potential side effects of these medications. HSAG recommends that **WLP** continue partnering with providers to determine why some members with severe mental illnesses are not being monitored for diabetes or for metabolic functioning, such as by providing education when needed to ensure behavioral health providers understand which tests to monitor and how to access lab testing. **WLP** should continue to work with providers and care coordination teams to implement appropriate interventions (e.g., process improvements, patient education campaigns, etc.) to improve the performance rate of this measure.
MCP's Response

a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***:

- In response to the recommendation to improve Chlamydia screening in women (CHL), we have undertaken several key initiatives. Firstly, we integrated Chlamydia screening rates into our obstetrics and pediatric quality improvement plans. This integration ensures that the metric is a priority within our performance metrics, thereby encouraging healthcare providers to enhance their screening practices. Additionally, we have carried out awareness campaigns to educate both staff and patients on the importance of regular Chlamydia screening. Ongoing activities involve continuous monitoring and analysis of screening rates to identify areas needing further improvement. We are also planning additional training sessions and patient education initiatives. These efforts are tailored to address the initial findings that led to this recommendation, aiming to substantially raise the performance percentages for Chlamydia screening among our patient population.
- Thank you for bringing to our attention the performance concerns under the Behavioral Health domain, specifically regarding Metabolic Monitoring for Children and Adolescents on Antipsychotics. We fully understand the importance of blood glucose and cholesterol testing in managing the potential side effects of antipsychotic medications in this population.

  We acknowledge that our performance in this area has ranked below the 25th percentile again this year, indicating a need for significant improvement. Ensuring that patients receiving behavioral health treatment are properly screened and monitored is a top priority for us.

  In response to the recommendations provided by HSAG, WellPoint is committed to taking the following actions:

  - Enhancing Provider Partnerships:
    - We will continue to strengthen our partnerships with providers to identify barriers to screening and monitoring for metabolic functioning.
    - Our team will collaborate more closely with providers to understand the specific challenges they face and provide targeted support. This can be done through development of survey and gathering the responses from providers.
  - Provider Education and Support:

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
▪ Creating comprehensive education campaigns aimed at behavioral health providers to emphasize the importance of regular blood glucose and cholesterol testing will be researched for future implementation. ▪ Educational materials are available to providers that outline the importance of BH and PH provider relationship. A training called "Referring Clients Between Physical & Mental Health Services" is available to providers to ensure that all providers are fully informed about the importance of both service types for the members. o Process Improvements: ▪ We will work with our care coordination teams to identify and implement process improvements that facilitate the monitoring process. ▪ This may include streamlining referral pathways to lab services, simplifying documentation requirements, and integrating reminders within electronic health records. o Patient Education Campaigns: ▪ Our plan can include launching patient education campaigns to raise awareness among members and their families about the importance of regular metabolic monitoring. ▪ These campaigns will empower patients and caregivers with information on the potential side effects of antipsychotic medications and the necessary steps for monitoring. o Intervention Strategies: ▪ Future development of targeted interventions aimed at improving our performance rate in this measure. ▪ This includes working closely with care coordination teams to ensure members with severe mental illnesses are flagged for necessary screenings and follow-ups. o Monitoring and Evaluation: ▪ Metrics to monitor the implementation and effectiveness of these initiatives can be created and used on an ongoing basis. ▪ Regular performance reviews can be conducted to track progress and make necessary adjustments to our strategies. We are committed to addressing these performance concerns and ensuring that our members receive the highest standard of care. Thank you for your guidance and partnership in this matter.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • We are pleased to report notable improvements in our CHL scores. The 16–20-year-old age cohort has achieved a score of 30.50%, while the 21–22-year-old cohort has attained a score of 43.58%. Combined, these age groups have reached an overall score of 35.84%. This progress underscores our ongoing commitment to improving care quality and outcomes for our members. • The educational trainings have been implemented and are ongoing. We are in the process of implementing the remaining initiatives for Metabolic Monitoring for Children and Adolescents on Antipsychotics.
c. Identify any barriers to implementing initiatives: • No barriers have been identified for initiatives relating to the Chlamydia Screening for Women measure.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
• No barriers have been identified for initiatives relating to the Metabolic Monitoring for Children and Adolescents on Antipsychotics measure.
HSAG Assessment: HSAG has determined that **WLP** partially addressed the prior year's recommendations. While **WLP** outlined strategies that impacted specific age stratifications for *Chlamydia Screening in Women* and had targeted interventions to improve performance rates *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total,* the overall measure rates did not improve. HSAG recommends that **WLP** continue to focus on improvement strategies and targeted interventions for those measures that continued to show low performance, as well as identify barriers.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **WLP** did not remediate two of the four CAP elements for the Member Rights and Member Information standard, indicating continued gaps in the MCO's processes to ensure all member materials were available and provided in Spanish and that the provider directory included all required information. HSAG required **WLP** to submit an action plan to address the deficiencies and provide assurances that all member materials were translated in Spanish and that **WLP** developed a methodology and outreach plan to collect accessibility data from its network providers and demonstrate significant progress in updating the provider directory with specific accessibility indicators. HSAG recommends that **WLP** conduct periodic oversight and monitoring processes to ensure that the actions taken have been fully implemented. • **WLP** did not remediate one CAP element under the Coverage and Authorization standard, indicating continued gaps in the MCO's processes for issuing an adverse benefit determination (ABD) for payment denials. HSAG recommends that **WLP** proceed with its existing plans of action to implement the ABD for denial of payment process to comply with the federal rule. • **WLP** did not remediate one element under the Grievance and Appeal Systems standard, indicating continued gaps in the MCO's appeal processes, as the MCO continued to inappropriately require a written appeal. HSAG recommends that **WLP** proceed with its existing plans of action to implement the revised ABD template and update its processes to not require written appeals following oral requests to ensure the MCO comes into compliance with this requirement.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • For the American Disabilities Act (ADA) Accessibility element, **WLP** performed a focused outreach to providers requesting specific ADA elements that are available in their practice/facility in 2023. There has been continued efforts with providers to increase the accessibility options in the provider directory. Additional symbols were added to the directories in the 1st quarter of 2024. • For the UM/Prior Auth Denial letters, the English version went live 5/10/2024 and the Spanish version went live 6/12/2024. The Spanish letter contains both static and dynamic text. The static text is currently being translated and the dynamic text is in development of implementation with estimated completion date of 1st quarter 2025.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
• Regarding the implementation of the Authorization Benefit Denial (ABD) of payment process to comply with the Federal Rule, the implementation was finalized in the 4th quarter of 2023. The Spanish portion was finalized in the 1st quarter of 2024. • Regarding the Grievance and Appeal Systems standard, Wellpoint updated its processes to not require written appeals following oral requests.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • This focused outreach provided a large jump from a yearly average of 22% in 2022 to 72% in 2023 for providers showing accessibility options in their provider directory listings. • The static text in the Auth Denial Letters is now translated in Spanish. There is currently a project of for Google Translate being implemented to provide the dynamic text translation. • Implementation of the ABD denial is in compliance with the Federal Rule. • Implementation of the removal of language in the Grievance and Appeal System standard for requiring a written appeal has been completed
c. Identify any barriers to implementing initiatives: • Barriers to the ADA Accessibility element is responsiveness of providers. • No barriers have been identified for the dynamic text of the Auth Denial Letters being translated into Spanish. • ABD denial does not have any barriers as it is fully implemented. • The Grievance and Appeal Systems standard is fully implemented.
HSAG Assessment: HSAG has determined that **WLP** addressed the prior recommendations based on MCO's reported initiatives. However, as the CY 2024 compliance review findings indicate continued opportunities for improvement pertaining to member written materials in the required minimum size font or in conspicuously visible font, the MCO should ensure that mechanisms are in place to remediate the opportunities for improvement identified.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • Seventy-four percent of **WLP** behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. HSAG recommends combining the findings from this analysis with member experience reports to determine if there may be an access issue for pediatric patients seeking new behavioral health services. The results of this analysis, along with member experience and grievance information, can help **WLP** assess whether this represents adequate access or a potential network adequacy concern for pediatric members seeking behavioral health services.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • Thank you for sharing the findings indicating that seventy-four percent of **WLP** behavioral health providers did not have a visit with at least one new pediatric member in CY 2022. We fully appreciate

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
the implications of this statistic and the importance of ensuring adequate access to behavioral health services for pediatric members. In response to HSAG's recommendation, we have conducted a thorough analysis combining these findings with member experience reports and grievance information. The results of our analysis did not identify any access issues for pediatric patients seeking new behavioral health services. While we did not find evidence of network adequacy concerns at this time, we recognize the importance of ongoing vigilance in this area. To prevent any potential issues from reoccurring, we will take the following steps: o Continued Monitoring: ▪ We will continue to closely monitor access to pediatric behavioral health services, regularly reviewing member experience data, feedback from care coordination teams, and grievance information to identify any emerging concerns. o Regular Assessments: ▪ We will conduct periodic assessments to ensure that our network continues to meet the needs of pediatric members, including evaluating provider availability and geographic distribution. o Stakeholder Engagement: ▪ We will maintain open communication with our providers, care coordinators, and other stakeholders to gather insights and address any potential barriers to access proactively. o Enhancing Communication: ▪ We will enhance our communication efforts to ensure that members and their families are aware of available behavioral health services and how to access them effectively. o Reporting and Transparency: ▪ We will provide regular updates to stakeholders on our monitoring efforts and any steps taken to address access concerns. We are committed to ensuring that our pediatric members have continuous and adequate access to behavioral health services. By maintaining rigorous monitoring and proactive measures, we aim to uphold high standards of care and service accessibility.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The initiatives for ensuring new pediatric access to behavioral health providers and education of providers are an ongoing effort and currently, **WLP** has no deficiencies in the network.
c. Identify any barriers to implementing initiatives: • No barriers have been identified for initiatives relating to new pediatric access to behavioral health providers.
HSAG Assessment: HSAG determined that **WLP** addressed the prior year's recommendations based on the MCO's reported initiatives. **WLP**'s assessment of its network adequacy for pediatric behavioral health providers did not find evidence of network adequacy concerns, however, **WLP** implemented steps to prevent any potential issues from occurring. Because the CY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of the CMS EQR Protocol 4, and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the CY 2023 NAV

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
activity, HSAG has provided additional recommendations to **WLP** within the "External Quality Review Activity Results" section, as necessary, based on the findings from the CY 2024 NAV audit.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: • **WLP** had low accuracy rates for the *Billing Provider ZIP Code* data element for professional encounters. HSAG recommends that **WLP** work with HHS to ensure that provider data are sourced from the same or a similar platform. • The data element accuracy rate for *Surgical Procedure Codes* for **WLP** was 0.0 percent. HSAG recommends that **WLP** monitor and update programmatic scripts to ensure that all conditions are being met to submit complete and accurate data.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **WLP** consistently populates the billing provider information exactly as received from the inbound claims, adhering to the Iowa Department of Health and Human Services (HHS) billing guidelines. Additionally, we will continue to collaborate with HHS to ensure that our data submission remains compliant with their requirements. • **WLP** made the recommended updates to the script used to extract the surgical procedure code.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The changes made to the script were updated in accordance with the 2024 HSAG request. No issues were identified with the accuracy rate of the surgical procedure codes.
c. Identify any barriers to implementing initiatives: • No barriers currently.
HSAG Assessment: HSAG has determined that **WLP** partially addressed the prior year's recommendations. For billing provider ZIP codes, HSAG identified low accuracy rates in the professional encounters and recommended that **WLP** work with HHS to ensure provider data is sourced correctly. In response, **WLP** stated that it follows HHS' billing guidelines and continues to collaborate with HHS to maintain compliance. However, it is not explicitly stated whether data sourcing issues have been fully resolved or ongoing monitoring has been implemented to prevent recurrence. Therefore, this issue remains partially addressed until further validation confirms improvement. Regarding surgical procedure codes, HSAG noted a 0.0 percent accuracy rate and recommended that **WLP** review and update programmatic scripts to ensure proper data submission. **WLP** confirmed that it updated the script as requested in 2024, and no further issues have been identified with the accuracy rate. Based on this response, this issue appears to be fully addressed. **WLP** reported no barriers to implementing these initiatives. However, to fully address the billing provider ZIP code issue, **WLP** should ensure that a formalized process for periodic data validation and monitoring is in

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
place. Continued collaboration with HHS and internal audit mechanisms will help maintain data accuracy and compliance over time. In conclusion, **WLP** has taken corrective actions to improve data accuracy, successfully resolving issues related to surgical procedure codes while still needing additional monitoring to fully address billing provider ZIP code accuracy. Continued oversight, proactive data validation, and regular internal checks will help ensure long-term compliance with HSAG's recommendations.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
HSAG recommended the following: • Adult members had less positive overall experiences with the specialist they saw most often and their health plan, as scores for the *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures were statistically significantly lower than the 2022 NCQA adult Medicaid national averages. HSAG recommends that **WLP** consider if any barriers exist to receiving timely care from specialists that may result in lower levels of experience or if there is a shortage of providers or certain specialists in the area. Additionally, **WLP** may conduct root cause analyses or focus studies to determine why adult members are potentially perceiving a lack of overall quality of care from their health plan. Once a root cause or probable reasons for lower ratings are identified, **WLP** can determine appropriate interventions, education, and actions to improve performance. • Parents/caretakers of child members in the CCC population had less positive overall experiences with their child's health plan, as the score for the *Rating of Health Plan* measure was statistically significantly lower than the 2022 NCQA CCC Medicaid national average. HSAG recommends that **WLP** conduct root cause analyses or focus studies to determine why parents/caretakers of child members in the CCC population are potentially perceiving a lack of overall quality of care from their child's health plan. Once a root cause or probable reasons for lower ratings are identified, **WLP** can determine appropriate interventions, education, and actions to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • To address the finding that adult members had less positive experiences with their specialists and health plan, several initiatives have been implemented and are currently underway. Completed activities include conducting root cause analyses and focus studies to identify potential barriers and reasons for lower ratings. We have also enhanced access to specialists by working closely with our healthcare network team to maintain network adequacy and address any barriers to timely care. Furthermore, efforts to contract with additional specialists in areas of need are ongoing to ensure members have more options and receive timely, quality care. • In response to the finding that parents and caretakers of child members in the CCC population had less positive experiences with their child's health plan, several initiatives have been implemented. Comprehensive root cause analyses and focus studies were conducted to identify potential reasons for lower ratings. We have enhanced access to specialists by collaborating with our healthcare network team to maintain network adequacy and are actively contracting with additional specialists in areas of need. Targeted interventions and educational programs have been introduced to improve care quality.

6. Prior Year Recommendation from the EQR Technical Report for CAHPS Analysis
Pediatric quality improvement providers' key performance indicators have been aligned to better serve pediatric members with chronic conditions. Furthermore, we are executing a contract amendment to decrease the caseloads of long-term services and supports case managers, allowing for increased focus on individual members. No barriers have been identified during the implementation of these initiatives, underscoring our commitment to enhancing care quality.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • N/A
c. Identify any barriers to implementing initiatives: • Overall, no barriers have been identified during the implementation of these initiatives.
HSAG Assessment: HSAG has determined that **WLP** addressed the prior year's recommendation, as rates for adults for the *Rating of Specialist Seen Most Often* and *Rating of Health Plan* measures were not statistically significantly lower than the 2023 NCQA adult Medicaid national averages.

6. Follow-Up on Prior EQR Recommendations for PAHPs

From the findings of each PAHP's performance for the CY 2024 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Managed Care Program. The recommendations provided to each PAHP for the EQR activities in the *Calendar Year 2023 External Quality Review Technical Report* are summarized in Table 6-1 and Table 6-2. The PAHP's summary of the activities that were either completed, or were implemented and still underway, to improve the finding that resulted in the recommendation, and as applicable, identifies performance improvement, and/or barriers identified are also provided in Table 6-1 and Table 6-2.

Delta Dental of Iowa

Table 6-1—Prior Year Recommendations and Responses for DDIA

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **DDIA** met 88 percent of the requirements within the Design stage of the project. The Design stage establishes the methodological framework for the PIP, and any gaps in the framework may impact the accuracy of the data reported. HSAG recommends that **DDIA** describe and collect data for the eligible population as defined in the HHS specifications.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DDIA** inadvertently submitted the incorrect Current Dental Terminology (CDT) codes with the CY23 PIP validation review and Delta Dental has ensured the correct CDT codes will be submitted during the CY24 PIP validation review to be in alignment with HHS specifications. The CDT codes will be reviewed and verified by the Quality Management and Improvement Committee.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The correct CDT codes will be submitted with **DDIA**'s CY24 PIP validation submission.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **DDIA** addressed the prior year's recommendations by accurately reporting the eligible population within the most recent submission.
2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • During review of the Rate Reporting Template with member-level detail, HSAG observed source code restrictions applied to numerator compliance for the *Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation and*

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
Received an Oral Evaluation 6–12 Months Prior to the Oral Evaluation measure. Although **Delta Dental** confirmed updates to its source code pertaining to the measure specifications, HSAG recommends that **DDIA** conduct additional review of the measurement specifications and conduct visual validation of the rate template using filters or formulas prior to HHS or HSAG submission to ensure all data are reported accurately against the technical specifications. • **DDIA**'s rates for the *Members Who Accessed Dental Care* measure continued to gradually decline in 2022 and 2023. HSAG recommends that **DDIA** conduct a segmentation analysis of the noncompliant members to identify trends in demographics for the noncompliant population. HSAG also recommends that **DDIA** identify targeted interventions to increase knowledge and awareness of dental care benefits for members within their first year of eligibility.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DDIA** previously used the source code that was utilized for the Performance Improvement Projects, which included incorrect CDT codes. **DDIA** has corrected the CDT codes included in that source code. **DDIA** conducts ongoing monitoring, peer review, and validation checks of all source codes to ensure accuracy. • During the Public Health Initiative – Unwinding, **DDIA** saw a large increase in membership causing the denominator to be larger, and access or onboarding of providers did not increase at the same rate as membership. Although there was a large shift in membership, and a fairly stagnant shift in provider access, **DDIA** was still able to provide services to over 223,000 members, which is in line with previous years. **DDIA** conducts and participates in various outreach methods to increase member awareness of dental benefits available to them.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There is an increased confidence level in the source code since correcting the CDT codes and by conducting additional peer review and data validation checks.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **DDIA** partially addressed the prior year's recommendations. While **DDIA** reported conducting additional validation checks and has increased confidence in the source code, HSAG identified another error in measure specifications during the 2024 PMV activity. In addition, performance rates for *Members Who Accessed Dental Care* did not improve for the CY 2024 review period.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **DDIA** did not remediate two of the three CAP elements for the Member Rights and Member Information standard, indicating continued gaps in the PAHP's processes to ensure that all critical member materials included appropriate taglines and that the provider directory included all required information. HSAG required **DDIA** to submit an action plan to address the deficiencies and demonstrate that taglines in the prevalent non-English languages in Iowa are in a conspicuously visible font size and explain the availability of written translation or oral interpretation to understand the information provided, include information on how to request auxiliary aids and services, and include the toll-free and TTY/TDD

