Calendar Year 2020 External Quality Review Technical Report

April 2021

HSAG HEALTH SERVICES ADVISORY GROUP

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 entities' (MCEs') performance related to the quality of, timeliness of, and access to care and services they provide, as mandated by 42 Code of Federal Regulations (CFR) §438.364. To meet this requirement, the Iowa Department of Human Services (DHS) 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.

The Iowa Medicaid Enterprise (IME) is the division of DHS that administers and oversees the Iowa Medicaid program, which contracts with two managed care organizations (MCOs) to provide physical health, behavioral health, and long-term services and supports (LTSS) to Medicaid members. Iowa's Medicaid 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]). DHS also contracts with two prepaid ambulatory health plans (PAHPs) to provide dental benefits for adult Medicaid (Dental Wellness Plan [DWP]) and Hawki members. The MCOs and PAHPs contracted with DHS during calendar year (CY) 2020 are displayed in Table 1-1.

Table 1-1—MCEs* in Iowa

MCO Name	MCO Short Name
Amerigroup Iowa	AGP
Iowa Total Care	ITC
PAHP Name	**PAHP Short Name**
Delta Dental of Iowa	DDIA
Managed Care of North America Dental	MCNA

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

Scope of External Quality Review (EQR) Activities

To conduct this assessment, HSAG used the results of mandatory and optional 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).[1-1] The purpose of these activities, in general, is to improve states' ability to oversee and

[1-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *External Quality Review (EQR) Protocols,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

manage MCEs they contract with for services, and help MCEs improve their performance with respect to quality of, timeliness of, and access to care and services. Effective 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 2020 assessment, HSAG used findings from the mandatory and optional EQR activities displayed in Table 1-2 to derive conclusions and make recommendations about the quality of, timeliness of, and access to care and services provided by each MCE. 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 MCE used sound methodology in its design, implementation, analysis, and reporting.	Validation of Performance Improvement Projects*
Performance Measure Validation (PMV)	The activity assesses whether the performance measures calculated by an MCE 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 MCE 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 extent to which an MCE has adequacy provider networks in coverage areas to deliver healthcare services to its managed care members.	Protocol 4. Validation of Network Adequacy**
Encounter Data Validation (EDV)	The activity validates the accuracy and completeness of encounter data submitted by an MCE.	Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan
Consumer Assessment of Healthcare Providers and Systems (CAHPS®)[1-2] Analysis	This activity assesses member experience with an MCE and its providers, and the quality of care they receive.	Protocol 6. Administration or Validation of Quality of Care Surveys

* Due to the timing of PIP activities, HSAG followed either *Protocol 1. Validation of Performance Improvement Projects: A Mandatory EQR-Related Activity*, October 2019, or the prior version, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.

** This activity will be mandatory effective no later than one year from the issuance of the associated EQR protocol. This protocol is currently in development by CMS.

[1-2] CAHPS® is a registered trademark of the Agency for Healthcare Research and Quality (AHRQ).

Statewide Findings and Conclusions

HSAG used its analyses and evaluations of EQR findings from the CY 2020 activities[1-3] to comprehensively assess the MCEs' performance in providing quality, timely, and accessible healthcare services to Medicaid and CHIP members. For each MCE reviewed, HSAG provides a summary of its overall key findings, conclusions, and recommendations based on the MCE's performance, which can be found in Section 3 and Section 4 of this report. The overall findings and conclusions for all MCEs were also compared and analyzed to develop overarching conclusions and recommendations for the Iowa Medicaid managed care program. Table 1-3 highlights substantive findings and actionable state-specific recommendations, when applicable, for DHS to further promote its goals and objectives in its quality strategy. Refer to Section 9 for more details.

Table 1-3—Statewide Substantive Findings

Program Strengths
• **Pregnancy Care**—By mandating a statewide PIP related to postpartum care, DHS and the MCOs have prioritized the health and wellbeing of mothers and infants to address the underlying causes of maternal and infant mortality and pregnancy-related complications that can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care.[1-4] Through implementation of the PIP, identification of barriers and subsequent interventions should result in improved overall health outcomes for Iowa mothers and their babies and should improve MCO-related Healthcare Effectiveness Data and Information Set (HEDIS®)[1-5] performance.
• **Accessibility to Physical Healthcare**—Accessibility to healthcare is important for the health and wellbeing of children, adolescents, and adults; and provides an opportunity for members to receive preventive services, including vaccines, screenings, and counseling in order to address acute issues, manage chronic conditions, reduce nonurgent emergency department (ED) visits and inpatient stays, and reduce the significant costs associated with unmanaged healthcare.[1-6] Members' accessibility to care is a priority for DHS and the MCOs, as evident from Iowa's quality strategy objectives, and the conclusions drawn from HSAG's comprehensive assessment of the MCOs through various EQR activities indicate adult and child members have access to primary care for physical and behavioral health services and are obtaining the preventive care they need, including immunizations, to maintain optimal health.
• **Encounter Data—**Through the EDV study findings, the MCEs demonstrated that they submit encounter data to DHS that are relatively complete and accurate. The availability of accurate and complete encounter data is important to the effective operation and oversight of the MCEs that serve members covered by Medicaid and CHIP.

[1-3] Due to the timing of CY 2020 EQR activities, some activities concluded in CY 2021.

[1-4] Office of Disease Prevention and Health Promotion. Healthy People 2020: Maternal, Infant, and Child Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health. Accessed on: Feb 2, 2021.

[1-5] HEDIS is a registered trademark of the National Committee for Quality Assurance (NCQA).

[1-6] Iowa Department of Public Health. Protecting and Improving the Health of Iowans. Re: Iowa's Maternal Mortality Review Committee Report, letter, March 5, 2020. Available at: https://idph.iowa.gov/Portals/1/userfiles/38/Final%202020%20MMRC%20report.pdf. Accessed on: Feb 1, 2021.

Program Weaknesses
• **Accessibility to Dental Healthcare**—Oral health is essential to a person's overall health and wellbeing. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.[1-7] Although both adult and child members have access to dental benefits through the Iowa Medicaid managed care program and the PAHPs have a sufficient number of dental providers as supported by the NAV results, members are not obtaining dental care as demonstrated through lower-performing PAHP performance measure rates, ineffective interventions, the PAHPs' failure to achieve statistically significant improvement as identified through the dental PIP activity, and compliance issues within the Practice Guidelines standard that could be preventing members from receiving the appropriate resources and materials to understand the importance of dental care. • **Provider Directories**—Complete and accurate provider information within an MCE's provider directory is an important resource for members to locate providers who meet their own individual needs. Additionally, inaccurate telephone numbers and location information may create barriers to accessing care. However, issues identified through the NAV and compliance review activities indicated members may not have comprehensive, accurate, and up-to-date provider information readily available to assist them in choosing an appropriate provider, as needed, to establish preventive and medically necessary care and services.

Program Recommendations	
Recommendation	**Associated Quality Strategy Objectives**
• To understand the barriers Iowa Medicaid members may face when accessing dental services and to better understand why members may not seek dental care, HSAG recommends that DHS consider requiring the PAHPs to conduct a CAHPS Dental Plan Survey or another similar type of survey that assesses the members' needs for dental care, use of dental services and transportation to visits, and self-perceived oral health status. • To improve members' access to comprehensive, accurate, and up-to-date provider information, HSAG recommends that DHS host a quality improvement (QI) workgroup with the MCEs, and other stakeholders as appropriate, to develop standardized formats for displaying provider data in the MCE provider directories. The goal of the workgroup should be to enhance members' ability to select a provider who can best support their healthcare, cultural, and social needs, thereby promoting trusting relationships between patients and providers and facilitating more meaningful engagement.	**Objective #1:** Promote appropriate utilization of services within acceptable standards of medical/dental practice. **Objective #2:** Ensure access to cost-effective healthcare through contract compliance. **Objective #8:** Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic health and dental care by focusing on specific populations.

[1-7] Office of Disease Prevention and Health Promotion. Healthy People 2020: Oral Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health. Accessed on: Feb 1, 2021.

2. Overview of the Iowa Medicaid 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 DHS to deliver all medically necessary, Medicaid-covered physical health, behavioral health, and LTSS benefits in a highly coordinated manner. DHS also contracts with PAHPs to deliver dental benefits to members enrolled in the DWP and Hawki program.[2-1]

Overview of Managed Care Entities (MCEs)

During the CY 2020 review period, DHS contracted with two MCOs and two PAHPs. These MCEs are responsible for the provision of services to Iowa Medicaid and CHIP members. Table 2-1 provides a profile for each MCO and PAHP.

Table 2-1—MCO and PAHP Profiles

MCOs	Total Enrollment[2-2]	Covered Services[2-3]	Service Area
AGP	412,180	• 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
ITC	290,252		

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

[2-2] Iowa Department of Human Services, Iowa Medicaid Enterprise. *IA Health Link Managed Care Organization SFY 2021 Quarter 1 Performance Data*. September 2020. Available at: https://dhs.iowa.gov/sites/default/files/SFY21_Q1_Report.pdf?010420211638. Accessed on: Feb 2, 2021.

[2-3] Iowa Department of Human Services. *2017 Comparison of the State of Iowa Medicaid Enterprise Basic Benefits Based on Eligibility Determination*. Available at: https://dhs.iowa.gov/sites/default/files/Comm519.pdf?120220202354. Accessed on: Feb 2, 2021.

PAHPs	Total Enrollment[2-4]	Covered Services[2-5,2-6]	Service Area
DDIA	307,590	• 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	136,392		

Quality Strategy

The Iowa Medicaid Managed Care Quality Assurance System[2-7,2-8] outlines DHS' strategy for assessing and improving the quality of managed care services offered by its contracted MCOs and PAHPs using a triple aim framework. The triple aim goal is to improve outcomes, improve patient experience, and ensure that Medicaid programs are financially sustainable. While the overarching goal of the quality plan and managed care is to improve the health of Iowa Medicaid members, DHS' program aims to accomplish the following:

2-4 December 2020 enrollment numbers provided to HSAG by DHS.

2-5 Iowa Department of Human Services. *Dental Wellness Plan Benefits*. Available at: https://dhs.iowa.gov/dental-wellness-plan/benefits. Accessed on: Feb 4, 2021.

2-6 DWP members have access to full dental benefits during the first year of enrollment. DWP members must complete "Healthy Behaviors" (composed of both an oral health self-assessment and preventive service) during the first year to keep full benefits and pay no monthly premiums the next year. More information on dental benefits can be found at https://dhs.iowa.gov/dental-wellness-plan/benefits.

2-7 Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Managed Care Quality Assurance System*: 2018. Available at: https://dhs.iowa.gov/sites/default/files/2018%20Managed%20Care%20Quality%20Plan.pdf?042320192039. Accessed on: Jan 23, 2021.

2-8 Iowa Department of Human Services Iowa Medicaid Enterprise. *Iowa Medicaid Dental Pre-Ambulatory Health Plan Quality Assurance System*: *2019*. Available at: https://dhs.iowa.gov/sites/default/files/2019%20Dental%20PAHP%20Quality%20Strategy.pdf?060520191449. Accessed on: Jan 23, 2021.

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

Quality Strategy Objective	MCOs	PAHPs
1. Promote appropriate utilization of services within acceptable standards of medical/dental practice.		
2. Ensure access to cost-effective healthcare through contract compliance by:	• Timely review of managed care network adequacy reports. • Incentivizing high performance in national Children's Access to Care and Adult Access to Care measures through financial incentives.	• Timely review of PAHP network adequacy reports. • Incentivizing access to preventive dental services.
3. Comply with State and federal regulatory requirements through the development and monitoring of quality improvement (QI) policies and procedures by: • Annually reviewing and providing feedback on MCO/PAHP quality strategies. • Quarterly reviewing of MCO/PAHP quality meeting minutes.		
4. Reduce healthcare costs while improving quality:	• Increasing provider participation and covered lives in accountable care organizations to 50 percent. • Increasing the utilization of a health risk screening tool that collects standardized social determinants of health (SDOH) data and measures patient confidence, then ties those results to value-based purchasing agreements.	• Encouraging member engagement in dental care through completion of oral health risk assessment (HRA) and a tiered benefit structure that expands benefits for members receiving preventive services.
5. Provide care coordination to members based on HRAs by:	• Quarterly monitoring of 70 percent initial HRA completion within 90 days of enrollment.	• Monitoring of HRA completion for members continuously enrolled for 6 months.
6. Ensure that transitions of care do not have adverse effects by:	• Maintaining historical utilization file transfers between DHS and MCOs, including the information needed to effectively transfer members. • Monitoring community rebalancing to ensure that members choosing to live in the community remain in the community.	• Maintaining historical utilization file transfers between the DHS and PAHPs, including the information needed to effectively transfer members.
7. Promote healthcare quality standards in managed care programs by monitoring processes for improvement opportunities and assist MCOs/PAHPs with implementation of improvement strategies through:	• Chartering a collaborative quality management committee that meets at least quarterly. • Regularly monitoring health outcomes measure performance.	• Regularly monitoring health outcomes measure performance.

Quality Strategy Objective	MCOs	PAHPs
8. Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic health and dental care by focusing on specific populations. The income maintenance worker collects race and ethnicity as reported by the individual on a voluntary basis during the eligibility process.		
9. Promote the use and interoperability of health information technology between providers, MCO/PAHPs, and Medicaid.		

Quality Initiatives

To accomplish the Iowa Medicaid Managed Care Quality Assurance System objectives, Iowa has several ongoing activities regarding quality initiatives. These initiatives are discussed below.

Health Home Program—In CY 2020, the Iowa Health Home Program implemented a process that uses analytics to identify data-driven improvements to meet the triple aim. Examples of these goals include identifying high-cost, high-utilization members to complete a root cause analysis to determine potential process changes to decrease costs, driving appropriate utilization and improving the quality of care for enrolled Health Home members in Iowa.

SDOH Data Collection—In CY 2020, DHS implemented a process to begin collecting member survey data from the MCOs regarding 13 specific SDOH measures. These measures focus on topics such as member living situations, safety and stress levels, and barriers to service access (including dental services). These data will be analyzed to assist in decision making and increase the quality of health outcomes for both individual members and the full population. By continually collecting these data using a standardized approach, DHS and the MCOs will be able to identify patterns of care, potential drivers of service utilization, and costs by detecting existing (and future potential) high-needs/high-cost cases.

3. Assessment of Managed Care Organization (MCO) Performance

MCO Methodology

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2020 review period to evaluate the performance of MCOs on providing quality, timely, and accessible healthcare services to IA Medicaid managed care 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. 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 outcome information for the availability and timeliness of services.

To identify strengths and weaknesses and draw conclusions for each MCO, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of healthcare services across the Iowa Medicaid program. The composite findings for each MCE were analyzed and aggregated to identify overarching conclusions and focus areas for the MCO in alignment with the priorities of DHS.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

PIPs

For the CY 2020 validation, the MCOs initiated two DHS-mandated PIP topics, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*, reporting the Design stage for the performance indicators to be collected. In addition to the two new topics, Amerigroup Iowa continued two topics from the prior year which were initiated in 2017, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction*.

The purpose of each PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. HSAG's PIP validation ensures that DHS and key stakeholders can have confidence that any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the MCO during the project.

Table 3-1 outlines the selected PIP topics and performance indicators for the MCOs.

Table 3-1—PIP Topic and Performance Indicators

MCO	PIP Topic	Performance Indicator
AGP	*Well-Child Visit in the Third, Fourth, Fifth, and Sixth Years of Life*	The percentage of members 3 to 6 years of age who had one or more well-child visits with a Primary Care Provider (PCP) during the measurement year.
	Member Satisfaction	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.
	Timeliness of Postpartum Care	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.
	CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	The percentage of members who answer Amerigroup Iowa CAHPS child survey Question #45 (DHS Question #50): The Customer Service at a Child's Health Plan gave information or help needed, with a response of Usually or Always.
ITC	*Timeliness of Postpartum Care*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.
	CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	CAHPS Measure: Customer Services at Child's Health Plan gave help or information needed.

PMV

The purpose of the PMV is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow State specifications and reporting requirements. HSAG determined results for each performance measure and assigned each an indicator designation of *Reportable (R), Do Not Report (DNR), Not Applicable (NA),* or *Not Reported (NR).*

DHS identified a set of performance measures that the MCOs were required to calculate and report. These measures were required to be reported following the measure specifications provided by DHS.

For the EQR time frame under evaluation, HSAG completed PMV activities for Amerigroup Iowa for state fiscal year (SFY) 2019 (July 1, 2018–June 30, 2019), and SFY 2020 (July 1, 2019–June 30, 2020). HSAG postponed the review of Amerigroup Iowa's SFY 2019 data at Amerigroup Iowa's request, and with DHS approval, to provide Amerigroup Iowa additional time to manually abstract its care plan performance data. HSAG also completed PMV activities for Iowa Total Care for SFY 2020 (July 1,

2019–June 30, 2020). The list of performance measures and measurement periods from both SFY 2019 and 2020 are listed in Table 3-2.

Table 3-2—Performance Measures for Validation

2019 and 2020 Performance Measures Selected by DHS for Validation[3-1]				
Measure Name and Description	**MCO**	**Measurement Period**	**Method**	**Steward**
Receipt of Authorized Services The percentage of eligible members who received authorized home- and community-based services (HCBS) documented in the person-centered care plan from the care plan's effective date through the service authorization end date and/or care plan end date.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020		
Receipt of Authorized One-Time Services The percentage of eligible members who received authorized, one-time HCBS in the person-centered care plan from the care plan's effective date through the service authorization end date and/or care plan end date.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020		
Provision of Care Plan The percentage of eligible members whose care plan was provided to all participants in the member's care team.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020	Hybrid	
Person-Centered Care Plan (PCCP) Meeting The percentage of eligible members who participated in planning and agreed to the time and/or location of the PCCP meeting.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020	Hybrid	
Care Team Lead Chosen by the Member The percentage of eligible members who chose his or her own care team lead.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020	Hybrid	

[3-1] There were technical specification changes in the performance measures from CY 2019 to CY 2020; therefore, AGP's CY 2020 rates are presented to align with these changes.

2019 and 2020 Performance Measures Selected by DHS for Validation[3-1]				
Measure Name and Description	**MCO**	**Measurement Period**	**Method**	**Steward**
Member Choice of Home and Community-Based Services (HCBS) Settings The percentage of eligible members whose care plan documents member choice and/or placement in alternative HCBS settings.	AGP	July 1, 2018–June 30, 2019	Administrative	DHS
	AGP and ITC	July 1, 2019–June 30, 2020	Hybrid	

Additionally, DHS required each MCO to contract with a National Committee for Quality Assurance (NCQA)-certified HEDIS licensed organization to undergo a full audit of its HEDIS reporting process. The reported measures are divided into performance measure domains of care as demonstrated in Table 3-3. As Iowa Total Care joined the Iowa Medicaid program in July 2019, HEDIS data for the reporting period are not available and will be included in future EQR technical reports.

Due to the possible effect of coronavirus disease 2019 (COVID-19) on HEDIS hybrid measures, specifically an MCO's ability to collect medical record data, NCQA allowed MCOs to report their audited HEDIS 2019 hybrid rates if they were better than the MCOs' HEDIS 2020 hybrid rates. MCOs were not required to rotate all hybrid measures but were required to rotate entire measures when there were multiple indicators (e.g., *Comprehensive Diabetes Care* [*CDC*]). NCQA's Interactive Data Submission System (IDSS) was not configured to capture rotation decisions, meaning that even when a hybrid measure was rotated, the measurement year will indicate 2019.

Table 3-3—HEDIS Measures

HEDIS Measure
Prevention and Screening
Adults' Access to Preventive/Ambulatory Health Services
Ages 20–44 Years
Ages 45–64 Years
Ages 65 and Older
Adults Body Mass Index (BMI) Assessment
Children and Adolescents' Access to Primary Care Practitioners
12–24 Months
25 Months–6 Years
7–11 Years
12–19 Years
Use of Imaging Studies for Low Back Pain
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents
BMI Percentile Documentation—Total

HEDIS Measure
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
Comprehensive Diabetes Care
Hemoglobin A1c (HbA1c) Testing
HbA1c Control (<8.0%)
*HbA1c Poor Control (>9.0%)**
Blood Pressure Control (<140/90 mm Hg)
Eye Exam (Retinal) Performed
Medical Attention for Nephropathy
Controlling High Blood Pressure
Statin Therapy for Patients With Cardiovascular Disease
Received Statin Therapy
Statin Therapy for Patients With Diabetes
Received Statin Therapy
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 ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence
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

HEDIS Measure
Initiation and Engagement of AOD Abuse or Dependence Treatment
Initiation of AOD Treatment—Total
Engagement of AOD 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
Adolescent Well-Care Visits
Childhood Immunization Status
Combination 3
Combination 10
Immunizations for Adolescents
Combination 1
Combination 2
Lead Screening in Children
Well-Child Visits in the First 15 Months of Life
Six or More Well-Child Visits
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life
Medication Management
Adherence to Antipsychotic Medications for Individuals With Schizophrenia
Antidepressant Medication Management
Effective Acute Phase Treatment
Effective Continuation Phase Treatment
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 ADHD Medication
Initiation Phase
Continuation and Maintenance Phase
Persistence of Beta-Blocker Treatment After a Heart Attack
Pharmacotherapy Management of COPD Exacerbation
Systemic Corticosteroid
Bronchodilator

HEDIS Measure
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

The compliance review in Iowa includes a review of 13 standards over a three-year cycle as detailed in Table 3-4. CY 2020 marked the third year of the current three-year cycle and comprised an evaluation of each MCO's performance in five program areas to determine compliance with State and federal standards.

Table 3-4—Compliance Review Standards

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

NAV

The CY 2020 Network Adequacy Validation activity consisted of a provider directory validation (PDV). The goal of the PDV was to determine if the information in the MCOs' online provider directories, found on the respective MCOs' websites, aligned with the data in the MCO provider files submitted to HSAG by the MCOs. As part of the PDV, HSAG compared the key elements (i.e., study indicators) published in the online provider directories with the data in the provider files and reviewed each MCO's

website to determine whether the website met the federal requirements in both the 42 CFR §438.10(h) and Medicaid MCO contract (e.g., the process for a member to obtain a paper copy of the directory).

EDV

In 2020, HSAG completed CY 2019 EDV activities for the following three MCOs: Amerigroup Iowa, Iowa Total Care, and UnitedHealthcare.[3-2] Because CY 2019 was the first year Iowa Total Care submitted encounter data to DHS, HSAG conducted an information systems (IS) review to understand and assess whether the IS infrastructures produced complete and accurate encounter data. For Amerigroup Iowa and UnitedHealthcare, HSAG had previously conducted an IS review (CY 2016); an administrative profile—analysis of the DHS' electronic encounter data completeness, accuracy, and timeliness (CY 2017); and a comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems (CY 2018). Medical record review (MRR) would typically follow a comparative analysis activity. However, MRR is a complex, resource-intensive process which requires a sufficient level of completeness and accuracy of DHS' encounter data prior to conducting the MRR activity. As such, based on the CY 2018 results of the comparative analysis, DHS and HSAG determined that an MRR activity was not recommended during the CY 2019 study for Amerigroup Iowa and UnitedHealthcare. Therefore, for these MCOs, HSAG conducted a comparative analysis along with technical assistance to ensure that discrepancies identified in the CY 2018 study were addressed, and to determine if the level of completeness and accuracy of DHS' encounter data was sufficient for future MRR activities. The comparative analysis focused on all encounter types (i.e., professional, institutional, and pharmacy encounters) with dates of service during CY 2018 submitted to DHS on or before June 30, 2019.

CAHPS 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. Amerigroup Iowa was responsible for obtaining a CAHPS vendor to administer the CAHPS surveys on the MCO's behalf. Due to changes to the MCOs participating in the Iowa Medicaid program over the past two years, HSAG only received data for Amerigroup Iowa. HSAG did not receive CAHPS data for Iowa Total Care.

The primary objective of the CAHPS surveys was to effectively and efficiently obtain information on members' experiences with their healthcare and health plan. 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.

[3-2] UnitedHealthcare Community Plan of the River Valley, Inc. (UnitedHealthcare [UHC]) exited the Iowa managed care program on June 30, 2019. As the CY 2019 EDV activity concluded in CY 2020, UnitedHealthcare results are not included in this report.

EQR Activity Results

Amerigroup Iowa

PIPs

Performance Results

Table 3-5 displays the overall validation status; the baseline, Remeasurement 1, and Remeasurement 2 results; and the MCO-designated goals, when applicable, for each PIP topic. Baseline data for the PIP topics initiated in 2020 will be included in the CY 2021 annual EQR report.

Table 3-5—Overall Validation Rating—AGP

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	*Met*	The percentage of members 3 to 6 years of age who had one or more well-child visits with a PCP during the measurement year.	53.9%	64.5% ↑	70.8% ↑	71.4%
Member Satisfaction	*Not Met*	The percentage of members who answer CAHPS adult survey Question #35 with a score of 9 or 10.	58.7%	61.9% ⇔	59.1% ⇔	67.1%
Timeliness of Postpartum Care	*Met*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.				
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	*Met*	The percentage of members who answer Amerigroup Iowa CAHPS child survey Question #45 (DHS Question #50): The Customer Service at a Child's Health Plan gave information or help needed, with a response of Usually or Always?				

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).
 = Design stage only; no data reported.

Table 3-6 displays the interventions implemented to address the barriers identified by the MCO through the use of QI and causal/barrier analysis processes for the two continuing PIP topics, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction*. The MCO had not progressed to implementing QI strategies for the two PIP topics initiated in 2020, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed.*

Table 3-6—Interventions—AGP

Intervention Descriptions	
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	***Member Satisfaction***
Educated providers on the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life (W34)* HEDIS measure, notifying them of any assigned members who have not had a well-child visit, and encouraged providers to reach out to those members to schedule an appointment.	Conducted post-call survey audits on customer service representatives and provided coaching, feedback, and additional training as needed.
Conducted telephonic outreach to members who have not had their well-child exam to assist them in scheduling an appointment.	Conducted audits of the database used by call center representatives as a source of truth to answer member questions, to ensure consistent and accurate information is being provided to members.
Sponsored clinic days at provider offices to promote preventive well-child visits. Developed a texting campaign script for clinic day event for members and parents/guardians.	

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Amerigroup Iowa met 100 percent of the requirements for data analysis and implementation of improvement strategies.

Strength: Amerigroup Iowa achieved, and sustained, statistically significant improvement over the baseline rate for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* PIP topic, indicating members 3 to 6 years of age had a well-child visit with their PCP and were assessed for any physical, emotional, and/or social issues.

Weaknesses

Weakness: Amerigroup Iowa did not achieve the overall goal of statistically significant improvement for the *Member Satisfaction* PIP topic.

Why the weakness exists: Amerigroup Iowa demonstrated slight improvement for Remeasurement 2 over the baseline rate and a decrease of 2.8 percentage points over Remeasurement 1; however, members continue to have a poorer perception of customer service representatives and may not be receiving complete and accurate information during their customer service calls.

Recommendation: Although the *Member Satisfaction* PIP has concluded, HSAG recommends that Amerigroup Iowa revisit its causal/barrier analysis to determine whether barriers identified continue to be barriers and determine if any new barriers exist that require the development of new innovative interventions.

PMV

Performance Results—SFY 2019

HSAG reviewed Amerigroup Iowa's eligibility and enrollment data, claims and encounters, case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, Amerigroup Iowa demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Amerigroup Iowa's processes. Prior to the interview portion of the PMV review, HSAG also requested that Amerigroup Iowa submit screen shots of its enrollment, claims, and case management systems for five members for performance measures 1 and 2, and five members for performance measures 3 through 6. This was to gain an understanding of Amerigroup Iowa's systems and its use of system-defined fields prior to the interview. HSAG did not identify any issues during the primary source verification (PSV) interview session.

Measure designation and reportable measure rates for SFY 2019 are displayed in Table 3-7, Table 3-8, and Table 3-9. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed. Amerigroup Iowa received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 3-7—SFY 2019 #1 Performance Measure Designation and Rates—AGP

Performance Measure		Measure Designation	Measure Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1	*Receipt of Authorized Services (Informational Only)*	R	27.16%	10.46%	21.30%	3.52%	37.56%

R = Reportable

Table 3-8—SFY 2019 #2 Performance Measure Designation and Rates—AGP

Performance Measure		Measure Designation	Measure Rate			
			0%	1–50%	51–90%	91–100%
2	*Receipt of Authorized One-Time Services (Informational Only)*	R	0.94%	0.06%	0.03%	1.14%

R = Reportable

Table 3-9—SFY 2019 #3, #4, #5, and #6 Performance Measure Designation and Rates—AGP

Performance Measure		Measure Designation	2019		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	R	1,438	835	58.07%
4	*Person-Centered Care Plan Meeting**	R	1,438	916	63.70%
5	*Care Team Lead Chosen by the Member*	R	1,438	1,024	71.21%
6	*Member Choice of HCBS Settings*	R	1,438	1,322	91.93%

R = Reportable

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

Strengths, Weaknesses, and Recommendations—SFY 2019

Strengths

Strength: Amerigroup Iowa made improvements to align its identification of the Index Care Plan effective date with the updated technical specifications, which ensures continued accuracy of performance measure reporting to support ongoing monitoring of its HCBS members' receipt of services authorized in their care plans.