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
telephone number of the PAHP's member/customer service unit as stipulated in 42 CFR §438.10. **DDIA** was also required to demonstrate that all critical member materials include taglines, develop a methodology and outreach plan to collect accessibility data from its network providers, and demonstrate significant progress in updating the provider directory with specific accessibility indicators. As such, HSAG recommends that **DDIA** continue to implement its action plans to assure full remediation of the deficiencies. HSAG also recommends that **DDIA** complete an annual review of its taglines for all critical member materials and the provider directory to ensure continued compliance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DDIA** updated its taglines document to ensure it aligned with both State and Federal requirements and double-checked that it was added to all critical member materials. **DDIA** outlined the use and importance of the taglines document within an internal policy-procedure to properly educate all staff on the use of taglines. **DDIA** implemented a Member Communications workgroup that is responsible for reviewing all member documents to ensure they are meeting the Member Rights and Member Information standards (i.e., font size, required information, reading level, taglines). **DDIA** has updated and displayed accessibility data on its network provider directory for all members to access. The Professional Relations (PR) team added questions to the credentialing and recredentialing forms and actively reached out to offices to collect the accessibility data for prompt implementation into the directory. Also, the PR team remains in frequent communication with provider offices and if a provider office were to relocate, the provider directory would be updated accordingly. All member and provider materials are reviewed, updated, and validated annually as part of our internal work plan.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **DDIA** staff is in alignment with use and importance of the taglines document. The additional data on provider's and their offices better assist customer service representatives when providing care coordination to members.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **DDIA** has addressed the prior recommendations based on the initiatives reported; however, since similar findings were determined in CY 2024, the PAHP should continue its current processes and initiatives focused on ensuring taglines are in conspicuously visible font and included in all critical member materials.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • Of the cases reached, 54.7 percent of provider locations accepted **DDIA**, 48.9 percent accepted Medicaid, and 40.1 percent accepted new patients. HSAG recommends that **DDIA** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect Medicaid acceptance and new patient acceptance) to address the provider data deficiencies and educate providers' offices on the Medicaid program. Additionally, **DDIA** should adhere to any remediation requirements imposed by HHS.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
• Among the cases reached, the overall appointment rate was 24.8 percent, with an overall average wait time of 55 calendar days for **DDIA**. HSAG recommends that **DDIA** work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **DDIA** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DDIA** conducted an internal review of provider offices after HSAG's study by calling and confirming new patient acceptance status for both Dental Wellness Plan (DWP) and Hawki programs. **DDIA** understands there may have been confusion from providers when answering this question during HSAG's study as they were answering for both DWP and Hawki programs collectively, and not separately. Some providers only accept new patients for one program, and not both. **DDIA** makes frequent contact with provider offices and during those conversations and meetings we verify information we have on file is correct. • **DDIA** updated the Provider Office Manual to include appointment requirements and updated the Member Handbooks by adding average appointment wait times for general dentist, specialist, and emergent services, along with contact information should a member have questions regarding appointment times.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG determined that **DDIA** addressed the prior year's recommendations based on the PAHP's reported initiatives. Because the CY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of the CMS EQR Protocol 4 and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the CY 2023 NAV activity, HSAG has provided additional recommendations to **DDIA** in the "External Quality Review Activity Results" section, as necessary, based on the findings from the CY 2024 NAV audit.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following:
• *Tooth Surface* information was captured without values in HHS' MMIS, suggesting a potential gap in the transmission of data to HHS through encounter submissions. Although **DDIA** has initiated discussions on these discrepancies with HHS, HSAG recommends continued collaboration to actively address and resolve the issue, ensuring accurate and complete data transmission for tooth surface information. • When *Oral Cavity Code* values were compared to values within HHS' data, some values did not match. HSAG recommends that **DDIA** submit all the detail lines for each claim to ensure a comprehensive and aligned representation of data elements, minimizing discrepancies in *Oral Cavity Code* values.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **DDIA** collaborated with HHS to resubmit and validate the encounter submissions and is implementing additional internal checks or processes to ensure internal changes do not influence reporting to HHS moving forward. • **DDIA** collaborated with HHS to resubmit and validate alignment in all data elements for Oral Cavity Code and is implementing additional internal checks or processes to ensure internal changes do not influence reporting to HHS moving forward.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that **DDIA** partially addressed the prior year's recommendations. For *Tooth Surface* information, HSAG identified a potential gap in data transmission to HHS, leading to missing values in MMIS. **DDIA** collaborated with HHS to resubmit and validate encounter submissions and is implementing additional internal checks to prevent future reporting discrepancies. While these actions demonstrate progress, the long-term effectiveness of these measures remains to be validated, making this issue partially addressed. Regarding *Oral Cavity Code* values, HSAG found discrepancies between **DDIA**'s submitted data and HHS' records. **DDIA** responded by working with HHS to resubmit and validate all data elements while also introducing internal controls to prevent reporting inconsistencies. These efforts align with HSAG's recommendations; however, ongoing monitoring is necessary to confirm sustained accuracy, so this issue is also considered partially addressed. **DDIA** reported no barriers to implementation, suggesting that the corrective actions were feasible and within operational capacity. However, to fully address the recommendations, **DDIA** should continue regular audits, data validation reviews, and ongoing collaboration with HHS to ensure that corrections remain effective over time. In conclusion, **DDIA** has taken proactive steps to improve data accuracy, but continued oversight and validation are needed to confirm that the implemented measures resolve the identified issues. Strengthening internal monitoring processes and maintaining consistent collaboration with HHS will be crucial to achieving full compliance with HSAG's recommendations.

Managed Care of North America Dental

Table 6-2—Prior Year Recommendations and Responses for MCNA

1. Prior Year Recommendation from the EQR Technical Report for Performance Improvement Projects:
HSAG recommended the following: • **MCNA** demonstrated a statistically significant decline in performance for the first performance indicator. HSAG recommends that **MCNA** revisit its causal barrier analysis to determine if any new barriers exist for the adult population that require the development of targeted strategies to improve performance.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MCNA**'s QI team gathered feedback from network providers through quarterly Quality Improvement Committee (QIC) and Dental Advisory Committee (DAC) meetings to identify any new provider and or member barriers they have encountered. Additionally, **MCNA** collected member feedback via inbound calls to the Member Hotline and through our Member Advocate Outreach Specialists, who serve as the voice of the community by partnering with local community organizations and engaging with members at outreach events. No additional barriers have been identified at this time. However, **MCNA** will continue to revisit its causal barrier analysis on a quarterly basis to identify new barriers and develop appropriate interventions to address them.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MCNA**'s performance for the first performance indicator has improved over the previous SFY rate.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementing initiatives.
HSAG Assessment: HSAG has determined that **MCNA** partially addressed the prior year's recommendations by obtaining feedback from providers and members on barriers to care; however, no new interventions were identified or developed. Therefore, HSAG continues to recommend that the PAHP assess whether it needs to develop new interventions to improve performance. The PAHP did demonstrate improvement in the first performance indicator rate as compared to the prior year.

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
HSAG recommended the following: • During PSV, **MCNA** was unable to reproduce an exact query output in comparison to the data set submission to HSAG for the *Providers Seeing Patients* measure. The query output during PSV contained a few variations in the number of patients associated with specific providers. HSAG recommends that **MCNA** notify the State when it identifies that State-specific reporting requirements may be unclear and could lead to multiple interpretations. HSAG also recommends that **MCNA** maintain query outputs for data set submissions. Recorded output documentation and inclusion of patient-level details will provide **MCNA** with the opportunity to conduct a root cause analysis and validate data set submission deviations if future concerns are noted. • **MCNA**'s rates for the *Members Who Accessed Dental Care* and *Members Who Received Preventive Dental Care* measures decreased gradually in 2022 and 2023. HSAG recommends that **MCNA** conduct a

2. Prior Year Recommendation from the EQR Technical Report for Performance Measures:
segmentation analysis of the noncompliant members to identify trends in demographics for the noncompliant population. HSAG also recommends that **MCNA** identify targeted interventions to increase knowledge and awareness of dental care benefits for members within their first year of eligibility.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MCNA** continues to notify the State when it identifies that State-specific reporting requirements may be unclear and could lead to multiple interpretations. MCNA Dental continues to maintain query outputs for data set submissions. **MCNA** recognizes recorded output documentation and inclusion of patient-level details and the opportunity in doing so; to conduct a root cause analysis and validate data set submission deviations if future concerns are noted.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MCNA** continues to conduct a segmentation analysis of the noncompliant members to identify trends in demographics for the noncompliant population. MCNA Dental continues to identify targeted interventions to increase knowledge and awareness of dental care benefits for members within their first year of eligibility.
c. Identify any barriers to implementing initiatives: • N/A
HSAG Assessment: HSAG has determined that **MCNA** addressed the prior year's recommendation. The CY 2024 PMV review identified no outstanding concerns or recommendations.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG recommended the following: • **MCNA** did not remediate the one CAP element for the Coordination and Continuity of Care standard, indicating a continued gap in the PAHP's processes to ensure that members complete the initial health risk screening in a timely manner. HSAG required **MCNA** to submit an updated action plan indicating that the PAHP had fully implemented interventions to maximize efforts to ensure members complete the initial health risk screening in a timely manner. As such, HSAG recommends that **MCNA** continue to implement its new outreach procedures and use internal data to track and subsequently increase the number of members who complete the initial health risk screening within 90 calendar days of enrollment.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • We created an outbound campaign that identified newly enrolled members who are enrolled for more than 60 days and less than 90 days and have not completed an OHA. We reach out to those members and encourage them to complete the OHA.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There are no significant improvement.
c. Identify any barriers to implementing initiatives: • There are no barriers at this time.

3. Prior Year Recommendation from the EQR Technical Report for Compliance Review:
HSAG Assessment: HSAG has determined that **MCNA** addressed the prior recommendations based on the initiatives reported.

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
HSAG recommended the following: • Of the cases reached, 73.3 percent of provider locations accepted MCNA Dental, 66.0 percent accepted Medicaid, and 38.0 percent accepted new patients. HSAG recommends that **MCNA** use the case-level analytic data files containing provider deficiencies identified during the survey (e.g., provider records with incorrect Medicaid acceptance and new patient acceptance) to address the provider data deficiencies and educate provider offices on the Medicaid program. Additionally, **MCNA** should adhere to any remediation requirements imposed by HHS. • Among the cases reached, the overall appointment rate was 18.7 percent, with an overall average wait time of 68 calendar days for **MCNA**. HSAG recommends that MCNA Dental work with its contracted providers to ensure that members are able to readily obtain available appointment dates and times. HSAG further recommends that **MCNA** consider working with its contracted providers to balance procedural efficiencies with providing clear and direct information to members about appointment availability.
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • **MCNA** uses our semi-annual site contact visits as an opportunity to validate and update provider facility information as needed. The PR team also uses these visits to complete appointment availability surveys. We use this time to educate offices who are outside of compliance for appointment wait times on what is expected per their contract and we follow-up again in 90 days to ensure the facilities have now become compliant. Please see the attached Network Validation procedure below: **<u>Network Validation Process for IA</u>** 1. Each external Provider Relations (PR) Representatives reach out to approximately 10 facilities per week, averaging 40 facilities per month per Representatives. This allows us to contact all facilities in our network on a semiannual basis, if not more frequently. 2. During our semi-annual visits, PR reps complete Site Contact Forms (SCF) and Access and Availability surveys (AAS). Our site contact forms contain the following network validation information which is verified during this visit. a. **Demographic Info:** Facility Address, County, Phone number. b. **General Info**: Plans accepted, Dentist Type. c. **Credentialing Info:** Credentialing update needed? If yes, we address during our visit. d. **Panel Info:** Is the office accepting new patients, new **MCNA** patients, do they see adults/children, what ages, do they see special needs patients and what ages? e. **Missed Appt Info:** Issues with missed appts, what percentage of members miss, does office send reminders and how, do they dismiss members for missed appointments and after how many and are they aware of our case management team to assist with missed appointments?

4. Prior Year Recommendation from the EQR Technical Report for Network Adequacy Validation:
f. **Online Directory Accuracy**: Name, address, phone number, website, location type, ages, languages, indicators, accessibility, and office hours. 3. Upon completion of the visit, PR has the office staff sign off on the visit confirming the information is accurate and/or confirming any changes that need to be made. 4. PR sends any information needing to be updated to the appropriate departments (with signed SCF as verification) to be corrected and waits for confirmation of completion. 5. Once confirmation of changes has been received, PR completes a secondary checks and balance verification in the system, then notifies the office of completion.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Our provider satisfaction survey results demonstrate a 10.98% increase in overall provider satisfaction when compared to the same period pre-intervention.
c. Identify any barriers to implementing initiatives: • Facilities continue to struggle to meet compliance timelines around routine care, as staffing issues remain a problem for facilities not only statewide but nationwide. In turn pushing scheduling back, many times outside of the compliance metrics we are striving to attain. In addition, the pent-up demand for appointments due to dental offices being closed from the pandemic is still a lingering issue. The state of IA has realized this issue and has passed legislation of a dental compact allowing providers to transfer their license from one state to another without repeating the process. We are awaiting direction from the state on how we will be able to incorporate this legislation to help boost our network and access & availability results.
HSAG Assessment: HSAG determined that **MCNA** addressed the prior year's recommendations based on the PAHP's reported initiatives. **MCNA** also provided an explanation about the barriers (i.e., lingering issues due to the pandemic) that contributed to the PAHP not meeting all state-established network adequacy standards. Because the CY 2024 NAV activity methodology was conducted as a new scope of work in alignment with the 2023 release of the CMS EQR Protocol 4 and therefore the methodology for conducting the NAV audit activities and the subsequent results were not comparable to the CY 2023 NAV activity, HSAG has provided additional recommendations to **MCNA** in the "External Quality Review Activity Results" section, as necessary, based on the findings from the CY 2024 NAV audit.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
HSAG recommended the following: • Errors were identified in the data files extracted for the study, specifically with **MCNA** submitted encounters, which included encounters not in their final status, as had been requested. Consequently, these errors resulted in discrepancies when compared to the HHS-submitted data. HSAG recommends that **MCNA** enhance its standard quality controls to ensure accurate data extraction in alignment with study requirements. Through the development of standardized data extraction procedures and robust quality control measures, **MCNA** can mitigate errors associated with extracted data.

5. Prior Year Recommendation from the EQR Technical Report for Encounter Data Validation:
MCP's Response
a. Describe initiatives implemented based on recommendations ***(include a brief summary of activities that were either completed or implemented, and any activities still underway to address the finding that resulted in the recommendation)***: • We reviewed our logic and our encounter exception rules and made the necessary updates in our logic to make sure the most recent Encounter was submitted. On previous submission, we were using the first encounter submitted.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • **MCNA** is always striving for 100% alignment for what the state is reporting. Billing Provider NPI's are now being retrieved from our encounter data as opposed to our claims data. EDV reports are now being sent to our EDI team (responsible for encounters) for a final quality check. As a result of this update, the record surplus rate was relatively low (approx. 5%) of records were present in HHS' data file but not found in **MCNA**'s submitted data file for the study.
c. Identify any barriers to implementing initiatives: • There were no barriers to implementation.
HSAG Assessment: HSAG has determined that **MCNA** partially addressed the prior year's recommendations. HSAG identified discrepancies in **MCNA**'s submitted encounters, specifically regarding non-final status encounters, which led to inconsistencies when compared to the HHS-submitted data. In response, **MCNA** reviewed and updated its data extraction logic and encounter exception rules to ensure that only the most recent encounter is submitted, rather than the first encounter recorded. These updates align with HSAG's recommendations and demonstrate a commitment to improving data accuracy. **MCNA** also enhanced its quality control processes, including retrieving Billing Provider NPIs from encounter data instead of claims data and implementing additional quality checks by routing EDV reports to its EDI team for review before submission. As a result of these updates, **MCNA** reports that the record surplus rate has been reduced to approximately 5 percent, indicating progress in improving data accuracy. No barriers were reported in implementing these initiatives, suggesting that the necessary updates were feasible within existing operational processes. However, to fully address HSAG's recommendations, **MCNA** should continue conducting regular data validation checks and refining its quality control measures to further reduce discrepancies in data extraction. In conclusion, **MCNA** has taken important steps to correct data extraction errors and improve encounter data quality. While notable progress has been made, ongoing monitoring and validation will be essential to achieving full compliance and ensuring sustained accuracy in future data submissions.

7. Managed Care Plan Comparative Information

In addition to performing a comprehensive assessment of each MCP's performance, HSAG uses a step-by-step process methodology to compare the findings and conclusions established for each MCP to assess the Iowa Managed Care Program. Specifically, HSAG identifies any patterns and commonalities that exist across the MCPs and the Iowa Managed Care Program, draws conclusions about the overall strengths and weaknesses of the program, and identifies areas in which HHS could leverage or modify Iowa's quality strategies to promote improvement.

External Quality Review Activity Results

This section provides the summarized results for the mandatory and optional EQR activities across the MCPs, when the activity methodologies and resulting findings were comparable.

Validation of Performance Improvement Projects

For the CY 2024 validation, the MCOs submitted methodologies for the two HHS-mandated PIP topics, and the PAHPs submitted Remeasurement 2 data for the HHS-mandated PIP topics. HSAG's validation evaluated the technical methods for the MCPs' PIPs (i.e., the PIP Design, Implementation, and Outcomes stages). Based on its technical review, HSAG determined the overall methodological validity of each MCP's PIP and assigned an overall confidence level of *High Confidence, Moderate Confidence, Low Confidence,* or *No Confidence* for the two required validation ratings identified below.

Table 7-1 below provides a comparison of the overall PIP validation statuses and the scores for all PIP activities, by MCP.

Table 7-1—Comparison of Validation Statuses and Scores by MCP

MCP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores		
				Met	Partially Met	Not Met	Met	Partially Met	Not Met
ITC	*SDOH Screening*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
MOL	*SDOH Screening*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		

MCP	PIP Topic	Validation Rating 1	Validation Rating 2	Design and Implementation Scores			Outcomes Scores		
				Met	Partially Met	Not Met	Met	Partially Met	Not Met
WLP	*SDOH Screening*	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
	Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	*High Confidence*	*Not Assessed*	100%	0%	0%	*Not Assessed*		
DDIA	*Annual Preventative Dental Visits*	*High Confidence*	*Moderate Confidence*	100%	0%	0%	33%	67%	0%
MCNA	*Increase the Percentage of Dental Services*	*High Confidence*	*Moderate Confidence*	100%	0%	0%	33%	67%	0%

Performance Measure Validation

Table 7-2 displays the MLTSS MY 2023 rates for the MCOs and the statewide weighted averages.

Table 7-2—MLTSS MCO Performance Measure Comparison and Statewide Aggregate Rates

Performance Measure		Measure Rates			
		ITC	MOL	WLP	Statewide Aggregate
1	*Managed Long-Term Services and Supports Admission to a Facility from the Community*				
	Short-Term Stay—Ages 18 to 64	0.29	38.23	0.74	0.06
	Short-Term Stay—Ages 65 to 74	1.06	NA	6.30	0.20
	Short-Term Stay—Ages 75 to 84	2.31	NA	4.26	0.28
	Short-Term Stay—Ages 85+	2.65	NA	2.12	0.30
	Medium-Term Stay—Ages 18 to 64	1.04	66.40	0.63	0.15
	Medium-Term Stay—Ages 65 to 74	3.17	NA	3.29	0.32
	Medium-Term Stay—Ages 75 to 84	3.95	NA	2.33	0.37
	Medium-Term Stay—Ages 85+	7.42	NA	4.24	0.70
	Long-Term Stay—Ages 18 to 64	4.76	NA	22.01	0.72
	Long-Term Stay—Ages 65 to 74	20.10	NA	72.60	2.82
	Long-Term Stay—Ages 75 to 84	36.03	NA	69.38	4.13
	Long-Term Stay—Ages 85+	64.67	NA	82.63	6.81
2	*Managed Long-Term Services and Supports Minimizing Facility Length of Stay*				
	Observed	18.84%	NA	10.80%	16.73%
	Risk-Adjusted	21.65%	NA	32.52%	25.57%
3	*Managed Long-Term Services and Supports Successful Transition After Long-Term Facility Stay*				
	Observed	52.29%	NA	0.00%	23.18%
	Risk-Adjusted	49.06%	NA	69.49%	60.43%

"NA" indicates that the denominator was too small to calculate a rate (n<30); therefore, a rate is not displayed. 7

Table 7-3 shows the aggregate CMS Core Set performance measure rates and measure designations for all Medicaid populations, including Fee-for-Service (FFS), as calculated by the HHS vendor, IBM. IBM was contracted by HHS to calculate statewide measure rates; therefore, MCO-specific comparison data for CMS Core Set reporting are not displayed in Table 7-3.