Weaknesses

Weakness: Amerigroup Iowa still maintains an entirely manual process to abstract data for reporting performance measure rates for the following performance measures: *Provision of Care Plan, Person-Centered Care Plan (PCCP) Meeting*, *Care Team Lead Chosen by the Member*, and *Member Choice of HCBS Settings.* Not only is this process labor intensive, it also adds a risk of manual error to rate reporting.

Why the weakness exists: Amerigroup Iowa has not implemented options to generate automated reportable data from its software.

Recommendation: HSAG recommends that Amerigroup Iowa revise its processes to allow automated reporting of data from its software, with quality assurance steps in place, eliminating the need for manual abstraction of performance measure data.

Performance Results—SFY 2020

Table 3-10—Performance Measure #1a: Receipt of Authorized Services*—AGP

Performance Measure		Measure Designation	2020 Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members with Applicable Percentage of Authorized Services Utilized*	R	10.46%	48.61%	22.98%	9.47%	8.48%

R = Reportable

* 2020 rates are provided for information only and are not comparable to 2019 rates due to methodology changes in 2020.

Table 3-11—Performance Measure #1b: Receipt of Authorized Services*—AGP

Performance Measure		Measure Designation	2020 Rate
1b	*The percentage of eligible members for whom 100 percent of HCBS services documented in members' care plans had a corresponding approved service authorization*	R	81.26%

R = Reportable

* This indicator is new for 2020 and rate is provided for information only.

Table 3-12—Performance Measure #2a, 2b, and 2c: Receipt of Authorized One-Time Services*—AGP

Performance Measure		Measure Designation	2020		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	R	1,510	34	2.25%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	R	34	21	61.76%
2c	*Percentage of Authorized One-Time Services Utilized*	R	26	19	73.08%

R = Reportable

* 2020 rates are provided for information only.

Table 3-13—Performance Measures #3, #4, #5, and #6—AGP

Performance Measure		Measure Designation	2020		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	R	1,531	623	40.69%
4	*Person-Centered Care Plan Meeting**	R	1,531	957	62.51%
5	*Care Team Lead Chosen by the Member*	R	1,531	1,103	72.04%
6	*Member Choice of HCBS Settings*	R	1,531	1,479	96.60%

R = Reportable

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

Strengths, Weaknesses, and Recommendations—SFY 2020

Strengths

Strength: Amerigroup Iowa demonstrated strength in ensuring members' choice of HCBS setting as the rate for performance measure #6, *Member Choice of HCBS Settings,* increased from 91.93 percent in 2019 to 96.90 percent in 2020. Amerigroup Iowa continued to focus on supporting members' choice of care settings by ensuring that member care plans include at least one goal related to living in a less restrictive care setting and that members reside in the least restrictive care setting.

Weaknesses

Weakness: Amerigroup Iowa continued to rely on manual abstraction to report performance measure rates, and due to performance measure methodology updates, was only able to report measures via the hybrid methodology using a sample of its eligible population.

Why the weakness exists: Amerigroup Iowa has indicated that it must manually abstract the results in order to accurately report delegated entity (e.g., health homes) data in its rates.

Recommendation: While the performance measure specifications were updated to allow for hybrid reporting of all measures, HSAG recommends that Amerigroup Iowa revise its processes to allow automated reporting of data from its software, with quality assurance steps in place, eliminating the need for manual abstraction of performance measure data. This would reduce administrative burden on Amerigroup Iowa while still providing a complete picture of the MCO's performance as it relates to care management of members receiving HCBS.

Performance Results—HEDIS

HSAG's review of the Final Audit Report (FAR) for HEDIS 2020 based on CY 2019 data showed that Amerigroup Iowa's HEDIS compliance auditor found Amerigroup Iowa's information systems and processes to be compliant with the applicable IS standards and the HEDIS reporting requirements for HEDIS 2020. Amerigroup Iowa contracted with an external software vendor with HEDIS Certified Measures℠[3-3] for measure production and rate calculation.

Table 3-14—HEDIS 2020 (CY 2019) Results—AGP

Measures	HEDIS 2019 (CY 2018) Rate	HEDIS 2020 (CY 2019) Rate	Difference**	Star Rating
Access to Preventive Care				
Adults' Access to Preventive/Ambulatory Health Services				
Ages 20–44 Years	84.86%	84.13%	-0.73%	★★★★
Ages 45–64 Years	90.88%	88.97%	-1.91%	★★★★
Ages 65 and Older	89.01%	90.43%	1.42%	★★★
Adults Body Mass Index (BMI) Assessment^				
Adults Body Mass Index (BMI) Assessment	96.84%	96.84%	0.00%	★★★★★
Children and Adolescents' Access to Primary Care Practitioners				
12–24 Months	96.71%	97.18%	0.47%	★★★★
25 Months–6 Years	90.64%	91.11%	0.47%	★★★★
7–11 Years	92.24%	93.12%	0.88%	★★★
12–19 Years	92.47%	93.70%	1.23%	★★★★
Use of Imaging Studies for Low Back Pain				
Use of Imaging Studies for Low Back Pain	70.19%	71.72%	1.53%	★★
Weight Assessment and Counseling for Nutrition and Physical Activity for Children/Adolescents^				
BMI Percentile Documentation—Total	78.83%	78.83%	0.00%	★★
Counseling for Nutrition—Total	65.45%	65.45%	0.00%	★★
Counseling for Physical Activity—Total	62.77%	62.77%	0.00%	★★
Women's Health				
Breast Cancer Screening				
Breast Cancer Screening	45.38%	55.96%	10.58%	★★

[3-3] HEDIS Certified Measures℠ is a service mark of the NCQA.

Measures	HEDIS 2019 (CY 2018) Rate	HEDIS 2020 (CY 2019) Rate	Difference**	Star Rating
Cervical Cancer Screening^				
Cervical Cancer Screening	63.02%	63.02%	0.00%	★★★
Chlamydia Screening in Women				
Total	47.44%	48.50%	1.06%	★
Non-Recommended Cervical Cancer Screening in Adolescent Females*				
Non-Recommended Cervical Cancer Screening in Adolescent Females	0.26%	0.28%	0.02%	★★★★
Prenatal and Postpartum Care^				
Timeliness of Prenatal Care	—	86.60%	NC	★★
Postpartum Care	—	62.63%	NC	★
Living With Illness				
Comprehensive Diabetes Care^				
Hemoglobin A1c (HbA1c) Testing	91.48%	91.48%	0.00%	★★★★
HbA1c Control (<8.0%)	59.85%	59.85%	0.00%	★★★★
*HbA1c Poor Control (>9.0%)**	27.98%	27.98%	0.00%	★★★★★
Blood Pressure Control (<140/90 mm Hg)	76.40%	76.40%	0.00%	★★★★★
Eye Exam (Retinal) Performed	61.31%	61.31%	0.00%	★★★
Medical Attention for Nephropathy	91.00%	91.00%	0.00%	★★★
Controlling High Blood Pressure^				
Controlling High Blood Pressure	69.59%	69.59%	0.00%	★★★★
Statin Therapy for Patients With Cardiovascular Disease				
Received Statin Therapy	46.15%	72.07%	25.92%	★
Statin Therapy for Patients With Diabetes				
Received Statin Therapy	41.80%	62.20%	20.40%	★★
Behavioral Health				
Diabetes Monitoring for People With Diabetes and Schizophrenia				
Diabetes Monitoring for People With Diabetes and Schizophrenia	44.80%	67.17%	22.37%	★

Measures	HEDIS 2019 (CY 2018) Rate	HEDIS 2020 (CY 2019) Rate	Difference**	Star Rating
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications				
Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications	77.59%	77.62%	0.03%	★
Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence				
7-Day Follow-Up—Total	44.04%	48.88%	4.84%	★★★★★
30-Day Follow-Up—Total	50.55%	55.19%	4.64%	★★★★★
Follow-Up After ED Visit for Mental Illness				
7-Day Follow-Up—Total	59.11%	67.82%	8.71%	★★★★★
30-Day Follow-Up—Total	73.57%	77.51%	3.94%	★★★★★
Follow-Up After Hospitalization for Mental Illness				
7-Day Follow-Up—Total	41.57%	47.54%	5.97%	★★★★
30-Day Follow-Up—Total	65.69%	69.03%	3.34%	★★★★
Initiation and Engagement of AOD Abuse or Dependence Treatment				
Initiation of AOD Treatment—Total	70.94%	74.22%	3.28%	★★★★★
Engagement of AOD Treatment—Total	26.06%	29.04%	2.98%	★★★★★
Metabolic Monitoring for Children and Adolescents on Antipsychotics				
Blood Glucose and Cholesterol Testing—Total	25.57%	27.35%	1.78%	★
Use of First-Line Psychosocial Care for Children and Adolescents on Antipsychotics				
Total	65.03%	66.79%	1.76%	★★★
Keeping Kids Healthy				
Adolescent Well-Care Visits^				
Adolescent Well-Care Visits	61.80%	61.80%	0.00%	★★★
Childhood Immunization Status^				
Combination 3	76.89%	76.89%	0.00%	★★★★
Combination 10	46.47%	46.47%	0.00%	★★★★
Immunizations for Adolescents^				
Combination 1	87.83%	87.83%	0.00%	★★★★
Combination 2	37.47%	37.47%	0.00%	★★★

Measures	HEDIS 2019 (CY 2018) Rate	HEDIS 2020 (CY 2019) Rate	Difference**	Star Rating
Lead Screening in Children^				
Lead Screening in Children	81.02%	81.02%	0.00%	★★★★
Well-Child Visits in the First 15 Months of Life^				
Six or More Well-Child Visits	69.59%	69.59%	0.00%	★★★
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life^				
Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life	76.04%	76.04%	0.00%	★★★
Medication Management				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia				
Adherence to Antipsychotic Medications for Individuals With Schizophrenia	62.76%	65.27%	2.51%	★★★
Antidepressant Medication Management				
Effective Acute Phase Treatment	52.31%	51.71%	-0.60%	★★
Effective Continuation Phase Treatment	35.33%	35.77%	0.44%	★★
Appropriate Testing for Pharyngitis				
Total	—	81.34%	NC	★★★
Appropriate Treatment for Upper Respiratory Infection				
Total	—	84.16%	NC	★
Asthma Medication Ratio				
Total	61.10%	60.64%	-0.46%	★★
Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis				
Total	—	43.43%	NC	★
Follow-Up Care for Children Prescribed ADHD Medication				
Initiation Phase	36.20%	41.65%	5.45%	★★
Continuation and Maintenance Phase	40.93%	51.02%	10.09%	★★
Persistence of Beta-Blocker Treatment After a Heart Attack				
Persistence of Beta-Blocker Treatment After a Heart Attack	80.45%	86.67%	6.22%	★★★★
Pharmacotherapy Management of COPD Exacerbation				
Systemic Corticosteroid	38.96%	59.27%	20.31%	★
Bronchodilator	45.54%	69.47%	23.93%	★

Measures	HEDIS 2019 (CY 2018) Rate	HEDIS 2020 (CY 2019) Rate	Difference**	Star Rating
Statin Therapy for Patients With Cardiovascular Disease				
Statin Adherence 80%—Total	65.56%	68.66%	3.10%	★★★
Statin Therapy for Patients With Diabetes				
Statin Adherence 80%—Total	63.37%	65.14%	1.77%	★★★
Use of Opioids at High Dosage*				
Use of Opioids at High Dosage	—	3.16%	NC	★★★
Use of Opioids From Multiple Providers				
*Multiple Prescribers**	22.74%	20.67%	-2.07%	★★
*Multiple Pharmacies**	3.24%	3.06%	-0.18%	★★★★
*Multiple Prescribers and Multiple Pharmacies**	2.08%	2.11%	0.03%	★★★

* For this indicator, a lower rate indicates better performance.
** May not equal the difference between HEDIS 2019 and HEDIS 2020 rates due to rounding.
— Indicates that the CY 2019 rate is not presented because the MCOs were not required to report the measure until CY 2020. This symbol may also indicate that NCQA recommended a break in trending; therefore, the CY 2019 rate is not displayed.
NC indicates that a comparison is not appropriate, or the prior year's rate was unavailable.
^ In alignment with DHS and NCQA guidance, results for this measure were rotated with the HEDIS 2019 (measure year [MY] 2018) hybrid rate.
HEDIS 2020 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—SFY 2020

Strengths

Strength: Amerigroup Iowa's performance under the Access to Preventive Care domain ranked at or above the 90th percentile for the *Adults Body Mass Index (BMI) Assessment* indicator, indicating members 18 to 74 years of age received a documented assessment to help them monitor and identify any risks and allow medical staff to provide focused advice and services to maintain healthier weight limits.

Strength: Amerigroup Iowa's performance under the Living With Illness domain ranked at or above the 90th percentile for the *Comprehensive Diabetes Care—HbA1c Poor Control (>9.0%)* and *Blood Pressure Control (<140/90 mm Hg)* indicators and between the 75th and 89th percentiles for the *Hemoglobin A1c (HbA1c) Testing* and *HbA1c Control (<8.0%)* indicators. These rates indicate that members 18 to 75 years of age received proper diabetes management to help control their blood glucose and reduce risk of complications related to type 1 and type 2 diabetes in order to prolong the life spans of these members.

Strength: Amerigroup Iowa's performance under the Behavioral Health domain ranked at or above the 90th percentile for six of the 12 indicators: *Follow-Up After ED Visit for Alcohol and Other Drug (AOD) Abuse or Dependence—7-Day* and *30 Day Follow-Up, Initiation and Engagement of AOD Abuse or Dependence Treatment—Initiation* and *Engagement of AOD Treatment,* and the *Follow-Up After ED Visit for Mental Illness—7-Day* and *30-Day Follow-Up.* The rates for these indicators show that Amerigroup Iowa is engaged in providing follow-up treatment services to improve physical and mental function and reduce repeat ED visits, hospital readmissions, and healthcare spending.

Weaknesses

Weakness: Amerigroup Iowa's performance under the Women's Health domain ranked below the 25th percentile for the *Chlamydia Screening in Women* and *Prenatal and Postpartum Care—Postpartum Care* indicators, indicating a large number of women are not being seen or screened by their providers. Untreated chlamydia infections can lead to serious and irreversible complications. Additionally, timely and adequate prenatal and postpartum care can promote the long-term health and wellbeing of new mothers and their infants.

Why the weakness exists: The low rate for *Chlamydia Screening in Women* suggests barriers exist for sexually active women between 16 and 24 years of age to access this important health screening. Additionally, the low *Prenatal and Postpartum Care—Postpartum Care* indicator rate suggests women are experiencing barriers to timely access to their providers for a postpartum care appointment.

Recommendation: HSAG recommends that Amerigroup Iowa conduct a root cause analysis or focused study to determine why women 16 to 24 years of age identified as sexually active are not getting screened for chlamydia to reduce the potential for serious and irreversible complications such as pelvic inflammatory disease and infertility.[3-4] In addition, HSAG recommends that Amerigroup Iowa conduct a root cause analysis or focused study to determine why women are not receiving timely postpartum care in order to manage chronic health conditions and help members access effective contraception, which left untreated can increase the risk of short interval pregnancies and preterm birth rates.[3-5] Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve low performance rates within the Women's Health domain.

Weakness: Amerigroup Iowa's performance under the Living With Illness domain ranked below the 25th percentile for the *Statin Therapy for Patients With Cardiovascular Disease—Received Statin Therapy* indicator, indicating that patients did not always have access to statin therapy. Having unhealthy cholesterol levels places members at significant risk for developing atherosclerotic cardiovascular disease.

[3-4] Office of Disease Prevention and Health Promotion. Healthy People 2020: Sexually Transmitted Diseases. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/sexually-transmitted-diseases. Accessed on: Jan 20, 2021.

[3-5] The American College of Obstetricians and Gynecologists. Interpregnancy Care. Available at: https://www.acog.org/clinical/clinical-guidance/obstetric-care-consensus/articles/2019/01/interpregnancy-care. Accessed on: Jan 20, 2021.

Why the weakness exists: The low rate for this indicator suggests potential barriers for members with cardiovascular disease to access appropriate medications to treat their healthcare condition.

Recommendation: HSAG recommends that Amerigroup Iowa conduct a root cause analysis or focused study to determine why its patients with cardiovascular disease who need statin therapy are not receiving medications to help lower their cholesterol and the risk of heart disease and stroke.[3-6] Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rate of the measure.

Weakness: Amerigroup Iowa's performance under the Behavioral Health domain ranked below the 25th percentile for the following indicators: *Diabetes Monitoring for People With Diabetes and Schizophrenia, Diabetes Screening for People With Schizophrenia or Bipolar Disorder Who Are Using Antipsychotic Medications*, and *Metabolic Monitoring for Children and Adolescents on Antipsychotics—Blood Glucose and Cholesterol Testing*. These low rates indicate that diabetic patients receiving behavioral healthcare are not always being monitored or screened properly, nor are children and adolescents using antipsychotic medications. 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 downstream. Additionally, monitoring of blood glucose and cholesterol testing is an important component of ensuring appropriate management of children and adolescents on antipsychotic medications.

Why the weakness exists: While the root cause of these weaknesses is currently unclear, these low rates suggest there are barriers to timely and appropriate access to key health screenings and monitoring for adults and children with behavioral health conditions.

Recommendation: HSAG recommends that Amerigroup Iowa conduct a root cause analysis or focused study to determine why its patients with severe mental illnesses and diabetes are not receiving monitoring or screening. Members with these conditions are two to three times more likely to suffer from premature death than the general population. The leading cause for this shortened life expectancy is cardiovascular disease, which can be related to ongoing member utilization of antipsychotic medications combined with general unhealthy lifestyles (e.g., lack of physical activity, lack of appropriate nutrition, etc.).[3-7] Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rates of these measures.

Weakness: Amerigroup Iowa's performance under the Medication Management domain ranked below the 25th percentile for the *Appropriate Treatment for Upper Respiratory Infection, Avoidance of Antibiotic Treatment for Acute Bronchitis/Bronchiolitis,* and *Pharmacotherapy Management of COPD Exacerbation—Systemic Corticosteroid* and *Bronchodilator* indicators, indicating some members are being prescribed antibiotics

[3-6] American Heart Association. Cholesterol Medications. Available at: https://www.heart.org/en/health-topics/cholesterol/prevention-and-treatment-of-high-cholesterol-hyperlipidemia/cholesterol-medications. Accessed on: Jan 20, 2021.

[3-7] Ringen PA, Engh JA, Birkenaes AB, et al. Increased Mortality in Schizophrenia Due to Cardiovascular Disease—A Non-Systematic Review of Epidemiology, Possible Causes, and Interventions. *Front Psychiatry*. 2014; 5: 137. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4175996/. Accessed on: Jan 20, 2021.

inappropriately, while some members are not receiving appropriate medication after a hospitalization or ED visit related to their chronic obstructive pulmonary disease (COPD). Misuse of antibiotics can have adverse clinical outcomes and encourage antibiotic resistance. Additionally, appropriate prescribing of medication following exacerbation can prevent future flare-ups and reduce costs of COPD.[3-8]

Why the weakness exists: The low rates for the Medication Management measures suggest barriers for members specifically related to appropriate medication management. There appears to be higher than appropriate antibiotic dispensing for upper respiratory infections (URIs) and acute bronchitis/bronchiolitis, and lower than appropriate medication dispensing for members who need a systemic corticosteroid or bronchodilator after a COPD-related hospital admission or ED visit.

Recommendation: HSAG recommends that Amerigroup Iowa conduct a root cause analysis or focused study to identify the barriers to medication management in order to minimize antibiotic exposure and preventive antibiotic resistance, which could reduce the spread of antibiotic-resistant bacterial infections, and to ensure members have timely access to appropriate medications after a hospitalization or ED visit related to COPD. Upon identification of a root cause, Amerigroup Iowa should implement appropriate interventions to improve the performance rates for these measures.[3-9]

Compliance Review

Performance Results

Table 3-15 presents Amerigroup Iowa's scores for each standard evaluated in the CY 2020 compliance review. Each element within a standard was scored as *Met*, *Not Met,* or *NA* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and virtual interviews with MCO staff members. Table 3-16 displays Amerigroup Iowa's scores for all standards reviewed over the three-year compliance review cycle.

Table 3-15—Summary of Standard Compliance Scores—AGP

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
V	Provider Selection	13	12	8	4	1	**67%**
VI	Member Information and Member Rights	22	22	17	5	0	**77%**
VIII	Enrollment and Disenrollment	7	7	6	1	0	**86%**
X	Subcontractual Relationships and Delegation	7	7	6	1	0	**86%**

[3-8] Ventola CL. The Antibiotic Resistance Crisis: Part 1: Causes and Threats. *Pharmacy and Therapeutics*. 2015 Apr;40(4): 277–283. Available at: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4378521/. Accessed on: Jan 20, 2021.

[3-9] Ibid.

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
XIII	Health Information Systems	9	9	8	1	0	**89%**
Total		**58**	**57**	**45**	**12**	**1**	**79%**

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.

Table 3-16—Summary of Standard Compliance Scores—AGP

Year Reviewed	Standard	Total Compliance Score
CY 2018	Standard I—Availability of Services	**95%**
CY 2018	Standard II—Assurances of Adequate Capacity and Services	**100%**
CY 2019	Standard III—Coordination and Continuity of Care	**81%**
CY 2019	Standard IV—Coverage and Authorization of Services	**82%**
CY 2020	Standard V—Provider Selection	**67%**
CY 2020	Standard VI—Member Information and Member Rights	**77%**
CY 2019	Standard VII—Confidentiality of Health Information	**80%**
CY 2020	Standard VIII—Enrollment and Disenrollment	**86%**
CY 2018	Standard IX—Grievances, Appeals and State Fair Hearings	**95%**
CY 2020	Standard X—Subcontractual Relationships and Delegation	**86%**
CY 2019	Standard XI—Practice Guidelines	**100%**
CY 2018	Standard XII—Quality Assessment and Performance Improvement	**92%**
CY 2020	Standard XIII—Health Information Systems	**89%**

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Amerigroup Iowa's member handbook contained all required content which provided a summary of benefits and coverage and enabled a member to understand how to effectively navigate through the Medicaid managed care program.

Strength: While Amerigroup Iowa performed poorly overall in the Provider Selection standard, Amerigroup Iowa excelled in meeting initial and recredentialing requirements for individual practitioners. The credentialing file reviews for practitioners identified adherence in 301 of 303 scoring components, demonstrating that Amerigroup Iowa appropriately verified each provider's qualifications prior to initial or continued inclusion in its network.

Weaknesses

Weakness: Amerigroup Iowa demonstrated challenges in implementing provider selection and retention requirements. Consistent and accurate application of contract requirements is necessary to ensure Amerigroup Iowa maintains quality providers who are available to serve Medicaid members.

Why the weakness exists: Various findings contributed to this weakness, including the following:

- While DHS is the entity responsible for collecting ownership and disclosure forms and periodically screening disclosed individuals against exclusion databases, Amerigroup Iowa did not maintain a process to ensure that should it receive a provider ownership and disclosure form, the form would be forwarded to DHS.
- Amerigroup Iowa did not calculate and report credentialing timeliness standards in accordance with contract requirements.
- The organizational credentialing file review identified opportunities for verifying appropriate healthcare licensures, and the timeliness of these verifications.

Recommendation: Amerigroup Iowa was required to submit a corrective action plan (CAP) to remediate these deficiencies. HSAG recommends that Amerigroup Iowa proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Amerigroup Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies.

Weakness: Amerigroup Iowa staff members appeared to lack knowledge of several requirements pertaining to the Member Information and Member Rights standard. Staff knowledge is imperative to ensure members receive timely and adequate information that can assist them in accessing care and services.

Why the weakness exists: During and after the interview session component of the compliance review, Amerigroup Iowa staff members struggled to articulate processes and to provide evidence of implementation of several requirements.

Recommendation: Amerigroup Iowa was required to submit a CAP to remediate the deficiencies in this standard. HSAG recommends that Amerigroup Iowa proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Amerigroup Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, Amerigroup Iowa should review program requirements with all appropriate staff members responsible for functions pertaining to member services, including member information, to ensure they have an appropriate understanding of the expectations under each requirement.

NAV

Performance Results

Table 3-17 displays 11 demographic indicators found in the sample of PCPs and obstetrics/gynecology (OB/GYN) providers pulled from the provider data submitted by Amerigroup Iowa compared against the information that could be retrieved from Amerigroup Iowa's online provider directory for the sample of 372 providers found in the online provider directory.

Table 3-17—Match Results for Demographic Indicators—AGP

Indicator		Exact Match		Unmatched*	
	Total	Count	Percent	Count	Percent
Provider First Name	372	371	99.7%	1	0.3%
Provider Middle Name	372	372	100.0%	0	0.0%
Provider Last Name	372	372	100.0%	0	0.0%
Provider Address 1	372	372	100.0%	0	0.0%
Provider Address 2	372	370	99.5%	2	0.5%
Provider City	372	372	100.0%	0	0.0%
Provider State	372	372	100.0%	0	0.0%
Provider Zip Code	372	372	100.0%	0	0.0%
Provider Telephone Number	372	369	99.2%	3	0.8%
Provider Specialty	372	372	100.0%	0	0.0%
Provider Accepting New Patients	372	338	90.9%	34**	9.1%

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

** The 34 unmatched cases include 18 cases wherein the "accepting new patient" status did not match and 16 cases wherein the information was not found in the online provider directory.

Table 3-18 displays a list of five available information and services indicators found in the submitted provider data against the information that could be reviewed in the online provider directory for the 372 providers initially found in the online provider directory.

Table 3-18—Presence of Available Information and Services Indicators—AGP

Indicator	Total	Present in Directory		Not Present in Directory		Information Pending	
		Count	Percent	Count	Percent	Count	Percent
Provider Accommodates Physical Disabilities	372	372	100.0%	0	0.0%	0	0.0%
Provider Completed Cultural Competency Training	372	372	100.0%	0	0.0%	0	0.0%
Non-English Language Speaking Provider	372	371	99.7%	1	0.3%	0	0.0%

Indicator	Total	Present in Directory		Not Present in Directory		Information Pending	
		Count	Percent	Count	Percent	Count	Percent
Provider Office Hours	372	368	98.9%	4	1.1%	0	0.0%
Provider URL	372	1	0.3%	371	99.7%	0	0.0%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The match rates for provider information in the online provider directory compared to Amerigroup Iowa's provider data were high (i.e., above 99 percent for all indicators assessed except for accepting new patients). This indicates that members likely have access to high-quality, accurate provider information through Amerigroup Iowa's online provider directory.

Strength: A high percentage of the provider records in Amerigroup Iowa's online provider directory included information regarding accommodations for physical disabilities, completion of cultural competency training, availability of non-English-speaking providers, and provider office hours.

Weaknesses

Weakness: Amerigroup Iowa's provider directory listed provider uniform resource locators (URLs) for less than 1 percent of the providers. As provider websites may have important information regarding new patient forms, question and answer documents, and additional information, these websites can be very beneficial to members.

Why the weakness exists: This weakness may exist because providers are not submitting this information to Amerigroup Iowa or because Amerigroup Iowa does not regularly request this information. Another reason may be that relatively few providers have developed their own websites.

Recommendation: HSAG recommends that Amerigroup Iowa conduct a root cause analysis to investigate whether the low percentage reported is due to a lack of providers with websites or if there are ways Amerigroup Iowa could be proactive in obtaining this information from the providers.

EDV

Performance Results

There are two aspects of record completeness—record omission and record surplus. Table 3-19 displays the percentage of records present in the files submitted by Amerigroup Iowa that were not found in DHS-submitted files (record omission), and the percentage of records present in DHS-submitted files but not present in the Amerigroup Iowa-submitted files (record surplus). Lower rates indicate better performance for both record omission and record surplus.

Table 3-19—Record Omission and Surplus Rates—AGP

Encounter Type	Omission	Surplus
Professional	1.2%	0.5%
Institutional	13.9%	0.1%
Pharmacy	3.4%	<0.1%

Table 3-20 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the professional encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance, while for the element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-20—Data Element Omission, Surplus, Absent, and Accuracy: Professional Encounters—AGP

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Absent[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	99.9%
Header Service To Date	0.0%	0.0%	0.0%	>99.9%
Billing Provider National Provider Identifier (NPI)	0.0%	3.1%	<0.1%	100.0%
Rendering Provider NPI	0.0%	44.1%	<0.1%	99.7%
Referring Provider NPI[A]	<0.1%	38.6%	61.4%	NA
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Secondary Diagnosis Code[A]	<0.1%	0.0%	51.1%	>99.9%
Procedure Code	0.0%	0.0%	0.0%	100.0%
Procedure Code Modifier[A]	0.0%	0.0%	55.2%	100.0%
Units of Service	0.0%	0.0%	0.0%	>99.9%
National Drug Code (NDC)[A]	<0.1%	<0.1%	98.9%	99.4%
Detail Paid Amount	0.0%	0.0%	0.0%	>99.9%

"NA" denotes that no records are present in both data sources with values present in both sources.