Table 7-3—CMS Core Set Performance Measure Rates

	Performance Measures	Measure Designation	Statewide Aggregate Measure Rate
1.	*Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis—Ages 3 Months to 17 Years*	*R*	27.24%
2.	*Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Initiation*	*R*	56.06%
	Follow-Up Care for Children Prescribed Attention-Deficit/Hyperactivity Disorder (ADHD) Medication—Continuation		60.87%
3.	*Ambulatory Care: Emergency Department (ED) Visits—Total*	*R*	31.45
4.	*Antidepressant Medication Management—Acute—Ages 18 to 64*	*R*	56.69%
	Antidepressant Medication Management—Acute—Ages 65+		NA
	Antidepressant Medication Management—Continuation—Ages 18 to 64		33.46%
	Antidepressant Medication Management—Continuation—Ages 65+		NA
5.	*Asthma Medication Ratio—Total*	*R*	59.82%
6.	*Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose Testing—Total*	*R*	48.25%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Cholesterol Testing—Total		25.00%
	Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total		24.04%
7.	*Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics—Total*	*R*	60.36%
8.	*Screening for Depression and Follow-Up Plan—Ages 18 to 64*	*R*	0.75%
	Screening for Depression and Follow-Up Plan—Ages 65+		1.71%
9.	*Screening for Depression and Follow-Up Plan—Ages 12 to 17*	*R*	1.08%
10.	*Chlamydia Screening in Women—Ages 16 to 20*	*R*	36.66%
11.	*Childhood Immunization Status—Combination 3*	*R*	35.91%
	Childhood Immunization Status—Combination 7		31.11%
	Childhood Immunization Status—Combination 10		15.29%
12.	*Developmental Screening in the First Three Years of Life—Total*	*R*	37.40%
13.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 18 to 64*	*R*	58.12%

	Performance Measures	Measure Designation	Statewide Aggregate Measure Rate
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 18 to 64		67.74%
	Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 65+		NA
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 65+		NA
14.	*Follow-Up After Emergency Department Visit for Substance Use—7-Day Follow-Up—Ages 13 to 17*	*R*	52.06%
	Follow-Up After Emergency Department Visit for Substance Use—30-Day Follow-Up—Ages 13 to 17		60.30%
15.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 18 to 64*	*R*	39.76%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 18 to 64		60.98%
	Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 65+		NA
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 65+		NA
16.	*Follow-Up After Hospitalization for Mental Illness—7-Day Follow-Up—Ages 6 to 17*	*R*	49.28%
	Follow-Up After Hospitalization for Mental Illness—30-Day Follow-Up—Ages 6 to 17		71.66%
17.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 18 to 64*	*R*	37.16%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 18 to 64		55.25%
	Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 65+		NA
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 65+		NA
18.	*Follow-Up After Emergency Department Visit for Mental Illness—7-Day Follow-Up—Ages 6 to 17*	*R*	49.52%
	Follow-Up After Emergency Department Visit for Mental Illness—30-Day Follow-Up—Ages 6 to 17		74.55%
19.	*Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—Ages 18 to 64*	*R*	88.40%

	Performance Measures	Measure Designation	Statewide Aggregate Measure Rate
	Diabetes Care for People with Serious Mental Illness: Hemoglobin A1c (HbA1c) Poor Control (>9.0%)—Ages 65+		NA
20.	*Initiation and Engagement of Substance Use Disorder Treatment—Initiation—Total*	*R*	39.74%
	Initiation and Engagement of Substance Use Disorder Treatment—Engagement—Total		16.38%
21.	*Immunizations for Adolescents—Combination 1*	*R*	60.57%
	Immunizations for Adolescents—Combination 2		19.34%
22.	*Lead Screening in Children*	*R*	68.49%
23.	*Oral Evaluation, Dental Services—Total*	*R*	42.87%
24.	*Use of Pharmacotherapy for Opioid Use Disorder—Total*	*R*	62.76%
25.	*Adherence to Antipsychotic Medications for Individuals With Schizophrenia*	*R*	73.01%
26.	*Sealant receipt on Permanent First Molars—At Least One Sealant*	*R*	27.20%
	Sealant receipt on Permanent First Molars—All Four Molars Sealed		22.49%
27.	*Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*	*R*	76.65%
28.	*Topical Fluoride for Children—Dental or Oral Health Services—Total*	*R*	21.67%
	Topical Fluoride for Children—Dental Services—Total		20.70%
	Topical Fluoride for Children—Oral Health Services—Total		0.39%
29.	*Well-Child Visits in the First 30 Months—First 15 Months*	*R*	61.73%
	Well-Child Visits in the First 30 Months—15–30 Months		65.48%
30.	*Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—BMI Percentile—Total*	*R*	27.08%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Nutrition—Total		10.59%
	Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents—Counseling for Physical Activity—Total		7.80%
31.	*Child and Adolescent Well-Care Visits—Total*	*R*	58.90%

Table 7-4 displays the HEDIS MY 2023 rates for **ITC** and **WLP** and the statewide weighted averages. **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not meet continuous enrollment criteria for HEDIS MY 2023 reporting.

Table 7-4—HEDIS MY 2023 Rates—MCO Comparison

Measures	WLP HEDIS MY 2023 Rate	ITC HEDIS MY 2023 Rate	Statewide HEDIS MY 2023 Weighted Averages
Access to Preventive Care			
Adults' Access to Preventive/Ambulatory Health Services			
20–44 Years	81.26% ★★★★★	80.15% ★★★★	80.74% ★★★★★
45–64 Years	87.29% ★★★★★	84.84% ★★★	86.15% ★★★★
65 Years and Older	95.45% ★★★★★	85.51% ★★★	90.92% ★★★★
Use of Imaging Studies for Low Back Pain			
Use of Imaging Studies for Low Back Pain	67.02% ★	65.46% ★	66.36% ★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents			
BMI Percentile Documentation—Total	79.56% ★★	79.56% ★★	79.56% ★★
Counseling for Nutrition—Total	66.42% ★★	65.94% ★★	66.21% ★★
Counseling for Physical Activity—Total	63.26% ★★	62.04% ★★	62.73% ★★
Women's Health			
Breast Cancer Screening			
Breast Cancer Screening	56.07% ★★★	53.98% ★★★	55.24% ★★★
Cervical Cancer Screening			
Cervical Cancer Screening	60.34% ★★★	57.66% ★★★	59.09% ★★★
Chlamydia Screening in Women			
Total	44.89% ★	47.38% ★	45.96% ★
Non-Recommended Cervical Cancer Screening in Adolescent Females*			
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.17% ★★★	0.33% ★★	0.24% ★★★
Prenatal and Postpartum Care			
Timeliness of Prenatal Care	88.08% ★★★	86.13% ★★★	87.16% ★★★

Measures	WLP HEDIS MY 2023 Rate	ITC HEDIS MY 2023 Rate	Statewide HEDIS MY 2023 Weighted Averages
Postpartum Care	83.70% ★★★★	82.48% ★★★	83.12% ★★★
Living With Illness			
Hemoglobin A1c Control for Patients With Diabetes			
HbA1c Control (<8%)	64.48% ★★★★★	56.45% ★★	61.00% ★★★★
*HbA1c Poor Control (>9.0%)**	27.25% ★★★★	31.14% ★★★	28.94% ★★★★
Blood Pressure Control for Patients With Diabetes			
Blood Pressure Control (<140/90 mm Hg)	81.75% ★★★★★	72.99% ★★★	77.96% ★★★★★
Eye Exam for Patients With Diabetes			
Eye Exam (Retinal) Performed	59.85% ★★★★	56.45% ★★★	58.38% ★★★
Controlling High Blood Pressure			
Controlling High Blood Pressure	71.29% ★★★★	69.83% ★★★★	70.66% ★★★★
Statin Therapy for Patients With Cardiovascular Disease			
Received Statin Therapy—Total	80.99% ★★	79.94% ★★	80.56% ★★
Statin Therapy for Patients With Diabetes			
Received Statin Therapy	67.68% ★★★	63.67% ★★	66.07% ★★★
Behavioral Health			
Diabetes Monitoring for People With Diabetes and Schizophrenia			
Diabetes Monitoring for People With Diabetes and Schizophrenia	75.47% ★★★★	68.91% ★★	72.90% ★★★
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications			
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	81.38% ★★	78.33% ★★	80.03% ★★
Follow-Up After Emergency Department Visit for Substance Use			
7 Day Follow-Up—Total	49.30% ★★★★★	58.66% ★★★★★	53.80% ★★★★★
30 Day Follow-Up—Total	60.75% ★★★★★	67.87% ★★★★★	64.17% ★★★★★
Follow-Up After ED Visit for Mental Illness			
7-Day Follow-Up—Total	70.81% ★★★★★	66.11% ★★★★★	68.80% ★★★★★

Measures	WLP HEDIS MY 2023 Rate	ITC HEDIS MY 2023 Rate	Statewide HEDIS MY 2023 Weighted Averages
30-Day Follow-Up—Total	81.66% ★★★★★	77.70% ★★★★★	79.97% ★★★★★
Follow-Up After Hospitalization for Mental Illness			
7-Day Follow-Up—Total	67.73% ★★★★★	57.71% ★★★★★	63.29% ★★★★★
30-Day Follow-Up—Total	81.78% ★★★★★	75.84% ★★★★★	79.15% ★★★★★
Initiation and Engagement of Substance Use Disorder Treatment			
Initiation of SUD Treatment—Total	49.83% ★★★★	45.26% ★★★	47.99% ★★★
Engagement of SUD Treatment—Total	19.43% ★★★★	16.62% ★★★	18.30% ★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics			
Blood Glucose and Cholesterol Testing–Total	26.43% ★	27.81% ★	26.94% ★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics			
Total	61.18% ★★★	61.64% ★★★	61.35% ★★★
Keeping Kids Healthy			
Childhood Immunization Status			
Combination 3	69.59% ★★★★	72.26% ★★★★	70.85% ★★★★
Combination 10	36.98% ★★★★	40.88% ★★★★	38.83% ★★★★
Immunizations for Adolescents			
Combination 1	86.62% ★★★★	85.88% ★★★★	86.33% ★★★★
Combination 2	31.39% ★★	30.54% ★★	31.06% ★★
Lead Screening in Children			
Lead Screening in Children	77.86% ★★★★	74.68% ★★★★	76.35% ★★★★
Well-Child Visits in the First 30 Months of Life			
Well-Child Visits in the First 15 Months—Six or More Well-Child Visits	67.39% ★★★★	67.23% ★★★★	67.32% ★★★★
Well-Child Visits for Age 15 Months-30 Months—Two or More Well-Child Visits	72.19% ★★★	72.93% ★★★	72.53% ★★★

Measures	WLP HEDIS MY 2023 Rate	ITC HEDIS MY 2023 Rate	Statewide HEDIS MY 2023 Weighted Averages
Child and Adolescent Well-Care Visits			
Total	54.62% ★★★	55.17% ★★★	54.86% ★★★
Medication Management			
Statin Therapy for Patients With Cardiovascular Disease			
Statin Adherence 80%—Total	69.01% ★★	62.43% ★	66.36% ★★
Statin Therapy for Patients With Diabetes			
Statin Adherence 80%—Total	66.42% ★★	62.11% ★★	64.75% ★★
Adherence to Antipsychotic Medications for Individuals with Schizophrenia			
Adherence to Antipsychotic Medications for Individuals with Schizophrenia	67.54% ★★★	61.98% ★★	65.22% ★★★
Antidepressant Medication Management			
Effective Acute Phase Treatment	65.35% ★★★	63.35% ★★★	64.51% ★★★
Effective Continuation Phase Treatment	46.04% ★★★	43.91% ★★	45.14% ★★★
Appropriate Testing for Pharyngitis			
Total	87.13% ★★★★	86.89% ★★★★	87.04% ★★★★
Appropriate Treatment for Upper Respiratory Infection			
Total	87.61% ★★	87.97% ★★	87.76% ★★
Asthma Medication Ratio			
Total	66.25% ★★★	65.50% ★★	65.97% ★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis			
Total	56.97% ★★	57.82% ★★	57.33% ★★
Follow-Up Care for Children Prescribed ADHD Medication			
Initiation Phase	48.26% ★★★	54.92% ★★★★	50.64% ★★★★
Continuation and Maintenance Phase	50.48% ★★	60.79% ★★★★	54.13% ★★★
Persistence of Beta-Blocker Treatment After a Heart Attack			
Persistence of Beta-Blocker Treatment After a Heart Attack	57.69% ★★★	58.67% ★★★	58.17% ★★★

Measures	WLP HEDIS MY 2023 Rate	ITC HEDIS MY 2023 Rate	Statewide HEDIS MY 2023 Weighted Averages
Pharmacotherapy Management of COPD Exacerbation			
Systemic Corticosteroid	72.35% ★★★	73.45% ★★★	72.79% ★★★
Bronchodilator	79.18% ★★	83.82% ★★★	81.00% ★★
Use of Opioids at High Dosage*			
Use of Opioids at High Dosage	2.66% ★★★	1.37% ★★★★	2.12% ★★★
Use of Opioids From Multiple Providers*			
Multiple Prescribers	17.55% ★★★	20.24% ★★	18.68% ★★
Multiple Pharmacies	1.66% ★★★★	2.42% ★★★	1.98% ★★★
Multiple Prescribers and Multiple Pharmacies	0.99% ★★★★	1.74% ★★★	1.31% ★★★

* For this indicator, a lower rate indicates better performance.
"NC" indicates that NCQA recommended a break in trending; therefore, the rate could not be compared to the national Medicaid MY 2022 benchmarks. HEDIS MY 2023 star ratings represent the following percentile comparisons:
★★★★★ = At or above the 90th percentile
★★★★ = At or above the 75th percentile but below the 90th percentile
★★★ = At or above the 50th percentile but below the 75th percentile
★★ = At or above the 25th percentile but below the 50th percentile
★ = Below the 25th percentile

Table 7-5 displays the DWP Adult rates for each PAHP and the statewide aggregate rate, and Table 7-6 displays the DWP Kids rates for each PAHP and the statewide aggregate rate. No rate comparison is provided for the Hawki population since **DDIA** is the only PAHP that oversees this member population.

Table 7-5—SFY 2024 Performance Measure Rates for DWP Adults—PAHP Comparison

Performance Measure		Measure Rates – DWP Adults		
		DDIA	MCNA	Statewide Aggregate
2	*Members Who Accessed Dental Care*	28.90%	16.50%	24.29%
3	*Members Who Received Preventive Dental Care*	74.72%	61.08%	71.27%
6*	*Members Who Received a Preventive Examination and a Follow-Up Examination. Percentage: (Distinct Count: [Members Who Received an Oral Evaluation During the Measurement Year, Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation, and received an Oral Evaluation 6–12 Months Prior to the Oral*	61.54%	41.88%	57.36%

Performance Measure		Measure Rates – DWP Adults		
		DDIA	MCNA	Statewide Aggregate
	Evaluation])/(Distinct Count: [Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation])			

*Performance measure #6 includes three distinct components.

Table 7-6—SFY 2024 Performance Measure Rates for DWP Kids—PAHP Comparison

Performance Measure		Measure Rates – DWP Kids		
		DDIA	MCNA	Statewide Aggregate
3	*Members Who Received Preventive Dental Care*	53.19%	43.07%	49.51%
7	*Providers Seeing Patients*	86.55%	88.71%	87.13%*

*The numerator and denominator criteria for the statewide aggregate were analyzed at the statewide level to account for potential duplication of providers contracted across **DDIA** and **MCNA**, which creates the potential for the aggregate rate to approximate or increase above the higher MCO-reported rate.

Compliance Review

HSAG calculated the Iowa Managed Care Program's performance in each of the seven compliance review standards that were reviewed during the first year of the three-year compliance review cycle. Table 7-7 compares the MCPs' compliance scores and the Iowa Managed Care Program aggregated score in each of the seven compliance review standards.

Table 7-7—MCP and Iowa Managed Care Program Compliance Review Scores for CY 2024

Standard	ITC	MOL	WLP	DDIA	MCNA	Iowa Managed Care Program
Standard I—Disenrollment: Requirements and Limitations	100%	86%	100%	100%	100%	**97%**
Standard II—Member Rights and Member Information	88%	79%	79%	85%	85%	**83%**
Standard III—Emergency and Poststabilization Services	100%	100%	100%	100%	100%	**100%**
Standard IV—Availability of Services	94%	94%	94%	100%	100%	**96%**

Standard	ITC	MOL	WLP	DDIA	MCNA	Iowa Managed Care Program
Standard V—Assurances of Adequate Capacity and Services	100%	100%	100%	100%	100%	**100%**
Standard VI—Coordination and Continuity of Care	83%	89%	78%	88%	88%	**84%**
Standard VII—Coverage and Authorization of Services	93%	88%	90%	90%	81%	**89%**
Combined Total	**93%**	**90%**	**90%**	**93%**	**90%**	**91%**

Network Adequacy Validation

HSAG assessed the MCOs' submitted reports and found that three MCOs were within standard for appointment wait time standards. Results were based on a review of the MCOs' reporting standards to determine if they directly corresponded to HHS' standards and indicators. Table 7-8 summarizes the appointment wait times within 100 percent of standard for the MCOs.

Table 7-8—MCO Appointment Wait Time Indicators Within 100 Percent

MCO	Provider Type	Indicator	Percent Within Standard
MOL	Specialty Care	30 days for routine care 1 day for urgent care	100%
WLP	Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	100%
ITC	Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	100% X-ray only

HSAG assessed the MCOs' submitted reports and found three MCOs fell below 100 percent of the standard. Table 7-9 summarizes the appointment wait times below 100 percent of standard.