[A] *Referring Provider NPI*, *Secondary Diagnosis Code*, *Procedure Code Modifier*, and *NDC* fields are situational (i.e., not required for every professional transaction).

[1] Element Omission is the number and percentage of records with values present in the MCOs' submitted files but not in DHS' data warehouse.

[2] Element Surplus is the number and percentage of records with values present in DHS' data warehouse but not in the MCOs' submitted files.

[3] Element Absent is the number and percentage of records with values not present in both DHS' data warehouse and the MCOs' submitted files.

[4] Element Accuracy is the number and percentage of records with values present and have the same values in both the MCOs' submitted files and DHS' data warehouse.

Table 3-21 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the institutional encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance, while for element accuracy indicator, higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-21—Data Element Omission, Surplus, Absent, and Accuracy: Institutional Encounters—AGP

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Absent[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	100.0%
Header Service From Date	0.0%	0.0%	0.0%	97.2%
Header Service To Date	0.0%	0.0%	0.0%	95.7%
Admission Date[A]	<0.1%	0.0%	80.8%	97.6%
Billing Provider NPI	0.0%	0.0%	0.0%	100.0%
Attending Provider NPI	1.3%	0.2%	0.1%	100.0%
Referring Provider NPI[A]	0.0%	0.0%	100.0%	NA
Primary Diagnosis Code	0.0%	0.0%	0.0%	100.0%
Secondary Diagnosis Code[A]	<0.1%	0.0%	20.3%	>99.9%
Procedure Code[A]	0.0%	0.0%	17.5%	100.0%
Procedure Code Modifier[A]	0.0%	0.0%	76.2%	100.0%
Units of Service	0.0%	0.0%	0.0%	100.0%
Primary Surgical Procedure Code[A]	0.6%	0.4%	95.2%	100.0%
Secondary Surgical Procedure Code[A]	0.4%	0.3%	97.0%	100.0%
NDC[A]	0.3%	<0.1%	92.8%	94.5%
Revenue Code	0.0%	0.0%	0.0%	99.8%
Diagnosis-related group (DRG)[A]	<0.1%	2.5%	91.1%	>99.9%
Header Paid Amount	0.0%	0.0%	0.0%	100.0%
Detail Paid Amount	0.0%	0.0%	0.0%	100.0%

"NA" denotes that no records are present in both data sources with values present in both sources.

[A] *Admission Date, Referring Provider NPI, Secondary Diagnosis Code, Procedure Code, Procedure Code Modifier, Primary Surgical Procedure Code, Secondary Surgical Procedure Code, NDC*, and *DRG Code* fields are situational (i.e., not required for every institutional transaction).

[1] Element Omission is the number and percentage of records with values present in the MCOs' submitted files but not in DHS' data warehouse.

[2] Element Surplus is the number and percentage of records with values present in DHS' data warehouse but not in the MCOs' submitted files.

[3] Element Absent is the number and percentage of records with values not present in both DHS' data warehouse and the MCOs' submitted files.

[4] Element Accuracy is the number and percentage of records with values present and have the same values in both the MCOs' submitted files and DHS' data warehouse.

Table 3-22 displays the element omission, element surplus, element absent, and element accuracy results for each key data element from the pharmacy encounters for Amerigroup Iowa. For the element omission and surplus indicators, lower rates indicate better performance, while for element accuracy indicator higher rates indicate better performance. However, for the element absent indicator, lower or higher rates do not indicate better or poor performance.

Table 3-22—Data Element Omission, Surplus, Absent, and Accuracy: Pharmacy Encounters—AGP

Key Data Elements	Element Omission[1]	Element Surplus[2]	Element Absent[3]	Element Accuracy[4]
Member ID	0.0%	0.0%	0.0%	>99.9%
Header Service From Date	0.0%	0.0%	0.0%	100.0%
Billing Provider NPI	0.0%	0.0%	0.0%	>99.9%
Prescribing Provider NPI	0.0%	0.0%	0.0%	100.0%
NDC	<0.1%	0.0%	0.0%	100.0%
Drug Quantity	0.0%	0.0%	0.0%	95.5%
Header Paid Amount	0.0%	0.4%	0.0%	98.0%
Dispensing Fee	0.0%	0.0%	0.0%	89.6%

[1] Element Omission is the number and percentage of records with values present in the MCOs' submitted files but not in DHS' data warehouse.

[2] Element Surplus is the number and percentage of records with values present in DHS' data warehouse but not in the MCOs' submitted files.

[3] Element Absent is the number and percentage of records with values not present in both DHS' data warehouse and the MCOs' submitted files.

[4] Element Accuracy is the number and percentage of records with values present and have the same values in both the MCOs' submitted files and DHS' data warehouse.

Table 3-23 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 for Amerigroup Iowa. For the all-element accuracy indicator, higher rates indicate better performance.

Table 3-23—All-Element Accuracy and Encounter Type—AGP

Professional Encounters	Institutional Encounters	Pharmacy Encounters
24.0%	89.5%	86.3%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Amerigroup Iowa's professional and pharmacy encounters exhibited complete data with low record omission and record surplus rates.

Strength: For institutional encounters, the record surplus rate was very low (i.e., 0.1 percent), suggesting nearly all of the encounters in DHS' data warehouse were corroborated by data extracted from Amerigroup Iowa's data system. The record omission rate was high (i.e., 13.9 percent); however, the MCO's and DHS' investigation of the root cause determined that the reason for the discrepancy was because DHS' data extract for the study did not include encounters that were being replaced by a more current iteration of the encounter.

Strength: Among encounters that could be matched between data extracted from DHS' data warehouse and data extracted from Amerigroup Iowa's data system, a high level of element completeness (i.e., low omission and surplus rates) was exhibited among all three encounter types, except for the *Rendering* and *Referring Provider NPI* fields from the professional encounter type. However, the discrepancies were determined to be due to how DHS processed these data elements in the Medicaid Management Information System (MMIS).

Strength: Among encounters that could be matched between the two data sources, a high level of element accuracy (i.e., data elements from both sources had the same values) was exhibited among all three encounter types, with very few exceptions.

Weaknesses

Weakness: Amerigroup Iowa's element accuracy rate for the pharmacy data element *Dispensing Fee* was relatively low at 89.6 percent.

Why the weakness exists: Based on Amerigroup Iowa's internal investigation, the root causes of the discrepancies were as follows:

- The discrepant values were associated with denied claims for which DHS-submitted data reported zero dollars due to a mapping issue which was corrected for paid claims but not corrected for denied claims.
- The discrepant values were associated with denied claims for which the Amerigroup Iowa-submitted *Dispensing Fee* amounts matched. However, the DHS-submitted data reported the value as a positive number, while the Amerigroup Iowa-submitted data reported the value as a negative number.
- The discrepant values were associated with voided claims (i.e., reversals) for which the *Dispensing Fee* amounts matched. However, the DHS-submitted data reported the value as a negative number, while the Amerigroup Iowa-submitted data reported the value as a positive number.

Recommendation: HSAG recommends that Amerigroup Iowa work with DHS to reconcile the reporting of either the denied or voided claims with the appropriate negative or positive numbers.

CAHPS Analysis

Performance Results

Table 3-24 presents Amerigroup Iowa's 2020 adult Medicaid, general child Medicaid, and children with chronic conditions (CCC) Medicaid CAHPS top-box scores.

Table 3-24—Summary of 2020 CAHPS Top-Box Scores—AGP

	2020 Adult Medicaid	2020 General Child Medicaid	2020 CCC Medicaid Supplemental
Composite Measures			
Getting Needed Care	88.3% ↑	88.2%	91.0%
Getting Care Quickly	86.5%	93.9%	95.8%
How Well Doctors Communicate	95.7%	97.6%	97.4%
Customer Service	85.5%	NA	NA
Global Ratings			
Rating of All Health Care	59.9% ↑	71.3%	70.7%
Rating of Personal Doctor	70.6%	77.9%	79.4%
Rating of Specialist Seen Most Often	68.8%	NA	73.0%
Rating of Health Plan	59.1%	66.9%	61.3% ↓
Effectiveness of Care*			
Advising Smokers and Tobacco Users to Quit	75.5%		
Discussing Cessation Medications	51.2%		
Discussing Cessation Strategies	49.0%		
CCC Composite Measures/Items			
Access to Specialized Services			NA
Family Centered Care (FCC): Personal Doctor Who Knows Child			91.2%
Coordination of Care for Children With Chronic Conditions			75.1%
Access to Prescription Medicines			90.8%
FCC: Getting Needed Information			93.8%

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."

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

↑ Indicates the 2020 score is at least 5 percentage points greater than the 2019 national average.

↓ Indicates the 2020 score is at least 5 percentage points less than the 2019 national average.

Indicates that the measure does not apply to the population.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Adult members had positive experiences with getting the care they needed and their healthcare, as the scores for these measures were at least 5 percentage points greater than the 2019 NCQA adult Medicaid national averages.

Weaknesses

Weakness: For the CCC Medicaid population, parents/caretakers of child members had less positive overall experiences with their child's health plan. The score for this measure was at least 5 percentage points less than the 2019 NCQA Medicaid national average.

Why the weakness exists: Parents/caretakers of child members in the CCC population are reporting a more negative experience with their child's health plan compared to national benchmarks, which could indicate parents/caretakers perceive that Amerigroup Iowa is not satisfactorily addressing their child's needs.

Recommendation: HSAG recommends that Amerigroup Iowa identify the potential sources of parents'/caretakers' dissatisfaction and focus efforts on improving their overall health plan experiences via initiatives implemented through the MCO's QI program. Additionally, HSAG recommends widely promoting the health plan experience results of members and parents/caretakers of child members to its contracted providers and staff, and soliciting feedback and recommendations to improve overall satisfaction with both Amerigroup Iowa and its contracted providers.

Iowa Total Care

PIPs

Performance Results

Table 3-25 displays the overall validation status for the PIP topics initiated during the 2020 validation. Iowa Total Care reported the Design stage which includes the PIP methodology and data collection methods. Baseline data will be included in the CY 2021 annual EQR report. Iowa Total Care had not progressed to initiating interventions during this validation year.

Table 3-25—Overall Validation Rating—ITC

PIP Topic	Validation Rating	Performance Indicator
Timeliness of Postpartum Care	*Partially Met*	The percentage of women who delivered a live birth on or between October 8th of the year prior to the measurement year and October 7th of the measurement year who had a postpartum care visit on or between 7 and 84 days after delivery.
CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed	*Met*	CAHPS Measure: Customer Services at Child's Health Plan gave help or information needed.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Iowa Total Care designed a methodologically sound PIP for the *CAHPS Measure* PIP topic.

Weaknesses

Weakness: Iowa Total Care had an opportunity to improve the documentation defining the eligible population for the *Timeliness of Postpartum Care* PIP topic.

Why the weakness exists: Iowa Total Care did not document the codes to be used to identify the eligible population and appropriate exclusions.

Recommendation: HSAG recommends that Iowa Total Care document the codes used to identify the population (i.e., HEDIS delivery value set codes) as well as the codes to identify exclusions (i.e., HEDIS non-live birth value set codes). Additionally, Iowa Total Care should address HSAG's feedback for all *Partially Met* scores in the next annual submission.

PMV

Performance Results

HSAG reviewed Iowa Total Care's eligibility and enrollment data, claims and encounters and case management systems, plan of care process, and data integration process, which included live demonstrations of each system. Overall, Iowa Total Care demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Iowa Total Care's processes. Prior to the interview component of the review, HSAG had requested that Iowa Total Care submit screen shots of its enrollment, claims, and case management systems for five members for performance measures 1 and 2, and five members for performance measures 3 through 6. This was to gain an understanding of Iowa Total Care's systems and its use of system-defined fields prior to the interview. Iowa Total Care was able to answer all of HSAG's questions, and HSAG did not identify any other issues during the PSV session of the interview.

Measure designation and reportable measure rates for SFY 2020 are displayed in Table 3-26, Table 3-27, Table 3-28, and Table 3-29. While individual rates are produced for each of the eight waiver populations, only the aggregate rate is displayed. Iowa Total Care received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 3-26—Performance Measure #1a: Receipt of Authorized Services*—ITC

Performance Measure		Measure Designation	2020 Rate				
			0%	1–49%	50–74%	75–89%	90–100%
1a	*Percentage of Eligible Members with Applicable Percentage of Authorized Services Utilized*	R	2.20%	56.29%	21.49%	8.18%	11.84%

R = Reportable
* 2020 rates are provided for information only.

Table 3-27—Performance Measure #1b: Receipt of Authorized Services*—ITC

Performance Measure		Measure Designation	2020 Rate
1b	*The percentage of eligible members for whom 100 percent of HCBS services documented in members' care plans had a corresponding approved service authorization*	R	96.75%

R = Reportable
* 2020 rates are provided for information only.

Table 3-28—Performance Measure #2a, 2b, and 2c: Receipt of Authorized One-Time Services—ITC*

Performance Measure		Measure Designation	2020		
			Denominator	Numerator	Rate
2a	*Members With One or More Documented Care Plan One-Time Service*	R	954	1	0.10%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	R	1	1	100.00%
2c	*Percentage of Authorized One-Time Services Utilized*	R	1	1	100.00%

R = Reportable

* 2020 rates are provided for information only.

Table 3-29—Performance Measures #3, #4, #5, and #6—ITC

Performance Measure		Measure Designation	2020		
			Denominator	Numerator	Rate
3	*Provision of Care Plan*	R	1207	670	55.51%
4	*Person-Centered Care Plan Meeting**	R	1207	1118	92.63%
5	*Care Team Lead Chosen by the Member*	R	1207	1160	96.11%
6	*Member Choice of HCBS Settings*	R	1207	1188	98.43%

R = Reportable

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

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Iowa Total Care continually completed process and system updates to consistently report accurate rates.

Weaknesses

Weakness: Iowa Total Care identified the need to retrain case managers based on its internal auditing, which showed inconsistent data entry processes.

Why the weakness exists: Iowa Total Care identified inconsistencies in the data entry process completed by its case managers, which led to Iowa Total Care's inability to rely solely on administrative processes for performance measure reporting; and therefore, maintained a partially manual abstraction process for performance measure production.

Recommendation: Throughout the SFY 2020 measurement period, Iowa Total Care retrained its case managers to correct the inconsistent use of standard system fields which was identified via internal audits. HSAG recommends that Iowa Total Care continue its efforts to train case managers on the appropriate use of standard system fields for consistent documentation. HSAG further recommends that Iowa Total Care continue its ongoing internal audits of case files to monitor training effectiveness.

Performance Results—HEDIS

As Iowa Total Care joined the Iowa Medicaid program in July 2019, HEDIS data for the reporting period are not available. HEDIS data for Iowa Total Care will be included in future EQR technical reports.

Compliance Review

Performance Results

Table 3-30 presents Iowa Total Care's scores for each standard evaluated in the CY 2020 compliance review. Each element within a standard was scored as *Met*, *Not Met,* or *NA* based on evidence found in MCO documents, policies, procedures, reports, meeting minutes, and virtual interviews with MCO staff members.

Of note, prior to joining the Iowa Medicaid program in July 2019, Iowa Total Care underwent a comprehensive readiness review that confirmed its ability and capacity to perform satisfactorily in all major operational areas outlined in 42 CFR §438.66(d)(4)(i–iv); therefore, only the CY 2020 compliance review standards are included in this annual assessment for Iowa Total Care.

Table 3-30—Summary of Standard Compliance Scores—ITC

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
V	Provider Selection	13	11	7	4	2	**64%**
VI	Member Information and Member Rights	22	22	20	2	0	**91%**
VIII	Enrollment and Disenrollment	7	7	7	0	0	**100%**
X	Subcontractual Relationships and Delegation	7	7	7	0	0	**100%**
XIII	Health Information Systems	9	9	9	0	0	**100%**
Total		**58**	**56**	**50**	**6**	**2**	**89%**

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

Strengths

Strength: Iowa Total Care achieved full compliance in the Enrollment and Disenrollment standard, demonstrating staff knowledge and adherence to disenrollment requirements and limitations.

Strength: Iowa Total Care achieved full compliance in the Subcontractual Relationships and Delegation standard and delegation file review, demonstrating that it maintained accountability of delegated managed care functions via comprehensive subcontracts and continued monitoring and oversight of delegated entities.

Strength: Iowa Total Care achieved full compliance in the Health Information Systems standard, demonstrating that it maintained a health information system that collects, analyzes, integrates, and reports data to provide information on areas including, but not limited to, utilization, claims, grievances and appeals, and disenrollments for reasons other than loss of Medicaid eligibility.

Strength: Iowa Total Care's member handbook contained all required content which provides a summary of benefits and coverage and enables a member to understand how to effectively navigate the Medicaid managed care program.

Strength: While Iowa Total Care performed poorly overall in the Provider Selection standard, it excelled in meeting initial credentialing requirements. The individual initial credentialing file reviews identified adherence in 148 of 149 scoring components, demonstrating that Iowa Total Care appropriately verified each provider's qualifications prior to inclusion in its network.

Weaknesses

Weakness: Iowa Total Care demonstrated challenges in implementing provider selection and retention requirements. Consistent and accurate application of contract requirements is necessary to ensure Iowa Total Care maintains quality providers who are available to serve Medicaid members.

Why the weakness exists: Various findings contributed to this weakness, including the following:

- While DHS is the entity responsible for collecting ownership and disclosure forms and periodically screening disclosed individuals against exclusion databases, Iowa Total Care did not maintain a process to ensure that should it receive a provider ownership and disclosure form, the form would be forwarded to DHS.
- Iowa Total Care did not calculate and report credentialing timeliness standards in accordance with contract requirements; specifically, Iowa Total Care did not provide written communication of a credentialing decision to organizational providers and therefore was unable to calculate overall credentialing timeliness.
- The organizational credentialing file review identified opportunities for verifying appropriate healthcare licensures, certifications, accreditation status, and/or quality on-site assessments.

Recommendation: Iowa Total Care was required to submit a CAP to remediate these deficiencies. HSAG recommends that Iowa Total Care proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented,

Iowa Total Care should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies.

NAV

Performance Results

Table 3-31 displays 11 demographic indicators found in the sample of PCPs and OB/GYN providers pulled from the provider data submitted by Iowa Total Care compared against the information that could be retrieved from the online provider directory for the sample of 358 providers found in the online provider directory.

Table 3-31—Match Results for Demographic Indicators—ITC

Indicator	Total	Exact Match		Unmatched*	
		Count	Percent	Count	Percent
Provider First Name	358	358	100.0%	0	0.0%
Provider Middle Name	358	358	100.0%	0	0.0%
Provider Last Name	358	358	100.0%	0	0.0%
Provider Address 1	358	357	99.7%	1	0.3%
Provider Address 2	358	355	99.2%	3	0.8%
Provider City	358	358	100.0%	0	0.0%
Provider State	358	358	100.0%	0	0.0%
Provider Zip Code	358	358	100.0%	0	0.0%
Provider Telephone Number	358	227	63.4%	131	36.6%
Provider Specialty	358	352	98.3%	6	1.7%
Provider Accepting New Patients	358	357	99.7%	1	0.3%

* Unmatched includes spelling discrepancies, incomplete information, or information not listed in the directory.

Table 3-32 displays a list of five available information and services indicators found in the submitted provider data against the information that could be reviewed in the online provider directory for the 358 providers initially found in the online provider directory.

Table 3-32—Presence of Available Information and Services Indicators—ITC

Indicator	Total	Present in Directory		Not Present in Directory		Information Pending	
		Count	Percent	Count	Percent	Count	Percent
Provider Accommodates Physical Disabilities	358	185	51.7%	0	0.0%	173	48.3%
Provider Completed Cultural Competency Training	358	23	6.4%	335	93.6%	0	0.0%
Non-English Language Speaking Provider	358	358	100.0%	0	0.0%	0	0.0%
Provider Office Hours	358	344	96.1%	14	3.9%	0	0.0%
Provider URL	358	2	0.6%	356	99.4%	0	0.0%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: The match rates for provider information in the online provider directory compared to Iowa Total Care's provider data were high (i.e., above 98 percent for all indicators assessed except for provider telephone number). This indicates that members likely have access to high quality, accurate provider information through Iowa Total Care's online provider directory.

Strength: A high percentage of the provider records in Iowa Total Care's online provider directory included information regarding availability of non-English-speaking providers and the provider office hours.

Weaknesses

Weakness: Iowa Total Care's provider directory accurately identified providers' telephone numbers in only 63 percent of the cases. A mismatch in the telephone number could lead to issues contacting the provider, while a misspelling of the provider's name is less likely to cause an issue with contacting the provider. As such, this is an issue that could directly affect a member's ability to access care.

Why the weakness exists: Discrepancies in provider telephone numbers could be the result of issues with maintenance of the online directory, the quality of the provider data submitted to HSAG, and/or Iowa Total Care not having an adequate process for capturing and maintaining current provider telephone numbers within its provider data system.

Recommendation: HSAG recommends that Iowa Total Care conduct a comprehensive review of its provider data and online directory to ensure that provider numbers are accurate and documented consistently in both data sources.

Weakness: Iowa Total Care's provider directory listed information about accommodations for members with physical disabilities for 52 percent of the providers. Since members requiring accommodations rely on these directories for choosing the best

provider for their healthcare, this information is necessary so they can make an educated and appropriate healthcare decision.

Why the weakness exists: Providers with incomplete accommodations documentation listed this information as "Information Pending." This may imply that Iowa Total Care is waiting for or making efforts to obtain the information.

Recommendation: HSAG recommends that Iowa Total Care work with its providers to obtain specific information related to each provider location's accommodations for members with physical disabilities. Subsequently, Iowa Total Care should update its online provider directory with accommodation documentation.

Weakness: Iowa Total Care's provider directory listed provider URLs for less than 1 percent of its providers. As provider websites may have important information regarding new patient forms, question and answer documents, and additional information, provider-specific websites can be very beneficial to members.

Why the weakness exists: This weakness may exist because providers are not submitting this information to Iowa Total Care or because Iowa Total Care does not have a process in place to request this information during initial credentialing and contracting or on an ongoing basis. Another reason may be that relatively few providers have developed their own websites.

Recommendation: HSAG recommends that Iowa Total Care conduct a root cause analysis to investigate whether the low percentage reported is due to a lack of providers with websites or if Iowa Total Care could be proactive in obtaining URL information from its network providers.

EDV

Performance Results

Because CY 2019 was the first year Iowa Total Care submitted encounter data to DHS, the EDV consisted of an IS review. The IS review included an evaluation of the data sources (specifically, the claims data to encounter data cycle), the systems in place to process the data, the systematic formatting that occurs prior to submission (if completed by a third party), and how data are verified from provider and member information.

- **Contractual and Data Submission Requirements**—Iowa Total Care had adequate policies and procedures in place to document and guide its encounter data processes.
- **Collection and Maintenance of Provider Data**—Iowa Total Care and its subcontractors collected and maintained their respective provider data and had processes to verify whether the provider information and the claims/encounters matched Iowa Total Care's provider data. Provider data were verified against the DHS provider data file, and records were selected for review and correction, when necessary.
- **Claims Submission and Payment**—Iowa Total Care's inpatient hospital claims were priced based on the Medicare Severity Diagnosis Related Group (MS-DRG) reimbursement methodology with rates effective on date of discharge, while outpatient claims were paid based on the cost-to-charge

ratio (i.e., percentage of billed charges) line by line, in accordance with DHS rules. Iowa Total Care used Health Management Systems (HMS) for third-party liability (TPL) identification and post-payment recovery, wherein member data were sent monthly and paid claims were sent weekly to HMS. At the time the questionnaire was administered, Iowa Total Care did not have an automated process in place for Medicare crossover claims at the time of the review; however, testing was underway with CMS' vendor and was on target for the January 2020 implementation for automation.

- **Completeness and Accuracy of Encounter Data**—Iowa Total Care appropriately applied edits at the point of claim submission and applied DHS-specific edits, as expected. Additionally, Iowa Total Care had a process to conduct audits; identify and remediate claim error trends, which included identifying root causes; and tracked corrective actions to ensure remediation. Medicare and third-party claims also passed through system edits to validate information for claims processing and to accurately pay claims based on TPL information received from DHS and HMS.
- **Timeliness of Claims and Encounter Data**—Iowa Total Care's claims system was appropriately configured to compare the received date of the claim against the dates of service. Claims received past the allowed time frame were denied. At the time of the review, Iowa Total Care did not have full insight into vendor data for true timeliness reporting. However, Iowa Total Care was monitoring how often its vendors were submitting data via a tracking document to ensure the vendors were submitting data weekly as required.
- **Tracking of Encounters**—Iowa Total Care had processes in place to track encounters sent to DHS. Iowa Total Care processed the 999 response files, the 277CA response files, and the proprietary response flat files to monitor the rejections/errors and process the corrections and resubmissions, if necessary.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Iowa Total Care demonstrated that it has policies and procedures in place to document and guide its encounter data processes.

Weaknesses

Weakness: Iowa Total Care did not have reporting metrics for true timeliness reporting based on its vendor data. Iowa Total Care only relied on a tracking document to monitor how often the vendors were submitting encounter data.

Why the weakness exists: Iowa Total Care acted as a pass-through for its vendors for outbound encounter submissions and indicated that it would include the capability of tracking true timeliness in its roadmap for the future.

Recommendation: HSAG recommends that Iowa Total Care work with its vendors to enhance monitoring metrics for encounter timeliness. Iowa Total Care may consider metrics based on the lag days between dates of service and the dates when encounters are submitted to DHS.

Weakness: Iowa Total Care did not have a Medicare crossover claims automation process in place.

Why the weakness exists: Testing of the process was underway with CMS' vendor at the time of the review, and Iowa Total Care was on target for a January 2020 implementation for automation.

Recommendation: HSAG recommends that Iowa Total Care follow up with DHS to confirm the automation process has been implemented successfully.

CAHPS Analysis

Performance Results

As Iowa Total Care joined the Iowa Medicaid program in July 2019, CAHPS data for the reporting period are not available and will be included in future EQR technical reports.

4. Assessment of Prepaid Ambulatory Health Plan (PAHP) Performance

PAHP Methodology

HSAG used findings across mandatory and optional EQR activities conducted during the CY 2020 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. 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 outcome information for the availability and timeliness of services.

To identify strengths and weaknesses and draw conclusions for each PAHP, HSAG analyzed and evaluated each EQR activity and its resulting findings related to the provision of dental services across the Medicaid program. The composite findings for each PAHP were analyzed and aggregated to identify overarching conclusions and focus areas for the PAHP in alignment with the priorities of DHS.

For more details about the technical methods for data collection and analysis, refer to Appendix A.

PIPs

For the CY 2020 validation, the PAHPs continued their DHS-mandated PIP topics that were initiated in CY 2018, reporting Remeasurement 1 study indicator outcomes. The purpose of each PIP is to achieve, through ongoing measurements and interventions, significant improvement sustained over time. HSAG's PIP validation ensures that DHS and key stakeholders can have confidence that any reported improvement is related to and can be reasonably linked to the QI strategies and activities conducted by the PAHP during the project.

Table 4-1 outlines the selected PIP topic and study indicators for the PAHPs.

Table 4-1—PIP Topic and Study Indicator

MCO	PIP Topic	Performance Indicator
DDIA	*Annual Dental Visits*	1. The percentage of Medicaid members 19 years of age and older who had at least one dental visit during the measurement year.
		2. The percentage of Hawki members 1 to 18 years of age who had at least one preventive dental visit during the measurement year.
MCNA	*Increase the Percentage of Dental Services*	The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.

PMV

The purpose of the PMV is to assess the accuracy of performance measures reported by PAHPs and to determine the extent to which these performance measures follow State specifications and reporting requirements. HSAG determined results for each performance measure and assigned each an indicator designation of *R, DNR, NA,* or *NR.*

DHS identified a set of performance measures that the PAHPs were required to calculate and report. These measures were required to be reported following the measure specifications provided by DHS. DHS identified the measurement period as July 1, 2019, through June 30, 2020.

Table 4-2—List of Performance Measures for PAHPs

2020 Performance Measures Selected by DHS for Validation		
Measure Name	**Method**	**Steward**
Members With at Least Six Months of Coverage	Administrative	DHS
Members Who Accessed Dental Care	Administrative	DHS
Members Who Received Preventive Dental Care	Administrative	DHS
Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation	Administrative	DHS
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	Administrative	DHS
Members Who Received a Preventive Examination and a Follow-Up Examination	Administrative	DHS

Additionally, DHS has established a quality withhold payment structure intended to incentivize the PAHPs to achieve high-quality care for their members. This quality withhold program includes six performance levels for *Access to Dental Services, Access to Preventive Dental Services*, and *Continued Preventive Utilization* performance measures. The PAHPs are eligible to receive up to 2 percent of their premium in a quality withhold payment, based on reaching the highest performance level in all three measures, with *Access to Dental Services*, *Access to Preventive Dental Services*, and *Continued Preventive Utilization* constituting 50 percent, 30 percent, and 20 percent of the withhold, respectively.

Compliance Review

The compliance review in Iowa includes a review of 13 standards over a three-year cycle as detailed in Table 4-3. CY 2020 marked the first year of the current three-year cycle and comprised an evaluation of each PAHP's performance in five program areas to determine compliance with State and federal standards.

Table 4-3—Compliance Review Standards[4-1]

Year One (CY 2020)	Year Two (CY 2021)	Year Three (CY 2022)
Standard III—Coordination and Continuity of Care	Standard I—Availability of Services	Review of PAHP's implementation of Year One and Year Two CAPs
Standard IV—Coverage and Authorization of Services	Standard II—Assurances of Adequate Capacity and Services	
Standard VII—Confidentiality of Health Information	Standard V—Provider Selection	
Standard IX—Grievance and Appeal System	Standard VI—Member Information and Member Rights	
Standard XI—Practice Guidelines	Standard VIII—Enrollment and Disenrollment	
Standard XII—Quality Assessment and Performance Improvement	Standard X—Subcontractual Relationships and Delegation	
	Standard XIII—Health Information Systems	

NAV

HSAG evaluated whether each PAHP has an adequate provider network to deliver dental services to its DWP Medicaid members using provider-to-member ratios and time/distance analyses. HSAG assessed the PAHP's general and specialty dental provider networks, including members' access to general dentists, orthodontists, endodontists, oral surgeons, pedodontists, periodontists, and prosthodontists. All members are required to have access to a general dentist within 30 minutes or 30 miles for members in urban areas AND 60 minutes or 60 miles for members in rural areas.[4-2] While DHS does not have a specific time/distance standard for the dental specialties, HSAG assess the average time and distance that a member travels to obtain dental specialty services.

EDV

In CY 2020, HSAG evaluated dental encounter data completeness and accuracy through a review of dental records for dental services rendered between January 1, 2019, and December 31, 2019. This study answered the following question: *Are the data elements on the dental encounters complete and accurate when compared to information contained within the dental records?*

[4-1] While Table 4-3 presents the three-year cycle DHS initially intended, DHS elected to begin a new three-year cycle in CY 2021 to align the MCO and PAHP compliance reviews. The new three-year cycle beginning in CY 2021 will be presented in future reports.

[4-2] Rural areas are defined as areas not designated as Metropolitan Statistical Areas (MSAs). Urban areas are defined as MSAs.

To answer the study question, HSAG conducted the following activities:

- Identified the eligible population and generated samples from data submitted by DHS for the study.
- Assisted the PAHPs to procure dental records from providers, as appropriate.
- Reviewed dental records against DHS' encounter data.
- Calculated study indicators based on the reviewed/abstracted data.
- Drafted and presented a report based on study results.

Key data elements associated with dental services evaluated in the dental record review included:

- Date of service.
- Current dental terminology (CDT) procedure code.

EQR Activity Results

Delta Dental of Iowa

PIPs

Performance Results

Table 4-4 displays the overall validation status, the baseline and Remeasurement 1 results, and the PAHP-designated goals for each study indicator.

Table 4-4—Overall Validation Rating—DDIA

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Annual Dental Visits	*Not Met*	1. The percentage of Medicaid members 19 years of age and older who had at least one dental visit during the measurement year.	44.2%	42.2% ↓		47.7%
		2. The percentage of Hawki members 1 to 18 years of age who had at least one preventive dental visit during the measurement year.	73.3%	72.3% ↓		76.5%

R1 = Remeasurement 1
R2 = Remeasurement 2 (to be included in CY 2021 annual assessment)
↑ = 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).

Table 4-5 displays the interventions implemented to address the barriers identified by the PAHP using QI and causal/barrier analysis processes.

Table 4-5—Remeasurement 1 Interventions—DDIA

Intervention Descriptions	
Sent text message and postcard reminders to members who had completed a preventive visit but had not completed the self-assessment. Sent voicemails, text messages, and postcards to Hawki members during Children's Dental Health month.	Sent postcards and text messages and conducted outreach calls during the first 90 days of member enrollment and to members who had not received dental services within five months of enrollment.
Sent postcards and text messages to members 19 to 20 years of age.	Mailed flyers, toothbrushes, toothpaste, and floss to all pregnant women.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Iowa designed a methodologically sound improvement project.

Weaknesses

Weakness: Delta Dental of Iowa met 44 percent of the requirements for data analysis and implementation of improvement strategies.

Why the weakness exists: Delta Dental of Iowa documented improvement strategies and interventions that were unclear or incomplete. Delta Dental of Iowa did not develop evaluation methods for each intervention in order to assess for and determine their effectiveness.

Recommendation: HSAG recommends that Delta Dental of Iowa revisit its causal/barrier analysis to determine and clearly document appropriate barriers. Delta Dental of Iowa should establish a process for evaluating each intervention and its impact on the study indicators to allow for continual refinement of improvement strategies.

Weakness: Delta Dental of Iowa demonstrated a decrease in the percentage of members with a dental visit for both study indicators during the first remeasurement period.

Why the weakness exists: Delta Dental of Iowa implemented passive interventions, such as member text messages and postcards, which are difficult to evaluate for effectiveness and may not impact the study indicator outcomes.

Recommendation: HSAG recommends that Delta Dental of Iowa develop active interventions that can be tracked and trended to determine the impact on the study indicator outcomes. The results should be used to guide decisions for QI efforts.

PMV

Performance Results

HSAG reviewed Delta Dental of Iowa's membership/eligibility data system, encounter data processing system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, Delta Dental of Iowa demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Delta Dental of Iowa's processes. During the interview component of the review, PSV was completed. Delta Dental of Iowa demonstrated an understanding of the measure specifications, as HSAG did not identify concerns with any of the cases reviewed during PSV. HSAG determined that Delta Dental of Iowa's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Measure designation and reportable measure rates displayed in Table 4-6. Delta Dental of Iowa received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-6—Performance Measure Designation and Rates—DDIA

Performance Measure		2019 Result*	Measure Designation	2020		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	212,825	R	220,844	—	—
2	*Members Who Accessed Dental Care*	38.7%	R	220,844	75,423	34.15%
3	*Members Who Received Preventive Dental Care*	79.0%	R	75,423	56,642	75.10%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	51,474	R	45,146	—	—
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*	32,537	R	—	29,326	—

	Performance Measure	2019 Result*	Measure Designation	2020		
				Denominator	Numerator	Rate
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	63.2%	R	45,146	29,326	64.96%

R = Reportable

* The 2019 Result column displays the comparable data as applicable to each performance measure. If a rate is applicable to a performance measure, it is displayed as a percentage. If a rate is not reported for a performance measure, only the numerator or denominator is displayed, as applicable, to allow year-over-year comparisons.

Dash (–) = A measure count or measure rate is not applicable.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Iowa consistently continued to appropriately gather data to report accurate performance rates.

Strength: Delta Dental of Iowa earned the highest level of the performance measure withhold payment for all three performance measures that were part of the quality withhold program.

Weaknesses

Weakness: While Delta Dental of Iowa earned the highest level of the performance measure withhold payment, all three rates declined in performance from the prior year: *Members Who Accessed Dental Care* decreased by 4.55 percent points and *Members Who Received Preventive Dental Care* decreased by 3.90 percent points.

Why the weakness exists: While the root cause of the decrease in rates is unknown, HSAG noted that Delta Dental of Iowa implemented passive interventions for its PIP, which also measures receipt of services, and this may be a contributing factor. Additionally, during a portion of the measurement period, service disruption likely occurred due to the COVID-19 pandemic.

Recommendation: HSAG recommends that Delta Dental of Iowa continue to ensure its members have timely access to appropriate dental preventive care and develop active interventions to positively impact measure rates and overall dental care for its members.

Compliance Review

Performance Results

Table 4-7 presents Delta Dental of Iowa's scores for each standard evaluated in the CY 2020 compliance review. Each element within a standard was scored as *Met*, *Not Met,* or *NA* based on evidence found in PAHP documents, policies, procedures, reports, meeting minutes, and virtual interviews with PAHP staff members.

Table 4-7—Summary of CY 2020 Compliance Review Results—DDIA

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Coordination and Continuity of Care	7	7	7	0	0	**100%**
IV	Coverage and Authorization of Services	18	18	12	6	0	**67%**
VII	Confidentiality of Health Information	8	8	8	0	0	**100%**
IX	Grievance and Appeal System	36	36	33	3	0	**92%**
XI	Practice Guidelines	3	3	0	3	0	**0%**
XII	Quality Assessment and Performance Improvement	5	5	4	1	0	**80%**
Total		**77**	**77**	**64**	**13**	**0**	**83%**

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

Strengths

Strength: Delta Dental of Iowa achieved full compliance for the Coordination and Continuity of Care standard, demonstrating that it maintained the capacity to make best-effort attempts to conduct an initial health screening of each member's needs and manage population health by focusing on restoring basic functionality for all members and improving the oral health of members over time through education, member engagement, and member support.

Strength: Delta Dental of Iowa achieved full compliance for the Confidentiality of Health Information standard, demonstrating that it uses and discloses individually identifiable health information in accordance with privacy requirements.

Weaknesses

Weakness: Delta Dental of Iowa did not have evidenced-based clinical practice guidelines (CPGs) adopted for the Iowa Medicaid line of business. According to the American Dental Association, "Clinical practice guidelines are the strongest resources to aid dental professionals in clinical decision making and help incorporate evidence gained through scientific investigation into patient care. Guidelines include recommendation statements intended to optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[4-3]

Why the weakness exists: Delta Dental of Iowa staff members had a general lack of understanding of the availability and purpose of CPGs and of the Medicaid managed care requirements for the adoption and dissemination of these guidelines.

Recommendation: Delta Dental of Iowa was required to submit a CAP to remediate these deficiencies. HSAG recommends that Delta Dental of Iowa proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Delta Dental of Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, HSAG recommends that Delta Dental of Iowa recruit Iowa providers to support the Iowa Medicaid program; for example, network providers can serve as members on Delta Dental of Iowa's QI committee or local dental advisory committee.

Weakness: Delta Dental of Iowa's prior authorization processes may contribute to the member's misunderstanding of critical communications pertaining to denied services and the member's right to appeal the decision. Staff knowledge of requirements and easily understood written member information are essential to ensure members are adequately informed and can participate in their healthcare decisions.

Why the weakness exists: Delta Dental of Iowa's adverse benefit determinations (ABDs) were not written in easily understood language and did not clearly identify the reason for the authorization request denial; policies did not include complete processes for providing members with a 10-day advance notice when services are terminated, suspended, or reduced and all exceptions to this rule, and staff members were not able to adequately speak to these requirements. Processes were not in place to provide members with an ABD for the denial of payment or when Delta Dental of Iowa did not make a timely authorization decision, and staff members were unable to adequately speak to these requirements.

Recommendation: Delta Dental of Iowa was required to submit a CAP to remediate these deficiencies. HSAG recommends that Delta Dental of Iowa proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Delta Dental of Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, Delta Dental of Iowa should consider obtaining member feedback when developing a new ABD template.

[4-3] American Dental Association. Center for Evidence-Based Dentistry™. Clinical Practice Guidelines. Available at: https://ebd.ada.org/en/evidence/guidelines. Accessed on: Jan 29, 2021.

Weakness: Delta Dental of Iowa lacked a formal process to conduct a comprehensive annual evaluation of its QAPI program. An annual evaluation is necessary to identify barriers and opportunities to improve the quality of, and access to, dental care and services.

Why the weakness exists: Delta Dental of Iowa staff members lacked the understanding of what comprised a thorough QAPI program and were challenged in developing a formal QAPI program since inception into the Iowa Medicaid program. CY 2020 marked the first year of Delta Dental of Iowa's development of a comprehensive QAPI program description and workplan; therefore, Delta Dental of Iowa has yet to complete a comprehensive annual evaluation.

Recommendation: Delta Dental of Iowa was required to submit a CAP to remediate these deficiencies. HSAG recommends that Delta Dental of Iowa proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Delta Dental of Iowa should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, HSAG recommends that Delta Dental of Iowa staff members research and familiarize themselves with QAPI program requirements and best practices.

NAV

Performance Results

Table 4-8 presents the percentage of members with access to general dentists within the time and distance standard, which states that PAHPs must ensure that 100 percent of their Medicaid members have access to dental providers within 30 miles or 30 minutes for members living in urban areas and 60 miles or 60 minutes for members living in rural areas.

Table 4-8—Percentage of Members With Access to General Dentists Within the Time and Distance Standard—DDIA

	Urban		Rural	
Provider Category	Percent of Members Within Standard	Standard Met (Yes/No)	Percent of Members Within Standard	Standard Met (Yes/No)
General Dentists	100%	Yes	100%	Yes

Table 4-9 displays average travel distances and travel times for members receiving dental coverage through Delta Dental of Iowa, stratified by providers' acceptance of new patients.

Table 4-9—Average Travel Distances (Miles) and Travel Times (Minutes), by Providers' Acceptance of New Patients—DDIA

Provider Category	Accepting New Patients* N = 487			Not Accepting New Patients* N = 589		
	First-Nearest	Second-Nearest	Third-Nearest	First-Nearest	Second-Nearest	Third-Nearest
	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)
General Dentists						
General Dentists	8.0/8.9	10.6/11.7	12.2/13.5	3.9/4.3	4.9/5.5	6.5/7.3
Dental Specialists						
Endodontists	70.1/83.5	100.0/129.0	104.4/136.0	81.8/119.3	92.9/136.2	92.9/136.2
Oral Surgeons	32.9/38.7	35.6/42.6	36.4/44.2	36.4/41.1	36.8/41.5	42.0/47.7
Periodontists	107.7/161.5	107.8/161.6	107.8/161.6	108.2/122.7	131.5/148.7	167.8/190.5
Prosthodontists	107.7/161.5	107.7/161.5	107.8/161.6	53.9/64.9	108.9/131.7	148.0/178.8

* Providers may be present in both categories (accepting and not accepting new patients), which may be dependent on whether a provider renders services at multiple locations.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Iowa maintains a provider network that is sufficient to ensure all members have access to a general dentist within the contract standard of 30 miles or 30 minutes for members living in urban areas and 60 miles or 60 minutes for members living in rural areas.

Strength: Delta Dental of Iowa members have reasonably short travel distances and associated times to general dentists and oral surgeons, regardless of whether the providers are accepting new patients. Additionally, since the travel times and distances for the nearest three providers are similar, most members may have a choice of at least a few general dentists or oral surgeons within a reasonable travel time and distance.

Weaknesses

Weakness: HSAG identified lengthy average drive times and distances for endodontists, periodontists, and prosthodontists, especially for members trying to establish a relationship with a new dental specialty provider.

Why the weakness exists: These lengthy drive times and distances are likely due to the limited number of dental specialty providers contracted with Delta Dental of Iowa. Additionally, as reported by the PAHP, barriers include the lack of specialty providers in rural areas and the low reimbursement fee schedule.

Recommendation: HSAG recommends that Delta Dental of Iowa continue its recruitment efforts for these dental specialty providers. HSAG further recommends that the PAHP consult with DHS for statewide opportunities to actively recruit specialty providers for the Iowa Medicaid managed care program.

EDV

Performance Results

Table 4-10 and Table 4-11 present the percentage of dental record documentation submissions and the major reasons Delta Dental of Iowa did not submit dental record documentation, respectively.

Table 4-10—Summary of Dental Records Requested and Received—DDIA

PAHP	Number of Records Requested	Number of Records Submitted	Percentage of Records Submitted
DDIA	146	144	98.6%

Table 4-11—Reasons Dental Records Not Submitted for Date of Service—DDIA

Reason	Number	Percent
Non-responsive provider or provider did not respond in a timely manner.	1	50.0%
Member was a patient of the practice; however, no documentation was available for requested dates of service.	1	50.0%
Provider refused to release dental records.	0	0.0%
Total	**2**	**100.0%**

Table 4-12 presents the percentage of dates of service and the associated procedure codes identified in the encounter data that were not supported by the members' dental records submitted by Delta Dental of Iowa (i.e., dental record omission), and the percentage of procedure codes from members' dental records that were not found in the encounter data (i.e., encounter data omission). Lower rates indicate better performance. Table 4-12 also presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on the members' dental records. Higher rates indicate better performance.

Table 4-12—Encounter Data Completeness Summary and Accuracy Results for Procedure Code—DDIA

Key Data Element	Dental Record Omission	Encounter Data Omission	Accuracy Rate
Date of Service	3.4%	NA	NA
Procedure Code	16.7%	7.9%	94.5%

"NA" denotes that the indicator (i.e., encounter data omission and accuracy) was not applicable to the specific data element.

Table 4-13 presents the percentage of dates of service present in both DHS' encounter data and the dental records with the same values for the key data element (i.e., *Procedure Code*). The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service where the encounter data dental procedure code had the same values as the dental procedure code documented in the dental record. Higher all-element accuracy rates indicate that the values populated in DHS' encounter data are more accurate and complete for the key data element when compared to dental records.

Table 4-13—All Element Accuracy—DDIA

Number of Dates of Service Present in Both Sources	Accuracy Rate
141	52.5%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Delta Dental of Iowa's dental record submission rate was very high, as the PAHP was able to obtain 144 of the 146 requested records from its contracted providers.

Strength: Dates of service documented in Delta Dental of Iowa's encounter data were well supported by documentation in the members' dental records, with a dental record omission rate of 3.4 percent.

Strength: Procedure codes found in members' dental records were well supported by the procedure codes found in Delta Dental of Iowa's submitted encounter data to DHS.

Weaknesses

Weakness: The percentage of procedure codes identified in Delta Dental of Iowa's encounter data that were not supported by the members' dental records was relatively high at 16.7 percent.

Why the weakness exists: Providers did not document or did not provide documentation outlining treatment or services performed in the submitted dental records, despite submitting the procedure code to Delta Dental of Iowa for payment.

Recommendation: HSAG recommends that Delta Dental of Iowa audit provider encounter data submissions for completeness and accuracy. Delta Dental of Iowa may consider developing provider education training regarding encounter data submissions, dental record documentation, and coding practices.

Managed Care of North America Dental

PIPs

Performance Results

Table 4-14 displays the overall validation status, the baseline and Remeasurement 1 results, and the PAHP-designated goal for the PIP topic.

Table 4-14—Overall Validation Rating—MCNA

PIP Topic	Validation Rating	Study Indicator	Study Indicator Results			
			Baseline	R1	R2	Goal
Increase the Percentage of Dental Services	*Not Met*	The percentage of members 19 years of age and older who had at least one dental visit during the measurement year.	24.4%	24.6% ⇔		26.4%

R1 = Remeasurement 1
R2 = Remeasurement 2 (to be included in CY 2021 annual assessment)
↑ = 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).

Table 4-15 displays the interventions implemented to address the barriers identified by Managed Care of North America Dental using QI and causal/barrier analysis processes.

Table 4-15—Remeasurement 1 Interventions—MCNA

Intervention Descriptions	
Developed a care gap alert, triggered when member services received a call from a member overdue for a dental visit. PAHP staff members provided education to members on available benefits, the importance of routine dental checkups, and offered to locate a provider and assist with scheduling an appointment.	Implemented a quarterly profiling report that educated provider offices on their performance, and assisted clinicians and their staff to eliminate administrative inefficiencies and showcase their utilization rates in comparison with their peers.
Conducted automated outbound calls to members who had not had a dental visit within six months, providing education on the importance of dental care, available benefits and informing member of available assistance with scheduling.	Mailed letters encouraging members to seek routine preventive care for members who had not had a dental checkup within a year.
Sent monthly text messages to members with no dental claims history offering assistance with finding a dentist.	Conducted a minimum of 10 outreach events in high-volume areas.

Strengths, Weaknesses, and Recommendations

Strengths	**Strength:** Managed Care of North America Dental designed a methodologically sound improvement project.
	Strength: Managed Care of North America Dental used appropriate QI tools to conduct a causal/barrier analysis and prioritize the identified barriers.
Weaknesses	**Weakness:** Although Managed Care of North America Dental demonstrated some improvement in the study indicator outcome for the first remeasurement, the goal of significant improvement was not achieved. **Why the weakness exists:** Managed Care of North America Dental implemented interventions that may not have a direct impact on the study indicator outcome. **Recommendation:** As Managed Care of North America Dental progresses to the second remeasurement, HSAG recommends that the PAHP revisit the causal/barrier analysis process to determine whether barriers identified continue to be barriers and determine if any new barriers exist that require the development of active interventions. Managed Care of North America Dental should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.

PMV

Performance Results

HSAG reviewed Managed Care of North America Dental's membership/eligibility data system, encounter data processing system, and data integration and rate calculation process, which included live demonstrations of each system. Overall, Managed Care of North America Dental demonstrated that it had the necessary systems, information management practices, processing environment, and control procedures in place to capture, access, translate, analyze, and report the selected measures. HSAG did not identify any concerns with Managed Care of North America Dental's processes. During the interview component of the review, the member-level data used by Managed Care of North America Dental to calculate the performance measure rates were readily available for the auditor's review. Managed Care of North America Dental was able to report valid and reportable rates. HSAG determined that Managed Care of North America Dental's data integration and measure reporting processes were adequate and ensured data integrity and accuracy.

Measure designation and reportable measure rates are displayed in Table 4-16. Managed Care of North America Dental received a measure designation of *Reportable* for all performance measures included in the PMV activity.

Table 4-16—Performance Measure Designation and Rates—MCNA

	Performance Measure	2019 Result*	2020 Measure Designation	2020		
				Denominator	Numerator	Rate
1	*Members With at Least Six Months of Coverage*	101,580	R	116,131	—	—
2	*Members Who Accessed Dental Care*	22.14%	R	116,131	22,949	19.76%
3	*Members Who Received Preventive Dental Care*	67.84%	R	22,949	14,487	63.13%
4	*Members Who Received an Oral Evaluation During the Measurement Year and Were Continuously Enrolled for the 12 Months Prior to the Oral Evaluation*	10,400	R	9,860	—	—
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*	4,095	R	—	4,165	—
6	*Members Who Received a Preventive Examination and a Follow-Up Examination*	39.38%	R	9,860	4,165	42.24%

R = Reportable

* The 2019 Result column displays the comparable data as applicable to each performance measure. If a rate is applicable to a performance measure, it is displayed as a percentage. If a rate is not reported for a performance measure, only the numerator or denominator is displayed, as applicable, to allow year-over-year comparisons.

Dash (–) = A measure count or measure rate is not applicable.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Managed Care of North America Dental earned the highest level of the performance measure withhold payment for the *Members Who Received a Preventive Examination and a Follow-Up Examination* performance measure that was part of the quality withhold program. This rate also increased by 2.86 percent points from 2019 to 2020.

Weaknesses

Weakness: Managed Care of North America Dental scored 19.76 percent for the *Members Who Accessed Dental Care* performance measure, which earned Managed Care of North America Dental the lowest level of the performance measure withhold payment for this performance measure. Additionally, Managed Care of North America Dental

experienced a decrease in two performance measures from 2019 to 2020; *Members Who Accessed Dental Care* decreased by 2.38 percent points, and *Members Who Received Preventive Dental Care* decreased by 4.71 percent points.

Why the weakness exists: While the root causes of the low rate and rate decreases have not yet been identified, Managed Care of North America Dental's performance suggests its interventions to ensure member access to dental care are not effective as members are continuing to experience barriers to accessing timely dental care.

Recommendation: HSAG recommends that Managed Care of North America Dental conduct a root cause analysis or focused study to determine why its members are not accessing timely dental care in alignment with the performance measure standards established by DHS. Upon identification of a root cause, Managed Care of North America Dental should implement appropriate interventions to improve member access which in turn should result in improved performance measure results.

Weakness: Managed Care of North America Dental scored 63.13 percent for *Members Who Received Preventive Dental Care,* which earned the Managed Care of North America Dental the lowest level of the performance measure withhold payment for this performance measure.

Why the weakness exists: Although the root cause is unclear, considering the rate for the *Members Who Received Preventive Dental Care* measure placed the PAHP at the lowest level of the performance measure withhold payment program, Managed Care of North America Dental interventions intended to improve member access to preventive dental care do not appear to have been effective.

Recommendation: HSAG recommends that Managed Care of North America Dental conduct a root cause analysis or focused study to determine why a portion of its members are not receiving preventive dental care at least once during at least six months of continuous enrollment. Upon identification of a root cause, Managed Care of North America Dental should implement appropriate interventions to improve the performance of these measures.

Compliance Review

Performance Results

Table 4-17 presents Managed Care of North America Dental's scores for each standard evaluated during the CY 2020 compliance review. Each element within a standard was scored as *Met*, *Not Met,* or *NA* based on evidence found in Managed Care of North America Dental's documents, policies, procedures, reports, meeting minutes, and virtual interviews with PAHP staff members.

Table 4-17—Summary of Standard Compliance Scores

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
III	Coordination and Continuity of Care	7	7	7	0	0	**100%**
IV	Coverage and Authorization of Services	18	18	16	2	0	**89%**

Compliance Monitoring Standard		Total Elements	Total Applicable Elements	Number of Elements			Total Compliance Score
				M	*NM*	*NA*	
VII	Confidentiality of Health Information	8	8	8	0	0	**100%**
IX	Grievance and Appeal System	36	36	35	1	0	**97%**
XI	Practice Guidelines	3	3	1	2	0	**33%**
XII	Quality Assessment and Performance Improvement	5	5	5	0	0	**100%**
Total		**77**	**77**	**72**	**5**	**0**	**94%**

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

Strengths

Strength: Managed Care of North America Dental achieved full compliance for the Coordination and Continuity of Care standard, demonstrating that it maintained the capacity to make best-effort attempts to conduct an initial health screening of each member's needs and manage population health by focusing on restoring basic functionality for all members and improving the oral health of members over time through education, member engagement, and members support.

Strength: Managed Care of North America Dental achieved full compliance for the Confidentiality of Health Information standard, demonstrating that it uses and discloses individually identifiable health information in accordance with privacy requirements.

Strength: Managed Care of North America Dental achieved full compliance in the Quality Assessment and Performance Improvement standard, an area in which strong performance is necessary to identify barriers and opportunities for improvement and subsequently implement performance improvement strategies to enhance the quality of, and access to, dental care and services.

Weaknesses

Weakness: Managed Care of North America Dental received a score of 33 percent for the Practice Guidelines standard, demonstrating that it had not fully implemented processes for adopting and disseminating evidenced-based CPGs for the Iowa Medicaid line of business. According to the American Dental Association, "CPGs aid dental professionals in clinical decision making and help incorporate evidence gained through scientific investigation into patient care. CPGs include recommendation statements intended to

optimize patient care that are informed by a systematic review of evidence and an assessment of the benefits and harms of alternative care options."[4-4]

Why the weakness exists: While Managed Care of North America Dental had recently established a Dental Advisory Committee (DAC) for Iowa that included three dental providers located in the State and was responsible for the adoption of CPGs, this committee did not exist during the time period of review. Further, MCNA Dental was unable to effectively demonstrate that it disseminated CPGs to all affected providers.

Recommendation: Managed Care of North America Dental was required to submit a CAP to remediate these deficiencies. HSAG recommends that Managed Care of North America Dental proactively and in a timely manner implement its CAP interventions. Once the interventions are fully implemented, Managed Care of North America Dental should conduct an internal evaluation to determine if the CAP sufficiently remediated all deficiencies. Additionally, while the DAC includes three dental providers, HSAG recommends that Managed Care of North America Dental continue to recruit providers of different specialties located in the State to support the DAC and the Iowa Medicaid program.

NAV

Performance Results

Table 4-18 presents the percentage of members with access to general dentists within the time and distance standard, which states that PAHPs must ensure that 100 percent of their Medicaid members have access to dental providers within 30 miles or 30 minutes for members living in urban areas and 60 miles or 60 minutes for members living in rural areas.

Table 4-18—Percentage of Members With Access to General Dentists Within the Time and Distance Standards—MCNA

	Urban		Rural	
Provider Category	Percent of Members Within Standard	Standard Met (Yes/No)	Percent of Members Within Standard	Standard Met (Yes/No)
General Dentists	99.2%	No	99.9%	No

Table 4-19 presents the average travel distances and travel times for members receiving dental coverage through Managed Care of North America Dental, stratified by providers' acceptance of new patients.