Table 7-9—MCO Appointment Wait Time Indicators Below 100 Percent

MCO	Provider Type	Standard	Percent Within Standard
ITC	PCP	4 to 6 weeks for routine care	98.9%
		48 hours for persistent care	98.2%
		1 day for urgent care	98.9%

MCO	Provider Type	Standard	Percent Within Standard
MOL	PCP	4 to 6 weeks for routine care	95%
		48 hours for persistent care	95%
		1 day for urgent care	97%
WLP	PCP	4 to 6 weeks for routine care	100%
		48 hours for persistent care	87%
		1 day for urgent care	95%
ITC	Specialty Care	30 days for routine care	94.2%
		1 day for urgent care	87%
WLP	Specialty Care	30 days for routine care	86%
		1 day for urgent care	86%
WLP	Behavioral Health Services—*Emergency*	Seen or referred to an appropriate provider upon presentation	71% prescribing non-life threatening 70% prescribing life threatening 70% non-prescribing non-life threatening 39% non-prescribing life threatening
ITC	Behavioral Health Services—*Mobile Crisis*	1 hour of presentation or request	100% prescribing 99.4% non-prescribing
ITC	Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	98.0% 1 hour prescribing 95.7% 1 hour non-prescribing 100% 24 hours prescribing and non-prescribing
MOL	Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	92%
WLP	Behavioral Health Services—*Urgent*	1 hour of presentation or within 24 hours of telephone contact	53% prescribing 66% non-prescribing
ITC	Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	100% prescribing 99.4% non-prescribing
MOL	Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	93%
WLP	Behavioral Health Services—*Persistent Symptoms*	Seen or referred to appropriate provider within 48 hours	86% prescribing 87% non-prescribing
ITC	Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	100% prescribing 98.8% non-prescribing

MCO	Provider Type	Standard	Percent Within Standard
MOL	Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	84%
WLP	Behavioral Health Services—*Routine*	Seen or referred to an appropriate provider within 3 weeks	85% prescribing initial visit 95% prescribing follow-up 79% non-prescribing initial visit 95% non-prescribing follow-up
ITC	Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours	99.3% prescribing 98.2% non-prescribing
WLP	Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours	93% prescribing 83% non-prescribing
ITC	Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours	98.7% 14 days and 120 days prescribing 96.3% 14 days non-prescribing 95.1% 120 days non-prescribing
WLP	Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours	95% prescribing 92% non-prescribing
ITC	General Optometry Services	3 weeks regular appointments	89.1%
		48 hours urgent care	87.0%
WLP	General Optometry Services	3 weeks regular appointments	88%
		48 hours urgent care	88%

HSAG determined the appointment wait times standards in Table 7-10 were not calculated and reported by MCOs, resulting in an "*Unable to Validate*" designation for each associated indicator. Table 7-10 uses an "X" to denote the standards and indicators that were determined *Unable to Validate* by MCO.

Table 7-10—Appointment Wait Time Indicators *Unable to Validate* by MCOs

Provider Type	Standard	ITC	MOL	WLP
Behavioral Health Services—*Emergency*	Seen or referred to an appropriate provider upon presentation	X	X	
Behavioral Health Services—*Mobile Crisis*	1 hour of presentation or request		X	X
Behavioral Health Services—*Substance Use Disorder & Pregnancy*	48 hours		X	

Provider Type	Standard	ITC	MOL	WLP
Behavioral Health Services—*Intravenous Drug Use*	14 days or 120 days if no program has capacity to admin and if interim services are available 48 hours		X	
Emergency Care	Immediate at nearest facility available	X	X	X
General Optometry Services	3 weeks regular appointments 48 hours urgent care		X	
Lab and X-Ray Services	3 weeks regular appointments 48 hours urgent care	Lab only		

HSAG assessed the PAHPs' submitted reports and found that both PAHPs met HHS' time and distance standards, with no deficiencies identified for each provider type and urbanicity. Table 7-11 summarizes the network adequacy indicators for the PAHPs.

Table 7-11—PAHP Time and Distance Standards

Provider Type	Compliance Determination	
Plan Name	**DDIA**	**MCNA**
Dental Provider—Urban	*Met*	*Met*
Dental Provider—Rural	*Met*	*Met*

Encounter Data Validation

Administrative Profile—MCO

For CY 2024, HSAG conducted an administrative profile analysis exclusively for **MOL**, as this was the second year that **MOL** had been submitting encounter data to HHS. **ITC** and **WLP** had previously undergone administrative profile analyses in CY 2017 and CY 2021, respectively. Given that the CY 2024 administrative profile was only conducted for **MOL**, no comparative findings will be reported in this section. For detailed **MOL** performance results, please refer to the "External Quality Review Activity Results" for **MOL** in Section 3.

Comparative Analysis—MCO

Table 7-12 displays the percentage of records present in the data files submitted by the MCOs that were not found in HHS' data files (record omission), and the percentage of records present in HHS' data files but not present in the data files submitted by the MCOs (record surplus). **Lower rates indicate better performance for both record omission and record surplus.**

Table 7-12—Record Omission and Surplus Rates, by MCO and Encounter Type

	Professional Encounters		Institutional Encounters		Pharmacy Encounters	
MCO	Omission	Surplus	Omission	Surplus	Omission	Surplus
ITC	0.1%	0.1%	0.8%	1.1%	2.6%	0.3%
MOL	1.2%	1.1%	0.6%	2.6%	0.4%	5.6%
WLP	0.5%	1.3%	0.4%	0.4%	0.6%	0.4%
Overall	**0.3%**	**0.8%**	**0.6%**	**0.8%**	**1.4%**	**0.7%**

Table 7-13 displays the results for element omission and element surplus values for each key data element from the professional encounters. **For the element omission and surplus indicators, lower rates indicate better performance.**

Table 7-13—Data Element Omission and Surplus: Professional Encounters

	Element Omission				Element Surplus			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.1%**	0.0%	1.8%	0.0%
Rendering Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.1%**	0.0%	1.8%	0.0%
Referring Provider NPI	**0.5%**	1.3%	0.0%	0.0%	**1.1%**	0.0%	0.0%	2.1%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Secondary Diagnosis Code(s)	**<0.1%**	<0.1%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Procedure Code (CPT/HCPCS)	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Procedure Code Modifier	**<0.1%**	<0.1%	<0.1%	0.0%	**<0.1%**	<0.1%	<0.1%	0.0%
Units of Service	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Drug Code	**<0.1%**	<0.1%	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-14 displays the results for element missing and element present values in both data sources for each key data element from the professional encounters. **For these values, neither higher nor lower rates indicate better or worse performance.**

Table 7-14—Data Element Missing and Present Values: Professional Encounters

	Element Missing in Both Sources[1]				Element Present in Both Sources[2]			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Detail Service From Date	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Detail Service To Date	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%

	Element Missing in Both Sources[1]				Element Present in Both Sources[2]			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Rendering Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Referring Provider NPI	**59.6%**	59.6%	53.2%	60.2%	**40.4%**	40.4%	46.8%	39.8%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Secondary Diagnosis Code(s)	**52.9%**	51.1%	47.0%	54.8%	**47.1%**	48.9%	53.0%	45.2%
Procedure Code (CPT/HCPCS)	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Procedure Code Modifier	**53.7%**	54.2%	56.7%	53.0%	**46.3%**	45.8%	43.3%	47.0%
Units of Service	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Drug Code	**95.3%**	95.1%	95.3%	95.4%	**4.7%**	4.9%	4.7%	4.6%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%

[1] Indicates that the element was not populated in either data source.
[2] Indicates that the element was populated in both data sources.

Table 7-15 displays the results for element omission and element surplus values for each key data element from the institutional encounters. **For the element omission and surplus indicators, lower rates indicate better performance.**

Table 7-15—Data Element Omission and Surplus: Institutional Encounters

	Element Omission				Element Surplus			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Header Service To Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Admission Date	**0.2%**	0.5%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Attending Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Referring Provider NPI	**<0.1%**	0.1%	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	0.0%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Secondary Diagnosis Code(s)	**1.7%**	0.0%	3.8%	3.0%	**<0.1%**	0.0%	<0.1%	0.0%
Procedure Code (CPT/HCPCS)	**0.1%**	0.1%	0.0%	0.1%	**0.1%**	0.2%	0.0%	0.0%
Procedure Code Modifier	**0.1%**	0.3%	0.0%	<0.1%	**0.1%**	0.3%	0.0%	0.0%
Units of Service	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Primary Surgical Procedure Code	**<0.1%**	<0.1%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Secondary Surgical Procedure Code(s)	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	<0.1%	0.0%	0.0%

	Element Omission				Element Surplus			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Drug Code	**0.2%**	0.4%	0.0%	<0.1%	**0.1%**	0.2%	0.0%	0.0%
Revenue Code	**<0.1%**	0.0%	<0.1%	<0.1%	**<0.1%**	<0.1%	0.0%	0.0%
DRG Code	**<0.1%**	<0.1%	<0.1%	<0.1%	**<0.1%**	<0.1%	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-16 displays results for the element missing and element present values in both data sources for each key data element from the institutional encounters. **For these values, neither higher nor lower rates indicate better or worse performance.**

Table 7-16—Data Element Missing and Present Values: Institutional Encounters

	Element Missing in Both Sources[1]				Element Present in Both Sources[2]			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Header Service To Date	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Admission Date	**81.5%**	80.9%	83.5%	81.8%	**18.5%**	19.1%	16.5%	18.2%
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Attending Provider NPI	**0.6%**	0.4%	9.1%	<0.1%	**99.4%**	99.6%	90.9%	>99.9%
Referring Provider NPI	**96.4%**	96.4%	96.2%	96.4%	**3.6%**	3.6%	3.8%	3.6%
Primary Diagnosis Code	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Secondary Diagnosis Code(s)	**15.5%**	16.8%	16.1%	14.3%	**84.5%**	83.2%	83.9%	85.7%
Procedure Code (CPT/HCPCS)	**15.4%**	16.3%	17.1%	14.4%	**84.6%**	83.7%	82.9%	85.6%
Procedure Code Modifier	**75.0%**	75.8%	77.2%	74.1%	**25.0%**	24.2%	22.8%	25.9%
Units of Service	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Primary Surgical Procedure Code	**94.9%**	94.3%	94.5%	95.5%	**5.1%**	5.7%	5.5%	4.5%
Secondary Surgical Procedure Code(s)	**96.7%**	96.2%	96.5%	97.1%	**3.3%**	3.8%	3.5%	2.9%
Drug Code	**89.0%**	88.7%	93.5%	88.9%	**11.0%**	11.3%	6.5%	11.1%
Revenue Code	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
DRG Code	**92.2%**	91.3%	92.1%	92.9%	**7.8%**	8.7%	7.9%	7.1%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Detail Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%

[1] Indicates that the element was not populated in either data source.
[2] Indicates that the element was populated in both data sources.

Table 7-17 displays the results for element omission and element surplus values for each key data element from the pharmacy encounters. **For the element omission and surplus indicators, lower rates indicate better performance.**

Table 7-17—Data Element Omission and Surplus: Pharmacy Encounters

	Element Omission				Element Surplus			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**<0.1%**	0.0%	0.0%	<0.1%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Prescribing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Drug Code	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Drug Quantity	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%
Dispensing Fee	**0.0%**	0.0%	0.0%	0.0%	**0.0%**	0.0%	0.0%	0.0%

Table 7-18 displays the results for element missing and element present values in both data sources for each key data element from the pharmacy encounters. **For these values, neither higher nor lower rates indicate better or worse performance.**

Table 7-18—Data Element Missing and Present Values: Pharmacy Encounters

	Element Missing in Both Sources[1]				Element Present in Both Sources[2]			
Key Data Elements	Overall	ITC	MOL	WLP	Overall	ITC	MOL	WLP
Member ID	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Header Service From Date	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Billing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Prescribing Provider NPI	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Drug Code	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Drug Quantity	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Header Paid Amount	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%
Dispensing Fee	**0.0%**	0.0%	0.0%	0.0%	**100.0%**	100.0%	100.0%	100.0%

[1] Indicates that the element was not populated in either data source.
[2] Indicates that the element was populated in both data sources.

Table 7-19 displays the percentage of records with the same values between the MCO-submitted data files and the HHS-submitted data files for each key data element associated with the professional encounters. **For this indicator, higher rates indicate better performance.**

Table 7-19—Data Element Accuracy: Professional Encounters

	Element Accuracy			
Key Data Elements	Overall	ITC	MOL	WLP
Member ID	**100.0%**	100.0%	100.0%	100.0%

Key Data Elements	Element Accuracy			
	Overall	ITC	MOL	WLP
Detail Service From Date	**>99.9%**	>99.9%	>99.9%	100.0%
Detail Service To Date	**>99.9%**	>99.9%	>99.9%	100.0%
Billing Provider NPI	**>99.9%**	>99.9%	>99.9%	100.0%
Rendering Provider NPI	**99.7%**	>99.9%	94.2%	99.9%
Referring Provider NPI	**>99.9%**	>99.9%	100.0%	100.0%
Primary Diagnosis Code	**>99.9%**	>99.9%	100.0%	100.0%
Secondary Diagnosis Code(s)	**>99.9%**	>99.9%	100.0%	100.0%
Procedure Code (CPT/HCPCS)	**>99.9%**	>99.9%	99.9%	>99.9%
Procedure Code Modifier	**98.5%**	96.8%	96.6%	100.0%
Units of Service	**99.5%**	98.8%	99.4%	>99.9%
Drug Code	**100.0%**	100.0%	100.0%	100.0%
Detail Paid Amount	**99.9%**	99.8%	99.4%	>99.9%

Table 7-20 displays the percentage of records with the same values between the MCO-submitted data files and the HHS-submitted data files for each key data element associated with the institutional encounters. **For this indicator, higher rates indicate better performance.**

Table 7-20—Data Element Accuracy: Institutional Encounters

Key Data Elements	Element Accuracy			
	Overall	ITC	MOL	WLP
Member ID	**100.0%**	100.0%	100.0%	100.0%
Header Service From Date	**>99.9%**	100.0%	99.8%	100.0%
Header Service To Date	**99.8%**	100.0%	96.3%	100.0%
Admission Date	**>99.9%**	>99.9%	>99.9%	>99.9%
Billing Provider NPI	**100.0%**	100.0%	100.0%	100.0%
Attending Provider NPI	**100.0%**	100.0%	100.0%	100.0%
Referring Provider NPI	**100.0%**	100.0%	100.0%	100.0%
Primary Diagnosis Code	**98.0%**	>99.9%	100.0%	96.1%
Secondary Diagnosis Code(s)	**80.8%**	91.2%	70.3%	72.9%
Procedure Code (CPT/HCPCS)	**98.9%**	97.6%	>99.9%	>99.9%
Procedure Code Modifier	**99.7%**	99.3%	100.0%	100.0%
Units of Service	**98.1%**	95.8%	>99.9%	>99.9%
Primary Surgical Procedure Code	**99.9%**	100.0%	98.9%	100.0%
Secondary Surgical Procedure Code(s)	**94.4%**	89.9%	97.7%	99.0%
Drug Code	**97.3%**	93.9%	100.0%	>99.9%
Revenue Code	**99.3%**	98.7%	99.9%	99.9%
DRG Code	**99.6%**	>99.9%	>99.9%	99.2%

	Element Accuracy			
Key Data Elements	Overall	ITC	MOL	WLP
Header Paid Amount	**99.6%**	99.0%	99.5%	100.0%
Detail Paid Amount	**99.5%**	98.8%	99.9%	>99.9%

Table 7-21 displays the percentage of records with the same values between the MCO-submitted data files and the HHS-submitted data files for each key data element associated with the pharmacy encounters. **For this indicator, higher rates indicate better performance.**

Table 7-21—Data Element Accuracy: Pharmacy Encounters

	Element Accuracy			
Key Data Elements	Overall	ITC	MOL	WLP
Member ID	**>99.9%**	100.0%	>99.9%	>99.9%
Header Service From Date	**100.0%**	100.0%	100.0%	100.0%
Billing Provider NPI	**99.7%**	>99.9%	99.4%	99.6%
Prescribing Provider NPI	**>99.9%**	>99.9%	>99.9%	>99.9%
Drug Code	**99.8%**	99.8%	99.9%	99.8%
Drug Quantity	**>99.9%**	>99.9%	>99.9%	>99.9%
Header Paid Amount	**99.5%**	98.9%	99.9%	99.8%
Dispensing Fee	**100.0%**	100.0%	100.0%	100.0%

Table 7-22 displays the all-element accuracy results for the percentage of records present in both data sources with the same values (whether missing or non-missing) for all key data elements relevant to each encounter data type.

Table 7-22—All Element Accuracy, by MCO and Encounter Type

MCO	Professional Encounters	Institutional Encounters	Pharmacy Encounters
ITC	96.5%	86.2%	98.7%
MOL	90.2%	69.8%	99.2%
WLP	97.8%	74.3%	99.2%
Overall	**96.9%**	**79.3%**	**99.1%**

Table 7-23 displays the overall encounter accuracy rates by MCO and encounter type. All results presented are based on the number of claims in the primary file, with a higher match rate indicating better performance.

Table 7-23—Overall Encounter Accuracy, by MCO and Encounter Type

MCO	HHS to MCO			MCO to HHS		
	Match	Partial Match	No Match	Match	Partial Match	No Match
Professional Encounters						
ITC	97.4%	2.5%	0.1%	97.4%	2.5%	0.1%
MOL	90.5%	8.9%	0.6%	89.9%	8.9%	1.3%
WLP	96.3%	2.4%	1.3%	97.2%	2.4%	0.5%
Overall	**96.5%**	**2.7%**	**0.8%**	**96.9%**	**2.7%**	**0.3%**
Institutional Encounters						
ITC	83.2%	16.0%	0.8%	83.8%	16.1%	0.1%
MOL	79.6%	18.2%	2.2%	81.1%	18.5%	0.4%
WLP	84.4%	15.3%	0.3%	84.4%	15.3%	0.3%
Overall	**83.6%**	**15.8%**	**0.6%**	**84.0%**	**15.8%**	**0.2%**
Pharmacy Encounters						
ITC	98.4%	1.2%	0.3%	96.2%	1.2%	2.6%
MOL	93.6%	0.7%	5.6%	98.8%	0.8%	0.4%
WLP	98.9%	0.7%	0.4%	98.7%	0.7%	0.6%
Overall	**98.4%**	**0.9%**	**0.7%**	**97.7%**	**0.9%**	**1.4%**

Note: The sum of Match, Partial Match, and No Match rates may not equal 100 percent due to rounding.

Dental Record Review—PAHP

Table 7-24 shows the dental record procurement status for each PAHP, detailing the number of dental records requested, as well as the number and percentage of dental records submitted by each PAHP, as indicated in the submitted tracking sheets. **For this indicator, higher rates indicate better performance.**

Table 7-24—Dental Record Procurement Status

PAHP	Number of Records Requested	Number of Records Submitted[1]	Percentage of Records Submitted
DDIA	146	146	100%
MCNA	146	143	97.9%
Overall	**292**	**289**	**99.0%**

[1]The number of dental records submitted was based on the PAHPs' responses indicated in the submitted tracking sheets.

Table 7-25 displays the dental record and encounter data omission rates for each key data element. **For the dental record omission and encounter data omission indicators, lower rates indicate better performance.**

Table 7-25—Encounter Data Completeness Summary

	Dental Record Omission			Encounter Data Omission		
Key Data Element	Overall Rate	DDIA Rate	MCNA Rate	Overall Rate	DDIA Rate	MCNA Rate
Date of Service	**1.4%**	0.0%	2.7%	**NA**	NA	NA
Dental Procedure Code	**10.0%**	9.6%	10.3%	**0.1%**	0.2%	0.0%

"NA" denotes that the indicator (i.e., encounter data omission) was not applicable to the specific data element.

Table 7-26 displays the element accuracy rates for the key data element *Dental Procedure Code* and the all-element accuracy rates. **For this indicator, higher rates indicate better performance.**

Table 7-26—Encounter Data Accuracy Summary

Key Data Element	Overall Rate	DDIA Rate	MCNA Rate
Dental Procedure Code	**99.3%**	99.5%	99.1%
All-Element Accuracy	**72.9%**	78.1%	67.6%

[1] The denominator for the element accuracy rate of the key data element was defined differently from that of the all-element accuracy rate. Therefore, the all-element accuracy rate could not be derived from the accuracy rate of the data element.

Consumer Assessment of Healthcare Providers and Systems Analysis

HSAG compared each MCO's and the MCO program's (i.e., **ITC** and **WLP** combined) results to the 2023 NCQA national averages to determine if the results were statistically significantly higher or lower than the 2023 NCQA national averages. Arrows in the tables note statistical significance.

Table 7-27 and Table 7-28 present the 2024 top-box scores for **ITC** and **WLP** compared to the top-box scores of the MCO program for the adult and child Medicaid populations, respectively. **MOL** was a new MCO in Iowa effective July 1, 2023; therefore, the MCO did not have CAHPS reporting data for CY 2024 and is not included in the comparison table.

Table 7-27—2024 MCO Adult CAHPS Comparisons

	ITC	WLP	MCO Program
Composite Measures			
Getting Needed Care	82.51%	85.02%	83.39%
Getting Care Quickly	84.72% ↑	84.53%	84.64% ↑
How Well Doctors Communicate	95.58% ↑	95.02% ↑	95.36% ↑
Customer Service	87.67%	NA	87.06%
Global Ratings			
Rating of All Health Care	49.31% ↓	52.38%	50.52% ↓
Rating of Personal Doctor	63.79%	68.38%	65.64%
Rating of Specialist Seen Most Often	59.79%	66.00%	61.90%
Rating of Health Plan	57.52%	57.41%	57.48% ↓
Individual Item Measure			
Coordination of Care	90.60% ↑	88.46%	89.72% ↑
Medical Assistance With Smoking and Tobacco Use Cessation Items*			
Advising Smokers and Tobacco Users to Quit	66.31% ↓	75.32%	69.55%
Discussing Cessation Medications	46.10%	43.67%	45.23% ↓
Discussing Cessation Strategies	43.42%	40.13%	42.24%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
* These scores follow NCQA's methodology of calculating a rolling two-year average.
↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.
↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

Table 7-28—2024 MCO Child CAHPS Comparisons[23]

	ITC	WLP	MCO Program
Composite Measures			
Getting Needed Care	90.91% ↑	84.77%	88.10% ↑
Getting Care Quickly	92.63% ↑	89.38% ↑	91.12% ↑
How Well Doctors Communicate	96.36% ↑	94.27%	95.42% ↑
Customer Service	90.85%	NA	88.22%
Global Ratings			
Rating of All Health Care	69.86%	70.07%	69.95%
Rating of Personal Doctor	80.90% ↑	76.32%	78.74% ↑
Rating of Specialist Seen Most Often	80.45% ↑	68.14%	74.80%
Rating of Health Plan	71.92%	67.71%	69.92%

A minimum of 100 responses is required for a measure to be reported as a CAHPS survey result. Measures that do not meet the minimum number of responses are denoted as "NA" (i.e., Not Applicable).
↑ Indicates the 2024 score is statistically significantly higher than the 2023 national average.
↓ Indicates the 2024 score is statistically significantly lower than the 2023 national average.

Scorecard

HHS contracted with HSAG in CY 2024 to develop a scorecard to evaluate the performance of Iowa Medicaid MCOs. The Iowa Medicaid scorecard demonstrates how the MCOs compare to 2024 NCQA Quality Compass national Medicaid health maintenance organization (HMO) benchmarks in key performance areas. The tool uses stars to display results for the MCOs, as shown in Table 7-29. Please refer to Appendix A for the detailed methodology used for this tool.

Table 7-29—Iowa Medicaid Scorecard Results—MCO Scorecard Performance Ratings

Rating	MCO Performance Compared to National Benchmarks	
★★★★★	**Highest Performance**	The MCO's measure rate was at or above the national Medicaid HMO 90th percentile
★★★★	**High Performance**	The MCO's measure rate was between the national Medicaid HMO 75th and 89th percentiles
★★★	**Average Performance**	The MCO's measure rate was between the national Medicaid HMO 50th and 74th percentiles

[23] Since **ITC** administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set, HSAG cannot perform MCO comparisons for the CCC composite measures/items. Therefore, these measures are not included in the table.

Rating	MCO Performance Compared to National Benchmarks	
★★	**Low Performance**	The MCO's measure rate was between the national Medicaid HMO 25th and 49th percentiles
★	**Lowest Performance**	The MCO's measure rate was below the national Medicaid HMO 25th percentile

Table 7-30 displays the 2024 Iowa Medicaid Scorecard results for each MCO.

Table 7-30—2024 Iowa Medicaid Scorecard Results

MCO	Doctors' Communication and Patient Engagement	Access to Preventive Care	Women's Health	Living With Illness	Behavioral Health	Medication Management
ITC	★★★	★★★★	★★★	★★★	★★★	★★★
MOL	*New	*New	*New	*New	*New	*New
WLP	★★★	★★★★	★★★	★★★	★★★★	★★★★

*Due to **MOL** being a new plan in 2023, data are not available yet. **MOL** will be included in future scorecards.

For 2024, **WLP** demonstrated the strongest performance by achieving High Performance for three of the six reporting categories (*Access to Preventive Care, Behavioral Health,* and *Medication Management*) and Average Performance for three of the six reporting categories (*Doctors' Communication and Patient Engagement, Women's Health,* and *Living With Illness*). **ITC** demonstrated Average Performance by achieving High Performance for one of the six reporting categories (*Access to Preventive Care*) and Average Performance for five of the six reporting categories (*Doctors' Communication and Patient Engagement, Women's Health, Living With Illness, Behavioral Health,* and *Medication Management*). Opportunities for improvement exist, with both MCOs having Average Performance in at least three of the reporting categories.

8. Programwide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the MCPs' performance and identified their strengths and weaknesses related to the provision of healthcare services. The aggregated findings from all EQR activities were thoroughly analyzed and reviewed across the continuum of program areas and the activities that comprise the Iowa Managed Care Program to identify programwide conclusions. The programwide conclusions are not intended to be inclusive of all EQR activity results; rather, only those results that had a substantial impact on an Iowa HHS Medicaid Quality Strategy strategic priority. HSAG presents these programwide conclusions and corresponding recommendations to HHS to drive progress toward achieving the strategic priorities and related objectives of the Iowa HHS Medicaid Quality Strategy and support improvement in the quality, timeliness, and accessibility of healthcare services furnished to Iowa Managed Care Program members. Table 8-1 displays each Iowa HHS Medicaid Quality Strategy strategic priority and indicates whether the EQR activity results positively (✓), negatively (✗), or minimally (m) impacted the Iowa Managed Care Program's progress toward achieving the applicable priorities, and the overall performance impact as it relates to the quality, timeliness, and accessibility of care and services provided to Medicaid members. If no trends were identified through an EQR activity that substantially impacted a priority, or EQR activities did not produce data for an Iowa HHS Medicaid Quality Strategy objective, a dash (–) is noted in Table 8-1.

Table 8-1—Programwide Conclusions and Recommendations

Performance Impact on Strategic Priorities and Objectives		Performance Domain
Strategic Priority 1.0—Access to Care		
✓	The aggregated statewide rate for *Follow-Up After ED Visit for Mental Illness* performance measure was at or above the 90th percentile, positively impacting the Iowa HHS Medicaid Quality Strategy objective to *Improve Behavioral Health Network Adequacy*.	☒ Quality ☒ Timeliness ☒ Access
✗	Both PAHPs demonstrated a decline in performance as compared to the baseline for at least one performance indicator for the preventive dental services PIP activity.	
m	The statewide dental aggregate rate for *Members Who Received A Preventive Examination and a Follow-Up Examination* performance measure for DWP Adults remained unchanged from the CY 2023 rate of 57.36 percent.	
–	Through the NAV activity, the MCOs demonstrated they were not calculating and reporting on appointment wait time standards for one or more of the following: behavioral health services-emergency; behavioral health services-mobile crisis; behavioral health services-substance use disorder and pregnancy; behavioral health services-intravenous drug use; emergency care; general optometry services; or lab and x-ray services. Therefore, access compliance with these provider types could not be assessed.	
–	During CY 2024, *SDOH Screening* PIP topic was initiated for the MCOs, and all MCOs received a designation of High Confidence for Validation Rating 1 of the Design phase. However, while no data were reported for this PIP during CY 2024, this PIP has the potential to impact the identification of SDOH issues that are barriers to accessing care in the future.	

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
–	The EQR activities do not produce sufficient data to assess the impact of the *Improve Access to Maternal Health* and *Improve Access to LTSS Services* Iowa HHS Medicaid Quality Strategy objectives, or the *Sealant Receipt on Permanent First Molars* indicator under the *Improve Access to Primary Care and Specialty Care* objective.	
Strategic Priority 2.0—Whole Person Coordinated Care		
✓	The aggregated statewide HEDIS rate for *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing—Total* was 26.94 percent, which was an improvement from the 23.6 percent baseline rate identified in the Iowa HHS Medicaid Quality Strategy, and this performance demonstrates a positive impact for the Iowa HHS Medicaid Quality Strategy objective to *Improve Integrated Coordinated Care for Members with a Behavioral Health Diagnosis*.	☒ Quality ☐ Timeliness ☐ Access
✓	The aggregated statewide HEDIS rate for *Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications* was 80.03 percent, which achieved the Iowa HHS Medicaid Quality Strategy objective to *Increase Diabetes Screening for People with Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications (SSD) from 75.6% to 80% by SFY2027*.	
✓	The aggregated statewide HEDIS rate for *Initiation and Engagement of Substance Use Disorder Treatment–Initiation of SUD Treatment—Total* was 47.99 percent and the *Initiation and Engagement of Substance Use Disorder Treatment–Engagement of SUD Treatment—Total* aggregated statewide HEDIS rate was 18.30 percent, indicating progress was made towards achieving the Iowa HHS Medicaid Quality Strategy objective to *Increase Initiation and Engagement of Substance Use Disorder Treatment (IET-AD) from 39.2% to 45% for initiation and from 15.5% to 20% for engagement By SFY2027.*	
✓	The *Prenatal and Postpartum Care* measure had statewide aggregate rates of 87.16 percent for prenatal care and 83.12 percent for postpartum care, which indicated a positive impact to the two indicators under the *Improve Prenatal and Postpartum Comprehensive Care Management* Iowa HHS Medicaid Quality Strategy objective.	
m	While statewide aggregate rates were reported through the PMV activity for MLTSS measures: *Admission to a Facility from the Community*, *Minimizing Facility Length of Stay* and *Successful Transition After Long-Term Facility Stay*, the Iowa HHS Medicaid Quality Strategy did not include performance targets for these measures. Therefore, the impact to the objective to *Improve Whole Person Coordinated Care for Member Enrolled in LTSS Services* could not be assessed.	
Strategic Priority 3.0—Health Equity		
–	The EQR activities did not produce sufficient data to assess the impact to *Address Disparities in Behavioral Health* and *Address Disparities in Primary and Specialty Care Services* Iowa HHS Medicaid Quality Strategy objectives. Of note, while performance measures that align with the Iowa HHS Medicaid Quality Strategy objectives are collected through the HEDIS audit process, the data included through the technical report process are not stratified by race, ethnicity, age, or geography.	☒ Quality ☐ Timeliness ☒ Access

	Performance Impact on Strategic Priorities and Objectives	Performance Domain
–	The aggregated findings for the EQR activities did not produce sufficient data for HSAG to comprehensively assess the impact that HHS' value-based arrangements have on reducing disparities in care in the focus area of low birth weight.	
Strategic Priority 4.0—Program Administration		
–	The EQR activities did not produce data to assess the impact on the Grievances, Appeals, and Exception to Policy objective.	☒ Quality ☐ Timeliness ☐ Access
Strategic Priority 5.0—Voice of the Customer		
✓	For the child Medicaid population *Rating of All Health Care* CAHPS measure, the statewide aggregate rate was 69.95 percent, which was higher than the CY 2023 rate.	☒ Quality ☐ Timeliness ☐ Access
✓	For the child Medicaid population *Customer Service* CAHPS measure, the statewide aggregate rate was 88.22 percent, which was higher than the CY 2023 rate.	
✓	For the child Medicaid population *Rating of Specialist Seen Most Often* CAHPS measure, the statewide aggregate rate was 74.80 percent, which was higher than the CY 2023 rate.	
✓	For the adult Medicaid population *Rating of Specialist Seen Most Often* CAHPS measure, the statewide aggregate rate was 61.90 percent, which was slightly higher than the CY 2023 rate.	
✗	The MCO Program (i.e., statewide aggregate rate) received a rate of 45.23 percent for the CAHPS measure, *Discussing Cessation Medications* for the adult Medicaid population, which was slightly lower than the CY 2023 rate.	
–	The aggregated findings for the EQR activities did not produce data for HSAG to comprehensively assess the impact to HHS' focus areas through surveys for continuity of care, experience of care stratified by waiver, and questions around grievances and appeals.	

Recommendations

Based on findings identified through the EQR activities that impacted the goals and objectives in the Iowa HHS Medicaid Quality Strategy, HSAG has identified the following recommendations to support improvement in the quality, timeliness, and access to healthcare services furnished to Iowa Managed Care Program members:

- To further enhance HHS' ability to measure the strategic priorities indicated in the Iowa HHS Medicaid Quality Strategy, HSAG recommends that HHS consider including specific, measurable, attainable, and timely goals and corresponding objectives for each of the strategic priorities and revise the Iowa HHS Medicaid Quality Strategy to reflect these updates. For example, related to the Access to Care strategic priority, HHS could consider adding objectives that tie to HEDIS performance measures for all HHS priority areas including behavioral health, maternal health, LTSS, primary care, and specialty care, and setting benchmarks for each objective.
- As indicated in the Iowa HHS Medicaid Quality Strategy, HHS plans to contractually require that MCOs engage in two additional PIPs per year (two HSAG validated PIPs and two non-HSAG validated PIPs) that focus on prevention and care of acute and chronic conditions, high risk services, oral health, etc. As such, HSAG recommends that HHS consider selecting the topics for the additional PIPs to ensure alignment with the Iowa HHS

Performance Impact on Strategic Priorities and Objectives	Performance Domain

Quality Strategy goals and objectives. Additionally, HHS could also require specific interventions that MCOs must implement for the PIPs that would facilitate comparability amongst the MCOs.

- HSAG recommends that HHS issue formal guidance to all MCPs, detailing its expectations for how the MCPs should assess appointment wait time standards and consider revisions to the survey protocol to ensure the MCPs' compliance with State standards are accurately measured. As CMS has implemented appointment timeliness standards effective in 2027, HHS should also ensure that these standards are incorporated into all MCP contracts, as applicable. Specifically, to comply with the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F), HHS should implement the following within the required effective dates:
  - Review the maximum appointment wait times standards (i.e., 15 business days for routine primary care [adult and pediatric] and obstetric/gynecological services; 10 business days for outpatient mental health and SUD appointments).
- HHS should contract with an independent vendor to perform secret shopper surveys of MCP compliance with appointment wait times and accuracy of provider directories and require directory inaccuracies to be sent to HHS within three days of discovery, per the Medicaid and Children's Health Insurance Program Managed Care Access, Finance, and Quality Final Rule (CMS–2439–F). Results from the secret shopper survey will provide assurances to HHS that the MCPs' networks have the capacity to serve the expected enrollment in their service area and that they offer appropriate access to preventive and primary care services for their members.
- To also ensure adherence to CMS–2439–F, HHS should ensure that an annual member experience survey for each MCP is conducted and analyze the responses to determine where opportunities for improvement exist and implement initiatives that target improvement.
- To comply with the CMS Interoperability and Prior Authorization Final Rule (CMS-0057-F), HHS should update the contracts with its MCPs as follows within the required effective dates for each specific requirement:
  - Require the MCPs to respond to prior authorization requests for covered items and services within seven calendar days for standard requests to improve patient care outcomes and ensure members have more timely access to services.
  - Require the MCPs to publicly report prior authorization data for members and providers to better understand the types of items and services which require prior authorization and how each MCP performed over time for approvals and denials. This requirement is to assure transparency and accountability in the healthcare system and allow for the efficiency of prior authorization practices of each MCP, and enables the MCPs to assess trends, identify areas for improvement, and work towards continuous process improvement while maintaining necessary quality checks for quality and appropriateness of care.
- Through the PAHP EDV activity, HSAG's dental record reviewers followed the requirements outlined in the *IA Dental Services Provider Manual* (*Appendix B*), which indicated that when procedure code D9999 was billed by a dental provider, supporting documentation for this code must be submitted with the claim. Based on HSAG's review of the submitted dental records, the dental records did not contain sufficient documentation to support the reported procedure code in the encounter data, which was a key factor in HSAG's assessment and impacted the PAHPs' findings through this activity. Following the completion of HSAG's analysis, HHS confirmed that Federally Qualified Health Centers (FQHCs) were not required to include supporting documentation when submitting claims for this procedure code. As such, HSAG recommends that HHS update the *IA Dental Services Provider Manual* (*Appendix B*) to ensure alignment with this direction for FQHC billing.

Appendix A. External Quality Review Activity Methodologies

Methods for Conducting External Quality Review Activities

Validation of Performance Improvement Projects

Activity Objectives

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

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

In its PIP evaluation and validation, HSAG used the Department of Health and Human Services, CMS publication, *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, February 2023.[24]

HSAG's validation of PIPs includes two key components of the QI process:

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

[24] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2024.

Technical Methods of Data Collection and Analysis

The HSAG PIP team consisted of, at a minimum, an analyst with expertise in statistics and PIP design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with HHS, developed the PIP Submission Form. Each MCP completed this form and submitted it to HSAG for review. The PIP Submission Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

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

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

1. Review the Selected PIP Topic
2. Review the PIP Aim Statement
3. Review the Identified PIP Population
4. Review the Sampling Method
5. Review the Selected Performance Indicator(s)
6. Review the Data Collection Procedures
7. Review the Data Analysis and Interpretation of PIP Results
8. Assess the Improvement Strategies
9. Assess the Likelihood that Significant and Sustained Improvement Occurred

HSAG used the following methodology to evaluate PIPs conducted by the MCPs to determine PIP validity and to rate the percentage of compliance with CMS' protocol for conducting PIPs (CMS EQR Protocol 1).

Each required step is evaluated on one or more elements that form a valid PIP. The HSAG PIP Review Team scores each evaluation element within a given step as *Met*, *Partially Met*, *Not Met*, *Not Applicable*, or *Not Assessed*. HSAG designates evaluation elements pivotal to the PIP process as "critical elements." For a PIP to produce valid and reliable results, all critical elements must be *Met*.