[4-4] American Dental Association. Center for Evidence-Based Dentistry™. Clinical Practice Guidelines. Available at: https://ebd.ada.org/en/evidence/guidelines. Accessed on: Jan 29, 2021.

Table 4-19—Average Travel Distances (Miles) and Travel Times (Minutes) by Providers' Acceptance of New Patients—MCNA

Provider Category	Accepting New Patients* N = 412			Not Accepting New Patients* N = 112		
	First-Nearest	Second-Nearest	Third-Nearest	First-Nearest	Second-Nearest	Third-Nearest
	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)	Dist. (Mi.)/ Time (Min.)
General Dentists						
General Dentists	10.8/12.1	13.4/15.1	14.0/15.8	10.3/11.6	13.1/14.8	15.6/17.7
Dental Specialists						
Endodontists	55.3/78.4	55.3/78.4	59.5/87.2	NA	NA	NA
Oral Surgeons	62.9/79.3	62.9/79.3	62.9/79.3	57.4/76.5	73.4/90.5	87.5/108.7
Periodontists	107.4/162.1	107.4/162.1	107.4/162.1	NA	NA	NA
Prosthodontists	77.6/117.5	107.4/162.1	107.4/162.1	91.2/113.2	NA	NA

* Providers may be present in both categories, accepting and not accepting new patients, which may be dependent on whether a provider renders services at multiple locations.

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Managed Care of North America Dental members have reasonably short travel distances and associated times to general dentists and oral surgeons, regardless of whether the providers are accepting new patients. Additionally, since the travel times and distances for the nearest three providers are similar, most members may have a choice of at least a few general dentists or oral surgeons within a reasonable travel time and distance.

Weaknesses

Weakness: HSAG identified lengthy average drive times and distances for endodontists, oral surgeons, periodontists, and prosthodontists, especially for members trying to establish a relationship with a new dental specialty provider.

Why the weakness exists: These lengthy drive times and distances are likely due to the limited number of dental specialty providers contracted with Managed Care of North America Dental. Additionally, as reported by the PAHP, barriers include the lack of specialty providers in rural areas, the low reimbursement fee schedule, and providers' perception of burdensome regulatory requirements and challenges managing the benefit plan.

Recommendation: HSAG recommends that Managed Care of North America Dental continue its recruitment efforts for these dental specialty providers. HSAG further recommends that the PAHP consult with DHS for statewide opportunities to actively recruit specialty providers for the Iowa Medicaid managed care program.

EDV

Performance Results

Table 4-20 and Table 4-21 present the percentage of dental record documentation submissions and the major reasons Managed Care of North America Dental did not submit dental record documentation, respectively.

Table 4-20—Summary of Dental Records Requested and Received—MCNA

PAHP	Number of Records Requested	Number of Records Submitted	Percentage of Records Submitted
MCNA	146	124	84.9%

Table 4-21—Reasons Dental Records Not Submitted for Date of Service—MCNA

Reason	Number	Percent*
Non-responsive provider or provider did not respond in a timely manner.	20	90.9%
Member was a patient of the practice; however, no documentation was available for requested dates of service.	1	4.5%
Provider refused to release dental records.	1	4.5%
Total	**22**	**100.0%**

* Due to rounding, the sum of the individual percentages may not add up to 100 percent.

Table 4-22 presents the percentage of dates of service and the associated procedure codes identified in the encounter data that were not supported by the members' dental records submitted by Managed Care of North America Dental (i.e., dental record omission), and the percentage of procedure codes from members' dental records that were not found in the encounter data (i.e., encounter data omission). Lower rates indicate better performance. Table 4-22 also presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on the members' dental records. Higher rate values indicate better performance.

Table 4-22—Encounter Data Completeness Summary and Accuracy Results for Procedure Code—MCNA

Key Data Element	Dental Record Omission	Encounter Data Omission	Accuracy Rate
Date of Service	15.8%	NA	NA
Procedure Code	25.3%	10.0%	89.7%

"NA" denotes that the indicator (i.e., encounter data omission and accuracy) was not applicable to the specific data element.

Table 4-23 presents the percentage of dates of service present in both DHS' encounter data and the dental records with the same values for the key data element (i.e., *Procedure Code*). The denominator is

the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service where the encounter data dental procedure code had the same values as the dental procedure code documented in the dental record. Higher all-element accuracy rates indicate that the values populated in DHS' encounter data are more accurate and complete for the key data element when compared to dental records.

Table 4-23—All Element Accuracy—MCNA

Number of Dates of Service Present in Both Sources	Accuracy Rate
123	32.5%

Strengths, Weaknesses, and Recommendations

Strengths

Strength: Procedure codes found in members' dental records were well supported by the procedure codes found in Managed Care of North America Dental's submitted encounter data to DHS.

Weaknesses

Weakness: Managed Care of North America Dental had a high number of dental records not submitted (i.e., 22 out of 146 sample cases) for the requested date of service.

Why the weakness exists: The main reason for the dental records not being submitted was cited as the provider was not responsive or did not respond in a timely manner.

Recommendation: HSAG recommends that Managed Care of North America Dental work with its contracted providers to ensure they comply with record procurement requirements.

Weakness: The percentage of procedure codes identified in Managed Care of North America Dental's encounter data that were not supported by the members' dental records were relatively high at 25.3 percent.

Why the weakness exists: Providers did not document or did not provide documentation outlining treatment or services performed in the submitted dental records, despite submitting the procedure code to Managed Care of North America Dental for payment.

Recommendation: HSAG recommends that Managed Care of North America Dental audit provider encounter data submissions for completeness and accuracy. Managed Care of North America Dental may consider developing provider education training regarding encounter data submissions, dental record documentation, and coding practices.

5. Follow-Up on Prior EQR Recommendations for MCOs

From the findings of each MCO's performance for the CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the Iowa Medicaid program. The recommendations provided to each MCO for the EQR activities in the *Calendar Year 2019 External Quality Review Technical Report* are summarized in Table 5-1 and Table 5-2. 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 and Table 5-2.

Amerigroup Iowa

Table 5-1—Prior Year Recommendations and Responses—AGP

1. Recommendation—Compliance Review
HSAG recommended the following: • Enhance internal monitoring of case management requirements for non-LTSS members. The enhanced monitoring should focus on the care plan development requirements identified in contract. • Enhance case management system capabilities to capture a member's risk stratification level assigned by a case manager as detailed above. Case managers regularly using the system should be involved in this process. Amerigroup should also consider using this risk stratification level for determining case managers' case load assignments. • Enhance internal monitoring of service authorization requests and NABDs. This process should include a review of a sample of notices to ensure content, readability, and timeliness requirements are met. • Review processes for monitoring service authorization time frame requirements of its delegates performing utilization management functions. Time frames must be calculated from the date/time the service authorization request is received to the date/time the notice is sent to a member. • Continue to collaborate with DHS to improve adherence to state-specific disclosure of protected health information and breach notification requirements.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Revisions have been made to the Care Plan and Notes to include the member's selections of who to involve in their care plan development and the communication plan to providers. Case management associates have been retrained on the revised documents. • Directions have been added to the template to include the member's assigned risk level and training was provided to case managers. • Service authorization notices have been reviewed to ensure content, readability, and timeliness requirements. • Time frame requirements for delegates performing utilization management have been reviewed and a correction made based on the findings of the audit. • Amerigroup continues to collaborate with DHS to improve our processes in reporting to the state.

1. Recommendation—Compliance Review
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Anticipate noted improvement in future reviews due to the improvements made. We continually monitor utilization management timeframes and notice content. We have improved our timing on reporting disclosures to the state.
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Response: HSAG has determined that Amerigroup Iowa addressed the prior recommendations. HSAG recommends that Amerigroup Iowa continue to review federal and state-specific requirements as they relate to the scope of compliance review activities. Additionally, HSAG recommends that Amerigroup Iowa review the updated managed care regulations and consult with DHS as needed to ensure adherence to DHS' expectations.
2. Recommendation—Validation of Performance Measures
HSAG concluded that there is much ambiguity around performance measures #1 and #2, and without clarification, the MCOs will continually calculate the performance measures incorrectly. This will not only adversely impact their rates; it will impede the ability to compare rates between plans. HSAG recommended that Amerigroup work with DHS to define a standard methodology for accounting for authorized services that extend (or end prior to) the end of the measurement period. HSAG also recommended that Amerigroup work with DHS to ensure its identification of Index Care Plan Effective Date relative to initial and addendum care plan dates meets DHS' intent of the measure.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Following the SFY 2019 review, Amerigroup began prorating the service authorizations and utilization based on the number of months that fell within the measurement period. This provided consistency in reporting to assist in the comparison of rates between plans. We will look for opportunities in 2021 to work with DHS to define a standard methodology for accounting for authorized services that extend (or end prior to) the end of the measurement period and to ensure our care plan effective dates meet the expectations of DHS.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Prorating the service authorizations and utilization based on the number of months, aligned Amerigroup reporting with the expectations of the PMV measurement periods while providing utilization rates that were more accurate.
c. Identify any barriers to implementing initiatives: • Each year we have completed the PMV of care plans we have learned ways to improve our processes and our reported rates demonstrate improvement from SFY 2018 to SFY 2019. However, this is a complex area with many variables and it is not as easily defined or quantified as other services our health plan provides.
HSAG Assessment: HSAG has determined that Amerigroup Iowa addressed the prior recommendations. HSAG continues to recommend that Amerigroup Iowa work with DHS to ensure understanding of all technical specifications for the measures. HSAG further recommends that Amerigroup Iowa revise its processes to allow automated reporting of data from its software, with quality assurance steps in place, eliminating the need for manual abstraction of performance measure data.

3. Recommendation—HEDIS Performance Measures
HSAG recommended that Amerigroup incorporate efforts for improvement for performance measures that fell below the 25th percentile and decreased by more than 5 percentage points from the following year's rates (HEDIS 2018 [CY 2017]). To prioritize its efforts, Amerigroup should identify a specific subset of these measures and develop initiatives to improve the performance of selected measures. The selected measures, and any subsequent initiatives and interventions, should be included as part of Amerigroup's QAPI program.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Amerigroup selected two measures, Measure #1 Chlamydia (CHL), 10th percentile, and Measure #2, Pharmacotherapy Management of COPD Exacerbation (PCE), 5th percentile or less. • For Measure #1, CHL, we continue to educate providers on the measure description and provide tools and resources to assist providers in educating members around CHL screening. We had targeted outreach campaigns scheduled for 2020; however, due to COVID [coronavirus], Anthem best practice [corporate partner]decided during these difficult times to suspend these types of member and provider outreach campaigns, so as to not overwhelm both providers and members. We plan to resume outreach regarding this measure in 2021. Amerigroup monitors denominator and numerator fluctuations through monthly HEDIS [Healthcare Effectiveness Data and Information Set] rates and monthly benchmark reports. This is done on a monthly basis by a team of Quality Management staff at the health plan and is shared ad hoc with providers. Amerigroup collaborates with the other MCO, Iowa Department of Public Health, American Cancer Society, and other key state partners, on a monthly basis to discuss best practices and identify barriers along with interventions to improve this measure. • For Measure #2, PCE, quality staff met with the corporate data management team on multiple occasions regarding pharmacy claims data. There were concerns regarding the transition to a new pharmacy vendor. A claims review and analysis was completed and no missing data was identified as a result of the data audit. Quality staff also conducts targeted education to providers regarding this measure via email and in-person/virtual if the provider requests. We initiated meetings with new pharmacy team members to review pharmacy department outreach to providers and members around the PCE pharmacy measure.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Measure #1 (CHL): We continue to show year over year growth in our final HEDIS rates yet our overall national quality percentile remains the same due to changes in the yearly National Quality Compass percentiles from NCQA [National Committee for Quality Assurance].[5-1] • Measure #2 (PCE): Amerigroup became a new health plan in 2016 mid-year. Our first year of HEDIS reporting was MY [measurement year] 2017. Although we did not realize any improvement in rates from MY 2017 to MY 2018, in MY 2019 we have seen a significant growth in our final HEDIS rate as well as increase in our National Quality Compass percentile.

[5-1] National Committee for Quality Assurance. *Quality Compass®: Benchmark and Compare Quality Data 2019*. Washington, DC: NCQA, September 2019.

3. Recommendation—HEDIS Performance Measures
Measure #1—Chlamydia (CHL): • **HEDIS 2018 MY 2017**–we were 47.67 (10th percentile) • **HEDIS 2019 MY 2018–**we were 47.44 (10th percentile) • **HEDIS 2020 MY 2019–**we were 48.50 (10th percentile) **Measure #2—For Pharmacotherapy management of COPD Exacerbation (PCE):** • **HEDIS 2018 MY 2017:** – Systemic Corticosteroid–42.76 (5th percentile) – Bronchodilator–48.74 (<5th percentile) • **HEDIS 2019 MY 2018:** – Systemic Corticosteroid–38.96 (less than 5th percentile) – Bronchodilator–45.54 (less than 5th percentile) • **HEDIS 2020 MY 2019:** – Systemic Corticosteroid–59.27 (10th percentile) – Bronchodilator–69.47 (10th percentile)
c. Identify any barriers to implementing initiatives: • Measure #1: CHL–Our membership essentially doubled in July of 2019, following another MCO's exit from the market. Even following that large membership jump, our membership continues to steadily increase month to month, impacting our denominator. Another barrier is a significant percentage of members who fall into this population consistently seek screening services at Department of Public Health for this screening. The Department of Public Health does not submit claims to the MCO, which results in missing claims data to capture numerator compliance. • Measure #2: PCE–At this time we see no barriers but continue to monitor on a quarterly basis and will address any new barriers as they arise.
HSAG Assessment: HSAG has determined that Amerigroup Iowa addressed the prior recommendations. HSAG recommends that Amerigroup Iowa continue to target lower-scoring measures and implement initiatives to improve its performance related to those measures.
4. Recommendation—Calculation of Potentially Preventable Events
When looking at medications of concern prescribed during an ED visit, the percentage of ED visits that resulted in a prescription of antibiotics was above the national ED antibiotic prescription rate. Additionally, none of the 10 most common CCS [Clinical Classification Software][5-2] categories for ED visits are appropriately treated by the use of antibiotics. While the analysis did not tie antibiotic prescriptions to specific CCS categories, this high antibiotic prescription rate could be indicative of inappropriate antibiotic use. HSAG recommended that DHS work with Amerigroup and hospitals to assist with developing or evaluating hospital antibiotic stewardship programs.

[5-2] Agency for Healthcare Research and Quality. HCUP CCS. Healthcare Cost and Utilization Project (HCUP). Mar 2017, Rockville, MD. Available at: www.hcup-us.ahrq.gov/toolssoftware/ccs/ccs.jsp. Accessed on: Feb 24, 2021.

4. Recommendation—Calculation of Potentially Preventable Events
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Amerigroup is required to follow the IME [Iowa Medicaid Enterprise] Preferred Drug List. Amerigroup Iowa is willing to partner with DHS to address this concern.
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: While Amerigroup Iowa is required to follow DHS' preferred drug list, Amerigroup Iowa did not appear to address HSAG's recommendation or evaluate hospital antibiotic stewardship programs. Amerigroup Iowa should work with its providers, specifically hospital systems, to provide education related to appropriate prescribing of antibiotics. Further, Amerigroup Iowa should conduct its own analysis to determine whether specific antibiotic prescriptions were tied to specific CCS categories and subsequently provide targeted education.
5. Recommendation—Validation of Performance Improvement Projects
HSAG recommended the following: • Ensure the accuracy of the statistical test performed, and the *p* value should be reported in the Step VII study indicator data table. • Revisit its causal/barrier analysis at least annually to ensure that the barriers identified continue to be barriers and to see if any new barriers exist that require the development of interventions. • Develop and implement timely interventions targeting the associated identified barriers. • Have a process in place for evaluating the performance of each intervention and the impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical. Decisions to revise, continue, or discontinue an intervention should be data-driven.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 have reviewed the above recommendations (bullets 1-3) and submitted the corrections on our final PIP [performance improvement project] submission in August 2020. • Regarding bullet 4–A team of Quality Management staff meets quarterly to review the PIPs progress and evaluates our performance, interventions, and improvement strategies. We use our quarterly HEDIS benchmark data for the Postpartum PIP. We review, analyze, and discuss focused interventions. For the CAHPS [Consumer Assessment of Healthcare Providers & Systems] PIP, we have a workgroup that meets a minimum of quarterly to review current data and interventions, and strategize to improve overall CAHPS scores for our member population.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.

5. Recommendation—Validation of Performance Improvement Projects
c. Identify any barriers to implementing initiatives: • Not applicable.
HSAG Assessment: HSAG has determined that Amerigroup Iowa addressed the prior recommendations.
6. Recommendation—Encounter Data Validation
HSAG recommended the following: • HSAG identified, from both DHS and the MCOs, errors in the data files extracted for the study. HSAG recommended that DHS and Amerigroup consider implementing standard quality controls to ensure accurate data extracts from their respective systems. Through the development of standard data extraction procedures and quality control, the number of errors associated with extracted data could be reduced, leading to the elimination of multiple data pulls. Moreover, stored procedures can be reused with minimal changes for future studies. • Based on reviews of data submitted by the MCOs, the Iowa MMIS Internal Control Number (ICN) field values were not well populated within the submitted data for the study. While the field values were not required to be used in the MCOs' reconciliation or any of the 837 processes, HSAG recommended that Amerigroup retain the ICN from the response file in their current processing systems to track transactions that have been accepted, rejected, or reconciled.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Amerigroup implemented a new, modernized encounter system in July 2020. This fully updated the way encounter data fields were mapped, validated, submitted, and remitted. It also replaced manual processes with automation capabilities to reduce human errors. State testing was performed prior to go-live to ensure expected levels of performance results. • Amerigroup completed a pharmacy reconciliation project to correct paid amounts and dispensing fees. • Amerigroup corrected mapping issues, improved front end enforcement and educated providers to reduce missing billing NPI [National Provider Identifier] and invalid Atypical IDs [identifications]. • Amerigroup confirmed that the MMIS [Medicaid Management Information System] Internal Control Number (ICN) from the response file is stored in the encounter system. Amerigroup has enterprise tools used for oversight of the submission process which consume the accepted and rejected status to report on accuracy, timeliness and completeness.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Submission accuracy rates post the new encounter system implementation are 99.9%. • Increased automation in the new encounter system reduced claim errors on resubmissions by assigning the correct ICN of the claim being replaced. • Pharmacy Financial Reconciliation for the clean-up period is 99.9%. • Inventory of encounters with missing billing NPI or invalid Atypical IDs is greatly reduced.
c. Identify any barriers to implementing initiatives: • At this time, there are no barriers. The State and Amerigroup meet weekly to address data quality issues, assign action owners responsible for follow up and track execution dates for encounter remediation.
HSAG Assessment: HSAG has determined that Amerigroup Iowa addressed the prior recommendations.

Iowa Total Care

Table 5-2—Prior Year Recommendations and Responses—ITC

1. Recommendation
Compliance Review—HSAG recommended the following: • Enhance internal monitoring of case management requirements for non-LTSS members. The enhanced monitoring should focus on the care plan development requirements identified in the contract.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • HSAG recommendations were considered for ITC's [Iowa Total Care's] corrective action plan. Internal monitoring was definitely enhanced which helped identify issues or risks for the process. Care Plan creation staff training was completed with the reinforcement of development of care plan Goals and Interventions to meet contract compliance. Daily managerial oversight is provided by use of the Daily Case Detail report. The Daily Case Detail report was enhanced to provide evidence of care plan problems, goals, barriers and interventions. Managers are able to easily identify any missing elements in the care plan documentation and provide follow re-training with care manager for correction to the care plan. This initiative supports daily operational oversight audits to ensure contract compliance.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Managerial review of the Daily Case Detail report to identify if elements are present in the expected numbers for each member's care plan. When missing elements are noted on the report, the manager alerts the case manager and corrections/updates are made in the care plan to assure contract compliance. The review of the Daily Case Detail report increased the overall compliance with the internal Care Management auditing. Care Plan development compliance increased by 20%.
c. Identify any barriers to implementing initiatives: • The Care Management team did not encounter barriers in the development of the Daily Case Detail report for monitoring. The data analytics team was able to utilize the data entered into the electronic medical record. Implementation of major EMR [electronic medical record] system upgrade affect appearance of Care Plan Creation. While this barrier was present, it did not cause significant implementation initiative concerns, just staff support to continue to create the care plan as previously.
HSAG Assessment: HSAG has determined that Iowa Total Care addressed the prior recommendations.

6. Follow-Up on Prior EQR Recommendations for PAHPs

From the findings of each PAHP's performance for the CY 2020 EQR activities, HSAG made recommendations for improving the quality of healthcare services furnished to members enrolled in the IA Medicaid program. The recommendations provided to each PAHP for the EQR activities in the *Calendar Year 2019 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—DDIA

1. Recommendation—Compliance Review
In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG provided recommendations for DDIA to support improvement in the quality, timeliness, and access to health care services furnished to its members: • Discussion during the on-site review determined that DDIA was voiding previously approved services when a benefit change occurred during the next fiscal year (FY), even though it had been authorized when the service was a covered benefit. HSAG recommended that DDIA seek clarification from DHS regarding the expectations to honor previously approved services when a benefit change is made. • Develop a standardized process to obtain missing clinical information for PA requests; for example, making three attempts to collect the documentation within 14 calendar days prior to rendering a decision to deny a service due to a lack of information. Additionally, HSAG recommended that DDIA update its provider manual to specify that decisions will be made within 14 calendar days, as opposed to 14 days. • Clarify in policy, situations for when DDIA fails to make a timely authorization decision (for example, due to a lack of staff) versus when an extension is appropriate and in the best interest of the member (for example, when additional clinical information is pending). Additionally, HSAG recommended that DDIA review its provider manual to ensure information pertaining to untimely authorization decisions required by this element is included. • Reevaluate its current process regarding when appeals should or should not be expedited. • Consider the following activities in its QAPI program description: – Performance measures – PIPs – Mechanisms to detect under- and overutilization – Mechanisms to assess the effectiveness of services for members with special healthcare needs – Adoption and dissemination of CPGs: specifically, those adopted from nationally recognized sources, such as the American Dental Association (ADA) – Provider network monitoring, such as access standards – Grievances and appeals and identified trends

1. Recommendation—Compliance Review

- Member outreach and education needs and activities
- Cultural competency
- SDOH
- Credentialing activities
- Oversight of delegated functions
- Quality of care (QOC) concerns and peer review

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

1. Recommendation—Compliance Review
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • Delta Dental of Iowa (DDIA) has consulted with Iowa Department of Human Services (DHS) to determine how DDIA should process prior authorizations that have been approved but the benefit level has changed. DDIA is still waiting on guidance from DHS. • DDIA developed and implemented the Government Programs Adverse Determination process and policy. Implementation started in May 2020. DDIA makes two contacts with providers to obtain missing clinical documentation for prior authorization request. The DDIA DWP Office Manual has been updated to state 14 calendar days. • DDIA has clarified in policies for when timely authorization decisions have not been made due to internal oversight as opposed to needing an extension for additional information that communication to the member and the provider must be conducted. DDIA has also reviewed the provider manual to ensure this information is included. • DDIA provided additional training to staff to clarify what makes an expedited appeal and the different ways in which a member can describe wanting one. The appeals policies and procedures were reviewed with staff at length and any questions or further clarification was provided. Appeals coordinator reviews appeal requests after CSR [customer service representative] has received to double check that the member has not requested an expedited appeal. • The DDIA Government Programs team has further developed the program's QAPI [quality assessment and performance improvement] and considered many additions to the program description, committee, annual workplan, and evaluation. The biggest undertaking for the QAPI was the development of the workplan and evaluation metrics for SFY [State fiscal year] 2021. The workplan was developed to mirror the timeframe of the contract and metrics were identified and goals set to analyze each quarter. An evaluation of the workplan, along with other components of the QAPI (performance measures, under and over utilization, performance improvement projects, etc.) will be included in the final assessment for the state fiscal year. The team will continue to adopt recommendations to the QAPI to ensure QI is woven into all aspects of the dental programs. • Government Programs internal staff has completed cultural competency training. The training that has been completed is the same training that we encourage for dentists, the DHHS [Department of Health and Human Services] cultural competency training for oral health professionals. New staff will be required to also complete the training. The completion of each member is tracked. Staff will complete this training annually and will identify new trainings, as applicable.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations. However, HSAG strongly recommends that Delta Dental of Iowa prioritize and continue to make enhancements to utilization management and QAPI processes. Delta Dental of Iowa should ensure that these processes align with federal managed care rules and expectations.

2. Recommendation—Validation of Performance Measures
HSAG concluded that there was some ambiguity surrounding the technical specifications for the selected dental measures. HSAG recommended that DDIA work with DHS to refine the specifications to more clearly define denominator and numerator elements, and to ensure the measure meets DHS' intent.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 has worked with IME [Iowa Medicaid Enterprise] to have clarifications and refinement to what is included and excluded in performance measure calculations. IME has updated the definitions included in the template, and those have been used for additional PM [performance measure] validation.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • The performance improvement has made the information match to what is being validated more consistently.
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations.
3. Recommendation—Validation of Performance Improvement Projects
DDIA must address identified deficiencies noted in this year's validation prior to submitting PIPs for the next annual validation in 2020. HSAG also recommended the following: • Ensure that the approved PIP methodology to calculate and report Remeasurement 1 data is followed and data are reported accurately in next year's annual submission. • Document the process and steps used to determine and prioritize barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • As the PIP progresses, DDIA's efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes. • Have a process in place for evaluating the performance of each intervention and impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical. Decisions to revise, continue, or discontinue an intervention should be data-driven.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 will ensure that the approved PIP [performance improvement project] methodology to calculate and report data accurately is followed in future submissions. • DDIA is documenting the process of determining QI [quality improvement] projects based on barriers we see and meeting minutes are taken. DDIA has also been working with other Delta Dental Medicaid teams to identify QI tools being developed and used that meet federal requirements.

3. Recommendation—Validation of Performance Improvement Projects
• During the implementation stage of the performance improvement projects, the team has incorporated control and intervention groups to develop more active interventions that will lead to more accurate measurements when analyzing results. • The PIP committee is meeting more frequently, not only to prioritize barriers and develop improvement projects, but also to analyze and evaluate completed interventions. It is then the recommendation of the committee to continue, adapt, or discontinue certain aspects of the interventions based on the utilization rates.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives: • DDIA is striving for active interventions given the information that is provided to contact members. Some members do not have a phone number on file, and some have not reported a change of address. The team is trying to address these barriers by using control and intervention groups to remove that barrier as a limitation when analyzing data.
HSAG Assessment: HSAG has determined that Delta Dental of Iowa partially addressed the prior recommendations and continued to implement passive interventions which are difficult to evaluate for effectiveness and may not impact the study indicator outcomes. HSAG continues to recommend that Delta Dental of Iowa develop active interventions that can be tracked and trended to determine the impact on the study indicator outcomes. A process for evaluating each intervention and its impact on the study indicators to allow for continual refinement of improvement strategies should be established.
4. Recommendation—Network Adequacy
HSAG recommended that DHS and DDIA continue to collaborate to identify and contract with additional providers in those areas with exceptionally long drive times and distances, as available. The provider categories of highest concern include endodontics, periodontics, and prosthodontics.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 reviews time and distance standards with DHS [Iowa Department of Human Services] on a quarterly basis and also provides a provider listing of all active providers in the DWP [Dental Wellness Plan] network that provides the number of members who have been seen within the last year at each practice location. The location of specialists such as endodontists, periodontists, and prosthodontists in the State of Iowa are not typically in more rural communities which does result in longer drive times for members to see specialists. DDIA continues to reach out to providers and encourage them to join the DWP network.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives: • The main reason specialists note when leaving or declining to join the DWP network is the reimbursement fee schedule and DDIA ensures to follow the guidelines of staying within 5% of the DHS FFS [fee-for-service] reimbursement schedule.

4. Recommendation—Network Adequacy
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations, but the PAHP should continue to document all outreach and contracting strategies that are being implemented to increase the available dental providers within its network and decrease the longer drive times for members to see specialty dental providers.
5. Recommendation—Encounter Data Validation
Based on reviews of data submitted by the PAHPs, the Iowa MMIS *ICN* field values were not well populated within the submitted data for the study. While the field values were not required to be used in the PAHPs' reconciliation or any of the 837 processes, HSAG recommended that DDIA retain the *ICN* from the response file in their current processing systems to track transactions that have been accepted, rejected, or reconciled.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 has investigated the origin of the ICN field information and has come to understand the ICN number that is present is the most recent transaction based on replacement logic. This information is stored in our system and is able to be reproduced based on the timeframe of claim submission to IME (i.e., more recent payment/check date submission for encounter files).
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable):
c. Identify any barriers to implementing initiatives:
HSAG Assessment: HSAG has determined that Delta Dental of Iowa addressed the prior recommendations.

Managed Care of North America Dental

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

1. Recommendation—Compliance Review
In addition to correcting the deficiencies identified during the compliance monitoring activity, HSAG provided recommendations for MCNA to support improvement in the quality, timeliness, and access to health care services furnished to its members: • Conduct ongoing education with its staff to ensure that when members are informed of the limited time frame to present additional information, it is clearly documented in each expedited appeal record. • Provide education to providers who meet the 80 percent threshold overall but may have scored poorly in certain areas when provider performance and adherence to CPGs are measured.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 [Managed Care of North America] Grievances and Appeals staff have been trained on informing members of the limited time frame to present additional information and the importance of documenting the members' records. There were two trainings performed regarding this initiative, one on March 15, 2019 and again on September 17, 2020. • MCNA's dental record audit passing letter was revised to include the standards that fell below goal. The revised letter has been approved by the leadership team and will be approved at the next quality improvement committee (QIC) meeting.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Management has audited approximately 60% of member expedited cases and has seen 100% improvement regarding notation in the members' records. • Not applicable, the letter is pending approval from the QIC after which it will be disseminated to providers. For those with a passing score, re-audits are not conducted for another three years.
c. Identify any barriers to implementing initiatives: • There have been no barriers found at this time. • Due to the COVID-19 [coronavirus] pandemic, dental record audits were put on hold as provider offices experienced closures, limited staff, and state mandates on elective/non-urgent care etc. therefore implementation of this initiative was delayed.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental addressed the prior recommendations.
2. Recommendation—Validation of Performance Measures
HSAG concluded that there was some ambiguity surrounding the technical specifications for the selected dental measures. HSAG recommended that MCNA work with DHS to refine the specifications to more clearly define denominator and numerator elements, and to ensure the measure meets DHS' intent.

2. Recommendation—Validation of Performance Measures
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 and DHS [Iowa Department of Human Services] corresponded in view of HSAG's recommendations. DHS acknowledged their desire to update specifications surrounding the numerator in that the numerator should only reflect paid services.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • There are no improvements to note in view of revised specifications. The revised specifications did not influence intervention methods; revised specifications are of a technical nature, not operational.
c. Identify any barriers to implementing initiatives: • There were no barriers identified.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental addressed the prior recommendations.

3. Recommendation—Validation of Performance Improvement Projects
DDIA must address identified deficiencies noted in the 2019 validation prior to submitting PIPs for the next annual validation in 2020. HSAG recommended the following: • Address identified deficiencies noted in this year's validation prior to submitting PIPs for the next annual validation in 2020. • Ensure that the approved PIP methodology to calculate and report Remeasurement 1 data is followed and data are reported accurately in next year's annual submission. • Document the process and steps used to determine and prioritize barriers to improvement and attach completed QI tools, meeting minutes, and/or data analysis results used for the causal/barrier analysis. • As the PIP progresses, MCNA's efforts in the Implementation stage should support the development of active interventions and sound measurement results leading to improved outcomes. • Have a process in place for evaluating the performance of each intervention and impact on the study indicators. The evaluation process should allow for continual refinement of the intervention/improvement strategy. The evaluation process should be ongoing and cyclical. Decisions to revise, continue, or discontinue an intervention should be data-driven.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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 addressed all identified deficiencies noted in the 2019 validation in the 2020 annual submission. • MCNA used the approved PIP [performance improvement project] methodology to calculate and accurately report Remeasurement 1 data in the 2020 annual submission. • MCNA documented the process and steps used to determine and prioritize barriers to improvement in the 2020 annual submission and also submitted a fishbone analysis and key driver diagram.

3. Recommendation—Validation of Performance Improvement Projects
• MCNA's interventions were implemented timely and evaluated monthly/quarterly for effectiveness to drive improved outcomes as evidenced in the 2020 annual submission. • MCNA's Quality Improvement team monitored and tracked the performance of each intervention and its impact on the study indicators on a monthly basis. Rates for study indicators were compared to the same point in time the previous year to determine if the rates were trending higher or lower. Outcomes were reported quarterly to MCNA's QIC where feedback was solicited and an intervention was discontinued.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Not applicable.
c. Identify any barriers to implementing initiatives: • There were no barriers to addressing recommendations in the 2019 PIP validation and subsequently all items were addressed in the 2020 annual submission.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental addressed the prior recommendations; however, the PAHP did not meet the goal of achieving statistically significant improvement. HSAG recommends revisiting the causal/barrier analysis process to determine whether barriers identified continue to be barriers and determine if any new barriers exist that require the development of active interventions. Managed Care of North America Dental should continue to evaluate the effectiveness of each intervention using the outcomes to determine each intervention's next steps.
4. Recommendation—Network Adequacy
HSAG recommended that: • DHS encourage MCNA to review its provider directory and identify providers who have not delivered services to any members in the past year to determine if the provider should remain contracted with the PAHP and why the provider has not provided any services to Medicaid members. • DHS and MCNA should continue to collaborate to identify and contract with additional providers in those areas with exceptionally long drive times and distances, as available. The provider categories of highest concern include endodontics, periodontics, and prosthodontics.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • The Provider Relations Representatives (PR Rep) identify providers who have not delivered services to any members throughout the year during the site contact visits. Site contact visits are conducted by phone, email or in person. The site contact includes asking a provider office whether they are seeing any patients in an effort to identify whether the provider is meeting accessibility and appointment availability standards. If it is determined that the provider has not delivered services to members, the PR Rep will work with the provider to agree to see patients moving forward. The PR Rep also works with the provider to determine if they are willing to see patients on an as needed basis and we let them know that the provider's information will be shared with our Member Services Unit, in the event a member needs to identify an available provider as needed to seek care. If a member requires the need to see a provider, the Member Services team will work with the provider to set an appointment with the member at the provider's office. It is the goal of the provider relations team to conduct a site contact visit to 100% of providers throughout the year.

4. Recommendation—Network Adequacy
• MCNA continues to collaborate with DHS to identify and contract with additional providers in those areas with exceptionally long drive times and distances, as available. MCNA understands the need to recruit and enroll specialists, including endodontics, periodontics, and prosthodontics in rural areas of the state. The Network Development team outreaches to non-contracted providers at least 3 times per year to determine if there is any interest in participation. In the fall of 2019, MCNA assembled a Dental Advisory Committee (DAC) for the purpose of not only to advise on QI measures, but to have the DAC get involved with working with the provider community to participate in the Medicaid program and participate in MCNA's dental provider network. MCNA also works closely with the Dental School at the University of IA[Iowa] to help with this outreach effort as well. Outreach efforts have been expanded to other states that border the state of IA.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • During 2020, MCNA employees were required to work from home due to the COVID 19 pandemic. MCNA Provider Representatives conducted site contact visits via phone and/or email to help identify providers that did not deliver services to members. While one provider agreed to terminate from the network, others have agreed to stay in the network. The Member Services team were informed of the providers who had not delivered services to ensure these providers are referred to provide services to members in need of care. MCNA will consider developing a letter to providers regarding this matter to encourage these providers to continue to deliver services to our members. • MCNA has improved specialist participation in the network. Contacting providers in bordering states has allowed MCNA to contract with the Dental School at Creighton University. See unique provider counts as follows:

December 2019	Unique Providers	December 2020	Unique Providers
Endodontics	10	Endodontics	15
Periodontics	7	Periodontics	13
Prosthodontics	13	Prosthodontics	23

c. Identify any barriers to implementing initiatives:

- Balancing the need to meet network access standards and ensuring the providers are delivering care is something MCNA takes seriously and can be challenging. While meeting network standards to ensure we are meeting the requirement to have available providers to provide care to members throughout the state, we also want to ensure that providers are utilizing care to our members. As our enrollment increases, we want to ensure that providers are available in all areas of the state to accommodate the needed care for our members. As such, MCNA encourages providers to deliver care through the PR Rep providing education, training, and having available resources to ensure ease in participation and care delivery. MCNA takes careful consideration before any recommendation to terminate a provider for not delivering care. This is to maintain the access standards and assure care delivery is available to our membership. MCNA already has policies in place for providers to determine whether they want to remain in the network. A provider may terminate at any time with notice per the MCNA Provider Agreement and may also choose to not re-credential (every 3 years from the initial credentialing date) to continue participation in the network. The PR Reps will strive to encourage providers to continue participation and help refer patients to such providers in an effort to increase utilization.
- Below are the biggest challenges or barriers to recruiting additional Endodontic, Periodontic and Prosthodontic providers in the state of IA per information gathered from our recruitment efforts:
  1. Limited number of specialists in the state of IA, specifically in rural areas
  2. Low reimbursement – specialists believe that the fees are too low

4. Recommendation—Network Adequacy
3. Regulatory requirements are burdensome 4. Benefit plan difficult to manage
HSAG Assessment: HSAG has determined that Managed Care of North America Dental addressed the prior recommendations but continued to face challenges in recruiting dental specialists. While several barriers have been identified, HSAG recommends that Managed Care of North America Dental continue recruitment strategies targeted at alleviating the barriers that are under Managed Care of North America Dental's control, such as working with dental specialists to better understand the need for regulatory requirements and initiating interventions to reduce administrative burden on the providers.
5. Recommendation—Encounter Data Validation
Based on reviews of data submitted by the PAHPs, the Iowa MMIS *ICN* field values were not well populated within the submitted data for the study. While the field values were not required to be used in the PAHPs' reconciliation or any of the 837 processes, HSAG recommended that the MCNA retain the *ICN* from the response file in their current processing systems to track transactions that have been accepted, rejected, or reconciled.
MCE's Response (Note—The narrative within the MCE's Response section was provided by the MCE and has not been altered by HSAG except for minor formatting)
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)***: • While MCNA retains all information received in the form of original files, the Iowa MMIS [Medicaid Management Information System] ICN [Internal Control Number] field had not been transferred into our main processing system because it was not needed for typical 837 processes. However, MCNA will implement changes based on HSAG's recommendation and will reprocess old encounter response files and transfer Iowa MMIS ICNs into our main processing system. MCNA will also transfer the MMIS ICN moving forward.
b. Identify any noted performance improvement as a result of initiatives implemented (if applicable): • Storing the MMIS ICN does not have a direct impact in performance improvement.
c. Identify any barriers to implementing initiatives: • There are no barriers to implementing the recommendation.
HSAG Assessment: HSAG has determined that Managed Care of North America Dental partially addressed the prior recommendations as it has yet to implement processing changes to transfer the ICN into its system.

7. MCO Comparative Information

In addition to performing a comprehensive assessment of the performance of each MCO, HSAG compared the findings and conclusions established for each MCO to assess the Iowa Medicaid managed care program. The overall findings of the MCOs were used to identify the overall strengths and weaknesses of the Iowa Medicaid managed care program and to identify areas in which DHS could leverage or modify the State's quality strategy to promote improvement.

MCO EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the MCOs.

PIPs

For the CY 2020 validation, the MCOs submitted the PIP Design for the two new DHS-mandated PIP topics initiated in 2020, *Timeliness of Postpartum Care* and *CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*. Amerigroup Iowa also submitted Remeasurement 2 data for its continuing PIP topics, *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* and *Member Satisfaction*. Table 7-1 below provides a comparison of the validation scores, by MCO.

Table 7-1—Comparison of Validation by MCO

Overall PIP Validation Status, by MCO			Design and Implementation Scores		
			Met	Partially Met	Not Met
AGP	*Well-Child Visits in the Third, Fourth, fifth, and Sixth Years of Life*	*Met*	95%	0%	5%
AGP	*Member Satisfaction*	*Not Met*	92%	0%	8%
AGP	*Timeliness of Postpartum Care*	*Met*	100%	0%	0%
AGP	*CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*	*Met*	100%	0%	0%
ITC	*Timeliness of Postpartum Care*	*Partially Met*	91%	9%	0%
ITC	*CAHPS Measure—Customer Service at Child's Health Plan Gave Information or Help Needed*	*Met*	100%	0%	0%

The validation statuses for the MCOs receiving an overall *Not Met* or *Partially Met* validation score were related to one or more criterial elements not receiving a *Met* score, which impacted the overall validation status. For the PIP topics initiated in 2017, achieving statistically significant improvement was a DHS-approved critical element, and only one of the two PIP topics submitted by Amerigroup Iowa achieved this high level of performance improvement. Although one of the two topics achieved some improvement, overall, it received a *Not Met* validation status.

PMV

The reportable rates for the MCOs are displayed below in Table 7-2, Table 7-3, Table 7-4, and Table 7-5.

Table 7-2—SFY 2020 Performance Measure #1a Rates—MCO Comparison

Performance Measure 1a					
Percentage of Eligible Members with Applicable Percentage of Authorized Services Utilized	**0%**	**1–49%**	**50–74%**	**75–89%**	**90–100%**
AGP	10.46%	48.61%	22.98%	9.47%	8.48%
ITC	2.20%	56.29%	21.49%	8.18%	11.84%

Table 7-3—SFY 2020 Performance Measure #1b Rates—MCO Comparison

Performance Measure 1b	
The percentage of eligible members for whom 100 percent of HCBS services documented in members' care plans had a corresponding approved service authorization	**Rate**
AGP	81.26%
ITC	96.75%

Table 7-4—SFY 2020 Performance Measure #2a, 2b, and 2c Rates—MCO Comparison

Performance Measure		MCO	
		AGP	**ITC**
2a	*Members With One or More Documented Care Plan One-Time Service*	2.25%	0.10%
2b	*Members With Documented Care Plan One-Time Service With Corresponding Approved Service Authorization*	61.76%	100.00%
2c	*Percentage of Authorized One-Time Services Utilized*	73.08%	100.00%

Table 7-5—SFY 2020 Performance Measure #3, #4, #5, and #6 Rates—MCO Comparison

Performance Measure		MCO	
		AGP	ITC
3	*Provision of Care Plan*	40.69%	55.51%
4	*Person-Centered Care Plan Meeting**	62.51%	92.63%
5	*Care Team Lead Chosen by the Member*	72.04%	96.11%
6	*Member Choice of HCBS Settings*	96.60%	98.43%

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

Compliance Review

HSAG calculated the Iowa Medicaid managed care program overall performance in each of the 13 performance areas reviewed during the current three-year cycle of compliance reviews. Table 7-6 presents the results of the MCOs that supported the Iowa Medicaid managed care program during the current three-year cycle.[7-1] Table 7-6 compares the Iowa Medicaid managed care program average compliance score in each of the 13 performance areas with the compliance score achieved by each MCO. The percentages of requirements met for each of the 13 standards reviewed during the CY 2018, CY 2019, and CY 2020 compliance reviews are provided. Additionally, Table 7-6 displays the five standards reviewed during CY 2020 highlighted in blue for ease of reference. As only Amerigroup Iowa had a complete review of all standards during the current three-year cycle, the total compliance score in Table 7-6 represents the aggregated score for each MCO for the current CY 2020 review.

Table 7-6—Summary of Current Three-Year Cycle of Compliance Review Results—MCOs

Year Reviewed	Standard	AGP	ITC	Program
CY 2018	Standard I—Availability of Services	95%	—	—
CY 2018	Standard II—Assurances of Adequate Capacity and Services	100%	—	—
CY 2019	Standard III—Coordination and Continuity of Care	81%	—	—
CY 2019	Standard IV—Coverage and Authorization of Services	82%	—	—

[7-1] During the current three-year cycle (CY 2018–CY 2020), UnitedHealthcare left the IA Medicaid program effective July 1, 2019, and Iowa Total Care entered the program effective July 1, 2019. While Iowa Total Care underwent a compliance review during CY 2019, this review was a follow-up to Iowa Total Care's 2019 readiness review and therefore not comparable to the CY 2019 compliance review standards reviewed for Amerigroup. Due to UnitedHealthcare's exit, results for this MCO are not included in the overall compliance review results and this annual assessment.

Year Reviewed	Standard	AGP	ITC	Program
CY 2020	Standard V—Provider Selection	67%	64%	65%
CY 2020	Standard VI—Member Information and Member Rights	77%	91%	84%
CY 2019	Standard VII—Confidentiality of Health Information	80%	—	—
CY 2020	Standard VIII—Enrollment and Disenrollment	86%	100%	93%
CY 2018	Standard IX—Grievances, Appeals and State Fair Hearings	95%	—	—
CY 2020	Standard X—Subcontractual Relationships and Delegation	86%	100%	93%
CY 2019	Standard XI—Practice Guidelines	100%	—	—
CY 2018	Standard XII—Quality Assessment and Performance Improvement	92%	—	—
CY 2020	Standard XIII—Health Information Systems	89%	100%	94%
	Total Compliance Score for CY 2020	**79%**	**89%**	**84%**

Dash (—) = no reported data available.

NAV

Table 7-7 shows the provider directory validation results by MCO and both MCOs combined.

Table 7-7—Validation Results by MCO and Provider Category

MCO and Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%
AGP							
OB/GYN Providers	189	186	98.4%	3	1.6%	0	0.0%
PCPs	189	186	98.4%	3	1.6%	0	0.0%
Total	378	372	98.4%	6	1.6%	0	0.0%
ITC							
OB/GYN Providers	187	178	95.2%	4	2.1%	5	2.7%
PCPs	188	180	95.7%	3	1.6%	5	2.7%
Total	375	358	95.5%	7	1.9%	10	2.7%
All MCOs							
OB/GYN Providers	376	364	96.8%	7	1.9%	5	1.3%

MCO and Provider Category	Number of Sampled Providers	Providers Found in Directory		Providers Not Found in Directory		Provider Locations Not Found in Directory	
		Count	%	Count	%	Count	%
PCPs	377	366	97.1%	6	1.6%	5	1.3%
Total	753	730	96.9%	13	1.7%	10	1.3%

Table 7-8—Match Results for Demographic Indicators

Indicator	AGP (N = 372)		ITC (N = 358)	
	Exact Match		Exact Match	
	Count	Percent	Count	Percent
Provider First Name	371	99.7%	358	100.0%
Provider Middle Name	372	100.0%	358	100.0%
Provider Last Name	372	100.0%	358	100.0%
Provider Address 1	372	100.0%	357	99.7%
Provider Address 2	370	99.5%	355	99.2%
Provider City	372	100.0%	358	100.0%
Provider State	372	100.0%	358	100.0%
Provider Zip Code	372	100.0%	358	100.0%
Provider Telephone Number	369	99.2%	227	63.4%
Provider Specialty	372	100.0%	0	0.0%
Provider Accepting New Patients	338	90.9%	357	99.7%

EDV

As Iowa Total Care and Amerigroup Iowa are currently on different cycles for EDV activities, comparative information is not available but will be included in future reports, as applicable.

CAHPS Analysis

As Iowa Total Care joined the Iowa Medicaid program in July 2019, CAHPS data for the reporting period are not available. Therefore, only data for Amerigroup Iowa are presented in this report, and a comparison is not available. Comparative CAHPS data across both MCOs will be included in future reports.

8. PAHP Comparative Information

In addition to performing a comprehensive assessment of the performance of each PAHP, HSAG compared the findings and conclusions established for each PAHP to assess the Iowa Medicaid managed care program. The overall findings of the PAHPs were used to identify the overall strengths and weaknesses of the Iowa Medicaid managed care program and to identify areas in which the State could leverage or modify the Iowa quality strategy to promote improvement.

PAHP EQR Activity Results

This section provides the summarized results for the mandatory EQR activities across the PAHPs.

PIPs

For the CY 2020 validation, the PAHPs submitted Remeasurement 1 data for their ongoing PAHP-specific PIP topics. Table 8-1 below provides a comparison of the validation scores, by PAHP.

Table 8-1—Comparison of Validation by PAHP

Overall PIP Validation Status, by PAHP		Design and Implementation Scores		
		Met	Partially Met	Not Met
DDIA	*Not Met*	65%	25%	10%
MCNA	*Not Met*	90%	0%	10%

The validation statuses for the PAHPs receiving an overall *Not Met* validation score were related to one or more critical elements not receiving a *Met* score, which impacted the overall validation status. For the 2020 PIP validation, achieving statistically significant improvement was a DHS-approved critical element. As a result, although Managed Care of North America Dental achieved some improvement, overall, it received a *Not Met* validation status. Delta Dental of Iowa demonstrated a statistically significant decline for both indicators; however, the PAHP had additional opportunities for improvement with its documentation resulting in a *Met* score for only 65 percent of the criteria.

PMV

Delta Dental of Iowa and Managed Care of North America Dental both received the rate designation of *Reportable* for all performance measures. The rates for the PAHPs are displayed in Table 8-2.

Table 8-2—SFY 2020 Performance Measure Rates—PAHP Comparison

Performance Measure		Measure Rates	
		DDIA	MCNA
2	*Members Who Accessed Dental Care*	34.15%	19.76%
3	*Members Who Received Preventive Dental Care*	75.10%	63.13%
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 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])*	64.96%	42.24%

* Performance measure #6 includes three distinct components.

Compliance Review

HSAG calculated the Iowa Medicaid managed care program overall performance in each of the six performance areas. Table 8-3 compares the Iowa Medicaid managed care program average compliance score in each of the six performance areas with the compliance score achieved by each PAHP. The percentages of requirements met for each of the six standards reviewed during the CY 2020 compliance review are provided.

Table 8-3—Summary of CY 2020 Compliance Review Results—PAHPs

Standard	DDIA	MCNA	Program
Standard III—Coordination and Continuity of Care	100%	100%	100%
Standard IV—Coverage and Authorization of Services	67%	89%	78%
Standard VII—Confidentiality of Health Information	100%	100%	100%
Standard IX—Grievance and Appeal System	92%	97%	94%
Standard XI—Practice Guidelines	0%	33%	17%
Standard XII—Quality Assessment and Performance Improvement Program	80%	100%	90%
Total Compliance Score	**83%**	**94%**	**88%**

Total Compliance Score—Elements scored *Met* were given full value (1 point each). The point values were then totaled, and the sum was divided by the number of applicable elements to derive percentage scores for each PAHP's standards and for the IA Medicaid program.

NAV

Table 8-4 illustrates the population of eligible members by PAHP and statewide. Of note, Dental Wellness Plan members residing in the State of Iowa who were at least 19 years of age on or prior to

July 31, 2020, were included in the counts. Each member was allocated to a sole PAHP based on enrollment as of July 31, 2020. As displayed, nearly two-thirds (64.5 percent) of eligible members were contracted with Delta Dental of Iowa for the rendering of dental services.

Table 8-4—Population of Eligible Members by PAHP

Category	DDIA	MCNA	Statewide
Members	227,549	125,063	352,612

Table 8-5 displays the number of providers and the provider-to-member ratios (i.e., the number of members for each contracted provider) by PAHP. Providers rendering services in the State of Iowa and bordering states in contiguous counties were included in the analysis. Managed Care of North America Dental had lower provider-to-member ratios, indicative of more robust dental services coverage, for five of the seven provider categories. However, the PAHP also had substantially fewer members; and for some provider categories with a limited number of providers (i.e., endodontists, orthodontists, periodontists, and prosthodontists), Managed Care of North America Dental's smaller provider ratios may be a result of having fewer members for approximately the same number of providers.

Table 8-5—Summary of Ratio Analysis Results for General Dentists and Dental Specialists by PAHP, Including Out-of-State Providers in Contiguous Counties

Provider Category	DDIA		MCNA		Statewide	
	Providers	Ratio	Providers	Ratio	Providers	Ratio
General Dentists						
General Dentists	861	1:264	437	1:286	953	1:370
Dental Specialists						
Endodontists	12	1:18,692	10	1:12,506	12	1:29,384
Oral Surgeons	63	1:3,612	34	1:3,678	67	1:5,263
Orthodontists*	11	1:20,686	12	1:10,422	18	1:19,590
Pedodontists**	45	1:5,057	31	1:4,034	60	1:5,877
Periodontists	10	1:22,755	9	1:13,896	11	1:32,056
Prosthodontists	20	1:11,377	18	1:6,948	21	1:16,791

* A count of the number of orthodontists in the PAHP provider networks is provided in the report since orthodontic services is only a benefit for adult members ages 19 to 20 years. Orthodontists were excluded from the provider ratio and time/distance analyses since most of the population served by these providers (i.e., children) are not included in this network analysis.

** A count of the number of pedodontists in the PAHP provider networks is provided in the report since pedodontists serve adult members ages 19 to 20 years and adult members with behavior management issues. Pedodontists were excluded from the provider ratio and time/distance analyses since most of the population served by these providers (i.e., children) are not included in this network analysis.

EDV

Table 8-6 and Table 8-7 present the percentage of dental record documentation submissions and the major reasons dental record documentation was not submitted by each PAHP, respectively.

Table 8-6—Summary of Dental Records Requested and Received

PAHP	Number of Records Requested	Number of Records Submitted	Percentage of Records Submitted
DDIA	146	144	98.6%
MCNA	146	124	84.9%
Statewide	**292**	**268**	**91.8%**

Table 8-7—Reasons Dental Records Not Submitted for Date of Service by PAHP

Reason	Statewide		DDIA		MCNA	
	Number	Percent	Number	Percent	Number	Percent*
Non-responsive provider or provider did not respond in a timely manner.	21	87.5%	1	50.0%	20	90.9%
Member was a patient of the practice; however, no documentation was available for requested dates of service.	2	8.3%	1	50.0%	1	4.5%
Provider refused to release dental records.	1	4.2%	0	0.0%	1	4.5%
Total	**24**	**100.0%**	**2**	**100.0%**	**22**	**100.0%**

* Due to rounding, the sum of the individual percentages may not add up to 100 percent.

Table 8-8 presents the percentage of dates of service identified in the encounter data that were not supported by the members' dental records submitted by each of the participating PAHPs (i.e., dental record omission). HSAG conducted the analysis at the date-of-service level. Lower rates indicate better performance. Of note, when reporting statewide rates, HSAG weighted each PAHP's raw rates based on the volume of dental visits among the eligible population for that PAHP. This approach will ensure that no PAHP was over- or underrepresented in the statewide rates.

Table 8-8—Dental Record Omission for Date of Service

PAHP	Date of Service Identified in the Encounter Data	Percent Not Supported by Documentation in the Members' Dental Records*
DDIA	146	3.4%
MCNA	146	15.8%
Statewide	**292**	**5.4%**

* Lower rates indicate better performance.

Table 8-9 presents the percentage of procedure codes identified in the encounter data that had no supporting documents in the members' dental records (i.e., dental record omission) and the percentage of procedure codes from members' dental records that were not found in the encounter data (i.e., encounter data omission). HSAG conducted the analyses at the procedure code level. For both rates, lower values indicate better performance.

Table 8-9—Dental Record Omission and Encounter Data Omission for Procedure Code

PAHP	Dental Record Omission		Encounter Data Omission	
	Number of Procedure Codes Identified in Encounter Data	Percent Not Supported by Members' Dental Records*	Number of Procedure Codes Identified in Members' Dental Records	Percent Not Found in the Encounter Data*
DDIA	502	16.7%	454	7.9%
MCNA	545	25.3%	452	10.0%
Statewide	**1,047**	**18.1%**	**906**	**8.3%**

* Lower rates indicate better performance.

Table 8-10 presents the percentage of procedure codes associated with validated dates of service from the encounter data that were correctly coded based on the members' dental records.

Table 8-10—Accuracy Results for Procedure Code

PAHP	Number of Procedure Codes Present in Both Sources	Accuracy Rate
DDIA	418	94.5%
MCNA	407	89.7%
Statewide	**825**	**93.7%**

Table 8-11 presents the percentage of dates of service present in both DHS' encounter data and the dental records with the same values for the key data element (i.e., *Procedure Code*). The denominator is the total number of dates of service that matched in both data sources. The numerator is the total number of dates of service where the encounter data dental procedure code has the same values as the dental procedure code documented in the dental record. Higher all-element accuracy rates indicate that the values populated in DHS' encounter data are more accurate and complete for the key data element when compared to dental records.

Table 8-11—All Element Accuracy

PAHP	Number of Dates of Service Present in Both Sources	Accuracy Rate
DDIA	141	52.5%
MCNA	123	32.5%
Statewide	**264**	**49.2%**

Statewide Conclusions and Recommendations

HSAG performed a comprehensive assessment of the performance of each MCE and of the overall strengths and weaknesses of the Iowa Medicaid managed care program related to the provision of healthcare services. All components of each EQR activity and the resulting findings were thoroughly analyzed and reviewed across the continuum of program areas and activities that comprise the Iowa Medicaid managed care program.

Strengths

Through this all-inclusive assessment of aggregated performance, HSAG identified several areas of strength in the program.