In alignment with CMS Protocol 1, HSAG assigns two PIP validation ratings, summarizing overall PIP performance. One validation rating reflects HSAG's confidence that the MCP adhered to acceptable methodology for all phases of design and data collection and conducted accurate data analysis and interpretation of PIP results. This validation rating is based on the scores for applicable evaluation elements in Steps 1 through 8 of the PIP Validation Tool. The second validation rating is only assigned for PIPs that have progressed to the Outcomes stage (Step 9) and reflects HSAG's confidence that the PIP's performance indicator results demonstrated evidence of significant improvement. The second validation rating is based on scores from Step 9 in the PIP Validation Tool. For each applicable validation rating, HSAG reports the percentage of applicable evaluation elements that received a *Met*

validation score and the corresponding confidence level: *High Confidence*, *Moderate Confidence*, *Low Confidence*, or *No Confidence*. The confidence level definitions for each validation rating are as follows:

1. **Overall Confidence of Adherence to Acceptable Methodology for All Phases of the PIP (Steps 1 Through 8)**
   - *High Confidence*: High confidence in reported PIP results. All critical evaluation elements were *Met*, and 90 percent to 100 percent of all evaluation elements were *Met* across all steps.
   - *Moderate Confidence*: Moderate confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 percent to 89 percent of all evaluation elements were *Met* across all steps.
   - *Low Confidence*: Low confidence in reported PIP results. Across all steps, 65 percent to 79 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Partially Met*.
   - *No Confidence*: No confidence in reported PIP results. Across all steps, less than 65 percent of all evaluation elements were *Met*; or one or more critical evaluation elements were *Not Met*.
2. **Overall Confidence That the PIP Achieved Significant Improvement (Step 9)**
   - *High Confidence*: All performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *Moderate Confidence*: One of the three scenarios below occurred:
     - All performance indicators demonstrated improvement over the baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over the baseline.
     - All performance indicators demonstrated improvement over the baseline, **and** none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
     - Some but not all performance indicators demonstrated improvement over baseline, **and** some but not all performance indicators demonstrated *statistically significant* improvement over baseline.
   - *Low Confidence*: The remeasurement methodology was not the same as the baseline methodology for at least one performance indicator **or** some but not all performance indicators demonstrated improvement over the baseline and none of the performance indicators demonstrated *statistically significant* improvement over the baseline.
   - *No Confidence*: The remeasurement methodology was not the same as the baseline methodology for all performance indicators **or** none of the performance indicators demonstrated improvement over the baseline.

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

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

Description of Data Obtained and Related Time Period

For CY 2024, the MCOs submitted methodologies for the two PIP topics. The MCOs used measure specifications developed by HHS and HSAG for the *SDOH Screening* PIP topic and HEDIS measure specifications for the *Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)* PIP. The PAHPs submitted Remeasurement 2 data for their continued PIP topics. The PAHPs used HHS-defined specifications in collecting their performance indicator data. The measures used for MCP PIPs were related to the domains of quality of care and access to care.

HSAG obtained the data needed to conduct the PIP validation from the MCPs' PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIPs aim statements, sampling and data collection methods and the QI activities completed. Table A-1 displays a description of the data obtained for each PIP topic.

Table A-1—MCO Data Obtained for Each PIP Topic

ITC PIP Topics	Aim Statements	Sampling Methods	Data Sources
SDOH Screening	1. Do targeted interventions increase the percentage of unduplicated newly enrolled Medicaid members during the measurement period that were screened for social determinants of health (SDOH) no later than ninety days after the effective date of enrollment? 2. Do targeted interventions increase the percentage of unduplicated existing Medicaid members who were due for a subsequent screening during the measurement period, were continuously enrolled for the prior 12 months, and were screened for SDOH during the measurement period?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	Does performing targeted interventions for children ages 6-12 years old that have a prescription dispensed for ADHD medication and had at least 3 follow-up care visits within a 300-day (10 month) period, one of which was within 30 days of	Sampling was not used.	• Administrative claims/encounters

ITC PIP Topics	Aim Statements	Sampling Methods	Data Sources
	when the first ADHD medication was dispensed and two of which occurred within 270 days (9 months), result in an increase of 2% points from the baseline rate?		
MOL PIP Topics	**Aim Statements**	**Sampling Methods**	**Data Sources**
SDOH Screening	1. Do targeted interventions increase the percentage of unduplicated newly enrolled Medicaid members during the measurement period that were screened for social determinants of health (SDOH) no later than ninety days after the effective date of enrollment? 2. Do targeted interventions increase the percentage of unduplicated existing Medicaid members who were due for a subsequent screening during the measurement period, were continuously enrolled for the prior 12 months and were screened for SDOH during the measurement period?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	1. Initial Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase? 2. Continuation and Maintenance Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who	Sampling was not used.	• Administrative claims/encounters

MOL PIP Topics	Aim Statements	Sampling Methods	Data Sources
	remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least 2 follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended?		

WLP PIP Topics	Aim Statements	Sampling Methods	Data Sources
SDOH Screening	1. Do targeted interventions increase the percentage of unduplicated newly enrolled Medicaid members during the measurement period that were screened for social determinants of health (SDOH) no later than ninety days after the effective date of enrollment? 2. Do targeted interventions increase the percentage of unduplicated existing Medicaid members who were due for a subsequent screening during the measurement period, were continuously enrolled for the prior 12 months and were screened for SDOH during the measurement period?	Sampling was not used.	• Health Risk Screening responses
Follow-Up Care for Children Prescribed ADHD Medication (ADD-HEDIS)	1. Initiation Phase: Do targeted interventions increase the percentage of members 6-12 years of age with a prescription dispensed for ADHD medication, who had one follow-up visit with a practitioner with prescribing authority during the 30-day initiation phase? 2. Continuation and Maintenance Phase: Do targeted interventions increase the percentage of	Sampling was not used.	• Administrative claims/encounters

WLP PIP Topics	Aim Statements	Sampling Methods	Data Sources
	members 6-12 years of age with a prescription dispensed for ADHD medication, who remained on the medication for at least 210 days and who, in addition to the visit in the initiation phase, had at least two follow-up visits with a practitioner within 270 days (9 months) after the initiation phase ended?		

HSAG obtained the data needed to conduct the PIP validation from each PAHP's annual PIP Submission Form. These forms provide annual performance indicator data and detailed information about each PIP's aim statements, sampling and data collection methods, and the QI activities completed. Table A-2 displays a description of the data obtained for each PIP topic.

Table A-2—PAHP Data Obtained for Each PIP Topic

DDIA PIP Topic	Aim Statements	Sampling Methods	Data Sources
Annual Preventative Dental Visits	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least one preventive dental visit during the measurement year? 2. Do targeted interventions increase the percentage of Hawki (Hawki) members 18 years of age and younger who had at least one preventive dental visit during the measurement year? 3. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year	Sampling was not used.	• Administrative claims/encounters
MCNA PIP Topic	**Aim Statements**	**Sampling Methods**	**Data Sources**
Increase the Percentage of Dental Services	1. Do targeted interventions increase the percentage of Dental Wellness Plan (DWP Adults) members 19 years and older who had at least	Sampling was not used.	• Administrative claims/encounters

MCNA PIP Topic	Aim Statements	Sampling Methods	Data Sources
	one preventive dental visit during the measurement year? 2. Do targeted interventions increase the percentage of Dental Wellness Plan Kids (DWP Kids) members 18 years of age and younger who had at least one preventive dental visit during the measurement year?		

The MCPs submitted each PIP Submission Form according to the approved timeline. After initial validation, the MCPs received HSAG's feedback, an opportunity for technical assistance, and resubmitted the PIP Submission Form for final validation. Table A-3 and Table A-4 display the indicator measurement periods for all PIP topics for the MCPs.

Table A-3—MCO Measurement Periods for PIP Topics

Data Obtained	Measurement Period
Baseline	January 1, 2024—December 31, 2024
Remeasurement 1	January 1, 2025—December 31, 2025
Remeasurement 2	January 1, 2026—December 31, 2026

Table A-4—PAHP Measurement Periods for Both PIP Topics

Data Obtained	Measurement Period
Baseline	July 1, 2021—June 30, 2022
Remeasurement 1	July 1, 2022—June 30, 2023
Remeasurement 2	July 1, 2023—June 30, 2024

Process for Drawing Conclusions

To draw conclusions about the quality, timeliness, and accessibility of care and services that the MCP provided to members, HSAG validated the PIPs to ensure the MCP used a sound methodology in its design and PIP implementation. The process assesses the validation findings on the likely validity and reliability of the results by assigning a validation score of *High Confidence, Moderate Confidence, Low Confidence* or *No Confidence*. HSAG further analyzed the quantitative results (e.g., performance indicator results compared to baseline and the PIP goal) and qualitative results (e.g., technical design of the PIP) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members.

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by all MCPs and to determine the extent to which performance measures reported by the MCPs follow State specifications and reporting requirements. HSAG also followed the guidelines set forth in CMS' *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, February 2023.[25]

HHS identified a set of performance measures for CMS Core Set reporting that it wanted to include in the validation activity. HHS also identified a set of performance measures that the MCOs and PAHPs were required to calculate and report, which were required to be reported following the CMS MLTSS measure specifications and the measure specifications provided by HHS, respectively.

Technical Methods of Data Collection and Analysis

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

- **Information Systems Capabilities Assessment Tool (ISCAT)**—The MCPs and the HHS vendor (IBM [26]) were required to submit a completed ISCAT that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation of the required HHS-developed measures, CMS Core Set measures, or CMS MLTSS measures. HSAG reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.
- **Source code (programming language) for performance measures**—IBM and the MCPs that calculated the performance measures using computer programming language were required to submit source code for each performance measure being validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications defined by HHS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCPs that did not use computer programming language to calculate the performance measures were required to submit documentation describing the actions taken to calculate each measure.
- **Supporting documentation**—The MCPs and IBM submitted documentation to HSAG that provided reviewers with additional information necessary to complete the validation process, including policies and procedures, file layouts, system flow diagrams, system log files, and data collection process descriptions. HSAG reviewed all supporting documentation and identified issues or areas needing clarification for further follow-up.

[25] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 17, 2025.

[26] IBM was included as part of the PMV activity with the MCPs, as IBM calculated CMS Core Set Reporting performance measure rates at the statewide level using encounter data submitted to HHS by the MCPs.

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV Protocol 2 cited earlier in this report. HSAG obtained a list of the performance measures selected by HHS for validation.

In collaboration with HHS, HSAG prepared a documentation request letter that was submitted to the MCPs and IBM, which outlined the steps in the PMV process. The documentation request letter included a request for the source code for each performance measure, a completed ISCAT, and any additional supporting documentation necessary to complete the audit. The letter also included a timeline for completion and instructions for the MCPs and IBM to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the MCPs and IBM.

Approximately two weeks prior to the PMV virtual review, HSAG provided MCPs and IBM with an agenda describing all review activities and indicated the type of staff needed for participation in each session. HSAG also conducted a pre-review conference call with the MCPs and IBM to discuss review logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the MCPs and IBM.

PMV Review Activities

HSAG conducted a virtual review with each MCP and the HHS vendor. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities included the following:

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

key staff familiar with the collection, processing, and monitoring of the MCP data used in producing performance measures.

  - **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the MCPs' and IBM's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - **System demonstrations**—HSAG staff requested that MCP and IBM staff demonstrate key information systems, database management systems, and analytic systems to support documented evidence and interview responses.

- **PSV**—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. Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across evaluated measures to verify that the MCPs and IBM had appropriately applied measure specifications for accurate rate reporting. The MCPs and IBM provided HSAG with a listing of the data the MCPs had reported to HHS, from which HSAG randomly selected a sample of cases and requested that the MCPs provide proof of service documentation.

Description of Data Obtained and Related Time Period

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

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

Table A-5 shows the data sources used in the CMS Core Set validation of performance measures and the periods to which the data applied. IBM's information has been included to demonstrate its involvement in the MCO PMV.

Table A-5—Description of MCO, PAHP, and IBM CMS Core Set Measure Data Sources

Data Obtained	Time Period to Which the Data Applied					
	ITC	MOL	WLP	DDIA	MCNA	IBM
Completed ISCAT	MY 2023 (January 1, 2023, to December 31, 2023)					
Source code for each performance measure						
Performance measure results						
Supporting documentation						
Virtual on-site interviews and systems demonstrations	October 15, 2024	October 8, 2024	October 18, 2024	October 15, 2024	October 16, 2024	November 1, 2024

Table A-6 shows data sources used in the MCO MLTSS validation of performance measures and the periods to which the data applied.

Table A-6—Description of MCO MLTSS Measure Data Sources

Data Obtained	Time Period to Which the Data Applied		
	ITC	MOL	WLP
Completed ISCAT	MY 2023 (January 1, 2023, to December 31, 2023)		
Source code for each performance measure			
Performance measure results			
Supporting documentation			
Virtual on-site interviews and systems demonstrations	October 15, 2024	October 8, 2024	October 18, 2024

Additionally, HHS provided HSAG with each MCO's audited MY 2023 HEDIS rates for HHS-selected measures, and HSAG reviewed the rates in comparison to national Medicaid percentiles to identify strengths and opportunities for improvement.

Table A-7 shows the data sources used in the validation of State-custom performance measures reported by the PAHPs and the periods to which the data applied.

Table A-7—Description of PAHP State-Custom Measure Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2024 (July 1, 2023, to June 30, 2024)	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	October 15, 2024	October 16, 2024

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that the MCPs provided to members, HSAG determined results for each performance indicator and assigned each an indicator designation of *Reportable*, *Do Not Report*, *Not Applicable*, or *Not Reported*. HSAG further analyzed the quantitative results (e.g., performance indicator results) and qualitative results (e.g., data collection and reporting processes) to identify strengths and weaknesses and determine whether each strength and weakness impacted one or more of the domains of quality, timeliness, or access. For each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members. Additionally, for each MCO's audited MY 2023 HEDIS rates for HHS-selected measures, strengths were identified as a greater than 5 percent improvement from the prior year or a rate that was above the national Medicaid 75th percentile. Weaknesses were identified as a greater than 5 percent decline from the prior year or a rate that fell at or below the national Medicaid 25th percentile.

Compliance Review

Activity Objectives

According to 42 CFR §438.358, a state or its EQRO must conduct a review within a three-year period to determine the MCPs' compliance with standards set forth in 42 CFR §438—Managed Care Subpart D, the disenrollment requirements and limitations described in §438.56, the member rights requirements described in §438.100, the emergency and poststabilization services requirements described in §438.114, and the quality assessment and performance improvement requirements described in §438.330. To complete this requirement, HSAG, through its EQRO contract with HHS, performed compliance reviews of the MCPs contracted with HHS to deliver services to Iowa Managed Care Program members. HSAG

followed the guidelines set forth in CMS' *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations*, February 2023.[27]

HHS requires its MCPs to undergo periodic compliance reviews to ensure that an assessment is conducted to meet federal requirements. CY 2024 began a new three-year compliance review cycle, in which HSAG reviewed the first half of the federal standards for compliance. The remaining federal standards will be reviewed in CY 2025, and in Year Three (CY 2026), a comprehensive evaluation of the MCPs' implementation of corrective actions taken to remediate any requirements (i.e., elements) that received a *Not Met* score during the first two years of the compliance review cycle (CYs 2024 and 2025).

As demonstrated in Table A-8, HSAG will complete a comprehensive review of compliance with all federal requirements as stipulated in 42 CFR §438.358 within a three-year period.

Table A-8—Iowa Compliance Review Three-Year Cycle for MCPs

Standards	Associated Federal Standards[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard I—Disenrollment: Requirements and Limitations	§438.56	§457.1212	✓		Review of each MCP's Year One and Year Two CAPs
Standard II—Member Rights and Member Information	§438.10 §438.100	§457.1207 §457.1220	✓		
Standard III—Emergency and Poststabilization Services	§438.114	§457.1228	✓		
Standard IV—Availability of Services	§438.206	§457.1230(a)	✓		
Standard V—Assurances of Adequate Capacity and Services	§438.207	§457.1230(b)	✓		
Standard VI—Coordination and Continuity of Care	§438.208	§457.1230(c)	✓		
Standard VII—Coverage and Authorization of Services	§438.210	§457.1230(d)	✓		
Standard VIII—Provider Selection	§438.214	§457.1233(a)		✓	
Standard IX—Confidentiality	§438.224	§457.1110 §457.1233(e)		✓	
Standard X—Grievance and Appeal Systems	§438.228	§457.1260		✓	
Standard XI—Subcontractual Relationships and Delegation	§438.230	§457.1233(b)		✓	
Standard XII—Practice Guidelines	§438.236	§457.1233(c)		✓	
Standard XIII—Health Information Systems[2]	§438.242	§457.1233(d)		✓	

[27] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3. Review of Compliance with Medicaid and CHIP Managed Care Regulations,* February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Jan 23, 2025.

Standards	Associated Federal Standards[1]		Year One (CY 2024)	Year Two (CY 2025)	Year Three (CY 2026)
	Medicaid	CHIP			
Standard XIV—Quality Assessment and Performance Improvement Program	§438.330	§457.1240(b)		✓	

[1] The compliance review standards comprise a review of all requirements, known as elements, under the associated federal citation, including all requirements that are cross referenced within each federal standard, as applicable (e.g., Standard X—Grievance and Appeal Systems includes a review of §438.228 and all requirements under Subpart F of 42 CFR Part 438).

[2] The Health Information Systems standard includes an assessment of each MCP's IS capabilities.

Technical Methods of Data Collection and Analysis

Prior to beginning the CY 2024 compliance review, HSAG developed data collection tools, referred to as compliance review tools, to document the findings from the review. The content of the tools was selected based on applicable federal and State regulations and on the requirements set forth in the contract between HHS and the MCPs as they related to the scope of the review. The review processes used by HSAG to evaluate each MCP's compliance were consistent with CMS EQR Protocol 3.

For each MCP, HSAG's desk review consisted of the following activities:

Pre-Site Review Activities:

- Collaborated with HHS to develop scope of work, compliance review methodology, and compliance review tools (i.e., Standards review tools).
- Prepared and forwarded to the MCP a timeline, description of the compliance process, pre-site review information packet, a submission requirements checklist, and a post-site review document tracker.
- Scheduled the site review with each MCP.
- Hosted a pre-site review preparation session with all MCPs.
- Generated a list of 10 sample records for the MCPs for care management and service and payment denial case file reviews.
- Conducted a desk review of supporting documentation the MCP submitted to HSAG.
- Followed up with each MCP, as needed, based on the results of HSAG's preliminary desk review.
- Developed an agenda for the site review interview sessions and provided the agenda to the MCP to facilitate preparation for HSAG's review.

Site Review Activities:

- Conducted an opening conference, with introductions and a review of the agenda and logistics for HSAG's review activities.
- Interviewed MCP key program staff members.

- Conducted an IS review of the data systems that the MCP used in its operations, applicable to the standards and elements under review.
- Conducted a review of case files to determine compliance in the program areas under review, including care management and service and payment denial records.
- Conducted a closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Post-Site Review Activities:

- Conducted a review of additional documentation submitted by the MCP.
- Documented findings and assigned each element a score of *Met, Not Met,* or *NA* for the Standards review (as described in the Data Aggregation and Analysis section) within the compliance review tool.
- Prepared an MCP-specific report detailing the findings of HSAG's review.
- Prepared an MCP-specific CAP template and required the MCPs to develop and submit remediation plans for each element that received a *Not Met* score.

Data Aggregation and Analysis:

For the CAP review, HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCP's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to the MCP during the period covered by HSAG's review. This scoring methodology is consistent with CMS EQR Protocol 3. The protocol describes the scoring as follows:

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

- All documentation listed under a regulatory provision, or component thereof, is present.
- Staff members are able to provide responses to reviewers that are consistent with each other and with the documentation.
- Documentation, staff responses, case file reviews, and IS reviews confirmed implementation of the requirement.

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- Documentation, staff responses, case file documentation, and IS reviews do not demonstrate adequate implementation of the requirement.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.

- For those provisions with multiple components, key components of the provision could not be identified and any findings of *Not Met* would result in an overall provision finding of noncompliance, regardless of the findings noted for the remaining components.

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

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

HSAG conducted file reviews of the MCPs' records for care management and service and payment denials to verify that the MCPs had put into practice what the MCPs had documented in their policies. HSAG selected 10 records each for care management and service and payment denials from the full universe of records provided by each MCP. The file reviews were not intended to be a statistically significant representation of all the MCPs' files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCP staff members. Based on the results of the file reviews, MCPs must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

To draw conclusions about the quality, timeliness, and accessibility of care and services provided to members within the program areas under review, HSAG aggregated and analyzed the data resulting from its desk and site review activities. The data that HSAG aggregated and analyzed included:

- Documented findings describing the MCP's progress in achieving compliance with State and federal requirements.
- Scores assigned to the MCP's performance for each requirement.
- The total compliance score calculated for each of the standards included as part of the CY 2024 compliance review.
- The overall compliance score calculated across the standards.
- Documented actions required to bring performance into compliance with the requirements for which HSAG assigned a score of *Not Met*.
- Documented recommendations for program enhancement, when applicable.

Description of Data Obtained

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas).
- Case files for prior authorization denials, care plans, credentialing and recredentialing records, grievance records, appeal records, contracts with delegated entities, etc.

HSAG obtained additional information for the compliance review through IS reviews of the MCP's data systems and through interactions, discussions, and interviews with the MCP's key staff members. Table A-9 lists the major data sources HSAG used in determining the MCP's performance in complying with requirements and the time period to which the data applied.

Table A-9—Description of MCP Data Sources and Applicable Time Period

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during or after the site review	July 1, 2023, through March 31, 2024
Information obtained from a review of a sample of care management case files	Listing of all members newly enrolled into care management on or after July 1, 2023
Information obtained from a review of a sample of service and payment denial files	Denials that occurred between July 1, 2023, and March 31, 2024
Information obtained through interviews	July 8, 2024, through July 19, 2024
Documentation submitted post-site review	July 10, 2024, through July 21, 2024

Process for Drawing Conclusions

To draw conclusions and provide an understanding of the strengths and weaknesses for each MCP individually, HSAG used the results of the program areas reviewed, including comprehensive case file reviews for two program areas. As any element not achieving compliance required a formal action plan, HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength— Any program area that did not require a CAP (i.e., achieved a compliance score of 100 percent)
- Weakness—Any program area with three or more elements with a *Not Met* score.

HSAG further analyzed the qualitative results of each strength and weakness (i.e., findings that resulted in the strength or weakness) to draw conclusions about the quality, timeliness, and accessibility of care and services that the MCP provided to members by determining whether each strength and weakness impacted one or more of the domains of quality, timeliness, and access. Additionally, for each weakness, HSAG made recommendations to support improvement in the quality, timeliness, and accessibility of care and services furnished to the MCP's Medicaid members

Network Adequacy Validation

Activity Objectives

42 CFR §438.350(a) requires states that contract with MCOs, prepaid inpatient health plans (PIHPs), and PAHPs to have a qualified EQRO perform an annual EQR that includes validation of network adequacy to ensure provider networks are sufficient to provide timely and accessible care to Medicaid and CHIP members across the continuum of services.

The objectives of the validation of network adequacy are to:

- Assess the accuracy of the Iowa HHS defined network adequacy indicators reported by the MCPs.
- Evaluate the collection of provider data, reliability and validity of network adequacy data, methods used to assess network adequacy, and systems and processes used.
- Determine an indicator-level validation rating, which refers to the overall confidence that an acceptable methodology was used for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators, as set forth by HHS.

Technical Methods of Data Collection and Analysis

HSAG collected network adequacy data from the MCPs via a secure file transfer protocol (SFTP) site and via virtual NAV audits. HSAG used the collected data to conduct the validation of network adequacy in accordance with CMS EQR Protocol 4.[28]

HSAG conducted a virtual review with the MCPs. HSAG collected information using several methods, including interviews, system demonstrations, review of source data output files, PSV, observation of data processing, and review of final network adequacy indicator-level reports. The virtual review activities performed for each MCP are described below:

- Opening meeting
- Review of ISCAT and supporting documentation
- Evaluation of underlying systems and processes
- Overview of data collection, integration, methods, and control procedures
- Network adequacy source data PSV and results
- Closing conference

HSAG conducted interviews with key MCP staff members who were involved with the calculation and reporting of network adequacy indicators.

[28] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 4. Validation of Network Adequacy: A Mandatory EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: July 2, 2024.

Network Adequacy Indicator Validation Rating Determinations

HSAG evaluated each MCP's ability to collect reliable and valid network adequacy monitoring data, use sound methods to assess the adequacy of its managed care networks, and produce accurate results to support the MCP's and the State's network adequacy monitoring efforts.

HSAG used the CMS EQR Protocol 4 indicator-specific worksheets to generate a validation rating that reflects HSAG's overall confidence that the MCPs used an acceptable methodology for all phases of design, data collection, analysis, and interpretation of the network adequacy indicators. Based on the results of the ISCA combined with the detailed validation of each indicator, HSAG assessed whether the network adequacy indicator results were valid, accurate, and reliable, and if the MCP's interpretation of data was accurate. HSAG determined validation ratings for each reported network adequacy indicator.

How Conclusions Were Drawn

HSAG calculated each network adequacy indicator's validation score by identifying the number of *Met* and *Not Met* elements recorded in HSAG's CMS EQR Protocol 4 Worksheet 4.6, noted in Table A-10.

Table A-10—Validation Score Calculation

Worksheet 4.6 Summary
A. Total number of *Met* elements
B. Total number of *Not Met* elements
Validation Score = A / (A + B) x 100%
Number of *Not Met* elements determined to have significant bias on the results

The overall validation rating refers to HSAG's overall confidence that acceptable methodology was used for all phases of data collection, analysis, and interpretation of the network adequacy indicators. The CMS EQR Protocol 4 defines validation rating designations at the indicator level, which are defined in Table A-11, and assigned by HSAG once HSAG has calculated the validation score for each indicator.

Table A-11—Indicator-Level Validation Rating Categories

Validation Score	Validation Rating
90.0% or greater	*High Confidence*
50.0% to 89.9%	*Moderate Confidence*
10.0% to 49.9%	*Low Confidence*
Less than 10% and/or any *Not Met* element has significant bias on the results	*No Confidence*

Significant bias was determined based on the magnitude of errors detected and not solely based on the number of elements *Met* or *Not Met*. HSAG determined that a *Not Met* element had significant bias on the results by:

- Requesting that the MCPs provide a root cause analysis of the finding.
- Working with the MCPs to quantify the estimated impact of an error, omission, or other finding on the indicator calculation.
- Reviewing the root cause, proposed corrective action, timeline for corrections, and estimated impact, within HSAG's NAV Oversight Review Committee, to determine the degree of bias.
- Finalizing a bias determination within HSAG's NAV Oversight Review Committee based on the following threshold:
  - The impact biased the reported network adequacy indicator result by more than 5 percentage points, the impact resulted in a change in network adequacy compliance (i.e., the indicator result changed from compliant to noncompliant or changed from noncompliant to compliant), or the impact was unable to be quantified and therefore was determined to have the potential for significant bias.

Encounter Data Validation

Activity Objectives

Accurate and complete encounter data are critical to the success of a managed care program. Therefore, HHS requires its contracted MCPs to submit high-quality encounter data. HHS 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 2024, HHS contracted HSAG to conduct an EDV study for both the MCOs and the PAHPs. HSAG's approach to conducting EDV studies is tailored to address the specific needs of its clients by customizing elements outlined in CMS EQR Protocol 5. [29]

MCOs

For CY 2024, HSAG conducted the following two core evaluation activities:

- **Administrative profile**—analysis of HHS' electronic encounter data completeness, accuracy, and timeliness. The goal of this activity was to evaluate the extent to which the electronic encounter data in HHS' data warehouse were complete, accurate, and submitted by the MCOs in a timely manner for encounters with dates of service from July 1, 2023, through October 31, 2023. This activity corresponds to Activity 3: Analyze Electronic Encounter Data in the CMS EQR Protocol 5.

[29] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, February 2023. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2023-eqr-protocols.pdf. Accessed on: Feb 7, 2024.

- **Comparative Analysis**— analysis of HHS' electronic encounter data completeness and accuracy through a comparison between HHS' electronic encounter data and the data extracted from the MCOs' data systems. The goal of this activity was to evaluate the extent to which the encounter data in HHS' data warehouse that were submitted by the MCOs were complete and accurate. This activity corresponds to Activity 3: Analyze Electronic Encounter Data, in the CMS EQR Protocol 5.

MOL began administering benefits and providing services to Iowa Managed Care Program members on July 1, 2023. As such, since 2024 is only the second year that **MOL** has been submitting encounter data to HHS, HSAG conducted an administrative profile analysis specifically for **MOL** in CY 2024. For **ITC** and **WLP** (formerly known as Amerigroup), HSAG had previously conducted an administrative profile analysis in CY 2020 and CY 2017, respectively. Therefore, HSAG did not conduct an administrative profile analysis for these MCOs in CY 2024. Instead, based on HHS' decision, HSAG conducted a comparative analysis for both **ITC** and **WLP**. Additionally, considering **MOL**'s relatively new status in submitting encounter data to HHS, HSAG also conducted a comparative analysis for **MOL** in CY 2024.

PAHPs

For CY 2024, HSAG conducted the following core evaluation activity for **DDIA** and **MCNA**:

- **Dental record review (DRR)**—analysis of HHS' electronic encounter data completeness and accuracy through a comparison of HHS' electronic encounter data to the information documented in the corresponding member's dental records. This activity corresponds to *Activity 4: Review Medical Records* in the CMS EQR Protocol 5.

The review aimed to verify whether key data elements in the encounter data (i.e., *Date of Service*, *Dental Procedure Code*), were supported by the information found in the dental records. The goal was to answer the following question:

- Are the data elements (i.e., listed in Table A-12) in the dental encounters complete and accurate when compared to information in the dental records?

Table A-12—Key Data Elements for DRR

Key Data Element
• Date of Service • Dental Procedure Code (Current Dental Terminology [CDT])

Technical Methods of Data Collection and Analysis

MCOs

Administrative Profile (**MOL** only)

The administrative profile, or analysis, of a state's encounter data is essential to gauging the general completeness, accuracy, and timeliness of encounter data, as well as whether encounter data are sufficiently robust for other uses such as performance measure calculation. The degree of data file completeness submitted by **MOL** provides valuable insight into the quality of HHS' overall encounter data system and represents the basis for establishing confidence in subsequent analytical and rate setting activities.

HSAG assessed the final adjudicated encounters with service dates from July 1, 2023, through October 31, 2023, which were extracted from HHS' data warehouse on or before June 30, 2024. In addition, the EDV study used member demographic/enrollment data and provider data to evaluate the validity of key data elements within the encounter data.

Once the final data were received and processed, HSAG conducted a series of analyses across various metrics by encounter type (i.e., 837 Professional [837P], 837 Institutional [837I], and Pharmacy—National Council for Prescription Drug Programs [NCPDP]) as outlined in the sections below.

- **Encounter data completeness:**
  - Monthly encounter volume (i.e., visits) by service month (i.e., the month when services occur)— If the number of members remained stable and there were no major changes to members' medical needs, the monthly visit/service counts should have minimal variation. A low count for any month would indicate incomplete data. Of note, instead of evaluating claim numbers, HSAG evaluated the encounter volume based on a unique visit key. For example, for an office visit, the visit key was based on the member ID number, rendering provider NPI, and date of service.
  - Monthly encounter volume (i.e., visits) per 1,000 MM by service month— Compared to the metric above, this metric normalized the visit/service counts by the member counts. Of note, HSAG calculated the monthly member counts for **MOL** using the member enrollment data extracted by HHS.
  - PMPM by service month— This metric aims to help HHS determine whether the encounter data were complete from a payment perspective. Of note, HSAG worked with HHS to determine whether HSAG should use the header paid amount or detail paid amount to calculate this metric.
  - Percentage of duplicate encounters— HSAG determined the detailed methodology (e.g., data elements and criteria) for defining duplicates after reviewing the encounter data extracted for the study and documented the method in this report. This metric allowed HHS to assess the number of potential duplicate encounters in HHS' data warehouse.

- **Encounter data timeliness**:
  - Percentage of encounters received by HHS within 30 days, 60 days, 90 days, etc.— HSAG assessed this percentage from **MOL**'s payment/adjudication date. This metric aims to help HHS evaluate **MOL**'s compliance with HHS' encounter data timeliness requirements.
  - Claims lag triangle— Illustrates the percentage of encounters received by HHS within two months, three months, etc., from the service month. This metric was designed to help HHS evaluate how quickly it could use the encounter data in the data warehouse for activities such as performance measure calculation and utilization statistics.
- **Encounter data accuracy**:
  - Percent present—Percentage of records with values present for a specific key data element listed in Table A-13.
  - Percent valid—Percentage of records with values valid for a specific key data element listed in Table A-13.

Table A-13— Key Data Elements for Percent Present and Percent Valid

Key Data Elements	Professional Encounters (837P)	Institutional Encounters (837I)	Pharmacy Encounters (NCPDP)	Criteria for Validity
Member ID	✓	✓	✓	• In member file supplied by HHS • Enrolled in the MCO on the date of service
Header Service From Date	✓	✓		• Header Service From Date ≤ Header Service To Date • Header Service From Date ≤ Paid Date
Header Service To Date	✓	✓		• Header Service To Date ≥ Header Service From Date • Header Service To Date ≤ Paid Date
Detail Service From Date	✓	✓		• Detail Service From Date ≤ Detail Service To Date • Detail Service From Date ≤ Paid Date
Detail Service To Date	✓	✓		• Detail Service To Date ≥ Detail Service From Date • Detail Service To Date ≤ Paid Date
Date of Service			✓	• Date of Service ≤ Paid Date
Billing Provider NPI	✓	✓	✓	In provider data when service occurred
Rendering Provider NPI	✓			In provider data when service occurred
Attending Provider NPI		✓		In provider data when service occurred

Key Data Elements	Professional Encounters (837P)	Institutional Encounters (837I)	Pharmacy Encounters (NCPDP)	Criteria for Validity
Servicing Provider Taxonomy Code	✓	✓		• In standard taxonomy code set • Matches provider data values
Referring Provider NPI	✓	✓		In provider data when service occurred
Prescribing Provider NPI			✓	In provider data when service occurred
Primary Diagnosis Codes	✓	✓		In national International Classification of Diseases, Tenth Revision, Clinical Modification (ICD-10-CM) diagnosis code sets for the correct code year
Secondary Diagnosis Codes	✓	✓		In national ICD-10-CM diagnosis code sets for the correct code year
Procedure Code (Current Procedural Terminology [CPT], Healthcare Common Procedure Coding System [HCPCS] CPT/HCPCS codes)	✓	✓		In national CPT/HCPCS code sets for the correct code year (e.g., in 2023 code set for services that occurred in 2023) **AND** satisfies CMS' Procedure-to-Procedure edits
Primary Surgical Procedure Codes		✓		In national ICD-10-PCS surgical procedure code sets for the correct code year
Secondary Surgical Procedure Codes		✓		In national ICD-10-PCS surgical procedure code sets for the correct code year
Revenue Codes		✓		In national standard revenue code sets for the correct code year
Diagnosis-Related Groups (DRG) Codes		✓		In national standard Medicare Severity (MS)-DRG code sets for the correct code year
Type of Bill Codes		✓		In national standard type of code set
Drug Codes	✓	✓	✓	In national drug code sets
MCO Paid Date	✓	✓	✓	MCO Paid Date ≥ Detail Service To Date
MCO Submit Date	✓	✓	✓	MCO Submission Date (i.e., the date when MCO submits encounters to HHS) ≥ MCO Paid Date

Key Data Elements	Professional Encounters (837P)	Institutional Encounters (837I)	Pharmacy Encounters (NCPDP)	Criteria for Validity
Header Paid Amount	✓	✓		Header Paid Amount equal to the sum of the Detail Paid Amounts
Detail Paid Amount	✓	✓		Zero or positive
Paid Amount			✓	Zero or positive
Header Third Party Liability (TPL) Paid Amount	✓	✓		Header TPL Paid Amount equal to the sum of the Detail TPL Paid Amounts
Detail TPL Paid Amount	✓	✓		Zero or positive
TPL Paid Amount			✓	Zero or positive

Comparative Analysis

All three MCOs (i.e., **ITC**, **MOL**, and **WLP**) were included in this component of the EDV activity for CY 2024. In this activity, HSAG developed a data requirements document requesting claims/encounter data from both HHS and the MCOs. A follow-up technical assistance session was held approximately one week after distributing the data requirements documents, thereby allowing the MCOs time to review and prepare their questions for the meeting.

HSAG used data from both HHS and the MCOs with dates of service from July 1, 2022, through October 31, 2023, for **ITC** and **WLP**, and from July 1, 2023, through October 31, 2023, for **MOL**, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources (i.e., HHS and the MCOs) represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters with MCO adjustment/paid dates on or before March 31, 2024, and submitted to HHS on or before April 30, 2024. This anchor date allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse. Once HSAG received data files from both data sources, the analytic team conducted a preliminary file review to ensure data were sufficient to conduct the evaluation. The preliminary file review included the following basic checks:

- Data extraction—Ensured data were extracted based on the data requirements document.
- Percentage present—Verified that required data fields were present in the file and had values in those fields.
- Percentage of valid values—Confirmed that the values included were the expected values (e.g., valid ICD-10 codes in the diagnosis field).
- Evaluation of matching claim numbers—Calculated the percentage of claim numbers that matched between the data extracted from HHS' data warehouse and the MCOs' data submitted to HSAG.

Based on the preliminary file review results, HSAG generated a report that highlighted major findings, requiring HHS or the MCOs to resubmit data, as needed.

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

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

- **Record Omission**—The number and percentage of records present in the MCOs' submitted data files but not in HHS' data warehouse.
- **Record Surplus**—The number and percentage of records present in HHS' data warehouse but not in the MCOs' submitted data files.

Second, based on the number of records present in both data sources, HSAG further examined completeness and accuracy for key data elements listed in Table A-14. The analyses focused on an element-level comparison for each data element.

Table A-14—Key Data Elements for Comparative Analysis

Key Data Elements	Professional Encounters (837P)	Institutional Encounters (837I)	Pharmacy Encounters (NCPDP)
Member ID	✓	✓	✓
Dates of Service			
Detail Service From Date	✓		
Detail Service To Date	✓		
Header Service From Date		✓	✓
Header Service To Date		✓	
Admission Date		✓	
Provider Information			
Billing Provider NPI	✓	✓	✓
Rendering Provider NPI	✓		
Attending Provider NPI		✓	
Prescribing Provider NPI			✓
Referring Provider NPI	✓	✓	
Diagnosis and Procedure Codes Information			
Primary Diagnosis Code	✓	✓	

Key Data Elements	Professional Encounters (837P)	Institutional Encounters (837I)	Pharmacy Encounters (NCPDP)
Secondary Diagnosis Code(s)	✓	✓	
Procedure Code (CPT, HCPCS)	✓	✓	
Procedure Code Modifier	✓	✓	
Units of Service	✓	✓	
Primary Surgical Procedure Code		✓	
Secondary Surgical Procedure Code(s)		✓	
Drug Code	✓	✓	✓
Drug Quantity			✓
Revenue Code		✓	
DRG Code		✓	
Payment Information			
Header Paid Amount		✓	✓
Detail Paid Amount	✓	✓	
Dispensing Fee			✓

For the matching records between HHS' and the MCOs' data from the first step, HSAG evaluated the element-level completeness based on the following metrics:

- **Element Omission**—The number and percentage of records with values present in the MCOs' submitted data files but not in HHS' data warehouse.
- **Element Surplus**—The number and percentage of records with values present in HHS' data warehouse but not in the MCOs' submitted data files.
- **Element Missing Values**—The number and percentage of records with values missing from both HHS' data warehouse and the MCOs' submitted data files.