- **Pregnancy Care**—By mandating a statewide PIP related to postpartum care, DHS has prioritized the health and wellbeing of mothers and infants to address the underlying causes of maternal and infant mortality and pregnancy-related complications that can be reduced by increasing access to quality preconception (before pregnancy), prenatal (during pregnancy), and interconception (between pregnancies) care. Additionally, healthy birth outcomes and early identification and treatment of developmental delays and disabilities and other health conditions among infants can prevent death or disability and enable children to reach their full potential.[9-1] According to the Iowa Department of Public Health's March 2020 Maternal Mortality Review Committee Report, Iowa's pregnancy-related maternal mortality was 9.4 deaths per 100,000 live births overall. The rate for non-Hispanic White women was 6.0, for non-Hispanic Black women 36.9, for Asian/Pacific Islander 23.5, and for Hispanic women 9.7. Of the 39 maternal deaths reviewed, most (56 percent) occurred postpartum.[9-2] Furthermore, according to the Centers for Disease Control and Prevention (CDC), Iowa has an infant mortality rate of 5.1 infant deaths per 1,000 live births.[9-3] Through the implementation of PIPs focusing on postpartum care, the MCOs' identification of barriers and subsequent interventions should result in improved overall health outcomes for Iowa mothers and their babies. Additionally, the MCOs should see improvements in their HEDIS rates related to the *Prenatal and Postpartum Care* measure, for which Amerigroup Iowa is performing below the national Medicaid 50th percentile.

9-1 Office of Disease Prevention and Health Promotion. Healthy People 2020: Maternal, Infant, and Child Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/maternal-infant-and-child-health. Accessed on: Feb 2, 2021.

9-2 Iowa Department of Public Health. Protecting and Improving the Health of Iowans. Re: Iowa's Maternal Mortality Review Committee Report, letter, March 5, 2020. Available at: https://idph.iowa.gov/Portals/1/userfiles/38/Final%202020%20MMRC%20report.pdf. Accessed on: Feb 1, 2021.

9-3 Centers for Disease Control and Prevention. National Center for Health Statistics: Iowa. Available at: https://www.cdc.gov/nchs/pressroom/states/iowa/ia.htm. Accessed on: Feb 2, 2021.

- **Accessibility to Physical Healthcare**—Accessibility to healthcare is important for the health and wellbeing of children, adolescents, and adults and provides an opportunity for members to receive preventive services, including vaccines, screenings, and counseling to address acute issues, manage chronic conditions, reduce nonurgent ED visits and inpatient stays, and reduce the significant costs associated with unmanaged healthcare. Members' accessibility to care is a priority for DHS, as evidenced by Iowa's quality strategy objectives, and the conclusions drawn from HSAG's comprehensive assessment of the MCOs through various EQR activities indicate adult and child members have access to primary care for physical and behavioral health services and are obtaining the preventive care they need, including immunizations, to maintain optimal health.[9-4]
  - The MCO PIP related to well-child visits for members 3 to 6 years of age demonstrated statistically significant improvement from the baseline rate in 2017.
  - HEDIS rates for the *Adults' Access to Preventive/Ambulatory Health Services* and *Children and Adolescents' Access to Primary Care Practitioners* indicators and all measure rates within the Keeping Kids Healthy domain performed at or above the national Medicaid 50th percentile, with nine of 15 measure rates performing at or above the 75th percentile.
  - All HEDIS rates under the *Comprehensive Diabetes Care* and *Controlling High Blood Pressure* measures performed at or above the national Medicaid 50th percentile, with five of seven measure rates performing at or above the 75th percentile.
  - Member satisfaction, as measured through CAHPS, indicated adult members reported better experiences related to the *Getting Needed Care* (how easy it is to get care from their doctor and from specialists) and *Rating of All Health Care* (overall satisfaction with health care) measures, in comparison to national averages.
- **Encounter Data**—Through the EDV study findings, the MCEs demonstrated that they are able to submit encounter data to DHS that are relatively complete and accurate. The availability of accurate and complete encounter data is important to the effective operation and oversight of the MCEs that serve members covered by Medicaid and CHIP.

Weaknesses

HSAG's comprehensive assessment of the MCEs and the Iowa Medicaid managed care program also identified areas of focus that represent significant opportunities for improvement within the program.

- **Accessibility to Dental Healthcare**—Oral health is essential to a person's overall health and wellbeing. Good oral health improves a person's ability to speak, smile, smell, taste, touch, chew, swallow, and make facial expressions to show feelings and emotions.[9-5] Although both adult and child members have access to dental benefits through the Iowa Medicaid managed care program and the PAHPs have a sufficient number of dental providers as supported by the NAV results, members

[9-4] While some of the MCO-related conclusions in this annual assessment are based on performance data from Amerigroup Iowa only, Amerigroup Iowa's membership comprises 60 percent of the overall Medicaid managed care enrollment.

[9-5] Office of Disease Prevention and Health Promotion. Healthy People 2020: Oral Health. Available at: https://www.healthypeople.gov/2020/topics-objectives/topic/oral-health. Accessed on: Feb 1, 2021.

are not obtaining dental care as demonstrated through lower-performing PAHP performance measure rates, ineffective interventions, the PAHPs' failure to achieve statistically significant improvement as identified through the dental PIP activity, and compliance issues within the Practice Guidelines standard that could be preventing members from receiving the appropriate resources and materials to understand the importance of dental care.

  - Delta Dental of Iowa and Managed Care of North America Dental experienced rate decreases from CY 2019 to CY 2020 for the following performance measures: *Members Who Accessed Dental Care* and *Members Who Received Preventive Dental Care*. Additionally, the CY 2020 rates overall for the *Members Who Received Preventive Dental Care* measure could be improved as Delta Dental of Iowa's rate was 75.10 percent and Managed Care of North America Dental's rate was 63.13 percent.
  - Delta Dental of Iowa and Managed Care of North America Dental overall PIP validation statuses for CY 2020 were *Not Met* as neither PAHP achieved statistically significant improvement over the baseline rate, indicating their interventions may not be effective at reducing barriers or improving members' adherence to recommended dental care.
  - The statewide compliance review score in the Practice Guidelines standard was 17 percent, as Delta Dental of Iowa had not adopted CPGs and Managed Care of North America Dental did not have an adequate process for disseminating the guidelines to all applicable providers. CPGs are intended to assist dental professionals in clinical decision making and help incorporate evidence gained through scientific investigation into patient care. Additionally, PAHPs are required under federal rule to use the CPGs to make utilization management decisions and provide CPG-aligned education to members regarding appropriate dental care.

- **Provider Directories—**Complete and accurate provider information within an MCE's provider directory is an important resource for members to locate providers who meet their own individual needs. Additionally, inaccurate telephone numbers and location information may create barriers to accessing care. However, issues identified through the NAV and compliance review activities indicated members may not have comprehensive, accurate, and up-to-date provider information readily available to assist them in choosing an appropriate provider, as needed, to establish preventive and medically necessary care and services.
  - As determined through the provider directory validation activity, Amerigroup Iowa's online provider directory did not include provider URLs for more than 99 percent of its providers. Having access to a provider URL can provide members with an additional resource for evaluating the provider and to gain more information about that provider's particular practice. Iowa Total Care's online provider directory had discrepant provider telephone numbers in 37 percent of the providers reviewed, indicating members could be challenged with contacting a provider to make an appointment for services. Additionally, Iowa Total Care's online directory did not include complete accessibility documentation for 52 percent of the providers reviewed, which could pose a barrier for members to select a provider who can accommodate their disabilities.
  - The Member Information and Member Rights compliance review standard was the second lowest-scoring standard during the CY 2020 review, indicating members may not have timely and adequate information available via the provider directory. While Amerigroup Iowa had a

wheelchair accessible indicator assigned to providers who had some accessibility accommodations, no further information was available for members to assess the provider's capability to support members with disabilities, such as wide entries, accessible exam tables and rooms, lifts, scales, bathrooms, grab bars, or other equipment. While Iowa Total Care scored well overall in the Member Information and Member Rights standard, the PAHP's online provider directory did not include information about organizational providers' cultural competency, which could assist members in selecting a provider that can deliver healthcare services that meet their specific social, cultural, and linguistic needs.

Quality Strategy Recommendations for the Iowa Medicaid Managed Care Program

The Iowa Medicaid Managed Care Quality Assurance System was designed to improve member health outcomes, improve member experience, and ensure that the Medicaid programs are financially sustainable. In consideration of the goals of this quality strategy and the comparative review of findings for all activities, HSAG recommends the following QI initiatives, which focus on improving member access to dental services and ensuring complete and accurate information is available to members, and target objectives #1, 2, and 8 within the Iowa Medicaid Managed Care Quality Assurance System.

Objective #1: Promote appropriate utilization of services within acceptable standards of medical/dental practice.

Objective #2: Ensure access to cost-effective healthcare through contract compliance.

Objective #8: Ensure data collection of race and ethnicity, as well as aid category, age, and gender in order to develop meaningful objectives for improvement in preventive and chronic health and dental care by focusing on specific populations.

- To understand the barriers Iowa Medicaid members may face when accessing dental services and to better understand why members may not seek dental care, HSAG recommends that DHS consider requiring the PAHPs to conduct a CAHPS Dental Plan Survey or another similar type of survey that assesses the members' needs for dental care, use of dental services and transportation to visits, and self-perceived oral health status.
  - DHS and/or the PAHPs should obtain a statistically significant sample of members to ensure complete representation of the Medicaid population enrolled in Iowa Medicaid managed care.
  - DHS should consider requiring survey indicators that can track general respondent demographic information, such as ZIP Code, gender, race/ethnicity, age, etc., to allow DHS and the PAHPs to stratify the responses and identify potential disparities within the population.
  - DHS and the PAHPs should use the results of the survey to design programs and interventions to improve access to dental care (e.g., targeted education, promotion of mobile clinics, active outreach initiatives such as health fairs, etc.) and remove barriers members face to accessing dental care (e.g., transportation, oral health literacy, and SDoH).
- To improve members' access to comprehensive, accurate, and up-to-date provider information, HSAG recommends that DHS host a QI workgroup with the MCEs, and other stakeholders as

appropriate, to develop standardized formats for displaying provider data in the MCE provider directories. The goal of the workgroup should be to enhance members' ability to select a provider who can best support their healthcare, cultural, and social needs, thereby promoting trusting relationships between patients and providers and facilitating more meaningful engagement.

- In alignment with CMS' guidance within the Federal Register,[9-6] DHS should lead the effort to determine how the provider directory information related to cultural competence data should be collected and displayed in clear, consistent, and meaningful ways to ensure consistency across the Medicaid managed care and FFS programs.
- DHS, the MCEs, and other stakeholders can explore methods to enhance provider data collection efforts during the IME enrollment and MCE contracting and credentialing processes. The workgroup could determine data fields within the provider applications that must be completed before the applications are accepted by IME and/or the MCEs (e.g., disability accommodations and accessible equipment available at the provider location, provider website/URL information, cultural and linguistic capabilities).
- DHS, the MCEs, and other stakeholders can consider how they may collaborate and leverage resources to reduce duplication of efforts at IME, the MCEs, and the providers offices to obtain up-to-date provider information related to practice location additions and changes, provider contact information, etc. The workgroup could consider whether a universal platform could be used by all entities to collect updated provider data and make applicable changes to their directories in a timely manner.

[9-6] Federal Register: The Daily Journal of the United States Government. Medicaid Program; Medicaid and Children's Health Insurance Program (CHIP) Managed Care. Available at: https://www.federalregister.gov/documents/2020/11/13/2020-24758/medicaid-program-medicaid-and-childrens-health-insurance-program-chip-managed-care. Accessed on: Feb 17, 2021.

Appendix A. External Quality Review Activity Methodologies

MCO Activity Methodologies

Validation of Performance Improvement Projects

Activity Objectives

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

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

For the continuing PIP topics, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012.[A-1] For the PIP topics initiated in 2020, HSAG used the Centers for Medicare & Medicaid Services (CMS) *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019.[A-2] 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 MCOs 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.

[A-1] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 17, 2021.

[A-2] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 1. Validation of Performance Improvement Projects (PIPs): A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

2. HSAG evaluates the implementation of the PIP. Once, designed, the PIP's effectiveness in improving outcomes depends on the systematic data collection process, analysis of data, and the identification of barriers and subsequent development of relevant interventions. Through this component, HSAG evaluates how well the MCOs improve its rates through implementation of effective processes (i.e., barriers analyses, intervention design, and evaluation results).

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with DHS, developed the PIP Summary Form. Each MCO completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

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

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

Step I. Appropriate Study Topic
Step II. Clearly Defined, Answerable Study Question(s)
Step III. Correctly Identified Study Population
Step IV. Clearly Defined Study Indicator(s)
Step V. Valid Sampling Techniques (if sampling was used)
Step VI. Accurate/Complete Data Collection
Step VII. Sufficient Data Analysis and Interpretation
Step VIII. Appropriate Improvement Strategies
Step IX. Real Improvement Achieved
Step X. Sustained Improvement Achieved

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

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

score when enhanced documentation would have demonstrated a stronger understanding and application of the PIP activities and evaluation elements.

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

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

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*

The MCOs 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 Comments, regardless of whether the evaluation element was critical or noncritical. HSAG conducted a final validation for any resubmitted PIPs. HSAG offered technical assistance to any MCO that requested an opportunity to review the initial validation scoring prior to resubmitting the PIP.

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

Description of Data Obtained and Related Time Period

For CY 2020, the MCOs submitted their PIP Design (Steps I through VI) for the two topics initiated in 2020. The MCOs used CAHPS measure specifications for the *Customer Service at Child's Health Plan Gave Information or Help Needed* performance indicator and HEDIS measure specifications for the *Timeliness of Postpartum Care* performance indicator. Amerigroup Iowa submitted Remeasurement 2 data (Steps I through VIII) for its existing topics, using CAHPS measure specifications for the *Member Satisfaction* performance indicator and HEDIS measure specifications for the *Well-Child Visits in the Third, Fourth, Fifth, and Sixth Years of Life* performance indicator. HSAG obtained the data needed to conduct the PIP validation from the MCOs' PIP Summary Form. These forms provided data and detailed information about each of the PIPs and the activities completed. The MCOs submitted each PIP Summary Form according to the approved timeline. After initial validation, the MCOs received HSAG's feedback and technical assistance and resubmitted the PIP Summary Form for final validation. Table

A-1 displays the study indicator measurement periods for the new PIP topics, and Table A-2 displays the measurement periods for the existing topics.

Table A-1—MCO Data Obtained and Measurement Periods for New PIP Topics

Data Obtained	Measurement Period
Baseline	January 1, 2020—December 31, 2020
Remeasurement 1	January 1, 2021—December 31, 2021
Remeasurement 2	January 1, 2022—December 31, 2022

Table A-2—AGP Data Obtained and Measurement Periods for Existing PIP Topics

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

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by MCOs and to determine the extent to which performance measures reported by the MCOs follow state specifications and reporting requirements. HSAG also followed the guidelines set forth in CMS' *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[A-3]

DHS identified a set of performance measures that the MCOs were required to calculate and report. These measures were required to be reported following the measure specifications provided by DHS.

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:

- **ISCAT**—The MCOs were required to submit a completed Information Systems Capabilities Assessment Tool (ISCAT) that provided information on their information systems; processes used for collecting, storing, and processing data; and processes used for performance measure calculation

[A-3] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity,* October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

of the required DHS-developed measures. HSAG reviewed all documentation, noting any potential issues, concerns, and items that needed additional clarification.

- **Source code (programming language) for performance measures**—The MCOs 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 DHS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). MCOs 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 MCOs 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.

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 DHS for validation.

In collaboration with DHS, HSAG prepared a documentation request letter that was submitted to the MCOs, 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 MCOs to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the MCOs.

Approximately two weeks prior to the PMV virtual review, HSAG provided MCOs 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 MCOs to discuss review logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the MCOs.

PMV Review Activities

HSAG conducted a virtual review with each MCO. HSAG collected information using several methods including interviews, system demonstration, review of data output files, PSV, observation of data processing, and review of data reports. The virtual review activities included the following:

- **Opening and organizational review**—This interview session included introductions of HSAG's validation team and key MCO staff involved in the support of the MCO'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 MCO 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 MCO's ISCAT responses, these interview sessions involved key MCO staff responsible for maintaining the information systems and executing the processes necessary to produce the performance measure rates. HSAG conducted interviews to confirm findings based on its documentation review, expanded or clarified outstanding questions, and ascertained that written policies and procedures were used and followed in daily practice. Specifically, HSAG staff evaluated the systems and processes used in the calculation of selected performance measures.
  - **Enrollment, eligibility, provider, and claims/encounter systems and processes**—These evaluation activities included a review of key information systems and focused on the data systems and processes critical to the calculation of measures. HSAG conducted interviews with key staff familiar with the collection, processing, and monitoring of the MCO data used in producing performance measures.
  - **Overview of data integration and control procedures**—This session included a review of the database management systems' processes used to integrate key source data and the MCO's calculation and reporting of performance measures, including accurate numerator and denominator identification and algorithmic compliance (which evaluated whether rate calculations were performed correctly, all data were combined appropriately, and numerator events were counted accurately).
  - **System demonstrations**—HSAG staff requested that MCO 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 MCOs had appropriately applied measure specifications for accurate rate reporting. The MCO provided HSAG with a listing of the data the MCO had reported to DHS from which HSAG randomly selected a sample of cases and requested that the MCO provide proof of service documentation. During the virtual review, these data were reviewed live in the MCO's systems for verification. This approach enabled the MCO to explain its processes regarding any exception processing or unique, case-specific nuances that may or may not impact final measure reporting.

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 MCO. The completed ISCATs provided HSAG with background information on the MCOs' 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 MCO (if applicable). If the MCOs did not produce source code to generate the performance indicators, the MCOs 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 provided by the MCOs.
- **Current Performance Measure Results**—HSAG obtained the calculated results from the MCOs.
- **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 MCO staff members as well as through systems demonstrations.

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

Table A-3—Description of MCO Data Sources

Data Obtained	Time Period to Which the Data Applied	
	AGP	ITC
Completed ISCAT	SFY 2019 SFY 2020	SFY 2020
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	October 6, 2020	October 7, 2020

Compliance Review

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the EQR of compliance with standards for the Iowa Medicaid managed care program addresses HSAG's:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the MCO's performance.

Activity Objectives

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

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

To accomplish its objective, and based on the results of collaborative planning with DHS, HSAG developed and used a data collection tool to assess and document the MCO's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHS contractual requirements. Beginning in CY 2018, DHS has requested that HSAG conduct compliance reviews over a three-year cycle with one-third of the standards being reviewed each year. The division of standards over the three years can be found in Table A-4.

The review tool developed for this year's review (CY 2020) included requirements that addressed the following performance areas:

- Standard V—Provider Selection
- Standard VI—Member Information and Member Rights
- Standard VIII—Enrollment and Disenrollment
- Standard X—Subcontractual Relationships and Delegation
- Standard XIII—Health Information Systems

Table A-4—Three-Year Cycle of Compliance Reviews

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

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

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

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHS and the MCO as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[A-4] for the following activities:

Pre-Virtual Review Activities

Pre-virtual review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the MCO a pre-audit information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-audit preparation session with the MCO.
- Conducting a pre-virtual desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHS, and of documents the MCO submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the MCO's operations, identify areas needing clarification, and begin compiling information before the virtual review.
- Generating a list of 10 sample records each for initial credentialing, recredentialing, and organization credentialing from the list of providers submitted to HSAG from the MCO.
- Generating a list of five sample records of subcontractors from the list of subcontractors submitted to HSAG from the MCO.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the MCO to facilitate preparation for HSAG's review.

[A-4] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 21, 2021.

Virtual Review Activities

Virtual review activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the MCO have available virtually.
- A review of credentialing and delegation records HSAG requested from the MCO.
- A review of the data systems that the MCO used in its operation such as credentialing, provider network management, and enrollment and disenrollment.
- Interviews conducted with the MCO's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- MCO-maintained records for credentialing and delegation oversight.
- MCO's online member handbook and provider directory.

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

Table A-5 lists the major data sources HSAG used in determining the MCO's performance in complying with requirements and the time period to which the data applied.

Table A-5—Description of MCO Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	November 1, 2019—April 30, 2020
Information obtained through interviews	August 24, 2020

Data Obtained	Time Period to Which the Data Applied
Information obtained from a review of a sample of credentialing records for file reviews	Providers who completed the credentialing process between November 1, 2019—April 30, 2020
Information obtained from a review of a sample of delegation records for file reviews	Subcontractors in effect as of April 30, 2020

HSAG used scores of *Met* and *Not Met* to indicate the degree to which the MCO's performance complied with the requirements. A designation of *NA* was used when a requirement was not applicable to an MCO during the period covered by HSAG's review. This scoring methodology is consistent with CMS' *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. The protocol describes the scoring as follows:

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

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

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

- There is compliance with all documentation requirements, but staff members are unable to consistently articulate processes during interviews.
- Staff members can describe and verify the existence of processes during the interviews, but documentation is incomplete or inconsistent with practice.
- No documentation is present and staff members have little or no knowledge of processes or issues addressed by the regulatory provisions.
- For those provisions with multiple components, key components of the provision could 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 of the standards and an overall percentage-of-compliance score across the standards. HSAG calculated the total score for each standard by totaling the number of *Met* (1 point) elements and the number of *Not Met* (0 points) elements, then dividing the summed score by the total number of applicable elements for that standard. Elements *Not Applicable* to the MCO were scored *NA* and were not included in the denominator of the total score.

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

For the member handbook, provider directory, and member rights checklists reviewed, HSAG scored each applicable element within the checklist as either (1) *Yes*, the element was contained within the

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

HSAG conducted file reviews of the MCO's records for credentialing and delegation to verify that the MCO had put into practice what the MCO had documented in its policy. HSAG selected 10 records of each type of credentialing record (initial credentialing, recredentialing, and organization credentialing) from the full universe of records provided by the MCO. HSAG also selected five records from the list of subcontractors provided by the MCO. The file reviews were not intended to be a statistically significant representation of all the MCO's files. Rather, the file reviews highlighted instances in which practices described in policy were not followed by MCO staff members. Based on the results of the file reviews, the MCO must determine whether any area found to be out of compliance was the result of an anomaly or if a more serious breach in policy occurred. Findings from the file reviews were documented within the applicable standard and element in the compliance review tool.

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

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

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

Network Adequacy Validation

Activity Objectives

The goal of the PDV was to determine if the information in the MCOs' online provider directories found on the respective MCOs' websites aligned with the data in the provider files submitted by the health

plans. This analysis assessed the accuracy of the provider directories in order to ensure members have adequate and accurate provider demographic and contact information.

Technical Methods of Data Collection and Analysis

The provider reviews were conducted on a sample of PCPs and OB/GYN providers enrolled with at least one of the two MCOs as of July 1, 2020. HSAG then defined a subgroup of active, office-based providers based on provider type and specialty (i.e., the sample frame). Table A-6 lists the provider categories included in the sample frame. The provider categories were identified by a combination of provider specialty and provider type.

Table A-6—Provider Categories Included in the Provider Directory Validation

Provider Category	Provider Specialties
PCPs	• Family Practice • General Practice • Internal Medicine • Physician Assistant • Nurse Practitioner • Pediatric Medicine
OB/GYN Providers	• Obstetrics • Gynecology • Nurse Midwife • Nurse Practitioner

A two-stage random sampling approach was used to generate a list of providers and provider locations for inclusion in the PDV. For each MCO, HSAG selected a statistically valid sample from the list of providers, based on a 95 percent confidence level and ±5 percent margin of error. Using the list of providers identified in the sample, HSAG identified all locations associated with those providers for each MCO. To prepare the sample for the validation, HSAG randomly selected a single provider location for each provider in the sample.

Provider Directory Validation: HSAG reviewers used an internally developed tool that displayed provider data submitted by the MCOs to capture the results of the validation. Reviewers validated each of the sampled providers by comparing the data displayed in the tool to the information found in each MCO's online provider directory. If the provider's identifying information and location were not found in the online provider directory, the reviewer noted the information and stopped the review. If the provider's sampled identifying information and location were found in the online provider directory, the reviewer noted the information and continued with the review. The reviewers compared 11 provider demographic indicators (Table A-7) against the information found in the online provider directories. Exact matches were noted, and other outcomes were classified accordingly. An additional five provider services indicators (Table A-7) were assessed as present or not present in the online provider directories. For example, for the provider services indicator Provider Completed Cultural Competency Training,

HSAG reviewers determined whether the information was present, rather than determining if the provider had actually completed the training.

Table A-7—List of Indicators for the PDV

Provider Demographic Indicators	Provider Services Indicators
Provider First Name	Provider Accommodates Physical Disabilities
Provider Middle Name	Provider Completed Cultural Competency Training
Provider Last Name	Non-English Language Speaking Provider
Provider Address 1	Provider Office Hours
Provider Address 2	Provider URL
Provider City	
Provider State	
Provider Zip Code	
Provider Telephone Number	
Provider Specialty	
Provider Accepting New Patients	

Study Indicators and Analysis

PDV responses were used to compare information found in the provider data submitted by the MCOs versus the information found in the MCOs' provider directories. The indicators and analyses of the PDV addressed four main objectives:

- **MCO directory validation:** For each MCO, HSAG reviewed the MCO directory to assess the presence of specific federal and Medicaid MCO contract requirements in the online provider directories.
- **Identification of the providers in the online directory:** Information on whether the sampled provider and the sampled provider location were found in the online directory. The information did not have to be an exact match (e.g., small variations in address, provider name misspellings). If the sampled provider and the sampled provider location could not be located in the survey, the PDV review could not continue.
- **Provider data accuracy:** For each MCO, HSAG assessed the degree to which the provider demographic information submitted by the MCOs exactly matched the information found in the online provider directories.
- **Provider data availability:** For each MCO, HSAG assessed the degree to which the provider services information was available in the online provider directories.

Description of Data Obtained and Related Time Period

HSAG obtained Medicaid provider information (including practice location and specialty) from the MCOs for all providers enrolled as of July 1, 2020. Upon receipt of the data, HSAG defined a subgroup of active, office-based PCP and OB/GYN providers based on provider type and specialty.

Encounter Data Validation

Activity Objectives

In 2020, HSAG completed CY 2019 EDV activities for the following three MCOs: Amerigroup Iowa, Iowa Total Care, and UnitedHealthcare. Because CY 2019 was the first year Iowa Total Care submitted encounter data to DHS, HSAG conducted an information systems (IS) review. The goal of the IS review is to understand and assess whether the IS infrastructures are likely to produce complete and accurate complete and accurate encounter data. For Amerigroup Iowa and UnitedHealthcare, HSAG had previously conducted an IS review (CY 2016), an administrative profile—analysis of the DHS' electronic encounter data completeness, accuracy, and timeliness (CY 2017), and a comparative analysis—analysis of DHS' electronic encounter data completeness and accuracy through a comparative analysis between DHS' electronic encounter data and the data extracted from the MCOs' data systems (CY 2018). MRR would typically follow a comparative analysis activity. However, MRR is a complex, resource-intensive process, which requires a sufficient level of completeness and accuracy of DHS' encounter data prior to conducting the MRR activity. As such, based on the CY 2018 results of the comparative analysis, DHS and HSAG determined that an MRR activity was not recommended during CY 2019 study for Amerigroup Iowa and UnitedHealthcare. Therefore, for these MCOs HSAG conducted a comparative analysis along with technical assistance to ensure that discrepancies identified in CY 2018 study were addressed, and to determine if the level of completeness and accuracy of DHS' encounter data was sufficient for future MRR activities.

Technical Methods of Data Collection and Analysis

Information Systems Review

The IS review seeks to define how each participant in the encounter data process collects and processes encounter data such that the data flow from the MCOs to DHS is understood. The IS review is key to understanding whether the IS infrastructures are likely to produce complete and accurate encounter data. To ensure the collection of critical information, HSAG employs a three-stage review process that includes a document review, development and fielding of a customized encounter data assessment, and follow-up with key staff members. Of note, HSAG conducted this activity for Iowa Total Care only because HSAG conducted the IS review activity for Amerigroup Iowa and UnitedHealthcare during CY 2016.

Stage 1—Document Review

HSAG initiated the IS review with a thorough desk review of documents related to encounter data initiatives/validation activities currently put forth by DHS. Documents reviewed included data

dictionaries, process flow charts, data system diagrams, encounter system edits, and DHS' current encounter data submission requirements, among others. The information obtained from this review is important for developing the targeted questionnaire to address specific topics of interest for DHS.

Stage 2—Development and Fielding of Customized Encounter Data Assessment

HSAG, in collaboration with DHS, developed a questionnaire customized to gather both general information and specific procedures for data processing, personnel, and data acquisition capabilities. Where applicable, this assessment included a review of supplemental documentation regarding other data systems, including enrollment and providers. Appendix A of the CY 2019 Managed Care Organization (MCO)Encounter Data Validation Report contains the blank questionnaire provided to the MCO.