Element-level accuracy was limited to those records with values present in both the MCOs' submitted data files and HHS' data warehouse. For each key data element, HSAG determined the number and percentage of records with the same values in both the MCOs' submitted data files and HHS' data warehouse (**element accuracy**).

For the records present in both HHS' and the MCOs' data, HSAG evaluated the number and percentage of records with the same values for all key data elements relevant to each encounter data type (**all-element accuracy**).

Finally, HSAG assessed the overall encounter accuracy by evaluating the claim contents across all claim lines, regardless of line number, based on the following metrics:

- **No Match**—The percentage of claim numbers that were present in one data file and not the other.
- **Partial Match**—The percentage of claim numbers that were present in both data files, with one or more detail lines/data elements that were not found in the other data file.
- **Match**—The percentage of claim numbers that were present in both data files, with all detail lines and data elements also found in both data files.

The overall encounter accuracy was based at the header level (i.e., unique claim number) of the encounter. This approach was not dependent on how the data were stored (i.e., line numbers) but rather the entire contents of the encounter.

Technical Assistance

To further support HHS in preparing the requested data files, HSAG conducted a technical assistance session, scheduled according to HHS' availability. During this session, HSAG reviewed the data submission requirements to ensure that all questions related to data preparation and extraction were addressed. Following the technical assistance session, HSAG updated the data submission requirements document and provided the final version to HHS for review and approval.

As a follow-up to the comparative analysis activity, HSAG provided technical assistance to HHS and the MCOs regarding the issues identified from the comparative analysis. First, HSAG drafted MCO-specific encounter data discrepancy reports highlighting key areas for investigation. Next, following HHS' review and approval, HSAG distributed these discrepancy reports to the MCOs, along with data samples to assist with their internal investigations. HSAG collaborated with HHS and the MCOs to review the potential root cause(s) of the key issues and requested written responses from the MCOs. Finally, HSAG reviewed the written responses and provided additional follow-up with the MCOs, if appropriate.

PAHPs

Dental Record Review

The technical methodology for data collection and analysis for the EDV activity involved several key components:

- **Eligible Population Identification and Sampling**: HSAG identified eligible members continuously enrolled in the PAHP during the review period and generated a sample of members based on this eligibility. Random sampling was used to select 146 members from the eligible population for each PAHP. The SURVEYSELECT procedure in SAS®,[30] was used to randomly select one dental visit for each sampled member.
- **Dental Record Procurement**: Each PAHP procured dental records from its contracted providers and submitted to HSAG through a secure data exchange platform. To improve procurement rates, HSAG conducted a technical assistance session to guide PAHPs in the procurement process.
- **Review Process**: HSAG's trained reviewers verified whether the selected service date from HHS' encounter data could be matched with the dental record. For any discrepancies, reviewers documented omissions or inaccuracies.
- **Data Collection and Tool**: An HSAG-designed electronic data collection tool was used to ensure consistency in documenting findings. This tool included built-in checks to ensure data accuracy.
- **Data Validation and Quality Control**: HSAG reviewers underwent thorough training and interrater reliability testing, and the collected data was cross-checked to ensure consistency and accuracy throughout the review process.

Review Indicators and Analysis: After the data collection, HSAG analysts conducted data analysis using specific review indicators. Table A-15 displays the review indicators that were used to report the dental record review results.

Table A-15—DRR Indicators

Study Indicator	Denominator	Numerator
Dental Record Procurement Rate: Percentage of records submitted. Additionally, the reasons for missing dental records will be presented.	Total number of requested sample cases.	Number of requested sample cases with dental records submitted for either the sampled date of service or the second date of service.

[30] SAS and all other SAS Institute Inc. product or service names are registered trademarks or trademarks of SAS Institute Inc. in the USA and other countries. ® indicates USA registration.

Study Indicator	Denominator	Numerator
Dental Record Omission Rate: Percentage of data elements (e.g., *Date of Service*) identified in HHS' data warehouse that are not found in the members' dental records.	Total number of data elements (e.g., *Date of Service*) identified in HHS' data warehouse (i.e., based on the sample dates of service that are found in HHS' data warehouse).	Number of data elements (e.g., *Date of Service*) in the denominator but not found in the dental records.
Data Omission Rate: Percentage of data elements (e.g., *Dental Procedure Code*) identified in members' dental records, but not found in HHS' data warehouse.	Total number of data elements (e.g., *Dental Procedure Code*) identified in members' dental records (i.e., based on the dental records procured for the sample dates of service).	Number of data elements (e.g., *Dental Procedure Code*) in the denominator but not found in HHS' data warehouse.
Dental Code Accuracy: Percentage of dental procedure codes supported by the dental records. Additionally, the frequency count of associated reasons for inaccuracy will be presented.	Total number of dental procedure codes that meet the following two criteria: • For dates of service that exist in both HHS' encounter data and the dental records. • Dental procedure codes present for both HHS' encounter data and the dental records.	Number of dental procedure codes supported by the dental records.
All-Element Accuracy Rate: Percentage of dates of service present in both HHS' encounter data and the dental records.	Total number of dates of service (i.e., including both the sample dates of service and second dates of service) that are in both HHS' encounter data and the dental records.	The number of dates of service in the denominator with the same dental procedure codes for a given date of service.

Description of Data Obtained and Related Time Period

MCOs

Administrative Profile

HSAG used various data sources including encounter data, member demographic/enrollment data, and provider data. HSAG examined encounters submitted by **MOL** with dates of service from July 1, 2023, through October 31, 2023. The enrollment data included a listing of enrollment spans for all Medicaid members who were actively enrolled with **MOL** during the study period. The provider data contained all billing and rendering providers that had a record in the encounter data.

Comparative Analysis

HSAG used data from both HHS and the MCOs with dates of service from July 1, 2022, through October 31, 2023, for **ITC** and **WLP**, and from July 1, 2023, through October 31, 2023, for **MOL**, to evaluate the accuracy and completeness of the encounter data. To ensure that the extracted data from both sources (i.e., HHS and the MCOs) represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters with MCO adjustment/paid dates on or before March 31, 2024, and submitted to HHS on or before April 30, 2024. This anchor date allowed enough time for the encounters to be submitted, processed, and available for evaluation in the HHS data warehouse.

PAHPs

Dental Record Review

Data obtained from HHS included:

- Dental encounter data with dates of service from July 1, 2022, through June 30, 2023.
- Member demographic and enrollment data.
- Provider data.

Data obtained from the PAHPs included:

- Dental records for services rendered from July 1, 2022, through June 30, 2023.

Process for Drawing Conclusions

To draw conclusions about the quality of each MCP's encounter data submissions to HHS, HSAG evaluated the results based on the EDV core activities. HSAG calculated the predefined study indicators and/or metrics associated with each of the study components. Since HHS had not yet established standards for results from these activities, to identify strengths and weaknesses, HSAG assessed the results based on the prior year results, when available. HSAG also leveraged its extensive experience working with other states in assessing the completeness and accuracy of MCPs' encounter data submissions to the State. This approach provided a comparative framework that enabled a thorough assessment of each MCP's performance. HSAG determined each MCP's substantial strengths and weaknesses as follows:

- Strength—Identified areas where data completeness and accuracy were consistently high, highlighting best practices and successful methodologies implemented by the MCPs.
- Weakness—Highlighted areas with recurring data discrepancies, assessing the impact on overall data reliability and compliance with HHS' requirements.

Additionally, for each identified weakness, HSAG provided recommendations to support improvements in the quality and timeliness of encounter data submissions to HHS, aiming to enhance data integrity and ensure alignment with state requirements.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

This activity assesses adult members' and parents'/caretakers' of child members experience with an MCO and its providers, and the quality of care they receive. The goal of the CAHPS Health Plan Surveys is to provide feedback that is actionable and will aid in improving members' overall experiences.

Technical Methods of Data Collection and Analysis

Two populations were surveyed for the MCOs: adult Medicaid and child Medicaid. Center for the Study of Services (CSS) and SPH Analytics, NCQA-certified vendors, administered the 2024 CAHPS surveys for **ITC** and **WLP**, respectively.

The technical methods of data collection were through the CAHPS 5.1H Adult Medicaid Health Plan Survey to the adult population, the CAHPS 5.1H Child Medicaid Health Plan Survey (with the CCC measurement set) to **WLP**'s child Medicaid population, and the CAHPS 5.1H Child Medicaid Health Plan Survey (without the CCC measurement set) to **ITC**'s child Medicaid population. **ITC** and **WLP** used a mixed-mode methodology for data collection (i.e., mail and telephone). **ITC** and **WLP** respondents were given the option of completing the survey in Spanish, as well as completing the survey on the Internet.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four composite scores, and three medical assistance with smoking and tobacco use cessation items (adult population only). Additionally, five CCC composite measures/items were used for the CCC-eligible population.[31] The global ratings reflected patients' overall member experience with their personal doctor, specialist, health plan, and all health care. The composite measures were derived from sets of questions to address different aspects of care (e.g., *Getting Needed Care*, *How Well Doctors Communicate*). The CCC composite measures/items evaluated the experience of families with children with chronic conditions accessing various services (e.g., specialized services, prescription medications). The medical assistance with smoking and tobacco use cessation items assessed the various aspects of providing assistance with smoking and tobacco use cessation.

[31] **ITC** administered the CAHPS 5.1H Child Medicaid Health Plan Survey without the CCC measurement set; therefore, results for the CCC Medicaid population are not available and cannot be presented.

Top-Box Score Calculations

For each of the four global ratings, the percentage of respondents who chose the top experience rating (i.e., a response value of 9 or 10 on a scale of 0 to 10) was calculated. This percentage is referred to as a question summary rate (or top-box score).

For each of the four composite measures and five CCC composite measures/items, the percentage of respondents who chose a positive response was calculated. CAHPS composite question response choices fell into one of two categories: (1) "Never," "Sometimes," "Usually," or "Always;" or (2) "No" or "Yes." A positive or top-box response for the composite measures and CCC composites/items was defined as a response of "Usually/Always" or "Yes." The percentage of top-box responses is referred to as a global proportion for the composite measures and CCC composite measures/items. For the medical assistance with smoking and tobacco use cessation items, responses of "Always/Usually/Sometimes" were used to determine if the respondent qualified for inclusion in the numerator. The scores presented follow NCQA's methodology of calculating a rolling average using the current and prior year results. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA (Not Applicable).

NCQA National Average Comparisons

HSAG compared each MCO's and the MCO program's (i.e., **ITC** and **WLP** combined) results to the 2023 NCQA national averages to determine if the results were statistically significantly different. Colored arrows in the tables note statistically significant differences. A green upward arrow (↑) indicates a top-box score was statistically significantly higher than the 2023 NCQA national average. Conversely, a red downward arrow (↓) indicates a top-box score was statistically significantly lower than the 2023 NCQA national average. In some instances, the scores presented for the MCOs were similar, but one was statistically significantly different from the national average and the other was not. In these instances, it was the difference in the number of respondents between the two MCOs that explained the different statistical results. It is more likely that a statistically significant result will be found in an MCO with a larger number of respondents. When a minimum of 100 responses for a measure was not achieved, the result of the measure was denoted as NA.

Description of Data Obtained and Related Time Period

Based on NCQA protocol, adult members included as eligible for the survey were 18 years of age or older as of December 31, 2023, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2023. Adult members and parents or caretakers of child members completed the surveys from February to May 2024.

Process for Drawing Conclusions

To draw conclusions about the quality and timeliness of, and access to care and services that each MCO provided to members, HSAG assigned each of the measures to one or more of these three domains and compared each MCO's and the MCO program's (i.e., MCOs combined) 2024 survey results to the 2023

NCQA national averages to determine if there were any statistically significant differences. This assignment to domains is depicted in Table A-16.

Table A-16—Assignment of CAHPS Measures to the Quality, Timeliness, and Access Domains

CAHPS Topic	Quality	Timeliness	Access
Rating of Health Plan	✓		
Rating of All Health Care	✓		
Rating of Personal Doctor	✓		
Rating of Specialist Seen Most Often	✓		
Getting Needed Care	✓		✓
Getting Care Quickly	✓	✓	
How Well Doctors Communicate	✓		
Customer Service	✓		
Advising Smokers and Tobacco Users to Quit	✓		
Discussing Cessation Medications	✓		
Discussing Cessation Strategies	✓		
Access to Specialized Services	✓		✓
Family Centered Care (FCC): Personal Doctor Who Knows Child	✓		
Coordination of Care for Children With Chronic Conditions	✓		
Access to Prescription Medicines			✓
FCC: Getting Needed Information	✓		

Scorecard

Activity Objectives

On November 8, 2018, CMS published the Medicaid and CHIP Managed Care Proposed Rule (CMS-2408-P) in the Federal Register. As per 42 CFR §438.334, each state contracting with an MCO to provide services to Medicaid members must adopt and implement a quality rating system (QRS). While the EQR protocol is not available yet for the QRS, on May 10, 2024, CMS published the final rule, which advised that Medicaid and CHIP (MAC) QRS or alternative QRS should align with the Medicare Advantage and Part D QRS, Marketplace QRS, the Medicaid and CHIP Child Core Set, the Medicaid Adult Core Set, and other similar CMS initiatives such as the Medicaid and CHIP Scorecard and the CMS Universal Foundation. The final rule includes a mandatory measure list, an initial rating methodology (either CMS' methodology or a CMS-approved alternative methodology has to be used), and the creation of a mandatory website by each state.

The scorecard is targeted toward a consumer audience; therefore, it is user friendly, easy to read, and addresses areas of interest for consumers.

Technical Methods of Data Collection and Analysis

MCO performance was evaluated in six separate reporting categories, identified as important to consumers.[32] Each reporting category consists of a set of measures that were evaluated together to form a category summary score. The reporting categories and descriptions of the types of measures they contain are listed below:

- **Doctors' Communication and Patient Engagement:** This category includes adult and child CAHPS composites and HEDIS measures related to patient satisfaction with providers and patient engagement.
- **Access to Preventive Care:** This category consists of CAHPS composites and HEDIS measures related to adults' and children's access to preventive care.
- **Women's Health:** This category consists of HEDIS measures related to screenings for women and maternal health.
- **Living With Illness:** This category consists of HEDIS measures related to diabetes, cardiovascular, and respiratory conditions.
- **Behavioral Health:** This category consists of HEDIS measures related to follow-up care for behavioral health, as well as appropriate care for adults on antidepressants and antipsychotics, and children on antipsychotics and medications for attention-deficit/hyperactivity disorder (ADHD).
- **Medication Management:** This category consists of HEDIS measures related to antibiotic stewardship, as well as medication management for opioid use and behavioral health conditions.

HSAG computed six reporting category summary scores and 15 subcategory summary scores for the MCO. HSAG compared each measure to 2024 NCQA Quality Compass national Medicaid HMO benchmarks and assigned star ratings for each measure. HSAG used the following methodology to assign a star rating for each individual measure:

Table A-17—Measure Rate Star Rating Descriptions

Rating	MCO Measure Rate Performance Compared to National Benchmarks
★★★★★	The MCO's measure rate was at or above the national Medicaid HMO 90th percentile
★★★★	The MCO's measure rate was between the national Medicaid HMO 75th and 89th percentiles
★★★	The MCO's measure rate was between the national Medicaid HMO 50th and 74th percentiles
★★	The MCO's measure rate was between the national Medicaid HMO 25th and 49th percentiles
★	The MCO's measure rate was below the national HMO Medicaid 25th percentile

[32] National Committee for Quality Assurance. "Ten Steps to a Successful Report Card Project, Producing Comparative Health Plan Reports for Consumers." October 1998.

In instances where data were missing (i.e., the audit designation was *Not Reported [NR], Biased Rate [BR],* or *Not Applicable [NA]*), HSAG handled the missing rates for measures as follows:

- Rates with an *NR* designation were assigned 1-star.
- Rates with a *BR* designation were assigned 1-star.
- Rates with an *NA* designation resulted in the removal of that measure.

To provide a more accurate rating of each performance measure, HSAG also assigned partial stars based on how close the rating was to the next star. Because a rating of five stars is the maximum star rating possible, HSAG only calculated partial stars for ratings below five stars. HSAG compared each MCO's rate to the national Medicaid percentiles to determine the percentile range (i.e., the lower and upper percentile bounds) the rate fell between (e.g., between the 25th and 50th percentiles) for calculating the partial star ratings at the measure level. For a one-star rating (i.e., below the 25th percentile), the 10th percentile was used as the lower percentile bound. The partial star rating for each measure was derived using the following formula:

$$Partial\ Star\ Rating = Star\ Rating + \left[\frac{(MCO\ Rate - PV_0)}{(PV_1 - PV_0)}\right]$$

Where: PV_0 = the actual rate value for the lower percentile bound
PV_1 = the actual rate value for the upper percentile bound
Star Rating = the star rating assigned for the MCO's rate (i.e., 1, 2, 3, or 4)
MCO Rate = the reported measure rate for the MCO

For example, if the national Medicaid 25th percentile was 40 percent, the national Medicaid 50th percentile was 60 percent, and an MCO had a rate of 45 percent for a measure, the MCO received two stars for falling between the 25th and 49th percentiles. The partial star rating was calculated as follows:

$$Partial\ Star\ Rating = 2 + \left[\frac{(45 - 40)}{(60 - 40)}\right] = 2.25$$

Once the partial star rating was calculated for each measure, the 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 Medication Management) and 15 subcategories (Satisfaction with Providers, Patient Engagement, Access, Preventive Care, Screening for Women, Maternal Health, Diabetes, Cardiovascular, Respiratory, Follow-Up Care, Adults on Antipsychotics, Children on Antipsychotics, Adults on Antidepressants, Antibiotic Stewardship, and Opioids) were calculated by taking the weighted average of all partial star ratings for all measures within the category and then rounding to the nearest star.

A five-level rating scale provides consumers with an easy-to-read "picture" of quality performance for the MCO and presents data in a meaningful manner. The MCO Scorecard uses stars to display MCO performance as follows:

Table A-18—MCO Scorecard Performance Ratings

Rating	MCO Performance Compared to National Benchmarks	
★★★★★	**Highest Performance**	The MCO's average performance was at or above the national Medicaid HMO 90th percentile
★★★★	**High Performance**	The MCO's average performance was between the national Medicaid HMO 75th and 89th percentiles
★★★	**Average Performance**	The MCO's average performance was between the national Medicaid HMO 50th and 74th percentiles
★★	**Low Performance**	The MCO's average performance was between the national Medicaid HMO 25th and 49th percentiles
★	**Lowest Performance**	The MCO's average performance was below the national Medicaid HMO 25th percentile

Description of Data Obtained and Related Time Period

HSAG analyzed MY 2023 HEDIS results, including MY 2023 CAHPS data from two MCOs, **ITC** and **WLP**, for presentation in the 2024 Iowa Medicaid Scorecard.