The questionnaire domains are listed below:

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

Stage 3—Key Personnel Follow-Up

After reviewing the completed assessment, HSAG followed up with emails to key MCO information technology personnel to clarify any questions from the questionnaire responses.

In summary, the IS review allowed HSAG to document current processes and develop a thematic process map identifying critical points that impacted the submission of quality encounter data. From this review, HSAG provided actionable recommendations based on the existing encounter data systems.

Comparative Analysis

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

- Data extraction—Data were extracted based on the data requirements document.
- Percentage present—Required data fields are present on the file and have values in those fields.
- Percentage of valid values—The values are the expected values; e.g., valid ICD-10 codes in the diagnosis field.

- Evaluation of matching claim numbers—The percentage of claim numbers that matched between the data extracted from DHS' data warehouse and the MCOs' data submitted to HSAG.

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

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

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

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

Second, based on the number of records present in both data sources, HSAG examined completeness and accuracy for key data elements listed in Table A-8. The analyses focused on an element-level comparison for each element.

Table A-8—Key Data Elements for Comparative Analysis

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

Key Data Elements	Professional	Institutional	Pharmacy
Drug Quantity			√
Revenue Code		√	
Diagnosis-Related Group (DRG) Code		√	
Header Paid Amount		√	√
Detail Paid Amount	√	√	
Dispensing Fee			√

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

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

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

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

Technical Assistance

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

Description of Data Obtained and Related Time Period

HSAG used data from both DHS and the MCOs with dates of service between January 1, 2018, and December 31, 2018, to evaluate the accuracy and completeness of the encounter data. Both paid and denied encounters were included in the analysis. To ensure that the extracted data from both sources represented the same universe of encounters, the data targeted professional, institutional, and pharmacy encounters submitted to DHS on or before June 30, 2019. This anchor date allowed sufficient time for the encounters to be submitted, processed, and available for evaluation in the DHS data warehouse.

Consumer Assessment of Healthcare Providers and Systems Analysis

Activity Objectives

This activity assesses 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 Amerigroup Iowa: adult Medicaid and child Medicaid. Center for the Study of Services (CSS), an NCQA-certified vendor, administered the 2020 CAHPS surveys for Amerigroup Iowa.

The technical methods of data collection were through the CAHPS 5.0H Adult Medicaid Health Plan Survey to the adult population, and the CAHPS 5.0H Child Medicaid Health Plan Survey (with the CCC measurement set) to the child Medicaid population. Amerigroup Iowa used a mail only methodology for data collection. Respondents were given the option of completing the survey in Spanish.

CAHPS Measures

The survey questions were categorized into various measures of member experience. These measures included four global ratings, four composite scores, and three Effectiveness of Care measures for the adult population only. Additionally, five CCC composite measures/items were used for the CCC-eligible population. 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 and 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 Effectiveness of Care measures assessed the various aspects of providing assistance with smoking and tobacco use cessation.

Top-Box Score Calculations

For each of the four global ratings, the percentage of respondents who chose the top experience ratings (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 response or top-box score).

For each of the five composite measures and 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

Effectiveness of Care measures, 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.

NCQA National Average Comparisons

A substantial increase or decrease is denoted by a change of 5 percentage points or more. Colors are used to note substantial differences. A green arrow indicates a top-box score that was at least 5 percentage points greater than the 2019 NCQA national average. A red arrow indicates a top-box score that was at least 5 percentage points less than the 2019 NCQA national average.

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, 2019, and child members included as eligible for the survey were 17 years of age or younger as of December 31, 2019. Adult members and parents or caretakers of child members completed the surveys from February to May 2020.

PAHP Activity Methodologies

Validation of Performance Improvement Projects

Activity Objectives

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

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

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

Because the PIPs were initiated in 2018, HSAG used the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS) publication, *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*,

Version 2.0, September 2012.[A-5] HSAG's validation of PIPs includes two key components of the QI process:

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

Technical Methods of Data Collection and Analysis

The HSAG PIP Review Team consisted of, at a minimum, an analyst with expertise in statistics and study design and a clinician with expertise in performance improvement processes. HSAG, in collaboration with DHS, developed the PIP Summary Form. Each PAHP completed this form and submitted it to HSAG for review. The PIP Summary Form standardized the process for submitting information regarding the PIPs and ensured that all CMS PIP protocol requirements were addressed.

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

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

Step I. Review the Selected Study Topic
Step II. Review the Study Question(s)
Step III. Review the Identified Study Population
Step IV. Review the Selected Study Indicator(s) [A-6]
Step V. Review Sampling Methods
Step VI. Review the Data Collection Procedures
Step VII. Review Data Analysis and Interpretation of Study Results

[A-5] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *EQR Protocol 3: Validating Performance Improvement Projects (PIPs): A Mandatory Protocol for External Quality Review (EQR)*, Version 2.0, September 2012. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/eqr-protocol-3.pdf. Accessed on: Feb 17, 2021.

[A-6] DDIA's PIP will have two study indicators: one for the adult population, and one for the Hawki population.

Step VIII. Assess the Improvement Strategies

Step IX. Assess for Real Improvement

Step X. Assess for Sustained Improvement

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

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

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

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

- *Met*: High confidence/confidence in reported PIP results. All critical evaluation elements were *Met*, and 80 to 100 percent of all evaluation elements were *Met* across all activities.
- *Partially Met*: Low confidence in reported PIP results. All critical evaluation elements were *Met*, and 60 to 79 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Partially Met*.
- *Not Met*: All critical evaluation elements were *Met*, and less than 60 percent of all evaluation elements were *Met* across all activities; or one or more critical evaluation elements were *Not Met.*

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

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

Description of Data Obtained and Related Time Period

For CY 2020, the PAHPs submitted Remeasurement 1 data (Steps I through VIII) for their PIP topics. The PAHPs used a modified HEDIS measure specification for the *Annual Dental Visits* performance indicator specific to annual dental visits. Delta Dental used a modified CMS-416 measure specification for the *Annual Dental Visits* performance indicator specific to preventive dental visits. HSAG obtained the data needed to conduct the PIP validation from the PAHPs' PIP Summary Form. These forms provided data and detailed information about each of the PIPs and the activities completed. The PAHPs submitted each PIP Summary Form according to the approved timeline. After initial validation, the PAHPs received HSAG's feedback and technical assistance and resubmitted the PIP Summary Form for final validation. For CY 2020, the PAHPs submitted Remeasurement 1 data. The study indicator measurement period dates are listed below.

Table A-9—PAHP Data Obtained and Measurement Periods

Data Obtained	Measurement Period
Baseline	January 1, 2018—December 31, 2018
Remeasurement 1	January 1, 2019—December 31, 2019
Remeasurement 2	January 1, 2020—December 31, 2020

Performance Measure Validation

Activity Objectives

The purpose of PMV is to assess the accuracy of performance measures reported by PAHPs and to determine the extent to which performance measures reported by the PAHPs follow State specifications and reporting requirements. HSAG followed CMS' *EQR Protocol 2: Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019.[A-7]

DHS identified a set of performance measures that the PAHPs were required to calculate and report. These measures were required to be reported following the measure specifications provided by DHS. DHS identified the measurement period as July 1, 2019–June 30, 2020.

[A-8] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 2. Validation of Performance Measures: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

Technical Methods of Data Collection and Analysis

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

- **ISCAT**—The PAHPs were required to submit a completed ISCAT for HSAG's review of the required DHS-developed measures. HSAG used the responses from the ISCAT to complete the pre-Webex review assessment of information systems.
- **Source code (programming language) for performance measures**—The PAHPs that calculated the performance measures using source code were required to submit the source code used to generate each performance measure validated. HSAG completed a line-by-line review of the supplied source code to ensure compliance with the measure specifications required by DHS. HSAG identified any areas of deviation from the specifications, evaluating the impact to the measure and assessing the degree of bias (if any). PAHPs that did not use source code to generate the performance measures were required to submit documentation describing the steps taken for calculation of each of the required performance measures.
- **Supporting documentation**—The PAHPs 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.

Pre-Audit Strategy

HSAG conducted the validation activities as outlined in the CMS PMV Protocol. HSAG obtained a list of the performance measures selected by DHS for validation.

In collaboration with DHS, HSAG prepared a documentation request letter that was submitted to the PAHPs, 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 PAHP to submit the required information to HSAG. HSAG responded to any audit-related questions received directly from the PAHPs.

Approximately two weeks prior to the PMV virtual review, HSAG provided the PAHPs with an agenda describing all review activities and indicating the type of staff needed to participate in each session. HSAG also conducted a pre-review conference call with the PAHPs to discuss review logistics and expectations, important deadlines, outstanding documentation, and any outstanding questions from the PAHPs.

Webex Review Activities

HSAG conducted a virtual review with the PAHPs. 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 meeting**—The opening meeting included an introduction of the validation team and key PAHP staff members involved in the PMV activities. The review purpose, the required documentation, basic meeting logistics, and queries to be performed were discussed.
- **Review of ISCAT documentation**—This session was designed to be interactive with key PAHP staff so that the validation team could obtain a complete picture of all steps taken to generate responses to the ISCAT and evaluate the degree of compliance with written documentation. HSAG conducted interviews to confirm findings from the documentation review, expanded or clarified outstanding issues, and ascertained that written policies and procedures were used and followed in daily practice.
- **Evaluation of system compliance**—The evaluation included a review of the information systems, focusing on the processing of enrollment and disenrollment data. Additionally, HSAG evaluated the processes used to collect and calculate the performance measures, including accurate numerator and denominator identification, and algorithmic compliance (which evaluated whether the PAHP performed rate calculations correctly, combined data appropriately, and counted numerator events accurately). Based on the desk review of each ISCAT, HSAG conducted interviews with key PAHP staff familiar with the processing, monitoring, and calculation of the performance measures. HSAG used interviews to confirm findings from the documentation review, expand or clarify outstanding issues, and verify that the PAHP used and followed written policies and procedures in daily practice.
- **Overview of data integration and control procedures**—The overview included discussion and observation of source code logic, a review of how all data sources were combined, and a review of how the analytic file was produced for the reporting of selected performance measure data. HSAG reviewed backup documentation on data integration and addressed data control and security procedures during this session.
- **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. Each PAHP provided HSAG with a listing of the data the PAHP had reported to DHS, from which HSAG selected a sample. HSAG selected a systematic sample from the submitted data and requested that the PAHP provide proof of service documents or system screen shots that allowed for validation against the source data in the system. During the virtual review, these data were also reviewed live in the PAHP's systems for verification, which provided the PAHP an opportunity to explain its processes regarding any exception processing or unique, case-specific nuances that may not impact final measure reporting. There may be instances in which a sample case is acceptable based on virtual review clarification and follow-up documentation provided by the PAHP.

  Using this technique, HSAG assessed the processes used to input, transmit, and track the data; confirm entry; and detect errors. HSAG selected cases across measures to verify that the PAHPs

have system documentation which supports that the PAHP appropriately includes records for measure reporting. This technique does not rely on a specific number of cases for review to determine compliance; rather, it is used to detect errors from a small number of cases. If errors were detected, the outcome was determined based on the type of error. For example, the review of one case may have been sufficient in detecting a programming language error and as a result, no additional cases related to that issue may have been reviewed. In other scenarios, one case error detected may result in the selection of additional cases to better examine the extent of the issue and its impact on reporting.

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

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 PAHP. The completed ISCATs provided HSAG with background information on and the PAHPs' 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 PAHP (if applicable). If the PAHP did not produce source code to generate the performance indicators, the PAHP 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 provided by the PAHPS.
- **Current Performance Measure Results—**HSAG obtained the calculated results from the PAHPs.
- **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 On-Site Interviews and Demonstrations—**HSAG also obtained information through interaction, discussion, and formal interviews with key PAHP staff.

Table A-10 shows the data sources used in the validation of performance measures and the periods to which the data applied.

Table A-10—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied	
	DDIA	MCNA
Completed ISCAT	SFY 2020	
Source code for each performance measure		
Performance measure results		
Supporting documentation		
Virtual on-site interviews and systems demonstrations	October 8, 2020	October 9, 2020

Compliance Review

The following description of the way HSAG conducted—in accordance with 42 CFR §438.358—the external quality review (EQR) of compliance with standards for the DWP addresses HSAG's:

- Objective of conducting the review of compliance with standards.
- Compliance review activities and technical methods of data collection.
- Description of data obtained.
- Data aggregation and analysis.

HSAG followed standardized processes in conducting the review of the PAHP's performance.

Activity Objectives

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

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

To accomplish its objective, and based on the results of collaborative planning with DHS, HSAG developed and used a data collection tool to assess and document the PAHP's compliance with certain federal Medicaid managed care regulations, State rules, and the associated DHS contractual requirements. The CY 2020 compliance review begins the first year of a new three-year cycle of compliance monitoring reviews. HSAG will conduct compliance reviews in Year One and Year Two with one-half of the standards being reviewed each year. In Year Three, HSAG will conduct a full CAP

review (Year One and Year Two) to assess the PAHP's implementation of its CAPs. The division of standards over the three years can be found in Table A-11.

The review tool developed for this year's review (CY 2020) included requirements that addressed the following performance areas:

- Standard III—Coordination and Continuity of Care
- Standard IV—Coverage and Authorization of Services
- Standard VII—Confidentiality of Health Information
- Standard IX—Grievance and Appeal System
- Standard XI—Practice Guidelines
- Standard XII—Quality Assessment and Performance Improvement

Table A-11—Compliance Review Standards[A-8]

Year One (CY 2020)	Year Two (CY 2021)	Year Three (CY 2022)
Standard III—Coordination and Continuity of Care	Standard I—Availability of Services	Review of PAHP's implementation of Year One and Year Two CAPs
Standard IV—Coverage and Authorization of Services	Standard II—Assurances of Adequate Capacity and Services	
Standard VII—Confidentiality of Health Information	Standard V—Provider Network	
Standard IX—Grievance and Appeal System	Standard VI—Member Information and Member Rights	
Standard XI—Practice Guidelines	Standard VIII—Enrollment and Disenrollment	
Standard XII—Quality Assessment and Performance Improvement	Standard X—Subcontractual Relationships and Delegation	
	Standard XIII—Health Information Systems	

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

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

[A-8] While Table A-11 presents the three-year cycle DHS initially intended, DHS elected to begin a new three-year cycle in CY 2021 in order to align the MCO and PAHP compliance reviews. The new three-year cycle beginning in CY 2021 will be presented in future reports.

Technical Methods of Data Collection and Analysis

Before beginning the compliance review, HSAG developed data collection tools to document the review. The requirements in the tools were selected based on applicable federal and State regulations and laws and on the requirements set forth in the contract between DHS and the PAHP as they related to the scope of the review. HSAG also followed the guidelines set forth in the Centers for Medicare & Medicaid Services' (CMS') *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019[2-9] for the following activities:

Pre-review activities included:

- Scheduling the virtual reviews.
- Developing the compliance review tools.
- Preparing and forwarding to the PAHP a pre-audit information packet and instructions for completing and submitting the requested documentation to HSAG for its desk review.
- Hosting a pre-audit preparation session with the PAHP.
- Conducting a desk review of documents. HSAG conducted a desk review of key documents and other information obtained from DHS, and of documents the PAHP submitted to HSAG. The desk review enabled HSAG reviewers to increase their knowledge and understanding of the PAHP's operations, identify areas needing clarification, and begin compiling information before the virtual review.
- Generating a list of 10 sample records each for denials, grievances, and appeals from the list of cases submitted to HSAG from the PAHP.
- Developing the agenda for the one-day virtual review.
- Providing the detailed agenda to the PAHP to facilitate preparation for HSAG's review.

Virtual review[A-10] activities included:

- An opening conference, with introductions and a review of the agenda and logistics for HSAG's one-day review activities.
- A review of the documents HSAG requested that the PAHP have available virtually.
- A review of denial, grievance, and appeal records HSAG requested from the PAHP.
- A review of the data systems that the PAHP used in its operation such as authorization of services, grievances, appeals, and quality management.

[A-9] Department of Health and Human Services, Centers for Medicare & Medicaid Services. *Protocol 3: Review of Compliance with Medicaid and CHIP Managed Care Regulations: A Mandatory EQR-Related Activity*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 21, 2021.

[A-10] Due to the coronavirus disease 2019 (COVID-19) pandemic, the on-site review was conducted virtually through a Webex session.

- Interviews conducted with the PAHP's key administrative and program staff members.
- A closing conference during which HSAG reviewers summarized their preliminary findings, as appropriate.

Description of Data Obtained and Related Time Period

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

- Committee meeting agendas, minutes, and handouts.
- Written policies and procedures.
- Management/monitoring reports and audits.
- Narrative and/or data reports across a broad range of performance and content areas.
- PAHP-maintained records for denials, grievances, and appeals.
- PAHP's quality assessment and performance improvement (QAPI) program.

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

Table A-12 lists the major data sources HSAG used in determining the PAHP's performance in complying with requirements and the time period to which the data applied.

Table A-12—Description of PAHP Data Sources

Data Obtained	Time Period to Which the Data Applied
Documentation submitted for HSAG's desk review and additional documentation available to HSAG during the virtual review	November 1, 2019—April 30, 2020
Information obtained through interviews	August 28, 2020
Information obtained from a review of a sample of denial, grievance, and appeal records for file reviews	Cases closed between April 1, 2020—June 22, 2020

Network Adequacy Validation

Activity Objectives

The purpose of the network capacity and geographic distribution analyses was to determine the geographic distribution of the providers relative to member populations and to assess the capacity of a given provider network.

Technical Methods of Data Collection and Analysis

HSAG cleaned, processed, and defined the unique set of dental providers, dental provider locations, and members for inclusion in the analysis. All Medicaid member and dental provider files were standardized and geo-coded using Quest Analytics software. The final Medicaid population was limited to the PAHP members residing within the State of Iowa. The full dental provider network identified by the PAHPs was limited to provider locations within the State or locations in a county contiguous to the State. Table A-13 shows the provider specialties used to report the adequacy of the PAHPs' dental provider networks and includes general and specialist dental providers.

Table A-13—Dental Provider Categories and Access Standards

Provider Specialty	Criteria for Members	Access Standard
General Dental Providers		
General Dentist	All members enrolled in a PAHP	30 minutes or 30 miles for members in urban areas AND 60 minutes or 60 miles for members in rural areas [A-11]
Dental Specialists		
Orthodontist	All members enrolled in a PAHP	No Access Standard Available
Endodontist	All members enrolled in a PAHP	No Access Standard Available
Oral Surgeon	All members enrolled in a PAHP	No Access Standard Available
Pedodontist*	NA	NA
Periodontist	All members enrolled in a PAHP	No Access Standard Available
Prosthodontist	All members enrolled in a PAHP	No Access Standard Available

* A count of the number of pedodontists in the PAHP provider networks was provided in the report since pedodontists serve adult members ages 19 to 20 years and adult members with behavior management issues. Pedodontists were excluded from the provider ratio and time/distance analyses since most of the population served by these providers (i.e., children) are not included in this network analysis report.

Provider Capacity Analysis: HSAG calculated the provider-to-member ratio (provider ratio) for each dental provider specialty listed in Table A-13 for each PAHP. Specifically, the provider ratio measures the number of dental providers by provider specialty (e.g., general dentists, orthodontists) relative to the number of members. A lower provider ratio suggests the potential for greater network access since a

[A-11] Rural areas were defined as areas not designated as Metropolitan Statistical Areas (MSAs). Urban areas were defined as MSAs.

larger pool of dental providers is available [A-12] to render services to individuals. Provider counts for this analysis were based on unique dental providers and not provider locations.

Geographic Network Distribution Analysis: HSAG evaluated the geographic distribution of dental providers relative to the PAHPs' members. While the provider capacity analysis identified whether the network infrastructure was sufficient in both the number of dental providers and variety of specialties, the geographic network distribution analysis evaluated whether the number of dental provider locations in a PAHP's provider network was proportional to the PAHP's Medicaid population.

To provide a comprehensive view of geographic access, HSAG calculated the following two spatial-derived metrics for the provider specialties listed in Table A-13:

- Percentage of members within predefined access standards in Table A-13.[A-13] A higher percentage of members meeting access standards indicates better geographic distribution of PAHP providers in comparison to the PAHP's Medicaid members.
- Average travel distance (in miles) and travel time[A-14] (in minutes) to the nearest one to three dental providers: A smaller distance or shorter travel time indicates greater accessibility to dental providers since individuals must travel fewer miles or minutes to access care. The average travel distance and travel time were stratified by urbanicity and were shown for providers accepting new patients.

HSAG used Quest Analytics software to calculate the duration of travel time or physical distance between the addresses of specific members and the addresses of their nearest one to three dental providers. All study results were stratified by PAHP and urbanicity.

Description of Data Obtained and Related Time Period

HSAG obtained Medicaid member demographic information and corresponding dental provider network files from DHS. The data included information on:

- The member demographic data including key data elements such as unique member identifier, gender, age, and residential address as of July 31, 2020.
- The member eligibility and enrollment files including the start and end dates for the PAHP enrollment.

[A-12] The availability based on provider ratio did not account for key practice characteristics—i.e., panel status, acceptance of new patients, and practice restrictions. Instead, the provider ratio analysis should be viewed as establishing a theoretical threshold for an acceptable *minimum* number of dental providers necessary to support a given volume of members.

[A-13] The percentage of members within predefined standards was only calculated for provider categories with predefined access standards.

[A-14] Average drive time may not mirror driver experience based on varying traffic conditions. Instead, average drive time should be interpreted as a standardized measure of the geographic distribution of dental providers relative to Medicaid members; the shorter the average drive time, the more similar the distribution of providers is relative to members.

- The dental provider data including providers actively enrolled in a PAHP as of July 31, 2020. Some of the key data elements were unique provider identifier, enrollment status with the PAHPs, provider type, provider specialty, and service address as of July 31, 2020.

Encounter Data Validation

Activity Objectives

In alignment with the Centers for Medicare & Medicaid Services (CMS) external quality review (EQR) *Protocol 5. Validation of Encounter Data Reported by the Medicaid and CHIP Managed Care Plan: An Optional EQR-Related Activity*, October 2019,[A-15] HSAG conducted an information system review with the two PAHPs in CY 2018 since it was the first year that HSAG conducted a dental EDV for DHS. Then during CY 2019, HSAG conducted a comparative analysis between DHS' electronic encounter data and the data extracted from the two PAHPs' data systems and provided technical assistance to the PAHPs based on the findings. Finally, for CY 2020, HSAG conducted the following core evaluation activity for the EDV study:

- Dental record review—analysis of DHS' electronic dental encounter data completeness and accuracy by comparing DHS' electronic dental encounter data to the information documented in the corresponding members' dental records.

The goal of the dental record review was to evaluate the extent to which encounters submitted to DHS by the PAHPs were complete and accurate, through a review of the member's dental records associated with the dental services rendered during the study period. This step corresponds to the important validation activity described in the CMS protocol—i.e., review medical records.

Technical Methods of Data Collection and Analysis

As outlined in the CMS protocol, MRR is a complex and resource-intensive process. Medical and clinical records are considered the "gold standard" for documenting access and the quality of healthcare services. During CY 2020, HSAG evaluated dental encounter data completeness and accuracy through a review of dental records for dental services rendered between January 1, 2019, and December 31, 2019. This study answered the following question: *Are the data elements on the dental encounters complete and accurate when compared to information contained within the dental records?*

To answer the study question, HSAG conducted the following activities:

- Identified the eligible population and generated samples from data submitted by DHS for the study.
- Assisted the PAHPs to procure dental records from providers, as appropriate.

[A-15] 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*, October 2019. Available at: https://www.medicaid.gov/medicaid/quality-of-care/downloads/2019-eqr-protocols.pdf. Accessed on: Feb 17, 2021.

- Reviewed dental records against DHS' encounter data.
- Calculated study indicators based on the reviewed/abstracted data.
- Drafted and presented a report based on study results.

Key data elements associated with dental services evaluated in the dental record review included:

- Date of service.
- Current dental terminology (CDT) procedure code.

Study Population

To be eligible for the dental record review, a member had to be continuously enrolled in the same PAHP during the study period (i.e., between January 1, 2019, and December 31, 2019), and had to have at least one dental visit during the study period. In addition, members with other insurance coverages were excluded from the eligible population since DHS does not have complete encounter data for all services these members received.

Sampling Strategy

HSAG used a two-stage sampling technique to select 146 members [A-16] per PAHP based on the member enrollment and encounter data received from DHS. HSAG first identified all members who met the study population criteria. HSAG then randomly selected the members by PAHP based on the required sample size. Next, for each selected sample member, HSAG used the SURVEYSELECT procedure in SAS®[A-17] to randomly select one dental visit [A-18] that occurred in the study period (i.e., January 1, 2019, through December 31, 2019).

Since an equal number of cases were selected from each PAHP to ensure adequate sample size when reporting rates at the PAHP level, adjustments were required to calculate the statewide rates to account for population differences among the PAHPs. When reporting statewide rates, HSAG weighted each PAHP's raw rates based on the volume of dental visits among the eligible population for that PAHP. This approach ensured that no PAHP was over- or under-represented in the statewide rates.

Dental Record Procurement

Upon receiving the final sample list from HSAG, the PAHPs were responsible for procuring the sampled members' dental records from their contracted providers for services that occurred during the study

[A-16] The sample size of 146 is based on a 90 percent confidence level and a margin of error of 7 percent.

[A-17] 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.

[A-18] To ensure that the dental record review included all services provided on the same date of service, encounters with the same date of service and same rendering provider were consolidated into one visit for sampling purposes.

period. In addition, the PAHPs were responsible for submitting the documentation to HSAG. To improve the procurement rate, HSAG conducted a one-hour technical assistance session with the PAHPs to review the EDV project and the procurement protocols after distributing the sample list. The PAHPs were instructed to submit dental records electronically via a secure file transfer protocol site to ensure the protection of personal health information. During the procurement process, HSAG worked with the PAHPs to answer questions and monitor the number of dental records submitted. For example, HSAG provided an initial submission status update when 40 percent of the records were expected to be submitted and a final submission status update following completion of the procurement period.

All electronic dental records HSAG received were maintained on a secure site, which allowed HSAG's trained reviewers to validate the cases from a centralized location under supervision and oversight. As with all record reviews and research activities, HSAG maintains a thorough Health Insurance Portability and Accountability Act of 1996 (HIPAA) compliance and protection program in accordance with federal regulations that includes recurring training as well as policies and procedures that address physical security, electronic security, and day-to-day operations.

Review of Dental Records

HSAG's experienced dental record reviewers were responsible for abstracting the dental records. To successfully complete the study, the project lead worked with the dental record review team beginning with the methodology phase. The dental record review team was involved with the tool design phase, as well as the tool testing to ensure that the abstracted data were complete and accurate. Based on the study methodology, clinical guidelines, and the tool design/testing results, the dental record review team drafted an abstraction instruction document specific to the study for training purposes. Concurrent with record procurement activities, the dental record review team trained the dental record reviewers on the specific study protocols and conducted interrater reliability and rater-to-standard testing. All dental record reviewers had to achieve a 95 percent accuracy rate for the training/testing cases before they could begin to review dental records.

During the dental record review activity, HSAG's trained reviewers collected and documented findings in an HSAG-designed electronic data collection tool. The tool was designed with edits to assist in the accuracy of data collection. The validation included a review of specific data element(s) identified in the sample cases and compared to corresponding documentation in the dental record. Interrater reliability among reviewers, as well as reviewer accuracy, were evaluated regularly throughout the study. Questions raised and decisions made during this evaluation process were documented in the abstraction instruction document and communicated to all reviewers in a timely manner. In addition, HSAG analysts reviewed the export files from the abstraction tool to ensure the abstraction results were complete, accurate, and consistent.

Study Indicators

Once HSAG's trained reviewers completed the dental record review, HSAG analysts exported information collected from the electronic tool, reviewed the data, and conducted the analyses for each PAHP. The four study indicators used to report the dental record review results included:

- **Dental record omission rate**—the percentage of dates of service identified in the electronic encounter data that were not found in the members' dental records. HSAG also calculated this rate for the dental procedure code.
- **Encounter data omission rate**—the percentage of dental procedure codes from members' dental records that were not found in the electronic encounter data.
- **Accuracy rate of coding**—the percentage of dental procedure codes associated with dates of service from the electronic encounter data that were correctly coded based on the members' dental records.
- **Overall accuracy rate**—the percentage of dates of service with all data element(s) coded correctly among all the validated dates of service from the electronic encounter data.

Description of Data Obtained and Related Time Period

HSAG used data obtained from DHS, including member enrollment and demographic data, provider data, and dental encounter data. The study included dental services rendered between January 1, 2019, and December 31, 2019. Additionally, to be eligible for the dental record review, a member had to be continuously enrolled in the same PAHP during the study period (i.e., between January 1, 2019, and December 31, 2019), and had to have at least one dental visit during the study period. HSAG also used the sampled members' dental records, procured by each PAHP from contracted providers for services that occurred during the study period.